

Sentara CarePlex Hospital Community Health Needs Assessment 2016



Sentara CarePlex Hospital 2016 Community Health Needs Assessment

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I. INTRODUCTION

Sentara CarePlex Hospital has conducted a community health needs assessment of the area that we serve. The assessment provides us with a picture of the health status of the residents in our communities and provides us with information about health and health-related problems that impact health status.

Our assessment includes a review of population characteristics such as age, educational level, and racial and ethnic composition because social factors are important determinants of health. The assessment also looks at risk factors like obesity and smoking and at health indicators such as infant mortality and preventable hospitalizations. Community input is important so the assessment also includes survey results from key stakeholders including public health, social services, service providers, and those who represent underserved populations. The report also includes findings from focus groups with community members on health issues and barriers to achieving good health.

The needs assessment identifies numerous health issues that our communities face. Considering factors such as size and scope of the health problem, the severity and intensity of the problem, the feasibility and effectiveness of possible interventions, health disparities associated with the need, the importance the community places on addressing the need, and consistency with our mission “to improve health every day”, we have identified a number of priority health problems in our area to address in our implementation strategy:

- Aging Well (Senior Care)
- Drug Use
- Access
- Health Literacy/Community Outreach

Our previous Community Health Needs Assessment also identified a number of health issues. An implementation strategy was developed to address these problems. The hospital has tracked progress on the implementation activities in order to evaluate the impact of these actions. The implementation progress report is available in the Appendix.

Sentara CarePlex Hospital works with a number of community partners to address health needs. Information on available resources is available from sources like 2-1-1 Virginia and Sentara.com. Together, we will work to improve the health of the communities we serve.

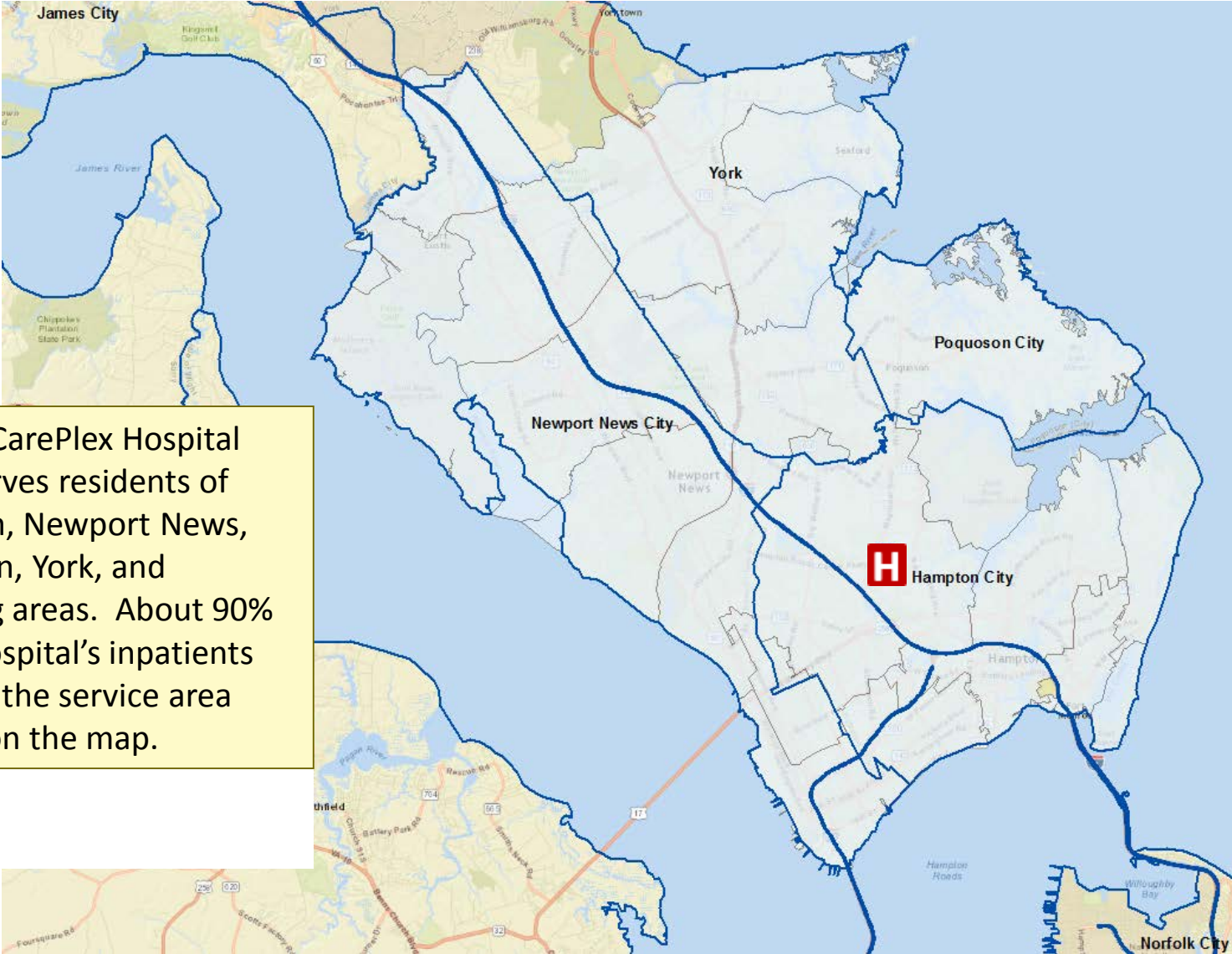
Your input is important to us so that we can incorporate your feedback into our assessments. You may use our online feedback form available on the Sentara.com website. Thanks!

Sentara CarePlex Hospital (SCH) 2016 Community Health Needs Assessment

Community Description

Community Description

Sentara CarePlex Hospital Service Area



Sentara CarePlex Hospital (SCH) serves residents of Hampton, Newport News, Poquoson, York, and adjoining areas. About 90% of the hospital's inpatients reside in the service area shaded on the map.

Key:
 SCH

Area-wide Key Demographic Characteristics

DEMOGRAPHIC CHARACTERISTICS						
	Selected Area		Virginia		USA	
2010 Total Population	380,085		8,001,038		308,745,538	
2016 Total Population	384,846		8,428,339		322,431,073	
2021 Total Population	393,355		8,801,874		334,341,965	
% Change 2016 - 2021	2.2%		4.4%		3.7%	
Median Household Income	\$54,075		\$65,624		\$55,720	
POPULATION DISTRIBUTION						
Age Distribution						
Age Group	2016	% of Total	2021	% of Total	Virginia 2016	USA 2016
0-14	73,552	19.1%	74,016	18.8%	18.5%	19.0%
15-17	14,936	3.9%	15,263	3.9%	3.8%	4.0%
18-24	44,388	11.5%	41,327	10.5%	10.0%	9.8%
25-34	58,296	15.1%	57,983	14.7%	13.6%	13.3%
35-54	94,640	24.6%	94,675	24.1%	26.8%	26.0%
55-64	47,647	12.4%	49,997	12.7%	12.9%	12.8%
65+	51,387	13.4%	60,094	15.3%	14.4%	15.1%
Total	384,846	100.0%	393,355	100.0%	100.0%	100.0%
EDUCATION LEVEL						
Education Level Distribution						
2016 Adult Education Level	Pop Age	% of Total	Virginia 2016	USA		
	25+	% of Total	% of Total	% of Total		
Less than High School	8,024	3.2%	4.8%	5.8%		
Some High School	17,423	6.9%	7.0%	7.8%		
High School Degree	67,423	26.8%	25.0%	27.9%		
Some College/Assoc. Degree	93,099	36.9%	27.3%	29.2%		
Bachelor's Degree or Greater	66,001	26.2%	35.8%	29.4%		
Total	251,970	100.0%	100.0%	100.0%		

- The area's 2016 total population is 384,846 with projected growth of 2.2% over the next five years.
 - This expected rate of growth is less than both the Virginia and U.S rates.
- The median household income (\$54,075) is 18% lower than the state and 3% lower than the US median income.
- Population by age group:
 - 26.6% of this population is aged 18-34, which is a greater percent compared to Virginia (23.6%) and the U.S. (23.1%).
 - The 65+ age cohort (13.4%) is a lower percent compared to Virginia (14.4%) and the U.S (15.1%).
- 10.1% of the population age 25+ has only some high school education or less.
 - This is less than Virginia (11.8%) and the U.S. (13.6%).

Area-wide Key Demographic Characteristics, Cont.

DEMOGRAPHIC CHARACTERISTICS						
				Virginia	USA	
	2016	2021	% Change	% Change	% Change	
Total Male Population	186,904	191,558	2.5%	4.5%	3.8%	
Total Female Population	197,942	201,797	1.9%	4.4%	3.6%	
Females, Child Bearing Age (15-44)	81,233	81,427	0.2%	1.3%	1.5%	
HOUSEHOLD INCOME DISTRIBUTION						
Income Distribution						
2016 Household Income			Virginia	USA		
	HH Count	% of Total	% of Total	% of Total		
<\$15K	17,107	11.3%	9.6%	12.3%		
\$15-25K	15,897	10.5%	8.3%	10.4%		
\$25-50K	38,933	25.7%	20.8%	23.4%		
\$50-75K	30,406	20.1%	17.6%	17.6%		
\$75-100K	19,466	12.9%	12.6%	12.0%		
Over \$100K	29,616	19.6%	31.1%	24.3%		
Total	151,425	100.0%	100.0%	100.0%		
RACE/ETHNICITY						
Race/Ethnicity Distribution						
Race/Ethnicity			Virginia	USA		
	2016 Pop	% of Total	% of Total	% of Total		
White Non-Hispanic	186,370	48.4%	62.5%	61.3%		
Black Non-Hispanic	142,634	37.1%	18.9%	12.3%		
Hispanic	27,743	7.2%	9.2%	17.8%		
Asian & Pacific Is. Non-Hispanic	13,076	3.4%	6.3%	5.4%		
All Others	15,023	3.9%	3.1%	3.1%		
Total	384,846	100.0%	100.0%	100.0%		

- The projected growth of Females, Child Bearing Age (15-44) is 0.2%, much lower than the state (1.3%) and the U.S. (1.5%).
- 21.8% of the population has a household income below \$25,000.
 - This is higher than Virginia (17.9%) and lower than the U.S. (22.7%).
 - 200% of the current Federal Poverty Level for a family of four is \$48,600.
- 7.2% of the population is Hispanic, which is lower than both Virginia (9.2%) and the U.S. (17.8%).
- 37.1% of the population is Black Non-Hispanic, nearly twice the portion of Virginia (18.9%) and over three times the U.S. portion (12.3%).

Key Demographic Data by ZIP Code

City, ZIP Code, & ZIP Name			Population and Age							
			2016 Population	Projected 2016-2021 % Change in Total Pop.	2016 % of Total Pop. that is age 65+	Projected 2016-2021 % Change in Pop. age 65+	2016 % of Total Pop. that is age 0-17	Projected 2016-2021 % Change in Pop. age 0-17	2016 % of Female Pop. that is age 15-44	Projected 2016-2021 % Change in Female Pop. age 15-44
Newport News	23601	Warwick/ Hilton Vill	25,208	1.8%	15.4%	13.6%	22.4%	4.1%	38.3%	-0.3%
Newport News	23602	Denbigh	40,562	2.0%	13.2%	14.8%	24.0%	3.7%	40.7%	-1.7%
Newport News	23603	Lee Hall	3,851	0.7%	5.8%	24.9%	30.0%	1.4%	47.5%	-4.2%
Newport News	23604	Fort Eustis	6,490	11.6%	0.2%	73.3%	25.8%	8.4%	60.3%	5.8%
Newport News	23605	Parkview	13,852	0.2%	13.3%	13.5%	22.3%	3.5%	40.9%	-2.8%
Newport News	23606	Oyster Point	30,623	4.7%	13.0%	15.3%	18.6%	7.7%	48.8%	4.2%
Newport News	23607	East End	24,398	1.0%	12.2%	14.0%	27.2%	1.3%	40.4%	0.2%
Newport News	23608	Patrick Henry	43,852	2.6%	9.8%	22.3%	26.7%	4.2%	44.0%	-1.8%
Hampton	23651	Fort Monroe	623	-3.9%	5.1%	6.3%	31.1%	-0.5%	46.5%	-9.3%
Hampton	23661	Wythe	13,901	0.2%	17.3%	14.8%	21.2%	-0.8%	35.9%	-2.2%
Poquoson	23662	Poquoson	12,095	1.0%	19.1%	16.8%	20.1%	-15.9%	33.8%	2.3%
Hampton	23663	Phoebus	13,948	0.5%	12.8%	15.9%	24.4%	0.0%	40.4%	-0.8%
Hampton	23664	Foxhill / Buckroe	10,413	0.3%	16.7%	17.7%	20.3%	-1.6%	34.3%	-1.3%
York	23665	Langley	5,628	4.3%	0.3%	68.4%	37.4%	1.5%	56.9%	-1.0%
Hampton	23666	Modem /Riverdale	51,232	3.0%	14.2%	17.8%	21.8%	2.7%	40.6%	1.0%
Hampton	23669	Olde Hampton	42,687	1.1%	14.0%	16.3%	21.5%	-0.5%	42.9%	-1.1%
York	23692	Grafton	18,320	2.0%	20.6%	13.8%	19.2%	-9.7%	32.8%	3.9%
York	23693	Tabb	23,603	3.5%	11.7%	31.9%	22.6%	-9.2%	37.0%	3.9%
York	23696	Seaford	3,560	-0.4%	20.2%	9.2%	21.3%	-11.6%	31.1%	6.0%
Total			384,846	2.2%	13.4%	16.9%	23.0%	0.9%	41.0%	0.2%
Virginia			8,428,339	4.4%	14.4%	20.2%	22.3%	2.0%	39.2%	1.3%
United States			322,431,073	3.7%	15.1%	17.6%	23.0%	0.9%	38.7%	1.5%

- The highest projected growth area in the SCH service region is Fort Eustis; Fort Monroe and Seaford are expected to decline over the next 5 years.
- Both the % of total population aged 65+ and the growth rate of this cohort is lower than Virginia and U.S. overall. Fort Eustis and Langley have less than 0.5% of the population in this age range with a high predicted growth rate over the next 5 years.
- The pediatric population is expected to grow at the national rate (0.9%), but 9 ZIP codes are predicted to remain flat or experience declines. 30% or more of the population of Lee Hall and Langley are children.
- The female population of childbearing age (15-44) in this service area is projected to grow by 0.2%, with 11 ZIP codes likely experiencing a decline. More than half the female population in Fort Eustis and Langley fall within this cohort, a much higher percentage than Virginia or the U.S.

Key Demographic Data by ZIP Code

City, ZIP Code, & ZIP Name			Race and Ethnicity			Income and Education	
			2016 % of Pop.: Black, Non-Hispanic	2016 % of Pop.: Asian, Non-Hispanic	2016 % of Pop.: Hispanic Ethnicity (Any Race)	% of Households with Income Below \$25,000	% of Pop age 25+ that did not Graduate from High School
Newport News	23601	Warwick/ Hilton Vill	31.2%	2.1%	5.7%	23.5%	10.3%
Newport News	23602	Denbigh	31.1%	4.6%	9.5%	15.7%	9.5%
Newport News	23603	Lee Hall	31.0%	2.5%	12.1%	19.5%	9.6%
Newport News	23604	Fort Eustis	13.3%	3.5%	14.6%	11.8%	0.4%
Newport News	23605	Parkview	52.3%	1.3%	6.5%	28.8%	15.7%
Newport News	23606	Oyster Point	18.8%	2.5%	10.6%	20.4%	11.3%
Newport News	23607	East End	80.7%	0.5%	3.2%	45.8%	23.0%
Newport News	23608	Patrick Henry	42.5%	4.7%	11.7%	19.5%	9.3%
Hampton	23651	Fort Monroe	14.1%	0.5%	10.8%	7.7%	0.3%
Hampton	23661	Wythe	60.2%	1.7%	4.5%	30.1%	12.9%
Poquoson	23662	Poquoson	1.2%	2.5%	2.7%	11.7%	7.2%
Hampton	23663	Phoebus	48.9%	1.9%	5.9%	27.8%	15.5%
Hampton	23664	Foxhill / Buckroe	21.5%	1.3%	5.6%	14.9%	9.7%
York	23665	Langley	14.6%	2.1%	14.5%	8.4%	1.5%
Hampton	23666	Modern /Riverdale	50.9%	3.3%	5.8%	22.2%	7.6%
Hampton	23669	Olde Hampton	47.3%	2.1%	5.6%	29.1%	10.7%
York	23692	Grafton	5.9%	4.1%	5.0%	10.3%	6.4%
York	23693	Tabb	11.9%	9.2%	5.7%	7.0%	3.6%
York	23696	Seaford	2.0%	1.7%	3.2%	7.0%	5.2%
Total			37.1%	3.2%	7.2%	21.8%	10.1%
Virginia			18.9%	6.3%	9.2%	17.9%	11.8%
United States			12.3%	5.4%	17.8%	22.7%	13.6%

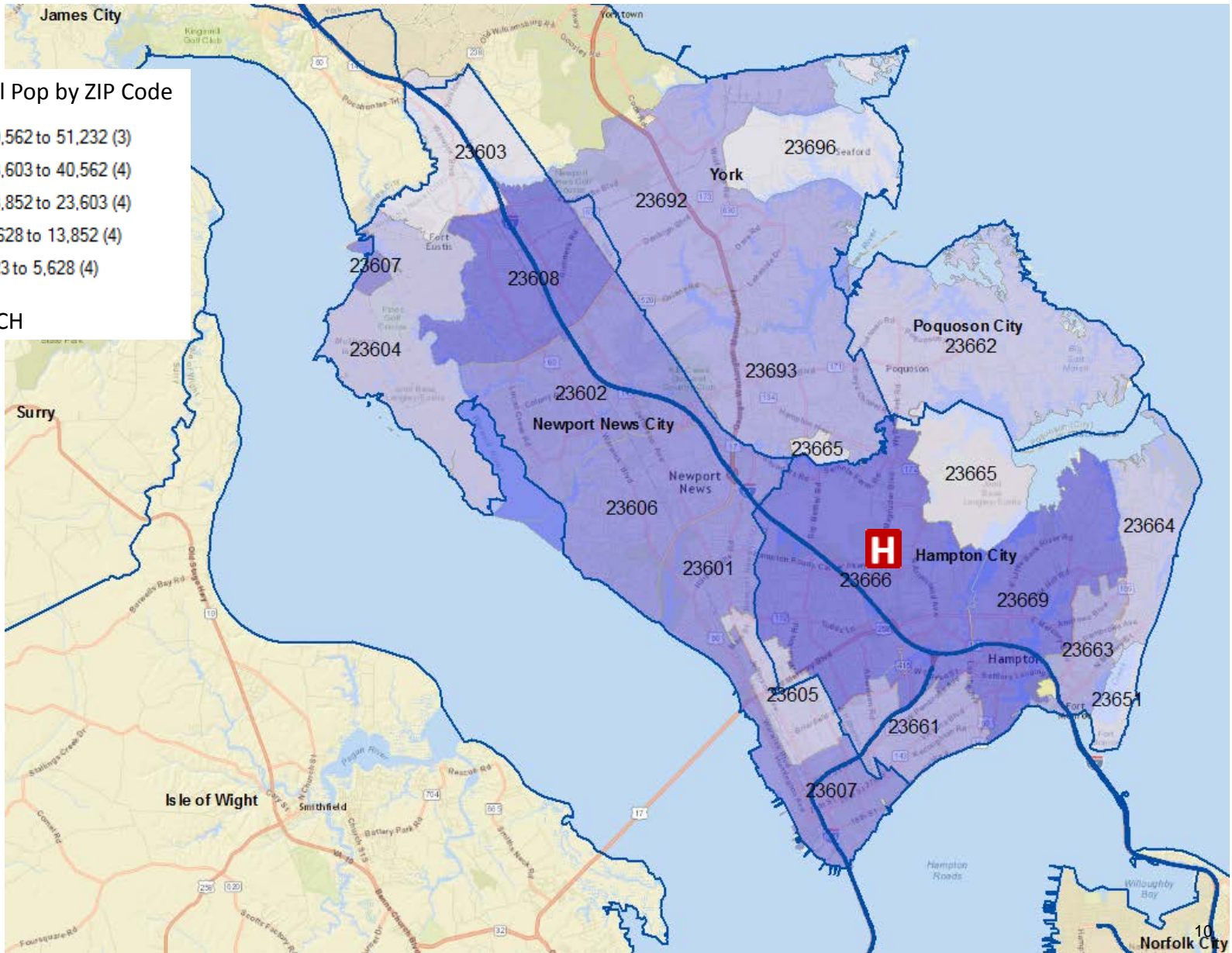
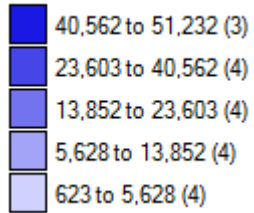
- The SCH service area overall has a larger portion of the population than the state and U.S. that is Black, Non-Hispanic; 4 ZIP codes are greater than 50%.
- All but one ZIP code have a smaller portion of Asian Non-Hispanic population than the state or U.S.
- This area has a 60% smaller proportion of Hispanic population than the U.S. as a whole (7.2% vs 17.8%); 7 ZIP codes have a larger portion of Hispanic population than Virginia.
- 6 ZIP codes in the SCH service area have a higher portion of households with income below \$25K than either Virginia or the U.S.
- 3 ZIP codes in the SCH service area have a higher percent of population age 25+ that did not graduate high school than either Virginia or the U.S.

Key Demographic Data by ZIP Code

City/County	ZIP Code	ZIP Name	Total Pop		% Change 2016-2021	2016 Pop Density / Sq Mile	% of Service Area Pop	% White NonHisp	% Black NonHisp	% Hispanic	% Asian NonHisp	% Other NonHisp
			2016	2021								
Newport News	23601	Warwick/ Hilton Vill	25,208	25,654	1.8%	3324	6.6%	57.2%	31.2%	5.7%	2.1%	3.8%
Newport News	23602	Denbigh	40,562	41,368	2.0%	2678	10.5%	50.0%	31.1%	9.5%	4.6%	4.7%
Newport News	23603	Lee Hall	3,851	3,879	0.7%	530	1.0%	49.6%	31.0%	12.1%	2.5%	4.9%
Newport News	23604	Fort Eustis	6,490	7,241	11.6%	558	1.7%	61.9%	13.3%	14.6%	3.5%	6.8%
Newport News	23605	Parkview	13,852	13,880	0.2%	3819	3.6%	36.3%	52.3%	6.5%	1.3%	3.6%
Newport News	23606	Oyster Point	30,623	32,077	4.7%	2958	8.0%	65.2%	18.8%	10.6%	2.5%	3.0%
Newport News	23607	East End	24,398	24,633	1.0%	3628	6.3%	12.2%	80.7%	3.2%	0.5%	3.4%
Newport News	23608	Patrick Henry	43,852	44,983	2.6%	4117	11.4%	36.0%	42.5%	11.7%	4.7%	5.0%
Hampton	23651	Fort Monroe	623	599	-3.9%	382	0.2%	70.3%	14.1%	10.8%	0.5%	4.3%
Hampton	23661	Wythe	13,901	13,926	0.2%	2853	3.6%	29.7%	60.2%	4.5%	1.7%	3.9%
Poquoson	23662	Poquoson	12,095	12,215	1.0%	700	3.1%	91.5%	1.2%	2.7%	2.5%	2.2%
Hampton	23663	Phoebus	13,948	14,014	0.5%	4330	3.6%	39.1%	48.9%	5.9%	1.9%	4.2%
Hampton	23664	Foxhill / Buckroe	10,413	10,443	0.3%	1783	2.7%	67.9%	21.5%	5.6%	1.3%	3.6%
York	23665	Langley	5,628	5,868	4.3%	820	1.5%	61.7%	14.6%	14.5%	2.1%	7.1%
Hampton	23666	Modern /Riverdale	51,232	52,763	3.0%	2506	13.3%	35.7%	50.9%	5.8%	3.3%	4.2%
Hampton	23669	Olde Hampton	42,687	43,138	1.1%	3217	11.1%	41.0%	47.3%	5.6%	2.1%	3.9%
York	23692	Grafton	18,320	18,688	2.0%	804	4.8%	82.4%	5.9%	5.0%	4.1%	2.7%
York	23693	Tabb	23,603	24,439	3.5%	1810	6.1%	68.7%	11.9%	5.7%	9.2%	4.5%
York	23696	Seaford	3,560	3,547	-0.4%	508	0.9%	91.5%	2.0%	3.2%	1.7%	1.6%
Total SCH Service Area			384,846	393,355	2.2%	2032	100.0%	48.4%	37.1%	7.2%	3.2%	4.1%
Virginia			8,428,339	8,801,874	4.4%	213.8		62.5%	18.9%	6.3%	9.2%	3.1%
USA			322,431,073	334,341,965	3.7%	91.4		61.3%	12.3%	5.4%	17.8%	3.1%

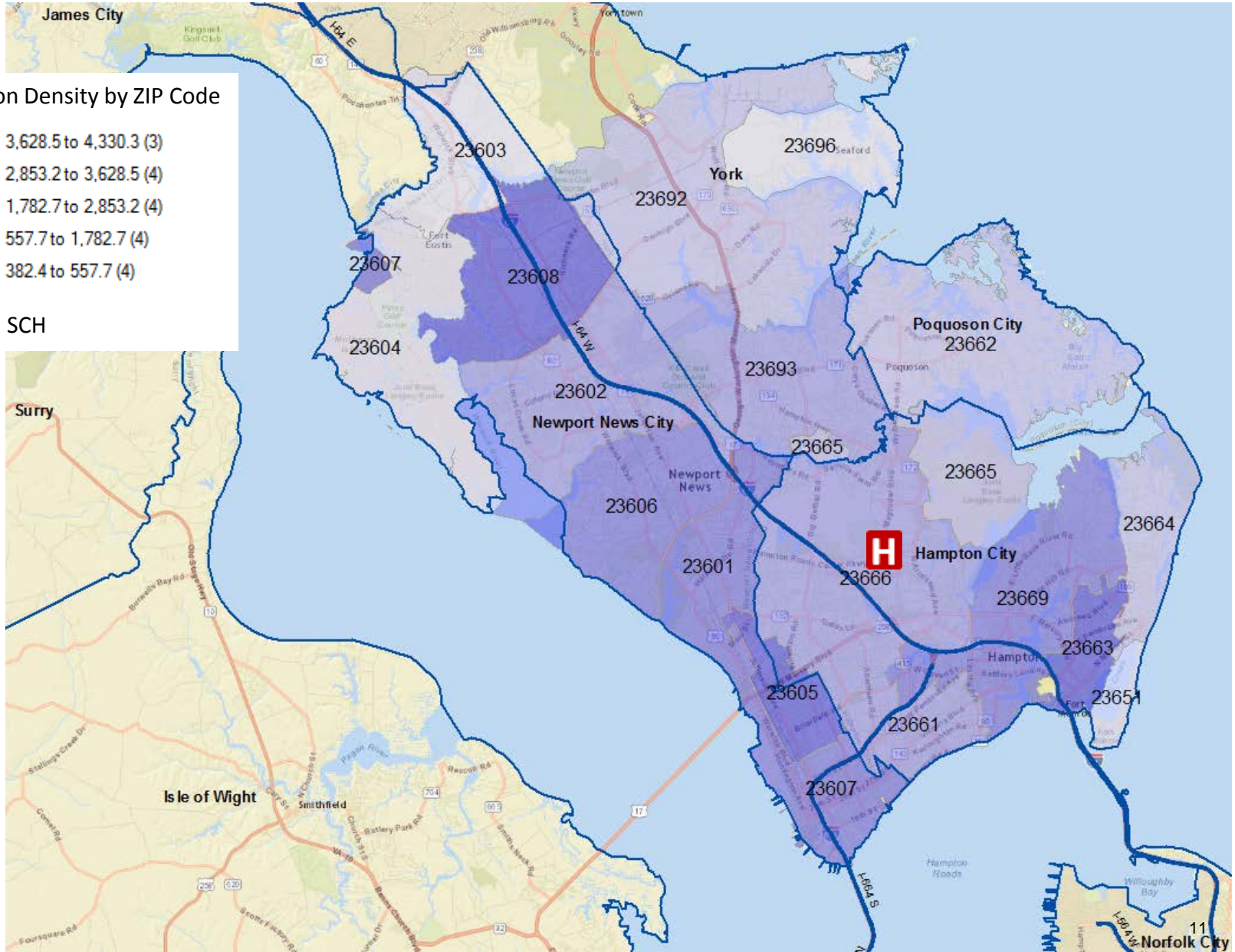
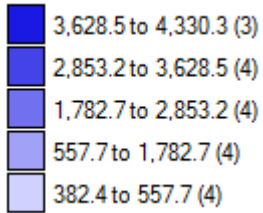
2016 Total Population by ZIP Code

2016 Total Pop by ZIP Code



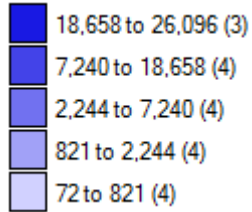
2016 Population Density by ZIP Code

Population Density by ZIP Code

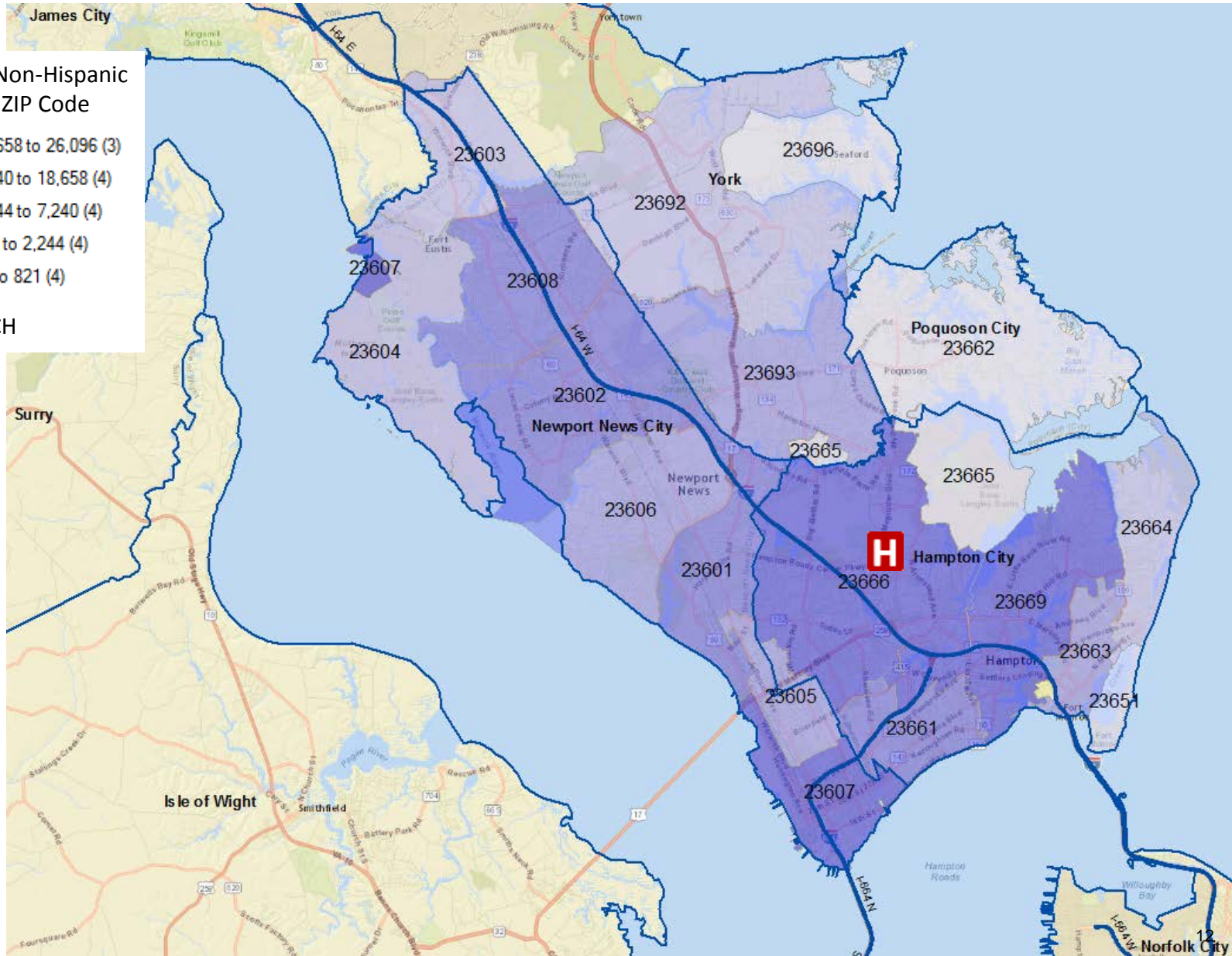


2016 Black, Non-Hispanic Population by ZIP Code

Black, Non-Hispanic Pop by ZIP Code

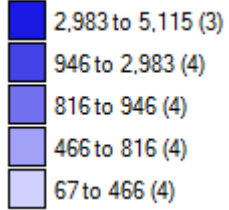


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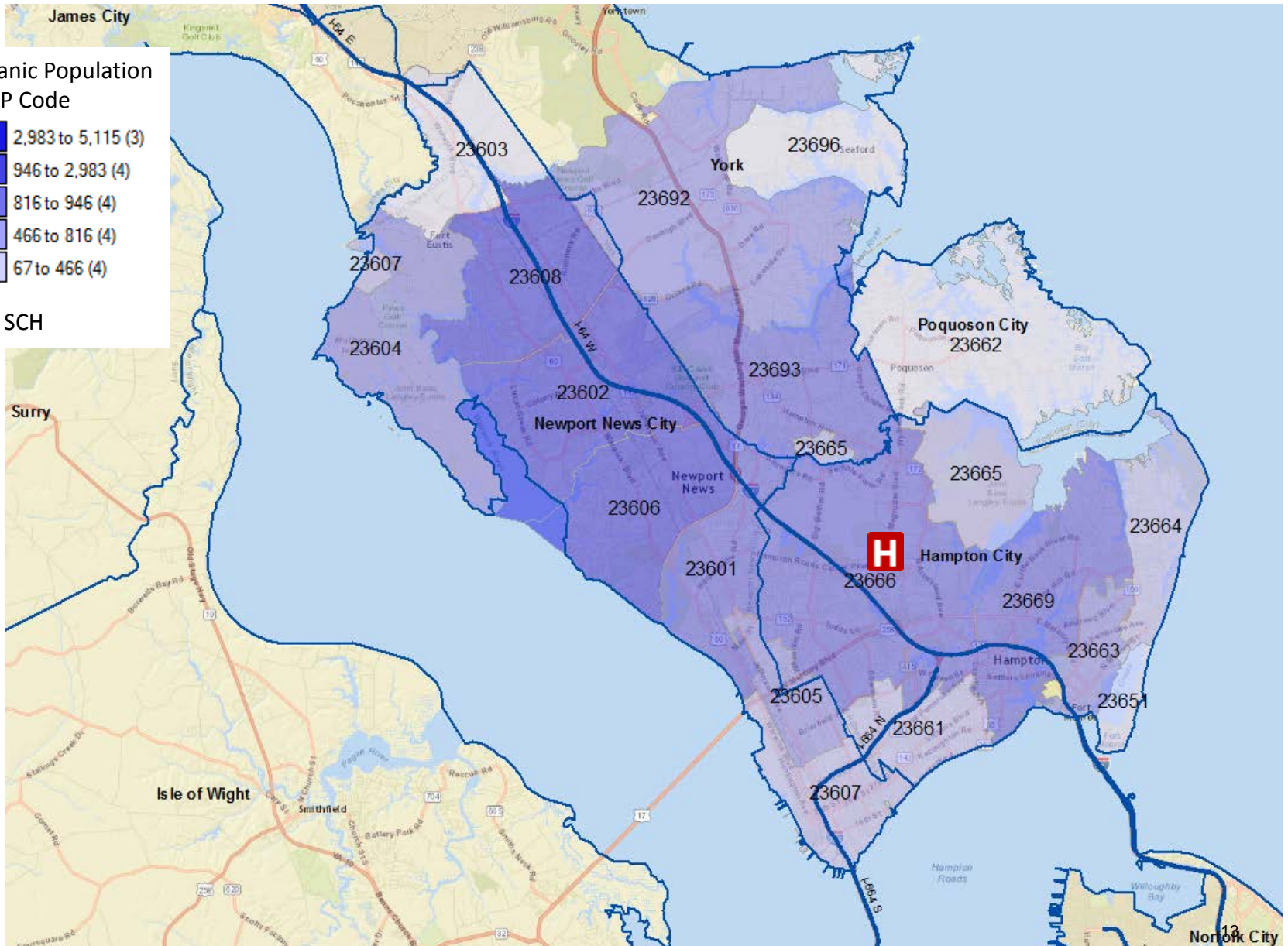


2016 Hispanic Population by ZIP Code

Hispanic Population
by ZIP Code



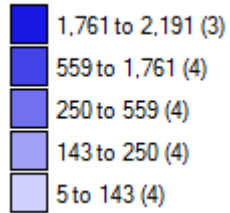
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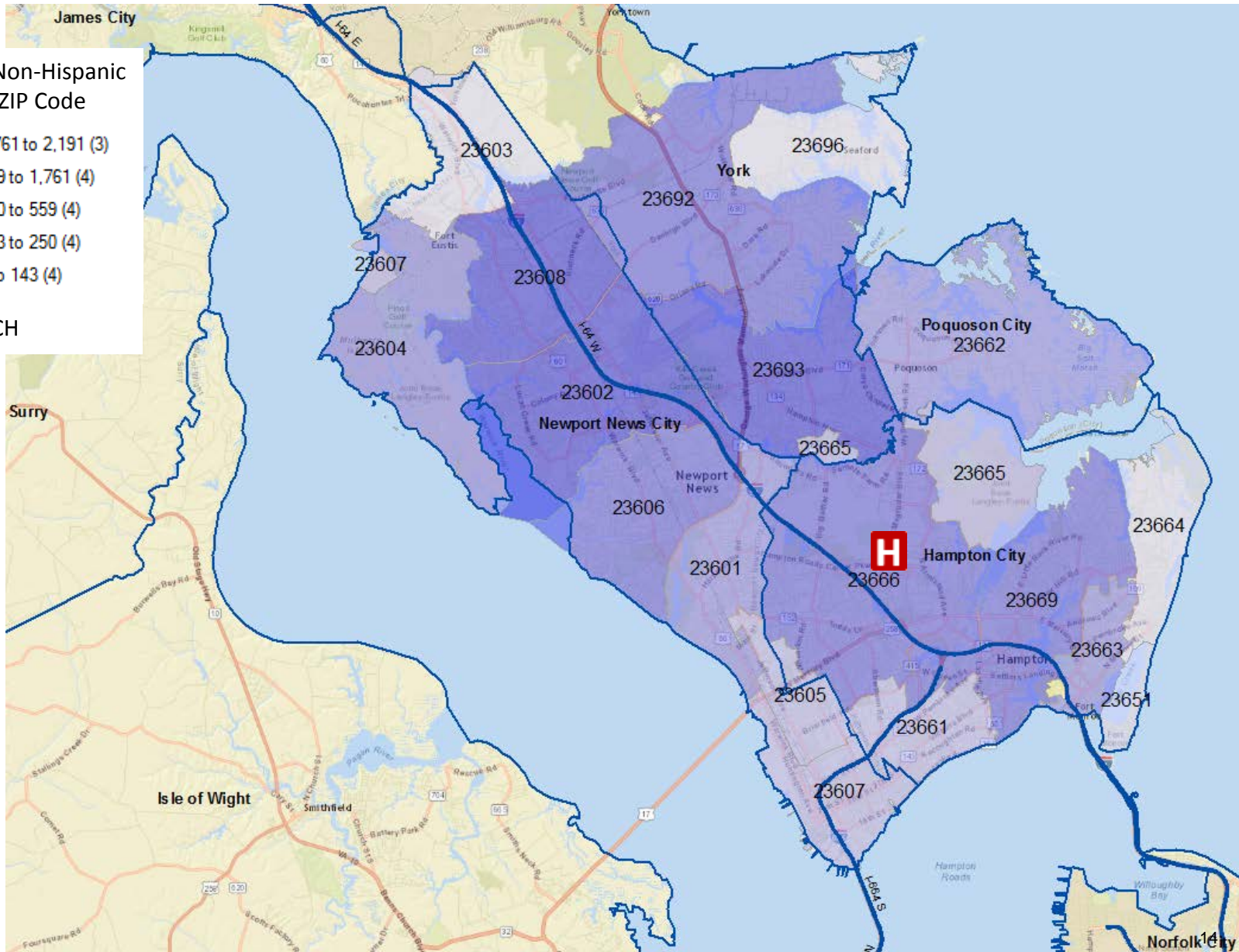
Source: Truven/Market Expert

2016 Asian, Non-Hispanic Population by ZIP Code

Asian, Non-Hispanic Pop by ZIP Code

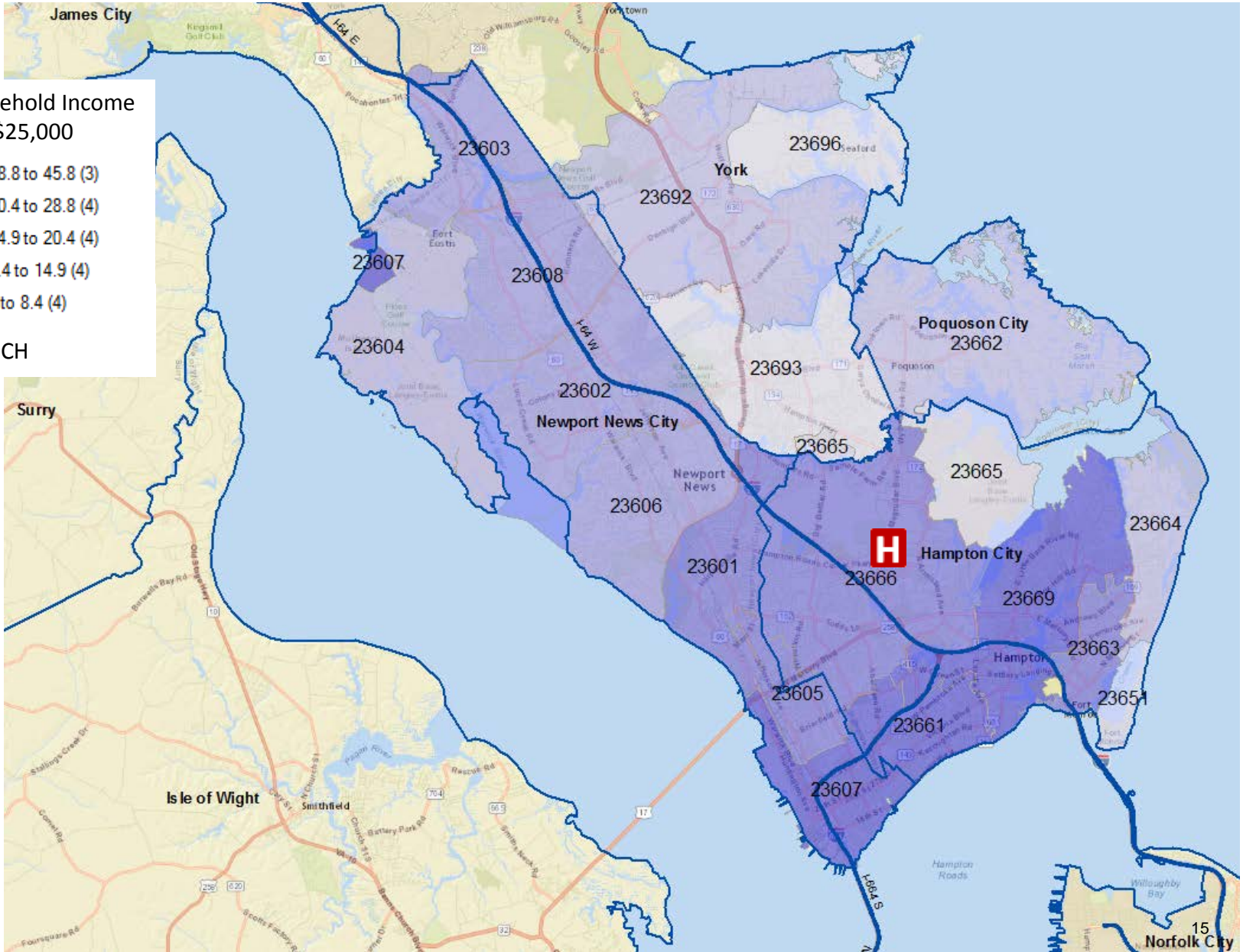
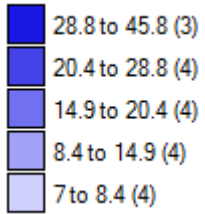


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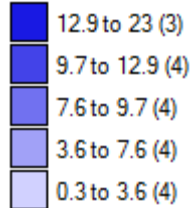
2016 % of Households with Income below \$25,000

% Household Income below \$25,000

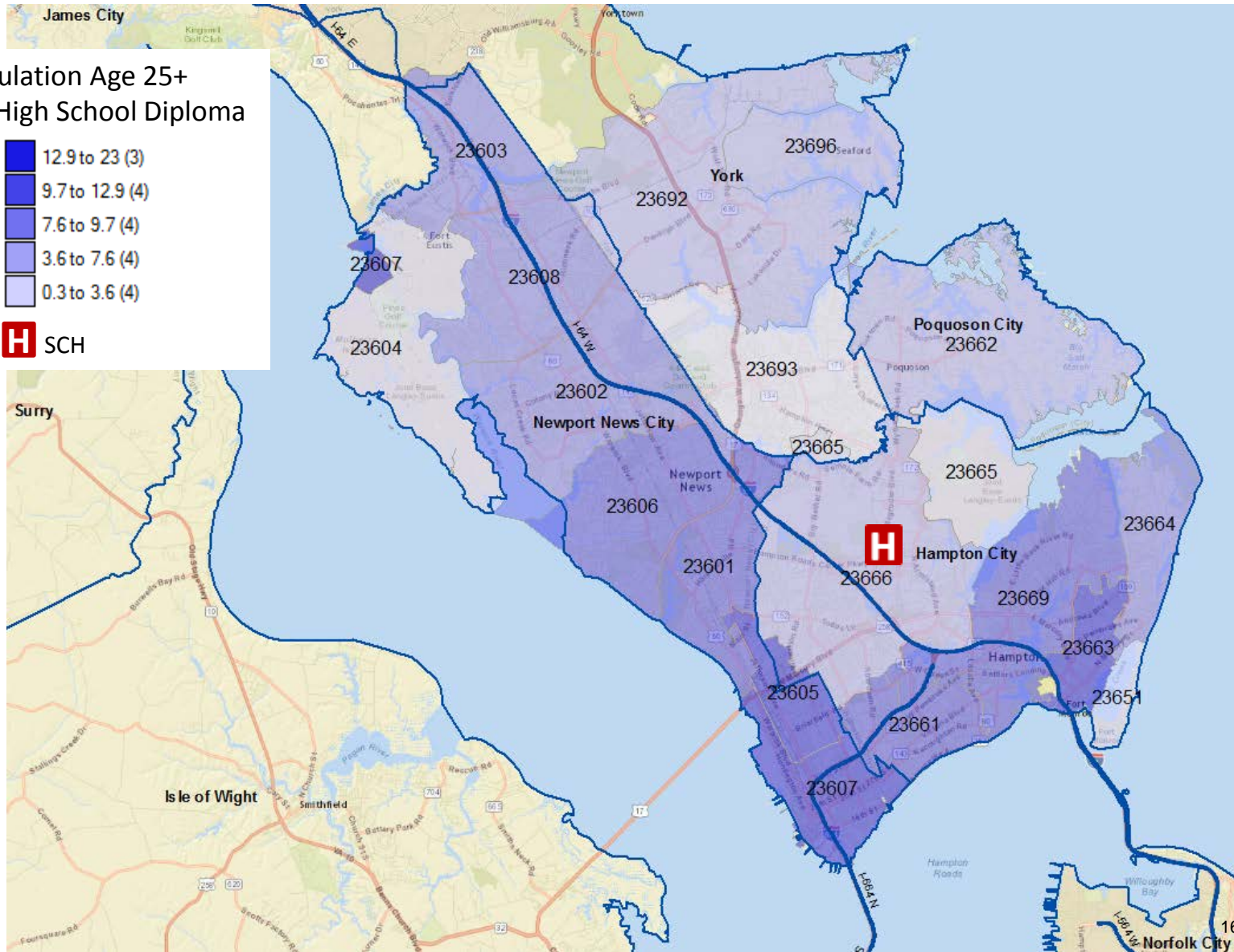


2016 % of Population Age 25+ without a High School Diploma

% of Population Age 25+ without High School Diploma



SCH



Source: Truven/Market Expert

ZIP Codes Included in SCH Service Area

City	ZIP	ZIP Common Name	State
Newport News	23601	Warwick/ Hilton Vill	VA
Newport News	23602	Denbigh	VA
Newport News	23603	Lee Hall	VA
Newport News	23604	Fort Eustis	VA
Newport News	23605	Parkview	VA
Newport News	23606	Oyster Point	VA
Newport News	23607	East End	VA
Newport News	23608	Patrick Henry	VA
Hampton	23651	Fort Monroe	VA
Hampton	23661	Wythe	VA
Poquoson	23662	Poquoson	VA
Hampton	23663	Phoebus	VA
Hampton	23664	Foxhill / Buckroe	VA
York	23665	Langley	VA
Hampton	23666	Modern /Riverdale	VA
Hampton	23669	Olde Hampton	VA
York	23692	Grafton	VA
York	23693	Tabb	VA
York	23696	Seaford	VA

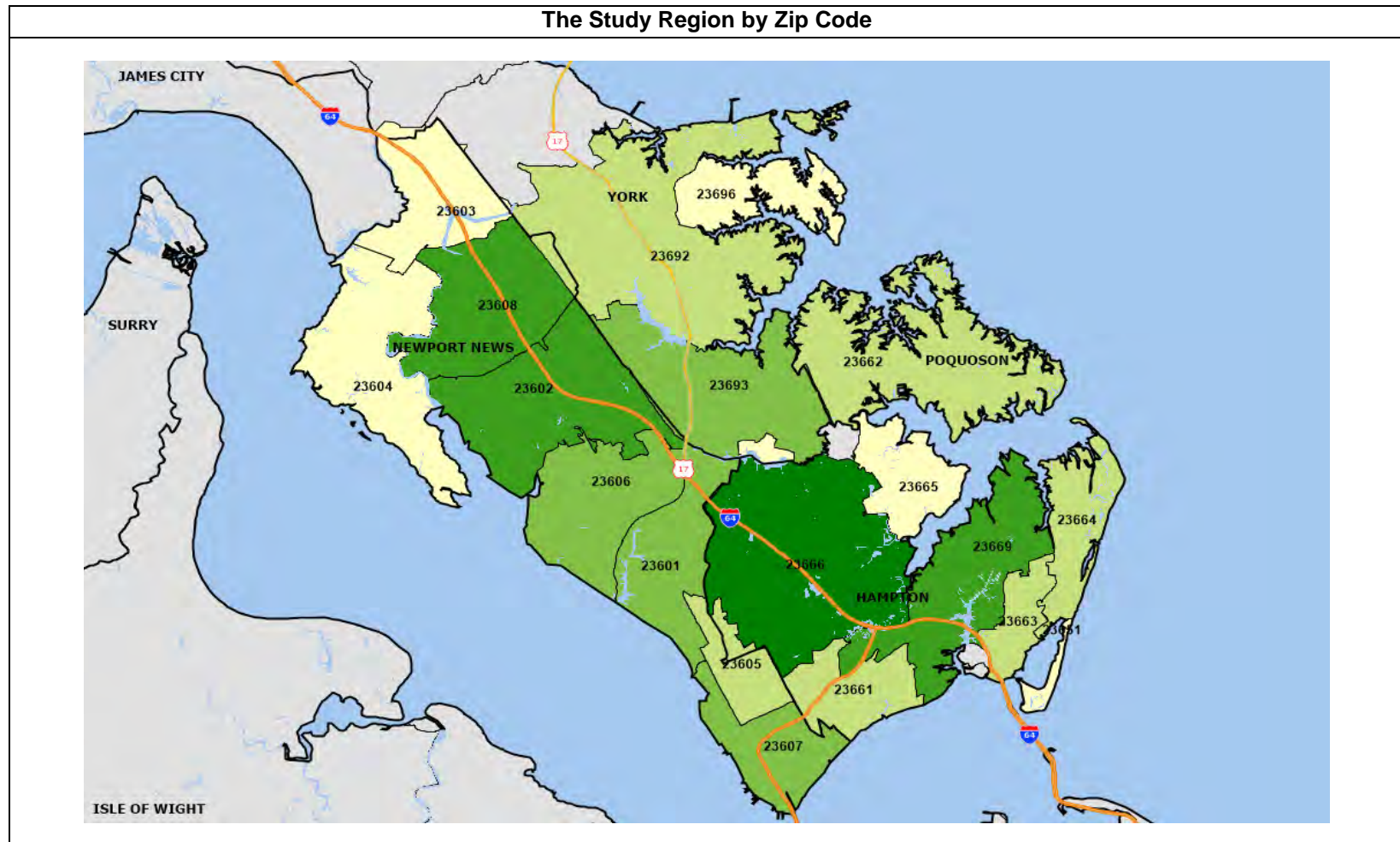
Health Status Indicators Report
Prepared for Sentara CarePlex Hospital
By Community Health Solutions
October 2016

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Introduction

This document presents a health status indicators report for Sentara CarePlex Hospital. The report was commissioned by Sentara Healthcare and Sentara CarePlex Hospital, and produced by Community Health Solutions. The study presents health status indicators for the Sentara CarePlex Hospital service area of 19 zip codes, which fall within the cities of Hampton, Newport News, and Poquoson; and York County.



The study draws upon multiple data sources to present seven health indicator profiles in the following categories:

1. Mortality Profile
2. Maternal and Infant Health Profile
3. Preventable Hospitalization Profile
4. Behavioral Health Hospitalization Profile
5. Adult Health Risk Factor Profile
6. Youth Health Risk Factor Profile
7. Uninsured Profile

The profiles are presented in order in the following pages. Following the profiles, *Appendix A* presents a set of Zip Code-Level maps of selected indicators. *Appendix B* provides detail on the methods used to produce the indicators.

Study Approach

This document contains a wide array of community health indicators from multiple sources. By design, the profiles do not include every possible indicator of community health. The profiles are focused on a core set of indicators that provide broad insight into community health, and for which there were readily available data sources. The results of this profile can be used to evaluate community health status compared to the Commonwealth of Virginia overall. The results can also be helpful for determining the number of people affected by specific health concerns. The analysis objectives for this study included the following:

- Provide a snapshot analysis (for the most current year of data) for each indicator profile.
- Provide a trend analysis (for the 2011-2013 timeframe) of selected indicators as requested by Sentara Healthcare.
- Provide both counts and rates (where available) for all indicators. *Counts* refer to the number of cases of a particular health condition, such as the number of newborns with low birth weight. *Rates* refer to the number of cases per capita, such as the percent of all newborns with low birth weight. Counts are helpful for understanding the magnitude of need within a region, while rates are helpful for comparing health indicators across geographies with different population sizes (i.e. the study region vs. Virginia statewide).
- For the snapshot indicators, identify where the study region rates were better or worse (higher or lower, depending on the indicator), than the state rate. For this report, a study region rate within one percent of the state rate is considered comparable (no difference).
- For the trend indicators, identify where the study region trend differs from the state trend. For this report, a percent change of one percent is considered relatively stable (no change).
- This analysis was conducted at the zip code level. There are indicators (e.g. pregnancy indicators) and rate-calculation models (age adjustment) that are not available at this geographic level.

1. Mortality Profile

This profile presents indicators of death counts and rates for the local area compared to Virginia. The indicators are based on analysis of death record data provided by the Virginia Department of Health, and demographic data from Alteryx, Inc. (see *Appendix B* for details on methods.)

Mortality Snapshot (2013)

As shown in *Exhibit 1A*:

- In 2013 there were 2,954 deaths in the study region.
- The leading causes of death in the study region were Malignant Neoplasms (cancer), Heart Disease, Chronic Lower Respiratory Diseases, Cerebrovascular Diseases (stroke), and Unintentional Injury.
- The death rates for the study region were higher (worse) than the state rates for all deaths combined; and specifically for Malignant Neoplasms (cancer); Diabetes; Alzheimer's Disease; Septicemia; Primary Hypertension and Renal Disease; and Parkinson's Disease.

Mortality Trend – All Deaths (2011-2013)

- **Trend by Cause:** As shown in *Exhibit 1B*, from 2011 to 2013, the study region rates:
 - Increased for Chronic Lower Respiratory Diseases, Diabetes, Nephritis and Nephrosis, Septicemia, Alzheimer's Disease, and Influenza and Pneumonia;
 - Declined for Heart Disease, Cerebrovascular Diseases (stroke), and Unintentional Injury; and
 - Remained relatively stable for all deaths combined, and Malignant Neoplasms (cancer).
 - Unlike the state, the study region rates increased for Chronic Lower Respiratory Diseases, Diabetes, Alzheimer's Disease, and Influenza and Pneumonia.
 - Unlike the state, the study region rates declined for Heart Disease and Unintentional Injury.
 - Unlike the state, the study region rates remained relatively stable for all deaths combined.
- **Trend by Race/Ethnicity:** As shown in *Exhibit 1C*, from 2011 to 2013, study region counts increased for the Black/African American population and remained relatively stable for the White population. The study region trends were consistent with the statewide trends.
- **Trend by Sex:** As shown in *Exhibit 1D*, from 2011 to 2013, study region counts increased for the both the female and male populations. The study region trends were consistent with the statewide trends.

Premature Death Trends (2011-2013)

- **Definition:** Consistent with conventions in the field, premature mortality can be defined as deaths that occur before age 75.
- **Leading Causes:** As shown in *Exhibit 1E*, over the 2011 to 2013 time period, there were 1,423 premature deaths in 2013. Roughly 48% of all deaths in the study region, and 45% of deaths in Virginia statewide could be classified as premature deaths.
- **Trend by Cause:** As shown in *Exhibit 1E*, from 2011-2013, study region premature death counts:
 - Increased for all premature deaths combined, and specifically for Malignant Neoplasms (cancer), Diabetes and Suicide;

- Declined for Heart Disease, Cerebrovascular Diseases (stroke), and Chronic Lower Respiratory Diseases; and
 - Remained stable for Unintentional Injury.
 - Unlike the state, the study region counts increased for Malignant Neoplasms (cancer), Diabetes and Suicide.
 - Unlike the state, the study region counts declined for Heart Disease, Cerebrovascular Diseases (stroke) and Chronic Lower Respiratory Diseases.
 - Unlike the state, the study region counts remained relatively stable for Unintentional Injury.
- **Trend by Race/Ethnicity:** As shown in *Exhibit 1F*, from 2011 to 2013, the study region premature death counts:
 - Increased for the Black/African American population; and
 - Remained relatively stable for the White population.
 - Unlike the state, the study region counts remained relatively stable for the White population.
- **Trend by Sex:** As shown in *Exhibit 1G*, from 2011 to 2013, the study region premature death counts increased for both the female and male populations. The study region trends were consistent with the statewide trends.

Exhibit 1A. Mortality Snapshot (2013)

Indicator	Virginia	Study Region
Counts		
Deaths by All Causes	62,309	2,954
Counts-Leading 14 Causes of Death		
Malignant Neoplasms, Deaths	14,348	701
Heart Disease, Deaths	13,543	565
Chronic Lower Respiratory Diseases, Deaths	3,168	137
Cerebrovascular Diseases, Deaths	3,278	135
Unintentional Injury, Deaths	2,794	116
Diabetes Mellitus, Deaths	1,618	104
Alzheimer's Disease, Deaths	1,634	84
Septicemia, Deaths	1,464	73
Nephritis and Nephrosis, Deaths	1,547	72
Influenza and Pneumonia, Deaths	1,430	61
Primary Hypertension and Renal Disease, Deaths	629	45
Suicide, Deaths	1,047	42
Chronic Liver Disease, Deaths	836	35
Parkinson's Disease, Deaths	549	30
Crude Death Rates per 100,000 Population		
Deaths by All Causes	755.5	775.0
Malignant Neoplasms, Deaths	174.0	183.9
Heart Disease, Deaths	164.2	148.2
Chronic Lower Respiratory Diseases, Deaths	38.4	35.9
Cerebrovascular Diseases, Deaths	39.7	35.4
Unintentional Injury, Deaths	33.9	30.4
Diabetes Mellitus, Deaths	19.6	27.3
Alzheimer's Disease, Deaths	19.8	22.0
Septicemia, Deaths	17.8	19.2
Nephritis and Nephrosis, Deaths	18.8	18.9
Influenza and Pneumonia, Deaths	17.3	16.0
Primary Hypertension and Renal Disease, Deaths	7.6	11.8
Suicide, Deaths	12.7	11.0
Chronic Liver Disease, Deaths	10.1	9.2
Parkinson's Disease, Deaths	6.7	7.9
<i>Note: Rates and/or percent change are not calculated where n<30.</i>		
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>		

Exhibit 1B. Mortality Trend (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
All Deaths (Leading 10 Causes)					
Total Deaths (All Causes)	2,863	2,938	2,954	3%	3%
Malignant Neoplasms (Cancer)	685	678	701	1%	2%
Heart Disease	637	594	565	3%	-11%
Cerebrovascular Disease (Stroke)	171	142	135	-1%	-21%
Chronic Lower Respiratory Diseases	131	135	137	2%	5%
Unintentional Injury	118	81	116	2%	-2%
Diabetes Mellitus	98	117	104	-1%	6%
Nephritis and Nephrosis	68	70	72	9%	6%
Septicemia	68	63	73	7%	7%
Alzheimer's Disease	56	81	84	-9%	50%
Influenza and Pneumonia	40	50	61	2%	53%
Crude Death Rates per 100,000 Population					
Total Deaths (All Causes)	767.2	769.2	775.0	2%	1%
Malignant Neoplasms (Cancer)	183.6	177.5	183.9	-1%	0%
Heart Disease	170.7	155.5	148.2	1%	-13%
Cerebrovascular Disease (Stroke)	45.8	37.2	35.4	-3%	-23%
Chronic Lower Respiratory Diseases	35.1	35.3	35.9	1%	2%
Unintentional Injury	31.6	21.2	30.4	1%	-4%
Diabetes Mellitus	26.3	30.6	27.3	-2%	4%
Nephritis and Nephrosis	18.2	18.3	18.9	7%	4%
Septicemia	18.2	16.5	19.2	5%	5%
Alzheimer's Disease	15.0	21.2	22.0	-10%	47%
Influenza and Pneumonia	10.7	13.1	16.0	0%	49%
<i>Note: Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>					
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>					

Exhibit 1C. All Deaths Trend by Race/Ethnicity (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
Asian	33	52	58	15%	--
Black/African American	1,053	1,064	1,109	4%	5%
White	1,767	1,817	1,766	1%	0%
Hispanic Ethnicity	33	44	40	8%	--
<i>Notes: Deaths with Other/Unknown race were not included in the analysis. Hispanic is a classification of ethnicity; therefore, Hispanic individuals are also included in the race categories. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>					
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>					

Exhibit 1D. All Deaths Trend by Sex (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
Female	1,447	1,463	1,501	3%	4%
Male	1,416	1,475	1,453	4%	3%
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>					

Exhibit 1E. Leading Causes – Premature Deaths Trend (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
Premature Deaths (Leading 10 Causes)					
Total Premature Deaths (All Causes)	1,349	1,402	1,423	4%	5%
Malignant Neoplasms	376	411	428	0%	14%
Heart Disease	270	235	249	6%	-8%
Unintentional Injury	88	61	88	-2%	0%
Diabetes	58	76	60	-1%	3%
Cerebrovascular Diseases	56	50	49	5%	-13%
Chronic Lower Respiratory Diseases	53	56	44	1%	-17%
Suicide	34	44	38	0%	12%
Nephritis and Nephrosis	32	27	29	16%	--
Septicemia	28	20	40	11%	--
Chronic Liver Disease	24	44	29	21%	--
<i>Note: Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>					
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>					

Exhibit 1F. Premature Mortality Trend by Race/Ethnicity (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
Asian	19	34	32	3%	--
Black/African American	616	621	668	3%	8%
White	708	743	706	2%	0%
Hispanic Ethnicity	21	26	24	0%	--
<i>Notes: Deaths with Other/Unknown race were not included in the analysis. Hispanic is a classification of ethnicity; therefore, Hispanic individuals are also included in the race categories. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>					
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>					

Exhibit 1G. Premature Mortality Trend by Sex (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
Female	557	570	593	3%	6%
Male	792	832	830	4%	5%
<i>Notes: Deaths with Other/Unknown sex were not included in the analysis. For this report, a percent change of one percent is considered relatively stable (no change).</i>					
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>					

2. Maternal and Infant Health Profile

This profile presents indicators of maternal and infant health for the local area compared to Virginia. The indicators are based on analysis of birth record data provided by the Virginia Department of Health, and demographic data from Alteryx, Inc. (see *Appendix B* for details on methods.)

Maternal and Infant Health Snapshot (2013)

- As shown in *Exhibit 2A*, in 2013 there were 5,221 live births in the study region. Among the live births were 466 low weight births, 505 late prenatal care births, 2,369 non-marital births, and 343 births to teens.
- The study region had a higher birth rate overall, and had higher rates (worse) than Virginia as a whole for non-marital births, births to teens overall, and births to teens age 15-19.

Maternal and Infant Health Trend (2011-2013)

- **Select Birth Indicators.** As shown in *Exhibit 2B*, from 2011 to 2013, the study region rates/percentages declined for live births overall, and remained relatively stable for low weight and non-marital births. The study region trends were consistent with the statewide trends.
- **Teenage Births Trend by Age Group.** As shown in *Exhibit 2C*, from 2011 to 2013, the study region counts declined for all births to teens of all age groups. The study region trends were consistent with the statewide trends.
- **Teenage Births Trend Race/Ethnicity.** As shown in *Exhibit 2D*, from 2011 to 2013, the study region counts declined for teens of all racial/ethnic groups. The study region trends were consistent with the statewide trends.

Exhibit 2A. Maternal and Infant Health Snapshot (2013)

Indicator	Virginia	Study Region
Counts		
Total Live Births	101,977	5,221
Low Weight Births (under 2,500 grams / 5 lb. 8 oz.)	8,178	466
Late Prenatal Care (No Prenatal Care in First 13 Weeks)	13,435	505
Non-Marital Births	35,289	2,369
Live Births to Teens Age 10-19	5,316	343
Live Births to Teens Age 18-19	4,073	277
Live Births to Teens Age 15-17	1,208	66
Live Births to Teens Age <15	35	0
Rates		
Live Birth Rate per 1,000 Population	12.3	13.7
Low Weight Births pct. of Total Live Births	8%	9%
Late Prenatal Care (No Prenatal Care in First 13 Weeks) pct. of Total Live Births	13%	10%
Non-Marital Births pct. of Total Live Births	35%	45%
Teenage (age 10-19) Live Birth Rate per 1,000 Teenage Female Population (age 10-19)	10.3	13.3
Teenage (age 18-19) Live Birth Rate per 1,000 Teenage Female Population (age 18-19)	36.4	45.8
Teenage (age 15-17) Live Birth Rate per 1,000 Teenage Female Population (age 15-17)	8.0	8.6
Teenage (age <15) Live Birth Rate per 1,000 Teenage Female Population (age <15)	0.1	0.0
<i>Source: Community Health Solutions analysis of birth record data from the Virginia Department of Health. See details in methods in Appendix B.</i>		

Exhibit 2B. Select Birth Indicators Trend (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
Total Live Births	5,326	5,272	5,221	-1%	-2%
Low Weight Births	449	486	466	0%	4%
Non-Marital Births	2,432	2,420	2,369	-3%	-3%
Rates	2011	2012	2013	Virginia	Study Region
Total Live Births (per 1,000 population)	14.3	13.8	13.7	-3%	-4%
Low Weight (as a percent of Total Live Births)	8%	9%	9%	0%	0%
Non-Marital Births (as a percent of Total Live Births)	46%	46%	45%	-1%	0%

Note: Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).
Source: Community Health Solutions analysis of birth record data from the Virginia Department of Health. See details in methods in Appendix B.

Exhibit 2C. Teenage Births Trend by Age Group (2011-2013)

Indicator	Study Region			% Change (2011-2013)		
	2011	2012	2013	Virginia	Study Region	
Counts						
Teenage (Age 10-19) Live Births						
Age	Total Teenage Live Births	432	407	343	-19%	-21%
	18-19	322	299	277	-15%	-14%
	15-17	103	105	66	-29%	-36%
	<15	7	3	0	-39%	--

Note: Rates and/or percent change are not calculated where n<30. Births with Other/Unknown age were not included in the analysis. For this report, a percent change of one percent is considered relatively stable (no change).
Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.

Exhibit 2D. Teenage Births Trend by Race/Ethnicity (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
		2011	2012	2013	Virginia	Study Region
Teenage (Age 10-19) Live Births						
Race	Black/African American	270	244	216	-23%	-20%
	White	134	124	90	-26%	-33%
Ethnicity	Hispanic Ethnicity	30	31	25	-5%	--
<i>Note: Rates and/or percent change are not calculated where n<30. Births with Other/Unknown race were not included in the analysis. Hispanic is classification of ethnicity; therefore, Hispanic individuals are also included in the race categories. For this report, a percent change of one percent is considered relatively stable (no change).</i>						
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>						

3. Preventable Hospitalization Profile

The Agency for Healthcare Research and Quality (AHRQ) defines a set of conditions (called Prevention Quality Indicators, or 'PQIs') for which hospitalization should be avoidable with proper outpatient health care. This profile presents indicators of preventable hospitalizations based on PQI definitions for the study region compared to Virginia. High rates of hospitalization for these conditions indicate potential gaps in access to quality outpatient services for community residents. The indicators are based on analysis of hospital discharge data provided by the Virginia Health Information (VHI), and demographic data from Alteryx, Inc. (see *Appendix B* for details on methods.) The analysis includes records of discharges of Virginia residents from Virginia hospitals excluding state and federal facilities.

Preventable Hospitalization Snapshot (2013)

As shown in *Exhibit 3A*:

- In 2013, there were 2,578 PQI hospital discharges from Virginia hospitals for residents of the study region.
- The leading PQI diagnoses in the study region were Congestive Heart Failure, COPD or Asthma in Older Adults (age 40+), Diabetes, Bacterial Pneumonia, and Dehydration.
- The study region discharge rate was higher than the statewide rate for Asthma in Younger Adults (age 18-39).

Preventable Hospitalization Trend (2011-2013)

- **By Leading Diagnoses.** As shown in *Exhibit 3B*, from 2011 to 2013, the study region rates:
 - Increased for Congestive Heart Failure;
 - Declined for COPD or Asthma in Older Adults (age 40+), Bacterial Pneumonia, Diabetes, and Urinary Tract Infection; and
 - Remained relatively stable for Total PQIs.
 - Unlike the state, the study region rate increased for Congestive Heart Failure.
 - Unlike the state, the study region rate declined for Diabetes.
 - Unlike the state, the study region rate remained relatively stable for Total PQIs.
- **By Age Group.** As shown in *Exhibit 3C*, from 2011 to 2013, the study region rates:
 - Increased for age 18-29 population;
 - Remained relatively stable for the age 30-44 population; and
 - Declined for the 45+ population.
 - Unlike the state, the study region rates increased for the age 18-29 population.
- **By Race/Ethnicity.** As shown in *Exhibit 3D*, from 2011 to 2013, the study region rates:
 - Increased for the Black/African American population; and
 - Declined for the White population.
 - Unlike the state, the study region rate increased for the Black/African American population.
- **By Payer.** As shown in *Exhibit 3E*, from 2011 to 2013, study region counts increased for all payer groups. Unlike the state, the study region counts increased for the Medicaid and Private payer populations.

Exhibit 3A. Preventable Hospitalization Snapshot (2013)

Indicator	Virginia	Study Region
Counts		
Total PQI Discharges (see note)	76,860	2,578
Congestive Heart Failure	18,239	781
COPD or Asthma In Older Adults (age 40+)	16,026	438
Diabetes	9,938	368
Bacterial Pneumonia	11,867	325
Dehydration	7,743	256
Urinary Tract Infection	8,452	209
Hypertension	2,768	115
Asthma in Younger Adults (age 18-39)	444	41
Perforated Appendix	1,189	36
Angina	941	13
Crude Rates per 100,000 Population		
Total PQI Discharges (see note)	932.0	676.4
Congestive Heart Failure	221.2	204.9
COPD or Asthma In Older Adults (age 40+)	194.3	114.9
Diabetes	120.5	96.5
Bacterial Pneumonia	143.9	85.3
Dehydration	93.9	67.2
Urinary Tract Infection	102.5	54.8
Hypertension	33.6	30.2
Asthma in Younger Adults (age 18-39)	5.4	10.8
Perforated Appendix	14.4	9.4
Angina	11.4	--
<i>Note: The sum of the individual diagnoses may differ slightly from the Total Discharges figure for technical reasons. Rates and/or percent change are not calculated where n<30.</i>		
<i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i>		

Exhibit 3B. Preventable Hospitalization Trend by Diagnosis (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
All PQI Discharges (see note)	2,509	2,443	2,578	-6%	3%
Congestive Heart Failure	704	724	781	-8%	11%
COPD or Asthma In Older Adults (age 40+)	448	395	438	-20%	-2%
Bacterial Pneumonia	404	337	325	-29%	-20%
Diabetes	384	404	368	-2%	-4%
Urinary Tract Infection	229	214	209	-22%	-9%
Crude Rates per 100,000 Population					
All PQI Discharges (see note)	672.3	639.6	676.4	-7%	1%
Congestive Heart Failure	188.6	189.5	204.9	-9%	9%
COPD or Asthma In Older Adults (age 40+)	120.0	103.4	114.9	-21%	-4%
Bacterial Pneumonia	108.3	88.2	85.3	-30%	-21%
Diabetes	102.9	105.8	96.5	0%	-6%
Urinary Tract Infection	61.4	56.0	54.8	-23%	-11%
<i>Note: The sum of the individual diagnoses may differ slightly from the Total Discharges figure for technical reasons. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>					
<i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i>					

Exhibit 3C. Preventable Hospitalization Trend by Age Group (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
Counts (Total PQI Discharges)		2011	2012	2013	Virginia	Study Region
Age	Adults Age 18-29	141	153	164	-23%	16%
	Adults Age 30-44	220	206	221	-21%	0%
	Adults Age 45-64	803	760	813	-18%	1%
	Seniors Age 65+	1,345	1,324	1,380	-20%	3%
Crude Rates per 100,000 Population						
Age	Adults Age 18-29	188.7	203.7	214.8	-24%	14%
	Adults Age 30-44	319.7	293.6	318.0	-21%	-1%
	Adults Age 45-64	831.0	756.4	816.2	-19%	-2%
	Seniors Age 65+	3,143.3	2,882.3	3,063.9	-23%	-3%
<p><i>Note: PQI Discharges with an unknown age were not included in the analysis. The sum of the individual diagnoses may differ slightly from the Total Discharges figure for technical reasons. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i></p> <p><i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i></p>						

Exhibit 3D. Preventable Hospitalization Trend by Race/Ethnicity (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
Counts (Total PQI Discharges)					Virginia	Study Region
Race	Asian	14	12	18	-11%	--
	Black/African American	1,030	1,008	1,108	-16%	8%
	White	1,398	1,292	1,302	-22%	-7%
Ethnicity	Hispanic Ethnicity	32	30	30	-30%	--
Crude Rates per 100,000 Population						
Race	Asian	--	--	--	-24%	--
	Black/African American	718.9	685.8	769.9	-21%	7%
	White	714.8	650.5	647.0	-19%	-9%
Ethnicity	Hispanic Ethnicity	132.0	131.1	126.7	-23%	--
<p><i>Note: -- Rates and/or percent change are not calculated where n<30. PQI Discharges with an Other/Unknown race were not included in the analysis. Hispanic is classification of ethnicity; therefore, Hispanic individuals are also included in the race categories. The sum of the individual diagnoses may differ slightly from the Total Discharges figure for technical reasons. For this report, a percent change of one percent is considered relatively stable (no change).</i></p> <p><i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i></p>						

Exhibit 3E. Preventable Hospitalization Trend by Payer (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
					Virginia	Study Region
Counts (Total PQI Discharges)					Virginia	Study Region
Payer	Medicare	1,511	1,471	1,545	2%	2%
	Medicaid	139	115	155	-6%	12%
	Private	389	443	466	-12%	20%
	Self-Pay/Uninsured	259	255	276	2%	7%
<p><i>Note: PQI Discharges with unknown payer were not included in the analysis. Enrollment data were not available to calculate rates. The sum of the individual diagnoses may differ slightly from the Total Discharges figure for technical reasons. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i></p>						
<p><i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i></p>						

4. Behavioral Health Hospitalization Profile

Behavioral health is another important indicator of community health status. The indicators in this Behavioral Health Hospitalization Profile are based on analysis of hospital discharge data provided by Virginia Health Information (VHI), and demographic data from Alteryx, Inc. (see *Appendix B* for details on methods.) The analysis includes records of discharges of adult Virginia residents from Virginia hospitals excluding state and federal facilities. Due to the lack of reporting on the part of a regional child/adolescent psychiatric hospital, the analysis in this profile does not include data for residents age 0-17.

Behavioral Health Hospitalization Snapshot-Age 18+ (2013)

As shown in *Exhibit 4A*:

- In 2013, there were 2,148 behavioral health (BH) discharges for residents of the study region.
- The leading diagnoses for behavioral health hospitalization in the study region were Affective Psychoses, Schizophrenic Disorders, Depressive Disorder, Alcoholic Psychoses, and Other Nonorganic Psychoses.
- The BH discharge rates for the study region were higher than the statewide rates for Schizophrenic Disorders, Depressive Disorder, and Other Nonorganic Psychoses.

Behavioral Hospitalization Trend-age 18+ (2011-2013)

- **By Leading Diagnoses.** As shown in *Exhibit 4B*, from 2011 to 2013, the study region rates:
 - Increased for Total BH Discharges (all BH diagnoses combined), Affective Psychoses, Schizophrenic Disorders, and Alcoholic Psychoses.
 - Unlike the state, the study region rate increased for Schizophrenic Disorders.
- **By Age Group.** As shown in *Exhibit 4C*, from 2011 to 2013, the study region rates:
 - Increased for the age 18-44 population;
 - Declined for the age 65+ population; and
 - Remained relatively stable for the age 45-64 population.
 - Unlike the state, the study region rate increased for the age 18-29 population.
 - Unlike the state, the study region rate decreased for age 65+ population.
 - Unlike the state, the study region rate remained relatively stable for the 45-64 population.
- **By Sex.** As shown in *Exhibit 4D*, from 2011 to 2013, the study region rates declined for the female population and increased for the male population. The study region trends were consistent with the statewide trends.
- **By Race/Ethnicity.** As shown in *Exhibit 4E*, from 2011 to 2013, the study region rates increased for the Black/African American and White populations. Unlike the state, the study region rate increased for the Black/African American population.
- **By Payer.** As shown in *Exhibit 4F*, from 2011 to 2013, the study region counts:
 - Increased for the Medicaid, Private Insurance, and Self-Pay/Uninsured populations; and
 - Declined for the Medicare population.
 - Unlike the state, the study region count increased for the Private population.
 - Unlike the state, the study region count declined for the Medicare population.

Exhibit 4A. Behavioral Health Hospitalization Snapshot-Age 18+ (2013)

Indicator	Virginia	Study Region
Counts-BH Discharges		
Total BH Diagnoses	53,638	2,148
Counts-Leading 14 BH Diagnoses		
Affective Psychoses	22,078	789
Schizophrenic Disorders	8,064	532
Depressive Disorder, Not Elsewhere Classified	2,608	187
Alcoholic Psychoses	4,033	132
Other Nonorganic Psychoses	1,951	108
Drug Psychoses	2,102	53
Alcohol Dependence Syndrome	2,388	40
Adjustment Reaction	2,031	39
Symptoms Involving Head or Neck	883	30
Neurotic Disorders	982	29
Altered Mental Status	976	22
Non Dependent Abuse of Drugs	575	16
Other Organic Psychotic Conditions-Chronic	795	15
Drug Dependence	810	12
<i>Note: Data for residents age 0-17 are not included. See details in Appendix B.</i>		
<i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i>		

Exhibit 4A. Behavioral Health Hospitalization Snapshot-Age 18+ (2013)- Continued

Indicator	Virginia	Study Region
Crude Rates Per 100,000 Population		
All Diagnoses	650.4	563.6
Affective Psychoses	267.7	207.0
Schizophrenic Disorders	97.8	139.6
Depressive Disorder, Not Elsewhere Classified	31.6	49.1
Alcoholic Psychoses	48.9	34.6
Other Nonorganic Psychoses	23.7	28.3
Drug Psychoses	25.5	13.9
Alcohol Dependence Syndrome	29.0	10.5
Adjustment Reaction	24.6	10.2
Symptoms Involving Head or Neck	10.7	7.9
Neurotic Disorders	11.9	--
Altered Mental Status	11.8	--
Non Dependent Abuse of Drugs	7.0	--
Other Organic Psychotic Conditions-Chronic	9.6	--
Drug Dependence	9.8	--
<i>Note: Rates and/or percent change are not calculated where n<30. Data for residents age 0-17 are not included. See details in Appendix B.</i>		
<i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i>		

Exhibit 4B. Behavioral Health Hospitalization Trend by Leading Diagnoses-Age 18+ (2011-2013)

Indicator	Study Region			% Change (2011-2013)	
	2011	2012	2013	Virginia	Study Region
Counts					
Total BH Discharges (All Diagnoses)	1,939	2,172	2,148	3%	11%
Affective Psychoses	661	766	789	-1%	19%
Schizophrenic Disorders	427	504	532	1%	25%
Alcoholic Psychoses	116	129	132	23%	14%
Crude Rates per 100,000 Population					
Total BH Discharges (All Diagnoses)	519.6	568.6	563.6	2%	8%
Affective Psychoses	177.1	200.5	207.0	2%	17%
Schizophrenic Disorders	114.4	131.9	139.6	0%	22%
Alcoholic Psychoses	31.1	33.8	34.6	21%	11%
<i>Note: Data for residents age 0-17 are not included. See details in Appendix B. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>					
<i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i>					

Exhibit 4C. Behavioral Health Hospitalization Trend by Age (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
		2011	2012	2013	Virginia	Study Region
Counts						
All BH Discharges						
Age	Adults Age 18-29	409	566	583	10%	43%
	Adults Age 30-44	539	594	627	2%	16%
	Adults Age 45-64	698	759	713	3%	2%
	Seniors Age 65+	293	253	225	-4%	-23%
Crude Rates per 100,000 Population						
Age	Adults Age 18-29	547.4	753.7	763.5	-2%	39%
	Adults Age 30-44	783.2	846.5	902.1	8%	15%
	Adults Age 45-64	722.4	755.4	715.8	2%	-1%
	Seniors Age 65+	684.7	550.8	499.5	3%	-27%
<i>Note: Data for residents age 0-17 are not included. See details in Appendix B. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>						
<i>Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.</i>						

Exhibit 4D. Behavioral Health Hospitalization Trend by Sex-Age 18+ (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
		2011	2012	2013	Virginia	Study Region
Counts						
All BH Discharges						
Sex	Female	1,054	1,134	1,050	-1%	0%
	Male	885	1,038	1,098	8%	24%
Crude Rates per 100,000 Population						
Sex	Female	548.3	575.5	532.6	-2%	-3%
	Male	489.1	561.4	596.8	7%	22%
<i>Note: Data for residents age 0-17 are not included. See details in Appendix B. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>						
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>						

Exhibit 4E. Behavioral Health Hospitalization Trend by Race/Ethnicity-Age 18+ (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
		2011	2012	2013	Virginia	Study Region
Counts						
All BH Discharges						
Race	Asian	17	27	19	14%	--
	Black/African American	868	1,008	994	2%	15%
	White	984	1,058	1,063	2%	8%
Ethnicity	Hispanic Ethnicity	33	48	24	-6%	--
Crude Rates per 100,000 Population						
Race	Asian	--	--	--	6%	--
	Black/African American	605.8	685.8	690.7	0%	14%
	White	503.1	532.7	528.2	2%	5%
Ethnicity	Hispanic Ethnicity	136.1	209.7	--	-7%	--
<i>Note: Rates and/or percent change are not calculated where n<30. Data for residents age 0-17 are not included. See details in Appendix B. For this report, a percent change of one percent is considered relatively stable (no change).</i>						
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>						

Exhibit 4F. Behavioral Health Hospitalization Trend by Payer-Age 18+ (2011-2013)

Indicator		Study Region			% Change (2011-2013)	
		2011	2012	2013	Virginia	Study Region
Counts						
All BH Discharges						
Payer	Medicare	695	651	606	5%	-13%
	Medicaid	254	328	393	12%	55%
	Private	712	865	766	-2%	8%
	Self-Pay/Uninsured	276	326	383	14%	39%
<i>Note: Data for residents age 0-17 are not included. See details in Appendix B. Enrollment data were not available to calculate rates. Rates and/or percent change are not calculated where n<30. For this report, a percent change of one percent is considered relatively stable (no change).</i>						
<i>Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.</i>						

5. Adult Health Risk Factor Profile

This profile presents indicators of adult health risks for adults age 18+ based on analysis of data from the Virginia Behavioral Risk Factor Surveillance Survey and demographic data from Alteryx, Inc. (see *Appendix B* for details on methods.) Please note that all indicators in this profile are estimates, and therefore subject to estimation error.

- As shown in *Exhibit 5*, substantial numbers of adults have lifestyle health risks related to nutrition, weight, physical inactivity, tobacco, and alcohol. For example,
 - An estimated 228,557 adults age 18+ (78%) are not meeting the guidelines for fruit and vegetable intake;
 - An estimated 180,341 adults age 18+ (62%) are overweight or obese;
 - An estimated 154,170 adults age 18+ (53%) are not meeting recommendations for physical activity;
 - An estimated 84,087 adults age 18+ (29%) have high blood pressure; and
 - An estimated 26,185 adults age 18+ (9%) have diabetes.

Exhibit 5. Adult Health Risk Factor Profile (2014 Estimates)

Indicator		Virginia	Study Region
Estimates-Counts			
<i>Estimated Adults age 18+</i>		6,393,583	291,977
Lifestyle Risk Factors	Less than Five Servings of Fruits and Vegetables Per Day	5,114,866	228,557
	Overweight or Obese	3,964,021	180,341
	Not Meeting Recommendations for Physical Activity in the Past 30 Days	3,068,920	154,170
	At-risk for Binge Drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	1,150,845	55,476
	Smoker	1,214,781	57,291
Chronic Conditions	High Cholesterol (was checked, and told by a doctor or other health professional it was high)	2,237,754	102,604
	High Blood Pressure (told by a doctor or other health professional)	1,918,075	84,087
	Arthritis (told by a doctor or other health professional)	1,534,460	70,651
	Diabetes (told by a doctor or other health professional)	575,422	26,185
General Health Status	Limited in any Activities because of Physical, Mental or Emotional Problems	1,214,781	59,759
	Fair or Poor Health Status	1,022,973	43,892
Estimates-Rates			
Lifestyle Risk Factors	Less than Five Servings of Fruits and Vegetables Per Day	80%	78%
	Overweight or Obese	62%	62%
	Not Meeting Recommendations for Physical Activity in the Past 30 Days	48%	53%
	At-risk for Binge Drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	18%	19%
	Smoker	19%	20%
Chronic Conditions	High Cholesterol (was checked, and told by a doctor or other health professional it was high)	35%	35%
	High Blood Pressure (told by a doctor or other health professional)	30%	29%
	Arthritis (told by a doctor or other health professional)	24%	24%
	Diabetes (told by a doctor or other health professional)	9%	9%
General Health Status	Limited in any Activities because of Physical, Mental or Emotional Problems	19%	20%
	Fair or Poor Health Status	16%	15%
Note: State-level estimates are provided for reference only, and direct comparisons of local estimates with state estimates are not recommended.			
Source: Estimates produced by Community Health Solutions using Virginia Behavioral Risk Factor Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix B. Data Sources for details.			

6. Youth Health Risk Factor Profile

This profile presents estimates of health risks for youth age 10-14 and 14-19. The indicators in this profile are estimates based on analysis of data from the Virginia Youth Risk Behavioral Surveillance System from the Centers for Disease Control (2013) and demographic data from Alteryx, Inc. (see *Appendix B* for details on methods.) Please note that all indicators in this profile are estimates, and therefore subject to estimation error.

- As shown in *Exhibit 6*, substantial numbers of youth have lifestyle health risks related to nutrition, weight, alcohol, mental health, physical inactivity, and tobacco. For example,
 - Only an estimated 2,688 youth age 14-19 (8%) and 3,003 youth age 10-14 (25%) met the guidelines for fruit and vegetable intake;
 - An estimated 9,556 youth age 14-19 (29%) are overweight or obese;
 - An estimated 18,468 youth age 14-19 (56%) and 8,002 youth age 10-14 (66%) did not meet the guidelines for physical activity;
 - An estimated 5,917 youth age 14-19 (18%) and 294 youth age 10-14 (2%) used tobacco in the past month; and
 - An estimated 8,056 youth age 14-19 (25%) felt sad or hopeless almost every day at least two weeks in a row.

Exhibit 6. Youth Health Risk Factor Profile (2014 Estimates)

Indicator	Virginia	Study Region
Counts (Estimates)		
High School Youth Age 14-19		
<i>Total Estimated High School Youth Age 14-19</i>	654,462	32,774
Met Guidelines for Fruit and Vegetable Intake	54,707	2,688
Overweight or Obese	179,050	9,556
Not Meeting Recommendations for Physical Activity in the Past Week	363,586	18,468
Used Tobacco in the Past 30 Days	118,572	5,917
Had at least One Drink of Alcohol At least One Day in the Past 30 Days	178,173	8,712
Felt Sad or Hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities)	165,270	8,056
Middle School Youth Age 10-14		
<i>Total Estimated Middle School Youth Age 10-14</i>	523,850	12,044
Met Guidelines for Fruit and Vegetable Intake	125,285	3,003
Not Meeting Recommendations for Physical Activity in the Past Week	345,407	8,002
Used Tobacco in the Past 30 Days	19,192	294
Rates (Percent Estimates)		
High School Youth Age 14-19		
Met Guidelines for Fruit and Vegetable Intake	8%	8%
Overweight or Obese	27%	29%
Not Meeting Recommendations for Physical Activity in the Past Week	56%	56%
Used Tobacco in the Past 30 Days	18%	18%
Had at least One Drink of Alcohol At least One Day in the Past 30 Days	27%	27%
Felt Sad or Hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities)	25%	25%
Middle School Youth Age 10-14		
Met Guidelines for Fruit and Vegetable Intake	24%	25%
Not Meeting Recommendations for Physical Activity in the Past Week	66%	66%
Used Tobacco in the Past 30 Days	4%	2%
<i>Note: State-level estimates are provided for reference only, and direct comparisons of local estimates with state estimates are not recommended.</i>		
<i>Source: Estimates produced by Community Health Solutions using Youth Risk Behavioral Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix B. Data Sources for details.</i>		

7. Uninsured Profile

This profile presents estimates of the uninsured population within the 0-64 age group. The indicators in this profile are estimates based on analysis of data from the U.S. Census Bureau Small Area Health Insurance Estimates and demographic estimates from Alteryx, Inc. (see *Appendix B* for details on methods.) Please note that all indicators in this profile are subject to estimation error.

As shown in *Exhibit 7*:

- At any given point in 2014, an estimated 49,206 residents of the study region were uninsured.
- The estimated number of uninsured children age 0-18 was 5,761 in the study region. Among uninsured children, it is estimated that 2,892 (50%) have family income below 200 percent of the federal poverty level, possibly making them income-eligible for coverage through the state Medicaid or FAMIS program.
- The estimated number of uninsured adults age 19-64 was 43,445 in the study region. Among uninsured adults, it is estimated that 23,330 (54%) have family income below 200 percent of the federal poverty level.

Exhibit 7. Uninsured Profile (2014 Estimates)

Indicator	Virginia	Study Region
Estimated Uninsured Counts*		
Uninsured Nonelderly Age 0-64	1,013,561	49,206
Uninsured Children Age 0-18	120,105	5,761
Uninsured Children Age 0-18 <=138% FPL	38,955	1,869
Uninsured Children Age 0-18 <=200% FPL	60,293	2,892
Uninsured Children Age 0-18 <=250% FPL	74,045	3,552
Uninsured Children Age 0-18 <=400% FPL	98,441	4,722
Uninsured Children Age 0-18 138-400% FPL	59,485	2,853
Uninsured Adults Age 19-64	893,456	43,445
Uninsured Adults Age 19-64 <=138% FPL	327,185	15,910
Uninsured Adults Age 19-64 <=200% FPL	479,797	23,330
Uninsured Adults Age 19-64 <=250% FPL	578,328	28,122
Uninsured Adults Age 19-64 <=400% FPL	749,463	36,443
Uninsured Adults Age 19-64 138-400% FPL	422,276	20,533
Estimated Uninsured Percent		
Uninsured Children Percent	6%	6%
Uninsured Adults Percent	17%	18%
<p><i>*Note: Federal poverty level (FPL) categories are cumulative. State-level estimates are provided for reference only, and direct comparisons of local estimates with state estimates are not recommended.</i></p> <p><i>Source: Estimates produced by Community Health Solutions using U.S. Census Bureau Small Area Health Insurance Estimates (2013) and local demographic estimates from Alteryx, Inc. See Appendix B for details on methods.</i></p>		

APPENDIX A: Zip Code-Level Maps

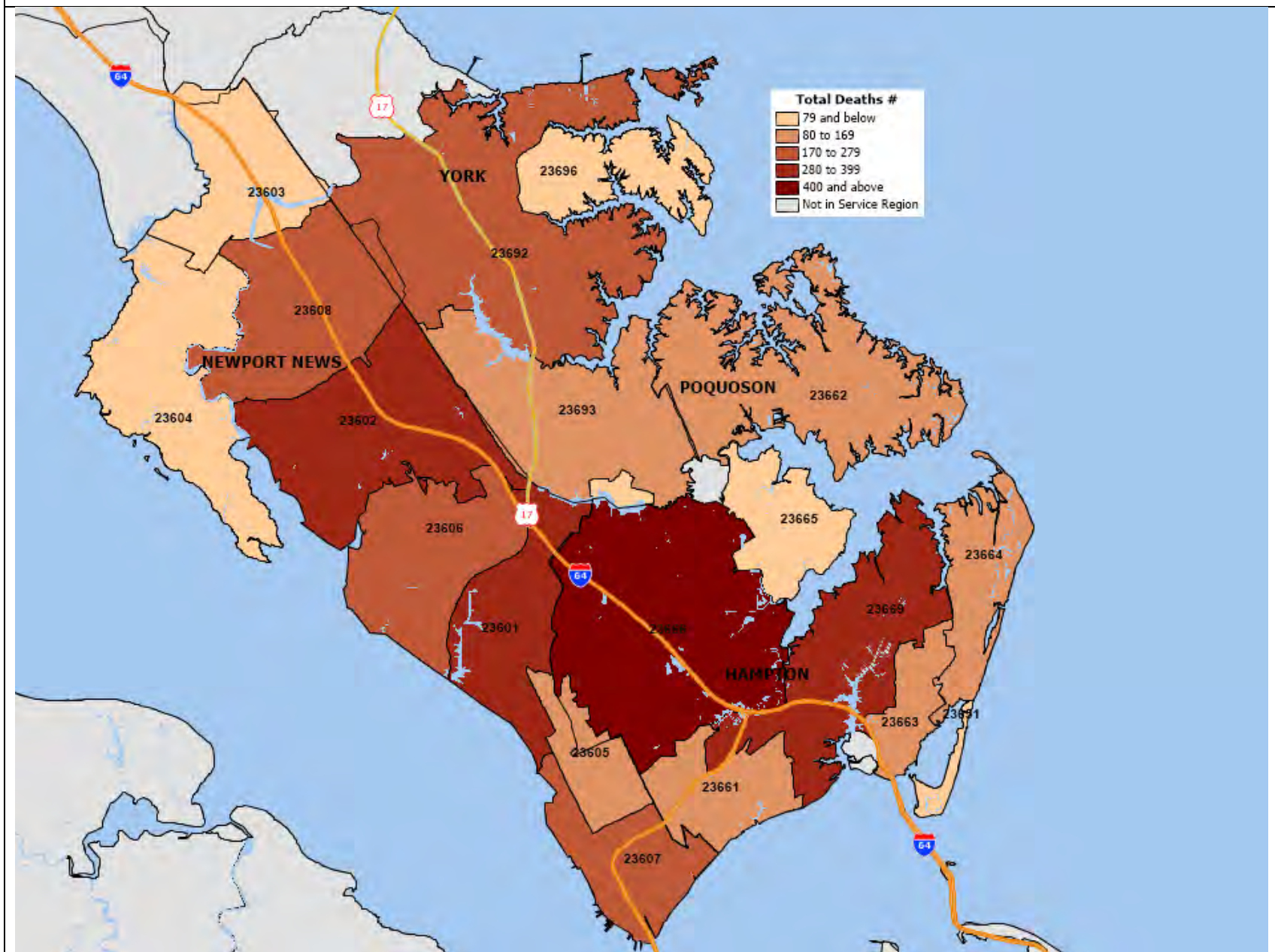
The Zip Code-Level maps in this section illustrate the geographic distribution of the zip code-level study region on key health status indicators. The maps in this section include the following for 2013/2014:

1. Total Deaths, 2013	9. Estimated Adult Age 18+ Smokers, 2014
2. Heart Disease Deaths, 2013	10. Estimated Adults Age 18+ with No Dental Visit in the Last Year, 2014
3. Cerebrovascular Disease (Stroke) Deaths, 2013	11. Estimated Adults Age 18+ with Diabetes, 2014
4. Malignant Neoplasms (Cancer) Deaths, 2013	12. Estimated Adults Age 18+ who are Overweight or Obese, 2014
5. Total Live Births, 2013	13. Estimated High School-aged Youth (age 14-19) who are Overweight or Obese, 2014
6. Total Teenage Live Births (age<18), 2013	14. Estimated Uninsured Children Age 0-18, 2014
7. Total Prevention Quality Indicator Hospitalization Discharges, 2013	15. Estimated Uninsured Adults, Age 19-64, 2014
8. Total Behavioral Health Hospitalization Discharges, 2013	

Technical Notes

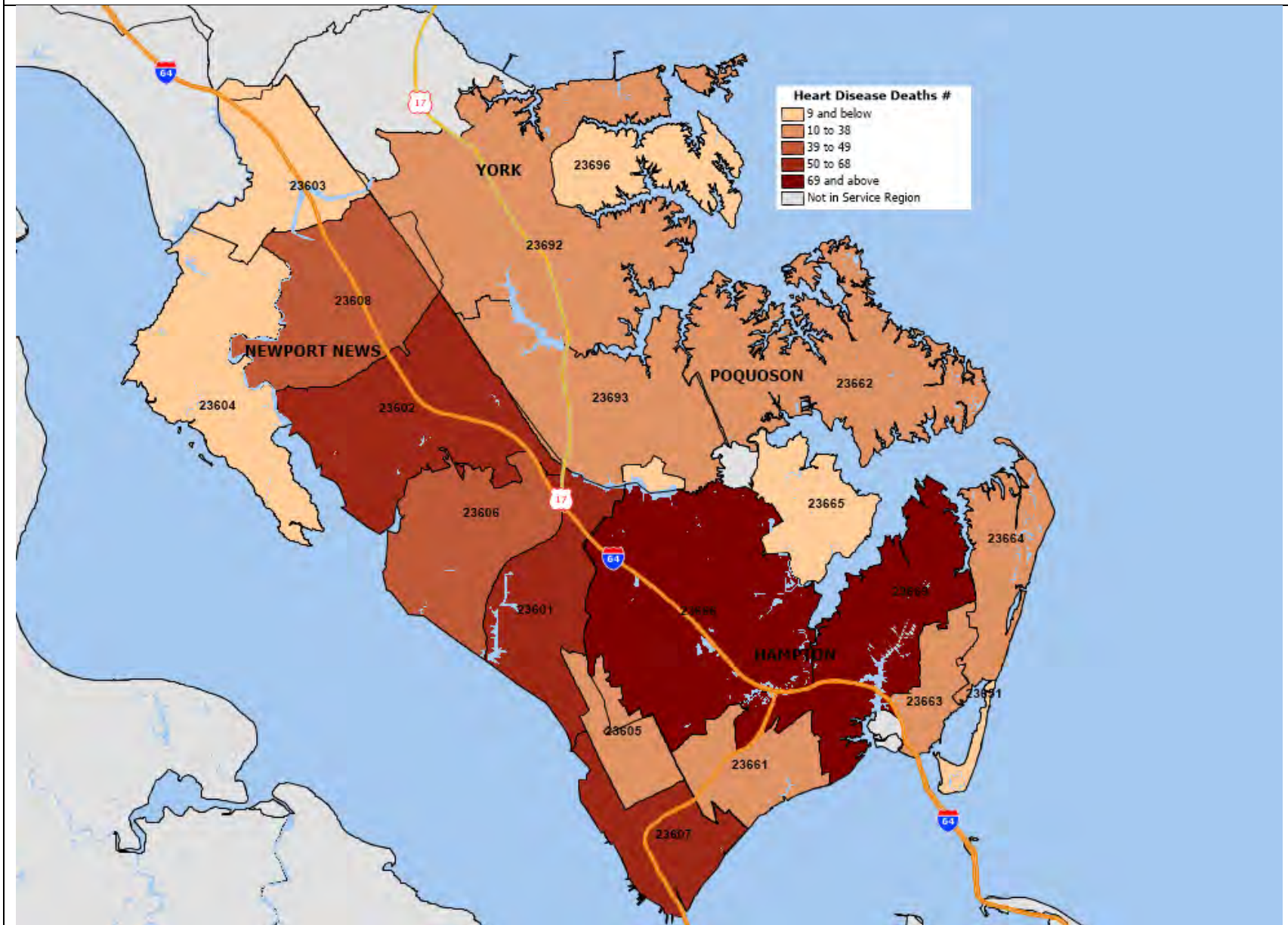
1. The maps and data include 19 zip codes, as identified by Sentara CarePlex Hospital, which fall within the cities of Hampton, Newport News, and Poquoson; and York County. It is important to note that zip code boundaries do not automatically align with city/county boundaries, and there are some zip codes that extend beyond the county boundaries. Also, not all zip codes in the region were identified by Sentara CarePlex Hospital as part of the Zip Code-Level Study Region.
2. The maps show counts rather than rates. Rates are not mapped at the zip code-level because in some zip codes the population is too small to support rate-based comparisons.
3. Data are presented in natural breaks.
4. Zip Code-Level Study Region zip codes with zero values are noted.

Map 1: Total Deaths, 2013



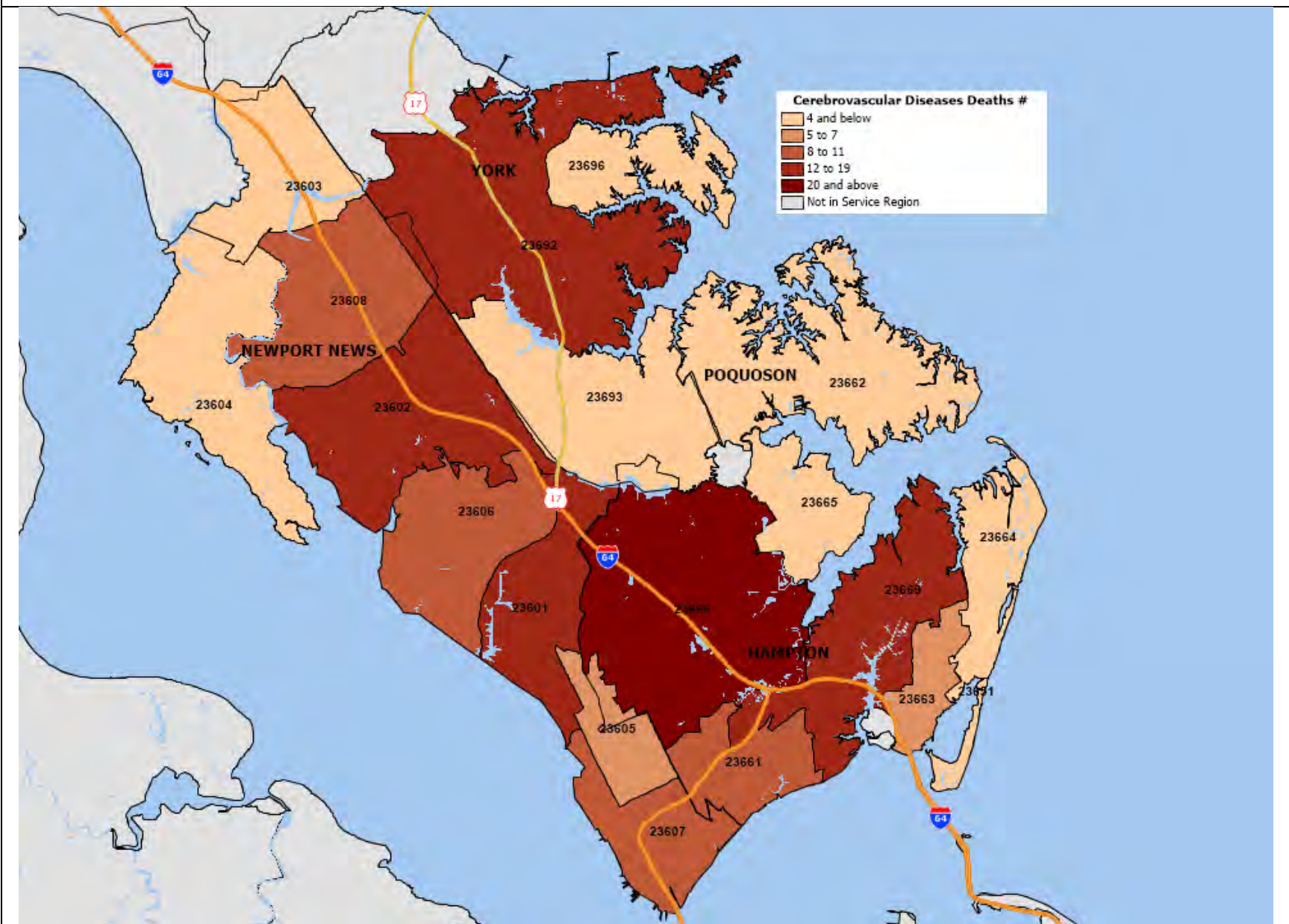
Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B.

Map 2: Heart Disease Deaths, 2013



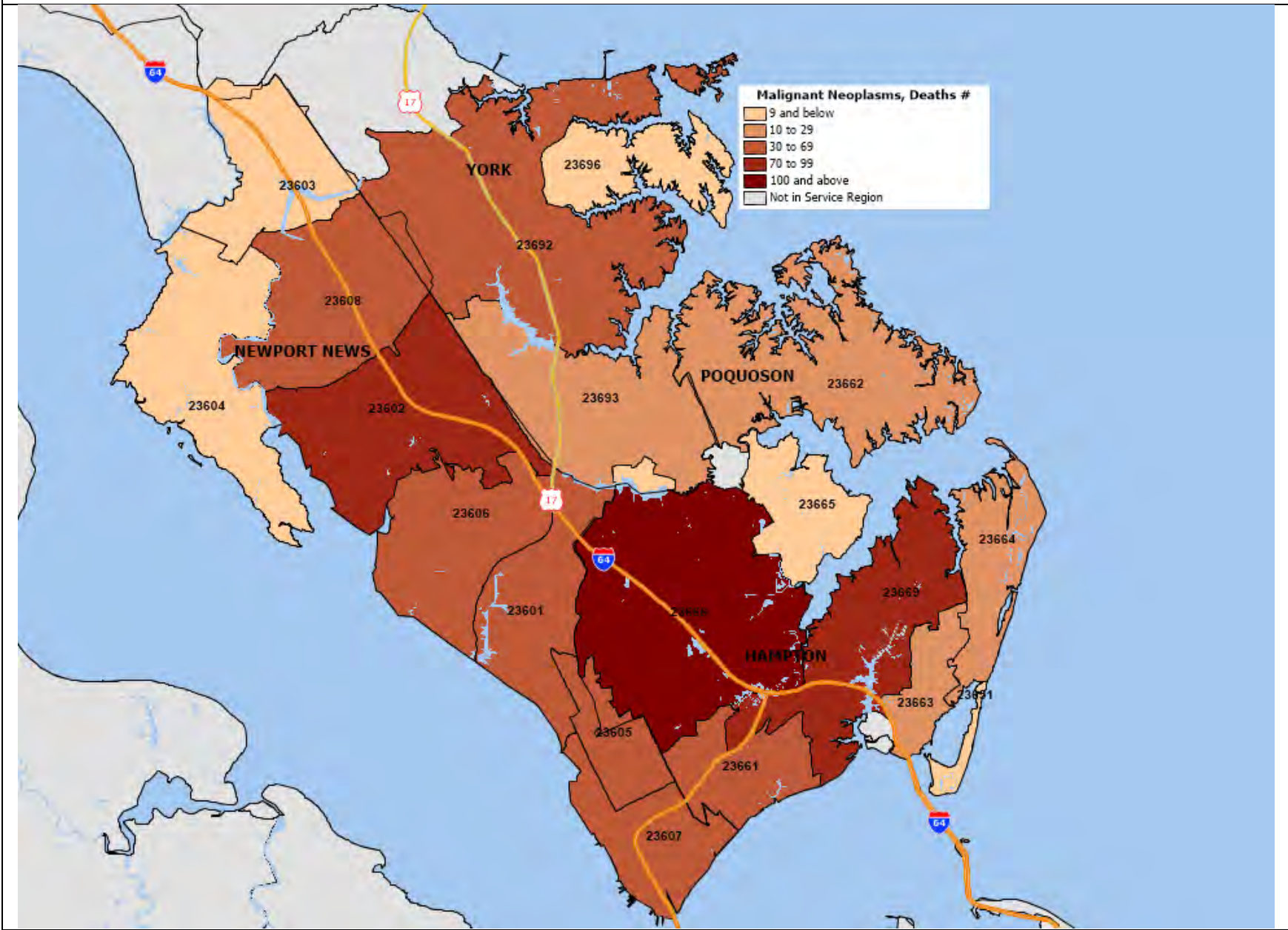
Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B. Notes: There were no reported heart disease deaths for zip codes 23604 and 23665.

Map 3: Cerebrovascular Disease (Stroke) Deaths, 2013



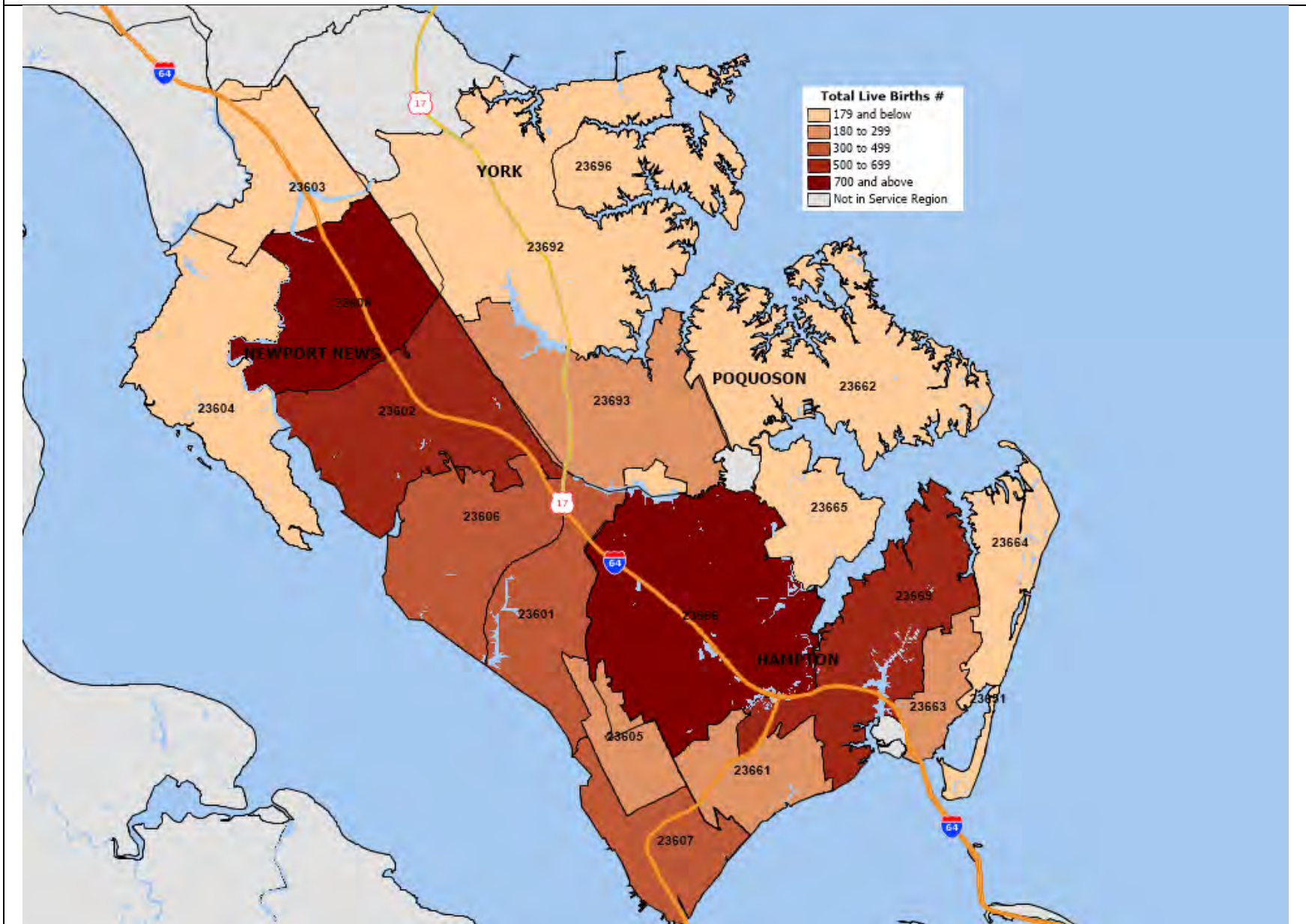
Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B. Notes: There were no reported stroke deaths for zip codes 23604, 23665 and 23651.

Map 4: Malignant Neoplasms (Cancer) Deaths, 2013



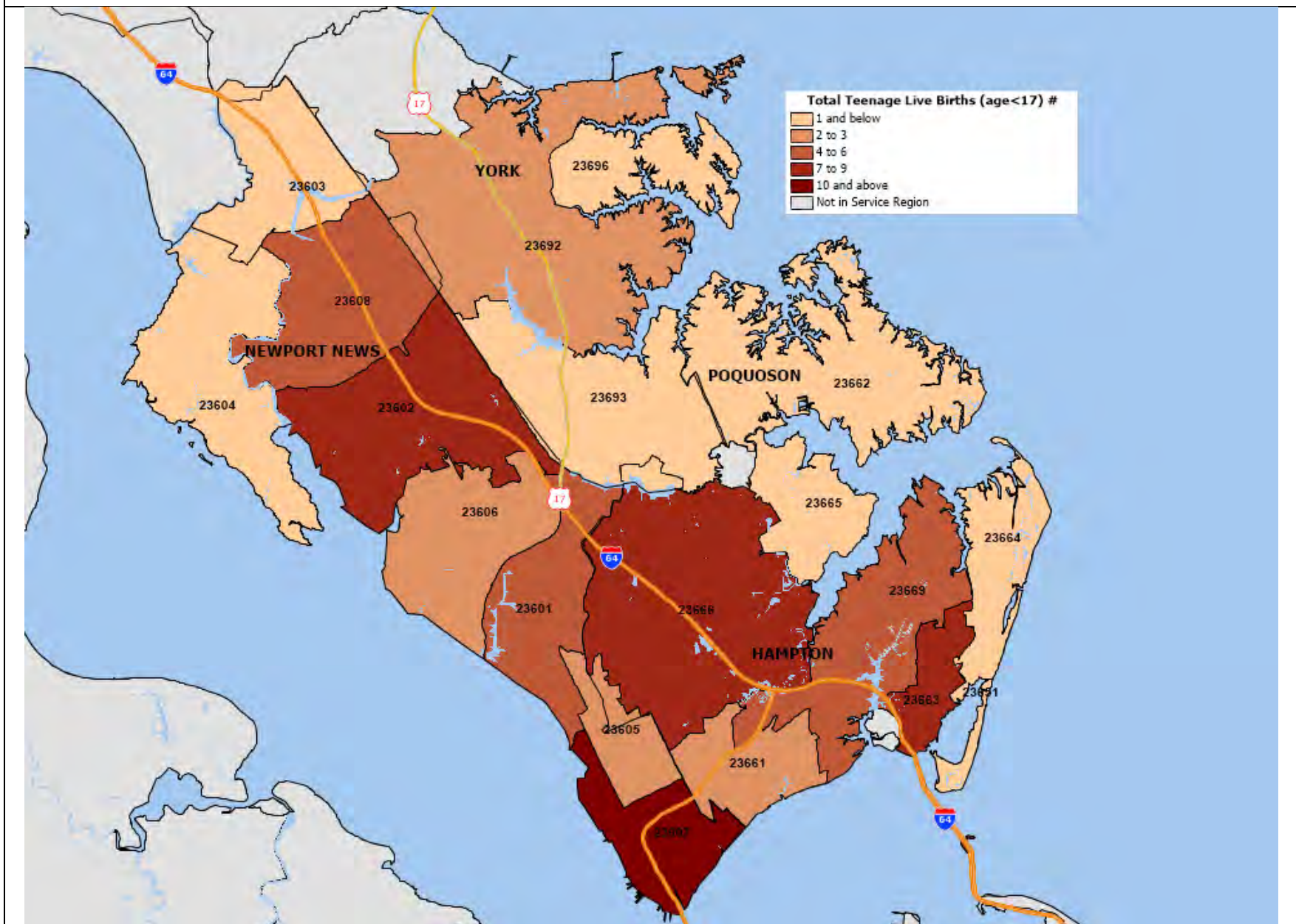
Source: Community Health Solutions analysis of death record data from the Virginia Department of Health. See details in methods in Appendix B. Notes: There were no reported cancer deaths for zip code 22134.

Map 5: Total Live Births, 2013



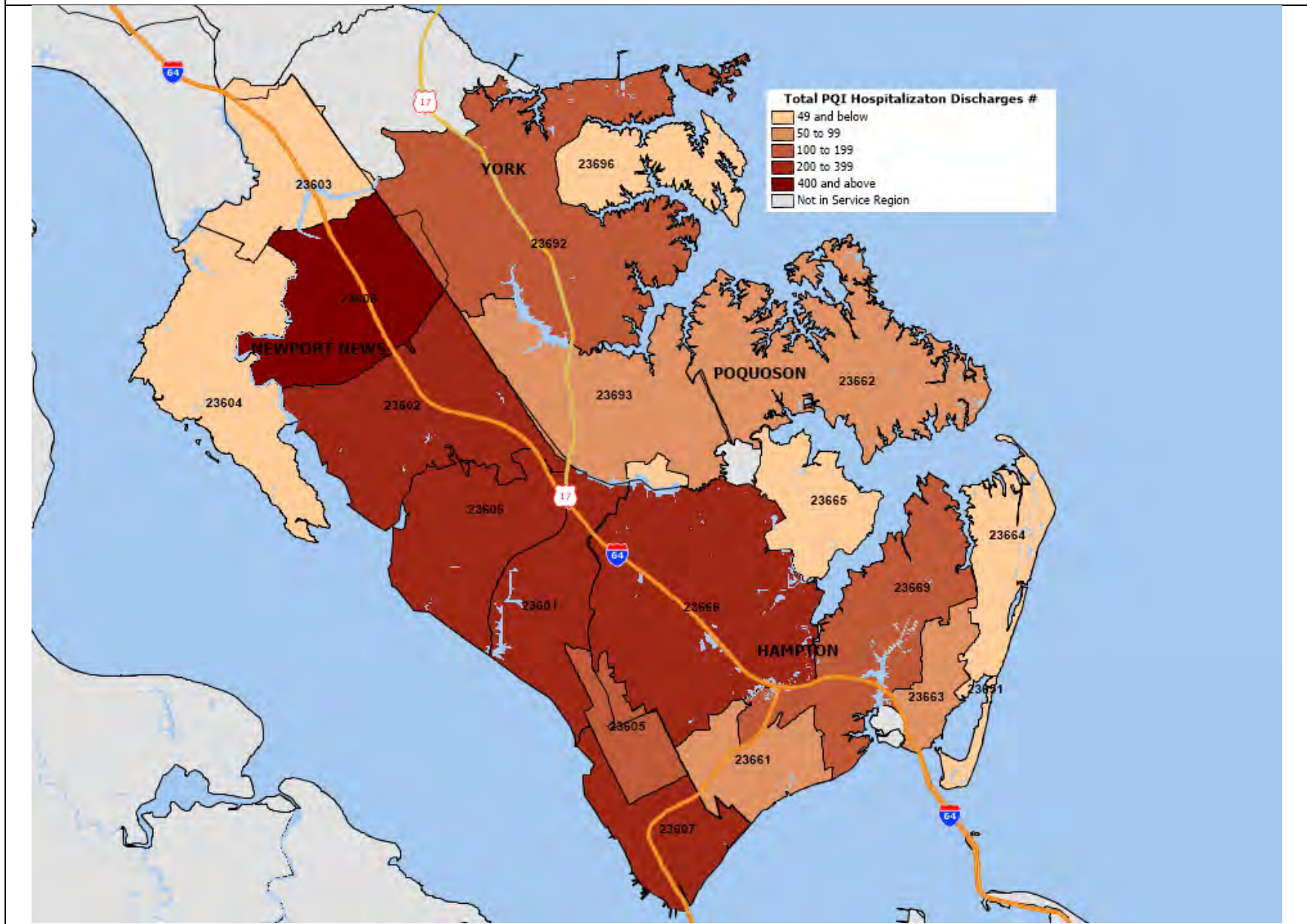
Source: Community Health Solutions analysis of birth record data from the Virginia Department of Health. See details in methods in Appendix B.

Map 6: Total Teenage Live Births (age <18), 2013



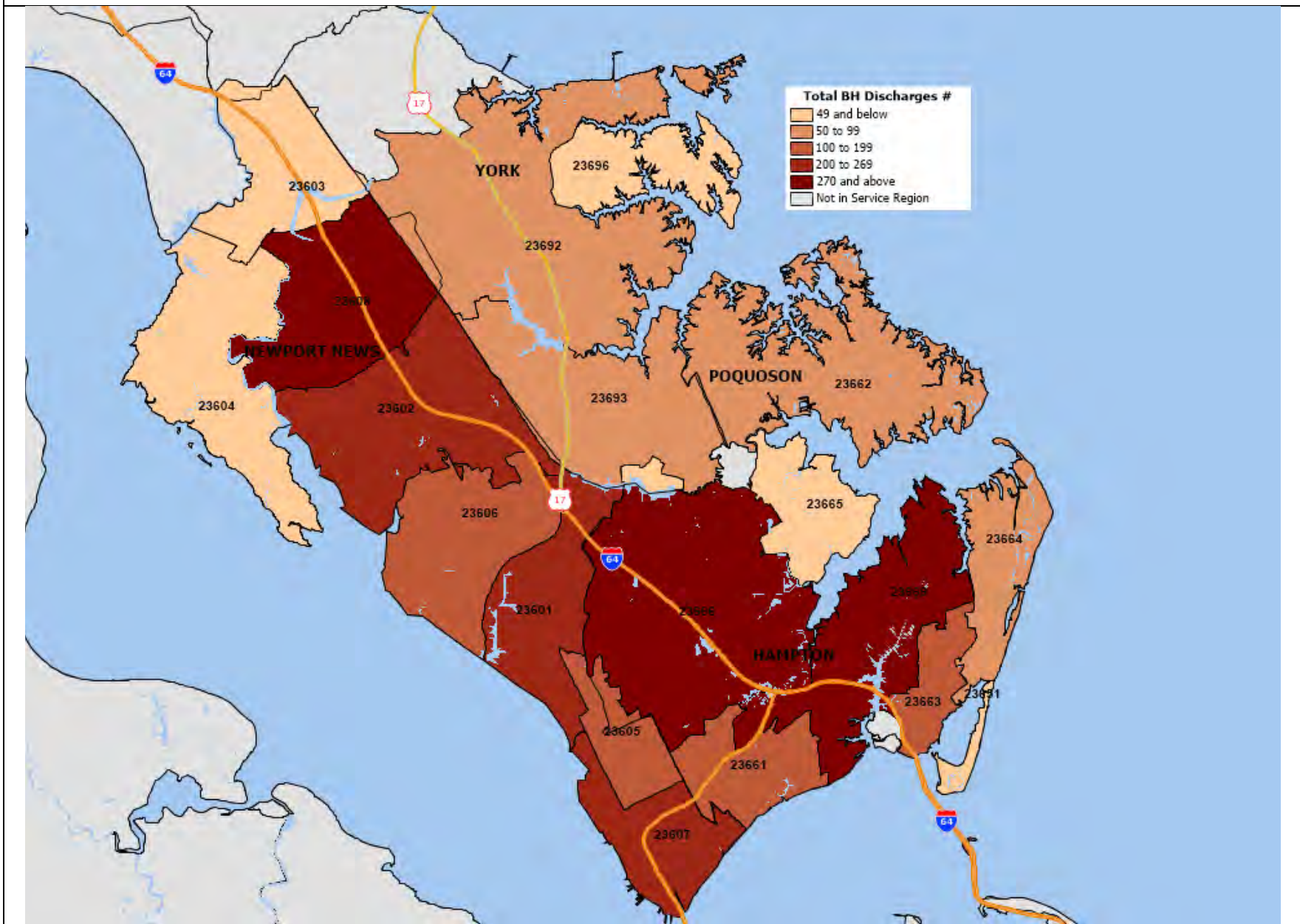
Source: Community Health Solutions analysis of birth record data from the Virginia Department of Health. See details in methods in Appendix B. Notes: There were no reported teenage live births for zip codes 23603, 23604, 23651, 23664, 23665, 23693 and 23696.

Map 7: Total Prevention Quality Indicator (PQI) Hospitalization Discharges, 2013



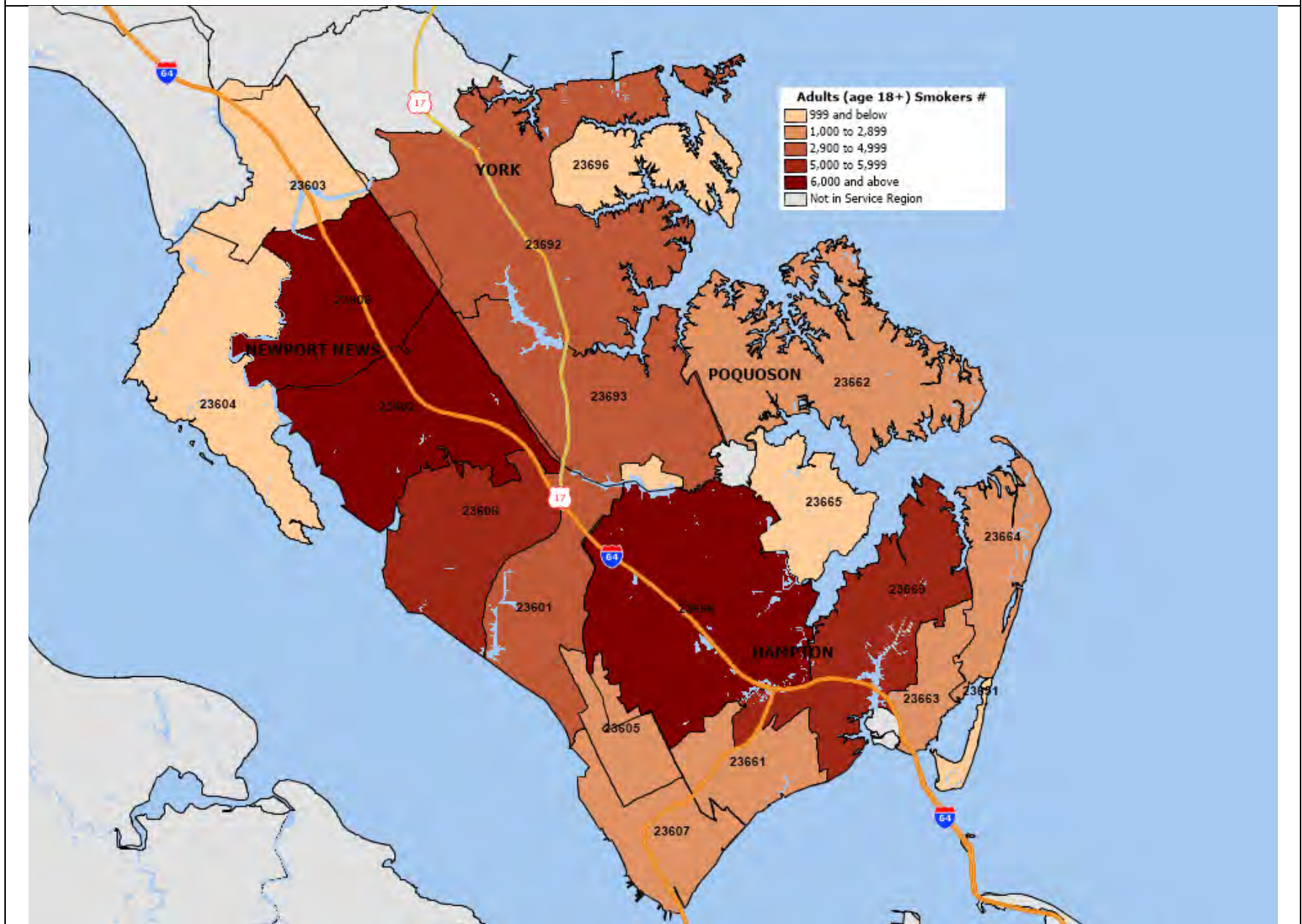
Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B. Notes: There were no PQI hospitalization discharges for zip code 23665.

Map 8: Total Behavioral Health (BH) Hospitalization Discharges, 2013



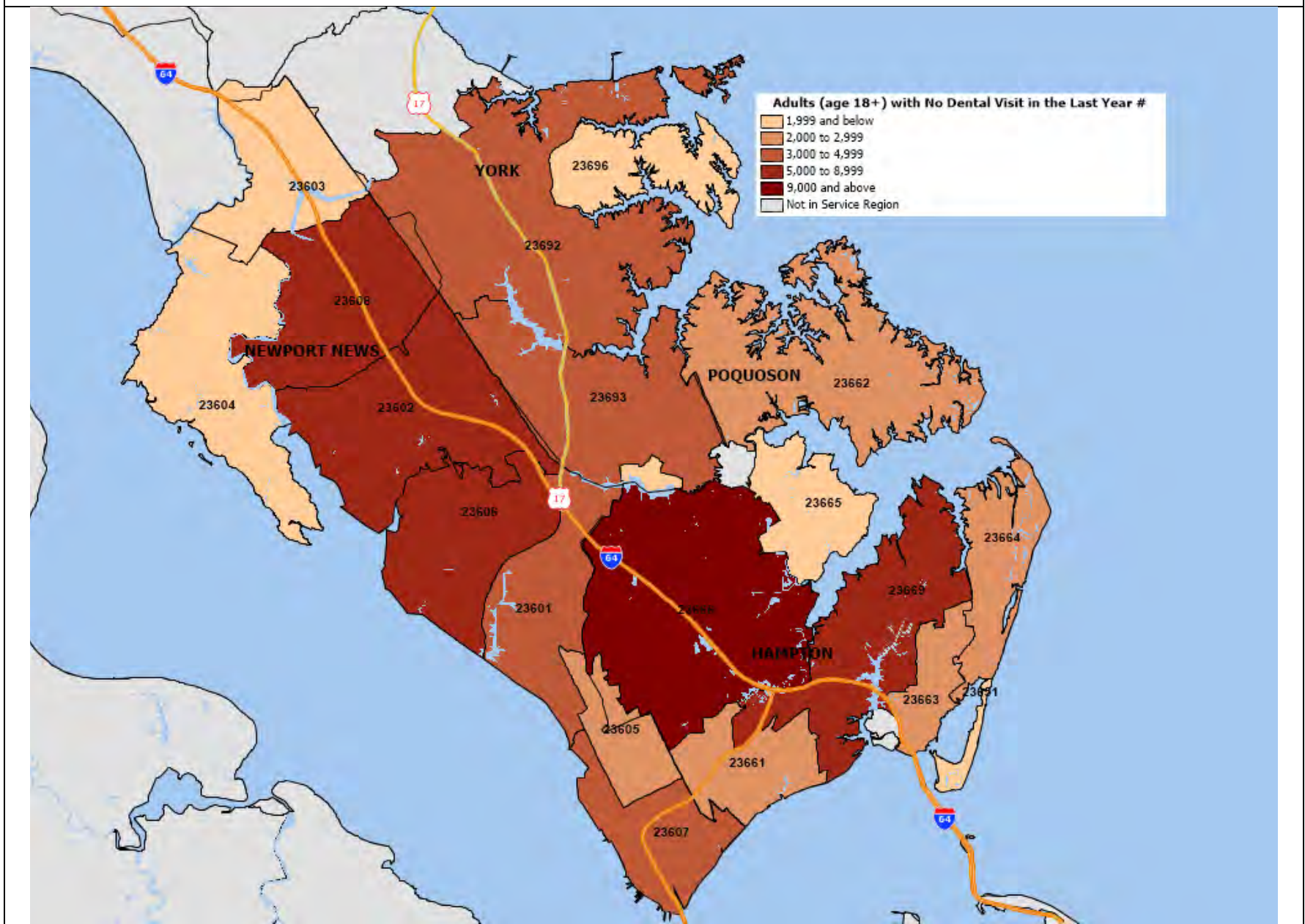
Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix B.

Map 9: Estimated Adults Age 18+ Smokers, 2014-Estimates



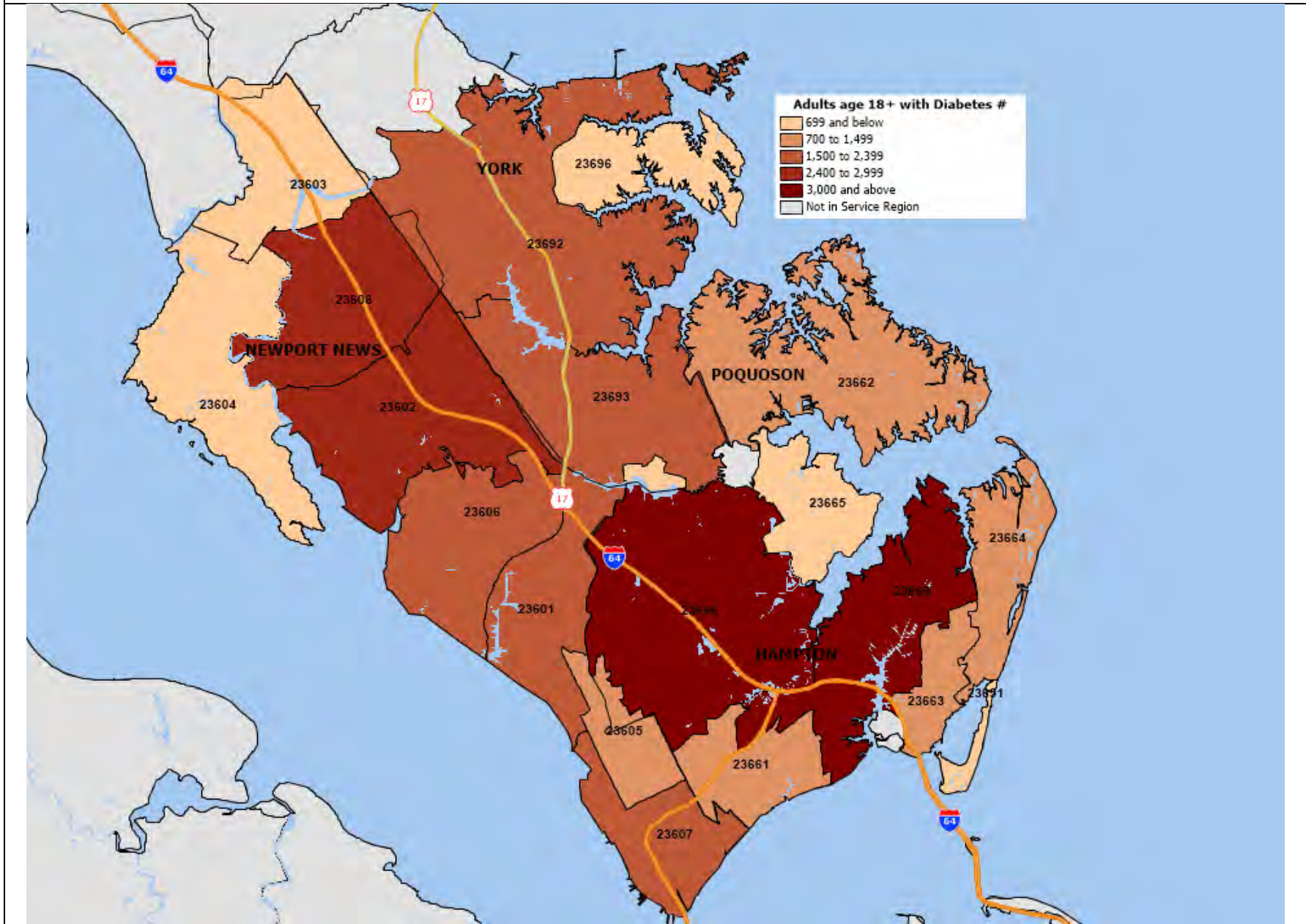
Source: Estimates produced by Community Health Solutions using Virginia Behavioral Risk Factor Surveillance System data and local demographic estimates from Alteryx, Inc. See details in methods in Appendix B.

Map 10: Estimated Adults Age 18+ with No Dental Visit in the Last Year, 2014-Estimates



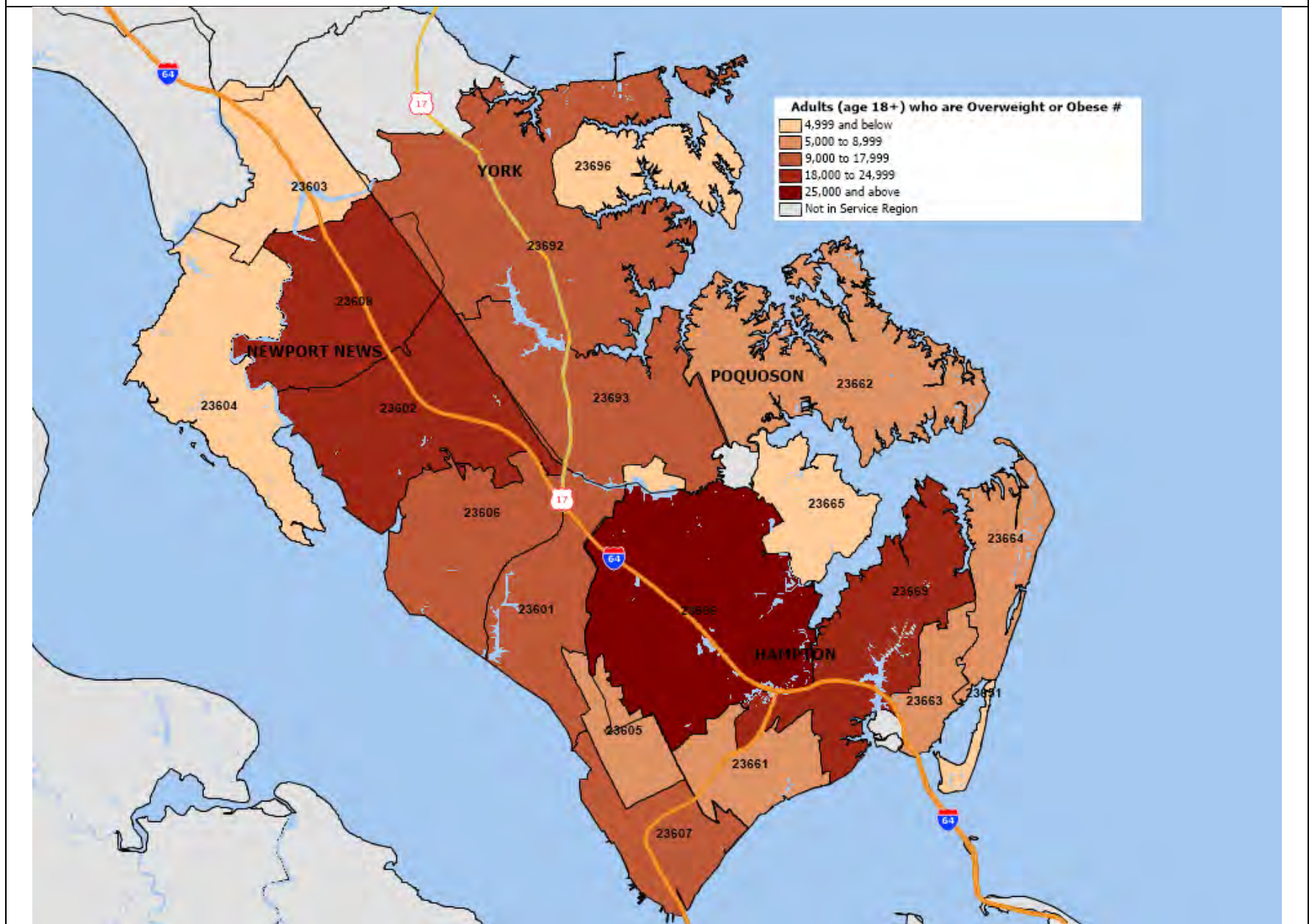
Source: Estimates produced by Community Health Solutions using Virginia Behavioral Risk Factor Surveillance System data and local demographic estimates from Alteryx, Inc. See details in methods in Appendix B.

Map 11: Estimated Adults Age 18+ with Diabetes, 2014 -Estimates



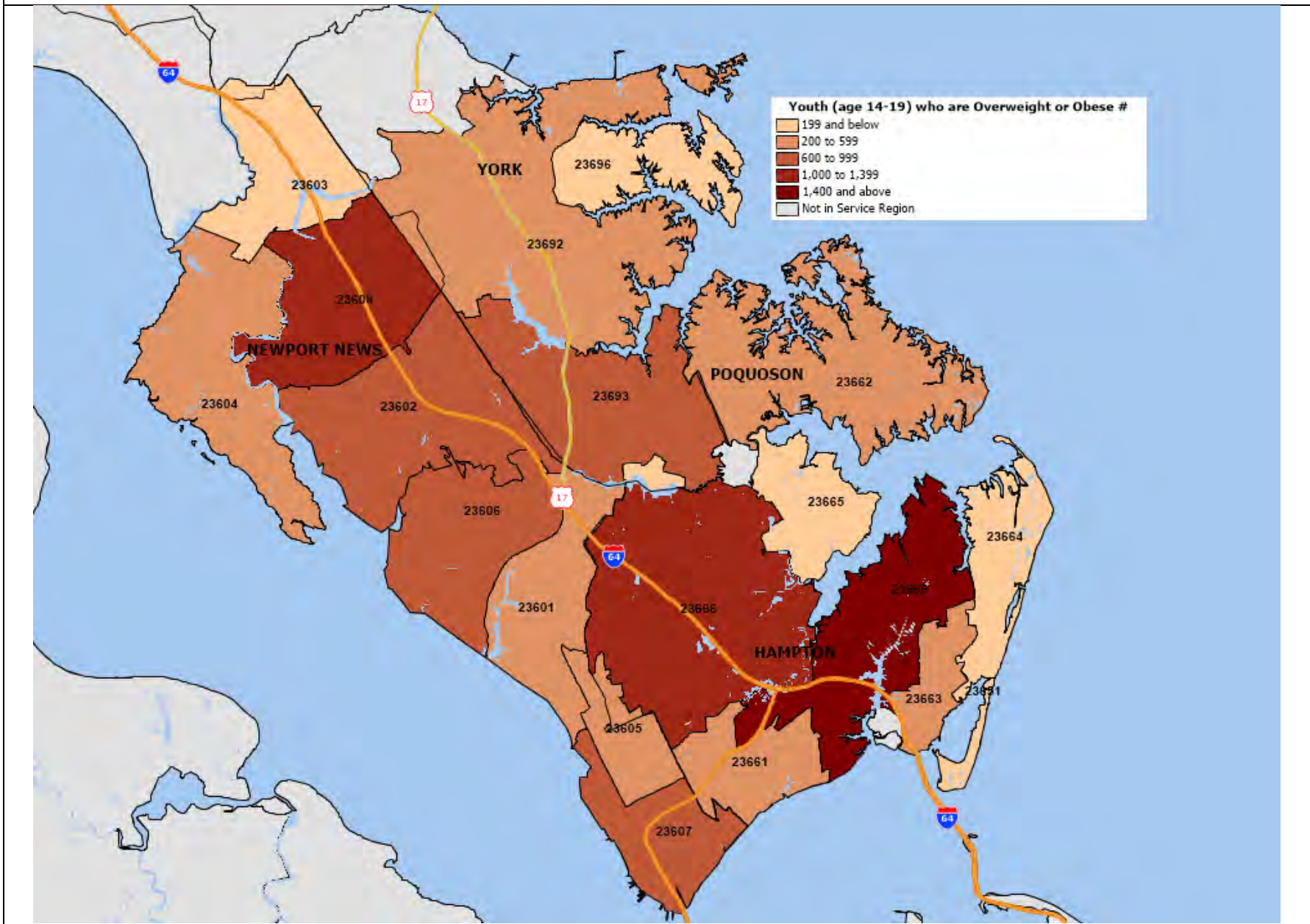
Source: Estimates produced by Community Health Solutions using Virginia Behavioral Risk Factor Surveillance System data and local demographic estimates from Alteryx, Inc. See details in methods in Appendix B.

Map 12: Estimated Adults Age 18+ who are Overweight or Obese, 2014-Estimates



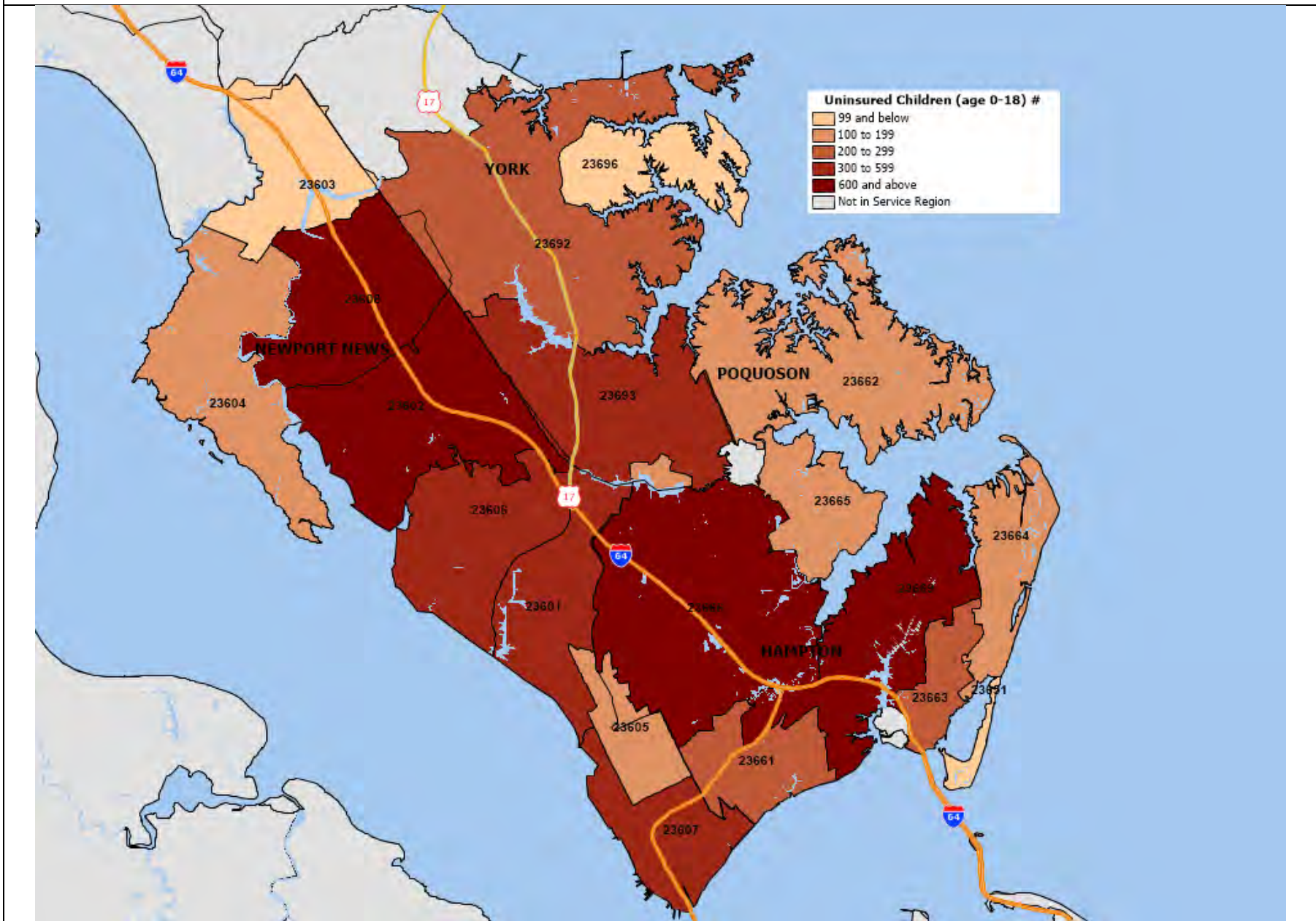
Source: Estimates produced by Community Health Solutions using Virginia Behavioral Risk Factor Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix B.

Map 13: Estimated High School-aged Youth (age 14-19) who are Overweight or Obese, 2014-Estimates



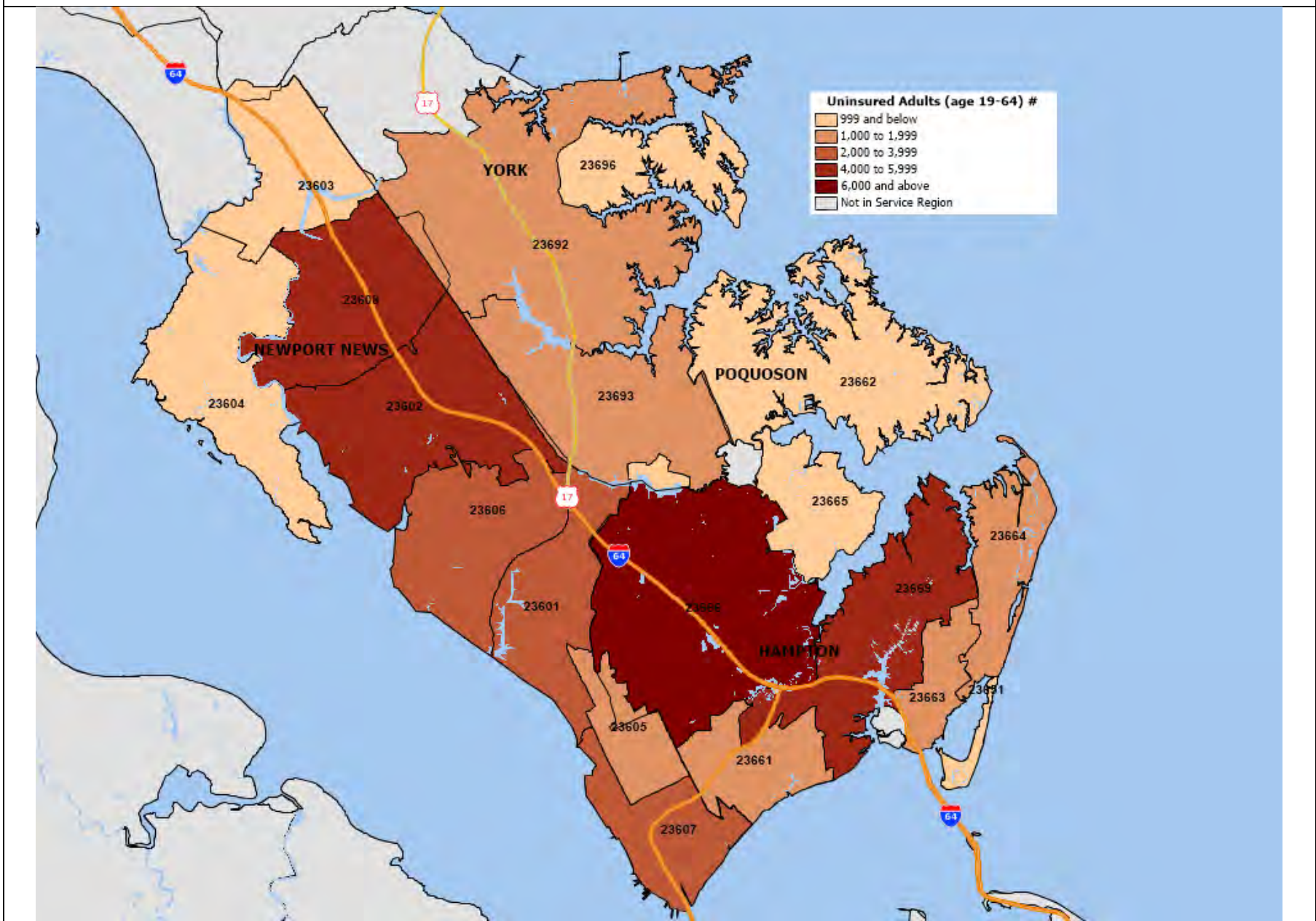
Source: Estimates produced by Community Health Solutions using Virginia Youth Risk Behavioral Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix B. Data Sources for details.

Map 14: Estimated Uninsured Children, Age 0-18, 2014-Estimates



Source: Estimates of uninsured are based on Community Health Solutions analysis of U.S. Census Bureau Small Area Health Insurance Estimates (2013) and demographic data from Alteryx, Inc. See Appendix B. Data Sources for details.

Map 15: Estimated Uninsured Adults, Age 19-64, 2014 -Estimates



Source: Estimates of uninsured are based on Community Health Solutions analysis of U.S. Census Bureau Small Area. Health Insurance Estimates (2013) and demographic data from Alteryx, Inc. See Appendix B. Data Sources for details.

APPENDIX B: Health Status Indicators Data Sources

Profile	Source
Important Note on Data Sources	The data used to produce the health status indicators in this report were obtained from public or commercial sources as indicated throughout this appendix. Community Health Solutions cannot, and does not guarantee the accuracy of these data sources.
1) Mortality Profile (also Appendix A. Maps 1-4)	Community Health Solutions analysis of Virginia Department of Health death record data (2011-2013). Locality-Level counts and rates were obtained from the Virginia Department of Health. The combined study region counts and rates were produced by Community Health Solutions.
2) Maternal and Infant Health Profile (also Appendix A. Maps 5-6)	Community Health Solutions analysis of Virginia Department of Health death record data (2011-2013). Locality-Level counts and rates were obtained from the Virginia Department of Health. The combined study region counts and rates were produced by Community Health Solutions.
3) Preventable Hospitalization Profile (also Appendix A. Map 7)	<p>Community Health Solutions analysis of hospital discharge data from the Virginia Health Information (VHI) 2011-013 datasets and demographic estimates from Alteryx, Inc. (2011-2013). Data include discharges for Virginia residents from Virginia hospitals reporting to Virginia Health Information, Inc.) The analysis includes records of discharges of Virginia residents from Virginia hospitals excluding state and federal facilities.</p> <p>Preventable Hospitalizations. The prevention quality indicator (PQI) definitions are based on definitions published by the Agency for Healthcare Research and Quality (AHRQ). The definitions are detailed in their specification of ICD-9 diagnosis codes and procedure codes. Not every hospital admission for congestive heart failure, bacterial pneumonia, etc. is included in the PQI definition; only those meeting the detailed specifications. Low birth weight is one of the PQI indicators, but for the purpose of this report, low birth weight is included in the Maternal and Infant Health Profile. Also, there are four diabetes-related PQI indicators which have been combined into one for the report. Within the Exhibits, the <i>All PQI Discharges</i> figures are based on an AHRQ methodology that counts a hospital discharge with multiple PQI diagnoses as one discharge. By comparison, the figures for individual discharges do include a small number of cases in which a single hospital discharge with more than one PQI diagnosis would be counted more than once. Also, AHRQ refined their method to exclude the perforated appendix PQI from its list, but this diagnosis is included in the data used for this study. As a result of these methodological factors, the sum of the individual PQI discharges may be slightly different than the total for All PQI Discharges. These differences or on the order of less than one percent. For more information on the AHRQ methodology, visit the AHRQ website at http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx.</p> <p>Behavioral Health Hospitalizations- Behavioral health data reported are based on the patient's primary diagnosis. The analysis includes records of discharges of adult Virginia residents from Virginia hospitals excluding state and federal facilities. Due to the lack of reporting on the part of a regional child/adolescent psychiatric hospital, the analysis in this profile does not include data for residents age 0-17.</p> <p><i>NOTE: Virginia Health Information (VHI) requires the following statement to be included in all reports utilizing its data: VHI has provided non-confidential patient level information used in this report which was compiled in accordance with Virginia law. VHI has no authority to independently verify this data. By accepting this report the requester agrees to assume all risks that may be associated with or arise from the use of inaccurately submitted data. VHI edits data received and is responsible for the accuracy of assembling this information, but does not represent that the subsequent use of this data was appropriate or endorse or support any conclusions or inferences that may be drawn from the use of this data.</i></p>
4) Behavioral Health Hospitalization Profile (also Appendix A. Map 8)	

Profile	Source
5) Adult Health Risk Factor Profile (also Appendix A. Maps 9-12)	<p>Estimates of chronic disease and risk behaviors for adults 18+ were produced by Community Health Solutions using:</p> <ul style="list-style-type: none"> • A multi-year dataset (2006-2010) from the Virginia Behavioral Risk Factor Surveillance System (BRFSS). For more information on BRFSS visit: http://www.cdc.gov/brfss/about/index.htm • Local demographic estimates from Alteryx, Inc. (2014) <p>Estimates are used when there are no primary sources of data available at the local level. The estimates are for planning purposes only and are not guaranteed for accuracy. The statistical model to produce the local estimates was developed by Community Health Solutions. In this model, state-level data were used to predict local counts and rates, with adjustments for local demographics. Consequently, differences between local rates and state rates may reflect estimation error rather than valid differences. Therefore, state-level estimates are provided for reference only, and direct comparisons of local estimates with state estimates are not recommended. Because of data limitations, it is not possible to assign specific margins of error or levels of significance to these statistical estimates. Likewise, it is not possible to calculate the statistical significance of differences between local rates and state rates.</p>
6) Youth Health Risk Factor Profile (also Appendix A. Map 13)	<p>Estimates of risk behaviors for youth age 14-19 and 10-14 were produced by Community Health Solutions using:</p> <ul style="list-style-type: none"> • Data from the Virginia Youth Risk Behavioral Surveillance System from the Centers for Disease Control (2013). For more information on YRBSS visit: http://www.cdc.gov/HealthyYouth/yrbs/index.htm • Local demographic estimates from Alteryx, Inc. (2014). <p>Estimates are used when there are no primary sources of data available at the local level. The estimates are for planning purposes only and are not guaranteed for accuracy. The statistical model to produce the local estimates was developed by Community Health Solutions. In this model, state-level data were used to predict local counts and rates, with adjustments for local demographics. Consequently, differences between local rates and state rates may reflect estimation error rather than valid differences. Therefore, state-level estimates are provided for reference only, and direct comparisons of local estimates with state estimates are not recommended. Because of data limitations, it is not possible to assign specific margins of error or levels of significance to these statistical estimates. Likewise, it is not possible to calculate the statistical significance of differences between local rates and state rates.</p>
7) Uninsured Profile (also Appendix A. Maps 14-15)	<p>Estimates of uninsured nonelderly age 0-64 were produced by Community Health Solutions using:</p> <ul style="list-style-type: none"> • U.S. Census Bureau Small Area Health Insurance Estimates (2013). For more information, visit: http://www.census.gov/did/www/sahie/data/index.html. • Local demographic estimates from Alteryx, Inc. (2014) <p>Estimates are used when there are no primary sources of data available at the local level. The estimates are for planning purposes only and are not guaranteed for accuracy. The statistical model to produce the local estimates was developed by Community Health Solutions. In this model, prior year locality-level rates were used to predict current year counts and rates, with adjustments for local demographics. Because of data limitations, it is not possible to assign specific margins of error or levels of significance to these statistical estimates. Likewise, it is not possible to calculate the statistical significance of differences between local rates and state rates. Additionally, populations in group living quarters (e.g. colleges) and undocumented populations may not be adequately addressed in this model.</p>

Community Insight Survey Results
Prepared for Sentara Careplex Hospital
By Community Health Solutions
August 2016

Community Survey Results

This report presents the results of a *Community Survey* commissioned by Sentara Careplex Hospital (Sentara Careplex). The survey is part of Sentara Careplex's 2016 Community Health Needs Assessment project. The survey was conducted jointly by Riverside Health System and Sentara Healthcare in an effort to obtain community input for the study. The *Community Survey* was conducted with a broad-based group of community stakeholders. The survey participants were asked to provide their viewpoints on:

- Important health concerns in the community;
- Significant service gaps in the community;
- Vulnerable/at-risk populations in the community;
- Vulnerable/at-risk geographic regions in the community;
- Existing health assets within the community;
- Health assets needed in the community; and
- Additional ideas or suggestions for improving community health.

The community stakeholder list included representatives from public health, education, social services, business, local government and local civic organizations, among others. Riverside Health System and Sentara Healthcare staff conducted outreach for community input via email, through personal phone calls, and in-person at local events and meetings. An email survey request was sent to 922 unduplicated community stakeholders, and a total of 82 stakeholders in the Sentara Careplex service area submitted a response (although not every respondent answered every question). The respondents provided rich insights about community health in the study region. The survey results are summarized in the report, and detailed, open-ended responses are provided in *Appendix A*.

1. Survey Respondents by Organization

As shown in *Exhibit 1* on the following page, survey respondents were asked to provide the name of their organization.

Exhibit 1. Survey Respondents by Organization

What is the name of your organization?

Note: A count is provided for organizations with multiple survey respondents.

Angels of Mercy Medical Clinic	Riverside Doctors' Hospital Williamsburg- Board Member
Auxiliary of Sentara Williamsburg Regional Medical Center (2)	Respite Care of Williamsburg United Methodist Church
Avalon	Retired
Bay Rivers Telehealth Alliance	Riverside Behavioral Health Center
Beyond Boobs!	Riverside Health System (2)
Brentwood Pediatrics	Riverside House Calls Practice
Catholic Charities of Eastern Virginia	Riverside Medical Group
Celebrate Healthcare LLC	Riverside Medical Group - ED
Center for Weight Loss Success	Riverside PACE
City of Hampton, City Manager's Office	Second Chances Comprehensive Services LLC
City of Newport News	Sentara Family and Patient Advisory Committee
Colonial Behavioral Health (3)	Sentara Patient Family Advisory Counsel
County of York	Sentara Williamsburg Regional Medical Center (2)
Dominion Physical Therapy	Southeastern Virginia Health System
ECPI Medical Careers Institute	Spectrum/York County Board of Supervisors Chair
Foundation for Rehabilitation and Endowment	The Community Free Clinic
Hampton City Schools	Thomas Nelson Community College
Hampton Health Department	Tidewater Diagnostic Imaging
Hampton Newport News CSB	TowneBank
Hampton Roads Neurosurgical and Spine Specialists	TPGM
Hampton Roads Specialty Hospital	United Way of Greater Williamsburg
Hospice House and Support Care of Williamsburg (2)	United Way of the Virginia Peninsula (2)
James City County	VersAbility Resources
James City County Board of Supervisors	Village Events, Ltd.
James City County Police Department	Virginia Peninsula Chamber of Commerce
Newport News Division of Emergency Management (2)	Virginia Peninsula Foodbank
Newport News Fire Department	Volunteer
Old Hampton Family Associates, PC	Williamsburg Area Faith in Action
Old Point National Bank	Williamsburg Community Foundation
PBMares Wealth Management	Williamsburg Dept. of Human Services
Peninsula Agency on Aging (3)	Williamsburg Emergency Physicians (2)
Peninsula Health District	Williamsburg Health Foundation (2)
Peninsula Metropolitan YMCA	Williamsburg Landing, Inc.
Peninsula Youth Hockey Association	York Board of Supervisors
Poquoson Police Department	York County

2. Community Health Concerns

Survey respondents were asked to review a list of common community health issues. The list of issues draws from the topics in *Healthy People 2020* with some refinements. The survey asked respondents to identify from the list what they view as important health concerns in the community. Respondents were also invited to identify additional issues not already defined on the list. *Exhibit 2* summarizes the results, including open-ended responses.

Exhibit 2		
Important Community Health Concerns Identified by Survey Respondents		
<i>Note: 82 of the 82 respondents answered this question. When interpreting the survey results, please note that although the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.</i>		
Answer Options	Response Percent	Response Count
Mental Health - Behavioral Health Conditions (e.g. depression, anxiety, etc.)	79%	65
Heart Disease	73%	60
High Blood Pressure / Hypertension	73%	60
Substance Abuse (prescription or illegal drugs)	72%	59
Obesity	68%	56
Dementia / Alzheimer's Disease	66%	54
Diabetes	65%	53
Cancer	54%	44
Alcohol Use	51%	42
Chronic Pain	48%	39
Stroke	48%	39
Respiratory Diseases (e.g. asthma, COPD, etc.)	46%	38
Violence – Domestic Violence	46%	38
Accidents / Injuries	43%	35
Violence – Other than domestic violence	43%	35
Hunger	42%	34
Tobacco Use	42%	34
Infant and Child Health	38%	31
Dental / Oral Health Care	37%	30
Arthritis	34%	28
Orthopedic Problems	34%	28
Environmental Health (e.g. pollution, mosquito control, water quality, etc.)	32%	26
Prenatal and Pregnancy Care	31%	25
Neurological Conditions (e.g. seizures, multiple sclerosis, traumatic brain injury, etc.)	29%	24
Renal (kidney) Disease	29%	24
Intellectual/Developmental Disabilities	28%	23
Bullying	27%	22
Physical Disabilities	26%	21
Drowning / Water Safety	23%	19
Continued		

**Exhibit 2
Important Community Health Concerns Identified by Survey Respondents**

Note: 82 of the 82 respondents answered this question. When interpreting the survey results, please note that although the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.

Answer Options	Response Percent	Response Count
Infectious Diseases	22%	18
Sexually Transmitted Diseases	21%	17
Autism	20%	16
Teen Pregnancy	20%	16
HIV/AIDS	17%	14
Other Health Problems (see below)	18%	15
Response #	Other Health Concerns (Open-Ended Responses)	
1	<ul style="list-style-type: none"> • Access to specialty care. • Uninsured. 	
2	<ul style="list-style-type: none"> • All are important to those who are facing them. Gaining Access to Services to address these needs is the challenge 	
3	<ul style="list-style-type: none"> • Frail elders in unsafe situations, negligence and poor nutrition. Keeping elder persons in their home with community support. 	
4	<ul style="list-style-type: none"> • Geriatric outpatient services, comprehensive pain management to include psych services 	
5	<ul style="list-style-type: none"> • I think all of these are important health issues, but rather than checking them all, check the ones that are of highest concern. Again, all are important. The most important and urgent issue currently is violence and, as a subset, those conditions that lead to violence such as substance abuse, mental health, child development and generational poverty. Bullying and obesity are also urgent matters. 	
6	<ul style="list-style-type: none"> • Issues associated with aging-social isolation, unable to drive to doctor appointments 	
7	<ul style="list-style-type: none"> • Lack of Mental Health for acute and chronic care 	
8	<ul style="list-style-type: none"> • lack of regular medical preventive care for many residents. 	
9	<ul style="list-style-type: none"> • Other Health Problems-the growing danger of antibiotic resistant bacteria. • The items selected are health issues that seem to be more prevalent. An aging population and growing numbers of obese individuals raises concerns and incidences of all the other health issues occurring. 	
10	<ul style="list-style-type: none"> • Sexual abuse is not listed; it is a serious health problem. All these I checked, homeless and those with no ID's have a serious problem getting help. 	
11	<ul style="list-style-type: none"> • Sexual assault both on college campus and off. We have seen a very big increase in clients in the last two years. 	
12	<ul style="list-style-type: none"> • The general conditions of seniors; particularly the "old old". 	
13	<ul style="list-style-type: none"> • The jurisdictions of Greater Williamsburg are in need of valid and easy-to-understand education regarding Mental Health. The community at-large would benefit from information on the high prevalence of mental health disorders which would help de-stigmatize the issue, and give people resources on where to turn for help. Also, due to the shortage among the mental health workforce, there is a need for additional training for primary care providers, at all credential levels, to be able to identify, diagnose, treat, and/or make referrals for their patients needing mental health care. 	

14	<ul style="list-style-type: none">• They are all important and usually interrelated, so it's difficult to isolate any one of the above. For example, poor diet and lack of proper nutrition is an issue here, as opposed to "hunger" outright, and, as you are aware, has many side effects.
15	<ul style="list-style-type: none">• VersAbility Resources serves people with a wide array of disabilities throughout the Hampton Roads region. My responses reflect the health concerns faced by people with disabilities.

3. Community Service Gaps

Survey respondents were asked to review a list of community services that are typically important for addressing the health needs of a community. Respondents were asked to identify from the list any services they think need strengthening in terms of availability, access, or quality. Respondents were also invited to identify additional service gaps not already defined on the list. *Exhibit 3* summarizes the results, including open-ended responses.

Exhibit 3		
Important Community Service Gaps Identified by Survey Respondents		
<i>Note: 80 of the 82 respondents answered this question. When interpreting the survey results, please note that although the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.</i>		
Answer Options	Response Percent	Response Count
Mental Health - Behavioral Health Services	64%	51
Aging Services	60%	48
Care Coordination and Transitions of Care	56%	45
Services for Vulnerable Populations (e.g. uninsured/underinsured, migrant workers, homeless, etc.)	54%	43
Health Care Insurance Coverage	53%	42
Services for Caregivers	53%	42
Health Promotion and Prevention Services	48%	38
Substance Abuse Services	45%	36
Chronic Disease Services (e.g. diabetes, high blood pressure, etc.)	44%	35
Transportation Services	43%	34
Food Safety Net (e.g. food bank, community gardens, school lunches, etc.)	40%	32
Long Term Care Services	39%	31
Chronic Pain Management Services	38%	30
Self-Management Services (e.g. nutrition, exercise, taking medications)	38%	30
Dental / Oral Health Care Services	34%	27
Home Health Services	34%	27
Social Services	31%	25
Veterans Services	28%	22
Cancer Services (e.g. screening, diagnosis, treatment, etc.)	25%	20
Primary Care Medical Services	25%	20
Domestic Violence Services	24%	19
Public Health Services	24%	19
Specialty Care Medical Services (cardiologists, oncologists, etc.)	23%	18
Early Intervention Services for Children	19%	15
School Health Services	19%	15
Hospice Services	18%	14
Intellectual/Developmental Disabilities Services	16%	13
Public Safety Services	16%	13
Family Planning Services	14%	11
Maternal, Infant and Child Health Services	14%	11
Environmental Health Services	11%	9
Continued on the following page		

Exhibit 3
Important Community Service Gaps Identified by Survey Respondents

Note: 80 of the 82 respondents answered this question. When interpreting the survey results, please note that although the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.

Answer Options		Response Percent	Response Count
Hospital Services (e.g. inpatient, outpatient, emergency care, etc.)		11%	9
Physical Rehabilitation		11%	9
Pharmacy Services		9%	7
Workplace Health and Safety Services		3%	2
Other Services (see responses below)		10%	8
Response #	Other Service Gaps (Open-Ended Responses)		
1	<ul style="list-style-type: none"> • Access to services through remote technology • Palliative Care and patient care navigation and advocacy 		
2	<ul style="list-style-type: none"> • Affordable, accessible adult day programs 		
3	<ul style="list-style-type: none"> • Companion care that is affordable for those who do not qualify for Medicaid but are still considered low income. 		
4	<ul style="list-style-type: none"> • If one does not have an ID, getting the services I checked off is almost impossible to get. 		
5	<ul style="list-style-type: none"> • Lack of adequate financial resources for the services listed directly impact availability and access. 		
6	<ul style="list-style-type: none"> • Many of these are in place, concerns are with affordability and quality of services provided. 		
7	<ul style="list-style-type: none"> • MAT- medication Assisted treatment for individuals who are chemically dependent particularly in the area of opioids and alcohol. 		
8	<ul style="list-style-type: none"> • The Health Care Insurance coverage needs fixing, since a lot of people still "fall through the cracks", are not covered properly, and have high deductibles and monthly premium costs. A number of seniors, who are solely on Social Security, cannot afford Assisted Living, etc. at \$5,000 a month, and must age in place in their own apartment. 		

4. Vulnerable/At-Risk Populations or Geographic Regions in the Community

Survey respondents were asked if there are particular populations within the community who are vulnerable/at-risk for health concerns or difficulties obtaining health services. Respondents were also asked if there are particular neighborhoods or geographic regions within the community where residents may be vulnerable/at-risk for health concerns or difficulties obtaining health services. *Exhibit 4* provides summary results. Please see *Appendix A, Exhibits A1 and A2* for detailed responses.

Exhibit 4 Vulnerable/At Risk Populations Identified by Survey Respondents	
<i>Respondents identified vulnerable/at risk populations within the following categories (displayed in alphabetical order, not by rank/percent). See Appendix A, Exhibit A1 for 55 detailed responses.</i>	<i>Respondents identified vulnerable/at-risk populations residing within the following places (displayed in alphabetical order, not by rank/percent). See Appendix A, Exhibit A2 for 36 detailed responses.</i>
<ul style="list-style-type: none"> • Children • Disabled • Elderly • Ethnic/Racial Minorities • Homeless • Low Income • Residents with Behavioral Health Conditions (mental health and substance abuse) • Residents without Transportation • Residents who have been Victims of Violence • Uninsured/Underinsured • Unemployed/Underemployed • Veterans 	<ul style="list-style-type: none"> • City of Hampton • City of Newport News • City of Williamsburg • James City County • York County • Areas with Lower Socioeconomic Status • Areas designated as Medically Underserved Areas or Health Professional Shortage Areas • Rural Areas with Less Supports • Hotels (for low income families) • Mobile Home Communities

5. Health Assets in the Community

Survey respondents were asked to identify health assets within the community that promote a culture of health. Respondents were also asked to identify health assets that the community needs, but may be lacking. *Exhibit 5* provides summary results. Please see *Appendix A, Exhibits A3 and A4* for detailed responses.

Exhibit 5 Health Assets in the Community as Identified by Survey Respondents	
<i>Respondents identified existing assets that promote a culture of health in the following categories (displayed in alphabetical order, not by rank/percent). See Appendix A, Exhibit A3 for 61 detailed responses.</i>	<i>Respondents identified assets that the community needs, but may be lacking, in the following categories (displayed in alphabetical order, not by rank/percent). See Appendix A, Exhibit A4 for 49 detailed responses.</i>
<ul style="list-style-type: none"> • Biking and Walking Trails • Community Organizations • Community Volunteers • Faith-Based Organizations • Free and Charitable Clinics • Hospitals and Health Systems • Natural Environment • Recreational Facilities • Safety Net Organizations 	<ul style="list-style-type: none"> • Access to Safe Parks and Recreation Facilities • Behavioral Health Services (Mental Health and Substance Abuse) • Community Services for Seniors • Community Services for Low Income Residents • Health Care Services for Seniors • Health Care Services for Low Income Residents • Primary Medical Care Services • Safe, affordable Housing • Specialty Medical Services • Transportation Services

6. Additional Ideas and Suggestions

Survey respondents were invited to share any additional ideas or suggestions for improving community health. Thirty respondents offered ideas and suggestions related to improving access to services, coordinating health services, creating educational opportunities, providing recreational activities, addressing transportation problems, addressing disparities, targeting resources to populations in need, and community collaboration. *Appendix A, Exhibit A5* provides a detailed listing of the 30 responses.

Appendix A. Detailed Community Survey Responses

Exhibit A1. Vulnerable/At-Risk Populations in the Community	
<p><i>Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.</i></p>	
Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?	
1	<ul style="list-style-type: none"> (I'm on the Bon Secours Community Health Needs Assessment Advisory Board, so I have information that I may have had otherwise.) The low income population and those who do not speak English well are particularly vulnerable. The biggest issue seems to be transportation to any kind of health services. The low income population is also particularly vulnerable because of poor eating habits, resulting in obesity, high blood pressure, and diabetes. It is difficult to afford nutritious food when you can barely afford food of any kind.
2	<ul style="list-style-type: none"> Single, unattached adults with various health, mental health and/or substance abuse histories, with low incomes and poor work histories as a result are in a "catch 22" situation they cannot get out of.
3	<ul style="list-style-type: none"> Aging Low income residents
4	<ul style="list-style-type: none"> Aging People with substance/alcohol use disorders and behavioral health issues Working poor Rural families Veterans
5	<ul style="list-style-type: none"> Both the direct victim, and the children who witness domestic violence are at risk for long term health issues. Sexual assault victims should have access to an advocate and a specialized sexual assault nurse examiner when they are brought to the emergency room and should not be further traumatized by asking them to go to another city.
6	<ul style="list-style-type: none"> Both the uninsured and underinsured The elderly on fixed incomes.
7	<ul style="list-style-type: none"> Co-occurring serious mental illness and mental health and/or substance use disorder; especially those who earn too much money to qualify for Medicaid but not enough to pay for their own insurance. I am quite concerned what will happen to the individuals who are currently covered under GAP insurance when the pilot project ends.
8	<ul style="list-style-type: none"> Dental services for nursing home residents is unobtainable due to lack of facilities that can accommodate wheelchairs and lack of payment. Psych services for pain management has been lacking for years in this area. Outpatient geriatric primary care; many primary care practices are not equipped to handle geriatric patients and geriatric syndromes. They don't have the time, training and expertise for this population.
9	<ul style="list-style-type: none"> Elderly/Aged Mental Health Physical and Developmental Disabilities
10	<ul style="list-style-type: none"> Frail elders who have no family or unreliable family to support them. Especially persons with chronic disease, who have visual and cognitive impairment. Medication management is a huge area of difficulty for these persons.
11	<ul style="list-style-type: none"> Homeless families
12	<ul style="list-style-type: none"> Homeless population, human sex trafficked females. The City of Williamsburg and James City County refuse to accept they exist, and the uninsured/underinsured.
13	<ul style="list-style-type: none"> Indigents Individuals with no insurance or poor plans.

Exhibit A1. Vulnerable/At-Risk Populations in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?

	<ul style="list-style-type: none"> • Geriatrics
14	<ul style="list-style-type: none"> • Individuals in a poverty situation
15	<ul style="list-style-type: none"> • Low income
16	<ul style="list-style-type: none"> • Low income populations-both elderly and transient • Uninsured residents
17	<ul style="list-style-type: none"> • Low income teenagers
18	<ul style="list-style-type: none"> • Low income • Seniors with limited income • Single adults with no children • Mobile home dwellers • Families living in hotels
19	<ul style="list-style-type: none"> • Low income • Uneducated • Mentally disabled(ill) population
20	<ul style="list-style-type: none"> • Lower income • Elderly populations • Those who speak a foreign language are most vulnerable to not getting services they need or understanding what they need to do to take care of their health needs at home.
21	<ul style="list-style-type: none"> • Low-income • Seasonally employed persons face significant challenges to securing affordable health insurance and therefore preventive health care including mental health care.
22	<ul style="list-style-type: none"> • Many older individuals are in need of safe, affordable housing and lack transportation resources to enable them to access health care. • Health care providers also need to become more aware of the importance of social determinants in achieving successful health outcomes long term.
23	<ul style="list-style-type: none"> • Many patients that are Medicaid eligible fail to renew their services causing lapses in insurances. Others are unaware of Medicaid transportation services and miss appointments. Medicaid transportation requires that participants give 5 days' notice prior to appointment. This poses a problem if a patient is sick and needs a same day appointment. These patients tend to use emergency rooms or urgent care services, as they are unable to get transportation during normal business hours. • Medicaid adolescents are at increased risk for anxiety and depression. Much if this is linked to family social situations (i.e. homelessness, poverty, lack of food and necessary resources).
24	<ul style="list-style-type: none"> • Mental health screenings and inpatient services
25	<ul style="list-style-type: none"> • Mental health • Elderly • Disabled
26	<ul style="list-style-type: none"> • People living in poverty- especially children • Seniors living alone
27	<ul style="list-style-type: none"> • People who are isolated and/or dealing with depression are more likely to have bad health outcomes, yet they are difficult to reach. Services for managing depression, especially in the elderly, are difficult to find.
28	<ul style="list-style-type: none"> • People with disabilities face inadequate access to dental care and transportation challenges in accessing health care.

Exhibit A1. Vulnerable/At-Risk Populations in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?

29	<ul style="list-style-type: none"> • People without access to regular health services including people who are: <ul style="list-style-type: none"> ○ Unemployed or under-employed ○ Having few or no transportation resources ○ Living in low-income environmentally unsafe housing ○ Limited literacy (including English speakers) ○ A number of vulnerable people fall into more than one of these categories
30	<ul style="list-style-type: none"> • Residents living at or below the poverty level
31	<ul style="list-style-type: none"> • Senior citizens living alone • Families in economically deprived communities
32	<ul style="list-style-type: none"> • Senior citizens • Children • Infants
33	<ul style="list-style-type: none"> • Seniors • Lower income
34	<ul style="list-style-type: none"> • Seniors-especially those who no longer drive [and] have no family nearby
35	<ul style="list-style-type: none"> • Teens • Homeless
36	<ul style="list-style-type: none"> • The city has an influx of immigrant refugees who are settling in the area. These individuals have limited or no English skills when they first arrive and have many mental health issues associated with past abuse and being so far from their home country with foreign customs they are not familiar with.
37	<ul style="list-style-type: none"> • The financially disadvantaged
38	<ul style="list-style-type: none"> • The homeless • The elderly
39	<ul style="list-style-type: none"> • The lower income population • Residents who speak English as a 2nd language • Single parent households
40	<ul style="list-style-type: none"> • The metro system in our area is poor. This means that individual would have a difficult time getting back and forth to doctor appointments.
41	<ul style="list-style-type: none"> • The poor elderly
42	<ul style="list-style-type: none"> • The poor, the elderly and special needs populations are vulnerable to injuries from falls or untreated/undiagnosed illnesses. They also have needs related to hunger and nutrition, poverty, and suitable housing.
43	<ul style="list-style-type: none"> • Under-employed/unemployed • Homeless • Minority immigrant population • Dementia / Alzheimer patients without a family support group.
44	<ul style="list-style-type: none"> • Underinsured and uninsured
45	<ul style="list-style-type: none"> • The uninsured - disjointed services. FQHC's such as SEVHS provide the primary care services but access to specialty services, procedures, diagnostic imaging are very limited and maybe nonexistent for the uninsured.
46	<ul style="list-style-type: none"> • The very elderly • Very poor

Exhibit A1. Vulnerable/At-Risk Populations in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?

47	<ul style="list-style-type: none"> • Underinsured and uninsured.
48	<ul style="list-style-type: none"> • Uninsured and underinsured populations • Elderly • Mentally ill and disabled, as well as their caregivers • Children • Young adults.
49	<ul style="list-style-type: none"> • Uninsured patients in Newport News and Hampton are at risk for major health problems. They have many complex care needs and the clinics are trying but there are so many patients and the clinics do not currently have the capacity to handle the volumes. Riverside makes major donations but the other hospitals need to support as well. Patients are in and out of the hospitals for major problems and if we develop a collaborative strategy to promote health and wellness for this population we will have a major impact and save precious dollars.
50	<ul style="list-style-type: none"> • Uninsured • Working poor and those below the poverty line (income) • Elderly
51	<ul style="list-style-type: none"> • Urban areas that have residents that fall into the Medicaid gap.
52	<ul style="list-style-type: none"> • Many lower income households do not go to the doctor or take their meds putting them at greater risk for health problems.
53	<ul style="list-style-type: none"> • Homeless • Mentally Ill • Low income
54	<ul style="list-style-type: none"> • Young black males • Poor families • The mentally ill
55	<ul style="list-style-type: none"> • Young women with cancer especially breast cancer

Exhibit A2. Vulnerable/At-Risk Regions in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Are there particular neighborhoods or geographic regions within the community where the resident population may vulnerable or at risk for health problems or difficulties obtaining health services?

1	<ul style="list-style-type: none"> All of the areas in my service area that are listed as MUA's - medically underserved and HPSA's.
2	<ul style="list-style-type: none"> All of the very low economic census tracts in Hampton, James City County, Williamsburg and Newport News.
3	<ul style="list-style-type: none"> All the lower SES neighborhoods.
4	<ul style="list-style-type: none"> Any of our woods have so many homeless, low budget hotels
5	<ul style="list-style-type: none"> Any place where the population is impoverished.
6	<ul style="list-style-type: none"> Buckroe / Phoebus areas
7	<ul style="list-style-type: none"> Census tracts: 502.4, 505, 506 Lackey area of York County
8	<ul style="list-style-type: none"> Downtown Newport News and Hampton are particularly at risk and have less adequate understanding of their chronic disease, less trust of the healthcare system and are at particular risk for poor nutrition, safety and ability to care for themselves.
9	<ul style="list-style-type: none"> Grove
10	<ul style="list-style-type: none"> Grove Chickahominy Road Other low income areas
11	<ul style="list-style-type: none"> Grove East End of Newport News for cancer screenings like mammograms
12	<ul style="list-style-type: none"> Grove Lackey Chickahominy Road Centerville Road Any place in the James City or York Counties that have limited access to public transportation
13	<ul style="list-style-type: none"> It varies, but there are lower socio-economic areas that are more impacted with more serious and chronic health issues for a number of reasons.
14	<ul style="list-style-type: none"> Lackey Grove
15	<ul style="list-style-type: none"> Low income seniors in any neighborhood throughout the region. Perception that in some neighborhoods all are wealthy, but that's not accurate. There are needy seniors in all areas. Some areas definitely have concentrations of low income populations: <ul style="list-style-type: none"> Grove area Chickahominy Haven
16	<ul style="list-style-type: none"> Lower income
17	<ul style="list-style-type: none"> Lower income areas
18	<ul style="list-style-type: none"> Newport News Rural areas with less supports
19	<ul style="list-style-type: none"> Newport News Hampton
20	<ul style="list-style-type: none"> Newport News residents
21	<ul style="list-style-type: none"> Nursing homes and long term health care facilities Southeast Community Northwest Community (Denbigh)
22	<ul style="list-style-type: none"> Residents in the East-end of Newport News

Exhibit A2. Vulnerable/At-Risk Regions in the Community

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Are there particular neighborhoods or geographic regions within the community where the resident population may vulnerable or at risk for health problems or difficulties obtaining health services?

	<ul style="list-style-type: none"> • Parts of Downtown Hampton, particularly zip code 23661
23	<ul style="list-style-type: none"> • Southeast Newport News
24	<ul style="list-style-type: none"> • Southeast Newport News • Sections of Hampton
25	<ul style="list-style-type: none"> • Southeast Newport News, • Grove area of James City County (and upper Newport News) • Lackey area of York County • Williamsburg/JCC areas that must depend on public transportation. The buses stop too early and don't go far enough for them to obtain some needed health services.
26	<ul style="list-style-type: none"> • Southeast portion of Newport News
27	<ul style="list-style-type: none"> • Southeastern area of Newport News
28	<ul style="list-style-type: none"> • The areas that are underserved tend to be those with lower socioeconomic status.
29	<ul style="list-style-type: none"> • The east and north ends of the city have more elderly and low-income individuals.
30	<ul style="list-style-type: none"> • The east end of Newport News.
31	<ul style="list-style-type: none"> • The metro system in our area is poor. This means that individual would have a difficult time getting back and forth to doctor appointments.
32	<ul style="list-style-type: none"> • The mobile home community located at 214 Wythe Creek Road has needs for enhanced services related to poverty, hunger, substance abuse, particularly among the elderly and special needs populations.
33	<ul style="list-style-type: none"> • The poorer communities: <ul style="list-style-type: none"> ○ Grove in James City County ○ East End in Newport News ○ North End in York
34	<ul style="list-style-type: none"> • The Southeast Community of Newport News is at major risk for health problems and some of the patients fall in the gaps. Once they are hospitalized for emergencies, they are back in the communities and very often care is not coordinated well from hospital to community. Patients lack health care literacy, they do not trust the health care systems and as a result they only seek health care when desperate. In addition, there are many mental health issues and there must be an answer to solving some of the mental health problems. We have not solved the bed issue for patients needing to be hospitalized and they end up on the streets and sometimes doing violent crimes. • The Denbigh section or the northern area of Newport News is developing a reputation for needing help must like the southeast of Newport News. People are uninsured, and they live in poverty. For both groups even if they work, they are living in poverty at the minimum wage. • Hampton has pockets of the same and the collaborative strategy must address the health of the population. The Health Departments seem to be limited in what they provide and this issue needs to be addressed. (Health Dept. Services vs. Needed Services)
35	<ul style="list-style-type: none"> • Downtown Newport News • Hampton
36	<ul style="list-style-type: none"> • South of Mercury Blvd

Exhibit A3. Health Assets in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?

1	<ul style="list-style-type: none"> • Three health networks
2	<ul style="list-style-type: none"> • A place where wildlife can be protected
3	<ul style="list-style-type: none"> • AA • Al Anon • Capital Trail • Freedom Park
4	<ul style="list-style-type: none"> • Any walking or biking trail.
5	<ul style="list-style-type: none"> • Bike trails • Walking trails • Beaches.
6	<ul style="list-style-type: none"> • Built and Natural resources • Programs (obesity, diabetic management)
7	<ul style="list-style-type: none"> • Church • People
8	<ul style="list-style-type: none"> • Clean air and water • Recreational opportunities
9	<ul style="list-style-type: none"> • Clinics that serve the uninsured/underinsured for an affordable cost.
10	<ul style="list-style-type: none"> • Community Health Foundation, • Parks and Recreation facilities- parks, trails, facilities in James City County • Community pools • Jamestown Beach • VA Cooperative Extension programs • Groups like Beyond Boobs!, Erase the Need • Nonprofit community organizations
11	<ul style="list-style-type: none"> • For the low income population, the most needed/important health assets are the institutions and the people who work/volunteer there. • Our community has the highest level of food insecurity in the state of Virginia, which tells me that our poverty rate is very high. These individuals can't be concerned with walking trails and beaches when they have other more important needs (health assets) not being met.
12	<ul style="list-style-type: none"> • FQHC • Free Clinics
13	<ul style="list-style-type: none"> • Free clinics • Great hospitals • Nonprofit health organizations (CDR,Beyond Boobs!,Bacon Street, the four free clinics) • Cancer medical professionals and facilities • YMCAs and Rec centers
14	<ul style="list-style-type: none"> • Hospital systems • Health department • Social services • Community centers

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Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?

	<ul style="list-style-type: none"> • YMCA • Parks and Recreation • School system • Daycare • After school programs • Buckroe beach • Community and civic organizations
15	<ul style="list-style-type: none"> • Hospitals • Health care systems • Schools • Churches
16	<ul style="list-style-type: none"> • Hospitals • Hospice Care • Walking Trails
17	<ul style="list-style-type: none"> • Hospitals • Urgent care facilities • Mental and behavioral health care facilities • Parks • Beaches • Outdoor and Indoor entertainment areas
18	<ul style="list-style-type: none"> • In general, we have good medical providers. • We also have access to many public parks and recreation activities that promote wellness
19	<ul style="list-style-type: none"> • James City County Parks and Recreation including their many parks, walking trails, and Rec Connect program. • Williamsburg Area Faith in Action is a wonderful health asset for our elderly population providing needed transportation services and respite care. • Williamsburg Health Foundation is a tremendous health asset for the Greater Williamsburg community providing more than \$4 million a year in grants to agencies and programs like Olde Towne Medical Center and the School Health Initiative Program.
20	<ul style="list-style-type: none"> • Local hospitals • Free clinics • Human service programs that address and support health and mental health issues.
21	<ul style="list-style-type: none"> • Local Parks and Rec programs • Area health systems • AAA's • Local food bank
22	<ul style="list-style-type: none"> • Medical professionals • Walking trails • Hospitals
23	<ul style="list-style-type: none"> • Medical specialists to serve a growing aging population. • Walking and biking trails.

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Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?

24	<ul style="list-style-type: none"> • Mental health agencies that can provide care to those within the home.
25	<ul style="list-style-type: none"> • Network of Care website: wmbgcares.org • Strong network of safety-net healthcare clinics, but are only serving approximately one-third of people with no health insurance.
26	<ul style="list-style-type: none"> • Newport News Park • Noland Trail • Sandy Bottom • Gosnold Park, • Old Sentara Fitness trail • These are great resources within the community that can be utilized by residents to promote fitness and leisurely fun.
27	<ul style="list-style-type: none"> • Noland • Sidewalks • Street lights • Green spaces
28	<ul style="list-style-type: none"> • Noland Trail • Matteson Trail
29	<ul style="list-style-type: none"> • Noland Trail/Lion Bridge • Newport News Bike Trail • YMCA • Riverview Park Walking Trail • Hunington Park • Riverside Wellness and Fitness Centers • 3K and 5K Walk Run Marathon events
30	<ul style="list-style-type: none"> • Open areas • Walking trails etc.
31	<ul style="list-style-type: none"> • Open, recreational spaces • Bike trails
32	<ul style="list-style-type: none"> • Outdoor recreation opportunities • Public and private gyms • Community centers
33	<ul style="list-style-type: none"> • Outdoor safe walking and biking trails.
34	<ul style="list-style-type: none"> • Parish thrift shop and food pantry • EMS services • Health screenings and flu shots • Red Cross blood drives.
35	<ul style="list-style-type: none"> • Parks
36	<ul style="list-style-type: none"> • Parks • Beaches
37	<ul style="list-style-type: none"> • Parks • Wellness centers

Exhibit A3. Health Assets in the Community

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Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?

	<ul style="list-style-type: none"> • Beaches • Libraries • Churches who house peer support groups or other community health activities.
38	<ul style="list-style-type: none"> • Peninsula Agency on Aging's programs, esp. Eastern Virginia Care Transitions Program, Chronic Disease Self-Management, Matter of Balance. • For youth- the SHIP programs. • Easier access to safe biking routes, share the road enforcement.
39	<ul style="list-style-type: none"> • People • Available • Programs • Natural resources
40	<ul style="list-style-type: none"> • Preventive health education • Nutrition education • Culture of wellness • Unfortunately, if you are not in the "well" group and are older then the services become more scarce.
41	<ul style="list-style-type: none"> • Primary care, acute care, emergency care and specialty care readily available and accessible. • Schools, parks, trails and organizations that promote a culture of health and provide access to and motivational incentives for healthy lifestyles.
42	<ul style="list-style-type: none"> • Professionals • Hospitals • Clinics • Natural environment
43	<ul style="list-style-type: none"> • Quality Care (Riverside/Sentara)
44	<ul style="list-style-type: none"> • Quality hospital systems • Public parks/beaches • Foodbank • CINCH
45	<ul style="list-style-type: none"> • Riverside Health System • Riverside and Sentara Wellness Centers • YMCA • Noland Trail • Newport News Park
46	<ul style="list-style-type: none"> • Sidewalks so people can walk, not the trails, they lead nowhere!
47	<ul style="list-style-type: none"> • The elderly tend to be uninsured or not insured enough. They tend to not seek medical care because of out of the pocket expense until they are so sick that someone else has to make the decisions for them.
48	<ul style="list-style-type: none"> • The integrated assets of Riverside Health System and Sentara • Hampton University's Proton Therapy Center • Grafton and Southeast Newport News Clinics • Newport News parks and Noland Trail • Peninsula Public Health • PACE

Exhibit A3. Health Assets in the Community

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Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?

49	<ul style="list-style-type: none"> • The two health systems • Senior living communities
50	<ul style="list-style-type: none"> • There are numerous organizations, both public and private, along with faith-based communities who are addressing these issues. • It would help to develop a better community health strategy that maximizes every entity's potential. I know that the Williamsburg Health Foundation is working on this.
51	<ul style="list-style-type: none"> • This area being strong in a senior population, I think we need more available places for assisted living that are affordable. • More educational programs for seniors
52	<ul style="list-style-type: none"> • This is a beautiful area, we have lots of parks and beaches, museums. • 2 major hospitals that are an asset to the community. • A Community Services Board that is the 2nd largest in the state and has a full continuum of services.
53	<ul style="list-style-type: none"> • Trails- James City County in particular has outstanding biking/walking trails. • There are many parks as well.
54	<ul style="list-style-type: none"> • Two hospitals • Old Towne Med Centre • Health provider volunteers
55	<ul style="list-style-type: none"> • Two hospitals • Miles of bike trails • Several good parks for those who can get there • Recent efforts to install sidewalks • Network of safety net clinics and a relatively strong group of non-profits focused on health and human services
56	<ul style="list-style-type: none"> • Walking and biking trails • Organized activities that are close to neighborhoods that may help mitigate isolation among the elderly and those dealing with depression.
57	<ul style="list-style-type: none"> • Walking trail and cost effective programs at the James City County Rec. Center. • Walking trails all over town. • Colonial Williamsburg is a lovely place to walk. • Many senior programs at the library. • Programs offered by Sentara Williamsburg Regional Medical Center
58	<ul style="list-style-type: none"> • Walking trails and parks. If our area were more 'walkable' it may help to curb some of the health issues our residents are facing.
59	<ul style="list-style-type: none"> • We live in beautiful communities but people are fearful to use the many trails or natural areas due to crime. • We have the Nolan Trail that seems to be safe but if you live in the Southeast, the beach is beautiful but crime, gangs etc. create a climate that affects safety. When growing up we were able to go anywhere and feel safe. Not the case anymore.
60	<ul style="list-style-type: none"> • Wellness Centers. • Athletic programs associated with educational facilities at all levels. • Chronic disease self-management programs.
61	<ul style="list-style-type: none"> • YMCA and similar facilities

Exhibit A4. Health Assets Needed in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Are there any health assets that the community needs, but may be lacking?

1	<ul style="list-style-type: none"> • A better system of walking, running, biking trails.
2	<ul style="list-style-type: none"> • Access to care is a huge issue, availability of substance abuse treatment,
3	<ul style="list-style-type: none"> • Access to gyms and practice time for public school student athletes.
4	<ul style="list-style-type: none"> • Access to specialty care and transportation is a barrier.
5	<ul style="list-style-type: none"> • Adequate transportation to access resources • Access to safe, affordable, housing
6	<ul style="list-style-type: none"> • Affordable fitness centers, esp. Low cost options for seniors at the rec centers that allow them access to all programs during less busy times.
7	<ul style="list-style-type: none"> • Affordable public transportation with a set schedule and routes. • Additional access to safety-net healthcare and the means to publicize this. • Health insurance that would become available through the state expanding Medicaid.
8	<ul style="list-style-type: none"> • All need a better job at getting their message out to the public.
9	<ul style="list-style-type: none"> • Better access to mental health care for children and low-income populations.
10	<ul style="list-style-type: none"> • Better Mental Health Services
11	<ul style="list-style-type: none"> • Better transportation • More dental health availability • More specialty health services. • More translators at health providers for those who do not speak English well
12	<ul style="list-style-type: none"> • Boys and Girls clubs to provide afterschool homework assistance. These such programs used to offer after school snacks and evening meals. These programs help to fill the gaps and helped to strengthen select children's positive surroundings. Tutoring programs and programs that provide free internet access to children could help at risk children increase chances of school and lifetime success.
13	<ul style="list-style-type: none"> • Chain grocery stores for low income areas - one is coming soon to the East End area of Newport News after many years of advocacy.
14	<ul style="list-style-type: none"> • Colonial Services Behavioral Health program is overwhelmed and insufficient.
15	<ul style="list-style-type: none"> • Community entities such as schools, churches lack educational opportunities to learn how to promote preventive health and healthy alternatives
16	<ul style="list-style-type: none"> • Connecting walking/bike trails (to get to downtown Hampton, safe routes to school, etc.) • increased access to healthy, affordable foods (Farmers markets, grocery stores)
17	<ul style="list-style-type: none"> • Efficient public transportation • Food access in the several food deserts • Safe and affordable housing
18	<ul style="list-style-type: none"> • Elderly care specifically assisted living, home health care options, and long term [care].
19	<ul style="list-style-type: none"> • Free or reasonable cost health clinics • More walking trails
20	<ul style="list-style-type: none"> • Homeless services are minimal
21	<ul style="list-style-type: none"> • I don't like making broad statements, but a large part of the issue is lack of affordability and lack of access to the right kind of services.
22	<ul style="list-style-type: none"> • Invest in upgrading Newport News park with quality

Exhibit A4. Health Assets Needed in the Community

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Are there any health assets that the community needs, but may be lacking?

	<ul style="list-style-type: none"> • Provide more family shelters and playground equipment • Provide quality bikes for guest to ride in NN Park. • Provide low cost classes for families on diabetes, kidney disease, mental illness and high blood pressure training and education.
23	<ul style="list-style-type: none"> • Long term health care in the home
24	<ul style="list-style-type: none"> • Lower cost to access the community rec centers. Indigent people cannot afford to go to any type of gym
25	<ul style="list-style-type: none"> • Many of the poor and elderly need assistance with maintaining their homes, particularly at the mobile home community located at 214 Wythe Creek Road. • Affordable medical care for the poor and family medical practices located in the city.
26	<ul style="list-style-type: none"> • Mental health (improving)
27	<ul style="list-style-type: none"> • Mental health services and professionals are in too short supply
28	<ul style="list-style-type: none"> • Mental health services • Substance abuse counselors
29	<ul style="list-style-type: none"> • More bike paths • Funding for all the nonprofits doing health related work • Older citizen's health activities like Thai Chi classes, etc. in the parks
30	<ul style="list-style-type: none"> • More eye surgeons • Affordable facilities for indoor exercise and work out equipment.
31	<ul style="list-style-type: none"> • More Medicaid Waivers so people with disabilities have resources to access services • Handicapped transportation to access health assets • Respite care • Dentists qualified and willing to treat people with disabilities and accept Medicaid • Autism-specific care and supports • More choices of insurance companies to ensure competition
32	<ul style="list-style-type: none"> • More resources and time in our public schools dedicated to health.
33	<ul style="list-style-type: none"> • Not sure of the trails that are in the Hampton area. If there are none available, it would be good to see Hampton put one in.
34	<ul style="list-style-type: none"> • One of our elderly patients was just informed by a dermatologist that the soonest his skin condition could be evaluated was in 2017 (more than 7 months from now). • There are still many parts of Williamsburg, York County and James City County that lack safe biking paths along roads.
35	<ul style="list-style-type: none"> • Pedestrian friendly environments which encourage people to walk to work, shop, entertainment. • Lack of pedestrian amenities encourage use of cars for short travel distances.
36	<ul style="list-style-type: none"> • Preservation for wildlife
37	<ul style="list-style-type: none"> • Psychiatry for all ages, inpatient and outpatient. Counselors cannot prescribe and prescribing providers are hard to find and, unfortunately many prescribing providers have English as a second language so can be hard for the elderly and patients with their own limited English proficiency to understand.
38	<ul style="list-style-type: none"> • Regular preventive health care so that the first responders and hospitals are not overwhelmed with non-emergency calls.
39	<ul style="list-style-type: none"> • Safe exercise areas in the troubled communities like the southeast. Only now is there a grocery store due to open in a month. • Safe walking areas that allow residents to walk without fear.

Exhibit A4. Health Assets Needed in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Are there any health assets that the community needs, but may be lacking?

40	<ul style="list-style-type: none"> • Sidewalks and bike travel corridors in Williamsburg/ James City County • Access to health care services through schools in rural areas • Affordable and timely Alcohol, substance abuse treatment and prevention and behavioral health services • Care navigation and case management for all who desire it regardless of disease state, age or insurance status
41	<ul style="list-style-type: none"> • Sidewalks • Streetlights • Bike paths
42	<ul style="list-style-type: none"> • Specialized senior services • Clinical care centers, e.g., physician offices devoted to the care of seniors
43	<ul style="list-style-type: none"> • Support for the frail elder population. Persons who are challenged to leave their home, have impairment in hearing and vision and understanding of the many medications and chronic diseases that they face daily.
44	<ul style="list-style-type: none"> • Transportation • Advocacy for the very elderly and weak patients
45	<ul style="list-style-type: none"> • We have a very good foundation of all of the health assets needed to keep our citizens healthy, we just have to connect the facilities and the services to the people.
46	<ul style="list-style-type: none"> • We would benefit from more specialists in certain areas to avoid delays in care, especially neurology and pain management
47	<ul style="list-style-type: none"> • Williamsburg and surrounding counties have no affordable access to gyms of any kind. In particular, the James City County Recreational Center and YMCA are not affordable for lower SES families. • There are abundant instructional/educational classes for kids but again for many families they are way too expensive. • There is very little help for children struggling academically and most needy kids cannot afford private tutors.
48	<ul style="list-style-type: none"> • Agencies are out there but more community partnerships are needed.
49	<ul style="list-style-type: none"> • York County doesn't have bus services to transport individuals to doctor appointments or other activities.

Exhibit A5. Additional Ideas and Suggestions

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Optional: Please use the space below to share any additional ideas or suggestions for improving community health.

1	<ul style="list-style-type: none"> • Access to medications via community hospitals via outpatient pharmacies that can supply generic medications at cost or just above costs to insure access to medications post hospitalizations and f/u with primary care physicians
2	<ul style="list-style-type: none"> • Access to specialty care • Transportation issues and congested traffic is a barrier to care.
3	<ul style="list-style-type: none"> • Additional crime prevention to lower the number of individuals who are killed or injured through gun violence. It seems to be getting worse.
4	<ul style="list-style-type: none"> • Affordable extracurricular activities for children especially in the summer • Increased educational opportunities • Affordable gym membership for needy families.
5	<ul style="list-style-type: none"> • Better coordination of home health follow-up services, integrated medical records
6	<ul style="list-style-type: none"> • Bring back Community Health Fair Day to include seminars, educational handouts • Vans with preventive healthcare staff available to train/educate and refer clients etc. • "Knowledge is power" and I believe that it will help to make our community a healthier environment! Thank you! This is exciting!
7	<ul style="list-style-type: none"> • Community partnership and fellowship
8	<ul style="list-style-type: none"> • Consider taking the resources to where the people are instead of the people having to come to the resources
9	<ul style="list-style-type: none"> • Doctors and their staffs should work for their patients
10	<ul style="list-style-type: none"> • Engage the public sector, the educational community, and the business community at a higher level to encourage collaboration to address the social determinants
11	<ul style="list-style-type: none"> • Find a way to end competition between two health systems and combine resources to provide better coverage for both facilities in this area.
12	<ul style="list-style-type: none"> • Free health screening programs for all age groups.
13	<ul style="list-style-type: none"> • Have free or people can volunteer their time in exchange for use of the rec centers.
14	<ul style="list-style-type: none"> • Hospitals, FQHC's and private providers must work together to provide overall health care services and coverage for all - uninsured, underinsured and insured.
15	<ul style="list-style-type: none"> • I believe I have made my point that the frail elder population does not have a presence or voice in the community. Services for this group who cannot leave their home is very limited.
16	<ul style="list-style-type: none"> • I would encourage health systems to promote population health by striking a balance between clinical care and utilization of non-clinical supports and services.
17	<ul style="list-style-type: none"> • Increased collaboration and communication among community organizations to improve the health of community members (strengthen current programs, don't reinvent or duplicate what's already being done, etc.)
18	<ul style="list-style-type: none"> • It isn't until every part of the community, be they health organizations working together, business, government, employers, and community volunteer organizations, etc. come together with a defined strategy and coordinated role for everyone that we will see a major change in how we approach this subject.
19	<ul style="list-style-type: none"> • More accessible bike paths and walking trails in James City County to encourage people to bicycle or walk to their places of work, school, church, and play. We live in a beautiful part of the country and should encourage residents to get out and walk instead of driving.
20	<ul style="list-style-type: none"> • More health education resources
21	<ul style="list-style-type: none"> • More resources are needed to support residents that are economically marginalized, particularly around general health care and dental services.
22	<ul style="list-style-type: none"> • Need to be prepared for rapidly growing older senior population (those 75 and older).

Exhibit A5. Additional Ideas and Suggestions

Note: The survey was conducted on a regional basis for multiple communities that fall within the Peninsula region. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the Sentara Careplex study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix B for details.

Optional: Please use the space below to share any additional ideas or suggestions for improving community health.

23	<ul style="list-style-type: none"> Place greater resources (and advocate for reimbursement mechanisms) that support health education (nutrition and physical activity support), self-management support (particularly for the prevention and management of prediabetes, diabetes, obesity, and heart disease), disease prevention, and health promotion.
24	<ul style="list-style-type: none"> Politicians need to invest more heavily in early childhood education services to make them available to all children regardless of ability to pay. Additionally, parents that lack the ability to parent effectively should have parenting classes more readily available.
25	<ul style="list-style-type: none"> Providing individuals with accessible home health care that is affordable could save the EMS and hospital services millions each year by reducing non-emergency patients.
26	<ul style="list-style-type: none"> Support for emergency preparedness. Emerging disease such as Zika.
27	<ul style="list-style-type: none"> The biggest need is to have regular stakeholder's meetings with all of the community health service providers to plan, discuss and work through issues as needed to improve our overall community health. I look forward to the meeting and the discussions.
28	<ul style="list-style-type: none"> The knowledge and skill level among health care workers with regard to advance care planning is poor, and this is reflected in the low percentage of residents with advance directives; it is also evident in those who receive unwanted aggressive treatments at the end of life, or the patients/families with unrealistic expectations at the end of life.
29	<ul style="list-style-type: none"> There are still many disparities within the communities. We need to address the racial divide in a serious way so that when diverse members of the community show up in the ER's they are not treated as drug seekers when they are ill or ignored for whatever reason. Sickle cell anemia is a condition that causes severe pain, yet patients with this disease report they are treated poorly because they are profiled as drug seekers. We all are products of our environments and we hold certain beliefs that affect the way we view each other. We need more open dialogue to learn about each other and know what it feels like to walk in each other's shoes. The profiling affects the poor most often and we must advocate for all. Thanks for the opportunity to share my views.
30	<ul style="list-style-type: none"> We need more care facilities after surgery for rehab that are not connected to aging facilities or ill patients.

Appendix B: Data Sources

Section	Source
Part I. Community Survey Results	
<p>1) Community Survey results as shown throughout Part 1.</p>	<p>Community Survey results are based on Community Health Solutions (CHS) analysis of <i>Community Survey</i> responses submitted by community stakeholders. The survey was conducted as follows:</p> <p>Riverside Health System and Sentara Healthcare worked collaboratively to conduct a joint community stakeholder survey for the following Peninsula region facilities:</p> <ul style="list-style-type: none"> • Riverside Doctors' Hospital Williamsburg; • Sentara Careplex Hospital; • Sentara Williamsburg Regional Medical Center; and • Four Riverside Peninsula market facilities (Riverside Hampton Roads Specialty Center, Riverside Regional Medical Center, Riverside Behavioral Health Center, and Riverside Rehabilitation Institute). <p>The two health systems collaborated on survey-related communications, and developed the survey instrument with technical support from CHS.</p> <p>Each system developed its own survey recipient list. The recipient lists were combined, and an email survey request was sent to 922 unduplicated community stakeholders on April 25, 2016. To enable assignment of responses to a particular facility's report, survey respondents were asked to identify the localities where they lived, worked, or both. A follow-up email request was sent on May 12, 2016. Additionally, Riverside Health System and Sentara Healthcare conducted outreach for community input via email, personal phone calls, and in-person at local events and meetings. The survey was closed on May 18, 2016, and a total of 163 survey responses were received.</p>

Community Focus Group Session Findings

In addition to the online Community Stakeholder Survey for community insight, Sentara CarePlex Hospital carried out a series of more in-depth Community Focus Groups to obtain greater insight from diverse stakeholders.

Focus groups were often drawn from existing hospital and community groups or sought from other populations in the community, including representatives of underserved communities and consumers of services. The questions below were utilized at each focus group sessions.

- What are the most serious health problems in our community?
- Who/what groups of individuals are most impacted by these problems?
- What keeps people from being healthy? In other words, what are the barriers to achieving good health?
- What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?
- What more can be done to improve health, particularly for those individuals and groups most in need?

5 focus group sessions were held in 4 month(s) 2016. The number of participants ranged from 6 to 16. When possible, representatives from the health department and other local hospitals were invited to attend the sessions.

1. Hispanic Community-joint focus group held with Bon Secours Hampton Roads
2. Senior Volunteers from Sentara CarePlex Hospital
3. Annual Community Priorities Workshop participants – Phoebus High School, Hampton, VA
4. Virginia Peninsula Chamber of Commerce-staff members
5. Virginia Peninsula Department of Health Staff members

A brief summary of the key findings for each topic is presented below.

Topic	Key Findings
What are the most serious health problems in our community?	<p>Surprising unanimity of responses from groups listed above. In descending order of priority, the following problems were identified in the Lower Peninsula Community:</p> <ol style="list-style-type: none"> 1. Abuse of opioids/drugs 2. Access to mental health resources 3. Obesity/Access to healthy foods 4. Diabetes/Cancer 5. Generational Violence manifested in gang and youth violence 6. Access to primary care providers

	<ol style="list-style-type: none"> 7. Getting help for the caregivers who help people 8. Health inequities among community members 9. Access of EDs for primary care needs 10. Redundancy of testing when going from provider to provider
<p>Who/what groups of individuals are most impacted by these problems?</p>	<p>Again, there was a consistent pattern of responses solicited from the groups above:</p> <ol style="list-style-type: none"> 1. Low income, socio-economic depressed community members 2. Uninsured, underinsured community members 3. Members of LGBTU community 4. Very youngest or very oldest community members 5. Transitional citizens
<p>What keeps people from being healthy? In other words, what are the barriers to achieving good health?</p>	<p>Answers to identifying barriers were quite varied but did demonstrate some consistent responses, namely:</p> <ol style="list-style-type: none"> 1. Cost of maintaining a healthy lifestyle. While often perceived as a choice, oftentimes these decisions were relegated to a lower priority than immediate lifestyle demands 2. Community members needs navigation throughout the health care journey 3. More effective discharge planning needed to reduce the silo mentality of current healthcare practices 4. Levels of education, i.e. perception was better educated population had more access and understanding of healthy choices and elimination of barriers 5. Age, specifically elderly do not question their medical decisions and at times are faced with conforming to contradictory instructions. 6. Some felt there were no solutions to the elimination of barriers, especially for those community members who do not personally prioritize and subscribe to a healthy lifestyle. 7. Transportation issues/proximity to services was listed for those groups not as mobile as others
<p>What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?</p>	<p>Responses were again somewhat consistent among all groups surveyed. Answers are listed below in no assigned priority:</p> <ol style="list-style-type: none"> 1. Expansion of “free” clinics throughout the community guaranteeing easy access and timely availability 2. Enhanced education perhaps reengineered/rebranded/re-bundled to impact a particular target population 3. Implement wellness checks throughout the community 4. Continue to engage city leadership in value of healthy lifestyles. As an example, Dental Clinic in NN is 100% funded by the

	<p>city</p> <ol style="list-style-type: none"> 5. Increased presence of community screening events 6. Implement wellness program for city employees 7. Establish and demonstrate economic benefit of medical safety net for community members focused on efforts of all three hospitals in the region. 8. Schools implementing a changed dietary program focused on healthy choices 9. Offering of parenting education classes
<p>What more can be done to improve health, particularly for those individuals and groups most in need?</p>	<ol style="list-style-type: none"> 1. Enhanced education became a consistent theme but perhaps delivered in a 'different' package or to a specific target group 2. Use resources of the faith based community to broaden the healthy choice options 3. Establish a new mentality of entitlement where benefits are offered only after guidelines for participation are agreed to 4. Expand the use of navigators to help direct community members through their health care decision processes 5. Establish health education seminars within assisted living centers 6. Consider adoptions of medical economic plan where providers are compensated based on wellness and not number of procedures performed (change the paradigm of how to keep people healthy which focuses on proactive strategies versus reactive efforts) 7. Work to change habits and value of sound healthy decisions at the earliest of ages, i.e. reinforce in elementary school children the advantages of a healthy life style.

V. APPENDIX

An evaluation of the progress toward the implementation strategies is included in the following pages.

Sentara Community Health Needs Assessment Implementation Strategy

2016 Q3 Progress Report

Hospital: Sentara CarePlex Hospital

Quarter (please indicate): First Quarter Second Quarter XX Third Quarter Year End

In support of Sentara’s 2014 goal to “demonstrate community benefit in the communities we serve”, Sentara will measure the progress toward the community health needs assessment implementation strategies selected by each hospital on a quarterly basis.

To complete this quarterly progress report, the health problems and implementation strategies can be pasted into this document from the hospital’s existing Three Year Implementation Strategy document. The quarterly progress should be identified in the third column below.

The quarterly report should include only key actions taken during the quarter; the report does not need to include all activities. Where possible the actions should be quantified, with outcomes measurements if available.

Reports should be emailed to Deb Anderson at dkanders@sentara.com within 15 days of the close of each quarter.

Health Problem	Three Year Implementation Strategies	Progress
ALL		
Problem #1 GENERAL	<ul style="list-style-type: none"> • Continue to partner with the Hampton and Newport News Health departments to help meet the needs of our community • Reach out to Mary Immaculate and Riverside Health to identify ways to collaborate on initiatives to avoid duplication of resources and better meet the needs of our community 	<ul style="list-style-type: none"> • Active member of CARE Coalition (chronic condition awareness & resources education): attend monthly CARE Coalition meetings to partner with local health departments and health systems • Partner with SWRMC CHNA management team to combine efforts to collaborate on future community events.

Health Problem	Three Year Implementation Strategies	Progress
	<ul style="list-style-type: none"> Continue to conduct Community Outreach and educational programs that focus on prevention and early detection of key community concerns (Cardiac disease/Stroke; Pulmonary disease; Obesity; Cancer; Diabetes; Flu Campaign). 	<ul style="list-style-type: none"> Submitted Grants to Virginia Health Foundation in collaboration with Bay Aging to provide ‘coaches’ to monitor in home care for our un/underinsured patient populations seen in the SCH and SPW EDs. In addition, submitted grant in collaboration with EVHSA to offer medical home and facilitate transfer to EVHSA facility for prompt, high-quality care of the same population mentioned above. SCH providing meeting space, marketing support, and resources for Stanford Chronic Disease Self-Management Program and Diabetes Self-Management Program meetings. Contracted with Community Health Solutions (CHS) to provide Community Indicator Analysis and Community Insight Survey of community professionals under a collaborative agreement with RRMCC. Conducted Community interviews in February with select community groups (Hispanic). Services provided by Optima Health and Preventive Services <p>Educational Presentations provided free of charge to the community:</p> <ul style="list-style-type: none"> Do I Really Need an Advance Medical Directive, Hampton City Hall – 8 attendees Colon Health-City Hall, 10 participants Hampton Relay for Life (Community Sponsor)

Health Problem	Three Year Implementation Strategies	Progress
		<ul style="list-style-type: none"> • Breast Health Presentation, Parkview Baptist Church, 45 participants • Neighborhood Night Out, 8/2/16, Hampton Convention Center, General Community Education, 200 participants • 105 SCH employees participated in Annual Heart Walk event • United Way Day of Caring – 31 employees
<p>Problem #2 Uninsured/ underinsured</p>	<ul style="list-style-type: none"> • Provide assistance for uninsured patients to sign up for health care insurance during open enrollment period • Evaluate Medical clinic services on campus at SCH 	<ul style="list-style-type: none"> ○ Continue to partner with Southeastern Virginia Health System at SCH and SPW to provide representatives on site 5 days a week to assist uninsured patients with signing up for health plans during open enrollment as well as assist in placement/enrollment in medical home for appropriate patients. July – Sept, 19 enrollees • Draft business plan in progress. Led by Joel Bundy, VPMA and Molly Burke, SMG Director. Cost estimates calculated, awaiting executive approval for Medical Home for un-/underinsured patients presenting to SCH ED in collaboration with future follow-up with EVHSA, Newport News, VA.
<p>Problem #3 OBESITY</p>	<ul style="list-style-type: none"> • Partner with Morrison’s to promote more healthy options on our menus for both patients and visitors. 	<ul style="list-style-type: none"> • Continue to offer healthy food alternatives. Implementing greater use of fresh seasonal vegetables and fruits. Updated menu to provide healthier options • Farmer’s market implemented in SCH cafeteria to provide healthier options. Well-received by staff and visitors. Program continues to be successful based on feedback from visitors/employees.

Health Problem	Three Year Implementation Strategies	Progress
Problem #4 Behavioral Health /Substance Abuse	<ul style="list-style-type: none"> Continue to partner with CSB to streamline processes and evaluate gaps to educate our staff and better support the needs of our community. 	<p>VPMA heads team to identify solutions for delays in mental health treatment as experienced in the EDs of SCH and SPW.</p> <ul style="list-style-type: none"> Director, ED, joined newly formed Consortium with Hampton PD to address community heroin addiction. Actively trained police department to perform <u>Revive Program for Narcan</u> administration.
Problem #5 Cancer	<ul style="list-style-type: none"> Provide cancer screening, early treatment options and community education 	<ul style="list-style-type: none"> Sentara CarePlex partnership with Health Department monthly “Every Woman’s Life” program; DGH breast center provides schedule of screening slots available for patients to receive services at a reduced rate. Diagnostics exams and Ultrasound follow-up also provided at SPW DGH breast center. Presentation on Skin Cancer Awareness and Prevention provided at The Chesapeake Retirement Community on April 22nd with 107 participants. Presentation included Dermascan(Skin Analyzer) in addition to Skin Cancer Education Mind, Body, and Soul Expo/ Community Health Fair held on May 9, 2016 – Information provided on breast cancer awareness and prevention in addition to the mammogram program for uninsured women. 31 participants Relay for Life of Hampton – Sentara sponsored event held at Darling Stadium on May 2016. Debra Flores, SCH Hospital President served as spokesperson for 2016 Hampton Relay. Support of Sentara Cancer Rehabilitation Program at 2 SCH rehab sites to provide free cancer rehab screenings to support patient’s rehabilitation.

Health Problem	Three Year Implementation Strategies	Progress
		<p>Program currently being rolled out. 15 referrals YTD.</p> <ul style="list-style-type: none"> • NASA Health and Safety Expo on June, – Education on Skin Cancer Awareness and DermaScan provided to 22 participants • Prostate Cancer Early Detection Program/Community Education, 7/1/16, Harbor Park, Norfolk 13 participants • Prostate Cancer Early Detection Program/Community Education, SVHS-Stonybrook, 50 participants • Mammography Screening, DGH CBC, Newport News, 20 participants • Provided early detection CT Lung Screenings for > 160 community members <p><i>Note: Please see additional events with Cancer education provided listed under Problem #1 – General community outreach</i></p>
<p>Problem # 6 Diabetes</p>	<ul style="list-style-type: none"> • Evaluate partnership with local podiatrist to offer a foot clinic • Community education and support through diabetes support groups 	<ul style="list-style-type: none"> • Outreach by physician liaisons provided to primary care providers to discuss the Foot & Ankle program. Free screening/education session held at SPW III, 46 participants • Establish Comprehensive Wound Center for treatment of diabetes-related wounds in partnership with Restorix Health. • Diabetes support group held on the third Thursday of every month
<p>Problem # 7 Senior Services</p>	<ul style="list-style-type: none"> • Senior Friendly Updates/ Renovations Throughout the Hospital and Campuses 	<ul style="list-style-type: none"> • Increasing and improving signage throughout facility based on community input. Replaced signage at Sentara Port Warwick with directional standards

Health Problem	Three Year Implementation Strategies	Progress
	<ul style="list-style-type: none"> • Provide Advance Care Planning education and services to the community 	<p>which were simplified and easier to read (i.e. replace Medical Arts Building designation with PW 1)</p> <ul style="list-style-type: none"> • Advanced Care for the Elderly (ACE) unit established in inpatient SCH unit. Significant decrease noted in patient falls, HAPU, CAUTI, CLABSI, Use of Restraints, and 30-Day Re-Admission rates for the 665 patients enrolled in this program. • Inpatient unit renovations include senior friendly updates such as non-glare flooring, increased contrast on handrails. Other inpatient units planned for similar renovations. • Provided advance care planning services to approx. 50 individuals at the Port Warwick campus. Offered to members of Peninsula LEAD program. • Provide no-charge Drive-Thru Flu program on Port Warwick Campus for 350 community participants prior to advent of flu season