Sentara Williamsburg Regional Medical Center

Community Health Needs Assessment 2019

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Sentara Williamsburg Regional Medical Center

Community Health Needs Assessment (CHNA)

2019

Table of Contents

Introduction

Sentara Williamsburg Regional Medical Center (SWRMC) 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:

- **Heart Health**
- **Cancer**
- **Nutrition and Outreach**
- **Behavioral Health, including Alzheimer's Disease/Dementia**

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 at the end of this report.

SWRMC 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.

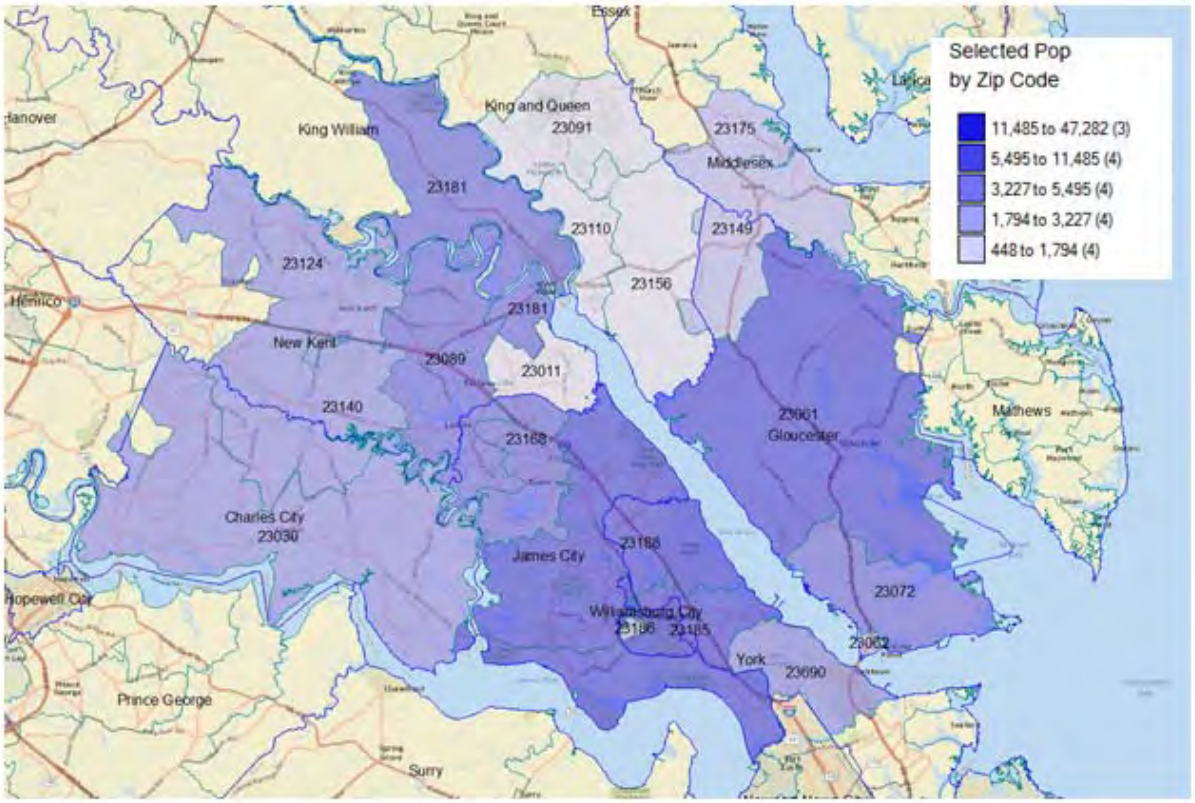
Your input is important to us so that we can incorporate your feedback into our assessments. You may use our online feedback form available on the Sentara.com website. Thanks!

Demographic Information

Population

Highlight Population: The service area of Sentara Williamsburg Regional Medical Center (SWRMC) comprises 9 localities: the City of Williamsburg, and the Counties of James City, Gloucester, York, Charles City, New Kent, King William, King and Queen, and Middlesex. Much of the data available for this assessment is only available at the City/County level so information for each entire county is included, although some places may be considered a secondary service are for the hospital. The combined population of the SWRMC service area numbers over 258,000 people.

Sentara Williamsburg Regional Medical Center Service Area:



Source: Truven/Market Expert

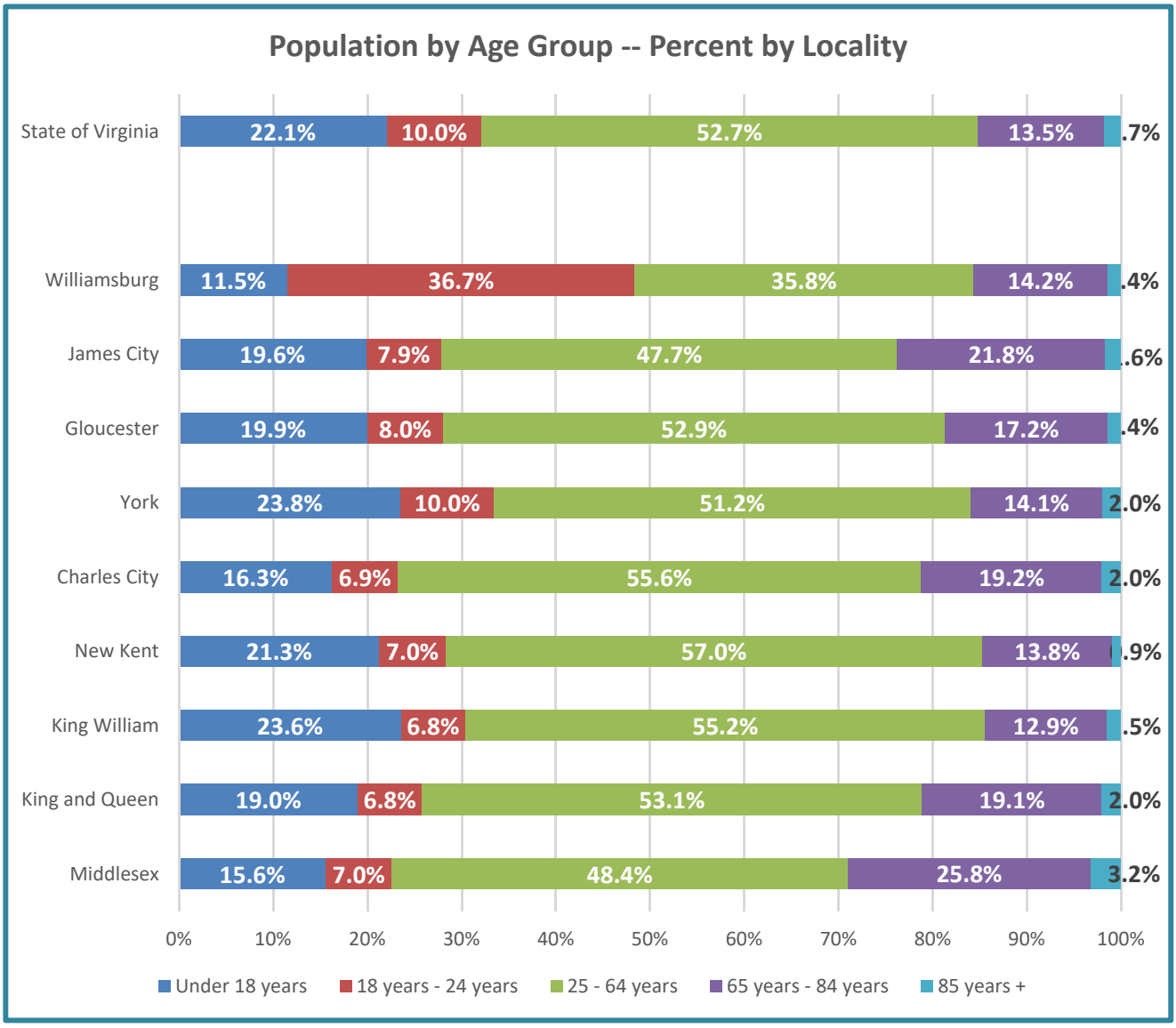
Population Change 2010 - 2018		
Locality	Population	% Change 2010 2018
State of Virginia	8,492,022	6.1%
Williamsburg	15,368	9.2%
James City	75,926	13.3%
Gloucester	37,241	1.0%
York	68,734	5.0%
Charles City*	7,086	2.9%
New Kent*	20,051	22.8%
King William*	16,156	7.7%
King and Queen*	7,140	1.1%
Middlesex*	10,728	1.4%

Highlight Population Change: The New Kent population has seen remarkable growth (22.8%) in the last 8 years. James City County, Williamsburg and King William County have seen growth above the state average, with York County experiencing slightly lower growth than the state as a whole. The more rural counties of Gloucester, Charles City, King and Queen and Middlesex had lower than average growth, less than half the growth rate of the state as a whole.

Unless Otherwise Stated for Specific Indicators: Source: Data provided by Claritas, updated in January 2018.
GHRConnects.org managed by Conduent Healthy Communities Institute
**Data for these counties provided by American Community Survey, US Census Bureau, 2016 data in all charts*

Population by Age

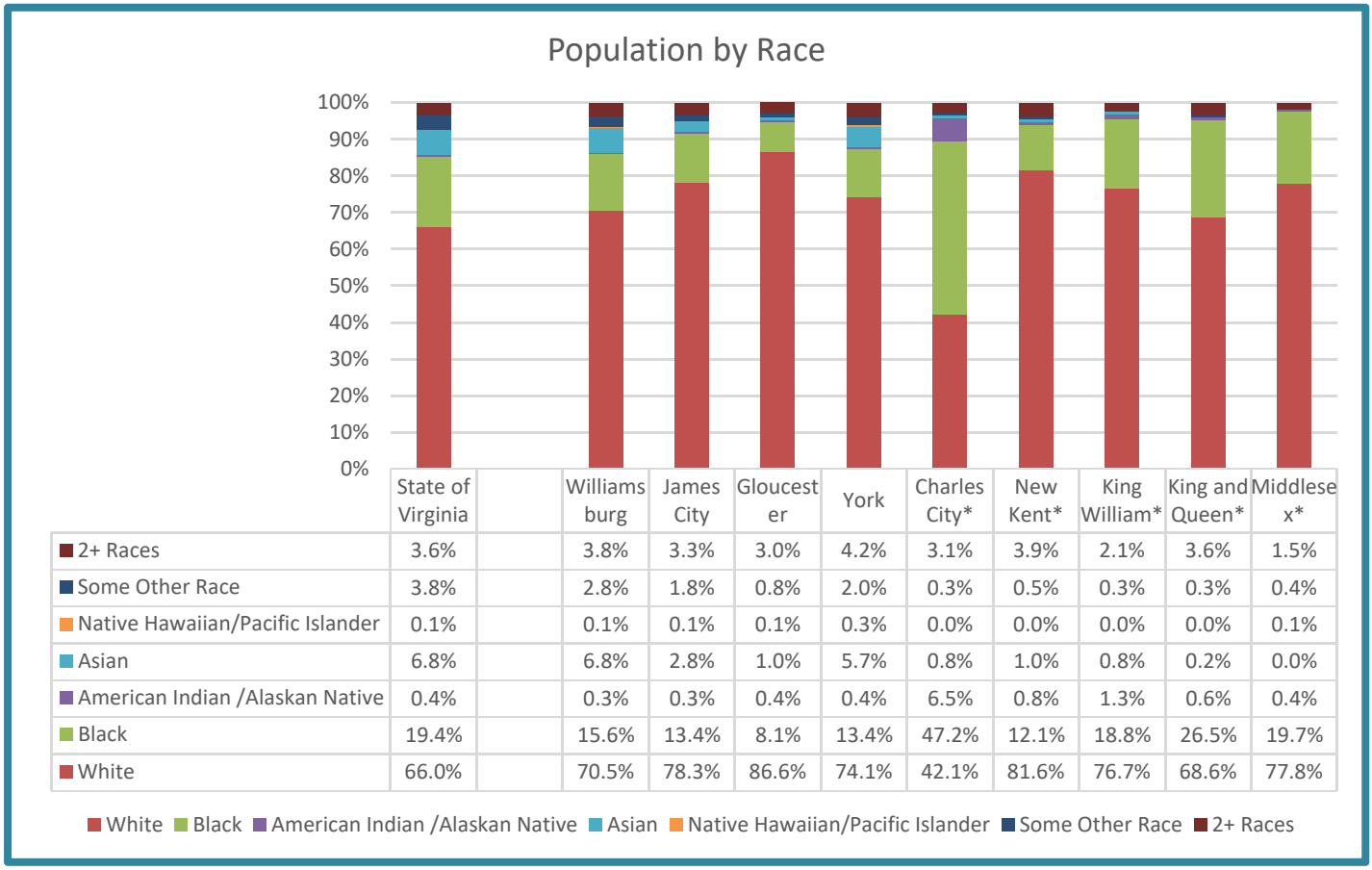
Highlight Population and Age: The service area has a higher percent of residents aged 65+ than the state as a whole, in some cases significantly higher (James City, Charles City, King and Queen and Middlesex Counties). Williamsburg, home of the College of William and Mary, has more than 3 times the percent of young adults compared to the state as a whole. The state has a higher population of both young adults and children than the majority of the service area.



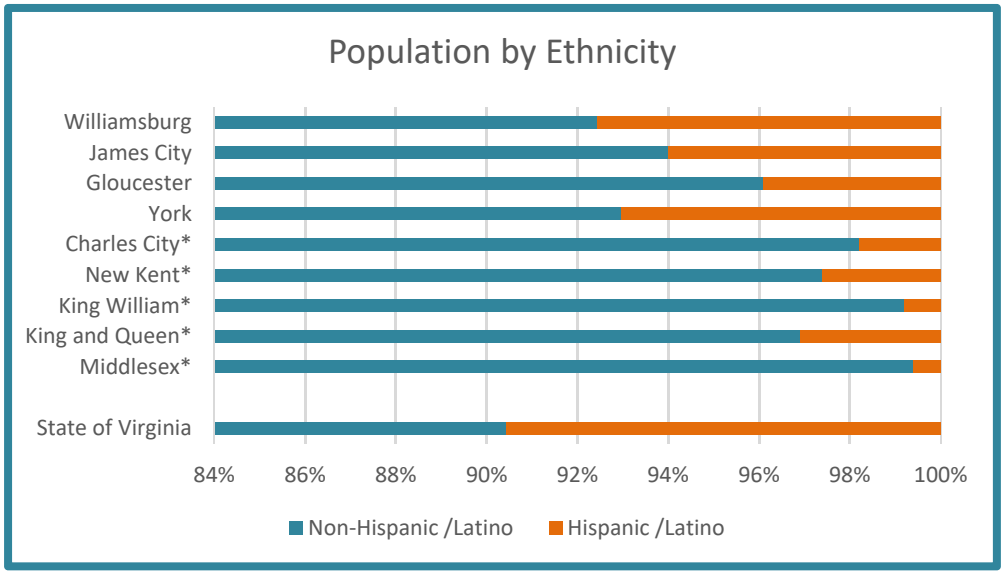
Population by Race and Ethnicity

Highlight Population and Race: The population of the service area is overwhelmingly white and black, with Williamsburg and York County the most diverse communities (13.9% and 12.5% combined non-white or black respectively) although neither place is as diverse as the state as a whole, with 14.6% not identifying as simply white or black. Each of the other localities have no more than 10% combined non-white or black population. The service area is home to small Asian communities, but the largest point of diversity in the service area is the percent who identify as multiracial.

Highlight Population Ethnicity: The service area population as a whole has a small Hispanic population, with Williamsburg home to the largest Hispanic community with 7.6% of the population followed by York County with 7.0%. James City County has 6.0% Hispanic residents, twice what the remaining localities have.

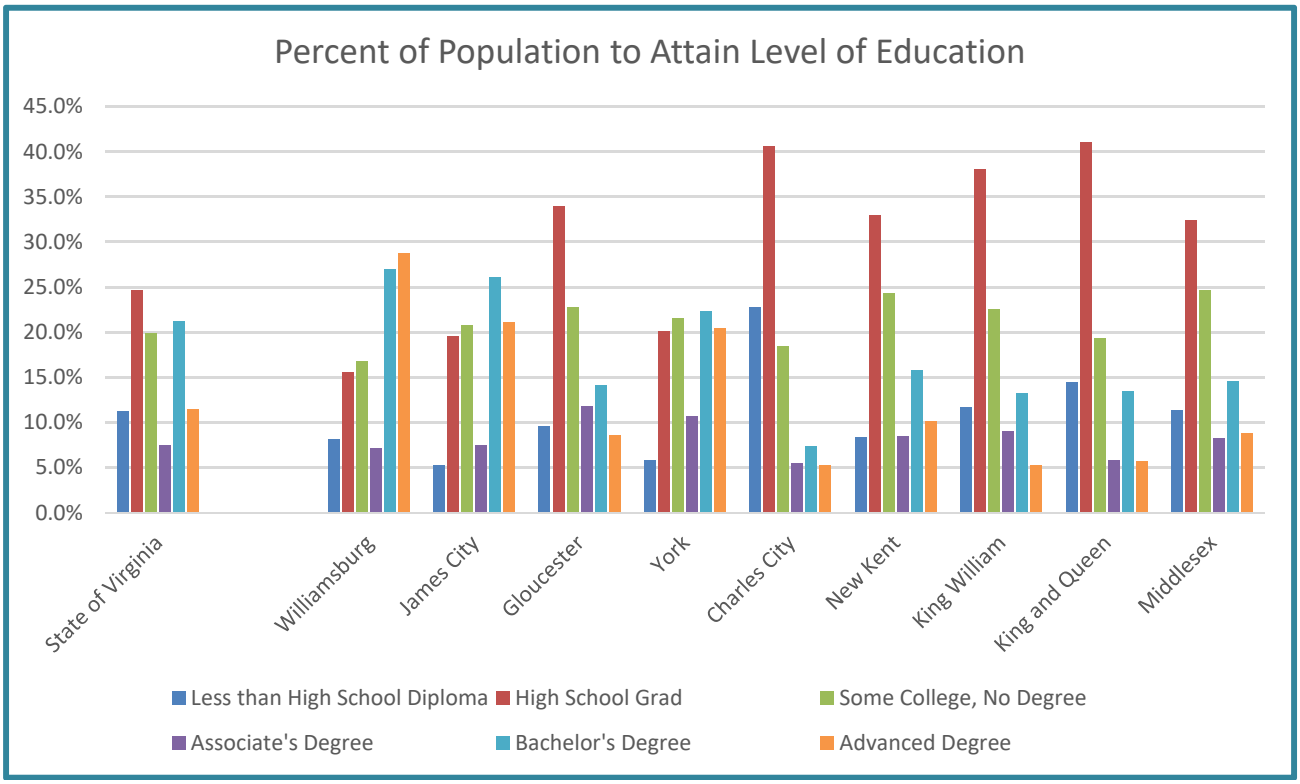


	State of Virginia		Williamsburg	James City	Gloucester	York	Charles City*	New Kent*	King William*	King and Queen*	Middlesex*
2+ Races	3.6%		3.8%	3.3%	3.0%	4.2%	3.1%	3.9%	2.1%	3.6%	1.5%
Some Other Race	3.8%		2.8%	1.8%	0.8%	2.0%	0.3%	0.5%	0.3%	0.3%	0.4%
Native Hawaiian/Pacific Islander	0.1%		0.1%	0.1%	0.1%	0.3%	0.0%	0.0%	0.0%	0.0%	0.1%
Asian	6.8%		6.8%	2.8%	1.0%	5.7%	0.8%	1.0%	0.8%	0.2%	0.0%
American Indian /Alaskan Native	0.4%		0.3%	0.3%	0.4%	0.4%	6.5%	0.8%	1.3%	0.6%	0.4%
Black	19.4%		15.6%	13.4%	8.1%	13.4%	47.2%	12.1%	18.8%	26.5%	19.7%
White	66.0%		70.5%	78.3%	86.6%	74.1%	42.1%	81.6%	76.7%	68.6%	77.8%



Population and Education

Highlight Education: Education is the basis for stable employment, and financial stability is the foundation for a sustainable household, which provides for the health needs of family members. Charles City, King and Queen, King William and Middlesex Counties have a higher percent of population with less than a high school diploma compared to the state as a whole. These counties also skew significantly to the lower levels of educational attainment both compared to the state and to the other localities within the service area, with Williamsburg, James City County and York County having a substantially larger percent of the population with advanced degrees.



Educational Attainment -- Percent of Population						
	Less than High School Diploma	High School Grad	Some College, No Degree	Associate's Degree	Bachelor's Degree	Advanced Degree
State of Virginia	11.2%	24.6%	19.9%	7.4%	21.2%	11.4%
Williamsburg	8.1%	15.6%	16.8%	7.1%	27.0%	28.8%
James City	5.2%	19.6%	20.7%	7.4%	26.1%	21.1%
Gloucester	9.6%	33.9%	22.7%	11.8%	14.1%	8.6%
York	5.8%	20.1%	21.6%	10.7%	22.4%	20.4%
Charles City	22.8%	40.6%	18.4%	5.5%	7.4%	5.3%
New Kent	8.3%	33.0%	24.3%	8.5%	15.8%	10.1%
King William	11.7%	38.1%	22.6%	9.0%	13.3%	5.3%
King and Queen	14.5%	41.1%	19.3%	5.8%	13.5%	5.7%
Middlesex	11.4%	32.4%	24.6%	8.2%	14.6%	8.8%

Income and Poverty

Highlight Income by Race: While simple poverty rates tell us something about the residents of the service area, by inserting race as a factor we see the racial disparities that constrain residents of the service area in their ability to support and sustain healthy, functioning households for themselves and their children. As with Virginia as a whole, black individuals are likely to have income that is approximately 70% of the general household income and approximately 65% of the income of white households.

Median Household Income by Race/Ethnicity

Locality	White	Black	Hispanic	All Races
State of Virginia	$ 76,180	$ 49,110	$ 65,576	$ 71,167
Williamsburg	$ 62,966	$ 34,843	$ 43,903	$ 49,412
James City	$ 75,038	$ 55,476	$ 59,639	$ 70,700
Gloucester	$ 83,116	$ 57,909	$ 61,287	$ 74,129
York	$ 61,764	$ 41,568	$ 46,188	$ 51,406
Charles City	$ 78,243	$ 46,290	$ 65,318	$ 65,386
New Kent	$ 78,025	$ 44,954	$ 92,568	$ 69,606
King William	$ 59,060	$ 32,934	$ 24,107	$ 40,368
King and Queen				
Middlesex	$ 66,143	$ 34,624	$ 24,737	$ 52,626

Highlight Poverty Calculation: Each year the federal government calculates the income required to provide the absolute, necessities to sustain a household in the United States. Because each additional family member does not increase the cost of a household to the same extent (for instance, the cost of housing 4 family members is not 1.3 times higher than the cost of housing 3 family members), the government publishes the federal poverty guidelines for families with a calculation for larger households. The table below presents the poverty level for up to 6 members. For more information, google "federal poverty guidelines" or visit https://aspe.hhs.gov/poverty-guidelines. **Highlight Poverty:** Poverty is perhaps the most impactful of the social determinants of health, affecting the ability to have stable housing, healthy food, the ability to maintain steady employment, and the ability to access health care when needed. The table below presents cumulative levels of poverty, in that those living below 200% of the federal poverty level are also living below 300%, etc.

2018 Federal Poverty Guidelines

Household Size: 1	$ 12,140
Household Size: 2	$ 16,460
Household Size: 3	$ 20,780
Household Size: 4	$ 25,100
Household Size: 5	$ 29,420
Household Size: 6	$ 33,740

Source: United States Department of Health and Human Services

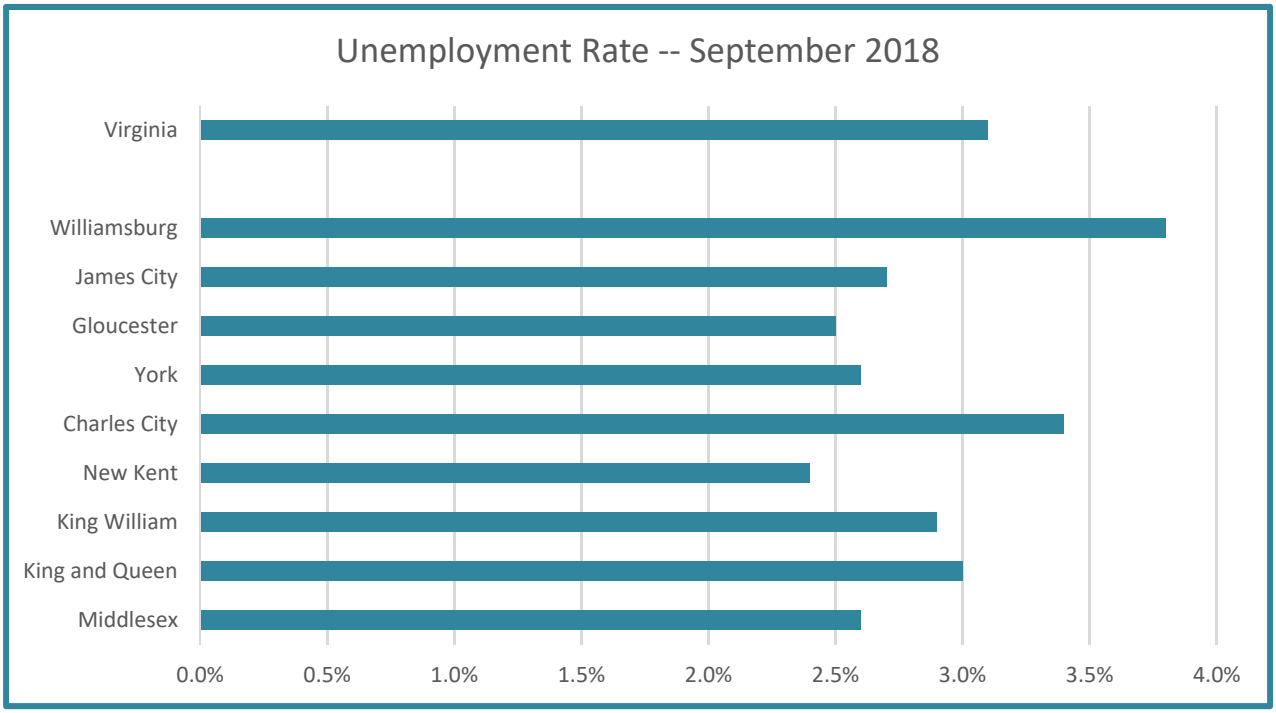
Source: US Census Bureau: American Factfinder 2017 Estimates

Percent of the Population Living at Specified Percent of the Federal Poverty Level

Poverty Level	100%	200%	300%	400%
State of Virginia	11.4%	26.6%	41.7%	55.0%
Williamsburg	22.8%	36.6%	48.2%	64.6%
James City	7.9%	18.9%	31.6%	45.7%
Gloucester	7.6%	21.7%	42.6%	58.7%
York	6.2%	15.8%	30.2%	45.3%
Charles City	14.6%	31.4%	48.7%	66.7%
New Kent	5.0%	11.8%	26.9%	46.5%
King William	12.1%	25.1%	42.3%	59.8%
King and Queen	14.2	40.6	56.5	70.3
Middlesex	10.9%	29.0%	52.4%	68.3%

Employment

Highlight Employment: Central to a healthy community is an economy that supports individuals in their efforts to live well. Unemployment is a key measure of the state of the local economy and with few exceptions, the rate is lower in the SWRMC service area than in the state as a whole. Only Williamsburg and Charles City County have unemployment rates higher than the state, while all the other localities have rates that are lower. Please note that the chart below is demarcated in half- percent segments.



Source: Virginia Economic Commission, Economic Information & Analytics, Local Area Unemployment Statistics, August 2018

Highlight Employers: The largest employers (in number of employees) in the region reflect the diversity of economic activity, with education, entertainment, City and County government, retail and manufacturing and healthcare all represented in the largest employers.

Three Largest Employers by Locality	
Williamsburg	College of William and Mary, Colonial Williamsburg Foundation, Colonial Williamsburg Hotel
James City	Busch Entertainment Corp., Williamsburg James City County School Board, Wal Mart
Gloucester	Gloucester County Schools, Riverside Regional Medical Center, County of Gloucester
York	York County School Board, County of York, Wal Mart
Charles City	Charles City County Public Schools, Bruce Howard Contracting, Inc., Atlantic Bulk Carrier Corp.
New Kent	New Kent County School Board, Curtis Contracting, Inc., County of New Kent
King William	Alliance Group Rock Tenn, King William County Schools, Nestle Purina Petcare Company
King and Queen	King and Queen County Public Schools, County of King and Queen, Ball Lumber Co.
Middlesex	Middle Peninsula Northern Neck Mental Health Center, Middlesex County Schools, Chesapeake Bay Agency on Aging

Source: Virginia Economic Commission, Community Profiles 2018

Health Status Indicators

Below are key health status indicators for the localities representing the **Sentara Williamsburg Regional Medical Center (SWRMC)** Service Area*: the cities of Gloucester and Williamsburg and the counties of Charles City, James City, King and Queen, King William, Middlesex, New Kent, and York. Links are also included to interactive data dashboards on the Greater Hampton Roads Indicators Dashboard, also known as GHRconnects. Here indicators can be explored for a comparison to other nearby localities, change over time, race/ethnicity, and gender, where available. In addition, more indicators are often available through the link.

The key health status indicators are organized in the following data profiles:

A. Mortality Profile

B. Hospitalizations for Chronic and Other Conditions Profile

C. Risk Factor Profile

D. Cancer Profile

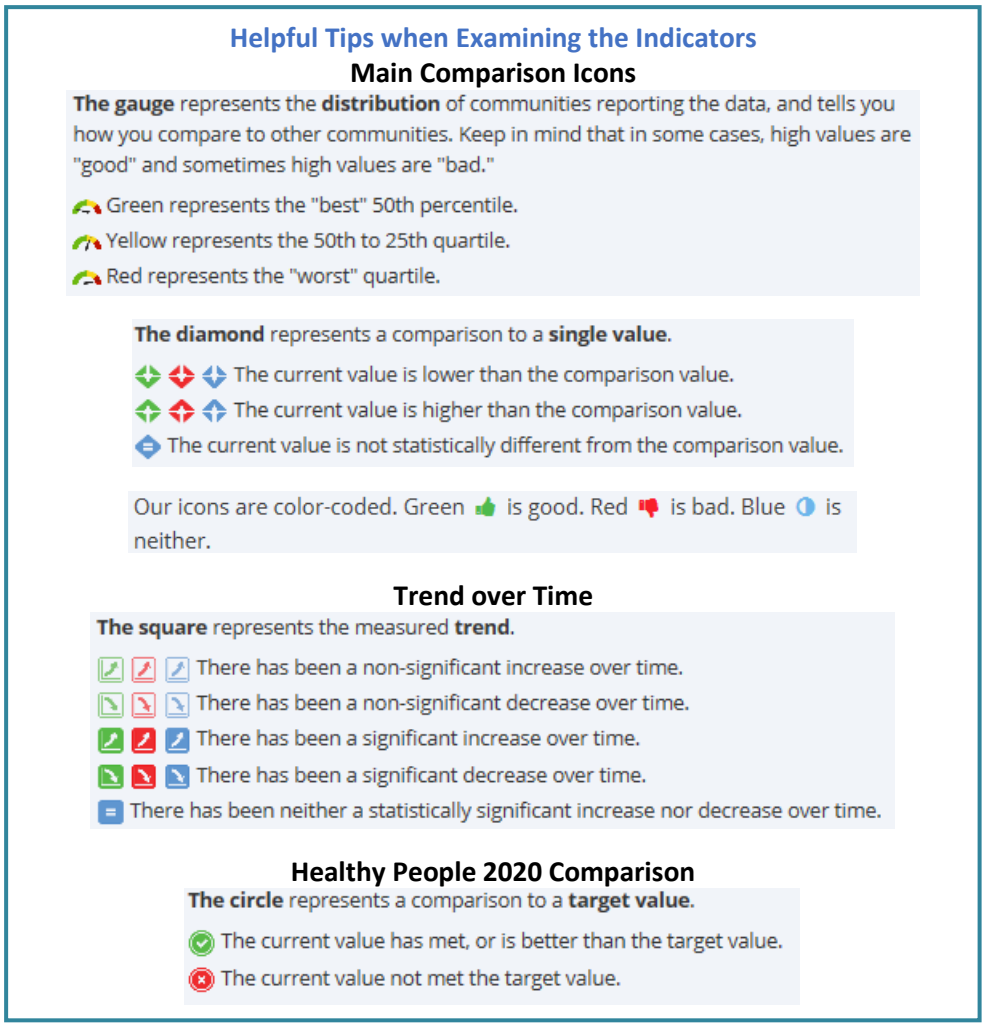
E. Behavioral Health Profile

F. Maternal and Infant Health Profile

G. Spotlight: Opioid Epidemic

H. Spotlight: Older Adults and Aging

*Note about the service area: Indicators through GHRconnects were available for 4 key localities: James City County, Williamsburg city, Gloucester city, and York County. Data for the other localities were included for select indicators, but were unable to be included in the interactive data links.



A. Mortality Profile

Highlights: Leading causes of death in localities of the SWRMC service area were examined. Cancer, heart disease, and accidents were the top three causes of death in the area. The top three causes of death in Virginia were cancer, heart disease, followed by stroke; accidents were the fifth leading cause of death. In the service area, the crude death rate from all causes and most of the leading causes of death were higher than the rates for the state overall. The exceptions were kidney disease, blood poisoning, and influenza and pneumonia, which all had lower rates compared to Virginia.

Leading Causes of Death and Death Rates for the Sentara Williamsburg Regional Medical Center Service Area, 2016

Leading Causes of Death	Charles City County	Gloucester	James City County	King and Queen County	King William County	Middlesex County	New Kent County	Williamsburg	York County	Total Service Area	Virginia
Counts											
All Causes	85	407	768	92	148	176	133	46	415	2,270	63,100
Cancer	18	103	199	22	38	39	42	7	103	571	14,646
Heart Disease	19	81	157	28	38	51	27	13	73	487	13,748
Alzheimer's Disease	3	22	39	6	6	15	5	--	28	124	1,765
Stroke	4	18	45	5	9	9	4	5	20	119	3,202
Accidents	10	28	29	2	13	8	9	--	20	119	3,070
Chronic Obstructive Pulmonary Disease (COPD)	5	21	33	7	4	7	5	--	30	112	3,096
Diabetes	3	9	19	2	3	3	6	2	17	64	1,671
Suicides	--	11	11	1	5	3	5	2	4	42	1,109
Kidney Disease	2	11	10	2	--	1	1	--	9	36	1,542
Blood Poisoning	3	3	10	1	1	2	5	--	6	31	1,336
Parkinson's Disease	1	2	14	2	2	1	--	2	7	31	729
Influenza and Pneumonia	--	8	--	1	3	3	--	3	3	25	1,490
Crude Death Rates per 100,000 Population											
All Causes	1,202.1	1,093.7	1,032.2	1,285.1	906.1	1,633.0	628.9	302.4	610.5	882.2	757.8
Cancer	254.6	276.8	267.5	307.3	232.6	361.8	198.6	46.0	151.5	221.9	175.9
Heart Disease	268.7	217.7	211.0	391.1	232.6	473.2	127.7	85.4	107.4	189.3	165.1
Alzheimer's Disease	42.4	59.1	52.4	83.8	36.7	139.2	23.6	--	41.2	48.2	21.2
Stroke	56.6	48.4	60.5	69.8	55.1	83.5	18.9	32.9	29.4	46.3	38.5
Accidents	141.4	75.2	39.0	27.9	79.6	74.2	42.6	--	29.4	46.3	36.9
Chronic Obstructive Pulmonary Disease (COPD)	70.7	56.4	44.4	97.8	24.5	64.9	23.6	--	44.1	43.5	37.2
Diabetes	42.4	24.2	25.5	27.9	18.4	27.8	28.4	13.1	25.0	24.9	20.1
Suicides	--	29.6	14.8	14.0	30.6	27.8	23.6	13.1	5.9	16.3	13.2
Kidney Disease	28.3	29.6	13.4	27.9	--	9.3	4.7	--	13.2	14.0	18.5
Blood Poisoning	42.4	8.1	10.0	14.0	6.1	18.6	23.6	--	8.8	12.0	16.0
Parkinson's Disease	14.1	5.4	18.8	27.9	12.2	9.3	--	13.1	10.3	12.0	8.7
Influenza and Pneumonia	--	21.5	--	14.0	18.4	27.8	--	19.7	4.4	9.7	17.9

Data Source: Deaths - VDH (OIM - Data Management)

GREEN = Rates are better compared to Virginia, **RED** = Rates are worse compared to Virginia

Link to interactive dashboard with age-adjusted rates: Mortality SWRMC

B. Hospitalizations for Chronic and Other Conditions Profile

These often could be avoided with proper outpatient care. Top conditions displayed.

Link to interactive dashboard: Hospitalizations SWRMC *(more conditions available)*

Highlights: Of the conditions examined, heart failure was the condition with the highest age-adjusted hospitalization rate in the SWRMC Service Area. Both Gloucester and James City County had rates higher than the Virginia rates. Other top conditions included community acquired pneumonia, diabetes and COPD.

Age-Adjusted Hospitalization Rate due to Heart Failure

	VALUE	COMPARED TO:	
County: Gloucester, VA	39.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)
County: James City, VA	37.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)
County: Williamsburg City, VA	3.7* Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)
County: York, VA	24.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)

Age-Adjusted Hospitalization Rate due to Diabetes

	VALUE	COMPARED TO:	
County: Gloucester, VA	14.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (18.9)
County: James City, VA	21.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (18.9)
County: York, VA	8.2 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (18.9)

Data not available for Williamsburg due to insufficient cases

Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia

	VALUE	COMPARED TO:	
County: Gloucester, VA	22.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)
County: James City, VA	21.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)
County: Williamsburg City, VA	3.8 Hospitalizations per 10,000 population 18+ years (2012-2014)	 VA Counties	 VA Value (21.9)
County: York, VA	11.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)

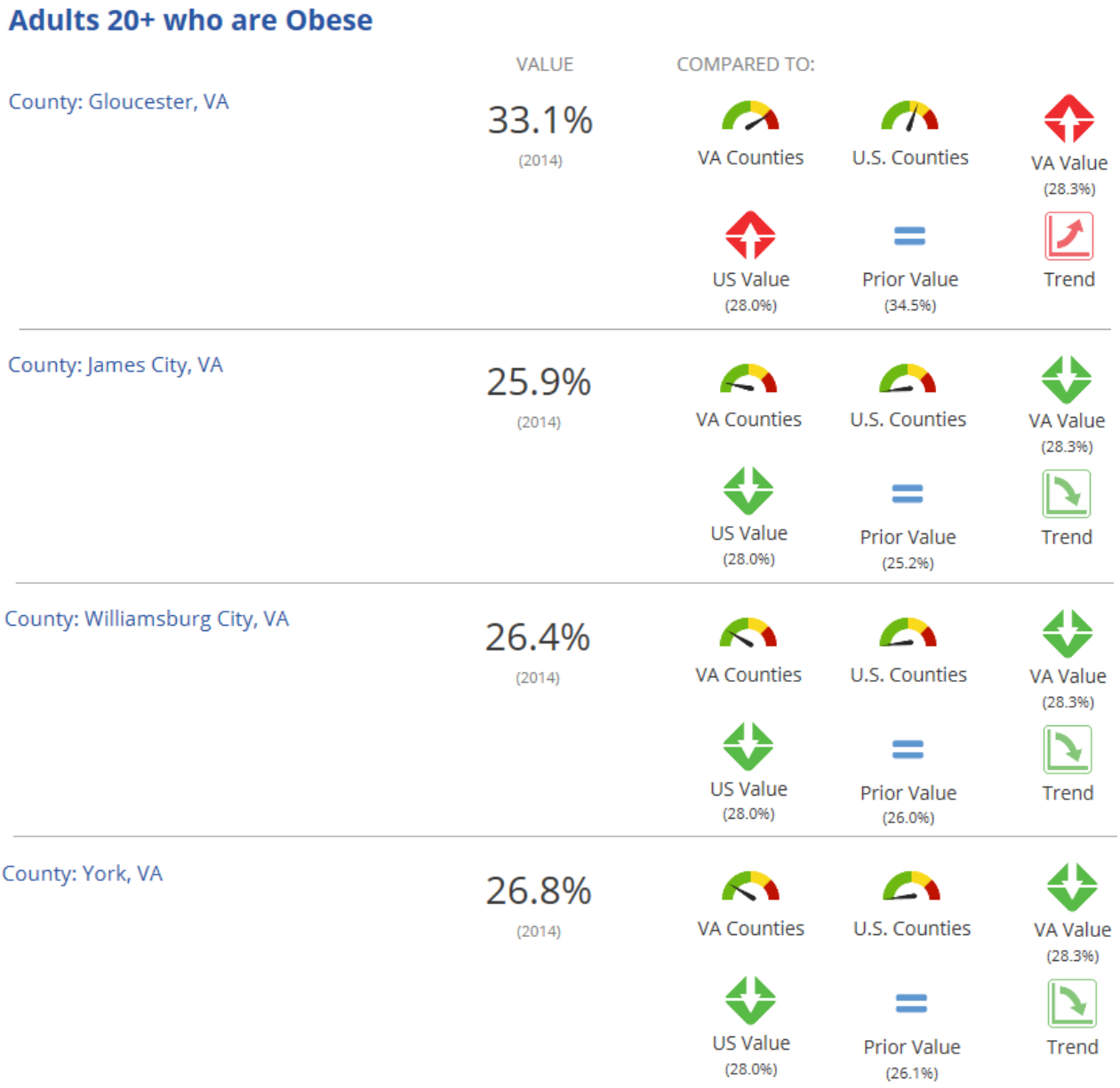
Age-Adjusted Hospitalization Rate due to COPD

	VALUE	COMPARED TO:	
County: Gloucester, VA	19.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.2)
County: James City, VA	13.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.2)
County: York, VA	6.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.2)

C. Risk Factors Profile

Link to interactive dashboard: Risk Factors SWRMC *(more indicators available)*

Highlights: The obesity percentage was higher only in Gloucester compared to Virginia and the United States (US) values, but lower in the other areas. Diabetes percentages were higher than Virginia and US values in Gloucester and James City County. The percentage of adults who drink excessively was higher in the four localities except for James City County compared to the state value. Smoking was also examined; there was a high percentages of smoking only in Williamsburg.



Adults 20+ with Diabetes

	VALUE	COMPARED TO:		
County: Gloucester, VA	11.3% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (11.1%)	Trend
County: James City, VA	10.7% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (10.5%)	Trend
County: Williamsburg City, VA	9.0% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (8.9%)	Trend
County: York, VA	9.5% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (9.5%)	Trend

Adults who Drink Excessively

	VALUE	COMPARED TO:				
County: Gloucester, VA	18.2% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)	US Value (18.0%)	Prior Value (18.1%)	HP 2020 Target (25.4%)
County: James City, VA	16.4% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)	US Value (18.0%)	Prior Value (16.8%)	HP 2020 Target (25.4%)
County: Williamsburg City, VA	18.6% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)	US Value (18.0%)	Prior Value (18.5%)	HP 2020 Target (25.4%)
County: York, VA	17.8% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)	US Value (18.0%)	Prior Value (18.0%)	HP 2020 Target (25.4%)

D. Cancer Profile

Link to interactive dashboard: Cancer SWRMC *(more indicators available)*

Highlights: Death and incidence rates for a variety of cancer types were examined. Mortality rates were highest among lung, prostate, and breast cancers. For many localities, mortality rates were suppressed due to insufficient numbers of cases (less than 3). For localities where rates could be calculated, York County and James City County had better mortality rates compared to the state rates. For lung cancer, Gloucester, King William, King and Queen, Middlesex, and New Kent counties had mortality rates worse than the state overall. In general, breast cancer, followed by prostate and then lung cancer had the highest new or incident case rates across the localities in the SWRMC service area. King William, Middlesex, and New Kent counties consistently had higher incidence rates across the cancer types than the state overall.

Age-Adjusted Cancer Death Rates by Cancer Type and City/County in the SWRMC Service Area, 2011-2015

Age-Adjusted Death Rate	Charles City County	Gloucester	James City County	King and Queen County	King William County	Middlesex County	New Kent County	Williamsburg	York County	Virginia
Breast Cancer per 100,000 females	--	19.0	21.0	--	--	--	--	--	17.7	21.8
Colorectal Cancer per 100,000 population	--	13.5	10.5	--	--	21.9	21.4	--	8.2	14.0
Lung Cancer per 100,000 population	39.1	63.1	32.5	56.8	46.2	47.3	63.9	20.7	34.4	44.0
Prostate Cancer per 100,000 males	--	34.5	17.3	--	--	--	--	--	13.6	20.2

Cancer Incidence Rates by Cancer Type and City/County in the SWRMC Service Area, 2011-2015

Incidence Rate	Charles City County	Gloucester	James City County	King and Queen County	King William County	Middlesex County	New Kent County	Williamsburg	York County	Virginia
Breast Cancer per 100,000 females	110.3	108.3	145.5	112.8	133.3	132.4	146.2	155.3	135.5	127.9
Colorectal Cancer per 100,000 population	36.5	33.7	32.7	45.9	61.2	42.8	44.1	26.6	32.0	36.0
Lung Cancer per 100,000 population	43.7	91.3	51.0	88.9	68.9	65.0	71.3	42.5	53.9	58.9
Prostate Cancer per 100,000 males	157.5	144.5	143.4	75.1	117.2	115.8	123.7	141.5	116.0	102.8

Data Source: Centers for Disease Control and Prevention National Cancer Institute. State Cancer Profiles at statecancerprofiles.cancer.gov.

GREEN = Rates are better compared to Virginia, **RED** = Rates are worse compared to Virginia

--Suppressed due to insufficient cases.

E. Behavioral Health Profile – Mental Health and Substance Abuse

Link to interactive dashboard: [Behavioral Health SWRMC](#) *(more indicators available)*

Highlights: Hospitalization rates due to mental health, suicide/self-intentional injury, and alcohol/substance abuse were examined. Data for Williamsburg was not available due to insufficient cases. Gloucester had higher hospitalization rates due to mental health compared to Virginia rates; the other localities in the service area had lower rates. For the other hospitalizations, all the localities had rates lower than the state values with the exception of Gloucester having a slightly higher rate for substance abuse.

Age-Adjusted Hospitalization Rate due to Mental Health

	VALUE	COMPARED TO:	
County: Gloucester, VA	58.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (53.0)
County: James City, VA	52.0 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (53.0)
County: York, VA	23.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (53.0)

Age-Adjusted Hospitalization Rate due to Suicide and Intentional Self-inflicted Injury

	VALUE	COMPARED TO:	
County: Gloucester, VA	14.0 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (28.1)
County: James City, VA	11.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (28.1)
County: York, VA	5.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (28.1)

Data not available for Williamsburg due to insufficient cases

Age-Adjusted Hospitalization Rate due to Alcohol Abuse

	VALUE	COMPARED TO:	
County: Gloucester, VA	7.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (12.6)
County: James City, VA	9.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (12.6)
County: York, VA	5.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (12.6)

Age-Adjusted Hospitalization Rate due to Substance Abuse

	VALUE	COMPARED TO:	
County: Gloucester, VA	6.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (6.2)
County: James City, VA	3.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (6.2)
County: York, VA	3.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (6.2)

Data not available for Williamsburg due to insufficient cases

F. Maternal & Infant Health Profile

Link to interactive dashboard: [Maternal & Infant Health SWRMC] *(more indicators available)*

Highlights: The four localities had percentages of babies with low birth weight less than the US and Virginia values; however, the trend over time from 2011 to 2016 was worsening. In addition, a notable health disparity was seen across the localities with babies born to black mothers having a higher percentage (for example, 16.0% among black mothers compared to 5.5% among white mothers in York County). The localities also had lower infant mortality rates compared to US and Virginia values; however, again, the trend was worsening over time except in Williamsburg (staying the same). Teen pregnancy rates were also examined; the localities had rates less than the state rate except for Williamsburg, which had a much higher rate.

Babies with Low Birth Weight

	VALUE	COMPARED TO:				
County: Gloucester, VA	7.3% (2016)	VA Counties	VA Value (8.1%)	US Value (8.2%)	Prior Value (7.9%)	Trend; HP 2020 Target (7.8%)
County: James City, VA	6.2% (2016)	VA Counties	VA Value (8.1%)	US Value (8.2%)	Prior Value (6.6%)	Trend; HP 2020 Target (7.8%)
County: Williamsburg City, VA	5.1% (2016)	VA Counties	VA Value (8.1%)	US Value (8.2%)	Prior Value (6.2%)	Trend; HP 2020 Target (7.8%)
County: York, VA	6.8% (2016)	VA Counties	VA Value (8.1%)	US Value (8.2%)	Prior Value (6.5%)	Trend; HP 2020 Target (7.8%)

Infant Mortality Rate

	VALUE	COMPARED TO:				
County: Gloucester, VA	5.6 Deaths per 1,000 live births (2016)	 VA Counties	 VA Value (5.8)	 US Value (5.9 in 2013-2015)	 Prior Value (10.9)	
		 Trend	 HP 2020 Target (6.0)			
County: James City, VA	4.7 Deaths per 1,000 live births (2016)	 VA Counties	 VA Value (5.8)	 US Value (5.9 in 2013-2015)	 Prior Value (7.1)	
		 Trend	 HP 2020 Target (6.0)			
County: Williamsburg City, VA	0.0 Deaths per 1,000 live births (2016)	 VA Counties	 VA Value (5.8)	 US Value (5.9 in 2013-2015)	 Prior Value (11.5)	
		 Trend	 HP 2020 Target (6.0)			
County: York, VA	2.8 Deaths per 1,000 live births (2016)	 VA Counties	 VA Value (5.8)	 US Value (5.9 in 2013-2015)	 Prior Value (1.6)	
		 Trend	 HP 2020 Target (6.0)			

Teen Pregnancy Rate

	VALUE	COMPARED TO:			
County: Gloucester, VA	8.6 Pregnancies per 1,000 females aged 15-17 (2016)	 VA Counties  HP 2020 Target (36.2)	 VA Value (8.7)	 Prior Value (3.0)	 Trend
County: James City, VA	5.7 Pregnancies per 1,000 females aged 15-17 (2016)	 VA Counties  HP 2020 Target (36.2)	 VA Value (8.7)	 Prior Value (5.7)	 Trend
County: Williamsburg City, VA	59.2 Pregnancies per 1,000 females aged 15-17 (2016)	 VA Counties  HP 2020 Target (36.2)	 VA Value (8.7)	 Prior Value (5.8)	 Trend
County: York, VA	3.3 Pregnancies per 1,000 females aged 15-17 (2016)	 VA Counties  HP 2020 Target (36.2)	 VA Value (8.7)	 Prior Value (3.8)	 Trend

G. Spotlight: Opioid Epidemic

In late 2016, the Virginia Health Commissioner declared the opioid crisis a public health emergency due to the growing number of opioid overdoses in Virginia. The declaration has helped to spur communities throughout the state to begin taking action across several areas to combat the epidemic: prevention (legal and illegal), harm reduction (such as naloxone/Narcan strategies), treatment, and culture change.

Link to interactive state data portal: http://www.vdh.virginia.gov/data/opioid-overdose/

Highlights: Based on 2017 data, death rates due to fentanyl/heroin overdose were higher than the state rate in James City County and York County; these rates were higher than 2016, too. Death rates due to prescription opioid overdose across the service area were below the state rate; rates were increasing in several localities compared to 2016, though. Emergency department visits in 2017 due to heroin and opioids were also examined. High rates of visits were seen among residents of King William County and New Kent County for heroin and opioids; additionally, a higher rate was seen for Middlesex County for opioid overdoses visits. Narcan administration rates by emergency medical service providers were increasing throughout the service area; this, in part, reflects greater access and training to the rescue saving drug that can rapidly reverse overdoses to combat the epidemic.

Virginia Opioid Epidemic Indicators for the SWRMC Service Area, 2017

Locality	Overdose Deaths						ED Visits				EMS
	Fentanyl and/or Heroin Overdose			Prescription Opioid Overdose			ED Heroin Overdose		ED Opioid Overdose		Narcan Administration Rate
	Count	Rate	2016 to 2017	Count	Rate	2016 to 2017	Rate	2016 to 2017	Rate	2016 to 2017	
Charles City County	0	0.0	↓	0	0.0	=	0.0	=	84.9	↓	0.0
Gloucester	6	16.1	↓	4	10.7	↑	8.1	↓	67.2	↓	59.1
James City County	3	4.0	↑	5	6.7	↑	6.7	↓	90.0	↓	26.9
King and Queen County	1	14.0	=	0	0.0	=	0.0	=	97.8	↓	55.9
King William County	2	12.2	↓	0	0.0	↓	67.3	↑	159.2	↑	67.3
Middlesex County	1	9.3	↑	0	0.0	↓	18.6	=	120.6	↑	37.1
New Kent County	1	4.7	=	1	4.7	↑	37.8	↑	104.0	↓	47.3
Williamsburg	0	0.0	↓	0	0.0	=	0.0	=	13.1	↑	13.1
York County	8	11.8	↑	2	2.9	↑	8.8	↓	64.7	↓	51.5
Virginia	928	11.0	↑	498	55.9	↑	18.9	↑	102.0	↑	53.9

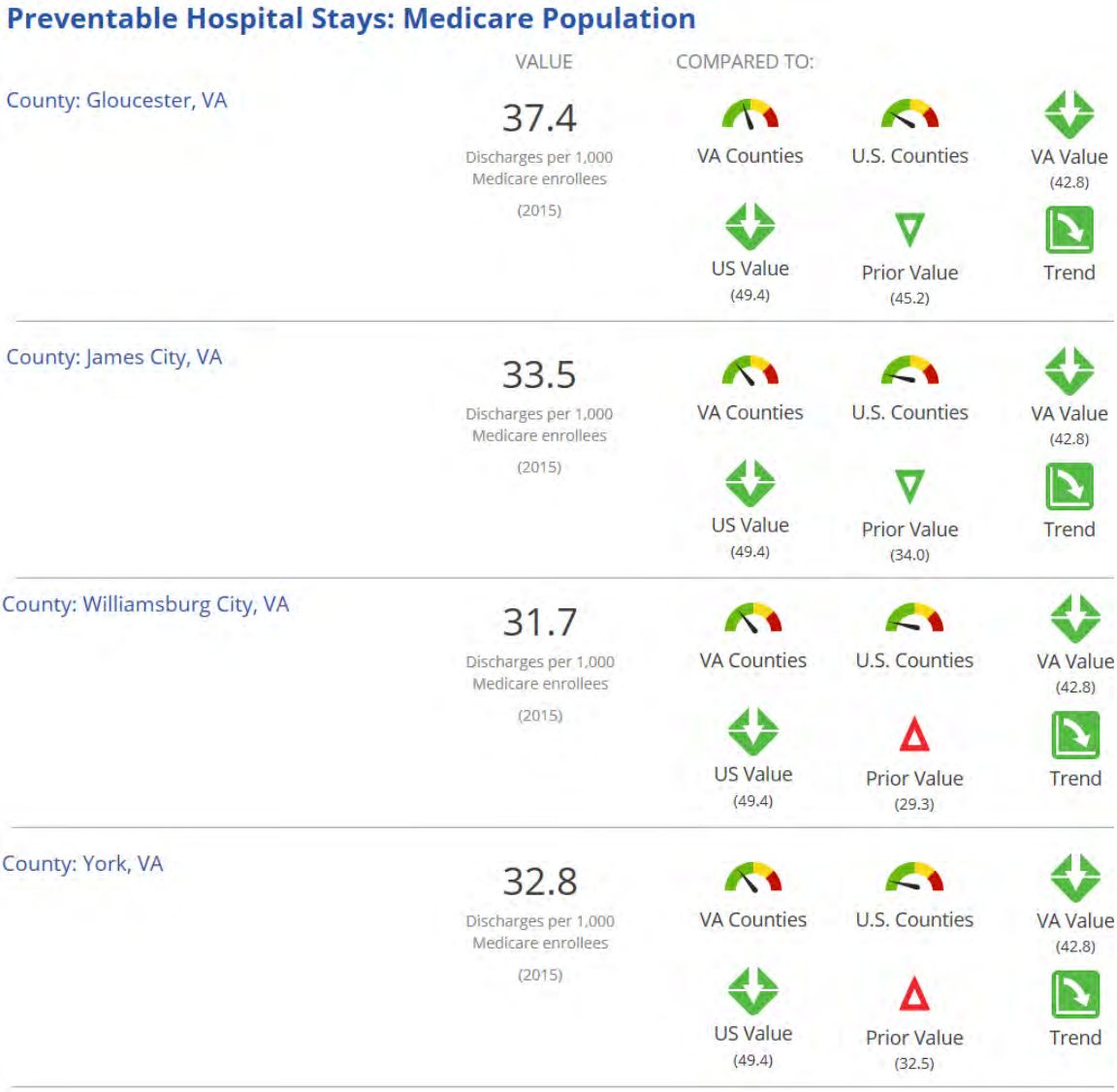
Rates per 100,000 Virginia Residents; **GREEN** = Rates are better compared to VA, **RED** = Rates are worse compared to VA
2016 to 2017 compares 2017 rates to 2016 rates; **Green arrow** = better than 2016, **Red arrow** = worse than 2016
Rates calculated with small numbers (<4) should be interpreted with caution.
Data Source: Virginia Department of Health. Virginia Opioid Addiction Data Portal.

H. Spotlight: Older Adults and Aging

In many communities, the population of older adults are growing at the fastest rate. Challenges come with an aging population, including health related factors and other factors that ultimately impact health. Below are a few indicators that represent key areas related to the wellness of this population.

Link to interactive dashboard: [Older Adults & Aging SWRMC]

Highlights: Preventable hospital stays among the Medicare population in the SWRMC service area are better than state and national rates; they have also been improving over time (since 2011). This is an indicator of quality outpatient care being available in the service area. The percentage of adults aged 65+ with a disability is only high in Gloucester compared to Virginia and US percentages. Similarly, adults aged 65+ with an independent living difficulty is only marginally higher in Gloucester (higher than the Virginia value but less than the US value). The percentage of Medicare population with Alzheimer's disease or dementia was also examined; this percentage in Williamsburg was in the worst quartile among the state but the trend from 2009 to 2015 was improving. While the percent was slightly less than the Virginia value for James City County (9.0% vs. 9.2%), the trend was worsening over time. Williamsburg also had a high percentage of people 65+ who live alone compared to state and national values; the trend over time was improving, though.



Adults 65+ with a Disability

	VALUE	COMPARED TO:		
County: Gloucester, VA	39.5% (2012-2016)	VA Value (33.3%)	US Value (35.8%)	Prior Value (35.9%)
		Trend		
County: James City, VA	27.0% (2012-2016)	VA Value (33.3%)	US Value (35.8%)	Prior Value (23.4%)
		Trend		
County: Williamsburg City, VA	27.5% (2012-2016)	VA Value (33.3%)	US Value (35.8%)	Prior Value (23.0%)
		Trend		
County: York, VA	28.1% (2012-2016)	VA Value (33.3%)	US Value (35.8%)	Prior Value (28.3%)
		Trend		

Adults 65+ with an Independent Living Difficulty

	VALUE	COMPARED TO:		
County: Gloucester, VA	14.5% (2012-2016)	VA Value (14.4%)	US Value (15.2%)	Prior Value (11.6%)
		Trend		
County: James City, VA	11.1% (2012-2016)	VA Value (14.4%)	US Value (15.2%)	Prior Value (10.9%)
		Trend		
County: Williamsburg City, VA	8.8% (2012-2016)	VA Value (14.4%)	US Value (15.2%)	Prior Value (7.6%)
		Trend		
County: York, VA	9.5% (2012-2016)	VA Value (14.4%)	US Value (15.2%)	Prior Value (11.3%)
		Trend		

Alzheimer's Disease or Dementia: Medicare Population

	VALUE	COMPARED TO:		
County: Gloucester, VA	7.6% (2015)	VA Counties	U.S. Counties	VA Value (9.2%)
		US Value (9.9%)	Prior Value (7.7%)	Trend
County: James City, VA	9.0% (2015)	VA Counties	U.S. Counties	VA Value (9.2%)
		US Value (9.9%)	Prior Value (8.8%)	Trend
County: Williamsburg City, VA	9.7% (2015)	VA Counties	U.S. Counties	VA Value (9.2%)
		US Value (9.9%)	Prior Value (9.0%)	Trend
County: York, VA	8.1% (2015)	VA Counties	U.S. Counties	VA Value (9.2%)
		US Value (9.9%)	Prior Value (7.8%)	Trend

People 65+ Living Alone

	VALUE	COMPARED TO:		
County: Gloucester, VA	25.0% (2012-2016)	VA Counties	U.S. Counties	VA Value (25.9%)
		US Value (26.4%)	Prior Value (23.4%)	Trend
County: James City, VA	20.7% (2012-2016)	VA Counties	U.S. Counties	VA Value (25.9%)
		US Value (26.4%)	Prior Value (21.6%)	Trend
County: Williamsburg City, VA	28.9% (2012-2016)	VA Counties	U.S. Counties	VA Value (25.9%)
		US Value (26.4%)	Prior Value (30.4%)	Trend
County: York, VA	19.4% (2012-2016)	VA Counties	U.S. Counties	VA Value (25.9%)
		US Value (26.4%)	Prior Value (19.8%)	Trend

Sources

Profile	Data Accessed & Maintained Via	Source/Agency
Mortality Profile	Virginia Department of Health Mortality Data Portal	Deaths – VDH (OIM – Data Management)
Hospitalizations for Chronic and Other Conditions Profile	Healthy Communities Institute. Greater Hampton Roads Community Indictors Dashboard. GHRconnects. http://www.ghrconnects.org/.	Virginia Health Information (VHI)
Risk Factor Profile		County Health Rankings; Centers for Disease Control and Prevention (CDC) 500 Cities Project
Cancer Profile	National Cancer Institute. State Cancer Profiles. https://statecancerprofiles.cancer.gov/.	National Cancer Institute
Behavioral Health Profile	Healthy Communities Institute. Greater Hampton Roads Community Indictors Dashboard. GHRconnects. http://www.ghrconnects.org/.	Virginia Health Information (VHI); County Health Rankings
Maternal and Infant Health Profile		Virginia Department of Health, Division of Health Statistics
Spotlight: Opioid Epidemic	Virginia Department of Health Data Portal. http://www.vdh.virginia.gov/data/opioid-overdose/.	Virginia Department of Health
Spotlight: Older Adults and Aging	Healthy Communities Institute. Greater Hampton Roads Community Indictors Dashboard. GHRconnects. http://www.ghrconnects.org/.	The Dartmouth Atlas of Health Care; American Community Survey-United States Census Bureau

Community Insight

The community insight component of this CHNA consisted of two methodologies: an online Community Key Stakeholder Survey carried by the Sentara Strategy Department and a series of more in-depth Community Focus Groups carried out by the hospital.

The Key Stakeholder Survey was conducted jointly with all Sentara hospitals in Hampton Roads in conjunction Bon Secours Hampton Roads, Children's Hospital of The King's Daughters, Riverside Health System, and the Department of Health. The survey tool was similar to but expanded from the survey utilized for the 2016 CHNA.

Community Focus Group Sessions were carried out by the hospital to gain more in-depth insight from community stakeholders. The questions below were utilized. The results of the focus groups are presented after the survey results.

- 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?
- Considering social determinants impact health outcomes more than clinical care, which of the following resonate as a key social determinant that we should be focusing on?

Key Stakeholder Survey: The survey was conducted jointly by Bon Secours Hampton Roads, Children's Hospital of The King's Daughters, Riverside Health System, Sentara Healthcare and the Department of Health in an effort to obtain community input for the study. The *Key Stakeholder 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 for adults and for children;
- Significant service gaps in the community for adults and for children;
- Issues impacting the ability of individuals to access care;
- Vulnerable populations in the community;
- Community assets that need strengthening in the community;
- 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. Health system and health department staff conducted outreach for community input via email and in-person and via teleconference at local events and meetings. An email survey request was sent to 922 unduplicated community stakeholders throughout Hampton Roads, and a total of 168 stakeholders in the Sentara Williamsburg Regional Medical Center (SWRMC) service area submitted a response, although not every respondent answered every question. The respondents provided rich insights about community health in the study region. This report summarized the survey results for those respondents affiliated with the SWRMC service area.

The stakeholders responding to the survey represent 66 organizations that each have special insight into the health factors that impact the community. The stakeholders work in hospitals and physician offices, City Departments of Social Services, Health Departments and community-based non-profit service organizations working to improve life in Hampton Roads. They are Emergency medical service providers, healthcare providers, fire fighters, pastors, public school teachers and administrators, and social service providers. Some are volunteers, others are career employees in their organizations.

Survey respondents were asked to identify the type of organization that best represents their perspective on health issues through employment or other affiliation. 147 out of the 168 respondents answered this question. The table below presents the roles the respondents play in the community.

Community Roles of Survey Respondents

Type of Organization	% Responses
Healthcare	52.4%
Community Nonprofit Organization (Food Bank, United Way, etc.)	15.0%
Local Government or Civic Organization	8.2%
Education	7.5%
Foundation	4.1%
Law Enforcement / Fire Department / Emergency Medical Services (EMS)	3.4%
Business Representative	2.0%
Faith-based Organization	1.4%
Financial Institution	0.7%

Additionally, respondents were asked to list a specific organization, if any, that they represent in taking the survey. Their responses are presented on the following page.

Organizations Represented in the Key Stakeholder Survey	
Access Partnership	Middlesex Department of Social Services
American Diabetes Association	New Kent County Public Schools
Bay Aging	New Kent County CSA
Bay Rivers Telehealth Alliance	New Kent Sheriff's Office
Bon Secours Mercy Health Mary Immaculate Hospital	Olde Towne Medical & Dental Center
Buy Fresh Buy Local Hampton Roads	Peninsula Agency on Aging, Inc.
Catholic Charities of Eastern Virginia	Peninsula Health Department
Center for Child & Family Services	Peninsula Metropolitan YMCA
Champions For Children	Respite of Williamsburg United Methodist Church
Charles City Department of Social Services	Riverside Health System
Chickahominy Health District	Riverside Tappahannock Hospital
Child Development Resources	Riverside. Lifelong Health and Aging
Child Development Resources Fatherhood Program	Riverside Walter Reed Hospital
Children's Hospital of The King's Daughters	Sentara Healthcare
City of Williamsburg Fire Department	Sentara Williamsburg Regional Medical Center
Colonial Behavioral Health	Sentara Williamsburg Patient & Family Advisory Council
Community Services Coalition (Historic Triangle Comm Center)	Summit Wellness At The Mount
Compassionate Care Hospice	The Barry Robinson Center
Consortium for Infant and Child Health (CINCH)/EVMS	The Orchard--A Riverside Healthy Living Community
Eastern Virginia Medical School	Town Council West Point
Eastern Virginia Medical School Ear, Nose and Throat	United Way of the Virginia Peninsula
Gloucester-Mathews Free Clinic	Versability Resources Inc.
Grace Covenant Presbyterian Church	Virginia Career Works- Greater Peninsula
Hampton and Peninsula Health Districts	Virginia Oral Health Coalition
James City County Social Services	Virginia Peninsula Foodbank
King and Queen Social Services	Women', Infants' and Children's program
King William County	Williamsburg Health Foundation
King William County District 4	Williamsburg-James City County Community Action Agency
Lackey Clinic	Williamsburg James City County School Board
Literacy for Life	York County Fire & Life Safety
Middle peninsula Northern Neck Community Services Board	York Juvenile Services
Middlesex County Public Schools	York Poquoson Social Services
Middlesex County School Board	Zaremba Center for Estate Planning and Elder Law

For both adults and, separately, children and teens, 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 five challenges from the list that they view as important health concerns in the community. Respondents were also invited to identify additional issues not already defined on the list. Of the 168 respondents, 138 provided their concerns for adult challenges. The responses for children's and teen's health concerns follow on subsequent pages.

Most Frequently Chosen Health Concerns -- Adults aged 18+		
Health Concern	**% Responses**	**Rating**
Heart Conditions (Heart Disease, Congestive Heart Failure / CHF, Heart Attacks / AMI, High Blood Pressure / Hypertension)	56.5%	1
Behavioral / Mental Health (Suicide, ADHD, Anxiety, Depression, etc.)	55.1%	2
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	52.2%	3
Overweight / Obesity	50.0%	4
Diabetes	44.9%	5
Cancer	31.9%	6
Alzheimer's Disease / Dementia	22.5%	7
Dental / Oral Care	20.3%	8
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	18.8%	9
Hunger	15.9%	10
Respiratory Diseases (Asthma, COPD, Emphysema)	15.2%	11
Accidents / Injuries (Unintentional)	13.8%	12
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	12.3%	13
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	12.3%	
Neurological Conditions (Stroke, Seizures, Multiple Sclerosis, Traumatic Brain Injury, etc.)	11.6%	14
Prenatal and Pregnancy Care	10.1%	15
Violence – Sexual and / or Domestic	10.1%	
Chronic Pain	8.0%	16
Intellectual / Developmental Disabilities / Autism	8.0%	
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	4.4%	17
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	4.4%	
Physical Disabilities	4.4%	
Bullying (Cyber, Workplace, etc)	2.2%	18
Drowning / Water Safety	0.7%	19

Emerging Themes: Throughout Hampton Roads, the most frequently chosen health concern for adults was behavioral health, followed by heart disease, alcohol and substance abuse, obesity, diabetes and cancer. This reflects a growing understanding that behavioral health is integral to overall wellness, as well as pointing to the persistent lack of services to address a health problem with a growing patient population as conditions previously undiagnosed are identified. For the SPAH service area, this order is reversed, although the difference between the two is only 1.4%.

In addition to responding to the pre-formulated survey list, ten individuals listed additional adult health concerns. The responses offer the themes of affordable care, management of chronic conditions, public awareness of current services, and the availability of mental/behavioral health assistance. The "free response" answers draw attention to the connections between what we think of as traditional medical conditions and the non-medical factors in our everyday lives that impact health, and which are known as the "social determinants of health." In these responses, as in the other free response sections of the survey, a broader vision of health is displayed. The following table presents additional health concerns for adults.

Free Response Additional Community Health Concerns -- Adults aged 18+
balanced diet, availability of healthy, fresh foods across income levels and geographic areas
How did Womens health and health care disparities not make this list
Affordable quality healthcare
Precariously Housed, those with chronic illnesses
Intellectual/Developmental Disabilities and Autism are issues because of the lack of services and lack of service coordination for affected individuals. Lack of health insurance is also a significant concern.
Age-related disabilities (in an aging population).
In my opinion, behavioral and mental health is a major concern in this area. Many are suffering and not getting the counseling they need due to the high costs, stigma behind seeking help, and labelling by employers or others for seeking therapy. Improved systems to address this could lead to a decrease in the number of adults dealing with alcohol and substance abuse. Violence in the community is a significant concern as well. Much of this starts at home and in the schools. Parenting education, particularly for new mothers and fathers would go a long way in preventing child abuse which often times causes those children to grow up traumatized and more apt to abuse others as a result. Parents should be required to learn how to properly care for their baby before leaving the hospital. Not enough is done in schools to prevent violence, bullying, and gang activity. It starts in the elementary schools. As a former teacher, I can attest that schools sweep violence under the rug so they do not have to report it. Also, in the 9 years I taught in a local school system, NOT ONCE did the police department come and talk to the children about drugs, alcohol, or gangs - and I taught in Newport News! Administration in schools often feel like their hands are tied in addressing bullying, so they don't. My middle-school-aged son reported a classmate that showed him cuts on her arm and told him that she did that when she was angry. His guidance counselor told him that that was private and not his business; that he shouldn't have told her about it. That response was unacceptable. Now, he doesn't trust his guidance counselor to help when there is trouble, so he does not feel comfortable reporting things that should be reported. Bullying can lead to behavioral and mental health concerns, alcohol and substance abuse, and eventually violence. This is how school shootings and other violent acts against classmates and staff occur.
People with multiple chronic diseases particularly the uninsured.
Lack of understanding of community resources that are already available to patients and are under utilized
Social Isolation, lack of transporting to get to appointments, shopping and social outings.

Emerging Themes: You will note that throughout the survey, where free response questions allow respondents to identify additional areas of interest we found that social and lifestyle elements were often included on the lists. Things such as transportation, affordability and the need for care coordination for health concerns and between organizations that focus on different types of assistance remind us that health is not a stand-alone experience but is instead woven into the lives we lead.

A follow-up question on the survey asks respondents to choose five healthcare services that need to be strengthened for adults in the SWRMC service area from a list of services that are common in communities across the country. Respondents were given the characteristics of improved access, quality of healthcare, and availability of the service as considerations to take into account when making their choices. The responses of 134 individuals are presented in the table on the next page.

Community Healthcare Services that Need to be Strengthened -- Adults aged 18+		
Healthcare Service	**% Responses**	**Rating**
Behavioral / Mental Health Services	60.5%	1
Alcohol / Substance Abuse Services	41.0%	2
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	39.6%	3
Health Insurance Coverage	38.1%	4
Aging Services	33.6%	5
Health Promotion and Prevention Services	32.1%	6
Dental / Oral Health Services	28.4%	7
Self-Management Services (Nutrition, Exercise, etc.)	26.1%	8
Care Coordination and Transitions of Care	22.4%	9
Social Services	17.2%	10
Long Term Services / Nursing Homes	15.7%	11
Family Planning and Maternal Health Services	14.9%	12
Public Health Services	14.9%	
Domestic Violence / Sexual Assault Services	14.2%	13
Home Health Services	14.2%	
Chronic Pain Management Services	11.9%	14
Cancer Services	11.2%	15
Primary Care	11.2%	
Telehealth / Telemedicine	11.2%	
Hospice and Palliative Care Services	8.2%	16
Hospital Services (Inpatient, outpatient, emergency care)	8.2%	
Pharmacy Services	6.7%	17
Physical Rehabilitation Services	1.5%	18
Bereavement Support Services	0.0%	19

Emerging Themes: Throughout the survey, behavioral health services top the list of services most in need of strengthening. Across Hampton Roads, health insurance is the second most frequently chosen response, with substance abuse services, chronic disease management services and aging services all following. Uncertainty about health insurance coverage and affordability is part of a changing healthcare landscape and will be addressed, though probably not completely resolved, through Medicaid expansion.

Respondents were also given the opportunity to add free response suggestions of other healthcare services that need to be strengthened for adults. The additional concerns of 12 respondents are listed in the table on the next page.

Free Response Community Healthcare Services that Need to be Strengthened -- Adults aged 18+
Hospital obstetrics services-deliveries.
Women's health
Health promotion and prevention is inherent in all of these categories.
Better quality of services in the Social Services Department. Someone that can do an anonymous check on how the Social Services and Health Department employees treat the public. Not to be totally critical but to offer problem solving solutions to better assist.
Transportation
Hospice and Palliative Care also important but there are many gaps in services and in education of providers and the public.
transportation to physician's offices
People need to feel comfortable and not be penalized for reporting another adult with a behavioral or mental health concern. Also, these services need to be widely available and affordable.
Transportation is a critical barrier to health care for many of our patients.
Also would select HEALTH INSURANCE Coverage and Health Promotion and Prevention Services.
Transport up to medical appointments- impossible to get affordable transporting in if you're crossing some jurisdictions. I.e., treatments in Richmond or Norfolk.
In the rural areas of Eastern Virginia, access to services is essential. Through the use of telemedicine access to many services available in urban areas may be increased empowering patients to address complex issues, coordinate care across settings and sectors, and improve self-care

Emerging Themes: Women's health, transportation and prevention efforts are seen as important additions to the list of services that need to be strengthened across Hampton Roads. Once again, it is evident that other lifestyle challenges such as housing and transportation are seen as important aspects of health related services.

Recognizing that partners in the collaboration that produced this survey may serve differing patient populations, and may have a different focus for needed information when addressing community needs, the survey repeated the two questions about adult health concerns and community services needed for children and teens from birth through age 17. Although the questions and intent are the same as the questions for adults, some of the listed health and community service needs are specific to the population aged 17 and under. Of 168 respondents, 133 answered these questions. The table on the next page presents the most frequently chosen responses.

Most Frequently Chosen Health Concerns -- Children and Teens ages 0 -- 17		
Health Concern	**% Responses**	**Rating**
Behavioral / Mental Health (Suicide, ADD, Anxiety, Depression)	75.9%	1
Overweight / Obesity	57.1%	2
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	42.1%	3
Bullying (Cyber, Workplace, etc)	41.4%	4
Violence In the Home – Child Abuse (Sexual, Physical, Emotional or Neglect) or Exposure	36.8%	5
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	30.8%	6
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	26.3%	7
Accidents / Injuries (Unintentional)	24.1%	8
Dental / Oral Care	24.1%	
Intellectual / Developmental Disabilities / Autism	23.3%	9
Hunger	22.6%	10
Teen Pregnancy	13.5%	11
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	12.0%	12
Diabetes	9.0%	13
Respiratory Diseases (Asthma and Cystic Fibrosis)	9.0%	
Eating Disorders	8.3%	14
Neurological Conditions (Epilepsy, Seizures, Tourette Syndrome-TICS, Sleep Disorders)	4.5%	15
Drowning / Water Safety	3.8%	16
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	3.8%	
Cancer	2.3%	17
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	2.3%	
Physical Disabilities	2.3%	
Heart Conditions (Congenital Heart Defects, Fainting and Rhythm Abnormalities)	0.8%	18
Chronic Pain	0.0%	19

Emerging Themes: Behavioral health is the most frequently chosen health concern for children and teens, perhaps resulting from the somewhat alarming choices that follow, including obesity, violence, bullying, and substance abuse. This tracks with the increased understanding that modern children live with a great deal of stress, both mental and physical, and it impacts their health in ways we are just beginning to understand. For a more detailed discussion of these effects, follow this link to the Adverse Childhood Experiences (ACES) website: https://www.cdc.gov/violenceprevention/acestudy/index.html

Five individuals provided additional thoughts on the most important health concerns for children and teens in the community. Their additions are presented below.

Free Response Additional Community Health Concerns -- Children and Teens ages 0 -- 17
No access to primary care without a long wait and well check first. I'm an urgent care doc and we see this all the time on both sides of the HRBT
Affordable quality healthcare
Many things affect children and teens with most connected to parenting skills.
Housing impacts health
Health promotion should be for children as well.

Emerging Themes: The responses reflect that children face the same challenges to access that adults do, while recognizing the effect of parenting and living conditions, often things that children have no control over.

The survey next asked respondents to choose five healthcare services for children and teens that need to be strengthened from a list of common healthcare services. Responses from 131 individuals are presented in the table on the next page.

Community Healthcare Services that Need to be Strengthened -- Children and Teens ages 0 -- 17		
Healthcare Service	**% Responses**	**Rating**
Behavioral / Mental Health Services	77.9%	1
Parent Education and Prevention Programming	57.3%	2
Child Abuse Prevention and Treatment Services	48.9%	3
Alcohol / Substance Use Services	42.8%	4
Self-Management Services (Nutrition, Exercise, etc.)	36.6%	5
Foster Care (Supporting children in the system and their host families)	34.4%	6
Dental / Oral Health Services	29.8%	7
Social Services	28.2%	8
Health Insurance Coverage	23.7%	9
Care Coordination and Transitions of Care	20.6%	10
Primary Care	19.1%	11
Public Health Services	19.1%	
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	11.5%	12
Telehealth / Telemedicine	8.4%	13
Chronic Pain Management Services	5.3%	14
Home Health Services	5.3%	
Pharmacy Services	3.8%	15
Bereavement Support Services	2.3%	16
Cancer Services	1.5%	17
Physical Rehabilitation Services	0.8%	18

Emerging Themes: Continuing the focus on the behavioral health needs of children and teens, behavioral and mental health services are most cited as needing to be strengthened. Across the survey area, this choice is followed by parent education and child abuse prevention and treatment services. As we understand more about how childhood events impact adult health, the call for these support services is likely to grow stronger. For a more detailed discussion of these effects, follow this link to the Adverse Childhood Experiences (ACES) website: https://www.cdc.gov/violenceprevention/acestudy/index.html

Free response additional services to be strengthened were suggested by 11 individuals and are presented in the table on the next page.

Free Response Community Health Services that Need to be Strengthened -- Children and Teens ages 0 -- 17
Violence prevention and gun safety education, Palliative care services
cardiac care.
Cannot emphasize more strongly the lack of adequate mental health resources for children, especially those with public insurance or no insurance.
Safe affordable quality childcare
Services can be strengthened but if parents aren't required to access services, it is of no help. Social Services is difficult to access, as is behavioral/mental health services. There is sufficient access to dental/oral health BUT parents must take minors for services.
Transportation
Prevention - effective prevention strategies will work if put in place correctly and with integrity. Abuse and violence prevention is the key in reducing incidents of domestic violence and abuse.
Home visiting programs
Transportation remains a barrier to health care for teens.
Water Safety/Drowning Prevention, Tween/Teen Leadership Programs
Schools are a primary source of care and support for children and teens in rural areas. By improving the health infrastructure of rural schools through telemedicine, schools can be equipped to support physical, behavioral, dental and chronic disease care services, teaching children at a young age how to be healthier adults.

Emerging Themes: Violence prevention and gun safety education is the community service most often cited as needing to be strengthened. Several other responses focused on parenting resources and prevention efforts.

Much of the information we gather on community health needs ties directly or indirectly to access to health care and other services. The table on the next page is an incomplete list of factors that might influence an individual's access to service. Although the list is brief, it can help clarify and prioritize program design. Of 168 respondents, 132 provided their list of access concerns.

Factors Impacting Access to Care and Services		
Factors	**% Responses**	**Rating**
Costs	84.1%	1
Transportation	75.8%	2
Health Insurance	62.1%	3
Time Off From Work	56.1%	4
Understanding the Use of Health Services	56.1%	
Childcare	42.4%	5
No / Limited Home Support Network	37.1%	6
Lack of Medical Providers	30.3%	7
Location of Health Services	25.8%	8
Discrimination	4.6%	9
No / Limited Phone Access	3.8%	10

Emerging Themes: Across Hampton Roads, the top three choices of factors impacting access to care are the same: cost, transportation and health insurance. All three are questions of affordability of care, a consistent concern across services areas and populations.

Ten individuals gave free response suggestions for other factors that impact access to care. Their suggestions are presented in the table on the next page.

Free Response Additional Comments About Access to Healthcare
Lack of providers in Rural areas
Few providers of services are available in evenings or weekends making it difficult for working parents to take time off.
Lack of Medicaid Providers and that will only become more serious as additional people enroll in the Program. Also, understanding the use of health services.
Lack of providers that accept insurance of certain types, including but not limited to Medicaid and/or Medicare.
These are all important. Understanding use of health services is easily a tie for the others I chose, as is child care.....
perception of issues confronting community
Child care costs can be equivalent to costs per month for rent or mortgage. If there are multiple children, it's even higher. Many parents cannot afford to work because of the cost of healthcare. They become reliant on the welfare system as a result. This is one reason you may have generations of families on welfare. Additionally, the Hampton Roads area has a serious lack of public transportation. Particularly on the Peninsula (Yorktown, James City, Williamsburg). You can't get to work.
Stigma
Language Barrier should be added
Poor broadband and cellular reception in rural areas make it difficult to access services that might be available via telemedicine, which could overcome several of these access obstacles such as transportation, time off from work, etc.

Emerging Themes: The lack of providers and the unavailability of providers to work extended hours, make access less feasible for those who work outside the home or have other scheduling constraints, and is the most often voiced barrier to care. Lack of childcare and language barriers are consistently cited across the Hampton Roads region as negative factors in accessing care.

Some aspects of access to care impact population segments differentially. Those with fewer resources, such as health insurance, sufficient income, and reliable transportation, struggle harder to access appropriate and sufficient care and other services. The survey included a question designed to identify which consumers face barriers that might be addressed through specific programming. Of 168 respondents, 131 answered the next two questions.

Most Vulnerable Populations in the Community Needing Support		
Populations	**% Responses**	**Rating**
Low Income Individuals	65.7%	1
Individuals Struggling with Substance Use or Abuse	49.6%	2
Uninsured / Underinsured Individuals	49.6%	
Individuals / Families / Children experiencing Homelessness	47.3%	3
Seniors / Elderly	44.3%	4
Caregivers (Examples: caring for a spouse with dementia or a child with autism)	38.9%	5
Children (age 0-17 years)	36.6%	6
Immigrants or community members who are not fluent in English	28.2%	7
Individuals with Intellectual or Developmental Disabilities	19.1%	8
Individuals Transitioning out of Incarceration	19.1%	
Unemployed Individuals	16.0%	9
Victims of Human Trafficking, Sexual Violence or Domestic Violence	14.5%	10
Individuals Struggling with Literacy	13.0%	11
Individuals with Physical Disabilities	11.5%	12
Individuals Needing Hospice / End of Life Support	10.7%	13
Veterans and Their Families	10.7%	
Migrant Workers	6.1%	14
Individuals in the LBGTQ+ community	5.3%	15

Emerging Themes: Respondents agreed across Hampton Roads that low-income individuals, the uninsured, families experiencing homelessness and those struggling with substance abuse are the most vulnerable people in the community, and need supportive services. These answers are consistent with the theme of life conditions creating health issues that we have seen throughout the survey.

Eight respondents provided free response additional suggestions for including additional populations, which covered a broad range of community segments and included commentary on the relationships between vulnerabilities and the resulting health issues. The additional suggestions are presented in full in the table on the following page.

Additional Vulnerable Populations Needing Support and Additional Information
Add seniors and un or underinsured
Affordable quality childcare
According to data, more people are insured but our organization receives more requests for help now because although they may have coverage, they cannot afford deductibles or monthly copays. Underinsured populations with low incomes or don't understand their benefits call daily for assistance.
Socially isolated individuals and individuals or families impacted by behavioral health/mental health issues
All of the above also have trouble accessing care for their kids - so all these fundamentally also impact access for children as a vulnerable population.
Taxpayers spend a lot of money on caring for and attempting to rehabilitate prisoners, yet when they are released, many are homeless, without a job, without any means to get what they need so they turn to drugs or crime and end up back in jail. This area needs better transitional services for those being released from jail. If we provide them with the education they need on soft skills and finding a job before being released from jail, then we provide them with programs to assist them in finding a job and supporting themselves, they are less likely to turn to crime and substance abuse. Unemployment services are difficult to obtain on the Peninsula due to the fact that the nearest employment office is in Hampton - 30+ minutes away! To compound the issue, public transportation is limited so you may not even be able to get there.
The VA just terminated funding for the Veteran's connected program for rural veterans to access care in their communities. Only 8-10% of veterans in the rural areas of Eastern Virginia are enrolled in VA services at the VAMC's in Hampton or Richmond. These populations are at increased risk of not accessing health services because they are no longer being paid for.
Wow. I could have chosen several others on this list (i.e., many more than 5)!

Emerging Themes: Often forgotten, people in transitions of any description are often more vulnerable as they face new situations. Prisoners transitioning out of incarceration face many challenges, with few resources to help them. Veterans transitioning out of active duty face substantial challenges in accessing care. Additionally, the contradiction of more people being technically covered by insurance but unable to pay for care because of a high deductible creates a mistaken impression of the state of health care coverage.

Finally, the survey explored the many factors in addition to medical care that determine an individual's health. Collectively called the social determinants of health, these factors are becoming increasingly recognized as contributing both directly and indirectly to individual health through processes as different as the effect of household mold on respiratory disease and the effect of stress from unemployment. The effects of social determinants are sometimes subtle, sometimes only discoverable after a health problem is identified, but often important in explaining health status. Of 168 respondents, 130 addressed this question. Respondents were asked to choose five community assets to be strengthened. Their responses are presented in the table below.

Community Assets that Need to be Strengthened		
Community Assets	**% Responses**	**Rating**
Affordable Housing	53.1%	1
Transportation	52.3%	2
Affordable Child Care	48.5%	3
Healthy Food Access (Fresh Fruits & Vegetables, Community Gardens, Farmers Markets, etc.)	42.3%	4
Employment Opportunity/Workforce Development	36.9%	5
Senior Services	33.9%	6
Homelessness	32.3%	7
Social Services	25.4%	8
Neighborhood Safety	23.9%	9
Early Childhood Education	21.5%	10
Social and Community Networks	20.0%	11
Safety Net Food System (Food Bank, WIC, SNAP, Meals on Wheels, etc.)	19.2%	12
Safe Play and Recreation Spaces (Playgrounds, Parks, Sports Fields)	18.5%	13
Education – Kindergarten through High School	17.7%	14
Public Safety Services (Police, Fire, EMT)	14.6%	15
Walk-able and Bike-able Communities (Sidewalks, Bike/Walking Trails)	14.6%	
Green Spaces	4.6%	16
Education – Post High School	3.9%	17
Environment – Air & Water Quality	3.1%	18
Public Spaces with Increased Accessibility for those with Disabilities	3.1%	
Housing Affordability & Stability	0.0%	19

Emerging Themes: Consistently across the survey area, the top four community assets in need of strengthening are affordable housing, transportation, access to healthy food, and affordable childcare. All of these choices share an element of cost, but also of infrastructure development and maintenance.

Respondents were also given the opportunity to increase the list by adding factors that impact health. Seven individuals added factors, listed in the table below.

Additional Community Assets and Additional Information
HRT services are awful! Maybe the powers to be can look into improving those services. Take a week and observe what would be improvements to these services
When a young family pays for child care, it cancels out a large portion of their income. Rent in a safe neighborhood is out of reach for many. Access to Healthy foods won't work if parents/individuals won't use them. Would like to see SNAP work more like WIC where only healthy foods can be purchased (currently, items like candy, soda, chips and other non-nutritional foods can be obtained with SNAP).
Community Task Forces that decide on prevention strategies for their communities...
Checked one education box, but all are necessary. This question is very hard to deal with, since most are needed.
Safe places to play and walkable/bikeable communities also rank high up there.
Safety Net Food System should be oriented to Healthy Food Access
health safety net

In closing, survey participants were asked to share any additional thoughts that had emerged through the process of responding to the survey questions. Nine respondents shared additional ideas, presented in the table on the next page. We appreciate the time and thought that went into each survey response, and are pleased to present the results here for input into service planning throughout the communities of Hampton Roads.

Additional Comments and Additional Information
Thank you for asking. I'd love to help from a public health standpoint if needed.
Positive changes are needed. Let's not just talk but be doers!
Need to identify a way to encourage or reward individuals to live a healthy lifestyle, eat nutritional foods, take responsibility for their health. We can continue to provide and strengthen services but unless an individual assumes some responsibility, it won't make a difference.
Quality, Cost, Access are three key goals for improving health care in our community
more than 5 in each area really should have been marked....
There is little vocal effective advocacy for patients ages 19-64.
Generally, York County is a healthy municipality but we too can improve across the spectrum of services.
Thank you for allowing me the opportunity to share my concerns
Bay Rivers Telehealth Alliance has conducted a number of Community Needs Assessments related to the provision of Telemedicine in the Northern Neck, Middle Peninsula and Eastern Shore related to Care Transitions, Geriatric Care, Rural Opioid Planning and School Based Health Services. In addition, we have developed a comprehensive data base for all of Eastern Virginia on the Veteran Population beyond the statistics of the Veterans Administration. We are happy to be of help if we can.

Emerging Themes: Several of the comments presented above reference the need to navigate, coordinate, advocate and educate the population on how to understand and access services. This is in essence the thrust of population health management, and confirms the importance of conducting community needs assessments to hear the voice of the community.

Community Focus Group Session Findings

In addition to the online surveys for community insight, Sentara Williamsburg Regional Medical Center 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?
- Considering social determinants impact health outcomes more than clinical care, which of the following resonate as a key social determinant that we should be focusing on?

Three focus group sessions were held in February, March and April 2019. The number of participants ranged from 2 to 6. When possible, representatives from the health department and other local hospitals were invited to attend the sessions.

1. WestRock Paper Mill (physician and nurse)
2. SWRMC Auxiliary (3 members)
3. James City County Satellite Rotary Club (6 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?	Obesity and the related effects, such as sleep apnea; Substance abuse, chronic disease (CHF, diabetes, etc.), Asthma in kids
Who/what groups of individuals are most impacted by these problems?	Shiftworkers, the working poor and those who live in rural areas. Kids and those in the lower socio-economic strata.
What keeps people from being healthy? In other words, what are the barriers to achieving good health?	Their physicians have never addressed the issue head on. Also, the food that is available easily when shift workers get off work is usually from a gas station; having to prioritize life needs (working multiple jobs, lower income, etc.), underinsured or not insured

What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?	Safety-net clinics, SHIP Program,
What more can be done to improve health, particularly for those individuals and groups most in need?	Trainings for REVIVE, Medication disposal outreach, free sleep studies, education on eating well and healthy habits, and behavioral change coaching, open a chronic condition clinic; taking the education out into the communities most affected (ie. the Grove, etc.)
Considering social determinants impact health outcomes more than clinical care, which of the following resonate as a key social determinant that we should be focusing on?	All of them!

Sentara Community Health Needs Assessment Implementation Strategy
2018 Progress Report
Hospital: SWRMC
Quarter (please indicate): ☐First Quarter ☐Second Quarter ☐Third Quarter ☒Year End

In support of community health needs assessment and related implementation strategies, 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 Laura Armstrong-Brauer at lrarmstr@sentara.com within 15 days of the close of each quarter.

Health Problem	Three Year Implementation Strategies	Progress
Problem #1- Mental Health	• Support the Sentara System- wide Behavioral Health Strategic Plan • Assess the ability to implement tele-psych in both Emergency Department and outpatient environments • Continue to work collaboratively with the Pavilion/Colonial Behavioral Health • Finalize physical renovations in ED Safe Rooms to ensure patients remain safe while hospitalized. • Ensure active participation with the Chronic Care Collaborative As part of the Sentara Behavioral Health Strategic plan • Provide ongoing staff education on de-escalation techniques • Continue Project SEARCH	Launched a new safe patient process to augment safety for patients with suicidal ideation in the ED. Lockers for visitor belongings added as well. SWRMC continues to participate in monthly Chronic Care Collaborative meetings Handle with Care De-escalation training kicked off in August- 4 hour sessions beginning August 14, continued through the end of the year. Online modules will be available in 2019 as well as expansion of hands-on training. 7 students have started with Project Search at SWRMC for this school year (2018-2019) Meetings continue with representatives from Eastern State Hospital to discuss management of their patients when transferred to SWRMC
Problem #2-Heart Disease	• Support the Sentara System-wide plan for Cardiovascular Services • Conduct community-based screenings supported by both SWRMC and RDH (Riverside Doctors Hospital), as well as area	HeartSafe Committee continues to meet monthly. Program Director hired and started in December. Oversight Committee adjusted structure of the subcommittees to better support the Program Director, once hired. The following committees

Health Problem	Three Year Implementation Strategies	Progress
	organizations to help identify at-risk residents. - Develop evidence-based cardiovascular standardized screening protocols and tools in conjunction with RDH and area physicians - In conjunction with area organizations, provide opportunities for Friends and Family CPR throughout the community - Promote a day for community-wide Blood Pressure Screening to include local EMS, Police Depts., school and libraries in conjunction with area hospitals. • Increase awareness/provide education as to the need for AEDs in our public areas and schools. • Work collaboratively with local businesses and schools, to include the hotel industry, to provide education as to when to call 911. • Continue to educate the community re: Heart Healthy Behaviors • Continue Community Health screening for total cholesterol, BP, BMI, counseling by RNs, health and wellness information.	were selected: Finance/Grants, Technology, "Champion" Recruitment, Marketing, and Events. David Masterson and Adria Vanhoozier continue to provide speaking engagements in the community. Outreach by Sentara Optima 11/07/18 Livng Well Expo at JCC; 43 participants with BPs, BMIs 11/15/18- Great American SmokeOut table in ED-9 participants 12/1 JCCRC BP Clinic and Diabetes Risk Assessment-22 participants. 21 BPs: Norm-9, Elev.-4, Stg1-3 Stg 2-5) 3 Diabetes Risk Assess.
Problem #3- Substance Abuse	• Determine feasibility of initiation of Pain Management Clinic • Consider community partnerships on alcohol and drug education/prevention • Continue to support annual Community 3D (Drinking, Drugs, and Distracted Driving • Collaborate with local organizations (Colonial Behavioral Health, Bacon Street, schools) to provide education to the community/patients about opiate addiction • Work with area schools (target middle and high schools) to provide alcohol and drug education/prevention and resources to help. • SMG will integrate Prescription Monitoring Program into EPIC/EMR so that providers have easy access to database for patients.	NA Drug take-back bin located in the SWRMC OP Pharmacy was emptied 20 times during 2018. The Safe Kids Coalition continues to provide regular events with education (fire safety, pedestrian safety, etc.)
Problem #4- Cancer	• Support Sentara system-wide Oncology Plan and the Peninsula Strategic Plan • Continue to support Women's Health Navigator (Breast Navigator)	Living Beyond Cancer Survivorship Program- November 7 with 12 participants Women's Health Navigator Stats (Q3) 2018- • Navigator Stats - Total of 50 pts open to navigation • New breast cancer-14

Health Problem	Three Year Implementation Strategies	Progress
	• Continue to offer Smoking Cessation Courses, and Tobacco Cessation kits, free mammograms through the Auxiliary, and head coverings/scarves and wigs through the Unique Boutique. • Promote new advanced interventional radiology services that support cancer initiatives at SWRMC. • Support pilot program Final Gift Hospice Vigil for terminally ill patients, which is an initiative which is being offered in partnership with Hospice Support Care of Williamsburg (HSCW.) This pilot commenced in 2017. • Continue to support and promote the newly launched Sentara Cancer Rehab Program at Sentara Outpatient Therapy Center at the YMCA. This program provides specialty-trained cancer therapists, free screenings to patients, and directs the patients with cancer to the appropriate level of care. • Work with community organizations to explore youth education on tobacco cessation. • Support ONS certifications for nurses	• Diagnostic-3 • High Risk-2 • 13 survivorship • Navigator Stats (Q4) 2018-49 patients open to navigation. 8 patients are from previous navigators. • New breast cancer Pts – 19 • Diagnostic- 5 • High Risk-1 • Closed to Survivorship-11 Free Mammograms/Bone densities : Q4: 62 (217 YTD through December) Unique Boutique: 6 clients (Q3), 40 through December. Article by Dr. Melinda Dunn (mammographers SWRMC) about breast cancer ran in Redbook, Good Housekeeping and Women's Day magazines in October. 10/15 -10/16- Breast Cancer Awareness and Scheduling at SWRMC Cafeteria, allowing option for women to schedule appointments conveniently. 10/18 Colonial Heritage Health Fair- provided info on Breast Care Interventional Radiologist has started work at SCP. SWRMC will be revisit the Final Vigil program during early 2019. Cancer Rehab Program: 20 lymphadema evaluations (102 evals through December); 5 cancer screens (9 YTD through December) and Cancer Rehab evals (8 through December)