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RIVERSIDE
Regional Medical Center

HAMPTON ROADS
SpecialtyHospital

RIVERSIDE
Rehabilitation Institute

# 2016 Community Health Needs Assessment and Implementation Plan

**This Community Health Needs Assessment and Implementation Strategy for Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital was conducted and developed between April 2016 and November 2016 to fulfill the requirements described in section 501(r)(3) of the Internal Revenue Code. It was formally approved and adopted by the Riverside Rehabilitation Institute Board of Directors on November 28, 2016; by the Hampton Roads Specialty Hospital Board of Directors of December 7, 2016; and by the Riverside Regional Medical Center Board of Directors on December 9, 2016.**

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# COMMUNITY HEALTH NEEDS ASSESSMENT

## Introduction

Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital are all part of Riverside Health System, with a mission to "care for others as we would care for those we love." While Riverside cares for its patients every day, it recognizes that caring for others can often mean those who are not in the hospital. Riverside understands it has a unique and important role in caring for the health of its community. Conducting a Community Health Needs Assessment allows Riverside to see the community as a broader population, and better understand the unique needs, concerns and priorities of the community it serves.

## Community Health Needs Assessment Process

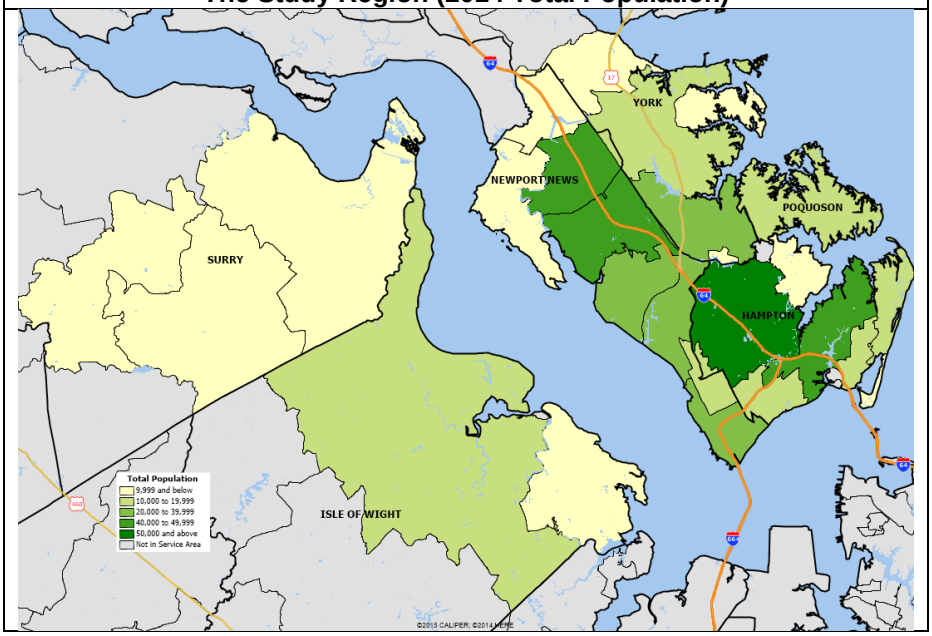
A Community Health Needs Assessment (CHNA) and Implementation Strategy for Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital was conducted between April 2016 and November 2016 in fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code. The CHNA was conducted with the assistance of Community Health Services, Inc. of Richmond, Virginia who collected the health indicator data and facilitated the community survey process.

The CHNA process consisted of four phases: data collection (quantitative), community input (qualitative), analysis and prioritization. The quantitative data is summarized in this report and represents a broad assessment of demographic and health indicators. The data sources are noted within each section. The community input data was gathered through an electronic survey process from April 13 – May 13, 2016. The survey recipients and respondents of the survey are noted in the report. Riverside's Marketing, Strategy and Development team worked with Community Health Services, Inc. to analyze the data and present it in summary form for review by community stakeholders. In November of 2016, a group of community stakeholders came together to review the data, ask questions, discuss area solutions and prioritize the needs to be addressed. The details of that meeting are noted in this report. Due to the overlap of services and organizations, the 2016 CHNA and Implementation Strategy was developed jointly by Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hamtpon Roads Specialty Hospital.

## Community Served by the Hospital

The community served by Riverside Regional Medical Center, Riverside Rehabilitation Institute and Hampton Roads Specialty Hospital is a geographic region that covers 25 ZIP codes across the cities of Hampton, Newport News and Poquoson and the counties of Isle of Wight, Surry and York.

The Study Region (2014 Total Population)




## Community Indicators

The community indicators present a wide array of quantitative community health indicators for the study region. To produce the profiles, Community Health Solutions analyzed data from multiple sources. By design, the analysis does not include every possible indicator of community health. The analysis is focused on a set of indicators that provide broad insight into community health, and for which there were readily available data sources. Detailed reviews follow below, but to summarize:

- **Demographic Profile:** As of 2014, the study region included an estimated 414,083 people. The population is expected to increase to 421,479 by 2019. Compared to Virginia as a whole, the study region is more urban, younger and has more Black / African American residents. The study region also has a higher percentage of low income households than Virginia as a whole.

- **Mortality Profile:** In 2013, the study region had 3,223 total deaths. The leading causes of death were malignant neoplasms (cancer), heart disease, chronic lower respiratory diseases, cerebrovascular diseases and unintentional injury. Death rates were higher than the statewide rate for all deaths combined and for malignant neoplasms, diabetes, Alzheimer's disease, septicemia, primary hypertension and renal disease, chronic liver diseae and Parkinson's disease.

- **Maternal & Infant Health Profile**: In 2013, the study region had 5,559 total live births. Compared to Virginia as a whole, the study region had higher rates of low weight births, non-marital births and teenage births. The teen pregnancy rate was higher than the statewide rate for the study region overall, and for the cities of Hampton and Newport

News. The five-year infant mortality rate was higher than the statewide rate for the study region overall and for the cities of Hampton, Newport News and Poquoson.

- **Preventable Hospitalization Discharge Profile:** The Agency for Healthcare Research and Quality (AHRQ) defines a set of conditions called Prevention Quality Indicators (PQIs) for which hospitalization should be avoidable with proper outpatient health care. High rates of hospitalization for these conditions indicate potential gaps in access to quality outpatient services for community residents. In 2013, residents of the study region had 2,687 PQI hospital discharges. The leading diagnoses for these discharges were congestive heart failure, chronic obstructive pulmonary disease (COPD) or asthma in older adults, diabetes, bacterial pneumonia and dehydration. The PQI discharge rates for the study region were higher than the Virginia statewide rates for perforated appendix and asthma in younger adults.

- **Behavioral Health Hospitalization Discharge Profile:** Behavioral health hospitalizations provide another important indicator of community health status. In 2013, residents of the study region had 2,573 hospital discharges from Virginia community hospitals for behavioral health conditions. The leading diagnoses for these discharges were affective psychoses, schizophrenic disorders, depressive disorders (not elsewhere classified), alcoholic psychoses and other nonorganic psychoses. The behavioral health discharge rates for the study region were higher than the Virginia statewide rates for schizophrenic disorders, depressive disorders and other nonorganic disorders.

- **Adult Health Risk Profile:** Estimates indicate that substantial numbers of adults (age 18+) in the study region have health risks related to nutrition, weight, physical inactivity, tobacco and alcohol. In addition, substantial numbers of adults have chronic conditions such as high cholesterol, high blood pressure, arthritis, diabetes and asthma.

- **Youth Health Risk Profile:** Estimates indicate that substantial numbers of youth (age 10-14 and 15-19) in the study region have health risks related to nutrition, weight, alcohol, mental health, tobacco, and physical inactivity.

- **Uninsured Profile:** At any given point in time in 2014, an estimated 52,550 nonelderly residents of the study region were uninsured. This included an estimated 6,296 children and 46,255 adults. The estimated uninsured rates were 6 percent for children age 0-18, 18 percent for adults age 19-64, and 14 percent for the population age 0-64.

- **Medically Underserved Profile:** Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are designated by the U.S. Health Resources and Services Administration as being at-risk for health care access problems. The designations are based on several factors including primary care provider supply, infant mortality, prevalence of poverty, and the prevalence of seniors age 65+. Five of the six localities that overlap with the study region have been partially or fully designated as MUAs/MUPs (cities of Hampton and Newport News and the counties of Isle of Wight, Surry and York).

## Demographic Profile

Trends in health-related demographics are instructive for anticipating changes in community health status. Changes in the size, age and racial/ethnic mix of the population can have a significant impact on overall health status, health needs and demand for local services.

As shown in *Exhibit II-1*, as of 2014, the study region included an estimated 414,083 people. The total population is projected to increase to 421,479 by 2019. Focusing on age groups, increases are expected for the 30-44 and 65+ age groups, but the age 0-17, 18-29 and 45-64 are expected to slightly decline. Focusing on racial/ethnic background, growth is projected for all of the listed groups, with the exception of the White population which is projected to remain stable.

**Exhibit II-1**
**Health Demographic Trend Profile for the Study Region, 2010-2019**

| Indicator | 2010 Census | 2014 Estimate | 2019 Projection | % Change 2014-2019 |
|---|---|---|---|---|
| Total Population | 412,263 | 414,083 | 421,479 | 2% |
| Population Density (per Sq. Mile) | 744.4 | 747.7 | 761.1 | 2% |
| Total Households | 160,796 | 161,702 | 165,719 | 2% |
| **Population by Age** | | | | |
| Children Age 0-17 | 99,070 | 97,281 | 96,750 | -1% |
| Adults Age 18-29 | 80,292 | 81,048 | 79,639 | -2% |
| Adults Age 30-44 | 75,651 | 75,414 | 77,397 | 3% |
| Adults Age 45-64 | 108,978 | 109,346 | 107,906 | -1% |
| Seniors Age 65+ | 48,278 | 50,994 | 59,787 | 17% |
| **Population by Race/Ethnicity** | | | | |
| Asian | 11,278 | 12,165 | 13,183 | 8% |
| Black/African American | 156,192 | 155,634 | 159,117 | 2% |
| White | 219,537 | 219,998 | 219,382 | 0% |
| Other or Multi-Race | 25,250 | 26,282 | 29,796 | 13% |
| Hispanic Ethnicity | 22,953 | 24,992 | 27,885 | 12% |

*Note: Hispanic is a classification of ethnicity; therefore, Hispanic individuals are also included in the race categories.*

*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.*

Community health is driven in part by community demographics. The age, sex, race, ethnicity, income and education status of a population are strong predictors of community health status and community health needs.

*Exhibit II-2* presents a snapshot of key health-related demographics of the study region. As of 2014, the study region included an estimated 414,083 people. Focusing on population rates as shown in the lower part of the Exhibit, compared to Virginia as a whole, the study region is more urban, younger and has more Black / African American residents. The study region also has more low income households than Virginia as a whole. *Note: Maps 1-13 in Appendix A (pages 39-45) show the geographic distribution of the population by ZIP code.*

| Exhibit II-2<br>Health Demographic Snapshot Profile, 2014 | | | |
|---|---|---|---|
| **Indicator** | | **Study Region** | **Virginia** |
| **Population Counts** | | | |
| Total Population | Population | 414,083 | 8,282,921 |
| Age | Children Age 0-17 | 97,281 | 1,889,338 |
| | Adults Age 18-29 | 81,048 | 1,417,141 |
| | Adults Age 30-44 | 75,414 | 1,678,713 |
| | Adults Age 45-64 | 109,346 | 2,241,450 |
| | Seniors Age 65+ | 50,994 | 1,056,279 |
| Sex | Female | 213,829 | 4,214,922 |
| | Male | 200,259 | 4,067,999 |
| Race | Asian | 12,165 | 486,905 |
| | Black/African American | 155,634 | 1,602,827 |
| | White | 219,998 | 5,616,313 |
| | Other or Multi-Race | 26,282 | 576,876 |
| Ethnicity | Hispanic Ethnicity | 24,992 | 705,701 |
| Income | Low Income Households (Households with Income < $25,000) | 36,250 | 594,210 |
| Education | Population Age 25+ Without a High School Diploma | 23,406 | 662,369 |
| **Population Rates** | | | |
| Total Population | Population Density (population per sq. mile) | 747.7 | 206.1 |
| Age | Children Age 0-17 percent of Total Population | 23% | 23% |
| | Adults Age 18-29 percent of Total Population | 20% | 17% |
| | Adults Age 30-44 percent of Total Population | 18% | 20% |
| | Adults Age 45-64 percent of Total Population | 26% | 27% |
| | Seniors Age 65+ percent of Total Population | 12% | 13% |
| Sex | Female percent of Total Population | 52% | 51% |
| | Male percent of Total Population | 48% | 49% |
| Race | Asian percent of Total Population | 3% | 6% |
| | Black/African American percent of Total Population | 38% | 19% |
| | White percent of Total Population | 53% | 68% |
| | Other or Multi-Race percent of Total Population | 6% | 7% |
| Ethnicity | Hispanic Ethnicity percent of Total Population | 6% | 9% |
| Income | Low Income Households (Households with Income <$25,000) percent of Total Households | 22% | 19% |
| Education | Population Age 25+ Without a High School Diploma percent of Total Population Age 25+ | 9% | 12% |
| *Note: Hispanic is a classification of ethnicity; therefore, Hispanic individuals are also included in the race categories.* | | | |
| *Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.* | | | |

## Mortality Profile

Mortality is one of the most commonly cited community health indicators. As shown in *Exhibit II-3*, in 2013, the study region had 3,223 total deaths. The leading causes of death were malignant neoplasms (cancer), heart disease, chronic lower respiratory diseases, cerebrovascular disease and unintentional injury. Study region death rates were higher than the statewide rates for all deaths combined, and for malignant neoplasms, diabetes, Alzheimer's disease, septicemia, primary hypertension and renal disease, chronic liver disease and Parkinson's disease. *Note: Maps 14-17 in Appendix A (pages 45-47) show the geographic distribution of deaths by ZIP code.*

**Exhibit II-3**
**Mortality Profile, 2013**

| Indicator | Study Region | Virginia |
|---|---|---|
| **Total Deaths** | | |
| Deaths by All Causes | 3,223 | 62,309 |
| **Deaths by Leading 14 Causes** | | |
| Malignant Neoplasms, Deaths | 773 | 14,348 |
| Heart Disease, Deaths | 628 | 13,543 |
| Chronic Lower Respiratory Diseases, Deaths | 154 | 3,168 |
| Cerebrovascular Diseases, Deaths | 144 | 3,278 |
| Unintentional Injury, Deaths | 125 | 2,794 |
| Diabetes Mellitus, Deaths | 112 | 1,618 |
| Alzheimer's Disease, Deaths | 89 | 1,634 |
| Septicemia, Deaths | 78 | 1,464 |
| Nephritis and Nephrosis, Deaths | 76 | 1,547 |
| Influenza and Pneumonia, Deaths | 67 | 1,430 |
| Primary Hypertension and Renal Disease, Deaths | 47 | 629 |
| Suicide, Deaths | 46 | 1,047 |
| Chronic Liver Disease, Deaths | 42 | 836 |
| Parkinson's Disease, Deaths | 31 | 549 |
| **Crude Death Rates per 100,000 Population** | | |
| Total Deaths | 780.0 | 755.5 |
| Malignant Neoplasms, Deaths | 187.1 | 174.0 |
| Heart Disease, Deaths | 152.0 | 164.2 |
| Chronic Lower Respiratory Diseases, Deaths | 37.3 | 38.4 |
| Cerebrovascular Diseases, Deaths | 34.9 | 39.7 |
| Unintentional Injury, Deaths | 30.3 | 33.9 |
| Diabetes Mellitus, Deaths | 27.1 | 19.6 |
| Alzheimer's Disease, Deaths | 21.5 | 19.8 |
| Septicemia, Deaths | 18.9 | 17.8 |
| Nephritis and Nephrosis, Deaths | 18.4 | 18.8 |
| Influenza and Pneumonia, Deaths | 16.2 | 17.3 |
| Primary Hypertension and Renal Disease, Deaths | 11.4 | 7.6 |
| Suicide, Deaths | 11.1 | 12.7 |
| Chronic Liver Disease, Deaths | 10.2 | 10.1 |
| Parkinson's Disease, Deaths | 7.5 | 6.7 |

*Source: Community Health Solutions analysis of mortality data from the Virginia Department of Health. See Appendix C. Data Sources for details.*

## Maternal and Infant Health Profile

Maternal and infant health indicators are another widely cited category of community health. As shown in *Exhibit II- 4A,* the study region had 5,559 total live births in 2013. Compared to Virginia as a whole, the study region had higher rates of low-weight births, non-marital births and teenage births. *Note: Maps 18-19 in Appendix A (pages 47-48) show the geographic distribution of births by ZIP code.*

**Exhibit II-4A**
**Maternal and Infant Health Profile, 2013**

| Indicators | Study Region | Virginia |
|---|---|---|
| **Counts** | | |
| Total Live Births | 5,559 | 101,977 |
| Low Weight Births (under 2,500 grams / 5 lb. 8 oz.) | 484 | 8,178 |
| Births Without Early Prenatal Care (No Prenatal Care in First 13 Weeks) | 540 | 13,435 |
| Non-Marital Births | 2,486 | 35,289 |
| Live Births to Teens Age 10-19 | 359 | 5,316 |
| Live Births to Teens Age 18-19 | 289 | 4,073 |
| Live Births to Teens Age 15-17 | 70 | 1,208 |
| Live Births to Teens Age <15 | 0 | 35 |
| **Rates** | | |
| Live Birth Rate per 1,000 Population | 13.5 | 12.3 |
| Low Weight Births pct. of Total Live Births | 9% | 8% |
| Births Without Early Prenatal Care (No Prenatal Care in First 13 Weeks) pct. of Total Live Births | 10% | 13% |
| Non-Marital Births pct. of Total Live Births | 45% | 35% |
| Live Births to Teens Age 10-19 (per 1,000 Female Teens Age 10-19) | 12.9 | 10.3 |
| Live Births to Teens Age 18-19 (per 1,000 Female Teens Age 18-19) | 45.4 | 36.4 |
| Live Births to Teens Age 15-17 (per 1,000 Female Teens Age 15-17) | 8.4 | 8.0 |
| Live Births to Teens Age <15 (per 1,000 Female Teens Age <15) | 0.0 | 0.1 |

*Source: Community Health Solutions analysis of data from the Virginia Department of Health.*

*Exhibit II-4B* below provides counts and rates of teen pregnancy and infant mortality for the six localities that overlap the study region. These indicators are shown at the city/county level because teen pregnancy and five-year infant mortality data is not readily available at the ZIP code level. As shown in the Exhibit, the teen pregnancy rate was higher than the statewide rate for the study region overall and for the cities of Hampton and Newport News. The five-year infant mortality rate was higher than the statewide rate for the study region overall and for the cities of Hampton, Newport News, and Poquoson.

**Exhibit II-4B**

**Teen Pregnancy and Infant Mortality, 2013**

| Indicators | Hampton City | Isle of Wight County | Newport News City | Poquoson City | Surry County | York County | Study Region | Virginia |
|---|---|---|---|---|---|---|---|---|
| **Teen Pregnancy Counts and Rates** | | | | | | | | |
| Total Teenage Pregnancies (age 10-19) (2013) | 173 | 28 | 280 | 8 | 5 | 23 | 517 | 7,447 |
| Teenage Pregnancy Rate per 1,000 Teenage Female Population (age 10-19) (2013) | 20.0 | 12.8 | 23.9 | 9.4 | 12.9 | 4.7 | 18.0 | 14.4 |
| **Infant Mortality Counts and Rates** | | | | | | | | |
| Total Infant Deaths (2009-2013) | 85 | 10 | 151 | 4 | 3 | 14 | 267 | 3,402 |
| Five-Year Infant Mortality Rate per 1,000 Live Births (2009-2013) | 9.9 | 6.1 | 7.7 | 9.2 | 0.0 | 6.5 | 9.1 | 6.6 |

*Note: Indicators are shown at the city and county level because teen pregnancy and five-year average infant mortality data are not readily available at the ZIP code level.*

*Source: Community Health Solutions analysis of data from the Virginia Department of Health*

## Preventable Hospitalization Discharge Profile

The Agency for Healthcare Research and Quality (AHRQ) identifies a defined set of conditions called Prevention Quality Indicators (PQIs) for which hospitalization should be avoidable with proper outpatient health care. High rates of hospitalization for these conditions indicate potential gaps in access to quality outpatient services for community residents.

As shown in *Exhibit II-5,* residents of the study region had 2,687 PQI hospital discharges in 2013. The leading diagnoses for these discharges were congestive heart failure, chronic obstructive pulmonary disease (COPD) or asthma in older adults, diabetes, baterial pneumonia and dehydration. The PQI discharge rates for the study region were higher than the Virginia statewide rates for perforated appendix and asthma in younger adults. *Note: Map 20 in Appendix A (page 48) shows the geographic distribution of Total PQI Discharges by ZIP code.*

**Exhibit II-5**
**Prevention Quality Indicator (PQI) Hospital Discharge Profile, 2013**

| Indicator | Study Region | Virginia |
|---|---|---|
| **Total PQI Discharges** | | |
| Total PQI Discharges | 2,687 | 76,860 |
| **PQI Discharges by Diagnosis** | | |
| Congestive Heart Failure, PQI Discharges | 814 | 16,026 |
| COPD or Asthma In Older Adults, PQI Discharges | 451 | 18,239 |
| Diabetes, PQI Discharges | 392 | 9,938 |
| Bacterial Pneumonia, PQI Discharges | 331 | 11,867 |
| Dehydration, PQI Discharges | 270 | 7,743 |
| Urinary Tract Infection, PQI Discharges | 221 | 8,452 |
| Hypertension, PQI Discharges | 118 | 2,768 |
| Perforated Appendix, PQI Discharges | 72 | 1,189 |
| Asthma in Younger Adults, PQI Discharges | 42 | 444 |
| Angina, PQI Discharges | 14 | 941 |
| **Crude Rates per 100,000 Population** | | |
| Total Prevention Quality Indicator (PQI) Discharges | 650.3 | 932.0 |
| Congestive Heart Failure, PQI Discharges | 197.0 | 221.2 |
| COPD or Asthma In Older Adults, PQI Discharges | 109.1 | 194.3 |
| Diabetes, PQI Discharges | 94.9 | 120.5 |
| Bacterial Pneumonia, PQI Discharges | 80.1 | 143.9 |
| Dehydration, PQI Discharges | 65.3 | 93.9 |
| Urinary Tract Infection, PQI Discharges | 53.5 | 102.5 |
| Hypertension, PQI Discharges | 28.6 | 33.6 |
| Perforated Appendix, PQI Discharges | 17.4 | 14.4 |
| Asthma in Younger Adults, PQI Discharges | 10.2 | 5.4 |
| Angina, PQI Discharges | -- | 11.4 |

*Note: -- Rates are not calculated where n<30. The sum of the individual diagnoses may differ slightly from the Total PQI Discharges figure for technical reasons. See Appendix C for details.*

*Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information, Inc. and local demographic estimates from Alteryx, Inc. See Appendix C. Data Sources for details.*

## Behavioral Health Hospitalization Discharge Profile

Behavioral health hospitalizations provide another important indicator of community health status. As shown in *Exhibit II-6,* residents of the study region had 2,573 hospital discharges from Virginia community hospitals for behavioral health conditions in 2013. The leading diagnoses for these discharges were affective psychoses, schizophrenic disorder, depressive disorders (not elsewhere classified), alcoholic psychoses and other nonorganic psychoses. The behavioral health discharge rates for the study region were higher than the statewide rate for schizophrenic disorders, depressive disorders and other nonorganiz disorders. *Note: Map 21 in Appendix A (page 49) shows the geographic distribution of behavioral health discharges by ZIP code.*

**Exhibit II-6**
**Behavioral Health Hospital Discharge Profile, 2013**

| Indicator | Study Region | Virginia |
|---|---|---|
| **Behavioral Health Discharges** | | |
| Total Behavioral Health Discharges by All Diagnoses | 2,573 | 60,600 |
| **Behavioral Health Discharges by Diagnosis** | | |
| Affective Psychoses, Behavioral Health Discharges | 1,047 | 26,709 |
| Schizophrenic Disorders, Behavioral Health Discharges | 561 | 8,136 |
| Depressive Disorder, Not Elsewhere Classified, Behavioral Health Discharges | 235 | 3,503 |
| Alcoholic Psychoses, Behavioral Health Discharges | 141 | 4,037 |
| Other Nonorganic Psychoses, Behavioral Health Discharges | 121 | 2,133 |
| Senility Without Mention of Psychosis, Behavioral Health Discharges | 74 | 1,688 |
| Drug Psychoses, Behavioral Health Discharges | 55 | 2,121 |
| Adjustment Reaction, Behavioral Health Discharges | 53 | 2,271 |
| Neurotic Disorders, Behavioral Health Discharges | 44 | 1,207 |
| Alcohol Dependence Syndrome, Behavioral Health Discharges | 42 | 2,391 |
| Symptoms Involving Head or Neck, Behavioral Health Discharges | 34 | 933 |
| Altered Mental Status, Behavioral Health Discharges | 29 | 1,000 |
| Other Organic Psychotic Conditions-Chronic, Behavioral Health Discharges | 19 | 795 |
| Non Dependent Abuse of Drugs, Behavioral Health Discharges | 17 | 600 |
| Drug Dependence, Behavioral Health Discharges | 14 | 816 |
| **Crude Rates per 100,000 Population** | | |
| Total Behavioral Health Discharges, Behavioral Health Discharges | 622.7 | 734.8 |
| Affective Psychoses, Behavioral Health Discharges | 253.4 | 323.9 |
| Schizophrenic Disorders, Behavioral Health Discharges | 135.8 | 98.7 |
| Depressive Disorder, Not Elsewhere Classified, Behavioral Health Discharges | 56.9 | 42.5 |
| Alcoholic Psychoses, Behavioral Health Discharges | 34.1 | 49.0 |
| Other Nonorganic Psychoses, Behavioral Health Discharges | 29.3 | 25.9 |
| Senility Without Mention of Psychosis, Behavioral Health Discharges | 17.9 | 20.5 |
| Drug Psychoses, Behavioral Health Discharges | 13.3 | 25.7 |
| Adjustment Reaction, Behavioral Health Discharges | 12.8 | 27.5 |
| Neurotic Disorders, Behavioral Health Discharges | 10.6 | 14.6 |
| Alcohol Dependence Syndrome, Behavioral Health Discharges | 10.2 | 29.0 |
| Symptoms Involving Head or Neck, Behavioral Health Discharges | 8.2 | 11.3 |
| Altered Mental Status, Behavioral Health Discharges | -- | 12.1 |

| Exhibit II-6<br>Behavioral Health Hospital Discharge Profile, 2013 | | |
|---|---|---|
| **Indicator** | **Study Region** | **Virginia** |
| Other Organic Psychotic Conditions-Chronic, Behavioral Health Discharges | -- | 9.6 |
| Non Dependent Abuse of Drugs, Behavioral Health Discharges | -- | 7.3 |
| Drug Dependence, Behavioral Health Discharges | -- | 9.9 |
| *Note: Rates are not calculated where n<30.* | | |
| *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 C. Rates are not calculated where n<30.* | | |

## Adult Health Risk Profile

This profile examines health risks for adults age 18+. Prevalence estimates of health risks, chronic disease and health status can be useful in developing prevention and improvement efforts. As shown in *Exhibit II-7*, estimates from 2014 indicate that substantial numbers of adults in the study region have health risks related to nutrition, weight, physical inactivity, tobacco and alcohol. In addition, substantial numbers of adults have chronic conditions such as high cholesterol, high blood pressure, arthritis, diabetes and asthma. *Note: Maps 22-25 in Appendix A (pages 49-51) show the geographic distribution of selected adult health risks by ZIP code.*

| Exhibit II-7<br>Adult Health Risk Factor Profile (Estimates), 2014 | | |
|---|---|---|
| **Indicator** | | **Study Region** |
| **Count (Estimates)** | | |
| *Estimated Adults age 18+* | | 316,802 |
| Risk Factors | Not Meeting Guidelines for Fruit and Vegetable Intake | 249,145 |
| | Overweight or Obese | 195,644 |
| | Not Meeting Recommendations for Physical Activity in the Past 30 Days | 166,036 |
| | Smoker | 61,228 |
| | At-risk for Binge Drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion) | 59,598 |
| Chronic Conditions | High Cholesterol (was checked, and told by a doctor or other health professional it was high) | 111,150 |
| | High Blood Pressure (told by a doctor or other health professional) | 91,246 |
| | Arthritis (told by a doctor or other health professional) | 75,762 |
| | Diabetes (told by a doctor or other health professional) | 28,536 |
| General Health Status | Limited in any Activities because of Physical, Mental or Emotional Problems | 64,694 |
| | Fair or Poor Health Status | 47,581 |
| **Percent (Estimates)** | | |
| Risk Factors | Not Meeting Guidelines for Fruit and Vegetable Intake | 79% |
| | Overweight or Obese | 62% |
| | Not Meeting Recommendations for Physical Activity in the Past 30 Days | 52% |
| | Smoker | 19% |
| | At-risk for Binge Drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion) | 19% |

| | | |
|---|---|---|
| Chronic Conditions | High Cholesterol (was checked, and told by a doctor or other health professional it was high) | 35% |
| | High Blood Pressure (told by a doctor or other health professional) | 29% |
| | Arthritis (told by a doctor or other health professional) | 24% |
| | Diabetes (told by a doctor or other health professional) | 9% |
| General Health Status | Limited in any Activities because of Physical, Mental or Emotional Problems | 20% |
| | Fair or Poor Health Status | 15% |
| *Source: Estimates produced by Community Health Solutions using Virginia Behavioral Risk Factor Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix C. Data Sources for details.* | | |

## Youth Health Risk Profile

This section examines selected health risks for youth age 10-19. These risks have received increasing attention as the population of American children has become more sedentary, more prone to unhealthy eating and more likely to develop unhealthy body weight. The long-term implications of these trends are serious, as these factors place children at higher risk for chronic disease both now and in adulthood.

As shown in *Exhibit II-8,* estimates from 2014 indicate that substantial numbers of youth in the study region have health risks related to nutrition, weight, alcohol, mental health, tobacco, and physical activity. *Note: Map 26 in Appendix A (page 51) shows the geographic distribution of youth overweight or obese by ZIP code.*

**Exhibit II-8**
**Youth Health Risk Factor Profile (Estimates), 2014**

| Indicator | Study Region |
|---|---|
| **Counts (Estimates)** | |
| **High School Youth Age 14-19** | |
| *Total Estimated High School Youth Age 14-19* | 35,345 |
| Not Meeting Guidelines for Fruit and Vegetable Intake | 32,448 |
| Overweight or Obese | 10,275 |
| Not Meeting Recommendations for Physical Activity in the Past Week | 19,856 |
| Used Tobacco in the Past 30 Days | 6,392 |
| Had at least One Drink of Alcohol At least One Day in the Past 30 Days | 9,424 |
| Felt Sad or Hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities) | 8,671 |
| **Middle School Youth Age 10-14** | |
| *Total Estimated Middle School Youth Age 10-14* | 13,094 |
| Not Meeting Guidelines for Fruit and Vegetable Intake | 9,840 |
| Not Meeting Recommendations for Physical Activity in the Past Week | 8,689 |
| Used Tobacco in the Past 30 Days | 319 |
| **Percent (Estimates)** | |
| **High School Youth Age 14-19** | |
| Not Meeting Guidelines for Fruit and Vegetable Intake | 92% |
| Overweight or Obese | 29% |
| Not Meeting Recommendations for Physical Activity in the Past Week | 56% |

| | |
|---|---|
| Used Tobacco in the Past 30 Days | 18% |
| Had at least One Drink of Alcohol At least One Day in the Past 30 Days | 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% |
| **Middle School Youth Age 10-14** | |
| Not Meeting Guidelines for Fruit and Vegetable Intake | 75% |
| Not Meeting Recommendations for Physical Activity in the Past Week | 66% |
| Used Tobacco in the Past 30 Days | 2% |
| *Source: Estimates produced by Community Health Solutions using Virginia Youth Risk Behavioral Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix C Data Sources for details.* | |

## Uninsured Profile

Decades of research show that health coverage matters when it comes to overall health status, access to health care, quality of life, school and work productivity and even mortality. *Exhibit II-9* shows the estimated number of uninsured individuals by income in the study region as of 2014. At a given point in time in 2014, an estimated 52,550 nonelderly residents of the study region were uninsured, including 6,296 children and 46,255 adults. The estimated uninsured rates were 6 percent for children age 0-18, 18 percent for adults age 19-64, and 14 percent for the population age 0-64. *Note: Maps 27-28 in Appendix A (page 52) show the geographic distribution of the uninsured population by ZIP code.*

**Exhibit II-9**
**Uninsured Profile (Estimates), 2014**

| Indicator | Study Region |
|---|---|
| **Estimated Uninsured Counts** | |
| Uninsured Nonelderly Age 0-64 | 52,550 |
| Uninsured Children Age 0-18 | 6,296 |
| Uninsured Children Age 0-18 <=138% FPL | 2,042 |
| Uninsured Children Age 0-18 <=200% FPL | 3,161 |
| Uninsured Children Age 0-18 <=250% FPL | 3,881 |
| Uninsured Children Age 0-18 <=400% FPL | 5,160 |
| Uninsured Children Age 0-18 138-400% FPL | 3,118 |
| Uninsured Adults Age 19-64 | 46,255 |
| Uninsured Adults Age 19-64 <=138% FPL | 16,939 |
| Uninsured Adults Age 19-64 <=200% FPL | 24,839 |
| Uninsured Adults Age 19-64 <=250% FPL | 29,940 |
| Uninsured Adults Age 19-64 <=400% FPL | 38,800 |
| Uninsured Adults Age 19-64 138-400% FPL | 21,861 |
| **Estimated Uninsured Percent** | |
| Children Age 0-18 | 6% |
| Adults Age 19-64 | 18% |
| Population Age 0-64 | 14% |

*Note: Federal poverty level (FPL) categories are cumulative.*

*Source: Estimates produced by Community Health Solutions using U.S. Census Bureau Small Area Health Insurance Estimates (2014) and local demographic estimates from Alteryx, Inc. See Appendix C for details on methods.*

## Medically Underserved Profile

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are designations used by the U.S. Health Resources and Services Administration to identify populations at-risk for health care access problems. The designations are based on several factors including primary care provider supply, infant mortality, prevalence of poverty and the prevalence of seniors age 65+.

As shown in *Exhibit II-10*, five of the six localities that overlap the study region have been partially or fully designated as MUAs/MUPs (cities of Hampton and Newport News and the counties of Isle of Wight, Surry and York). For a more detailed description, visit the U.S. Health Resources and Service Administration designation webpage at http://muafind.hrsa.gov/.

**Exhibit II-10**
**Medically Underserved Areas Profile**

| Locality | MUA/MUP Designation | Census Tracts |
|---|---|---|
| Hampton City | Partial | 22 of 33 census tracts |
| Isle of Wight County | Full | 8 of 8 census tracts |
| Newport News City | Partial | 17 of 44 census tracts |
| Poquoson City | None | 0 of 3 census tracts |
| Surry County | Full | 2 of 2 census tracts |
| York County | Partial | 3 of 14 census tracts |

*Source: Community Health Solutions analysis of U.S. Health Resources and Services Administration data.*

## Community Input

In an effort to obtain community input for the study, a community survey was conducted. Due to the overlap of service areas, Riverside Health System and Sentara Health System worked together to conduct a joint survey 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
- Health assets within the community
- Health assets needed in the community
- Additional ideas or suggestions for improving community health

The survey was sent to a group of 922 community stakeholders. The community stakeholder list included representatives from public health, education, social services, business, local government and local civic organizations, among others. Riverside conducted outreach for community input via email, through personal phone calls, and in-person at local events and meetings. A total of 120 stakeholders (13%) submitted a response (although not every respondent answered every question).

- **Community Health Concerns:** Respondents identified specific health concerns, with the most commonly mentioned being mental health, substance abuse, heart disease, obesity, high blood pressure/hypertension and dementia/Alzheimer's Disease.

- **Community Service Gaps:** Respondents identified community service gaps, with the most commonly mentioned being mental health services, aging services, care coordination and transitions of care, health care insurance coverage and health promotion and prevention.

- **Vulnerable or At-Risk Populations:** Respondents identified a variety of vulnerable/at-risk populations in the community. Commonly mentioned examples included the chronically ill, children, population with disabilities, elderly population, ethnic/racial minorities, homeless, low income population, population with behavioral health conditions, population without access to healthcare services, population without transportation, the uninsured/underinsured, the unemployed, veterans and other populations with particular health concerns. Respondents also identified vulnerable/at-risk neighborhoods or geographic regions in the community, including low income neighborhoods and specific areas throughout the region.

- **Health Assets in the Community:** Respondents identified diverse health assets in the community. Commonly mentioned examples included biking and walking trails, community organizations, faith-based organizations, hospitals and health systems, the natural environment, recreational facilities and safety net organizations.

- **Health Assets Needed in the Community:** Respondents identified health assets that could use enhancement. Commonly mentioned examples included access to safe parks and recreational facilities, behavioral health services, community and health care services for seniors, primary and specialty medical care services, affordable housing and transportation services.

- **Additional Ideas and Suggestions:** Respondents offered a variety of ideas and suggestions for improving community health. Examples included additional transportation resources, collaboration among local healthcare organizations, coordination of healthcare services, health education and prevention, improving access to healthcare services, improving access to recreational facilities and resources for the elderly population.

## Survey Respondents

*Exhibit I-1* below lists the organizational affiliations of the survey respondents.

**Exhibit I-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 | Poquoson Police Department |
| Auxiliary of Sentara Williamsburg Regional Medical Center (3) | Riverside Doctors' Hospital Williamsburg - Board Member |
| Avalon | Respite Care of Williamsburg |
| Bay Rivers Telehealth Alliance | Retired |
| Beyond Boobs! | Riverside Behavioral Health Center |
| Catholic Charities of Eastern Virginia | Riverside Health System - Hospice |
| Celebrate Healthcare LLC | Riverside PACE |
| Center for Weight Loss Success | Riverside Medical Group (43) |
| 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 Williamsburg Regional Medical Center (2) |
| County of York (2) | Southeastern Virginia Health System |
| Dominion Physical Therapy | Spectrum/York County BOS Chair |
| ECPI Medical Careers Institute | The Community Free Clinic |
| Foundation for Rehabilitation and Endowment | Tidewater Diagnostic Imaging |
| Hampton City Schools | Thomas Nelson Community College |
| Hampton Health Department | TowneBank |
| Hampton Newport News CSB | United Methodist Church |
| Hampton Roads Neurosurgical and Spine Specialists | United Way of Greater Williamsburg |
| Hampton Roads Specialty Hospital | United Way of the Virginia Peninsula (2) |
| Hospice House & Support Care of Williamsburg (2) | VersAbility Resources |
| James City County | Village Events, Ltd. |
| James City County Board of Supervisors | Virginia Peninsula Chamber of Commerce |
| James City County Police Department | Virginia Peninsula Foodbank |
| Newport News Division of Emergency Management (2) | Volunteer |
| Newport News Fire Department | Williamsburg Area Faith in Action |

| Exhibit I-1<br>Survey Respondents by Organization | |
|---|---|
| **What is the name of your organization?** | |
| *Note: A count is provided for organizations with multiple survey respondents.* | |
| Old Hampton Family Associates, PC | Williamsburg Community Foundation |
| Old Point National Bank | Williamsburg Dept. of Human Services |
| PBMares Wealth Management | Williamsburg Emergency Physicians (2) |
| Peninsula Agency on Aging (3) | Williamsburg Health Foundation (2) |
| Peninsula Health District | Williamsburg Landing, Inc. |
| Peninsula Metropolitan YMCA | York Board of Supervisors |
| Peninsula Youth Hockey Association | |

## 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. As shown in Exhibit I-2, respondents identified more than 40 specific health concerns, with the most commonly mentioned being mental health, substance abuse, heart disesase, obesity, high blood pressure / hypertension and dementia / Alzheimer's disease.

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

*Note: 119 of the 120 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 |
|---|---|---|
| Mental Health - Behavioral Health Conditions (e.g. depression, anxiety, etc.) | 77% | 92 |
| Substance Abuse (prescription or illegal drugs) | 72% | 86 |
| Heart Disease | 69% | 82 |
| Obesity | 69% | 82 |
| High Blood Pressure / Hypertension | 66% | 79 |
| Dementia / Alzheimer's Disease | 64% | 76 |
| Diabetes | 60% | 71 |
| Alcohol Use | 52% | 62 |
| Chronic Pain | 52% | 62 |
| Cancer | 49% | 58 |
| Accidents / Injuries | 45% | 54 |
| Stroke | 43% | 51 |
| Tobacco Use | 43% | 51 |
| Violence – Domestic Violence | 41% | 49 |
| Respiratory Diseases (e.g. asthma, COPD, etc.) | 40% | 48 |
| Violence – Other than domestic violence | 40% | 47 |
| Dental / Oral Health Care | 36% | 43 |
| Arthritis | 34% | 41 |
| Infant and Child Health | 34% | 40 |
| Hunger | 32% | 38 |
| Orthopedic Problems | 31% | 37 |
| Prenatal and Pregnancy Care | 30% | 36 |
| Environmental Health (e.g. pollution, mosquito control, water quality, etc.) | 29% | 35 |
| Neurological Conditions (e.g. seizures, multiple sclerosis, traumatic brain injury, etc.) | 28% | 33 |
| Renal (kidney) Disease | 26% | 31 |
| Intellectual/Developmental Disabilities | 25% | 30 |
| Physical Disabilities | 24% | 28 |
| Sexually Transmitted Diseases | 23% | 27 |
| Bullying | 22% | 26 |
| Drowning / Water Safety | 22% | 26 |
| Infectious Diseases | 19% | 23 |
| Teen Pregnancy | 18% | 22 |
| Autism | 16% | 19 |
| Other Health Problems (see responses on the following page) | 17% | 20 |

**Exhibit I-2**
**Important Community Health Concerns Identified by Survey Respondents (continued)**

| Response # | Other Health Concerns (Open-Ended Reponses) |
|---|---|
| 1 | • Access to low cost birth control and STD testing, (James City County)<br>• Pregnancy care<br>• Homelessness in our area |
| 2 | • Access to specialty care<br>• Uninsured |
| 3 | • All are important to those who are facing them; gaining Access to Services to address these needs is the challenge. |
| 4 | • Failing health education in primary and secondary public schools<br>• Availability of competent physicians in primary care<br>• Inadequate government funding of preventative health care and excessive government funding of futile care at end of life. |
| 5 | • Frail elders in unsafe situations; negligence and poor nutrition<br>• Keeping elder persons in their home with community support. |
| 6 | • Frailty |
| 7 | • Geriatric outpatient services<br>• Comprehensive pain management to include psych services |
| 8 | • 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. |
| 9 | • Issues associated with aging-social isolation; unable to drive to doctor appointments |
| 10 | • Lack of mental health for acute and chronic care |
| 11 | • Lack of regular medical preventive care for many residents |
| 12 | • The growing danger of antibiotic resistant bacteria.<br>• 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. |
| 13 | • Sexual abuse is not listed, [and] it is a serious health problem.<br>• Homeless<br>• Those with no ID's have a serious problem getting help. |
| 14 | • Sexual assault both on college campus and off. We have seen a very big increase in clients in the last two years. |
| 15 | • Since I take care of children as a pediatrician, I have focused on the areas that affect them the most. |
| 16 | • The general conditions of seniors; particularly the “old old” |
| 17 | • 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. |

**Continued on the following page**

| Exhibit I-2<br>Important Community Health Concerns Identified by Survey Respondents (continued) | |
|---|---|
| **Response #** | **Other Health Concerns (Open-Ended Reponses)** |
| 18 | • 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. |
| 19 | • Transportation access to dialysis |
| 20 | • 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. |

## 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.

As shown in Exhibit I-3, respondents identified specific community service gaps, with the most commonly mentioned mental health services, aging services, care coordination and transitions of care, health care insurance and health promotion and prevention.

**Exhibit I-3**
**Important Community Service Gaps Identified by Survey Respondents**

*Note: 117 of the 120 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 |
|---|---|---|
| Mental Heath - Behavioral Health Services | 60% | 70 |
| Aging Services | 57% | 67 |
| Care Coordination and Transitions of Care | 55% | 64 |
| Health Care Insurance Coverage | 49% | 57 |
| Health Promotion and Prevention Services | 46% | 54 |
| Chronic Pain Management Services | 45% | 53 |
| Services for Vulnerable Populations (e.g. uninsured/underinsured, migrant workers, homeless, etc.) | 45% | 53 |
| Substance Abuse Services | 45% | 53 |
| Services for Caregivers | 43% | 50 |
| Chronic Disease Services (e.g. diabetes, high blood pressure, etc.) | 40% | 47 |
| Transportation Services | 37% | 43 |
| Self-Management Services (e.g. nutrition, exercise, taking medications) | 34% | 40 |
| Dental/Oral Health Care Services | 32% | 38 |
| Food Safety Net (e.g. food bank, community gardens, school lunches, etc.) | 31% | 36 |
| Long Term Care Services | 31% | 36 |
| Home Health Services | 30% | 35 |
| Social Services | 27% | 32 |
| Cancer Services (e.g. screening, diagnosis, treatment, etc.) | 23% | 27 |
| Veterans Services | 23% | 27 |
| Primary Care Medical Services | 21% | 25 |
| Domestic Violence Services | 21% | 24 |
| Public Health Services | 20% | 23 |
| Hospice Services | 19% | 22 |
| Early Intervention Services for Children | 17% | 20 |
| Specialty Care Medical Services (cardiologists, oncologists, etc.) | 17% | 20 |
| Family Planning Services | 15% | 17 |
| Intellectual/Developmental Disabilities Services | 15% | 17 |
| Maternal, Infant and Child Health Services | 14% | 16 |
| School Health Services | 14% | 16 |

**Exhibit I-3**
**Important Community Service Gaps Identified by Survey Respondents**

*Note: 117 of the 120 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 |
|---|---|---|
| Public Safety Services | 12% | 14 |
| Hospital Services (e.g. inpatient, outpatient, emergency care, etc.) | 10% | 12 |
| Physical Rehabilitation | 9% | 10 |
| Environmental Health Services | 8% | 9 |
| Pharmacy Services | 8% | 9 |
| Workplace Health and Safety Services | 2% | 2 |
| Other Services (see below) | 13% | 15 |

| Response # | Other Service Gaps (Open-Ended Reponses) |
|---|---|
| 1 | • Access to services through remote technology<br>• Palliative Care and patient care navigation and advocacy |
| 2 | • Affordable, accessible adult day programs |
| 3 | • Companion Care that is affordable for those who do not qualify for Medicaid but are still considered low income. |
| 4 | • I see many families with inadequate resources and a great need for parent education for high risk families starting at birth. |
| 5 | • If one does not have an ID, getting the services is almost impossible to get. |
| 6 | • Insufficient coordination of care between the three hospitals and office based physicians. |
| 7 | • Lack of adequate financial resources for the services listed directly impact availability and access. |
| 8 | • Long term services and supports<br>• Palliative Care-education, training and workforce development |
| 9 | • Many of these are in place, concerns are with affordability and quality of services provided. |
| 10 | • MAT- Medication Assisted treatment for individuals who are chemically dependent particularly in the area of opioids and alcohol. |
| 11 | • Medication assistance |
| 12 | • Obesity prevention and therapy |
| 13 | • Special need for mental health professionals for outpatient clinical care. |
| 14 | • 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.<br>• 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. |
| 15 | • Women's Health Care - only 1 OB group |

## Vulnerable and 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. Identified populations and regions include the following. Please see *Appendix B (page 56)* for a detailed listing. Community input included:

- Chronically Ill
- Children
- Disabled
- Elderly
- Ethnic/Racial Minorities
- Homeless
- Low Income
- Residents with Behavioral Health Conditions (mental health and substance abuse)
- Residents of Particular Neighborhoods (see *Appendix B*)
- Residents without Transportation
- Residents who have been Victims of Violence
- Uninsured/Underinsured
- Unemployed
- Veterans

## Health Assets in the Community

Survey respondents were asked to identify health assets within the community that promote a culture of health. *Exhibit I-4* summarizes the results. Respondents were also asked to identify health assets that the community needs, but may be lacking.

**Exhibit I-4**
**Health Assets in the Community as Identified by Survey Respondents**

| Existing Assets that Promote a Culture of Health (by Category) | Assets the Community Needs, but May be Lacking (by Category) |
|---|---|
| • Biking and Walking Trails<br>• Community Organizations<br>• Faith-Based Organizations<br>• Hospitals and Health Systems<br>• Natural Environment<br>• Recreational Facilities<br>• Safety Net Organizations | • Access to Safe Parks and Recreation Facilities<br>• Behavioral Health Services (Mental Health and Substance Abuse)<br>• Community Services for Seniors<br>• Health Care Services for Seniors<br>• Primary Medical Care Services<br>• Safe, Affordable Housing<br>• Specialty Medical Services<br>• Transportation Services |

## Additional Ideas and Suggestions

Survey respondents offered open-ended responses with additional ideas and suggestions for improving community health. Common themes are listed below, and detailed responses are listed in *Appendix B (page 56)*.

- Additional Transportation Resources
- Collaboration among Local Healthcare Organizations
- Coordination of Healthcare Services
- Health Education and Prevention
- Improving Access to Healthcare Services
- Improving Access to Recreational facilities
- Resources for the Elderly Population

## Progress Made From the 2013 Implementation Plan

An important component of the 2016 CHNA is to review the work accomplished since the 2013 Implementation Plan. It is important to note that in 2013, the Williamsburg region was also combined into the plan, while in 2016 it has conducted its own CHNA process serpeate from the Peninsula plan. There were five key focus areas as a part of the 2013 Implementation Plan for the combined Peninsula and Williamsburg regions.

- ***Services for the Elderly:*** An identified issue was the need to increase awareness of, and access to, existing medical and community resources focused on the elderly. In response, Riverside worked to expand the senior navigation programs across the health system.

- ***Healthy Lifestyle, Nutrition and Wellness:*** Healthy lifestyle choices was another critcial issue identifed. Specifically, the focus was on how to improve community members' long term health through education of healthy lifestyle choices. To address this, Riverside offered regular public talks. Topics inlcuded numerous health issues, including nutrition, preventative health care and important screening tests. Riverside also partnered with local communities on wellness issues.

- ***Awareness and Navigation of Resources***: The need to increase awareness of existing health resources was also identified. Riverside worked to focus on care transitions across the system to ensure patients can access appropriate community resources at each stage in their health journey. Additionally, Riverside Nurse line directs people to appropriate community resources.

- ***Behavioral Health:*** Finally, the need to increase awareness of, and connection to, existing behavioral health resources was also identified. Riverside worked closely with community partners, including the Hampton Newport News CSB to address the behavioral health needs in the community. Additionally, Riverside Behavioral Health Center in Hampton was aligned as part of Riverside Regional Medical Center to increase access to care for the community.

The hospital made every effort to solicit feedback from the community by providing a feedback mechanism on the hospital's website. However, at the time of this publication, no written feedback had been received on the 2013 CHNA and Implementation Plan.

## Prioritization of the 2016 Significant Health Needs

In order to appropriately review the health indicator data and community survey input, a group of key community stakeholders came together on November 4, 2016. The meeting reflected key stakeholders from across the region. Participants included: Riverside Health System, Hampton Roads Specialty Hospital, Riverside Rehabilitation Institute, Riverside Regional Medical Center, Riverside Behavioral Health Center, PEMS, Hampton VA Medical Center, York County, Peninsula Agency on Aging, Lackey Free Clinic, United Way of the Virginia Peninsula, and LINK. Additional community members from

neighboring localities, clinics, hospitals and public health departments were also invited but were unable to attend.

The group reviewed the demographic and health indicator data as well as the community survey results. Additionally, there was a review and discussion of the 2013 CHNA Implementation Plans and the work that had been accomplished. There were multiple discussions about what the data actually reflected in the community, and which efforts had been working.

The prioritization was done by a voting process, with everyone except Liz Williams and Carrie Schmidt (the facilitators) participating. Health needs that could be voted for included the four focus areas from the 2013 CHNA Implementation Plan, top health issues from the 2016 health indicator data, top health concerns and community service gaps from the 2016 survey, and any additional issues the group wanted to add. Each participant was given three stickers and asked to place them on the issue(s) they felt were the most important. Individuals could place as many stickers on one issue as they wanted.

| **2013 CHNA Focus Areas** | **2016 Top Health Indicator Issues** | **2016 Top Health Concerns from the Survey** | **2016 Top Community Service Gaps from the Survey** | **Additional Issues from Group** |
|---|---|---|---|---|
| • Services for the Elderly<br>• Healthy Lifestyle, Nutrition and Wellness<br>• Awareness and Navigation of Resources<br>• Behavioral Health | • Cancer<br>• Heart Disease<br>• Chronic Lower Respiratory Disease<br>• Cerebrovascular Disease (Stroke)<br>• Unintentional Injury<br>• Diabetes<br>• Alzheimer's Disease<br>• Septicemia<br>• Nephritis<br>• Influenza / Pneumonia | • Mental Health (non Substance Abuse)<br>• Mental Health (Substance Abuse)<br>• Heart Disease<br>• Obesity<br>• High Blood Pressure / Hypertension<br>• Dementia / Alzheimer's<br>• Diabetes<br>• Alcohol Use<br>• Chronic Pain<br>• Cancer<br>• Accidents / Injuries<br>• Stroke | • Mental Health (Behavioral Health Svcs)<br>• Aging Services<br>• Care Coordination and Transitions of Care<br>• Healthcare Insurance Coverage<br>• Health Promotion and Prevention Services<br>• Chronic Pain Management Services<br>• Services for Vulnerable Populations (uninsured / underinsured, migrant workers, homeless, etc.)<br>• Substance Abuse Services<br>• Services for Caregivers | • Child Abuse<br>• Housing / Homelessness<br>• Violence |

Results of the prioritization exercise were as follows (If the need is not listed, it received less than four votes):

| **Health Need** | **Number of Votes** |
|---|---|
| Mental Health (Substance Abuse and Non Substance Abuse combined) | 19 |
| Healthy Lifestyle Issues (Obesity, Tobacco, Diabetes, Heart Disease, Healthy Living) | 13 |
| Housing | 9 |
| Vulnerable Populations | 8 |
| Health Insurance | 4 |

# IMPLEMENTATION STRATEGY

## Strategy Process for Addressing Prioritized Health Needs

Following the prioritization of the health needs by the community stakeholder group, the next step was to develop an implementation strategy to impact these concerns in the community. The group had some significant discussion about the five focus areas and what additional work, if any, could be done to advance the efforts. There was also discussion about the underlying root causes of these issues.

Next the group spent time trying to identify what "vulnerable populations" meant and how to best support them. Suggested vulnerable populations included individuals seeking mental health care, those without insurance, children, low income populations, unaccompanied minors and the elderly.

One particular focus of the conversation was the need to increase individuals' awareness of existing services and how to access them. This was noted to be key for connecting individuals with health insurance programs where able, accessing clinics or specialists as needed, or understanidng what established community service programs were avaiable. The United Way reinforced its commitment and desire to serve in this role as a connector in the community. The group discussed how supporting the United Way in this role of connector could impact the areas of health insurance coveregae, housing and other vulnerable populations, including veterans.

A second component of the discussion focused on the need to increase the capacity of the safety net organizations to care for individuals who are not insured. Additionally, there was a lot of discussion on how to best direct these individuals to access care in the clinic settings as opposed to the emergency rooms. Again, the importance of the United Way as a connector was noted in the discussion.

Additionally, transportation continued to come up as a key barrier in accessing the existing programs in the community. This was also noted to be true for veterans seeking access care eligible through their VA benefits, as well as for the civilian population.

There was also discussion about the issue of healthy living, heart health and wellness. While the group ackowledged the issues were being addressed in the community through multiple organziations, everyone felt it was too important of an issue to remove from the CHNA focus.

The group also spent significant time reviewing the state of mental health care and substance abuse services on the Peninsula. It was noted that Riverside had restructured RBHC to be a part of RRMC to increase access to mental health services to a broader part of the population. Additionally, Riverside had been piloting the use of LCSWs in primary care offices, a well as increasing tele -mental health capacity. The Hampton VA Medical Center noted that they were also expanding capacity for mental health and were adding a new two story building to their campus for that purpose. There was also discussion about how both facilities and clinics had noted the increasing incidence of both adult and pediatric patients with serious medical issues as well as serious psychiatric problems at the same time.

Finally, the group spent time discussing the opiate epidemic in the region (and the nation). It was noted that the Emergency Nurses Association had facilitated converstaions between Riverside, Sentara and Bon Secours emergency rooms and all were now following standard practices with regards to opiate

prescriptions. This is also connected to the Hampton Roads Working Group on Heroin, which is being led by the area health departments but supported by all of the health systems. The group noted there were opportunities in this area, such as getting narcan available to more first responders and educating primary care and urgent care providers on new standard practices.

## Significant Health Needs To Be Addressed

- Mental Health
- Healthy Lifestyle / Heart Health / Obesity / Diabetes
- Housing
- Vulnerable Populations
- Health Insurance

## Significant Health Needs Not Being Addressed

Not every need identified in the CHNA process can be addressed as a priority area.

Due to the limitation of resources, the size of the issue and the capacity of existing organizations to impact the problem, the following issues were not identified as priorities:

- Chronic Respiratory Conditions
- Stroke
- Cancer
- Reproductive health
- Infant mortality
- Septicemia
- Nephritis
- Unintentional injury
- Domestic violence
- Chronic pain

Additionally, issues that did not rank as top health indicator problems in the quantitative analysis or noted as perceived community health issues in the survey are not going to be addressed as a part of the 2016 CHNA and Implementation Strategy. Examples of these areas include:

- Environmental Health
- Drowning / Water Safety
- Autism
- HIV / AIDS
- Dental / Oral Care
- Neurological Problems

- Arthritis
- Hunger
- Renal Disease
- Orthopedic Problems
- Sexually Transmitted Diseases
- Violence
- Physical Disabilities
- Bullying

## Initial Implementation Strategy

In order to impact the five focus areas, several key implementation strategies are being adopted. For each area of focus, background information, action steps and anticipated resources are noted.

### *Mental Health & Substance Abuse*

*Background:*
As in the rest of the country, mental health and substance abuse are perceived as underserved health needs across the Peninsula region. Providing quality health care services to those facing psychiatric illness or substance abuse is part of how Riverside cares for others as they would care for those they love.

*Action Steps & Resources:*
Riverside will continue to focus on providing care to this population, as well as exploring opportunities to improve services. Riverside will also continue to partner with other organizations, such as the Community Services Board, the Hampton VA Hospital, other hospitals and first responders to continue to address these issues in the community. Riverside will also participate in the Hampton Roads Working Group on Heroin to help address the continuing opiate addiction crisis in the community.

### *Healthy Lifestyle / Heart Health SaContinu/ Obesity/ Diabetes*

*Background:*
As the health indicator data notes, the population across the Peninsula region struggles with obesity and obesity-related conditions, such as hypertension and diabetes. The chronic dieases associated with unhealthy lifestyle choices continue to be seen in the clincs, emergency rooms and hospitals across the market.

*Action Steps & Resources:*
Riverside is committed to continuing to help educate the community on not only the importance of healthy lifestyle choices, but on how to change their health behaviors. This will be done through patient care in clinics, as well as through public education programs across the community. Riverside will also work with other community partners to support ongoing initiatives that encourage health and wellness.

### *Access and Connection*

*Background:*
While there are many existing programs in place to assist individuals through a medical issue, many people have trouble accessing the programs due to lack of awareness, lack of financial access or sometimes through lack of physicial transportation to access the service.

*Action Steps & Resources:*

1. Riverside will continue support the United Way as it works to re-establish itself in the community as the organization committed to connecting individuals to services across the region.
2. Riverside will work with other community partners to explore additional transportation solutions that could help increase access to medical services.

***Safety Net Capcity***

*Background:*

Virginia chose not to implement the Medicaid expansion through the Affordable Care Act. This leaves a large number of individuals in an uninsured gap where they earn too much to be eligible for Medicaid but not enough to access the subsidies through the insurance exchange to be able to purchase a private plan. In the Peninsula region, these individuals are largely being served through charitable services – whether through qualifying for financial assistance at Riverside and other providers or through the services offered at area free clinics, such as Newport News Clinic or Lackey Free Clinic. This safety net plays a crucial role in caring for the population across the Peninsula.

*Action Steps & Resources:*

Riverside will continue to provide care to individuals who may be uninsured or underinsured in accordance with its Financial Assistance Policy. Additionally, Riverside will work closely with other safety net providers in the community to not only increase access to medical services, but to work towards ensuring that the care provided is high quality and seamless as individual patients move between care providers.

## Questions, Comments and Copies

To view an electronic copy of this document, please visit www.riversideonline.com/community_benefit.

For questions or comments on this Community Health Needs Assessment and Implementation Plan, please contact Riverside's Marketing, Strategy and Development department at 757-534-7051 or via the comments section on www.riversideonline.com/community_benefit.

To obtain a paper copy, please visit the Administration Department of Riverside Regional Medical Center, Riverside Rehabilitation Institute or Hampton Roads Specialty Hospital, or call 757-534-7051.

# APPENDIX A. ZIP Code-Level Maps for the Study Region

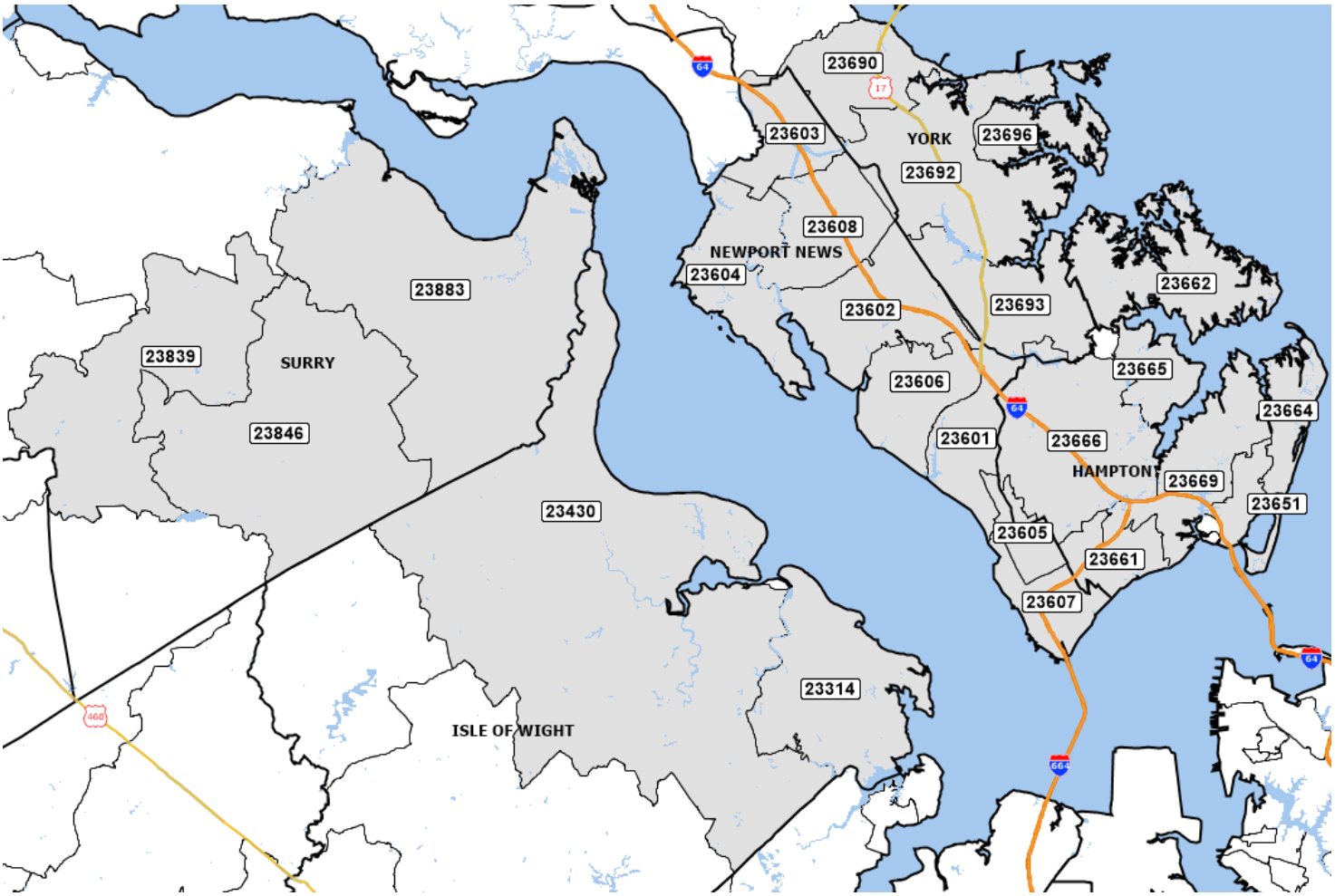
The maps in this section illustrate the geographic distribution of the ZIP code-level study region population on key demographic and health indicators. The results can also be used alongside the Community Survey Results and the Community Indicators to help inform plans for community health initiatives. The exhibits in this section include the following.



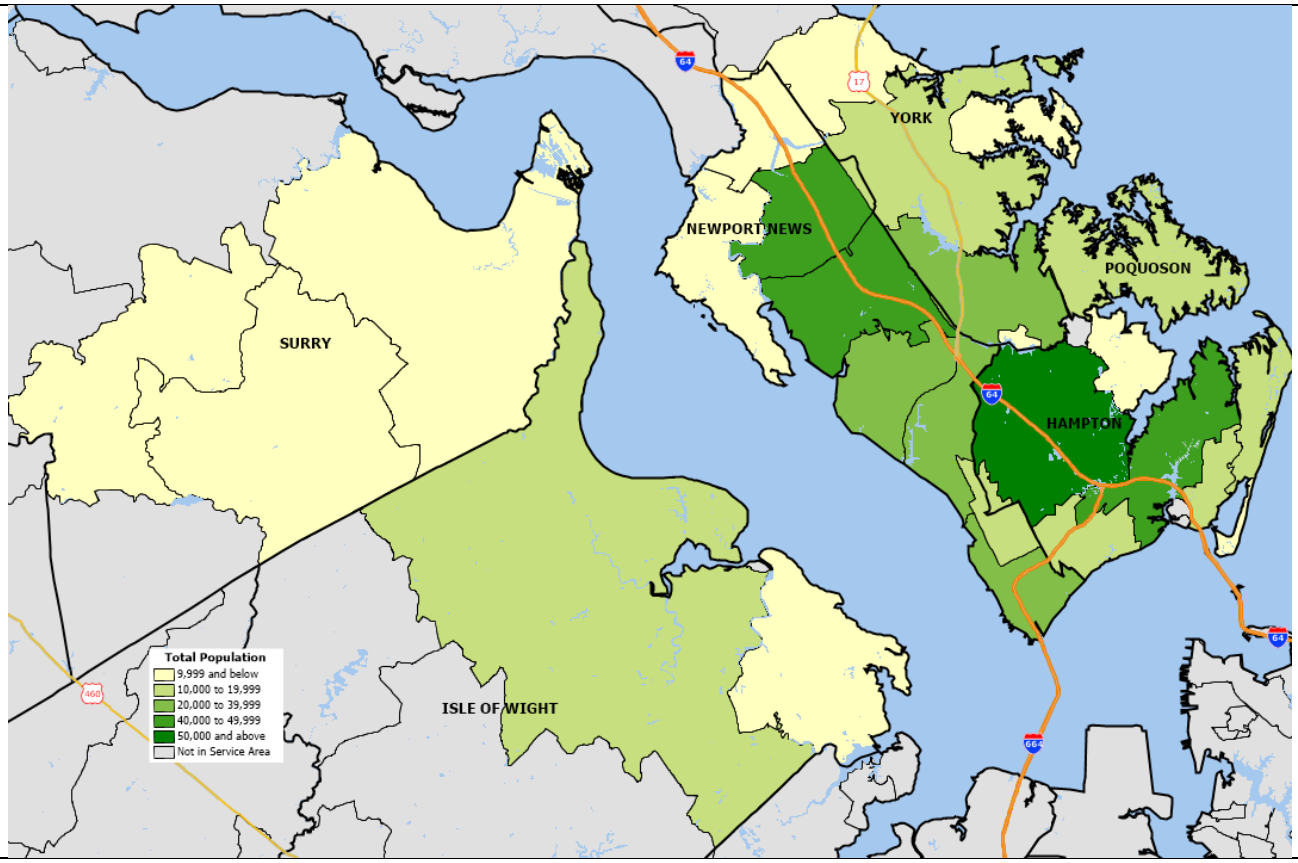
## **Technical Notes**

1. The maps and data include 25 ZIP codes, as identified by Riverside Health System Hospitals, most of which fall within six localities: the cities of Hampton, Newport News, and Poquoson; and the counties of Isle of Wight, Surry and York. Because ZIP code boundaries do not automatically align with city/county boundaries, there are some ZIP codes that extend beyond the county boundaries. Additionally, many residents of the service region use P.O. Boxes which are assigned to ZIP codes. Some of these ZIP codes can be mapped, but data are unavailable.
2. A reference map is provided first, to assist the ready in locating the ZIP codes of interest, as the data maps do not have ZIP codes labeled for readability.
3. 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.
4. Data are presented in natural breaks.
5. ZIP Code-Level Study Region ZIP codes with zero values are noted.

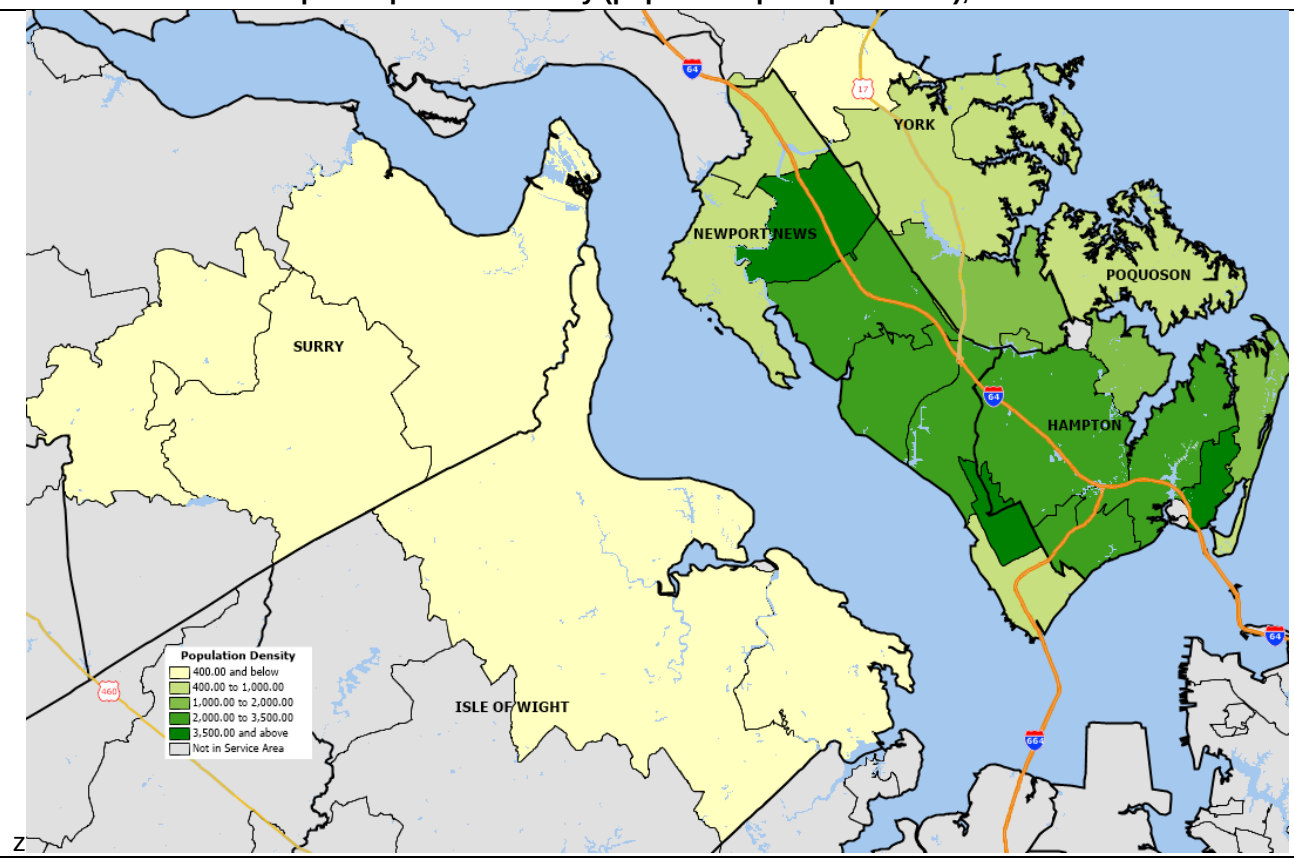
**ZIP Code Reference Map**



**Map 1: Total Population, 2014**



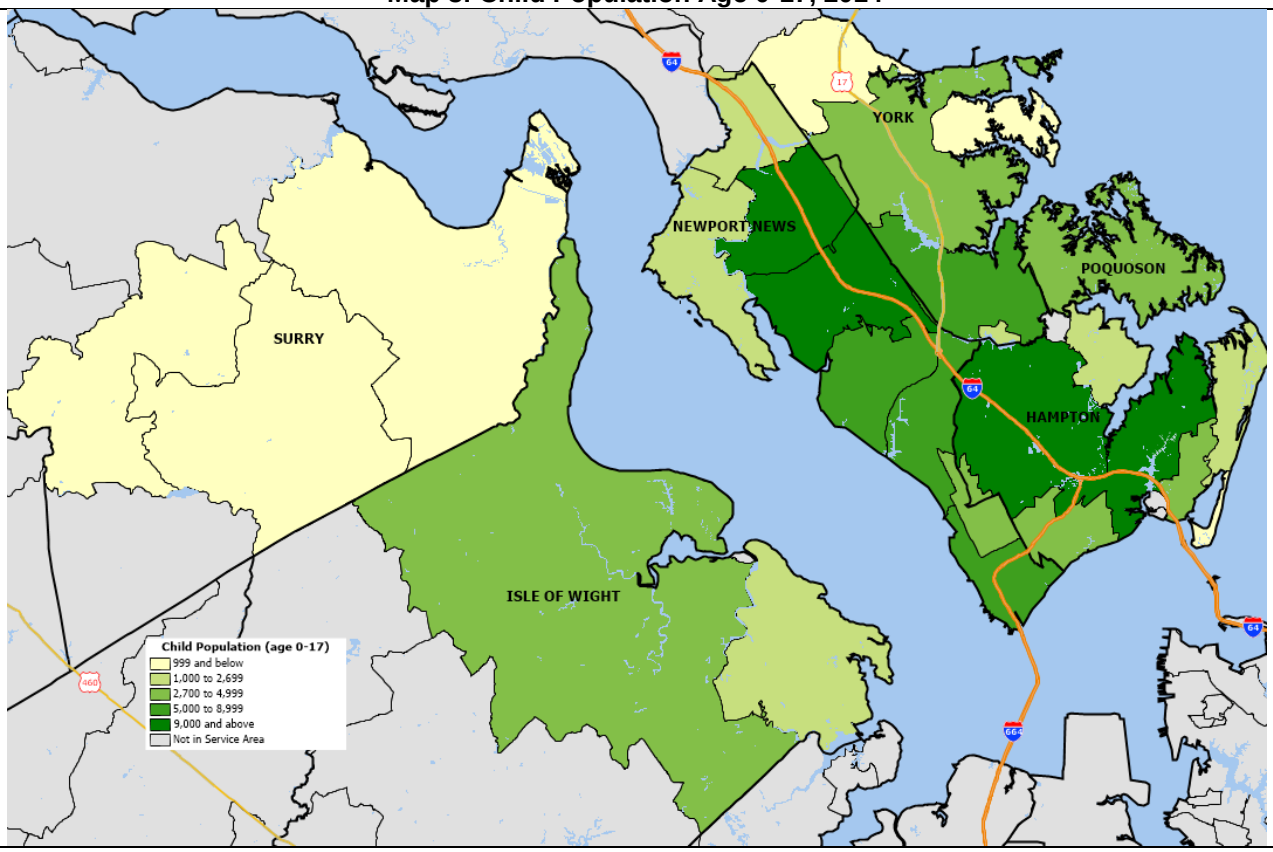

**Map 2: Population Density (population per square mile), 2014**



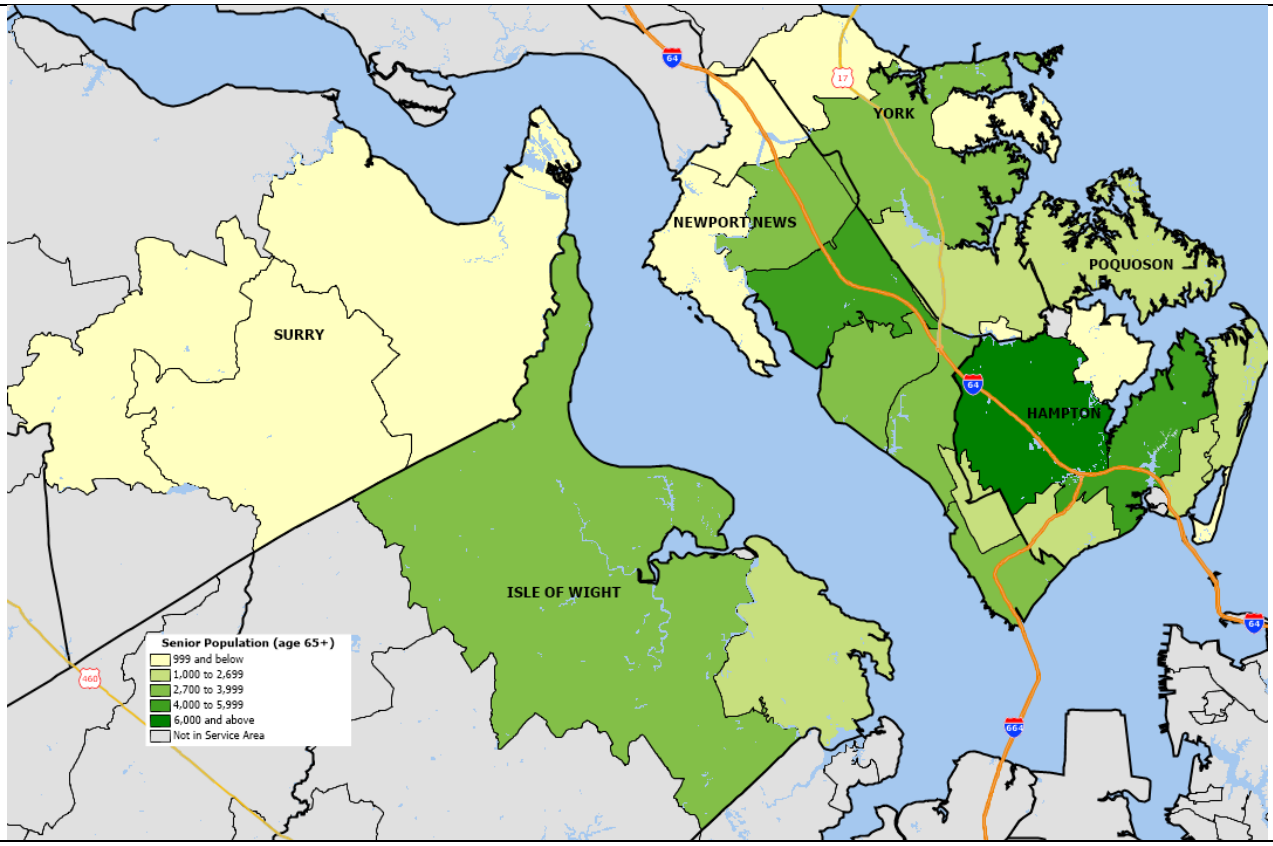

Z

*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 3: Child Population Age 0-17, 2014**

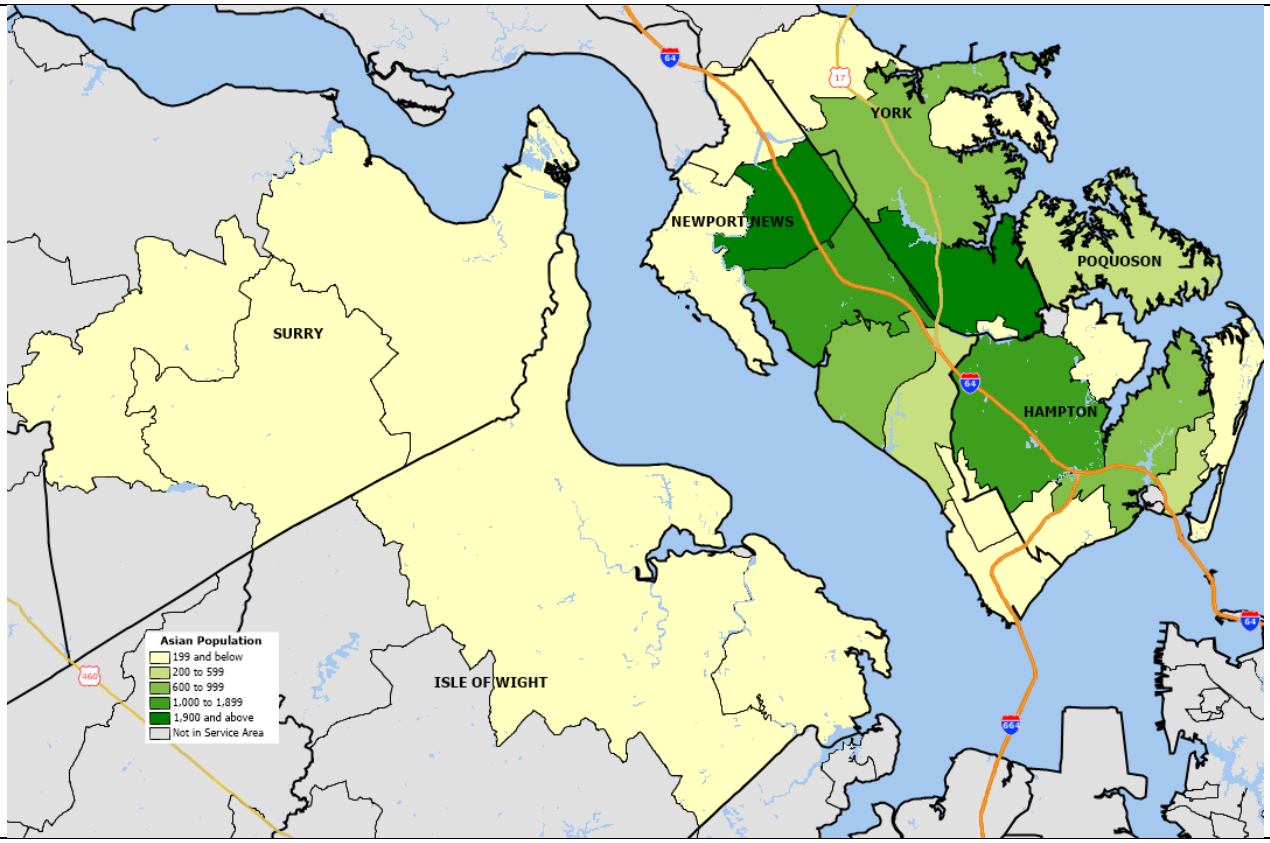



**Map 4: Senior Population Age 65+, 2014**

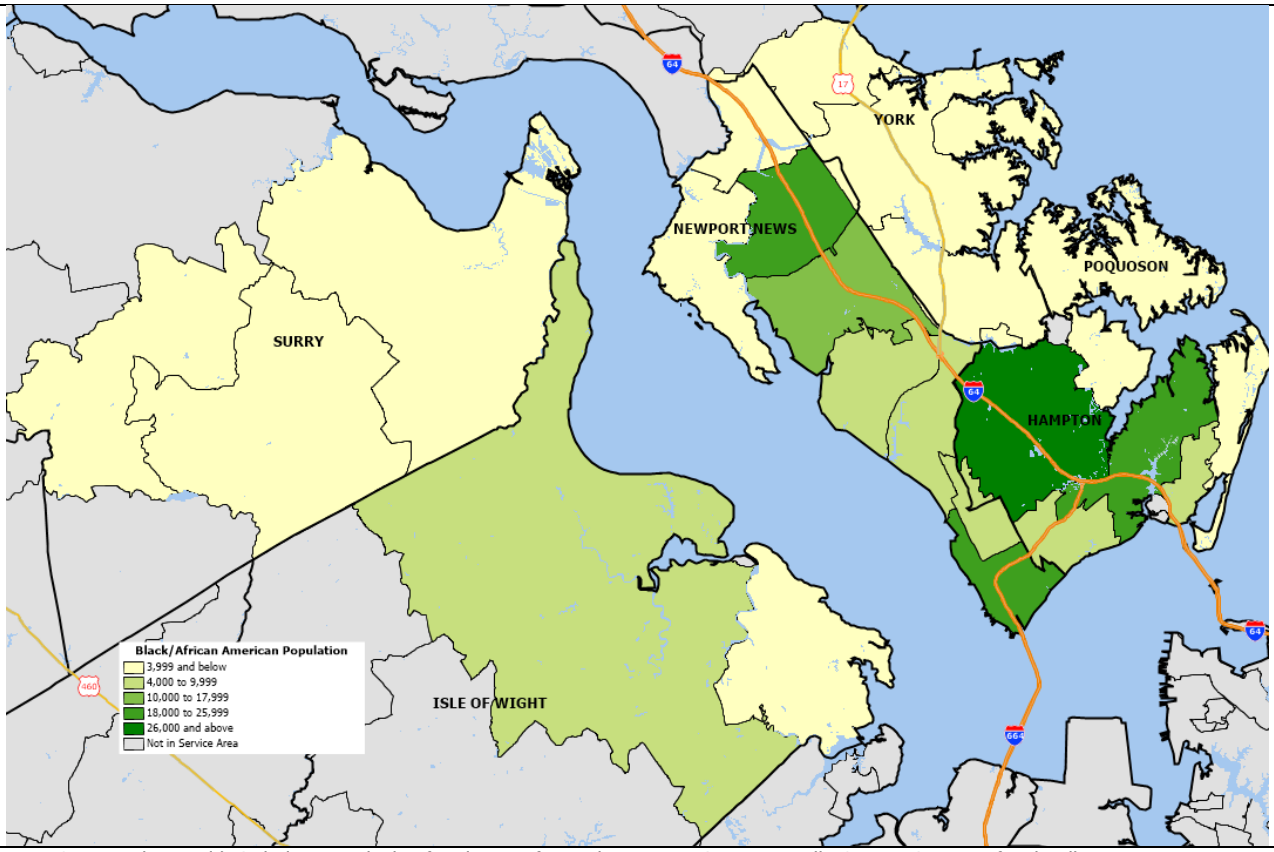



*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 5: Asian Population, 2014**

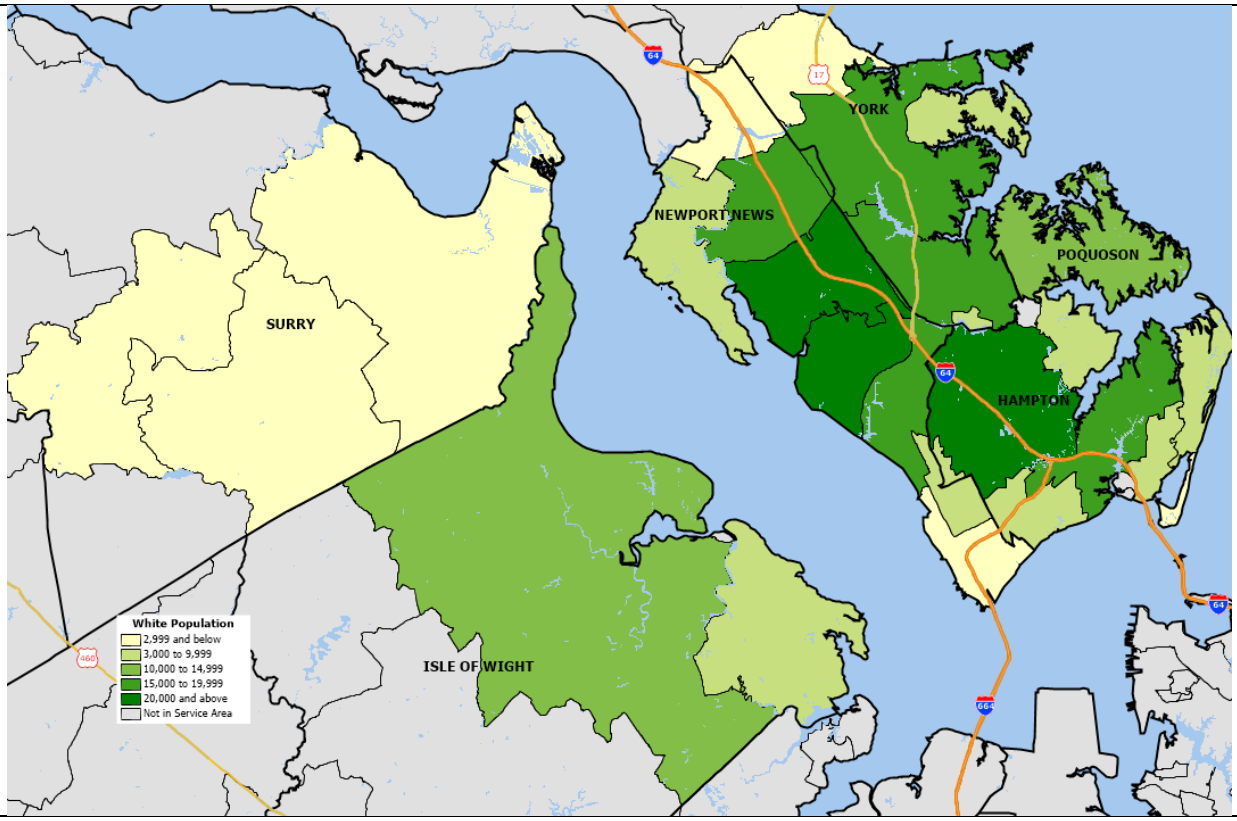



**Map 6: Black/African American Population, 2014**

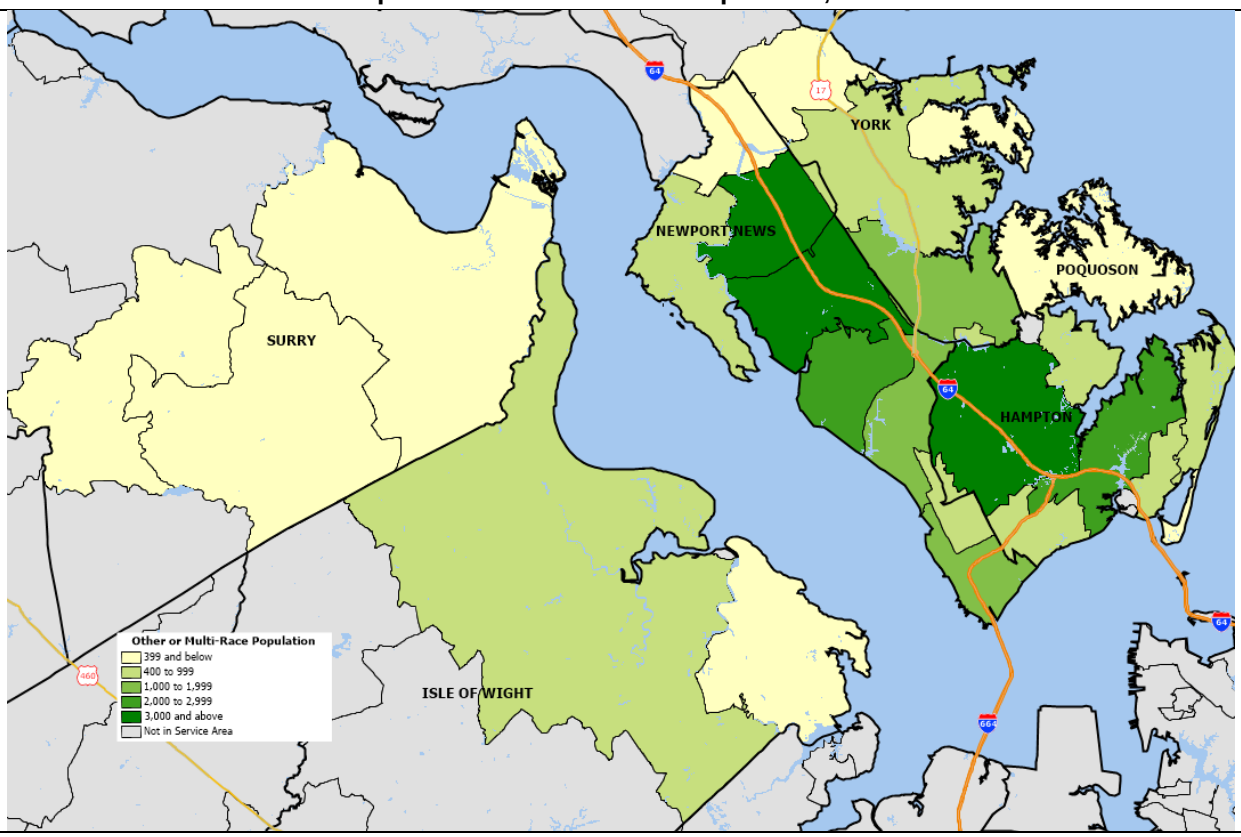



*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 7: White Population, 2014**

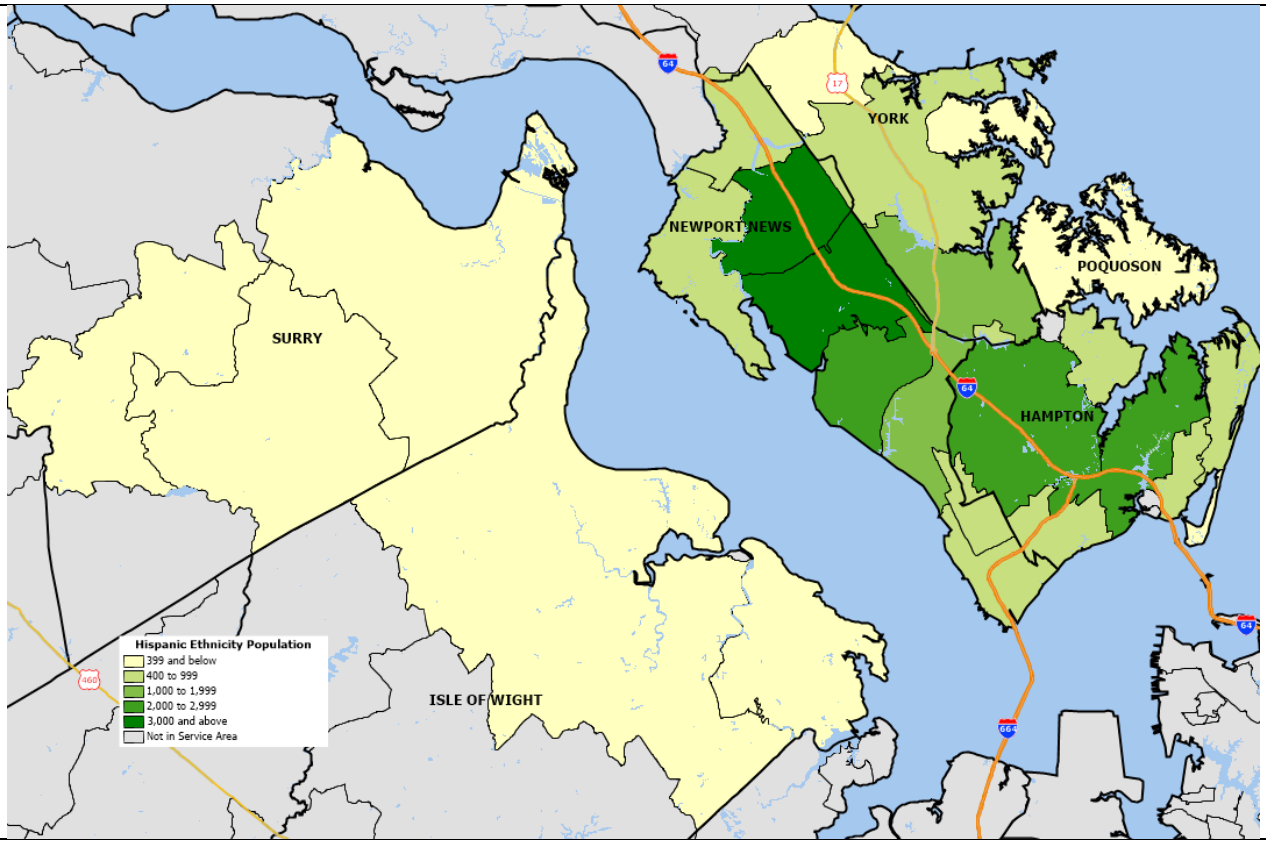



**Map 8: Other or Multi-Race Population, 2014**

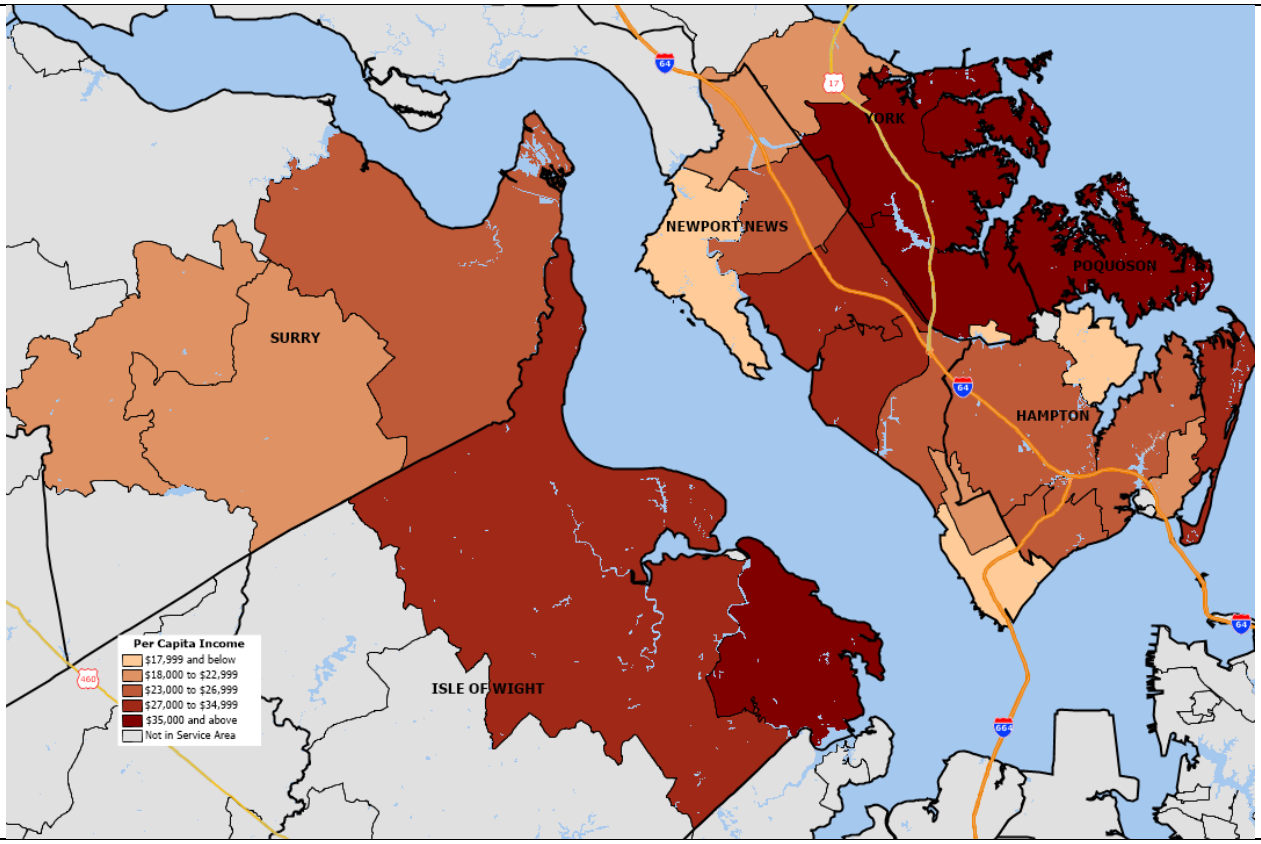



*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 9: Hispanic Ethnicity Population, 2014**

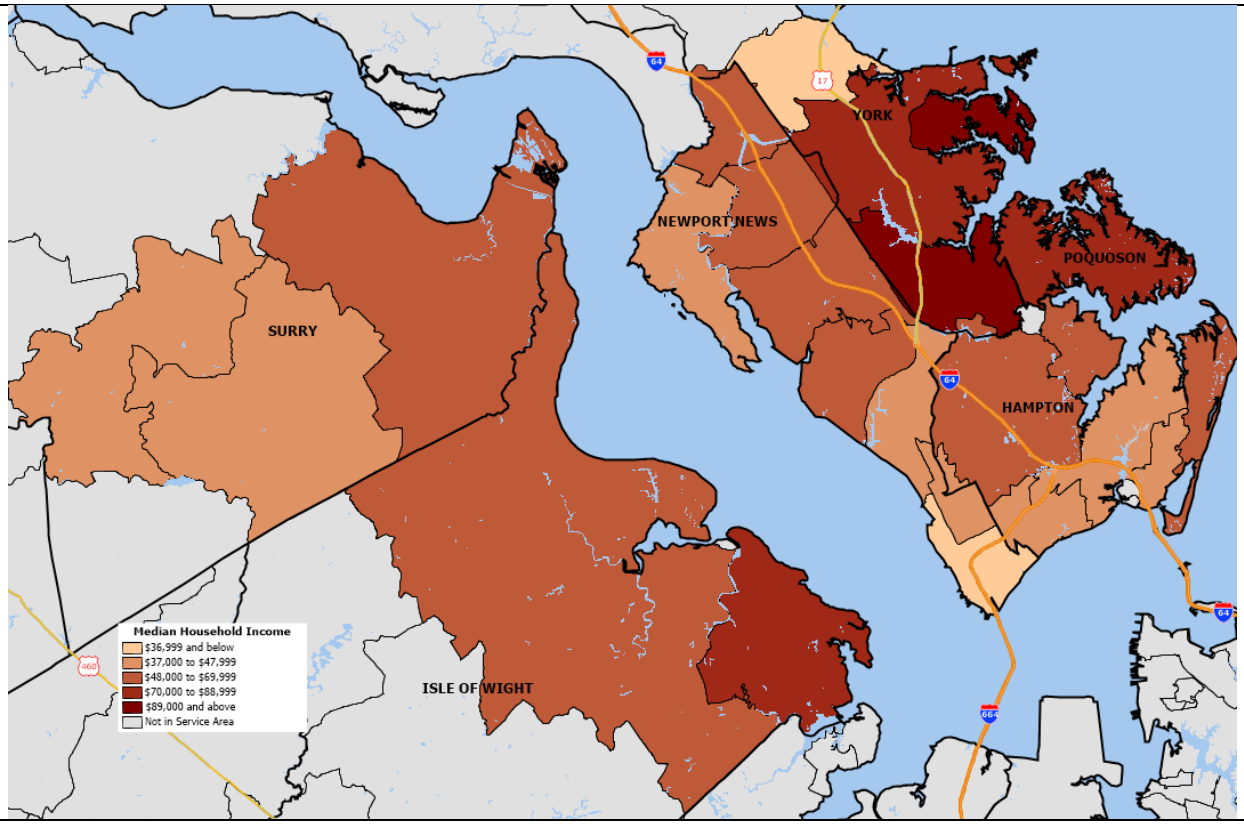



**Map 10: Per Capita Income, 2014**

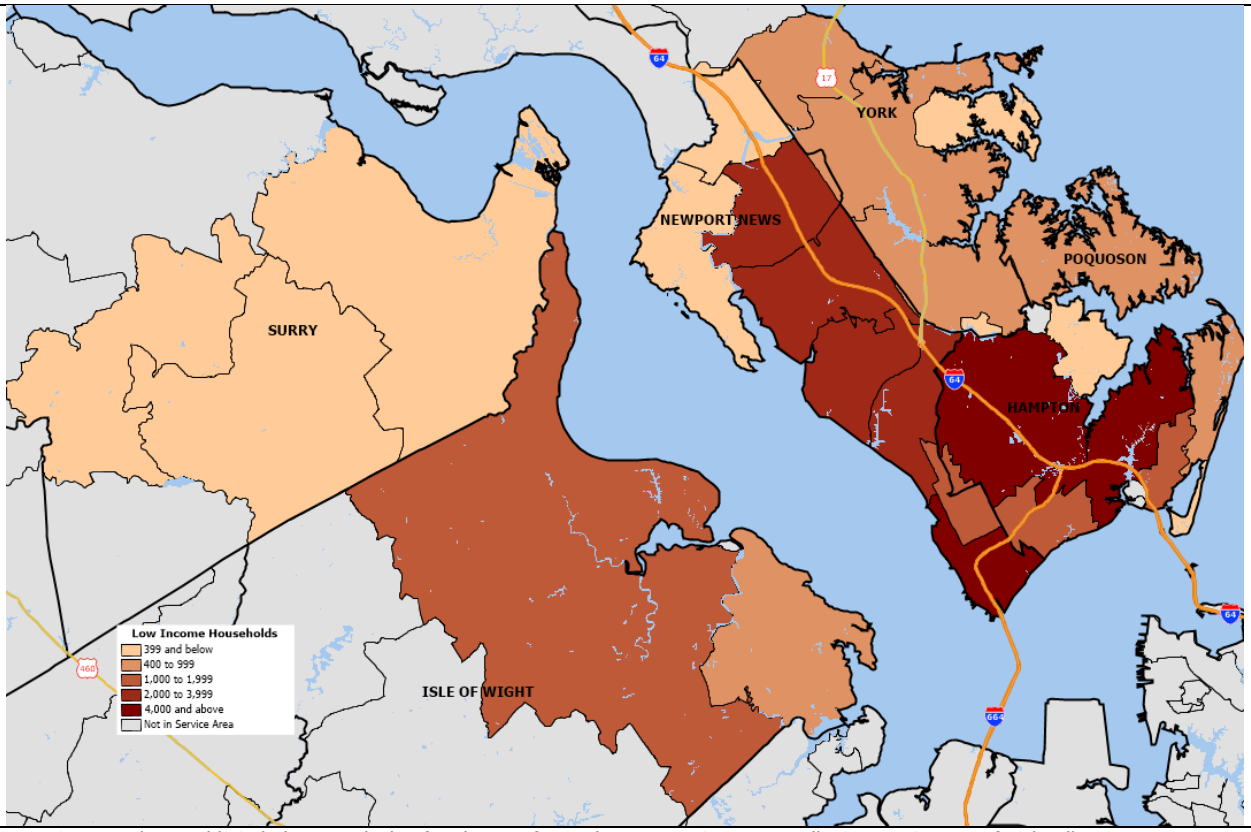



*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 11: Median Household Income, 2014**

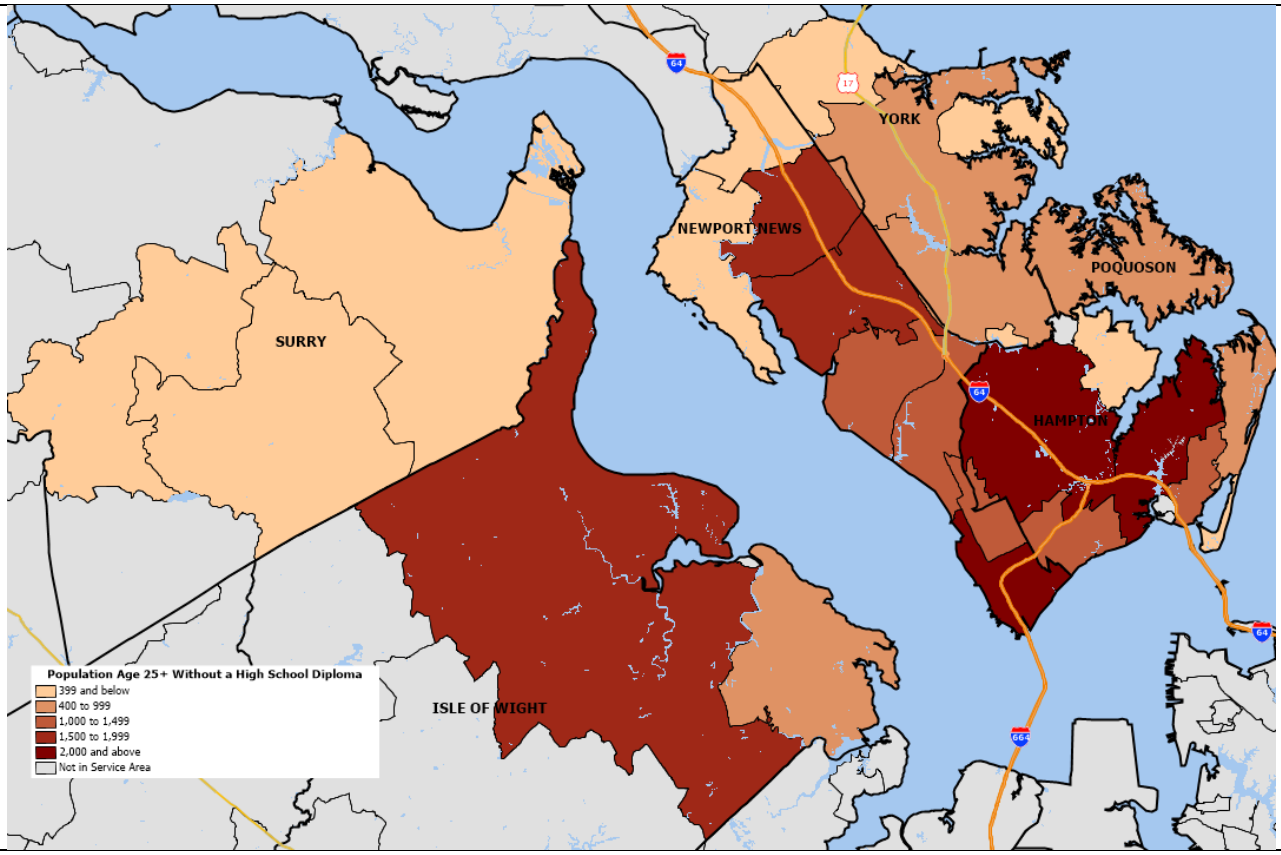



**Map 12: Low Income Households (Households with Income<$25,000), 2014**

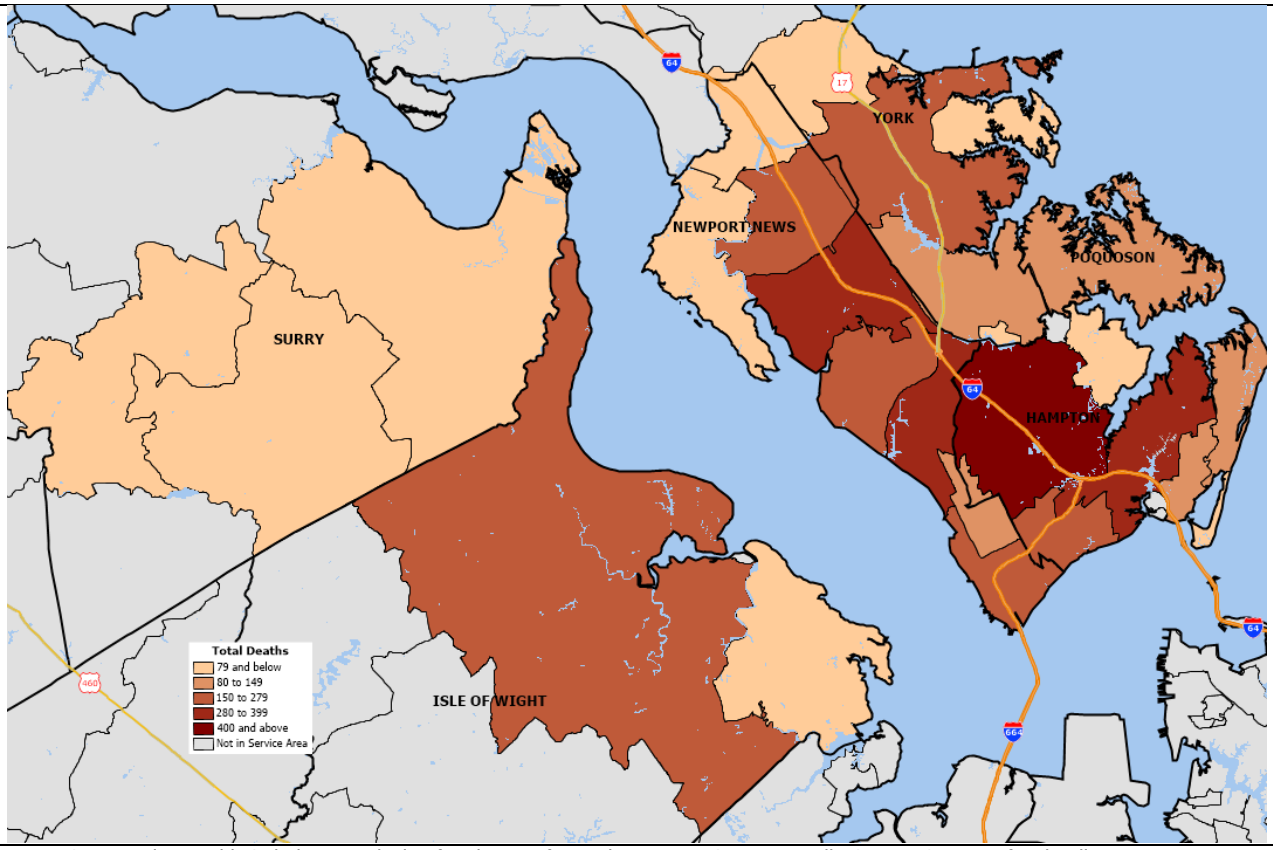



*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 13: Population Age 25+ Without a High School Diploma, 2014**

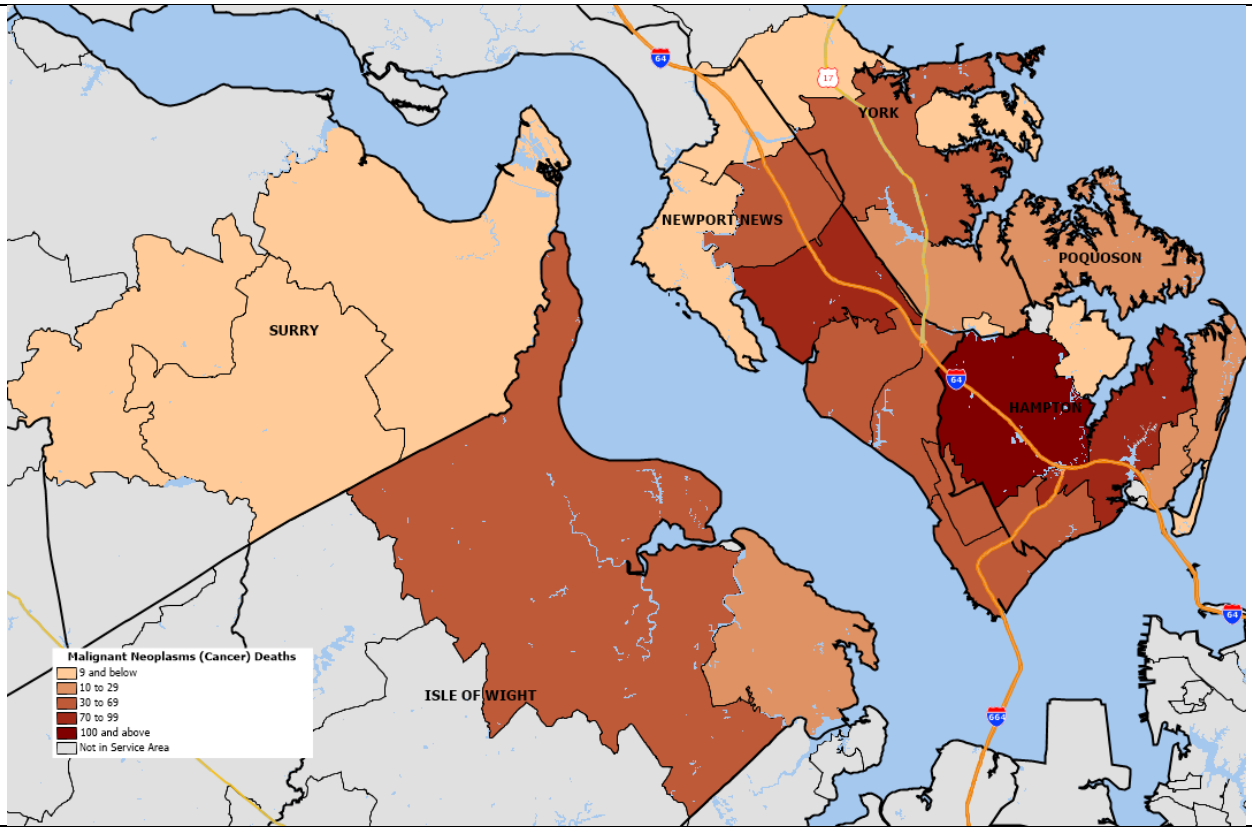



**Map 14: Total Deaths, 2013**

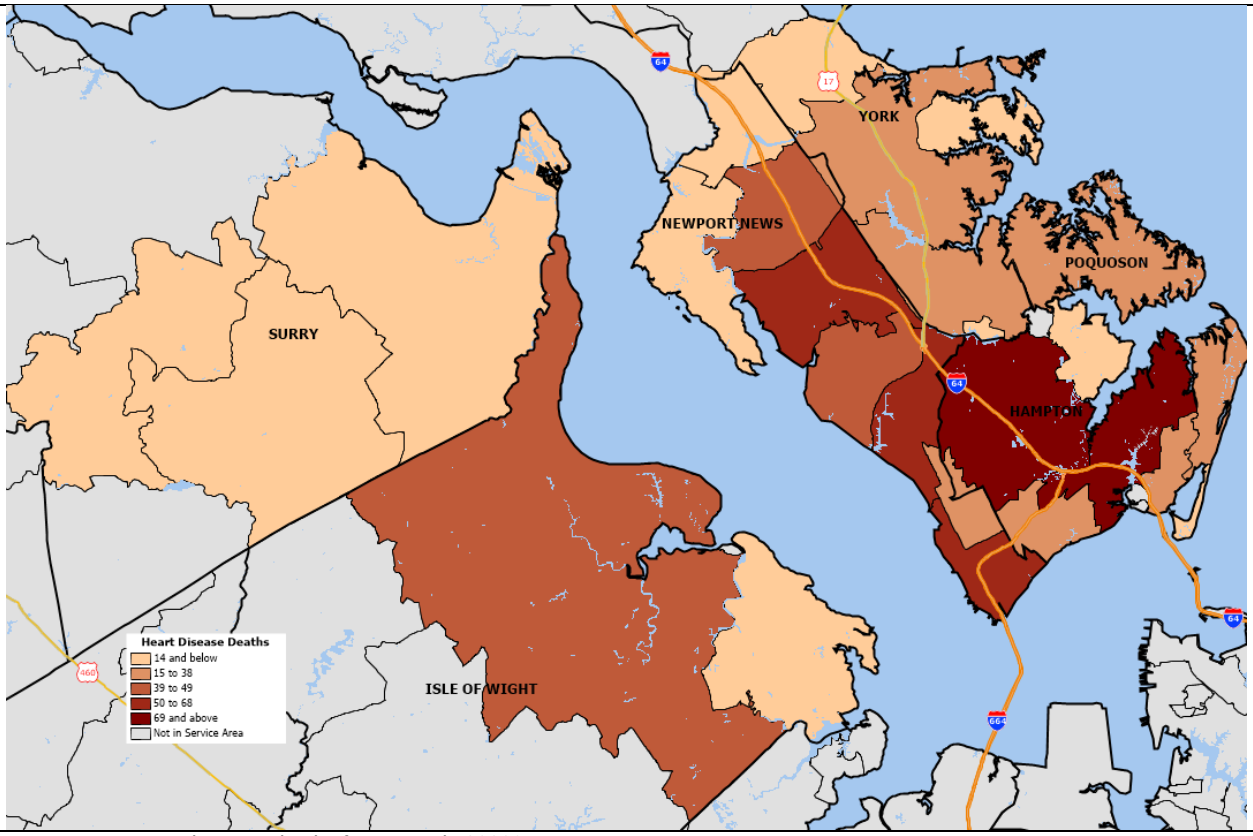



*Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 15: Malignant Neoplasm (Cancer) Deaths, 2013***

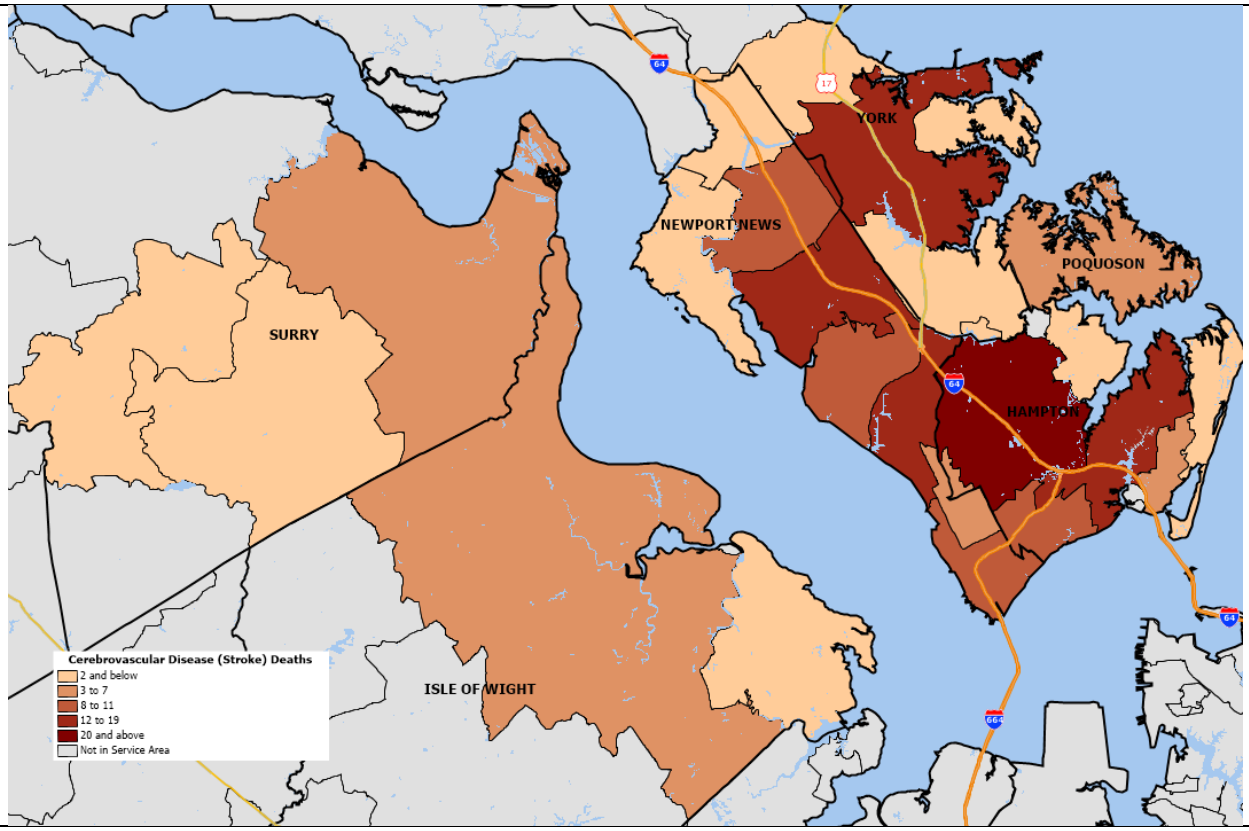



**Map 16: Heart Disease Deaths, 2013***

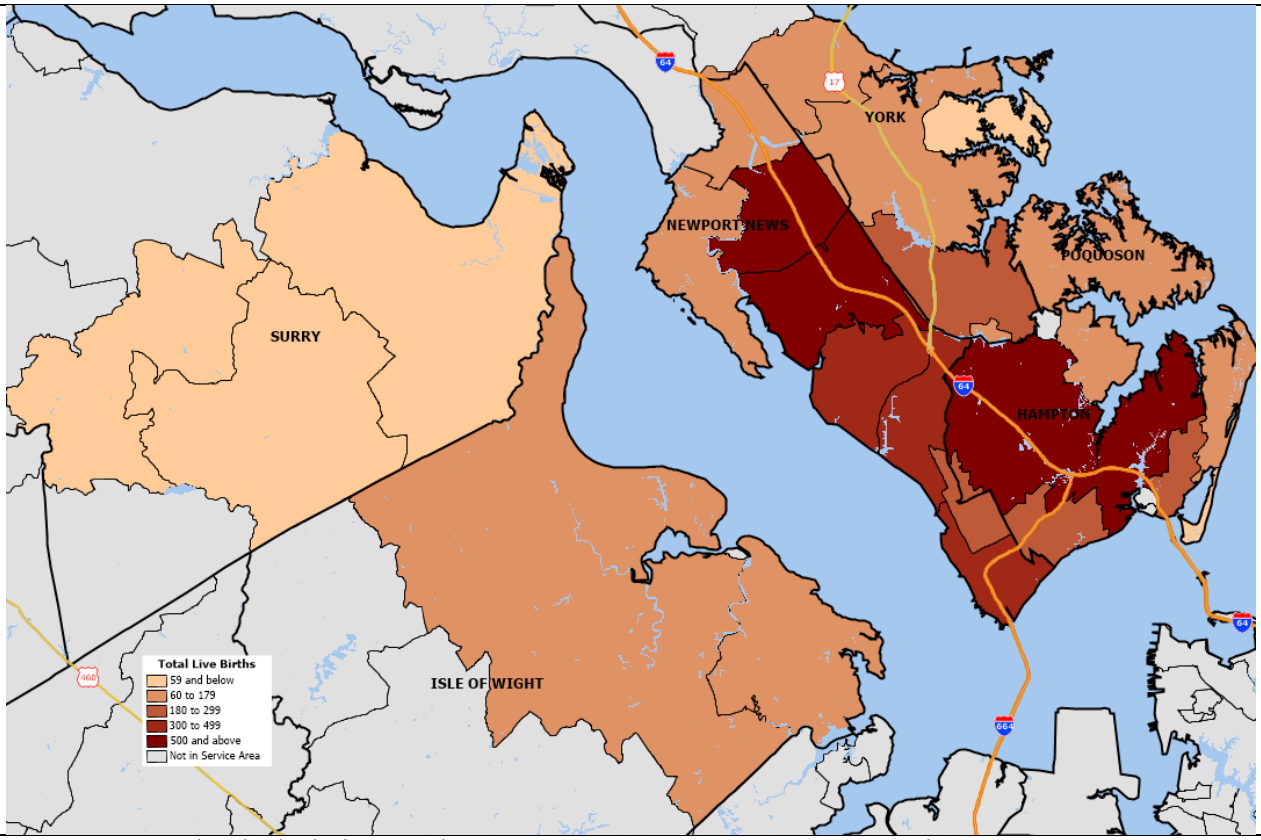



**There were no reported cancer deaths for ZIP code 23839.*
**There were no reported heart disease deaths for ZIP codes 23604 and 23665.*
*Source: Community Health Solutions analysis of data from the Virginia Department of Health. See Appendix C Data Sources for details.*

**Map 17: Cerebrovascular Disease (Stroke) Deaths, 2013***

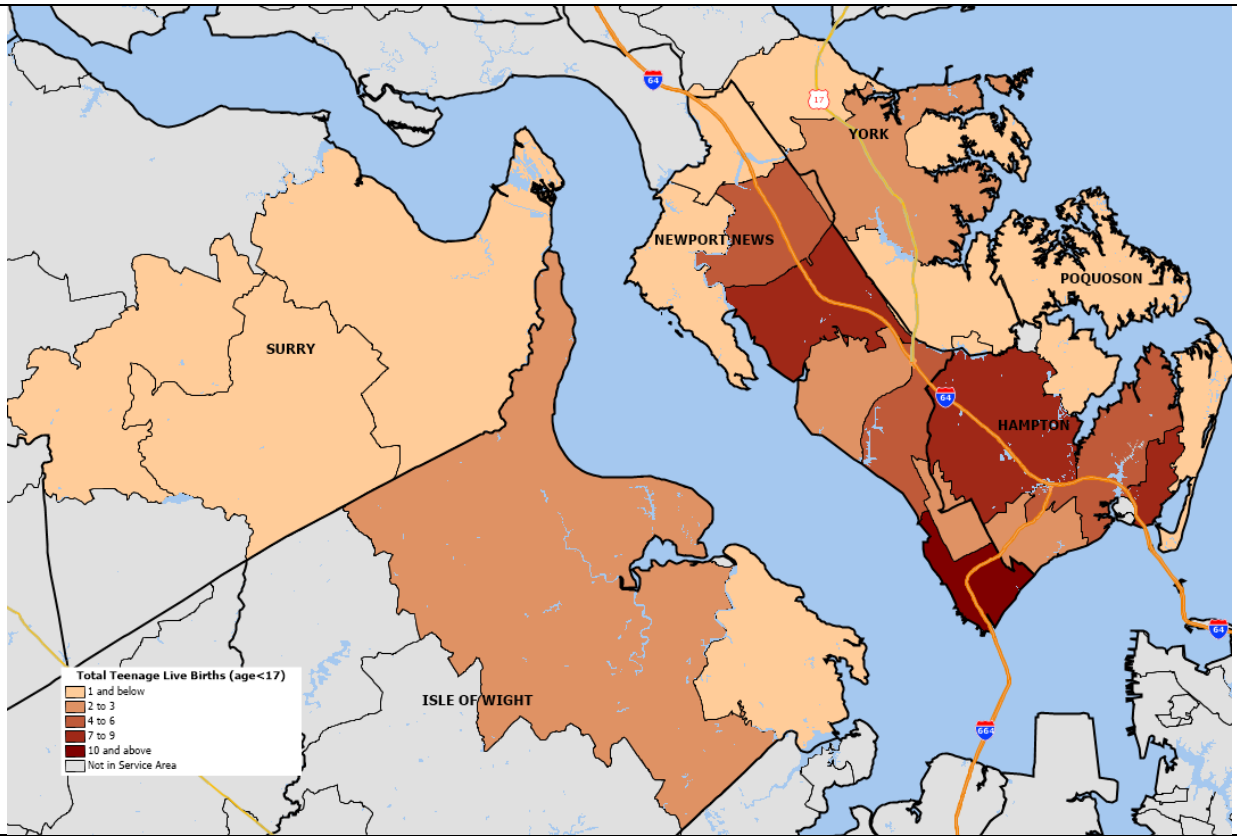



**Map 18: Total Live Births, 2013**

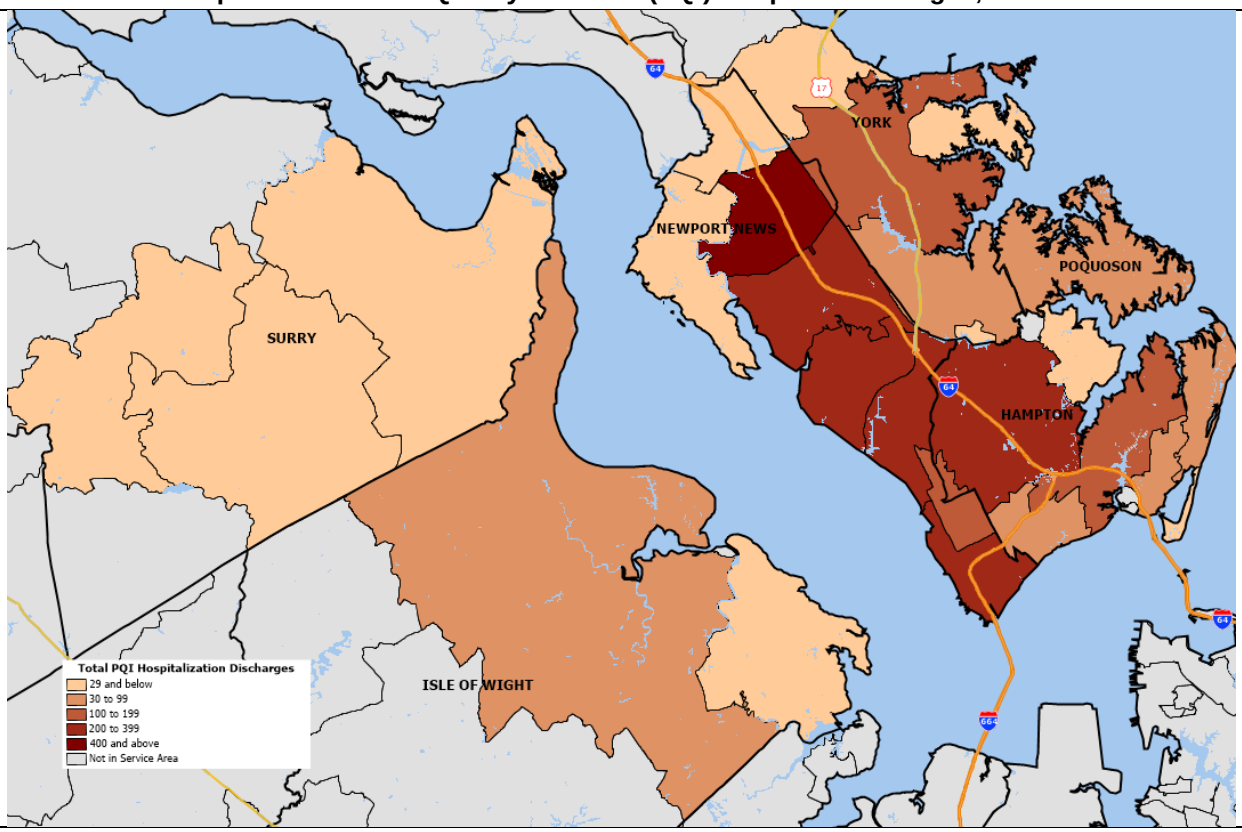



**There were no reported stroke deaths for ZIP codes 23314, 23604, 23651, 23665, 23690, 23839 and 23846.*
*Source: Community Health Solutions analysis of data from the Virginia Department of Health. See Appendix C Data Sources for details.*

**Map 19: Total Teenage Live Births (age <18), 2013***




**Map 20: Prevention Quality Indicator (PQI) Hospital Discharges, 2013***

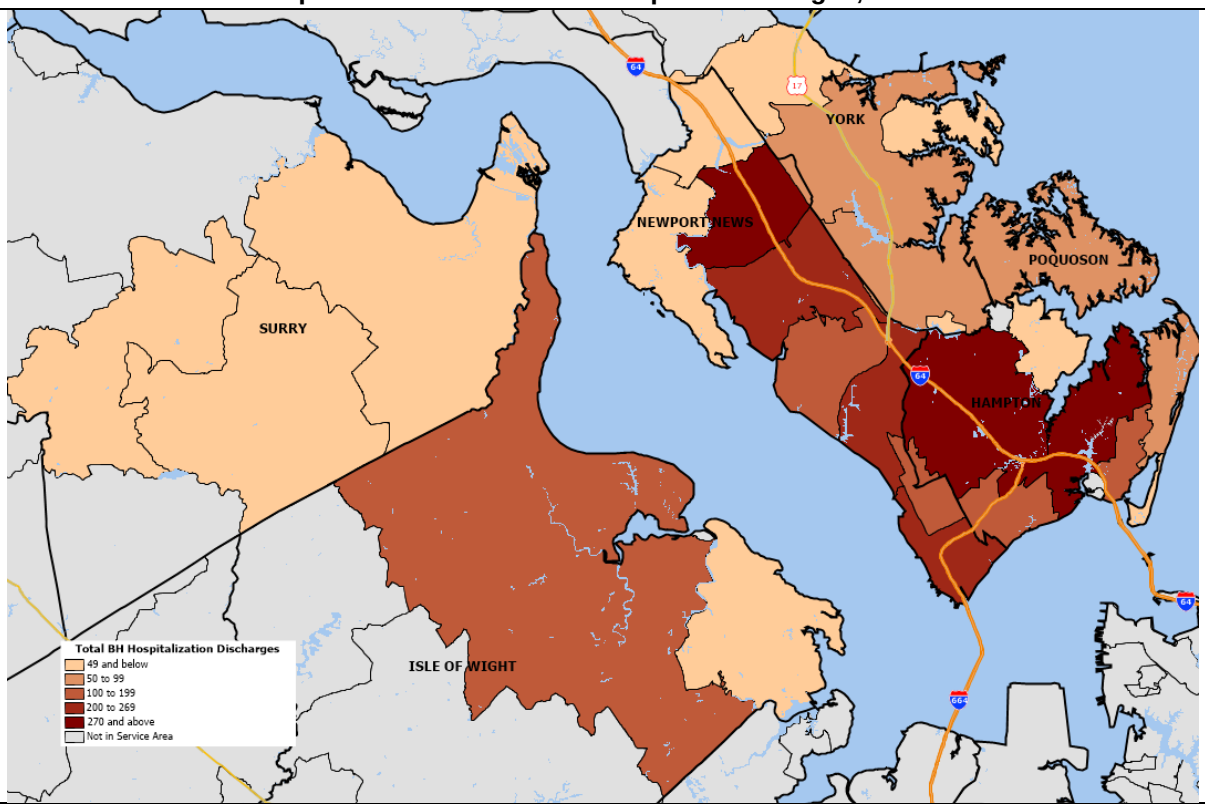



**There were no reported teenage live births (age <18) for ZIP codes 23603, 23604, 23651, 23664, 23665, 23693, 23696, 23839, 23846 and 23883.*

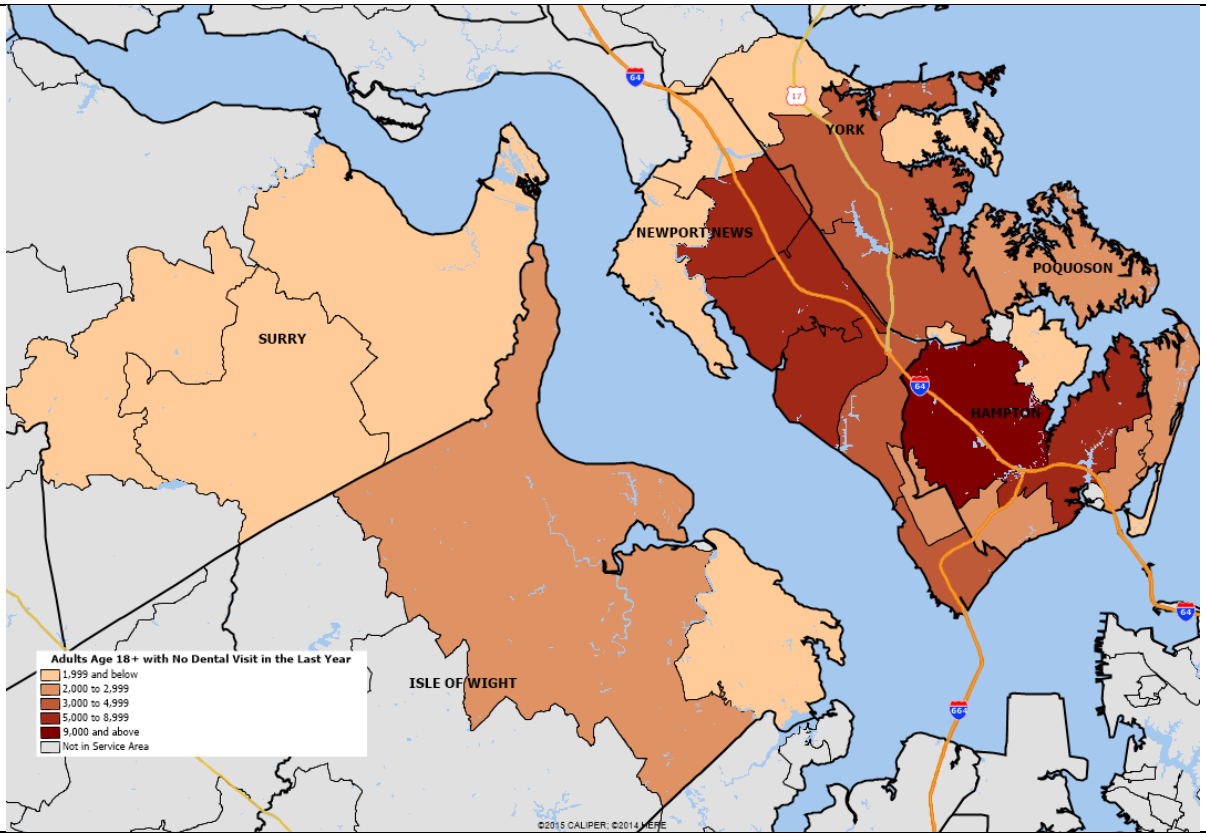
**There were no reported Prevention Quality Indicator (PQI) hospital discharges for ZIP code 23665.*

*Source: Community Health Solutions analysis of data from the Virginia Department of Health. See Appendix C Data Sources for details.*

**Map 21: Behavioral Health Hospital Discharges, 2013***



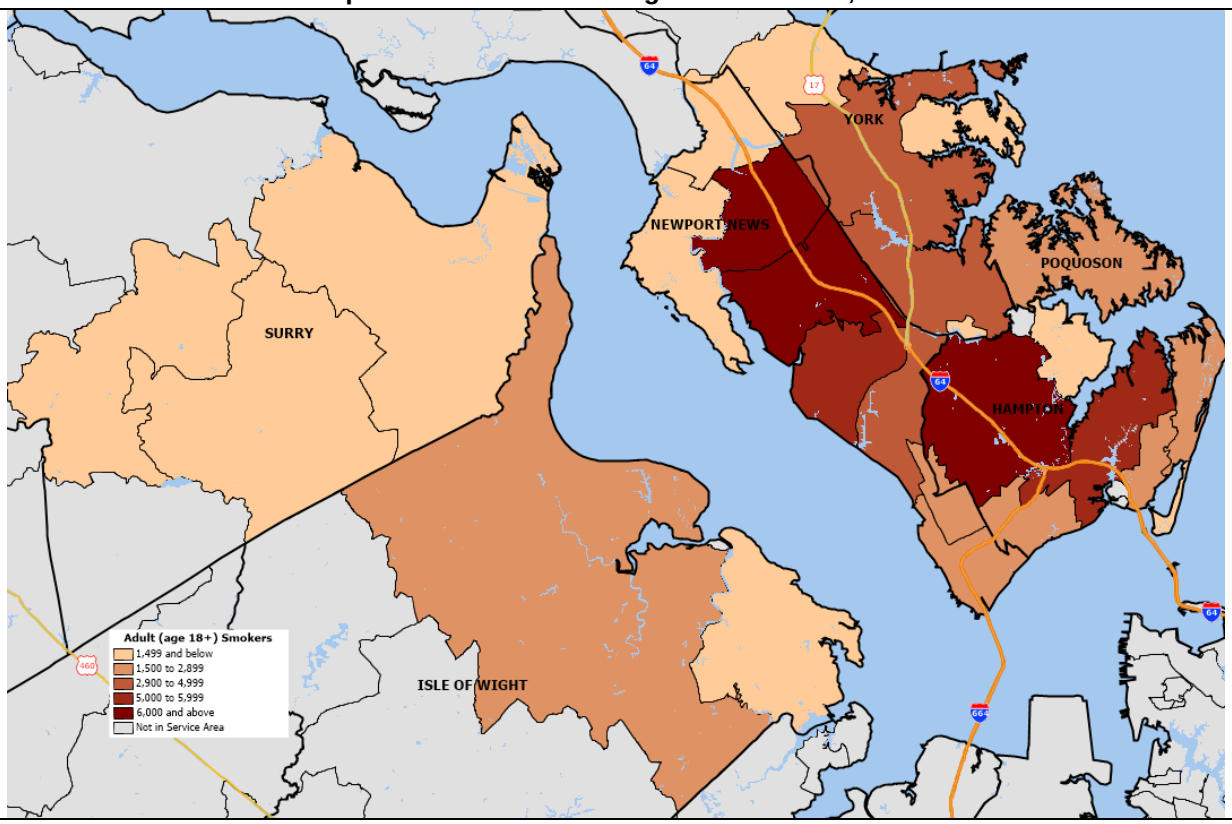

**Map 22: Estimated Adults Age 18+ with No Dental Visit in the Last Year, 2014**



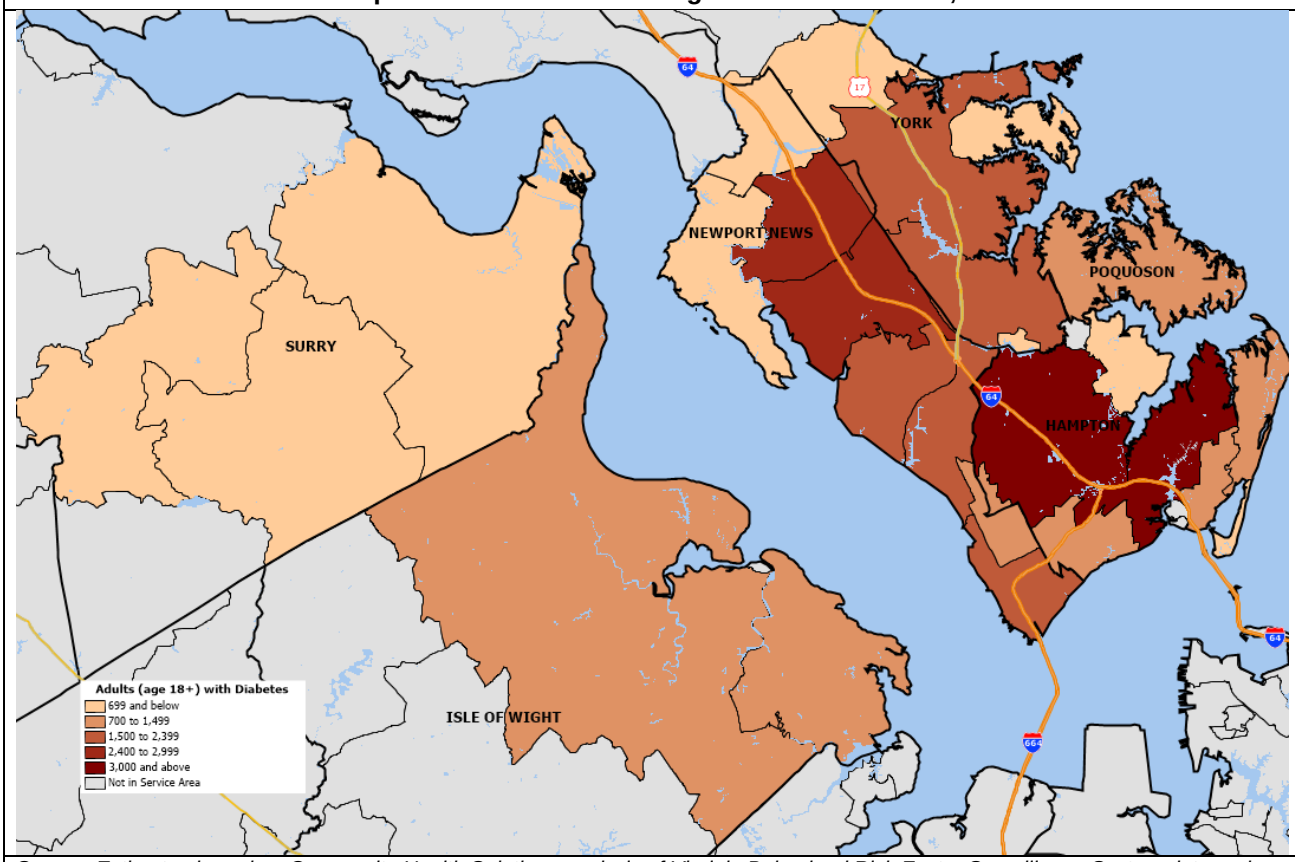

**There were no reported behavioral health discharges for ZIP code 23846.*

*Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information, Inc. Estimates based on Community Health Solutions analysis of Virginia Behavioral Risk Factor Surveillance System data and estimates from Alteryx, Inc. See Appendix C. Data Sources for details.*

**Map 23: Estimated Adult Age 18+ Smokers, 2014**

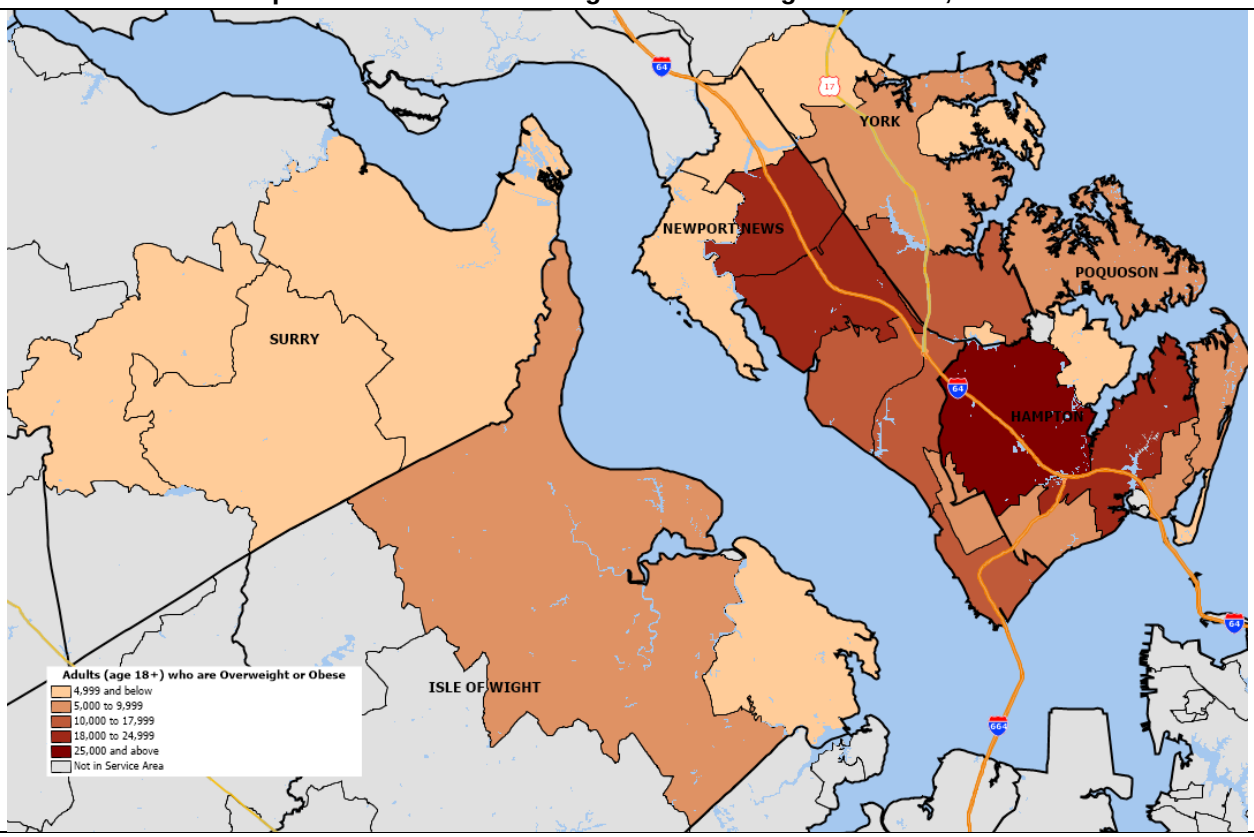



**Map 24: Estimated Adults Age 18+ with Diabetes, 2014**

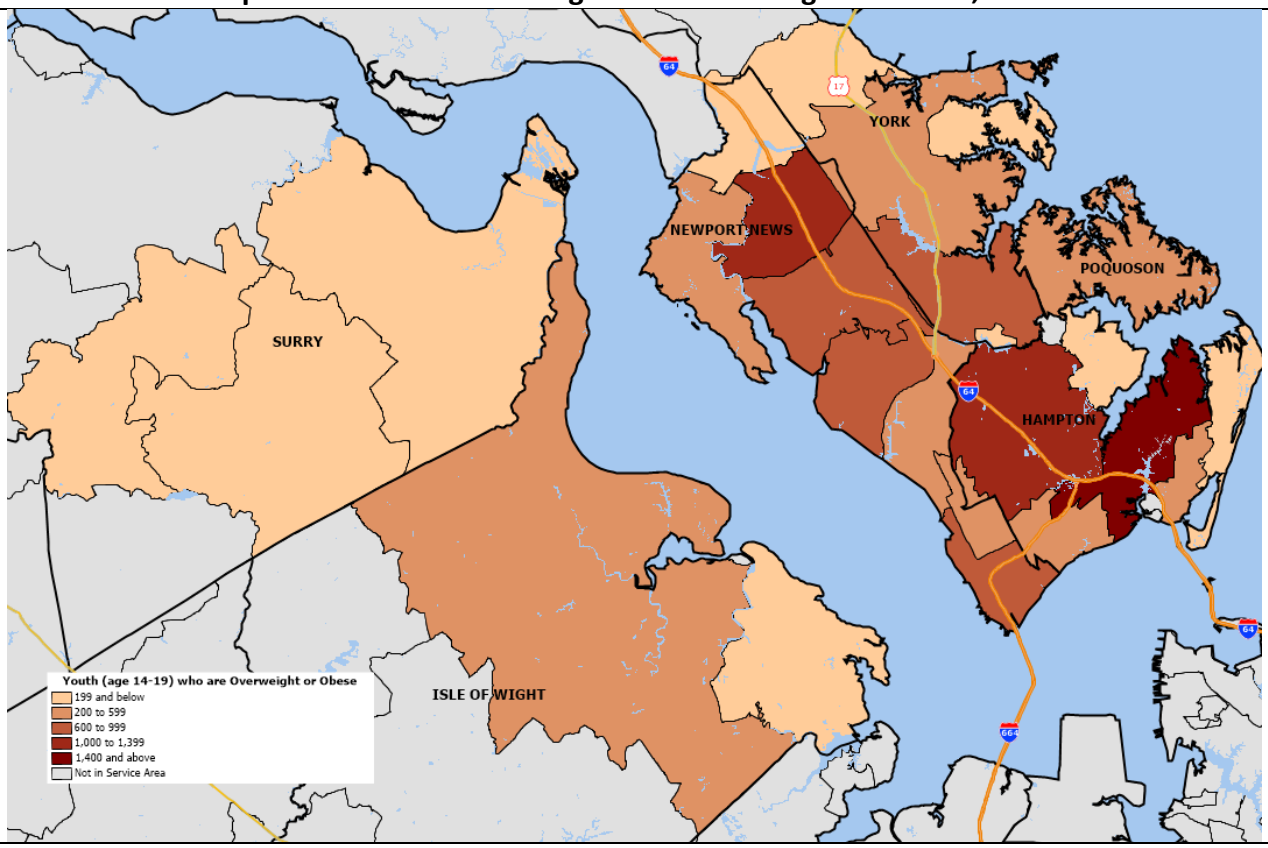



*Source: Estimates based on Community Health Solutions analysis of Virginia Behavioral Risk Factor Surveillance System data and estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

**Map 25: Estimated Adults Age 18+ Overweight or Obese, 2014**

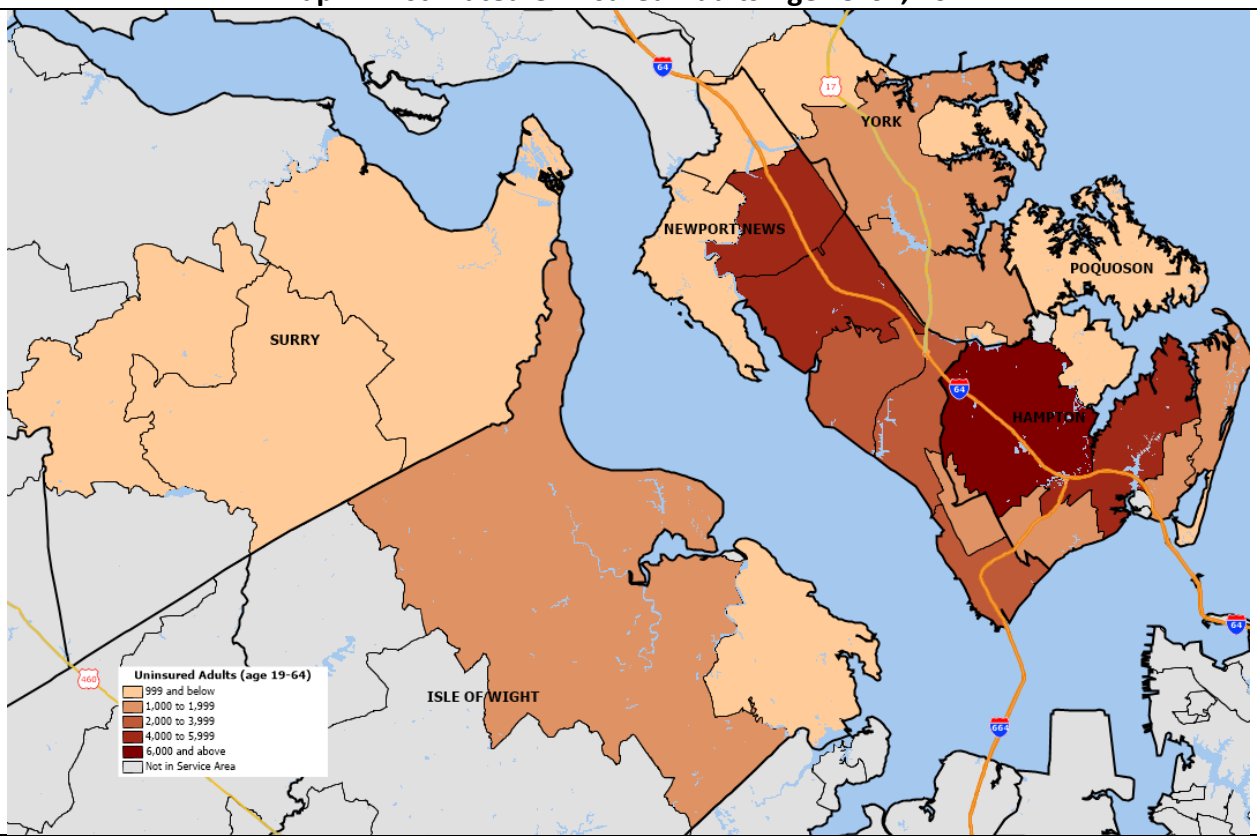



**Map 26: Estimated Youth Age 14-19 Overweight or Obese, 2014***

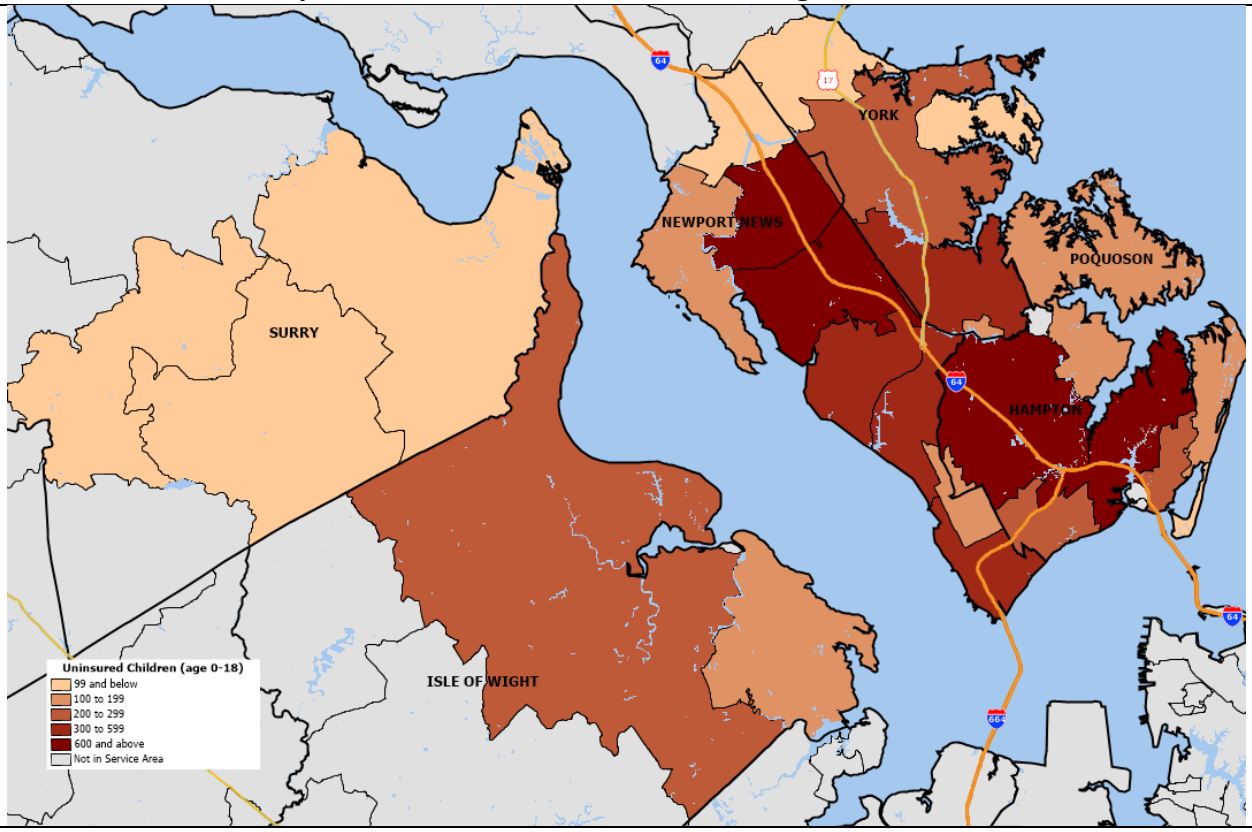



*Source: Estimates based on Community Health Solutions analysis of Virginia Youth Risk Behavioral Surveillance System data and estimates from Alteryx, Inc. See Appendix C Data Sources for details.*

## Map 27: Estimated Uninsured Adults Age 19-64, 2014




## Map 28: Estimated Uninsured Children Age 0-18, 2014*




*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. (2014). See Appendix C Data Sources for details.*

ZIP Code Map Table

| ZIP Code | Total Population, 2014 | Population Density, 2014 | Child Population Age 0-17, 2014 | Senior Population Age 65+, 2014 | Asian Population, 2014 | Black/African American Population, 2014 | White Population, 2014 | Other or Multi-Race Population, 2014 | Hispanic Ethnicity Population, 2014 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| 23314 | 7,449 | 208.9 | 1,635 | 1,067 | 120 | 1,378 | 5,660 | 291 | 210 |
| 23430 | 17,377 | 132.1 | 3,942 | 2,878 | 150 | 4,868 | 11,869 | 491 | 378 |
| 23601 | 25,193 | 3,319.2 | 5,612 | 3,546 | 471 | 7,829 | 15,366 | 1,525 | 1,313 |
| 23602 | 41,128 | 2,714.7 | 9,839 | 4,993 | 1,747 | 13,599 | 22,275 | 3,507 | 3,470 |
| 23603 | 3,978 | 545.7 | 1,221 | 193 | 95 | 1,254 | 2,249 | 380 | 453 |
| 23604 | 5,894 | 505.5 | 1,626 | 7 | 191 | 1,166 | 3,873 | 664 | 869 |
| 23605 | 12,871 | 3,545.7 | 2,798 | 1,600 | 151 | 6,735 | 5,156 | 828 | 730 |
| 23606 | 29,116 | 2,802.3 | 5,311 | 3,679 | 666 | 5,673 | 20,573 | 2,203 | 2,568 |
| 23607 | 24,188 | 515.7 | 6,764 | 2,791 | 105 | 20,267 | 2,764 | 1,052 | 656 |
| 23608 | 42,236 | 3,969.5 | 11,351 | 3,456 | 1,927 | 18,315 | 17,878 | 4,115 | 4,469 |
| 23651 | 646 | 414.1 | 213 | 42 | 6 | 132 | 441 | 67 | 84 |
| 23661 | 14,406 | 2,958.1 | 3,186 | 2,250 | 192 | 9,242 | 4,287 | 685 | 507 |
| 23662 | 12,158 | 673.9 | 2,732 | 2,047 | 272 | 121 | 11,485 | 281 | 262 |
| 23663 | 14,339 | 4,453.1 | 3,658 | 1,651 | 274 | 7,477 | 5,699 | 887 | 744 |
| 23664 | 10,209 | 1,748.1 | 2,153 | 1,555 | 132 | 2,091 | 7,414 | 572 | 504 |
| 23665 | 5,305 | 1,233.7 | 1,977 | 9 | 141 | 985 | 3,540 | 639 | 687 |
| 23666 | 51,195 | 2,520.7 | 11,181 | 6,531 | 1,686 | 26,078 | 20,340 | 3,092 | 2,630 |
| 23669 | 42,791 | 3,374.7 | 9,564 | 5,400 | 835 | 21,180 | 18,332 | 2,443 | 2,108 |
| 23690 | 3,307 | 129.6 | 862 | 298 | 65 | 1,438 | 1,593 | 211 | 261 |
| 23692 | 18,838 | 826.6 | 4,070 | 3,482 | 725 | 1,122 | 16,230 | 760 | 759 |
| 23693 | 23,810 | 1,827.3 | 5,920 | 2,208 | 2,139 | 2,771 | 17,502 | 1,399 | 1,165 |
| 23696 | 3,719 | 529.8 | 867 | 664 | 64 | 81 | 3,481 | 92 | 106 |
| 23839 | 734 | 28.1 | 163 | 131 | 3 | 317 | 395 | 19 | 16 |
| 23846 | 831 | 19.7 | 174 | 145 | 3 | 346 | 463 | 19 | 8 |
| 23883 | 2,365 | 35.8 | 462 | 371 | 5 | 1,169 | 1,133 | 60 | 35 |

ZIP Code Map Table (Continued)

| ZIP Code | Per Capita Income, 2014 | Median Household Income, 2014 | Low Income Households (Households with Income <$25,000), 2014 | Population Age 25+ Without a High School Diploma, 2014 | Total Deaths, 2013 | Heart Disease Deaths, 2013 | Cerebrovascular Disease (Stroke) Deaths, 2013 | Malignant Neoplasms (Cancer) Deaths, 2013 | Total Live Births, 2013 |
|---|---|---|---|---|---|---|---|---|---|
| 23314 | $ 35,265 | $ 74,634 | 440 | 435 | 50 | 10 | 0 | 14 | 98 |
| 23430 | $ 30,886 | $ 61,275 | 1,458 | 1,508 | 169 | 43 | 5 | 45 | 133 |
| 23601 | $ 25,835 | $ 45,961 | 2,950 | 1,272 | 285 | 54 | 14 | 60 | 374 |
| 23602 | $ 27,967 | $ 55,997 | 3,009 | 1,816 | 305 | 61 | 14 | 75 | 579 |
| 23603 | $ 22,300 | $ 48,691 | 256 | 70 | 21 | 3 | 1 | 4 | 75 |
| 23604 | $ 13,689 | $ 43,542 | 156 | 66 | 3 | 0 | 0 | 2 | 67 |
| 23605 | $ 20,783 | $ 37,501 | 1,819 | 1,303 | 118 | 16 | 5 | 37 | 252 |
| 23606 | $ 28,802 | $ 51,390 | 2,374 | 1,101 | 213 | 47 | 8 | 52 | 357 |
| 23607 | $ 15,753 | $ 26,024 | 4,481 | 3,066 | 226 | 56 | 8 | 44 | 442 |
| 23608 | $ 24,184 | $ 52,632 | 2,932 | 1,657 | 237 | 39 | 9 | 45 | 710 |
| 23651 | $ 27,428 | $ 49,709 | 25 | 2 | 7 | 1 | 0 | 1 | 6 |
| 23661 | $ 23,927 | $ 41,484 | 1,751 | 1,365 | 152 | 21 | 10 | 46 | 186 |
| 23662 | $ 37,665 | $ 80,196 | 594 | 450 | 88 | 15 | 3 | 21 | 90 |
| 23663 | $ 19,540 | $ 41,417 | 1,656 | 1,367 | 114 | 24 | 6 | 26 | 203 |
| 23664 | $ 31,547 | $ 52,098 | 899 | 658 | 89 | 22 | 2 | 19 | 124 |
| 23665 | $ 17,569 | $ 54,911 | 160 | 41 | 3 | 0 | 0 | 1 | 123 |
| 23666 | $ 26,361 | $ 51,106 | 4,149 | 2,764 | 459 | 81 | 23 | 107 | 712 |
| 23669 | $ 23,389 | $ 44,734 | 4,842 | 2,635 | 358 | 69 | 17 | 84 | 581 |
| 23690 | $ 18,780 | $ 32,151 | 503 | 188 | 19 | 2 | 0 | 5 | 67 |
| 23692 | $ 39,925 | $ 80,726 | 693 | 531 | 173 | 30 | 12 | 45 | 130 |
| 23693 | $ 39,385 | $ 91,297 | 622 | 437 | 86 | 24 | 1 | 25 | 188 |
| 23696 | $ 39,865 | $ 89,333 | 133 | 156 | 17 | 2 | 2 | 7 | 22 |
| 23839 | $ 20,607 | $ 40,485 | 67 | 107 | 5 | 1 | 0 | 0 | 8 |
| 23846 | $ 21,268 | $ 46,239 | 67 | 139 | 8 | 1 | 0 | 5 | 11 |
| 23883 | $ 25,216 | $ 55,066 | 214 | 272 | 18 | 6 | 4 | 3 | 21 |

ZIP Code Map Table (Continued)

| ZIP Code | Total Teenage Live Births (age<17), 2013 | Total Prevention Quality Indicator Hospitalization Discharges, 2013 | Total Behavioral Health Hospitalization Discharges, 2013 | Estimated Adult Age 18+ Smokers, 2014 | Estimated Adults Age 18+ with No Dental Visit in the Last Year, 2014 | Estimated Adults Age 18+ with Diabetes, 2014 | Estimated Adults Age 18+ who are Overweight or Obese, 2014 | Estimated High School-aged Youth (age 14-19) who are Overweight or Obese, 2014 | Estimated Uninsured Children Age 0-18, 2014 | Estimated Uninsured Adults, Age 19-64, 2014 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| 23314 | 1 | 23 | 34 | 1,045 | 1,121 | 743 | 3,446 | 151 | 121 | 652 |
| 23430 | 2 | 58 | 109 | 2,148 | 2,683 | 1,091 | 8,317 | 396 | 291 | 1,447 |
| 23601 | 4 | 271 | 222 | 4,022 | 3,969 | 1,530 | 12,245 | 480 | 351 | 3,000 |
| 23602 | 7 | 319 | 243 | 6,443 | 5,771 | 2,687 | 18,843 | 832 | 618 | 4,910 |
| 23603 | 0 | 8 | 17 | 724 | 723 | 191 | 1,692 | 114 | 77 | 477 |
| 23604 | 0 | 7 | 13 | 928 | 973 | 203 | 2,472 | 266 | 113 | 761 |
| 23605 | 2 | 125 | 112 | 2,065 | 2,461 | 776 | 6,691 | 251 | 176 | 1,585 |
| 23606 | 3 | 244 | 168 | 5,123 | 5,289 | 2,112 | 14,719 | 869 | 368 | 3,667 |
| 23607 | 19 | 289 | 259 | 2,683 | 3,559 | 1,836 | 10,941 | 687 | 427 | 2,715 |
| 23608 | 5 | 431 | 274 | 7,171 | 7,212 | 2,496 | 18,894 | 1,038 | 714 | 5,108 |
| 23651 | 0 | 4 | 3 | 108 | 164 | 59 | 290 | 12 | 13 | 73 |
| 23661 | 3 | 79 | 108 | 2,026 | 2,659 | 916 | 7,251 | 357 | 202 | 1,670 |
| 23662 | 1 | 65 | 53 | 1,914 | 2,383 | 1,128 | 5,668 | 284 | 176 | 934 |
| 23663 | 8 | 51 | 100 | 1,778 | 2,270 | 829 | 6,649 | 379 | 232 | 1,676 |
| 23664 | 0 | 39 | 65 | 1,583 | 2,027 | 737 | 5,094 | 198 | 136 | 1,214 |
| 23665 | 0 | 0 | 7 | 559 | 427 | 157 | 1,769 | 124 | 123 | 618 |
| 23666 | 7 | 232 | 317 | 7,465 | 9,041 | 3,601 | 25,202 | 1,080 | 704 | 6,258 |
| 23669 | 5 | 144 | 296 | 5,314 | 7,002 | 3,220 | 20,466 | 1,420 | 638 | 5,086 |
| 23690 | 1 | 16 | 16 | 304 | 458 | 148 | 1,556 | 81 | 55 | 273 |
| 23692 | 2 | 151 | 73 | 2,909 | 3,665 | 1,843 | 9,191 | 438 | 261 | 1,432 |
| 23693 | 0 | 92 | 51 | 3,722 | 4,160 | 1,551 | 10,525 | 647 | 381 | 1,984 |
| 23696 | 0 | 27 | 13 | 754 | 923 | 311 | 1,741 | 82 | 55 | 278 |
| 23839 | 0 | 3 | 4 | 47 | 50 | 72 | 363 | 17 | 14 | 77 |
| 23846 | 0 | 1 | 0 | 88 | 114 | 89 | 421 | 19 | 15 | 90 |
| 23883 | 0 | 8 | 16 | 305 | 355 | 207 | 1,200 | 54 | 39 | 270 |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
|---|---|
| *Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for one or more Riverside facilities. 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 Riverside Peninsula market facilities' study regions (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.* | |
| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 1 | • (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 | • Aging, low income residents |
| 3 | • Aging; people with substance/alcohol use disorders and behavioral health issues, working poor, rural families, veterans |
| 4 | • Autism resources in the area seem lacking from both health care systems |
| 5 | • Both the direct victim and the children who witness domestic violence are at risk for long term health issues.<br>• 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 | • Both the uninsured and underinsured as well as the elderly on fixed incomes. |
| 7 | • Children in at risk socioeconomic groups-many have adults that either don't or can't look out for their best interests; we need more proactive interventions/safety nets. |
| 8 | • Children in poverty with single parents<br>• Children with behavioral/mental health problems<br>• Children with developmental delays |
| 9 | • 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. |

**Exhibit B1. Vulnerable/At-Risk Populations in the Community**

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| | **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** |
|---|---|
| 10 | • Dental services for nursing home residents is unobtainable due to lack of facilities that can accommodate wheelchairs and lack of payment.<br>• Psych services for pain management has been lacking for years in this area.<br>• 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. |
| 11 | • Elderly population |
| 12 | • Elderly/Aged<br>• Mental Health<br>• Physical and Developmental Disabilities |
| 13 | • 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. |
| 14 | • Homeless |
| 15 | • Homeless and PORT participants.<br>• Senior population.<br>• All groups have limited resources and transportation to get the services. |
| 16 | • Homeless families |
| 17 | • Uninsured/underinsured. |
| 18 | • I have moved here so recently, I'm not sure that I could accurately comment. |
| 19 | • Indigents, individuals with no insurance or poor plans<br>• Geriatrics |
| 20 | • Individuals in a poverty situation |
| 21 | • Low Income |
| 22 | • Low income populations, both elderly and transient<br>• Uninsured residents |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
|---|---|
| *Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for one or more Riverside facilities. 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 Riverside Peninsula market facilities' study regions (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.* | |
| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 23 | • Low income teenagers |
| 24 | • Low income<br>• Older adults with frailty and ability to live at home independently |
| 25 | • Low income, seniors with limited income<br>• Single adults with no children<br>• Mobile home dwellers<br>• Families living in hotels |
| 26 | • Low income<br>• Smokers<br>• Drug abusers<br>• Obesity patients<br>• Elderly |
| 27 | • Low income<br>• Uneducated<br>• Mentally disabled(ill) population |
| 28 | • Low socio-economic groups |
| 29 | • Lower income and elderly populations<br>• 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. |
| 30 | • Lower socioeconomic populations are at higher risk for developing obesity and the related comorbidities. |
| 31 | • Low-income and seasonally employed persons face significant challenges to securing affordable health insurance and therefore preventive health care including mental health care. |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
|---|---|
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| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 32 | • Many older individuals are in need of safe, affordable housing and lack transportation resources to enable them to access health care.<br>• Health care providers also need to become more aware of the importance of social determinants in achieving successful health outcomes long term. |
| 33 | • 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 |
| 34 | • MCD/MCR/Duals<br>• Behavioral Health<br>• Frail and Elderly |
| 35 | • Mental health screenings and inpatient services |
| 36 | • Mental health<br>• Elderly<br>• Disabled |
| 37 | • Mostly unemployed people<br>• Those with health insurance being unable to get their medications or tests completed. |
| 38 | • Non-English speaking residents<br>• Mental health patients<br>• Substance abuse |
| 39 | • People living in poverty especially children<br>• Seniors living alone |
| 40 | • 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. |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
|---|---|
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| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 41 | • People with disabilities face inadequate access to dental care and transportation challenges in accessing health care. |
| 42 | • Unemployed or under-employed;<br>• [Those residents] having few or no transportation resources;<br>• [Those residents] living in low-income environmentally unsafe housing<br>• Limited literacy (including English speakers).<br>• A number of vulnerable people fall into more than one of these categories. |
| 43 | • Residents living at or below the poverty level. |
| 44 | • Senior citizens living alone<br>• Families in economically deprived communities |
| 45 | • Senior citizens<br>• Children<br>• Infants |
| 46 | • Seniors<br>• Lower income |
| 47 | • Seniors-especially those who no longer drive [and/or] have no family nearby. |
| 48 | • 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. |
| 49 | • Teens<br>• Homeless |
| 50 | • 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. |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
|---|---|
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| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 51 | • The elderly<br>• Those patients with mental health issues |
| 52 | • The financially disadvantaged |
| 53 | • The homeless<br>• The elderly |
| 54 | • The lower income population<br>• Residents who speak English as a 2nd language |
| 55 | • The metro system in our area is poor. This means that individual would have a difficult time getting back and forth to doctor appointments. |
| 56 | • The people most at risk in our community are the poor/underinsured.<br>• Obesity is a growing epidemic and no one is treating it, the result is increased demands on a healthcare system that is already over taxed. |
| 57 | • The poor<br>• Elderly |
| 58 | • The poor<br>• 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. |
| 59 | • The under-employed/unemployed<br>• Homeless<br>• Minority immigrant population<br>• Dementia / Alzheimer patients without a family support group. |
| 60 | • The underinsured and uninsured |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
|---|---|
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| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 61 | • 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. |
| 62 | • The uninsured patients who I see as outpatients still have difficulty with access to diagnostic testing, as opposed to inpatients who generally can have any study done. As you know, this is not unique to our area. |
| 63 | • The uninsured population continues to present challenges due to decreased access to affordable ongoing care and medication assistance in a timely manner.<br>• The drug addiction issue seems to be escalating rapidly with pain med overutilization and heroin addictions. |
| 64 | • The very elderly<br>• Very poor |
| 65 | • Those suffering from mental health problems and/or homeless. |
| 66 | • Underinsured/uninsured. |
| 67 | • Uninsured/underinsured populations<br>• Elderly<br>• Mentally ill and disabled-as well as their caregivers<br>• Children<br>• Young adults |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
|---|---|
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| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 68 | • 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. |
| 69 | • Uninsured with mental illness. There seems to be a large population of uninsured psychiatric patients and not enough services to go around. |
| 70 | • Uninsured<br>• Indigent<br>• Those with chronic conditions who are unable to obtain primary care |
| 71 | • Uninsured/underinsured<br>• Anyone with a 2K+ deductible<br>• Homeless<br>• Elderly with no family |
| 72 | • Uninsured<br>• working poor<br>• Those below the poverty line (income)<br>• Elderly |
| 73 | • Urban areas that have residents that fall into the Medicaid gap. |
| 74 | • Veterans<br>• Elderly |
| 75 | • Working aged people who are not working |

| Exhibit B1. Vulnerable/At-Risk Populations in the Community | |
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| **Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties obtaining health services?** | |
| 76 | • Yes, many lower income households do not go to the doctor or take their meds putting them at greater risk for health problems. |
| 77 | • Homeless<br>• Mentally Ill<br>• Low income |
| 78 | • Young black males<br>• Poor families<br>• The mentally ill |
| 79 | • Young women with cancer- especially breast cancer |

| Exhibit B2. Vulnerable/At-Risk Regions in the Community | |
|---|---|
| *Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for one or more Riverside facilities. 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 Riverside Peninsula market facilities' study regions (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C 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 | • All of the areas in my service area that are listed as MUA's - medically underserved and HPSA's. |
| 2 | • All of the very low economic census tracts in Hampton, and Newport News. |
| 3 | • All the lower SES neighborhoods. |
| 4 | • Many of our neighborhoods have so many homeless, low budget hotels |
| 5 | • Any place where the population is impoverished. |
| 6 | • Areas in Newport News and Hampton |
| 7 | • PCPs from Brentwood and Mercury West describe this the most |
| 8 | • Buckroe / Phoebus areas |
| 9 | • Census tracts: 502.4, 505, 506 Lackey area of York County |
| 10 | • Downtown area on Newport News |
| 11 | • 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. |
| 12 | • Downtown Newport News and pockets in the Denbigh section. Gang violence is now affecting the health of the population in Newport News. With the breakdown of the family unit, support systems have eroded. |
| 13 | • East End Newport News community |

| Exhibit B2. 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?** | |
| 14 | • Grove |
| 15 | • Grove<br>• Chickahominy Road<br>• Other low income areas |
| 16 | • Grove<br>• East End of Newport News for cancer screenings like mammograms |
| 17 | • Grove<br>• Lackey<br>• Chickahominy Road<br>• Centerville Road<br>• Any place in York County that have limited access to public transportation |
| 18 | • Hampton/Newport News |
| 19 | • 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. |
| 20 | • Lackey<br>• Grove |
| 21 | • 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, e.g., Grove area, Chickahominy Haven. |
| 22 | • Low income, and those who are caught in between - making too much for Medicaid, but can't afford Obama care. |

| Exhibit B2. 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?** | |
| 23 | • Lower income |
| 24 | • Lower income areas |
| 25 | • Lower Newport News |
| 26 | • Newport News<br>• Rural areas with less supports |
| 27 | • Newport News<br>• Hampton |
| 28 | • Newport News residents |
| 29 | • Nursing homes<br>• Long term health care facilities<br>• Southeast Community<br>• Northwest Community (Denbigh) |
| 30 | • Residents in the East-end of Newport News<br>• Residents of the rural areas of Isle of Wight County<br>• Parts of Downtown Hampton, particularly ZIP code 23661 |
| 31 | • Southeast Newport News |
| 32 | • Southeast Newport News<br>• Sections of Hampton |
| 33 | • Southeast Newport News<br>• Upper Newport News<br>• Lackey area of York County |
| 34 | • Southeast portion of Newport News |

| Exhibit B2. 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?** | |
| 35 | • Southeastern area of Newport News |
| 36 | • Southwest Newport News |
| 37 | • The areas that are underserved tend to be those with lower socioeconomic status. |
| 38 | • The east and north ends of the city have more elderly and low-income individuals. |
| 39 | • The east end of Newport News |
| 40 | • 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 | • 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. |
| 42 | • East End in Newport News<br>• North End in York |
| 43 | • 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.<br>• 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.<br>• 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) |

| Exhibit B2. 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?** | |
| 44 | • Downtown Newport News<br>• Hampton |
| 45 | • Downtown Newport News<br>• South of Mercury Blvd |

| Exhibit B3. Health Assets in the Community | |
|---|---|
| *Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for one or more Riverside facilities. 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 Riverside Peninsula market facilities' study regions (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C 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 | • 3 health networks |
| 2 | • A place where wild life can be protected |
| 3 | • A very strong and supportive community of health care workers. |
| 4 | • AA<br>• Al Anon<br>• Capital Trail<br>• Freedom Park |
| 5 | • Any walking/biking trail. |
| 6 | • Bike paths<br>• Walking trails |
| 7 | • Bike trails<br>• Walking trails |
| 8 | • Boo Williams<br>• Noland Trail |
| 9 | • Built and Natural resources<br>• Programs (obesity, diabetic management) |
| 10 | • CHKD for kids--but they cannot do it all<br>• Children and families need more safe places to play<br>• Parents need places to learn about how to be a parent<br>• We need more full service grocery stores in low income areas to improve access to healthy food |
| 11 | • Church<br>• People |
| 12 | • Clean air and water<br>• Recreational opportunities |

| Exhibit B3. 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?** | |
| 13 | • Clinics<br>• Hospitals |
| 14 | • Community Health Foundation<br>• Community pools<br>• Jamestown Beach, VA<br>• Cooperative Extension programs<br>• Beyond Boobs!<br>• Erase the Need<br>• Nonprofit community organizations |
| 15 | • Dietary/exercise/weight control/lifestyle counseling for uninsured/indigent populations. It seems the lower socioeconomic status patients are most times the least healthy, making poor lifestyle decisions regarding their health. |
| 16 | • 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. |
| 17 | • FQHC<br>• Free Clinics |
| 18 | • Free clinics<br>• Great hospitals,<br>• Nonprofit health organizations (CDR, Beyond Boobs!, free clinics)<br>• Cancer medical professionals and facilities<br>• YMCAs and Rec centers. |

| Exhibit B3. Health Assets in the Community | |
|---|---|
| *Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for one or more Riverside facilities. 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 Riverside Peninsula market facilities' study regions (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C 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?** | |
| 19 | • Hospital systems<br>• Health department<br>• Social services<br>• Community centers<br>• YMCA<br>• Parks and Recreation<br>• School system<br>• Day care and after school programs<br>• Buckroe beach<br>• Community and civic organizations |
| 20 | • Hospitals<br>• Health care systems<br>• Schools |
| 21 | • Hospitals<br>• Hospice Care |
| 22 | • Hospitals<br>• Urgent Care facilities<br>• Mental and Behavioral Health Care facilities<br>• Parks<br>• Beaches<br>• Outdoor and Indoor entertainment areas. |
| 23 | • I think that the insured have great access to healthcare resources as well as healthy lifestyle resources. |
| 24 | • In general, we have good medical providers.<br>• We also have access to many public parks and recreation activities that promote wellness |

| Exhibit B3. 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?** | |
| 25 | • Local hospitals<br>• Free clinics<br>• Human service programs that address and support health and mental health issues. |
| 26 | • Local Parks & Rec programs<br>• Area health systems<br>• AAA's<br>• Local food bank |
| 27 | • Medical Professionals<br>• Walking Trails<br>• Hospitals |
| 28 | • Medical specialists to serve a growing aging population<br>• Walking and biking trails. |
| 29 | • Mental health agencies that can provide care to those within the home. |
| 30 | • People<br>• Community programs<br>• Primary, secondary, and tertiary healthcare. |
| 31 | • Multiple beaches and parks are available |
| 32 | • Strong network of safety-net healthcare clinics, but are only serving approximately one-third of people with no health insurance. |

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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?** | |
| 33 | • Newport News Park<br>• Noland Trail<br>• Sandy Bottom<br>• Gosnold Park<br>• Old Sentara Fitness trail<br>• These are great resources within the community that can be utilized by residents to promote fitness and leisurely fun. |
| 34 | • Noland trail |
| 35 | • Noland Trail/Mariners Museum<br>• Newport News City Park<br>• Huntington Beach/Park<br>• Riverside Health System<br>• Getting more wide sidewalks for bikes and bike trails<br>• Community Free clinic<br>• Peninsula on Aging |
| 36 | • Noland<br>• Sidewalks<br>• Street lights<br>• Green spaces |
| 37 | • Noland Trail<br>• Matteson Trail |

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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?** | |
| 38 | • Noland Trail/Lion Bridge Newport News<br>• Bike Trail<br>• YMCA<br>• Riverview Park Walking Trail<br>• Huntington Park<br>• Riverside Wellness and Fitness Centers<br>• 3K & 5K Walk Run Marathon events |
| 39 | • Open areas<br>• Walking trails |
| 40 | • Open, recreational spaces<br>• Bike trails |
| 41 | • Outdoor recreation opportunities<br>• Public and private gyms<br>• Community centers |
| 42 | • Outdoor safe walking and biking trails |
| 43 | • Parish thrift shop and food pantry<br>• EMS services<br>• Health screenings and flu shots<br>• Red Cross blood drives |
| 44 | • Parks |
| 45 | • Parks<br>• Beaches |
| 46 | • Parks<br>• Events |

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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?** | |
| 47 | • Parks<br>• Wellness centers<br>• Beaches<br>• Libraries<br>• Churches who house peer support groups or other community health activities |
| 48 | • Peer pressure<br>• Community expectations<br>• Word of mouth |
| 49 | • Peninsula Agency on Aging's programs, esp. Eastern Virginia Care Transitions Program, Chronic Disease Self-Management, Matter of Balance.<br>• For youth-the SHIP programs<br>• Easier access to safe biking routes, share the road enforcement. |
| 50 | • People- the ones with the most impact on patients as far as prevention and treatment of obesity are PCPs and they don't have enough time to do obesity counseling and appropriate referrals |
| 51 | • People<br>• Long term services and supports (underfunded)<br>• Institutions<br>• Public Health - underfunded |
| 52 | • People<br>• Available programs<br>• Natural resources |

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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?** | |
| 53 | • People<br>• Health education programs<br>• Support groups,<br>• Stronger push on health risks for smokers in the younger population and ETOH / drug abuse / addiction |
| 54 | • People<br>• Programs |
| 55 | • Preventive health education<br>• Nutrition education<br>• Culture of wellness.<br>• Unfortunately, if you are not in the "well" group and are older than the services become more scarce. |
| 56 | • Primary care<br>• Acute care<br>• Emergency care<br>• Specialty care readily available and accessible<br>• Schools<br>• Parks<br>• Trails<br>• Organizations that promote a culture of health and provide access to and motivational incentives for healthy lifestyles. |
| 57 | • Professionals<br>• Hospitals<br>• Clinics<br>• Natural environment |
| 58 | • Programs to help people stay in their homes when they are ill or disabled. |

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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?** | |
| 59 | • Quality Care (Riverside/Sentara) |
| 60 | • Quality hospital systems<br>• Public parks/beaches<br>• Foodbank<br>• CINCH |
| 61 | • Riverside Health System<br>• Riverside and Sentara Wellness Centers<br>• YMCA<br>• Noland Trail<br>• Newport News Park |
| 62 | • Riverview park<br>• Mariners museum<br>• Noland trail<br>• Yorktown beaches |
| 63 | • Sidewalks so people can walk; not the trails, they lead nowhere! |
| 64 | • Strong competent physician and nursing staffs |
| 65 | • The elderly tend to be uninsured or not insured enough. They tend to not seek medical care because<br>of out of the pocket expense until they are so sick that someone else has to make the decisions for them. |
| 66 | • The integrated assets of Riverside Health System and Sentara<br>• HU's Proton Therapy Center<br>• Grafton and Southeast NN Clinics<br>• NN parks and Noland Trail<br>• Peninsula Public Health<br>• PACE |

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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?** | |
| 67 | • The parks of Newport News |
| 68 | • The two health systems<br>• Senior living communities |
| 69 | • 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. |
| 70 | • 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. |
| 71 | • This is a beautiful area, we have lots of parks and beaches, museums.<br>• 2 major hospitals that are an asset to the community.<br>• A Community Services Board that is the 2nd largest in the state and has a full continuum of services. |
| 72 | • Trails<br>• There are many parks as well. |
| 73 | • Two hospitals<br>• Old Towne Med Centre<br>• Health provider volunteers |
| 74 | • Two hospitals<br>• Miles of bike trails<br>• Several good parks for those who can get there<br>• Recent efforts to install sidewalks<br>• Network of safety net clinics |

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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?** | |
| 75 | • Walking and biking trails<br>• Organized activities that are close to neighborhoods that may help mitigate isolation among the elderly and those dealing with depression. |
| 76 | • Walking trail<br>• Walking trails all over town.<br>• Many senior programs at the library |
| 77 | • Walking trails<br>• Parks<br>• If our area were more 'walkable' it may help to curb some of the health issues our residents are facing. |
| 78 | • Walking trails<br>• Programs like mall walk |
| 79 | • Walking trails<br>• Affordable water aerobic facilities |
| 80 | • We live in beautiful communities but people are fearful to use the many trails or natural areas due to crime.<br>• 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.<br>• Create a climate that affects safety; when growing up we were able to go anywhere and feel safe, this is not the case anymore. |
| 81 | • Wellness Centers.<br>• Athletic programs associated with educational facilities at all levels.<br>• Chronic disease self-management programs. |

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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?** | |
| 82 | • YMCA and similar facilities |

| Exhibit B4. Health Assets Needed in the Community | |
|---|---|
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| **Are there any health assets that the community needs, but may be lacking?** | |
| 1 | • A better system of walking, running, biking trails. |
| 2 | • A chronic pain treatment center |
| 3 | • Access to care is a huge issue- availability of substance abuse treatment. |
| 4 | • Access to gyms and practice time for public school student athletes. |
| 5 | • Access to specialty care and transportation is a barrier. |
| 6 | • Adequate transportation to access resources.<br>• Access to safe, affordable, housing |
| 7 | • Affordable fitness centers, especially low cost options for seniors at the rec centers that allow them access to all programs during less busy times. |
| 8 | • Affordable public transportation with a set schedule and routes<br>• Additional access to safety-net healthcare and the means to publicize this.<br>• Health insurance that would become available through the state expanding Medicaid. |
| 9 | • All need a better job at getting their message out to the public. |
| 10 | • Behavioral Health is our most pressing need. |
| 11 | • Better access to mental health care for children and low-income populations. |
| 12 | • Better Mental Health Services |
| 13 | • Better transportation options |
| 14 | • Better transportation<br>• More dental health availability<br>• More specialty health services<br>• More translators at health providers for those who do not speak English well. |

| Exhibit B4. Health Assets Needed in the Community | |
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| **Are there any health assets that the community needs, but may be lacking?** | |
| 15 | • 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. |
| 16 | • Chain grocery stores for low income areas - one is coming soon to the East End area of Newport News after many years of advocacy. |
| 17 | • Connecting walking/bike trails (to get to downtown Hampton, safe routes to school, etc.)<br>• Increased access to healthy, affordable foods (Farmers markets, grocery stores) |
| 18 | • Efficient public transportation<br>• Food access in the several food deserts<br>• Safe and affordable housing |
| 19 | • Elderly care specifically assisted living<br>• home health care options<br>• Long term [care] |
| 20 | • ETOH and drug abuse programs for the younger population (18 - 30), including mental health. |
| 21 | • Free or reasonable cost health clinics.<br>• More walking trails. |
| 22 | • Greater mental health services |
| 23 | • Homeless services are minimal |
| 24 | • Hospice and/or palliative care facility |
| 25 | • Hospice inpatient facilities |
| 26 | • 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. |
| 27 | • I would like to see free smoking cessation classes offered by both Riverside and Sentara in every community. |

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| **Are there any health assets that the community needs, but may be lacking?** | |
| 28 | • Invest in upgrading Newport News park with quality<br>• Provide more family shelters and playground equipment<br>• Provide quality bikes for guest to ride in Newport News Park.<br>• Provide low cost classes for families on diabetes, kidney disease, mental illness and high blood pressure training and education. |
| 29 | • Lacking primary care access |
| 30 | • Long term health care in the home |
| 31 | • Lower cost to access the community rec centers. indigent people cannot afford to go to any type of gym |
| 32 | • 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. |
| 33 | • Mental health (improving) |
| 34 | • Mental health services and professionals are in too short supply |
| 35 | • Mental health services, substance abuse counselors |
| 36 | • More bike paths, funding for all the nonprofits doing health related work, older citizens health activities like Thai Chi classes, etc. in the parks |
| 37 | • More Eye surgeons, affordable facilities for indoor exercise and work out equipment. |
| 38 | • More indoor walking facilities |
| 39 | • More long term services and supports that allow aging in place<br>• Dementia care resources<br>• Chronic Disease Self-Management Programs<br>• Geriatric and Palliative care medicine resources |

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| **Are there any health assets that the community needs, but may be lacking?** | |
| 40 | • More Medicaid Waivers so people with disabilities have resources to access services<br>• Handicapped Transportation to access health assets<br>• Respite care<br>• Dentists qualified and willing to treat people with disabilities and accept Medicaid<br>• Autism-specific care and supports<br>• More choices of insurance companies to ensure competition |
| 41 | • More mental health and substance abuse counseling |
| 42 | • More resources and time in our public schools dedicated to health. |
| 43 | • Need more dental "clinic" options. There is PORT for winter months for homeless but nothing for summer months that I know of. |
| 44 | • 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. |
| 45 | • 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). |
| 46 | • Outpatient mental health / psychiatry services capable of seeing volume of patients in need |
| 47 | • Pedestrian friendly environments which encourage people to walk to work, shop, entertainment. Lack of pedestrian amenities encourage use of cars for short travel distances. |
| 48 | • Preservation for wild life |
| 49 | • 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. |
| 50 | • Regular preventive health care so that the first responders and hospitals are not overwhelmed with non-emergency calls. |

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| **Are there any health assets that the community needs, but may be lacking?** | |
| 51 | • 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. |
| 52 | • Safe walking trails; better/more public transportation. Middle age and older fitness experts/leaders. |
| 53 | • Access to health care services through schools in rural areas<br>Affordable and timely Alcohol, substance abuse treatment and prevention and behavioral health services<br>Care navigation and case management for all who desire it regardless of disease state,<br>• Age or insurance status |
| 54 | • Sidewalks, streetlights, bike paths. |
| 55 | • Specialized senior services clinical care centers<br>• physician offices devoted to the care of seniors |
| 56 | • 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. |
| 57 | • Transportation<br>• Advocacy for the very elderly and weak patients |
| 58 | • 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. |
| 59 | • We would benefit from more specialists in certain areas to avoid delays in care, especially neurology and pain management |
| 60 | • Yes, agencies are out there but more community partnerships are needed. |
| 61 | • York County doesn't have bus services to transport individuals to doctor appointments or other activities. |

| Exhibit B5. Additional Ideas and Suggestions | |
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| **Optional: Please use the space below to share any additional ideas or suggestions for improving community health.** | |
| 1 | • Access to medications via community hospitals via outpatient pharmacies that can supply generic medications at cost or just above costs to insure assess to medications post hospitalizations and f/u with primary care physicians. |
| 2 | • Access to specialty care<br>• Transportation issues and congested traffic is a barrier to care |
| 3 | • Additional crime prevention to lower the number of individuals who are killed or injured through gun violence. It seems to be getting worse. |
| 4 | • Affordable extracurricular activities for children especially in the summer<br>• Increased educational opportunities<br>• Affordable gym membership for needy families |
| 5 | • Bariatric surgery coverage for Riverside employees. It is hard to show the benefits of a program if we don't even offer it to our own employees.<br>• We also need a Medical weight loss program. |
| 6 | • Better coordination of home health follow-up services, integrated medical records |
| 7 | • 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! |
| 8 | • Can someone please honestly explain why patients we've been taking care of for years that have Sentara Optima insurance can no longer be cared for by Riverside doctors? And yet I get called several times a month by Sentara doctors seeking my advice. [This] doesn't sit well with patients nor physicians. Is that in the best interests of the community??? |
| 9 | • Community partnership and fellowship |
| 10 | • Consider taking the resources to where the people are instead of the people having to come to the resources |
| 11 | • Doctors and their staffs should work for their patients. |
| 12 | • Engage the public sector, the educational community, and the business community at a higher level to encourage collaboration to address the social determinants |
| 13 | • Find a way to end competition between two health systems and combine resources to provide better coverage for both facilities in this area. |

| Exhibit B5. Additional Ideas and Suggestions | |
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| **Optional: Please use the space below to share any additional ideas or suggestions for improving community health.** | |
| 14 | • Free health screening programs for all age groups. |
| 15 | • Get rid of cigarettes sales<br>• Only healthy foods in schools-cheap but healthy meals for kids in schools. |
| 16 | • Have free/people volunteer their time in exchange for use of the rec centers. |
| 17 | • Hospitals, FQHC's and private providers must work together to provide overall health care services and coverage for all - uninsured, underinsured and insured. |
| 18 | • 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. |
| 19 | • I would encourage health systems to promote population health by striking a balance between clinical care and utilization of non-clinical supports and services. |
| 20 | • Improving access to obtaining medications I believe is a big problem amongst patients. |
| 21 | • 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.) |
| 22 | • Innovative public transportation solutions to reduce current and future air pollution until electric cars are widespread<br>• Local tax credits to encourage use of hybrid /electric vehicles. |
| 23 | • 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. |
| 24 | • 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. |
| 25 | • More community outreach like the caravan that Bon Secours does in their service areas. That would be great in our area of a more spread out population in James City County, New Kent and the lower income population. Staff [the caravan] w/ NPs and volunteers.<br>• Educate Health Wellness Educators within this population. See / Visit Cross Over Clinic in Richmond - they have a great model.<br>The large Hispanic population (growing quickly) need care too! |
| 26 | • More health education resources |

| Exhibit B5. Additional Ideas and Suggestions | |
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| | |
| **Optional: Please use the space below to share any additional ideas or suggestions for improving community health.** | |
| 27 | • More resources are needed to support residents that are economically marginalized, particularly around general health care and dental services. |
| 28 | • Need to be prepared for rapidly growing older senior population (those 75 and older). |
| 29 | • Organize more health fairs/primary/specialty care in areas of low income and economically underserved.<br>• More job training for unemployed<br>• Drug testing for persons getting public assistance of any kind then drug rehab if positive screening<br>• More Behavior health resources-expand CSB resources through increased funding or outsourcing to private resources.<br>• Inpatient detox programs. |
| 30 | • Place greater resources (and advocate for reimbursement mechanisms) that support health education (nutrition & physical activity support), self-management support (particularly for the prevention and management of prediabetes, diabetes, obesity, and heart disease), disease prevention, and health promotion. |
| 31 | • Politicians need to invest more heavily in early childhood education services to make them available to all children regardless of ability to pay.<br>• Additionally, parents that lack the ability to parent effectively should have parenting classes more readily available. |
| 32 | • 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. |
| 33 | • Support for emergency preparedness.<br>• Emerging disease such as zika. |
| 34 | • 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. |
| 35 | • 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. |

| Exhibit B5. Additional Ideas and Suggestions | |
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| | |
| **Optional: Please use the space below to share any additional ideas or suggestions for improving community health.** | |
| 36 | • 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. |
| 37 | • Two large community based [organizations] aren't taxed [and] do not provide the community with outpatient mental health services. Doesn't seem possible and still meet the not for profit bar to service the community. |
| 38 | • We need more care facilities after surgery for rehab that are not connected to aging facilities or ill patients. |
| 39 | • We need more free clinics in this area. Health care systems can start the process, but get help from local industry/business for funding.<br>• Transportation is a major issue for lot of patients in getting to medical offices or diagnostic centers. If we can provide inexpensive transportation it will improve medical compliance. |
| 40 | • Workforce development for aging related services across the spectrum from administration to care workers |

Appendix C: Data Sources

| Section | Source |
|---|---|
| **Part I. Community Survey Results** | |
| 1) Community Survey results as shown throughout Part 1. | Community Survey results are based on Community Health Solutions (CHS) analysis of *Community Survey* responses submitted by community stakeholders. The survey was conducted as follows:<br><br>Riverside Health System and Sentara Healthcare worked collaboratively to conduct a joint community stakeholder survey for the following Peninsula region facilities:<br>• Riverside Doctors' Hospital Williamsburg;<br>• Sentara Careplex Hospital;<br>• Sentara Williamsburg Regional Medical Center; and<br>• Riverside Peninsula market facilities (Hampton Roads Specialty Hospital, Riverside Regional Medical Center, and Riverside Rehabilitation Institute).<br><br>The two health systems collaborated on survey-related communications, and developed the survey instrument with technical support from CHS.<br><br>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.<br><br>Riverside Health System and Sentara Health reviewed the name, organization and localities selected for each of the 163 responses, and instructed CHS on the allocation of responses by geographical study region for each of the participating facilities. The summary data and comments in this report are from those respondents who reported that they lived or worked within the facility's study region (although in some cases, respondents also identified communities beyond the study region within their comments). |

| Section | Source |
|---|---|
| **Part II. Community Indicator Profile** | |
| 1) Health Demographic Trend Profile<br>2) Health Demographic Snapshot<br>(also Appendix A. Maps 1-13) | Community Health Solutions analysis of demographic estimates from Alteryx, Inc. (2014 and 2019). Alteryx, Inc., is a commercial vendor of demographic data. Note that demographic estimates may vary from other sources of local demographic indicators. |
| 3) Mortality Profile<br>(also Appendix A. Maps 14-17) | Community Health Solutions analysis of Virginia Department of Health death record data (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. |
| 4) Maternal and Infant Health Profile (also Appendix A. Maps 18-19) | Community Health Solutions analysis of Virginia Department of Health death record data (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. |

| Section | Source |
|---|---|
| 5) Preventable Hospitalization Profile (also Appendix A. Map 20)<br><br>6) Behavioral Health Hospitalization Profile (also Appendix A. Map 21) | Community Health Solutions analysis of hospital discharge data from the Virginia Health Information (VHI) 2013 dataset and demographic estimates from Alteryx, Inc. (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. Data reported are based on the patient's primary diagnosis.<br><br>**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.<br><br>Within the Exhibits, the *All PQI Discharges* 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 www.qualityindicators.ahrq.gov/pqi_overview.htm<br><br>*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.* |

| Section | Source |
|---|---|
| 7) Adult Health Risk Factor Profile (also Appendix A. Maps 22-25) | Estimates of chronic disease and risk behaviors for adults 18+ were produced by Community Health Solutions using:<br><br>• 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<br>• Local demographic estimates from Alteryx, Inc. (2014)<br><br>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 not provided in this report. Because of data limitations, it is not possible to assign specific margins of error or levels of significance to these statistical estimates. |
| 8) Youth Health Risk Factor Profile (also Appendix A. Maps 26) | Estimates of risk behaviors for youth age 14-19 and 10-14 were produced by Community Health Solutions using:<br><br>• 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<br>• Local demographic estimates from Alteryx, Inc. (2014).<br><br>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 not provided in this report. 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. |

| Section | Source |
|---|---|
| 9) Uninsured Profile (also Appendix A. Maps 27-28) | Estimates of uninsured nonelderly age 0-64 were produced by Community Health Solutions using:<br><br>• U.S. Census Bureau Small Area Health Insurance Estimates (2013). For more information, visit: http://www.census.gov/did/www/sahie/data/index.html.<br>• Local demographic estimates from Alteryx, Inc. (2014)<br><br>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. |
| 10) Medically Underserved Profile | Community Health Solutions analysis of U.S. Health Resources and Services Administration data. For more information, visit: http://muafind.hrsa.gov/. |

# Appendix D: Community Survey Recipients

The following organizations were included in the initial survey distribution. The list of those who responded is on page 19. It is possible that not every group received the initial survey due to challenges collecting correct contact information for all of the individuals. In many cases, multiple individuals at an organization were sent the survey. For example, every member of the County Boards of Supervisors were sent the survey. Additionally, every physician, nurse practitioner and physician assistant at Riverside Medical Group was sent a survey.

| Category | Organization | Notes |
|---|---|---|
| **FAITH COMMUNITIES** | • Hospital chaplains<br>• Queen Street Baptist Church, Hampton<br>• Hampton United Methodist Church<br>• Hidenwood Presbyterian Church<br>• Emmanuel Baptist Church<br>• First Baptist Church of Newport News<br>• Gesthemane Baptist Church | These individuals can represent both the needs of the local government as well as representing the input of the broader community, and in some cases the minority populations who attend the place of worship. |
| **CHAMBERS OF COMMERCE, LOCAL BUSINESSES AND CIVIC LEADERS, COMMUNITY ORGANIZATIONS** | • Peninsula Chamber of Commerce<br>• Isle of Wight Chamber of Commerce<br>• York County Chamber of Commerce<br>• Ferguson Corporation<br>• Canon of Virginia<br>• Mariner's Museum<br>• York County Realty<br>• Old Point Bank<br>• Civic Leaders<br>• Bayport Credit Union<br>• Busch Gardens<br>• WM Jordan<br>• PB Mares<br>• Fort Monroe Authority<br>• Newport News Shipbuilding / Huntington Ingalls<br>• Versability Resources<br>• Transitions<br>• Red Cross<br>• Avalon<br>• Beyond Boobs<br>• United Way of Virginia Peninsula<br>• Hampton FAPT<br>• LINK | |
| **PUBLIC HEALTH EXPERTS** | • Peninsula District of the Virginia Department of Health<br>• Isle of Wight / Suffolk District of the Virginia Department of Health<br>• Hampton District of the Virginia Department of Health<br>• Colonial Behavioral Health (Community Services Board)<br>• Hampton Newport News Community Services Board | |

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| **COUNTY / LOCAL GOVERNMENT** | • County Administrator, York County<br>• York County Social Services<br>• York County Board of Supervisors<br>• York County Sherrif<br>• York County Fire Chief<br>• Newport News City Council<br>• Newport News Mayor, Vice Mayor<br>• Newport News City Manager<br>• Newport News Sheriff<br>• Newport News Emergency Services<br>• Newport News EOC<br>• Newport News CERT Program<br>• Newport News Fire Chief, Asst Fire Chief<br>• Newport News EMS<br>• Newport News Human Services<br>• HamptonCityCouncil<br>• Hampton Mayor, Vice Mayor<br>• Hampton City Manager<br>• Hampton Emergency Operations<br>• Hampton Sheriff<br>• Hampton Fire Chief, Asst Fire Chief<br>• Hampton Social Services<br>• Poquoson Mayor, Vice Mayor<br>• Poquoson City Manager<br>• Poquoson City Council<br>• Poquoson Fire Chief<br>• Poquoson EMS<br>• York-Poquoson Dept of Social Services<br>• Smithfield Mayor, Vice Mayor<br>• Smithfield Town Council<br>• Smithfield Chief of Police<br>• Smithfield Fire Chief<br>• Isle of Wight County Board of Supervisors<br>• Isle of Wight County Interim Administrator<br>• Isle of Wight County Emegency Services<br>• Surry County Office on Youth | While sheriffs and first responders may represent public health issues, the intent is for the various representatives on the Boards of Supervisors to present their neighborhoods, including low income and minority members of their communities. |
| **HEALTHCARE ORGANIZATIONS** | • Peninsula Agency on Aging<br>• Lackey Free Clinic<br>• PICH Clinic<br>• Free Clinic – H.E.L.P of Hampton<br>• Community Free Clinic of Newport News<br>• Center for Child and Family Services<br>• Evolve Therapeutic<br>• Christian Therapeutic<br>• National Counseling Group<br>• Divine Behavioral Health Services<br>• Peninsula EMS Council<br>• Riverside Behavioral Health Center<br>• Riverside Rehabilitation Institute<br>• Hampton Roads Specialty Hospital<br>• Riverside Regional Medical Center<br>• Riverside Board Members<br>• RMG Phsyicians & Advances Practice Providers- Peninsula | These organizations work to represent the medically underserved, low income, minority and broad populations across the Peninsula, as well as the health of the local environment on which the local economy is based. |

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| **SCHOOLS** | • Hampton University<br>• Christopher Newport University<br>• York County Public Schools<br>• York County School Board<br>• York County School Superintendent<br>• Newport News Public Schools<br>• School Board, Newport News Public Schools<br>• Newport News Public Schools Superintendent<br>• Hampton City Schools<br>• Hampton City Schools, Superintendent<br>• School Board Members, Hampton City Schools<br>• Poquoson City Schools<br>• Pooquoson School Superintendent<br>• Poquoson School Board Members<br>• Isle of Wight County Schools<br>• Isle of Wigh School Superintendent<br>• Isle of Wight School Board Members | |