Riverside Doctors' Hospital of Williamsburg
2019 Community Health Needs Assessment

This Community Health Needs Assessment and Implementation Strategy for Riverside Doctors' Hospital of Williamsburg was conducted and developed between June 2018 and May 2019 to fulfill the requirements described in section 501(r)(3) of the Internal Revenue Code. It was formally approved and adopted by the Riverside Doctors' Hospital of Williamsburg Board of Directors on September 23, 2019.

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COMMUNITY HEALTH NEEDS ASSESSMENT

Introduction

Riverside Doctors' Hospital of Williamsburg is 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 Doctors' Hospital of Williamsburg 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 view 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 Doctors' Hospital of Williamsburg was conducted between June 2018 and May 2019 in fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code. The data assessment process was conducted by Riverside's Marketing, Strategy and Development Department utilizing publically available information for the health indicator data. The community survey process was done in conjunction with Bon Secours of Hampton Roads, Children's Hospital of the King's Daughters, Sentara Healthcare and multiple local districts of the Virginia Department of Health. Details about the joint survey process are noted in that section of the report.

The CHNA process consisted of four phases: data collection (quantitative), community input (qualitative), analysis and prioritization. The quantitative data is summarized in the first section of this report, and represents a broad assessment of demographic and health indicators. The data sources are noted within each section. The qualitative community input data is summarized in the second section of this report and was gathered through an electronic survey process from October 23, 2018 – December 14, 2018.

Community Served by the Hospital

The community served by Riverside Doctors' Hospital of Williamsburg is a geographic region that covers 14 ZIP codes across the City of Williamsburg, James City County, New Kent County, Charles City County and King William County.

Community Indicators

The community indicators present a wide array of quantitative community health indicators for the study region. To produce the profiles, RHS 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 public data sources. Detailed reviews follow below, but to summarize:

- **Demographic Profile:** As of 2017, the study region included an estimated 134,852 people. The population is expected to increase 10.5% by 2022. Compared to Virginia as a whole, the study region is more educated and older. The study region also has a lower percentage of low income households than Virginia as a whole. These comparative patterns were also seen in the 2011 demographic profile reported in the 2012/2013 CHNA and the 2014 data reported in the 2016 CHNA.

- **Mortality Profile:** In 2016, the study region had 1,205 total deaths. The leading causes of death included unspecified dementia, acute myocardial infarction (heart attack), malignant neoplasms of the lung (lung cancer), Alzheimer's disease and atherosclerotic heart disease. While the crude death rates were higher than the statewide rates in many categories, the age adjusted death rates were much closer to or lower than the rates seen at the state level.

- **Maternal & Infant Health Profile**: In 2016, the study region had 1,260 total live births. Compared to Virginia as a whole, the study region had lower rates of births, births to teens age 18-19 and low weight births as a percent of all births.

- **Behavioral Health Hospitalization Discharge Profile:** Behavioral health (BH) hospitalizations provide another important indicator of community health status. In 2017, residents of the study region had 702 hospital discharges from Virginia community hospitals for behavioral health conditions. The leading diagnosis for these discharges was psychoses. Fatal drug overdoses are down in the service area compared to Virginia as a whole.

- **Health Risk Profile:** Health behaviors have a tremendous impact on the state of a community's health. The service area has higher rates of diabetes and physical inactivity than the Commonwealth as a whole. In New Kent, Charles City and King William counties tend to have varying higher rates of obesity, excessive drinking and smoking. With the exception of Williamsburg City, the service area still has more than 50% of the school children eligible to receive a free lunch and the higher rates of adults facing food insecurity than the Commonwealth. The HIV rate in the service area is significantly lower than Virginia.

- **Uninsured Profile:** At any given point in time in 2016, an estimated 9,328 nonelderly residents of the study region were uninsured. This included an estimated 1,399 children and 7,929 adults. The estimated uninsured rates were 5.2% for children age 0-18, 10.6% for adults age 19-64, and 9.2% for the population age 0-64. The estimated uninsured rate for the population under 65 is generally comparable to the estimated rate in 2011 as reported in the 2012/2013 CHNA and to the 2014 rate reported in 2016.

- **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+. Four of the five localities that overlap with the study region have been designated as MUAs/MUPs. The City of Williamsburg has a designated Medically Underserved Population (MUP). Charles City, King William and New Kent Counties are Medically Underserved Areas (MUAs). James City County is not designated as an MUA or MUP.

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. In order to have the most reliable data, the demographic profile was based on the census projections for Charles City, New Kent, King William and James City Counties and the City of Williamsburg as a whole instead of separating by individual ZIP codes within the cities and counties.

As shown in Exhibit I-A, as of 2017, the study region included an estimated 134,852 people. The total population is projected to increase 10.5% by 2022. Focusing on age groups, growth is anticipated for all age groups. Focusing on racial/ethnic background, growth is projected for all of the listed groups as well. The Hispanic Ethnicity population is expected to grow by 24.8%.

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 I-B presents a snapshot of key health-related demographics of the study region compared to Virginia as a whole. Focusing on population rates, compared to Virginia as a whole, the study region is more educated and has a lower percentage of lower income households than Virginia as a whole. These comparative patterns were also seen in the 2011 demographic profile reported in the 2012/2013 CHNA and in the 2014 profile reported in the 2016 CHNA.

Exhibit I-A
Community Health Demographic Trend Profile, 2010-2022

Exhibit II-1
Health Demographic Trend Profile for the Study Region, 2010-2022

Indicator	2010 Census	2017 Estimate	2022 Projection	% Change 2017- 2022
Total Population	122,693	134,852	148,986	10.5%
Population Density (per Sq. Mile)	137.6	151.3	167.1	10.5%
Total Households	47,178	51,921	57,927	11.6%
Population by Age				
Children Age 0-19	29,491	30,917	32,513	5.2%
Adults Age 19-34	21,724	24,909	28,015	12.5%
Adults Age 35-44	14,951	14,535	15,908	9.5%
Adults Age 45-64	35,370	37,104	38,149	2.8%
Seniors Age 65+	21,158	27,386	34,400	25.6%
Population by Race/Ethnicity				
White	94,520	102,837	112,117	9.0%
Black/African American	19,588	21,209	23,692	11.7%
American Indian or Alaska Native	1,172	1,263	1,374	8.8%
Asian / Native Hawaiian / Other Pacific Islander	2,690	3,491	4,179	19.7%
Some Other Race	1,514	2,009	2,482	23.5%
Two or More Races	3,209	4,043	5,142	27.2%
Hispanic Ethnicity	4,767	6,486	8,093	24.8%

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

Exhibit I-B
Community Health Demographic Snapshot Profile, 2017

Exhibit II-2 Health Demographic Snapshot Profile, 2017			
Indicator		**Study Region**	**Virginia**
Population Counts			
Total Population	Population	134,852	8,453,091
Age	Children Age 0-19	30,917	2,113,825
	Adults Age 19-34	24,909	1,796,873
	Adults Age 35-44	14,535	1,100,177
	Adults Age 45-64	37,104	2,245,888
	Seniors Age 65+	27,386	1,196,328
Sex	Female	69,348	4,294,256
	Male	65,503	4,158,836
Race	White	102,837	5,361,326
	Black	21,209	1,637,782
	American Indian or Alaska Native	1,263	32,518
	Asian / Native Hawaiian / Other Pacific Islander	3,491	554,158
	Some Other Race	2,009	306,572
	Two or More Races	4,043	290,736
Ethnicity	Hispanic Ethnicity	6,486	774,121
Income	Low Income Households (Households with Income < $25,000)	7,309	545,927
Education	Population Age 25+ Without a High School Diploma	8,159	696,580
Population Rates			
Total Population	Population Density (population per sq. mile)	151.3	207.06
Age	Children Age 0-19 percent of Total Population	22.9%	25.0%
	Adults Age 19-34 percent of Total Population	18.5%	21.3%
	Adults Age 35-44 percent of Total Population	10.8%	13.0%
	Adults Age 45-64 percent of Total Population	27.5%	26.6%
	Seniors Age 65+ percent of Total Population	20.3%	14.2%
Sex	Female percent of Total Population	51.4%	50.8%
	Male percent of Total Population	48.6%	49.2%
Race	White percent of Total Population	76.3%	66.6%
	Black percent of Total Population	15.7%	19.4%
	American Indian or Alaska Native percent of Total Population	0.9%	0.4%
	Asian / Native Hawaiian / Other Pacific Islander percent of Total Population	2.6%	6.6%
	Some Other Race percent of Total Population	1.5%	3.6%
	Two or More Races percent of Total Population	3.0%	3.4%
Ethnicity	Hispanic Ethnicity percent of Total Population	4.8%	9.2%
Income	Low Income Households (Households with Income <$25,000) percent of Total Households	14.1%	17.0%
Education	Population Age 25+ Without a High School Diploma percent of Total Population Age 25+	8.7%	12.1%
Note: Hispanic is a classification of ethnicity; therefore, Hispanic individuals are also included in the race categories.			

Mortality Profile

Mortality is one of the most commonly cited community health indicators. As shown in Exhibit I-C in 2016, the study region had 1,205 total deaths. The top five leading causes of death were unspecified dementia (74), acute myocardial infarction (heart attack) (66), malignant neoplasms of the lung or bronchus (lung cancer) (57), Alzheimer's disease (52) and atherosclerotic heart disease (46). Study region crude and age-adjusted death rates per 100,000 are noted below, and they vary by cause of death in their comparison to statewide rates. For example, while the crude death rate per 100,000 was higher than the statewide rate (898.1 vs 790.2), the age adjusted death rate per 100,000 was lower (628.2 vs 715.5). This pattern is seen repeatedly, but for causes of death that include AMI and malignant neoplasms, the age adjusted death rates were worse than statewide rates.

The 2016 mortality profile presented Exhibit I-C is generally comparable to the 2010 mortality profile reported in the 2012/2013 CHNA and the 2013 profile presented in the 2016 CHNA. Please note that the data for the 2013 and 2016 CHNAs was in combined categories, and the data is this analysis is at the sub-category level. When sub-categories are combined, cancer and heart disease continue to be the leading causes of death.

Exhibit I-C
Mortality Profile, 2016

Cause of Death	Study Area (2016)			Virginia (2016)		
	Number of Deaths	Crude Death Rate per 100,000	Age Adjusted Death Rate per 100,000	Number of Deaths	Crude Death Rate per 100,000	Age Adjusted Death Rate per 100,000
All Deaths	1205	898.1	628.2	66,473	790.2	715.5
Unspecified dementia	74	55.2	36.9	3,365	40.0	37.3
Acute myocardial infarction, unspecified	66	49.2	33	2,358	28.0	24.8
Bronchus or lung, unspecified - Malignant neoplasms	57	42.5	28.1	3,727	44.3	38.1
Alzheimer disease, unspecified	52	38.8	25.8	2,363	28.1	26.3
Atherosclerotic heart disease	46	34.3	23.5	2,912	34.6	31.1
Chronic obstructive pulmonary disease, unspecified	36	26.8	17.6	2,528	30.1	27.0
Stroke, not specified as hemorrhage or infarction	30	22.4	15	1,692	20.1	18.5
Malignant neoplasm without specification of site	25	18.6	11.6	831	9.9	8.7
Breast, unspecified - Malignant neoplasms	23	17.1	11.6	1,118	13.3	11.5
Atherosclerotic cardiovascular disease, so described	23	17.1	12	1,075	12.8	11.2
Pancreas, unspecified - Malignant neoplasms	22	16.4	10.2	1,056	12.6	10.8
Congestive heart failure	20	14.9	10.2	1,605	19.1	17.4
Septicemia, unspecified	19	*Unreliable / Number too small to calculate*		1177	114	12.6
Parkinson Disease	19	*Unreliable / Number too small to calculate*		739	8.8	8.3
Malignant neoplasm of prostate	16	*Unreliable / Number too small to calculate*		1,039	12.4	11.3
Unspecified diabetes mellitus without complications	16	*Unreliable / Number too small to calculate*		841	10	8.7
Colon – unspecified, malignant neoplasm	14	*Unreliable / Number too small to calculate*		979	11.6	10.3
Other fall on same level	14	*Unreliable / Number too small to calculate*		837	10.0	10.0
Atrial fibrillation and flutter	13	*Unreliable / Number too small to calculate*		646	7.7	7.1
Pneumonitis due to food and vomit	13	*Unreliable / Number too small to calculate*		599	7.1	6.5

Malignant neoplasm of ovary	11	*Unreliable / Number too small to calculate*	360	4.3	3.7
Aortic (valve) stenosis	10	*Unreliable / Number too small to calculate*	310	3.7	3.4
SOURCE: Internal analysis of data from Centers for Disease Control and Prevention's WONDER online database wonder.cdc.gov					

Maternal and Infant Health Profile

Maternal and infant health indicators are another widely cited category of community health. As shown in Exhibit I-D, the study region had 1,260 total live births in 2016. Compared to Virginia as a whole, the study region had lower birth rates, lower teen birth rates and a lower percentage of low birth weight babies than Virginia as a whole.

Comparing the 2016 profile in Exhibit I-D to the 2010 profile reported in the 2012/2013 CHNA and the 2013 profile reported in the 12016 CHNA, the study region had similar rates for most maternal and infant health indicators.

Exhibit I-D
Maternal and Infant Health Profile, 2016

	Study Area (2016)	Virginia (2016)
Total Live Births	1,260	101,220
Rate of Live Births Per 100,000	9.3	12.2
Total Low Weight Births	86	8,266
Low Weight Birth as Percent of Total Births	6.8%	8.2%
Total Live Births to Teens (age 10-19)	48	4,140
Teenage Birth Rate	5.7	7.9
Live Births to Teens Age <15	1	84
Live Births to Teens Age 15-17	13	1,346
Live Births to Teens Age 18-19	34	4,199
Total Infant Deaths	3	593
Infant Death Rate	2.4	5.8
SOURCE: Internal analysis of data from the Virginia Department of Health www.vdh.gov/HealthStats/stats.htm		

Behavioral Health Hospitalization Discharge Profile

Behavioral health (BH) hospitalizations provide another important indicator of community health status. As shown in Exhibit I-E, residents of the study region had 702 hospital discharges from Virginia community hospitals for behavioral health conditions in 2017. The leading diagnosis for these discharges was psychoses (501). The crude BH discharge rate for the study region (5.21) was 34% below the Virginia rate (7.88).

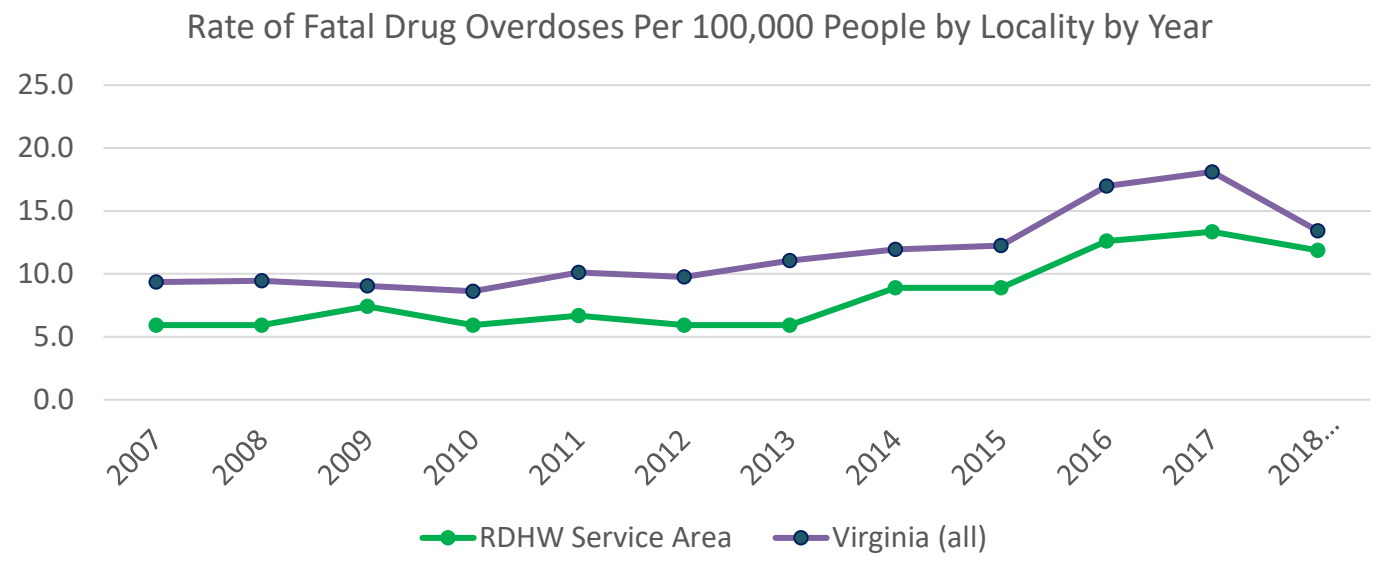
The leading causes of behavioral health hospitalization in 2017 were generally the same as in the 2011 profile reported in the 2012/2013 CHNA and the 2013 profile reported in the 2016 CHNA. A more detailed analysis of ranks and rates between the two study years is not feasible due to changes in diagnostic definitions and other technical factors.

Separate from the inpatient behavioral health admissions, it is important to also note the increase in ED visits from drug overdoses as well as the overall increase in deaths from drug overdoses since the last CHNA that has been seen across the Commonwealth. The Virginia Department of Health reports that Fatal Drug Overdose has been the leading cause of unnatural death in Virginia since 2013 and that opioids have been the driving force in this increase. VDH notes that statewide rural areas face higher deaths from illicit opioids while urban areas have higher impacts from Rx opioids.

Exhibit I-E
Behavioral Health Hospital Discharge Profile, 2017

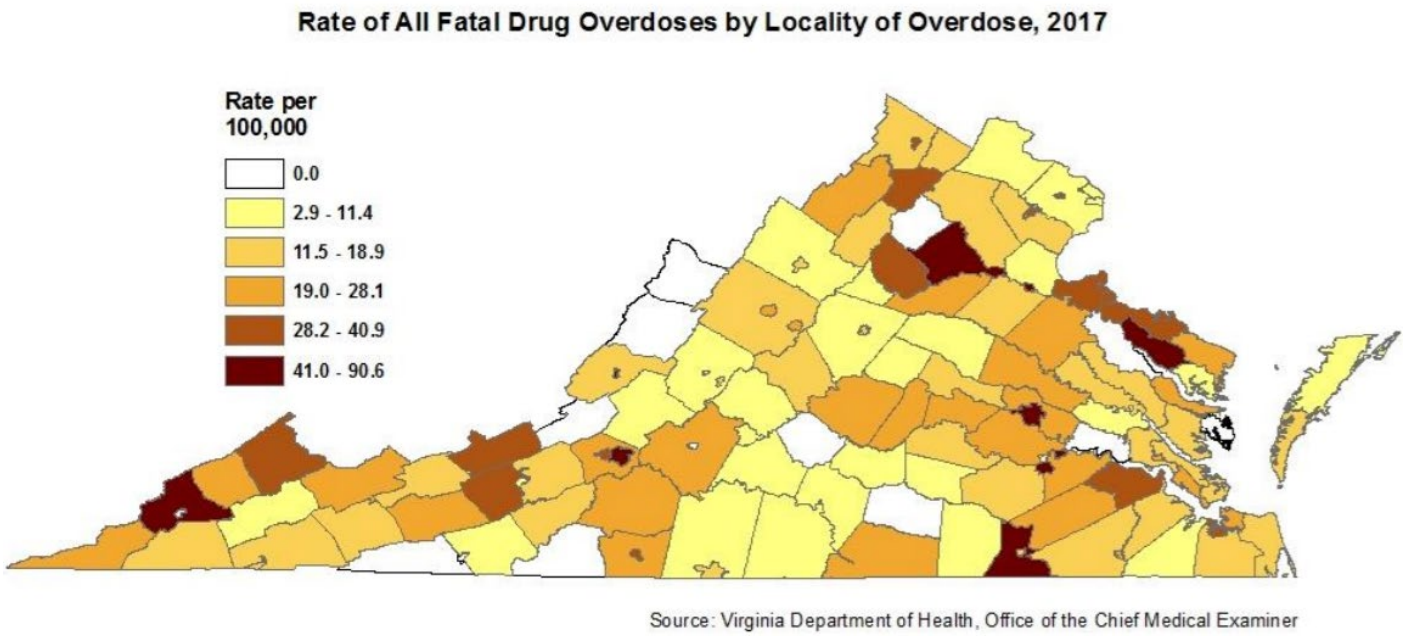
		Service Area Cities & Counties (2017)		Virginia (2017)	
DRG	DRG Description	Number of Inpatient Discharges	Crude Rate per 100,000	Number of Inpatient Discharges	Crude Rate per 100,000
	All inpatient behavioral health discharges	702	5.21	66,640	7.88
880	Acute adjustment reaction & psychosocial dysfunction	9	0.07	1,256	0.15
881	Depressive neuroses	47	0.35	4,737	0.56
882	Neuroses except depressive	23	0.17	2,149	0.25
883	Disorders of personality & impulse control	2	0.01	353	0.04
884	Organic disturbances & mental retardation	21	0.16	1,311	0.16
885	Psychoses	501	3.72	44,837	5.30
886	Behavioral & developmental disorders	3	0.02	334	0.04
887	Other mental disorder diagnoses	2	0.01	58	0.01
894	Alcohol / drug abuse or dependence, left AMA (Against Medical Advice)	4	0.03	844	0.10
895	Alcohol / drug abuse or dependence with rehabilitation therapy		0	873	0.10
896	Alcohol / drug abuse or dependence without rehabilitation therapy with MCC (Major Complicating Condition)	12	0.09	1,084	0.13
897	Alcohol / drug abuse or dependence without rehabilitation therapy without MCC	78	0.58	8,804	1.04
SOURCE: Inpatient Hospital Discharge data from Virginia Health Information (VHI), 2017					

Exhibit 1-F
Rate of Fatal Drug Overdoses per 100,000 (2007 - 2018)



Source: Virginia Department of Health Fatal Drug Overdose Report

Exhibit 1-G
Rate of Fatal Drug Overdoses by Locality of Overdose (2017)



Source: Virginia Department of Health, Office of the Chief Medical Examiner

Health Risk Profile

This section 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 I-H, estimates from 2016 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. The 2016 profile generally reflects the health risk patterns found in 2011 as reported in the 2012/2013 CHNA. Available data are not sufficient to support a more detailed comparative analysis between the study years.

Exhibit I-H
Health Risk Profile, 2016

***Note: This data comes from a wide variety of sources. Most draw from years at least 2-3 years prior. Please note the sources and years for additional context for each measure.**

	Williamsburg City	James City County	New Kent County	Charles City County	King William County	Virginia (All)
Diabetes: % of adults that report having been diagnosed with diabetes						
2013	9.6%	9.8%	10.5%	14.0%	10.0%	9.6%
2016	8.8%	12.5%	15.3%	15.4%	14.2%	9.4%
2019	10.8%	12.5%	14.6%	16.0%	14.8%	10.0%
Obesity: % of adults that report a BMI >= 30						
2013	28.1%	34.1%	29.8%	33.7%	29.9%	28.1%
2016	26.5%	31.0%	35.3%	36.4%	31.1%	27.3%
2019	27.1%	27.5%	29.6%	35.0%	25.9%	28.8%
Excessive Drinking: % of adults that report excessive or binge drinking						
2013			17.8%		21.7%	15.9%
2016	18.1%	14.8%	12.7%	13.1%	12.1%	16.6%
2019	18.6%	16.4%	19.0%	14.2%	18.3%	17.4%
Physical Inactivity: % of adults that report being physically inactive						
2013	23.3%	29.1%	30.5%%	31.6%	31.5%	24.0%
2016	23.2%	28.3%	30.5%%	29.9%	26.3%	22.2%
2019	22.1%	17.1%	23.5%	26.8%	26.5%	21.6%
Food Insecurity: % of adults that report worrying that they will						
2013						
2016	7.1%	12.4%	17.0%	14.2%	13.3%	11.9%
2019	5.2%	12.0%	16.3%	14.8%	12.4%	10.6%
Free School Lunch: % of children eligible to receive free lunch at school						
2013	32.0%	22.3%	17.9%	54.7%	27.5%	30.8%
2016	9.3%	51.0%	67.4%	49.6%	61.1%	32.1%
2019	16.3%	50.8%	71.5%	57.7%	69.4%	41.2%

	Williamsburg	James City County	New Kent County	Charles City County	King William County	Virginia (All)
Smoking: % of adults that smoke						
2013			24.0%			18.3%
2016	15.0%	18.0%	19.7%	19.2%	15.2%	19.5%
2019	16.1%	13.0%	14.3%	17.6%	15.7%	15.3%
HIV Rate: HIV+ Individuals per 100,000 population						
2013	487	54	114	187	44	307
2016	58	180	381	220	219	320
2019	58	192	290	286	264	308
Mammography: % of Female Medicare Enrollees Ages 65-74 That Had a Screening Mammogram (NOTE – changed data source in 2019)						
2013	76.2%	62.9%	69.0%	76.9%	72.1%	66.0%
2016	69.0%	64.0%	72.0%	54.0%	67.0%	63.0%
2019	56.0%	56.0%	48.0%	48.0%	44.0%	43.0%
Mental Health Provider Ratio: The number of Mental Health Providers Population Ratio						
2013	1413:1	935:1	4641:1	3638:1		2216:1
2016	2008:1		932:1	3512:1	920:1	685:1
2019	2147:1	383:1	1856:1	7004:1	1856:1	628:1
Preventable Hospitalizations: Number of Hospital Stays for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees (NOTE: reporting switched from per 1,000 in 2013 & 2016 to per 100,000 in 2019)						
2013	35	64	58	35	25	58
2016	33	45	44	50	23	49
2019	3613	4725	3233	4475	3529	4,454
Violent Crime Rate: The number of violent crimes per 100,000 population						
2013	142	164	165	78	108	233
2016	79	143	147	82	84	200
2019	182	122	146	71	71	207

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 I-I shows the estimated number of uninsured individuals by income in the study region as of 2016. At a given point in time in 2016, an estimated 9,328 nonelderly residents of the study region were uninsured, including 1,399 children and 7,929 adults. The estimated uninsured rates were 5.2% for children age 0-18, 10.6% for adults age 19-64, and 9.2% for the population age 0-64. This is a lower rate in every category than Virginia has as a whole. The estimated uninsured rate for the population under 65 is generally comparable to the estimated rate in 2011 as reported in the 2012/2013 CHNA and the 2014 rate reported in the 2016 CHNA. Available data are not sufficient to support a more detailed comparative analysis between the study years.

Exhibit I-I
Uninsured Profile (Estimates), 2016

	Study Area (2016)		Virginia (2016)	
	Number of Uninsured	% of Total Population In Age Group	Number of Uninsured	% of Total Population In Age Group
Children (Age 0-18)	1,399	5.2%	94,398	4.9%
Adults (Age 19-64)	7,929	10.6%	606,611	11.8%
All Under 65	9,328	9.2%	701,009	9.9%
SOURCE: Urban Institute for the Virginia Health Care Foundation, based on the 2016 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). www.vhcf.org/wp-content/uploads/2018/03/VHCF-Final-Tables-2016-28Feb2018.pdf				

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 I-J, three of the five localities that overlap with the zip code study region have been designated as Medically Underserved Areas (King William, New Kent and Charles City Counties). The City of Williamsburg has a Medically Underserved population designation. James City County does not have MUA or MUP designation. For a more detailed description, visit the U.S. Health Resources and Service Administration designation webpage at http://muafind.hrsa.gov/.

Exhibit I-J
Medically Underserved Areas Profile, 2016

Locality	MUA / MUP Designation	Index of Medical Underservice Score
City of Williamsburg (Low Income)	Medically Underserved Population	49.6
Charles City County	Medically Underserved Area	61.3
James City County	No Designation	
King William County	Medically Underserved Area	56.6
New Kent County	Medically Underserved Area	53.2
SOURCE: United States Health Resources and Service Administration muafind.HRSA.gov		

Community Input

In an effort to obtain community input for the study, a community survey was conducted. This survey data is an important way to ensure the members of the community have a voice in the CHNA, but it is important to note that this is not a representative sample so the input should be considered as qualitative and directional data only. That said, the insight and consistency in responses still proves helpful in prioritizing the issues to address.
Due to the overlap of service areas, a joint survey was developed by the Peninsula Community Health Collaborative (PCHC). The PCHC is comprised of representatives from Bon Secours Hampton Roads, The Children's Hospital of the King's Daughters, Riverside Health System, Sentara Healthcare, local organizations such as the United Way and the Foodbank as well as multiple districts of the Virginia Department of Health.

The survey participants were asked to provide their perspective on:

- Community Health Issues affecting Adults
- Community Health Services for Adults that need to be strengthened
- Community Health Issues affecting Children and Teens
- Community Health Services for Children and Teens that need to be strengthened
- Issues that affect individuals access to care in the community
- Vulnerable populations in the community that need additional services or support
- Community Assets that need to be strengthened

In prior years, response rates to each health system's survey was low, and there had been feedback that people did not like answering multiple surveys that asked basically the same question. In response to this concern, the PCHC allowed the health systems to work together and create a more streamlined approach to garnering community input for the CHNA process.

There were two versions of the survey created, one aimed at key community health stakeholders, leaders and clinicians, and one for the broader community. The stakeholder survey was sent directly to 1,670 identified individuals across southeast Virginia. The invitation was emailed from the Virginia Department of Health and included a letter signed by the CEOs of the four area health systems and the Medical Director of two local health districts. The stakeholders included local leaders in government, law enforcement, education, business, behavioral health, and civic groups as well as clinicians and other community health figures leaders. Additionally, the community survey was promoted on the hospital websites and on social media for the hospitals and health department. Riverside also followed up with a number of individuals personally to ensure their participation in the survey.

The survey was facilitated using SurveyMonkey, and online survey tool. Each survey asked respondents to identify the community they were answering for when they took the survey. This allowed the same survey to be used across multiple regions and for multiple hospitals. Once the survey was closed, each hospital was able to filter the data to only use the responses relevant to their unique service area.

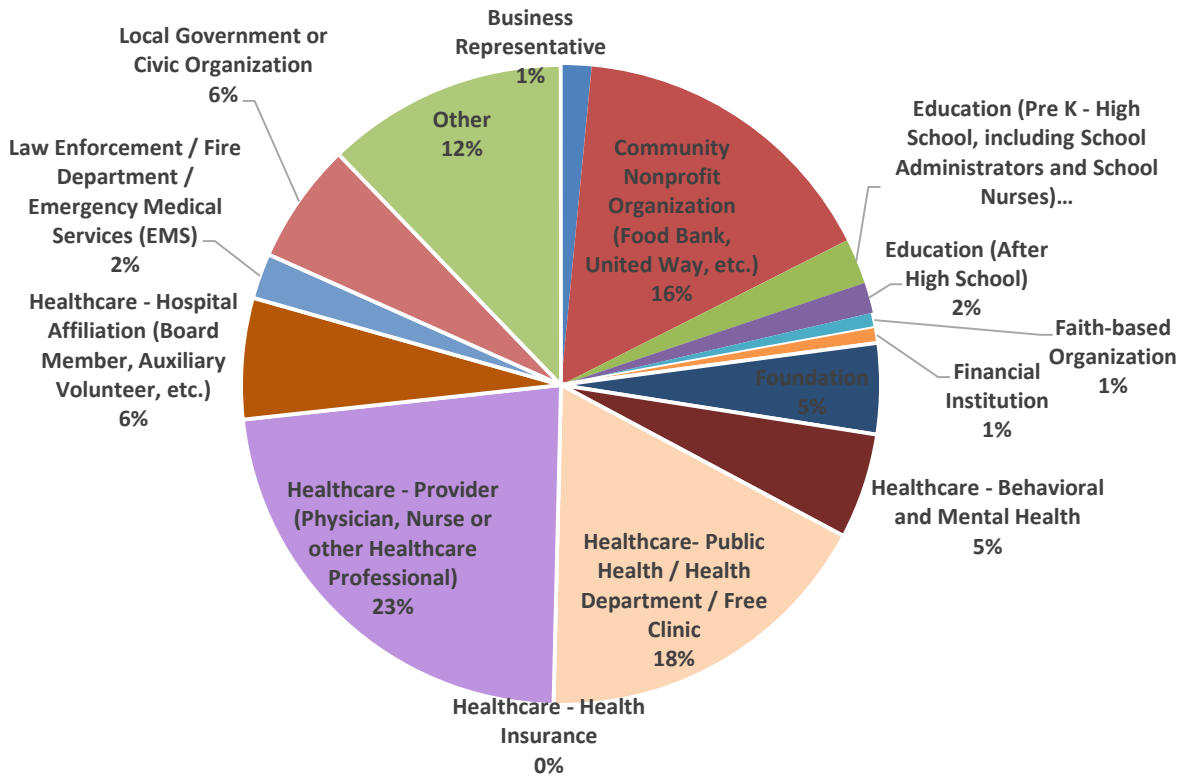
Survey Respondents

The survey was open between October 23, 2018 and December 14, 2018. During that time, 137 respondents completed the stakeholder survey and 22 respondents completed the community survey who identified areas within RDHW's service area as their community. This is a combined response of 159, which is a 39.5% increase over the 114 surveys received in 2016. RDHW attributes the tremendous increase in responses to the unified approach to the survey with the other health systems which decreased survey fatigue for key stakeholders as well as combined the promotional strength of all of the hospitals to grow awareness of and interest in the survey.

Community respondents were not asked to identify their organizational affiliations, but the key stakeholders were asked that question. Where completed, the responses are included in the appendix as written by the respondents. The breakdown of the types of organizations is included in the Exhibit II-A.

Exhibit II-A
Employer Affiliation of Survey Respondents

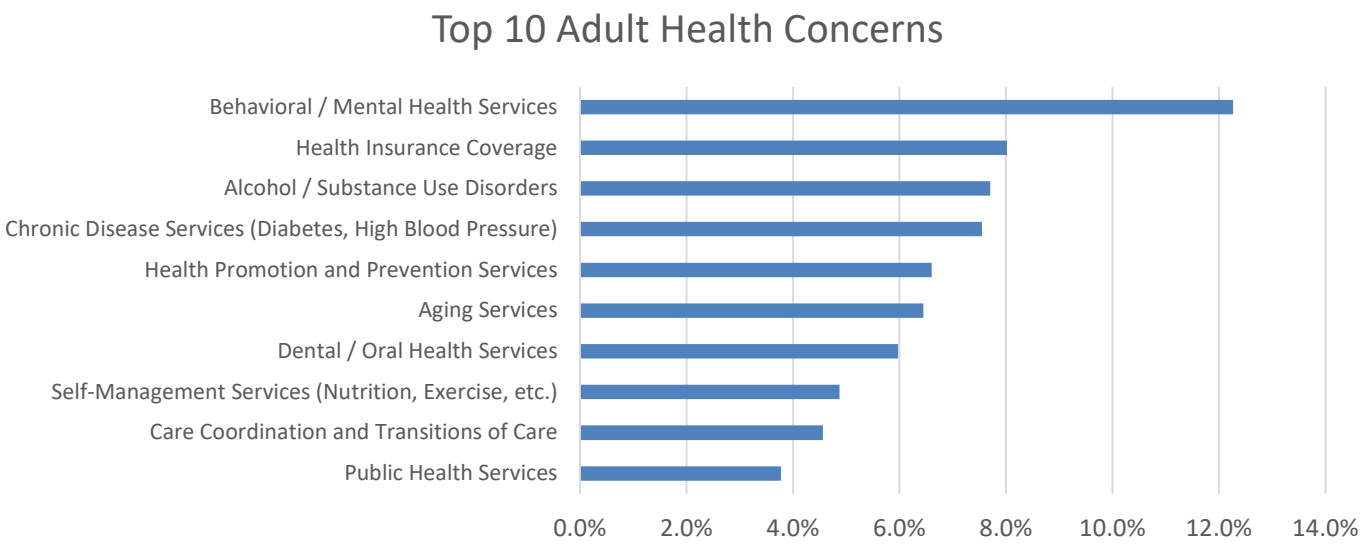
Type of Employer or Organizational Affiliation *(n=122 of 137 respondents)*



Community Health Issues Affecting Adults

Survey respondents were asked to review a list of common community health issues affecting adults aged 18 and over. The list of issues drew from the topics in Healthy People 2020 with some refinements. The survey asked respondents to identify from a provided list up to five issues they viewed as the most important health concerns affecting adults in their community. Respondents were also invited to identify additional issues not already defined on the list. Exhibit II - B shows the ten issues most frequently indicated as being the most important in the community. See **appendix** for all survey responses.

Exhibit II-B
Top Community Health Issues Facing Adults
132 of 159 respondents with up to five priorities each; 655 responses

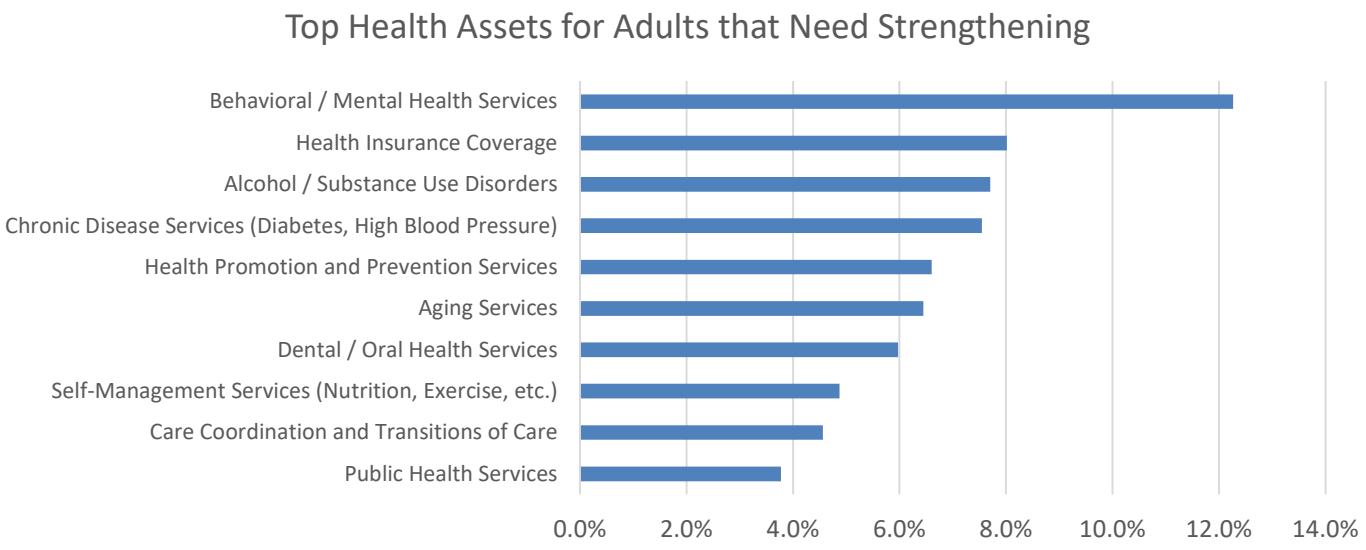


Community Health Services for Adults

Survey respondents were asked to review a list of community services that are typically important for addressing the health needs of adults in a community. Respondents were asked to identify from the list the five services they thought most needed strengthening in their community in terms of availability, access or quality. Respondents were also invited to identify additional service gaps not already defined on the list. Exhibit II - C shows the ten community health services most frequently indicated as being in need of strengthening. See **appendix** for all survey responses.

Exhibit II-C
Top Community Health Services for Adults In Need of Strengthening

129 of 159 respondents with up to five priorities each; 636 responses

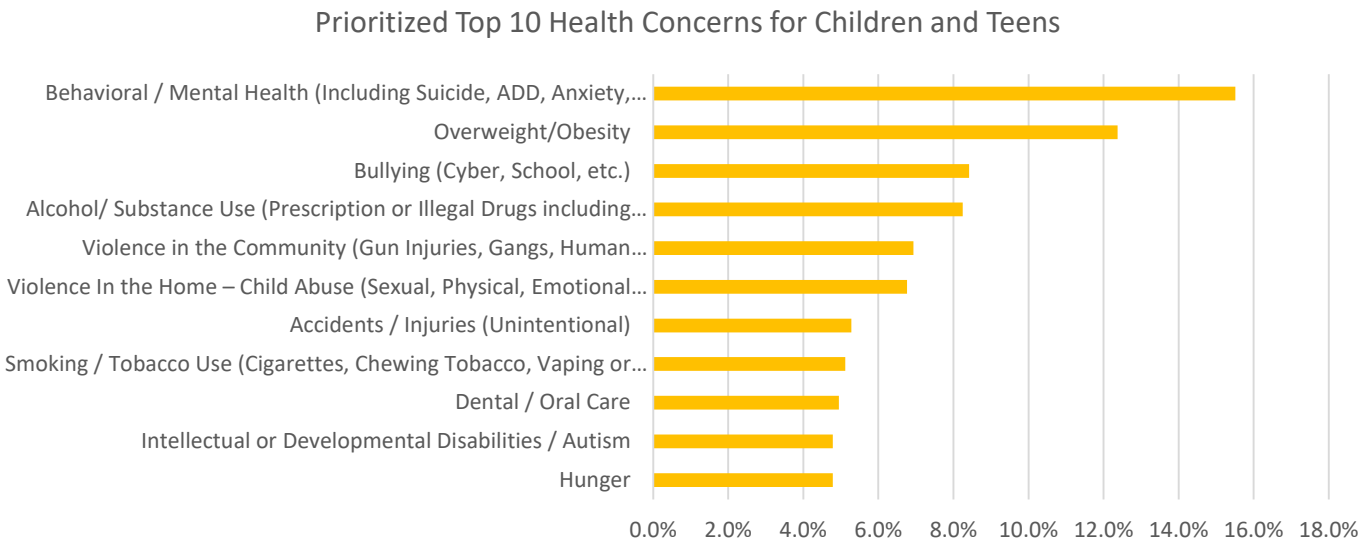


Community Health Issues Affecting Children & Teens

Survey respondents were asked to review a list of common community health issues affecting children and teens, ages 0 - 17. The list of issues drew from the topics in Healthy People 2020 with some refinements. The survey asked respondents to identify from the list up to five issues they viewed as the most important health concerns in their community. Respondents were also invited to identify additional issues not already defined on the list. Exhibit II - D shows the ten issues most frequently indicated as being the most important in the community. See **appendix** for all survey responses.

Exhibit II-D
Top Community Health Issues Affecting Children and Teens

126 of 159 respondents with up to five priorities each; 606 responses

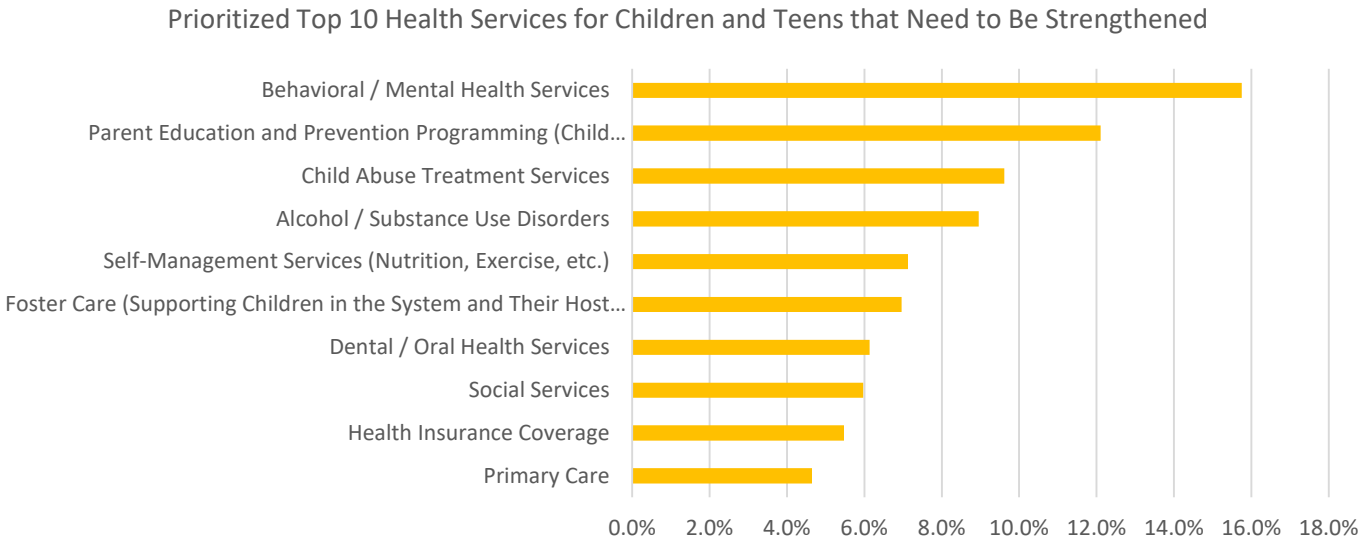


Community Health Services for Children & Teens

Survey respondents were asked to review a list of community services that are typically important for addressing the health needs children and teens in a community. Respondents were asked to identify from the list the five services they thought most needed strengthening in their community in terms of availability, access or quality. Respondents were also invited to identify additional service gaps not already defined on the list. Exhibit II - E shows the ten community health services most frequently indicated as being in need of strengthening. See **appendix** for all survey responses.

Exhibit II-E
Top Community Health Services for Children and Teens In Need of Strengthening

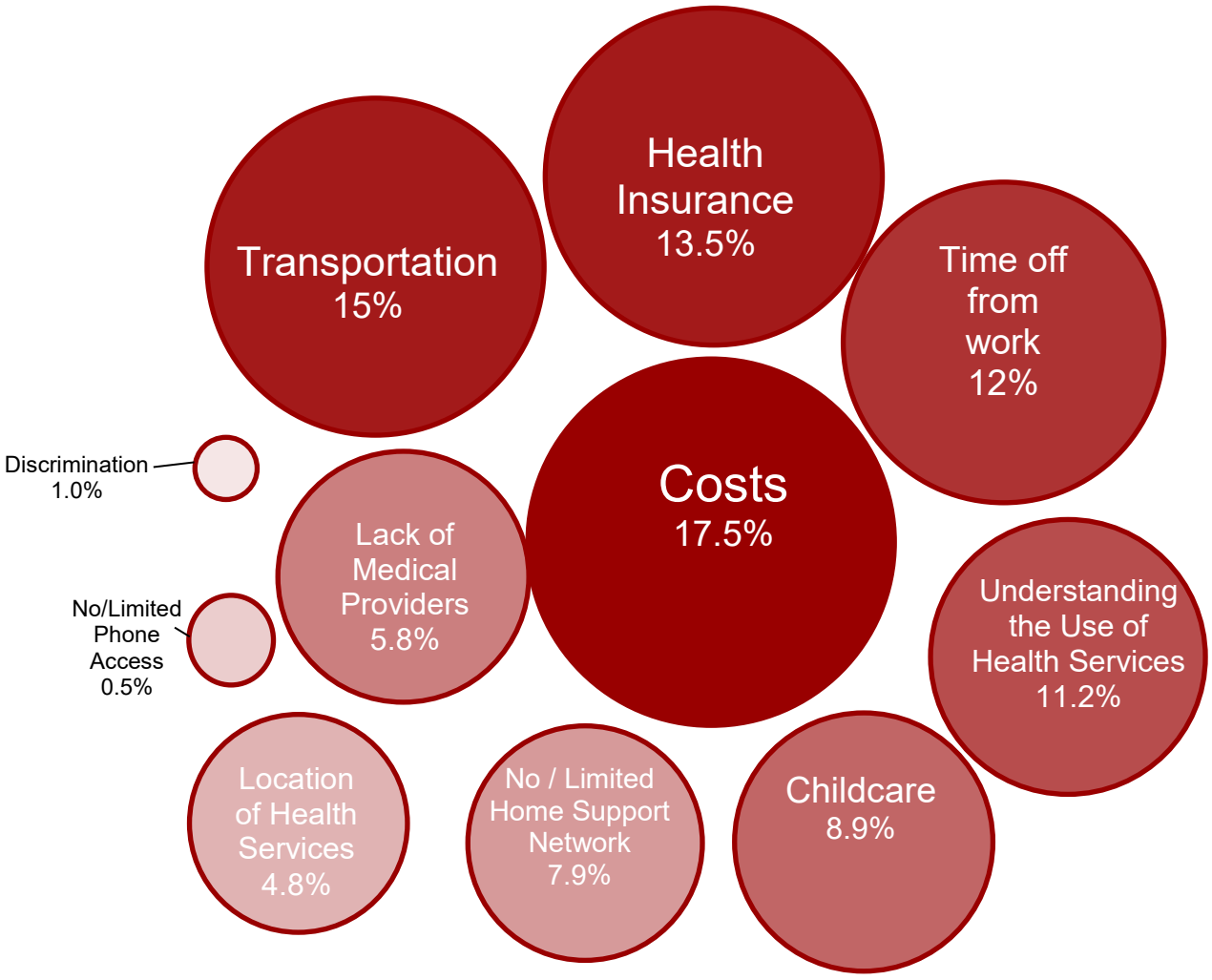
124 of 159 respondents with up to five priorities each; 603 responses



Community Issues Affecting Access to Healthcare

Survey respondents were asked to review a list of issues that may affect the ability for individuals to access healthcare. The survey asked respondents to identify from the list up to five issues they viewed as most affecting access to healthcare in their community. Respondents were also invited to identify additional issues not already defined on the list. Exhibit II-F shows the issues affecting access to care as they were ranked by the survey respondents. See **appendix** for all survey responses.

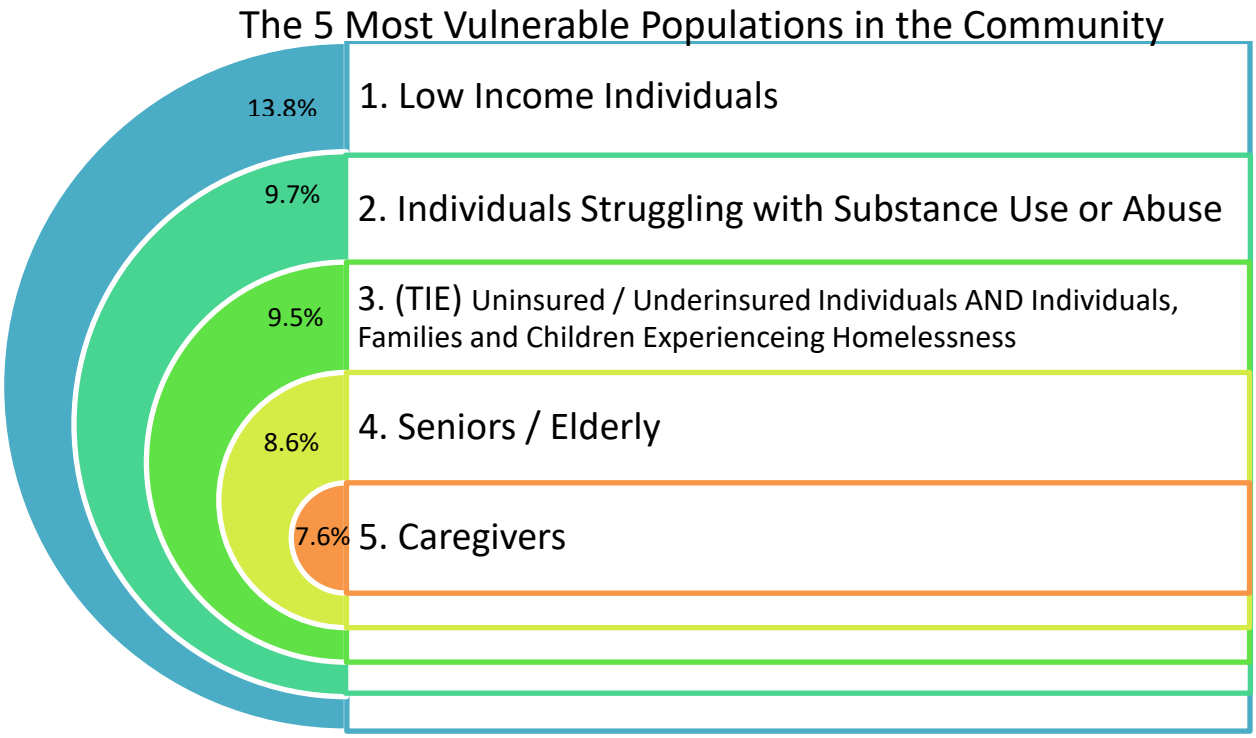
Exhibit II-F
Top Community Issues Impacting Access to Healthcare
125 of 159 respondents with up to five priorities each; 606 responses



Vulnerable Populations

Survey respondents were asked to review a list of populations that may need additional services or support to maintain their health. Respondents were asked to identify from the list the five populations they think are most in need of additional services or support in their community. Respondents were also invited to identify additional populations not already defined on the list. Exhibit II-G shows the five populations most frequently indicated as being in need of additional services or support. See **appendix** for all survey responses.

Exhibit II-G
Five Most Vulnerable Populations in the Community
124 of 159 respondents with up to five priorities each; 608 responses



Percent of respondents that indicated the population is in need of additional support

Health Assets in the Community

Survey respondents were asked to review a list of assets outside of the direct provision of healthcare that may impact health. Respondents were asked to identify from the list the five community health assets they think are most in need of strengthening in their community. Respondents were also invited to identify additional community health assets not already defined on the list. Exhibit II-H shows the five community health assets most frequently indicated as being in need of strengthening. See **appendix** for all survey responses.

Exhibit II-H
Top Community Health Assets In Need of Strengthening
70 respondents with up to 5 priorities each = 343 responses

Progress Made From the 2016 Implementation Plan

An important component of the 2019 CHNA is to review the work accomplished since the 2016 Implementation Plan. There is one primary focus area with multiple parts for the 2016 Implementation Plan for the Williamsburg region.

Creating a Heart Safe Community

Working collaboratively, Riverside Doctors' Hospital Williamsburg, Sentara Williamsburg Regional Medical Center, Williamsburg Health Foundation, Fire and EMS services in Williamsburg, James City County and York County, The College of William & Mary, Greater Williamsburg Chamber of Commerce and a community member Williamsburg received the designation as a Heart Safe Community.

This comprehensive initiative has advanced significantly with the funding of a full-time executive director. There are multiple milestones in the first phase of the implementation to include training 1,000 community members on CPR and user of AEDs by the end of 2019; upgrading of the CAD system which was funded through the local government; and launching a community health fair in October 2019 focusing on education, screenings and awareness building.

The Pulse Point App which will be implemented in the 2019-2022 plan has been funded by Riverside and Sentara.

Prioritization of the 2019 Significant Health Needs

In order to appropriately review the health indicator data and community survey input, the administrative leadership team of Riverside Doctors' Hospital Williamsburg approached the community needs assessment in a similar fashion as the 2016 plan. RDHW and Sentara Williamsburg Regional Medical Center came together in the summer of 2019 to discuss the results of the assessment. It was determined that continuing a joint implementation plan between the hospitals would be appropriate, as both facilities serve the same region and work with the same community stakeholders. 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 2016 CHNA Implementation Plans and the work that had been accomplished. There are ongoing discussions about what the data reflected in the community, and which efforts had been working.

A major initiative of the 2016 CHNA was the designation as a Heart Safe Community. As noted above, significant progress has been made and all the organizations involved are committed to continuing the focus on this initiative. Moreover, the quantitative analysis of the community indicators shows that heart disease remains one of the top five leading causes of death in the study region. The health risk profiles for the Williamsburg region exhibit higher rates of diabetes, physical inactivity and obesity.

Both the mortality statistics and the health risk profile activated the interest of RDHW and SWRMC to create an action plan around diabetes, obesity and improved nutrition. This was further amplified in the qualitative survey of Top Assets for Adults in Need of Strengthening, Exhibit II-C, where community leaders identified both chronic disease services and health promotion and prevention services making the top five list.

The additional action plan focus is related to aging services with a focus on Alzheimer's and Dementia. Riverside Health System operates the Riverside Center for Excellence in Aging and Lifelong Health. This center is dedicated to improving the care and better meet the needs of a growing older population. The center integrates interdisciplinary aging research with clinical capabilities to develop innovative programming that can be applied and sustained by Riverside for the community, and other providers of aging-related services. Further, the Greater Williamsburg Chamber of Commerce, Health Alliance has a subcommittee focused on Alzheimer's in Williamsburg and RDHW plans to be an active member in that regional effort.

The decision to make aging services a focus is a direct response from the quantitative data showing that the study region is a more educated and older population than Virginia as a whole and that unspecified dementia rose to the number one leading cause of death. Alzheimer's was also in the top causes of death in the 2019 mortality profile.

IMPLEMENTATION STRATEGY

Strategy Process for Addressing Prioritized Health Needs

Since the Heart Safe Community was the primary action plan in 2016, the process for the 2019 plan is to advance the actions identified and to monitor and evaluate the success of the tools. The Heart Safe Community is a model for demonstrating the strength of a community that comes together to improve the health of its citizens. The participants represent a broad range of constituents who bring their time and specific talents to action. They include: Riverside Doctors' Hospital Williamsburg, Sentara Williamsburg Regional Medical Center, Williamsburg Health Foundation, Fire and EMS services in Williamsburg, James City County and York County, The College of William & Mary, Greater Williamsburg Chamber of Commerce and the community.

RDHW will use a similar model as the plans for the Diabetes, Obesity, Physical Inactivity and Improved Nutrition action plan. In collaboration with Sentara, a series of workshops will be coordinated and offered throughout the community. In addition, RDHW will continue to participate with non-profit organizations to sponsor and staff events promoting physical activities while hosting some of those events on the hospital campus proper. Riverside will provide and promote lecture series focused on wellness and health through the Riverside clinical team of physicians, nurses and therapists at no charge to the community.

The strategy to address the aging services action plan will be led by the Riverside Center for Excellence in Aging and Lifelong health. The center is staffed by a number of clinical researchers and professionals who make older adult needs their lifelong focus. The center has established a number of local, regional and national affiliations and partnerships enabling Riverside access to evidence-based protocols and resources. The team at CEALH will work in collaboration with the administrative team at RDHW to educate and promote the services that may be of greatest benefit to those adults living with dementia and Alzheimer's. In addition, the services will also focus on the caregivers empowering them to manage care and decision-making more effectively.

Significant Health Need To Be Addressed

- Heart Disease
- Diabetes
- Obesity
- Improved nutrition
- Physical activity
- Aging Services
    a. Alzheimer's
    b. Dementia

Significant Health Needs Not Being Addressed

Not every need identified in the CHNA process can be addressed as a priority area for the 2019 CHNA Implementation Plan. The areas not selected may still be addressed through other programs or services offered by or supported by the hospital, but not as part of this plan.

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

- Cancer
- Mental Health
- Chronic Respiratory Conditions
- Stroke
- Congestive Heart Failure
- Reproductive health
- Psychoses
- Depressive neuroses
- Smoking Cessation
- Violent Crime
- Health Insurance Coverage
- Alcohol/Substance Abuse Disorders
- Dental/Oral Health Services

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 2019 CHNA and Implementation Strategy. Examples of these areas include:

- Hunger
- Bullying
- Drowning / Water Safety
- Violence in the Community
- HIV / AIDS

- Accidents/Injuries (unintentional)
- Foster Care
- Social Services
- Transportation

Initial Implementation Strategy

Background information, action steps and anticipated resources are noted.

Advancing the Heart Safe Community

Background:

In the 2016 CHNA, heart disease was a leading cause of death in the region leading to a community collaborative of building a Heart Safe Community achieving the national designation for the region. In 2019, heart disease continues to be one of the five leading causes of death and the health risk profiles for the region exhibit higher rates of diabetes, physical inactivity and obesity.

Action Steps:

Continue the collaboration with Riverside Doctors' Hospital Williamsburg, Sentara Williamsburg Regional Medical Center, Williamsburg Health Foundation, Fire and EMS services in Williamsburg, James City County and York County, The College of William & Mary, Greater Williamsburg Chamber of Commerce and the community to advance the Heart Safe Community.

- Creating Deliverables for each area of focus:
    - ***Education and Prevention*** (offer ongoing CPR classes, education on the importance of calling 911, developing heart healthy habits, in the region)
    - ***Screening*** (Distribute the AEDs throughout the community provide heart screenings such as blood pressure Developing standardized CVD screening protocol, identifying best avenues / locations for screenings to access at-risk populations)
    - ***Pulse Point*** (Implementing the App with the help of EMS in the local jurisdictions)
    - ***Clinical Care*** (working with area cardiologists to create pathways for uninsured / underinsured patients to access specialty care once identified through the screening process).
- Monitoring and evaluating the success of the tools
- Continuing the efforts to build the funds necessary through grants, donations and other sources.

Resources:
The community collaborative will continue to work together to implement the deliverables in the 2019-2022 CHNA.

Alzheimer's and Dementia

Background:

The study region is more educated and older than Virginia as a whole. In the 2019 mortality profile unspecified dementia rose to the number one leading cause of death and Alzheimer's was also in the top causes of death in the community. These may be attributed to the aging population.

Action Steps:

Through Riverside's Center for Excellence in Aging and Lifelong Health (CEALH), a number of community services are available to those living with Alzheimer's and Dementia as well as support services for their caregivers. The community resources include:

- **The Riverside Geriatric Assessment Clinic** is located in the region and offers a unique and highly focused services by an interdisciplinary team of Geriatrician, pharmacist, RN, and Counselor to provide definitive and dignified diagnosis of cognitive status. Community resources, education and support, discussion of safety concerns and advance care planning are also offered.
- In addition, the Geriatric Assessment Center has access to **the Benjamin Rose Institute on Aging Care Consultation program**. This 12-month program assists caregiving families by empowering them to manage care and decision-making more effectively, find simple and practical solutions to challenges, find services and understand insurances and emotional support throughout the caregiving journey.
- **A Memory Cafe** is offered in the study region in partnership with the Peninsula Agency on Aging providing socialization opportunity for those living with dementia and their care partners at no charge.
- **The Caring for you, Caring for me program** is an evidence-informed caregiving education program of the Rosalynn Carter Institute for Caregiving addressing elder care issues. This program brings family and professional caregivers together in a relaxed setting to discuss common issues, share strategies and resources and gain a better understanding of each other's perspectives on caregiving.
- **Dealing with Dementia** is an evidence-informed educational program of the Rosalynn Carter Institute for Caregiving for family and professional caregivers of those living with dementia to learn supportive resources available through Riverside and the larger community.
- **Riverside** will participate on the **Greater Williamsburg Chamber of Commerce, Health Alliance** subcommittee focused on Alzheimer's in the Williamsburg area contributing time and resources to this broad community initiative.

Resources:

The Riverside Center for Excellence in Aging and Lifelong Health actively pursues grants and donations to sustain and expand the system's efforts in the care and support of aging related needs. The center has long established partnerships locally, regionally and nationally that provide access to evidence-based programming and resources.

Diabetes, Obesity, Physical Inactivity and Improved Nutrition

Background:

The Williamsburg/James City County and surrounding regions have a higher rate of diabetes and obesity than Virginia as a whole. The opportunity to collaborate with Sentara Healthcare and other community partners to impact the community locally is a key imperative. Further, this will also have positive implications to the Heart Safe Community.

Action Steps:

RDHW provides programs and services to its team members and will coordinate actions with Sentara Williamsburg Regional Medical Center and various local non-profits to promote wellness in the community at-large. The following actions steps have been identified:

- **Workshops:** Working with SWRMC (Sentara) establish a year-long schedule of workshops for the community and employees focused on wellness, nutrition, plant- based eating, and topics focused to provide individuals with the tools, knowledge and support to adopt a healthy lifestyle.
- **Diabetes Prevention and Management Program**: Provide and promote the Riverside Diabetes Partnership Program to RDHW team members. The program is focused on managing blood pressure, A1C levels, BMI and reduce emergency department visits. The Riverside Diabetes Nurse Educator offers medical nutrition appointments and guidance to self-management. These are offered to team members and available to the community.
- **Community Organizations**: Participate with community organizations to sponsor physical activity events such as walks, golf tournaments, pickle ball and other wellness oriented events. Some of the community organizations include: The ARC of Greater Williamsburg, Williamsburg Parks and Recreation and Virginia Fire Chiefs Foundation.
- **Riverside Community Lectures**: Provide and promote the "Doctor is In" series with a variety of health topics and screenings through the help of the Riverside clinical team of physicians, nurses and therapists. This series of lectures are available at no charge to the community.

Resources:

RDHW will provide the expertise of its clinical team of physicians, nurses, therapists and support teams to develop and staff these workshops and lecture series in the community. Riverside also allocates a sponsorship budget to support community non-profit organizations with events as well as donated hours of service by Riverside team members for activities that provide value to the community.

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 Doctors' Hospital Williamsburg at 757-585-2200 or via the comments section on www.riversideonline.com/community_benefit.

To obtain a paper copy, please visit the Riverside Doctors' Hospital of Williamsburg Administration Department located at 1500 Commonwealth Ave, Williamsburg, VA 23185.

Appendices

Appendix A

Specific Organizational Affiliations of Respondents *(as entered by respondents on the survey)*
Access Partnership
American Diabetes Association
Bay Rivers Telehealth Alliance
Bon Secours Mercy Health Mary Immaculate Hospital
Buy Fresh Buy Local Hampton Roads
Catholic Charities of Eastern Virginia
Center for Child and Family Services
Champions for Children
Charles City DSS
Chickahominy Health District
Child Development Resources
Child Development Resources Fatherhood Program
Children's Hospital of the King's Daughters
CHKD
CHKD
CHKD
Citizen Volunteer
City of Williamsburg Fire Department
Colonial Behavioral Health
Colonial Behavioral Health
Community Services Coalition (Historic Triangle Community Center)
Compassionate Care Hospice
Consortium for Infant and Child Health (CINCH) / EVMS
Eastern Virginia Medical School
EVMS
EVMS
EVMS ENT
Hampton and Peninsula Health Districts
James City County Social Services
King William County
King William County District 4
Lackey Clinic
Lackey Clinic
Literacy for Life
Middle Peninsula Northern Neck CSB

New Kent County Public Schools
New Kent County CSA
New Kent Sheriff's Office
Olde Towne Medical and Dental Clinic
Olde Towne Medical Dental Center
Organization
Peninsula Agency on Aging
Peninsula Agency on Aging
Peninsula Agency on Aging
Peninsula Health Department
Peninsula Health Department
Peninsula Metropolitan YMCA
Peninsula Metropolitan YMCA
PHC
Respite of Williamsburg United Methodist Church
Riverside Health System
Riverside Health System
Riverside Health System
Riverside Lifelong Health and Aging
RWRH
Sentara
Sentara Hospital Williamsburg VA
Sentara Williamsburg Patient and Family Advisory Council
The Barry Robinson Center
The Orchard – A Riverside Health Living Community
Town Council West Point
United Way of the Virginia Peninsula
United Way of the Virginia Peninsula
VersAbility Resources
Virginia Career Works – Greater Peninsula
Virginia Oral Health Coalition
Virginia Peninsula Foodbank
WIC
WIC
Williamsburg Health Foundation
Williamsburg Health Foundation
Williamsburg Health Foundation
Williamsburg-James City County Community Action Agency
WJCC School Board
York Juvenile Services

Appendix B

Community Health Issues Affecting Adults (Ages 18+) Ranked by Survey Respondents		
Note: 132 of 159 respondents answered this question.		
Answer Options	Response Percent	Response Count
Behavioral / Mental Health (Suicide, ADHD, Anxiety, Depression, etc.)	11.9%	78
Heart Conditions (Heart Disease, Congestive Heart Failure / CHF, Heart Attacks / AMI, High Blood Pressure / Hypertension)	10.8%	71
Alcohol/Substance Abuse (Prescription or Illegal Drugs including Opioids)	10.1%	66
Overweight / Obesity	9.9%	65
Diabetes	8.7%	57
Cancer	6.6%	46
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	4.4%	29
Dental / Oral Care	4.4%	29
Alzheimer's Disease / Dementia	4.3%	28
Hunger	2.9%	19
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	2.7%	18
Respiratory Diseases (Asthma, COPD, Emphysema)	2.6%	17
Neurological Conditions (Stroke, Seizures, Multiple Sclerosis, Traumatic Brain Injury, etc.)	2.6%	17
Accidents / Injuries (Unintentional)	2.6%	17
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	2.4%	16
Chronic Pain	2.4%	16
Prenatal and Pregnancy Care	2.1%	14
Intellectual / Developmental Disabilities / Autism	1.7%	11
Violence – Sexual and / or Domestic	1.2%	8
Physical Disabilities	1.1%	7
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	1.1%	7
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	0.6%	4
Bullying (Cyber, Workplace, etc)	0.6%	4
Drowning / Water Safety	0.2%	1

Other Health Issues Affecting Adults (Ages 18+): Respondents were asked to share other health concerns if they were not listed above or to use this space to provide any additional information on their above selections.
How did women's health and healthcare disparities not make this list
Balanced diet, availability of healthy, fresh foods across income levels and geographic areas
Precariously housed chronic illnesses
Age-related disabilities (in an aging population)
Lack of understanding of community resources that are already available
Intellectual/Developmental Disabilities and Autism are issues because of the lack of services and lack of service coordination for affected individuals. Lack of health insurance is also a significant concern.
Affordable quality healthcare
Social Isolation, lack of transporting to get to appointments, shopping and social outings.
In my opinion, behavioral and mental health is a major concern in this area. Many are suffering and not getting the counseling they need due to the high costs, stigma behind seeking help, and labelling by employers or others for seeking therapy.
People with multiple chronic diseases particularly the uninsured.
More DRs working with the aging generation

Appendix C

Community Health Services for Adults (Ages 18+) In Need of Strengthening Ranked by Survey Respondents		
Note: 129 of 159 respondents answered this question.		
Answer Options	Response Percent	Response Count
Behavioral / Mental Health Services	12.3%	78
Health Insurance Coverage	8.0%	51
Alcohol / Substance Abuse Services	7.7%	49
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	7.5%	48
Health Promotion and Prevention Services	6.6%	42
Aging Services	6.4%	41
Dental / Oral Health Services	6.0%	38
Self-Management Services (Nutrition, Exercise, etc.)	4.9%	31
Care Coordination and Transitions of Care	4.6%	29
Public Health Services	3.8%	24
Social Services	3.5%	22
Long Term Services / Nursing Homes	3.3%	21
Family Planning and Maternal Health Services	3.1%	20
Home Health Services	3.0%	19
Chronic Pain Management Services	2.4%	15
Telehealth / Telemedicine	2.4%	15
Domestic Violence / Sexual Assault Services	2.2%	14
Primary Care	2.2%	14
Hospice and Palliative Care Services	1.9%	12
Hospital Services (Inpatient, outpatient, emergency care)	1.9%	12
Cancer Services	1.7%	11
Access to Care (Availability, Language, Costs, Lack of Providers, etc.)	0.9%	6
Pharmacy Services	0.9%	6
Physical Rehabilitation Services	0.3%	2
Bereavement Support Services	0.2%	1

Other Community Health Services for Adults (Ages 18+): Respondents were asked to share other needed community health services if they were not listed above or to use this space to provide any additional information on their above selections.
Women's Health
Transportation to physician's offices
Transportation is a critical barrier to health care for many of our patients
Transportation
I work with children
Transportation is a critical barrier to health care for many of our patients.
Transportation

Transportation is a major issue for the aging population
I work with children
Health promotion and prevention is inherent in all of these categories.
Hospice and Palliative Care also important but there are many gaps in services and in education of providers and the public.
Better quality of services in the Social Services Department. Someone that can do an anonymous check on how the Social Services and Health Department employees treat the public. Not to be totally critical but to offer problem solving solutions to better assist.
Transport up to medical appointments- impossible to get affordable transporting in if you're crossing some jurisdictions. I.e., treatments in Richmond or Norfolk.
People need to feel comfortable and not be penalized for reporting another adult with a behavioral or mental health concern. Also, these services need to be widely available and affordable.
Also would select HEALTH INSURANCE Coverage and Health Promotion and Prevention Services.

Appendix D

Community Health Issues Affecting Children & Teens (Age 0 - 17) Ranked by Survey Respondents		
Note: 126 of 159 respondents answered this question.		
Answer Options	Response Percent	Response Count
Behavioral / Mental Health (Suicide, ADD, Anxiety, Depression)	15.5%	94
Overweight / Obesity	12.4%	75
Bullying (Cyber, Workplace, etc)	8.4%	51
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	8.3%	50
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	6.9%	42
Violence In the Home – Child Abuse (Sexual, Physical, Emotional or Neglect) or Exposure to Domestic Violence	6.8%	41
Accidents / Injuries (Unintentional)	5.3%	32
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	5.1%	31
Dental / Oral Care	5.0%	30
Hunger	4.8%	29
Intellectual / Developmental Disabilities / Autism	4.8%	29
Teen Pregnancy	2.6%	16
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	2.5%	15
Respiratory Diseases (Asthma and Cystic Fibrosis)	2.1%	13
Diabetes	1.8%	11
Eating Disorders	1.8%	11
Drowning / Water Safety	1.2%	7
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	0.8%	5
Physical Disabilities	0.8%	5
Cancer	0.5%	3
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	0.5%	3
Neurological Conditions (Epilepsy, Seizures, Tourette Syndrome-TICS, Sleep Disorders)	0.5%	3
Chronic Pain	0.2%	1
Heart Conditions (Congenital Heart Defects, Fainting and Rhythm Abnormalities)	0.2%	1

Other Health Issues Affecting Children & Teens (Ages 0 – 17): Respondents were asked to share other health concerns if they were not listed above or to use this space to provide any additional information on their above selections.
Many things affect children and teens with most connected to parenting skills.
I do not see children Only Adult patient population
Health promotion should be for children as well.

No access to primary care without a long wait and well check first. I'm an urgent care doc and we see this all the time on both sides of the hrbt
Affordable quality healthcare
Housing impacts health
Where I live, a lot of kids don't have enough food at home.

Appendix E

Community Health Services for Children & Teens (Age 0 - 17) In Need of Strengthening Ranked by Survey Respondents		
Note: 124 of 159 respondents answered this question.		
Answer Options	Response Percent	Response Count
Behavioral / Mental Health Services	15.8%	95
Parent Education and Prevention Programming	12.1%	73
Child Abuse Prevention and Treatment Services	9.6%	58
Alcohol / Substance Use Services	9.0%	54
Self-Management Services (Nutrition, Exercise, etc.)	7.1%	43
Foster Care (Supporting children in the system and their host families)	7.0%	42
Dental / Oral Health Services	6.1%	37
Social Services	6.0%	36
Health Insurance Coverage	5.5%	33
Primary Care	4.6%	28
Care Coordination and Transitions of Care	4.5%	27
Public Health Services	4.1%	25
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	2.2%	13
Telehealth / Telemedicine	1.5%	9
Chronic Pain Management Services	1.0%	6
Pharmacy Services	0.7%	4
Home Health Services	0.5%	3
Cancer Services	0.3%	2
Bereavement Support Services	0.2%	1
Physical Rehabilitation Services	0.2%	1

Other Community Health Services for Children & Teens (Ages 0 – 17): Respondents were asked to share other needed community health services if they were not listed above or to use this space to provide any additional information on your above selections.
Violence prevention and gun safety education Palliative care services
Transportation remains a barrier to health care for teens.
Transportation
Prevention - effective prevention strategies will work if put in place correctly and with integrity. Abuse and violence prevention is the key in reducing incidents of domestic violence and abuse.
Services can be strengthened but if parents aren't required to access services, it is of no help. Social Services is difficult to access, as is behavioral/mental health services. There is sufficient access to dental/oral health BUT parents must take minors for services.
Only see adult patient population

Home visiting programs
cardiac care
Cannot emphasize more strongly the lack of adequate mental health resources for children, especially those with public insurance or no insurance.
Water Safety/Drowning Prevention Tween/Teen Leadership Programs
Safe affordable quality childcare
I have no children

Appendix F

Community Issues Affecting Access to Healthcare Ranked by Survey Respondents		
Note: 125 of 159 respondents answered this question.		
Answer Options	Response Percent	Response Count
Costs	17.5%	106
Transportation	15.0%	91
Health Insurance	13.5%	82
Time Off From Work	12.0%	73
Understanding the Use of Health Services	11.2%	68
Childcare	8.9%	54
No / Limited Home Support Network	7.9%	48
Lack of Medical Providers	5.8%	35
Location of Health Services	4.8%	29
Discrimination	1.0%	6
No / Limited Phone Access	0.5%	3

Access Issues: Respondents were asked to use this space to provide any additional information on why they selected these concerns.
perception of issues confronting community
Few providers of services are available in evenings or weekends making it difficult for working parents to take time off.
These are all important. Understanding use of health services is easily a tie for the others I chose, as is child care.....
Language Barrier should be added
Lack of providers in Rural areas
Lack of Medicaid Providers and that will only become more serious as additional people enroll in the Program. Also, understanding the use of health services.
Lack of providers that accept insurance of certain types, including but not limited to Medicaid and/or Medicare.
Child care costs can be equivalent to costs per month for rent or mortgage. If there are multiple children, it's even higher. Many parents cannot afford to work because of the cost of healthcare. They become reliant on the welfare system as a result. This is one reason you may have generations of families on welfare. Additionally, the Hampton Roads area has a serious lack of public transportation. Particularly on the Peninsula (Yorktown, James City, Williamsburg). You can't work if you can't get to work.
There is a lot of people in my area where I live that speak only Spanish at home but no English out in the local area.

Appendix G

Vulnerable Populations In Need of Additional Services or Support Ranked by Survey Respondents		
Note: 124 of 159 respondents answered this question.		
Answer Options	Response Percent	Response Count
Low Income Individuals	13.8%	84
Individuals Struggling with Substance Use or Abuse	9.7%	59
Uninsured / Underinsured Individuals	9.5%	58
Individuals / Families / Children experiencing Homelessness	9.5%	58
Seniors / Elderly	8.6%	52
Caregivers (Examples: caring for a spouse with dementia or a child with autism)	7.6%	46
Children (age 0-17 years)	7.2%	44
Immigrants or community members who are not fluent in English	6.3%	38
Individuals Transitioning out of Incarceration	3.9%	24
Individuals with Intellectual or Developmental Disabilities	3.6%	22
Victims of Human Trafficking, Sexual Violence or Domestic Violence	3.0%	18
Unemployed Individuals	3.0%	18
Individuals Struggling with Literacy	2.8%	17
Individuals with Physical Disabilities	2.6%	16
Individuals Needing Hospice / End of Life Support	2.5%	15
Veterans and Their Families	2.3%	14
Individuals in the LBGTQ+ community	1.3%	8
Migrant Workers	1.2%	7

Other Vulnerable Populations: Respondents were asked to share other vulnerable populations if they were not listed above or to use this space to provide any additional information on their above selections.
According to data, more people are insured but our organization receives more requests for help now because although they may have coverage, they cannot afford deductibles or monthly copays. Underinsured populations with low incomes or don't understand their benefits call daily for assistance.
All of the above also have trouble accessing care for their kids - so all these fundamentally also impact access for children as a vulnerable population.
Add seniors and un or underinsured
Wow. I could have chosen several others on this list (i.e., many more than 5)!
Affordable quality childcare

Socially isolated individuals and individuals or families impacted by behavioral health/mental health issues Tried to select more inclusive categories that would affect the specific demographic groups
Taxpayers spend a lot of money on caring for and attempting to rehabilitate prisoners, yet when they are released, many are homeless, without a job, without any means to get what they need so they turn to drugs or crime and end up back in jail. This area needs better transitional services for those being released from jail. If we provide them with the education they need on soft skills and finding a job before being released from jail, then we provide them with programs to assist them in finding a job and supporting themselves, they are less likely to turn to crime and substance abuse. Unemployment services are difficult to obtain on the Peninsula due to the fact that the nearest employment office is in Hampton - 30+ minutes away! To compound the issue, public transportation is limited so you may not even be able to get there.

Appendix H

Community Health Assets In Need of Strengthening Ranked by Survey Respondents		
Note: 123 of 159 respondents answered this question.		
Answer Options	Response Percent	Response Count
Affordable Child Care	20.6%	64
Healthy Food Access (Fresh Fruits & Vegetables, Community Gardens, Farmers Markets, etc.)	17.0%	53
Senior Services	13.8%	43
Social Services	10.6%	33
Early Childhood Education	9.0%	28
Safe Play and Recreation Spaces (Playgrounds, Parks, Sports Fields)	6.8%	21
Public Safety Services (Police, Fire, EMT)	5.1%	16
Safe Sidewalks, Trails and Bike Access	4.5%	14
Safe, Affordable Housing	2.6%	8
Education – Post High School	1.9%	6
Transportation	1.9%	6
Employment Opportunity / Workforce Development	1.6%	5
Environment – Air and Water Quality	1.6%	5
Education – Kindergarten through High School	1.3%	4
Safety Net Food System (Food Bank, WIC)	1.0%	3
Education – Special Education Services	0.3%	1
Social and Community Networks	0.3%	1
Green Space	0%	0
Homelessness	0%	0
Housing Affordability & Stability	0%	0
Neighborhood Safety	0%	0
Public Space with Increased Accessibility for those with Disabilities	0%	0

Other Community Assets: Respondents were asked to share other community assets if they were not listed above or to use this space to provide any additional information on their above selections.
Health safety net
Community Task Forces that decide on prevention strategies for their communities...
When a young family pays for child care, it cancels out a large portion of their income. Rent in a safe neighborhood is out of reach for many. Access to Healthy foods won't work if parents/individuals won't use them. Would like to see SNAP work more like WIC where only healthy foods can be purchased (currently, items like candy, soda, chips and other non-nutritional foods can be obtained with SNAP).
Safe places to play and walkable/bikeable communities also rank high up there.
HRT services are awful! Maybe the powers to be can look into improving those services. Take a week and observe what would be improvements to these services

Checked one education box, but all are necessary. This question is very hard to deal with, since most are needed.
Safety Net Food System should be oriented to Healthy Food Access

Appendix I

Respondents were asked to express any final comments or closing ideas
There is little vocal effective advocacy for patients ages 19-64.
Need to identify a way to encourage or reward individuals to live a healthy lifestyle, eat nutritional foods, and take responsibility for their health. We can continue to provide and strengthen services but unless an individual assumes some responsibility, it won't make a difference.
More than 5 in each area really should have been marked....
Thank you for allowing me the opportunity to share my concerns
Thank you for asking. I'd love to help from a public health standpoint if needed.
Positive changes are needed. Let's not just talk but be doers!
Quality, Cost, Access are three key goals for improving health care in our community