Riverside Walter Reed Hospital- 2019 Community Health Needs Assessment

This Community Health Needs Assessment and Implementation Strategy for Riverside Walter Reed Hospital 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 Walter Reed Hospital Board of Directors on October 22, 2019.

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT

Introduction

Riverside Walter Reed Hospital 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 Walter Reed Hospital 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.

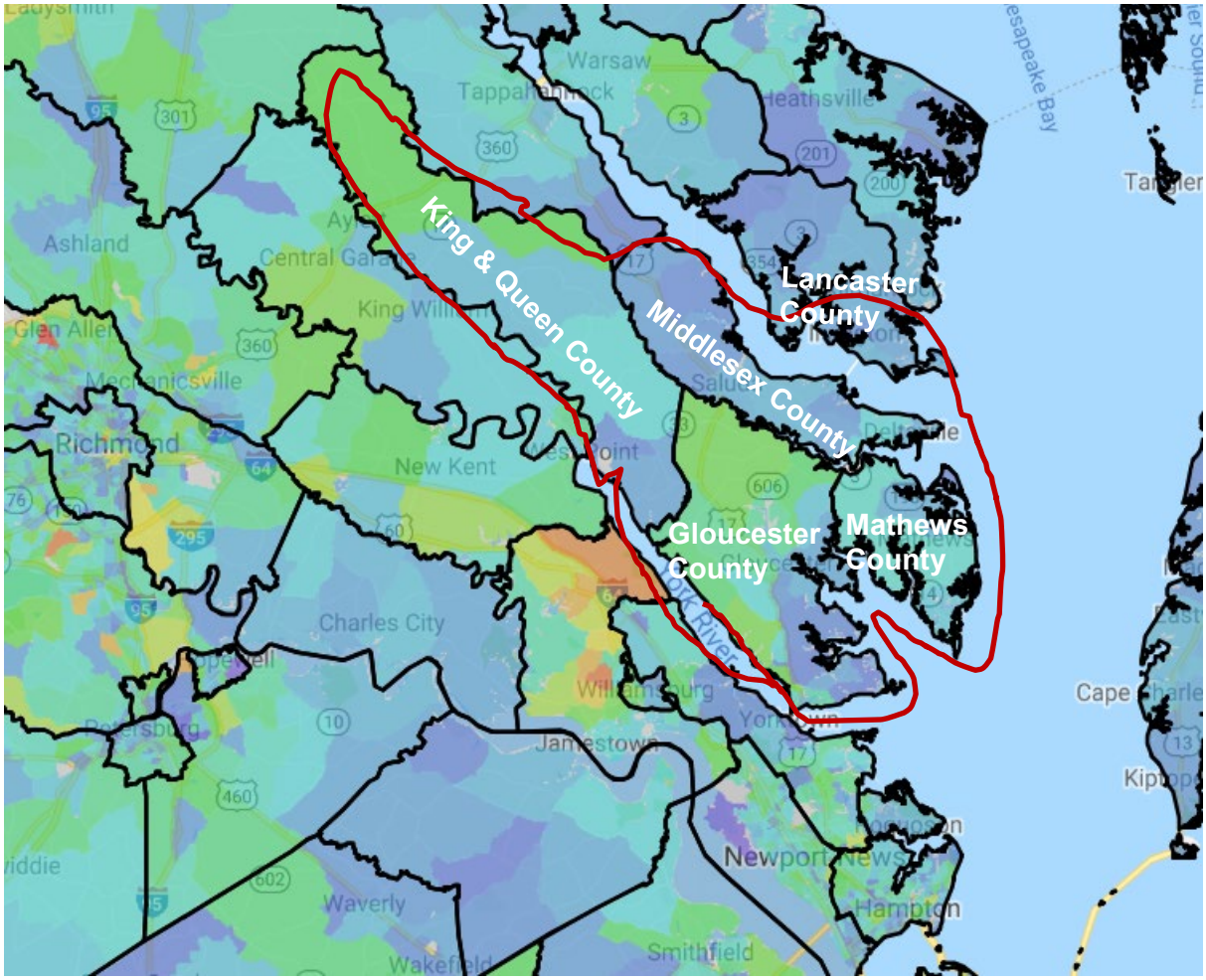
Community Health Needs Assessment Process

A Community Health Needs Assessment (CHNA) and Implementation Strategy for Riverside Walter Reed Hospital 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 Walter Reed Hospital is a geographic region that covers 37 ZIP codes across the counties of Gloucester, Mathews, Middlesex, Lancaster, King and Queen, King William and Accomack Counties. As many health indicators are reported at the city and county level rather than the ZIP level, the quantitative data analyzed in this report was pulled for Gloucester, Mathews, Middlesex and King and Queen counties only. The ZIPs served by RWRH in King William County were included in the Riverside Doctors' Hospital of Williamsburg CHNA. The ZIPs served by RWRH in Lancaster County served by RWRH were included in the Riverside Tappahannock Hospital (RTH) CHNA. Similarly, the ZIPs served by RTH in King and Queen County served by RTH were included in this report. Additionally, the ZIP for Tangier Island was included in the Riverside Shore Memorial Hospital (RSMH) CHNA. While Tangier is not considered part of the Middle Peninsula, the clinic on the island is maintained by RWRH physicians, so RHS often includes the analysis of that population in its RWRH numbers. But, as it is part of Accomack County, the population was included in the RSMH analysis.


King & Queen County
Middlesex County
Lancaster County
Gloucester County
Mathews County
Warsaw
Tappahannock
Ashland
Central Garage
King William
Mechanicsville
Richmond
New Kent
West Point
Charles City
Williamsburg
Jamestown
Yorktown
Newport News
Hampton
Waverly
Smithfield
Wakefield
Cape Charles
Chesapeake Bay

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 64,381people. The population is expected to increase 2.9% by 2022. Compared to Virginia as a whole, the study region is more rural, older, and less racially diverse. The study region also has a higher 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 823 total deaths. The leading causes of death included malignant neoplasms of the lung, Alzheimer's disease, atherosclerotic heart disease, COPD and Acute Myocardial Infarction (AMI). The study region's age adjusted death rate per 100,000 was 850.1, which is higher than the Virginia rate of 715.5.

- **Maternal & Infant Health Profile**: In 2016, the study region had 568 total live births. Compared to Virginia as a whole, the study region had lower rates of births, births to teenage 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 475 hospital discharges from Virginia community hospitals for behavioral health conditions. The leading diagnosis for these discharges was psychoses. Fatal drug overdoses are up in the service area and Virginia as a whole. Three of the last four years the service area had a higher rate of death by fatal overdose per 100,000 than 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 obesity, smoking and physical inactivity than the Commonwealth as a whole. While better than Virginia's total rates, the service area still has approximately one third of the school children eligible to receive a free lunch, and approximately 10% of the total population facing food insecurity. The HIV rate in the service area is significantly lower than Virginia. And, with the notable exception of Middlesex County, the area enjoys a much lower rate of violent crimes than the state as a whole.

- **Uninsured Profile:** At any given point in time in 2016, an estimated 5,098 nonelderly residents of the study region were uninsured. This included an estimated 748 children and 4,350 adults. The estimated uninsured rates were 6% for children age 0-18, 14.3% for adults age 19-64, and 12.4% 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+. Three of the four localities that overlap with the study region have been fully designated as MUAs/MUPs (King and Queen, Mathews and Middlesex counties). Gloucester County previously had partial designation as a MUA, but as of 2016 had improved to the point where it no longer qualified for MUA designation.

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 Gloucester, Mathews, Middlesex and King & Queen Counties as a whole instead of separating by individual ZIP codes within the counties. The ZIPs served by RWRH in Lancaster County were included in the Riverside Tappahannock Hospital (RTH) CHNA. Similarly, the ZIPs served by RTH in King and Queen County were included in this report. Additionally, the ZIP for Tangier Island was included in the Riverside Shore Memorial Hospital (RSMH) CHNA. While Tangier is not considered part of the Middle Peninsula, the clinic on the island is maintained by RWRH physicians, so RHS often includes the analysis of that population in its RWRH numbers. But, as it is part of Accomack County, the population was included in the RSMH analysis.

As shown in Exhibit I-A, as of 2017, the study region included an estimated 64,381 people. The total population is projected to increase by 2.9% in 2022. Focusing on age groups, a decline is projected for the 0-19 and 45-64 age groups while growth is anticipated for the 19-34, 35-44 and 65+ age groups. Focusing on racial/ethnic background, growth is projected for all of the listed groups. The Hispanic Ethnicity population is expected to grow by 19%.

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 rural, older, and less racially diverse. The study region also has a higher 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

Demographic Category		2010 Census	2017 Estimate	2022 Projection	% Change 2017-2022
Total Population		**63,684**	**64,381**	**66,266**	**2.9%**
Population Density (Population per Sq. Mile)		**83**	**84**	**87**	**2.9%**
Total Households		**25,717**	**26,012**	**27,028**	**3.9%**
Population by Age					
Age	**Children Age 0 – 19**	**14,455**	**13,333**	**12,992**	**-2.6%**
	Adults Age 19-34	**9,100**	**10,344**	**10,954**	**5.9%**
	Adults Age 35-44	**7,831**	**6,670**	**6,808**	**2.1%**
	Adults Age 45-64	**20,648**	**19,920**	**18,809**	**-5.6%**
	Adults Age 65+	**11,651**	**14,114**	**16,704**	**18.3%**
Population by Race / Ethnicity					
	White	**53,343**	**53,608**	**54,510**	**1.7%**
	Black/ African American	**7,966**	**7,707**	**8,164**	**5.9%**
	American Indian or Alaskan Native	**307**	**337**	**357**	**5.9%**
	Asian / Native Hawaiian / Other Pacific Islander	**391**	**538**	**613**	**14.1**
	Some Other Race	**351**	**521**	**623**	**19.6%**
	Two or More Races	**1,327**	**1,671**	**2,000**	**19.7%**
	Hispanic Ethnicity	**1,389**	**2,021**	**2,408**	**19.1%**

SOURCE: Internal analysis of demographic data pulled through Buxton's SCOUT, based on US Census data (2010, 2017 & 2022 Projections), Alteryx and Experian.

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

Indicator		Study Area		Virginia	
Demographic Category		Count	% of Total Population	Count	% of Total Population
Total Population		64,381	100%	8,453,091	100%
Population Density (Population per Sq. Mile)		84.1		207.06	
Age	Children Age 0 – 19	13,333	20.7%	2,113,825	25%
	Adults Age 19-34	10,344	16.1%	1,796,973	21.3%
	Adults Age 35-44	6,670	10.4%	1,100,177	13.0%
	Adults Age 45-64	19,920	30.9%	2,245,888	26.6%
	Adults Age 65+	14,114	21.9%	1,196,328	14.2%
	Female	32,723	50.8%	4,294,256	50.8%
	Male	31,656	49.2%	4,158,836	49.2%
	White	7,707	83.3%	5,361,326	66.6%
	Black	337	12.0%	1,637,782	19.4%
	American Indian or Alaskan Native	538	0.5%	32,518	0.4%
	Asian / Native Hawaiian / Other Pacific Islander	521	0.8%	554,158	6.6%
	Some Other Race	1,671	0.8%	306,572	3.6%
	Two or More Races	53,608	2.6%	290,736	3.4%
	Hispanic Ethnicity	2,021	3.1%	774,121	9.2%
	Low Income Households (HH Income < $25,000)	4,909	18.9%	545,927	17.0%
	Population Age 25+ Without a High School Diploma	5,543	11.7%	696,580	12.1%

SOURCE: Internal analysis of demographic data pulled through Buxton's SCOUT, based on US Census data, Alteryx and Experian.

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 823 total deaths. The top five leading causes of death were malignant neoplasms of the lung or bronchus (lung cancer) (63), Alzheimer's disease (46) and heart disease (44), chronic obstructive pulmonary disease (38) and acute myocardial infarction (heart attack) (34). Study region crude death rates per 100,000 were higher than the statewide rates for all deaths combined, and for each of the noted categories. Age adjusted death rate per 100,000 for the study region was 850.1, which is higher than the Virginia rate of 715.5.

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. However, it should be noted that Alzheimer's disease has increased as a cause of death both in raw numbers and in age adjusted rates per 100,000. It is also higher than the statewide rate (44.6 per 100,000 for service area vs 26.3 per 100,000 for the state). However, the unspecified dementia rate is lower than the state rate. This may be an area of interest for further study to identify if it is a significant difference for the community

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	823	1,287.3	850.1	66,473	790.2	715.5
Bronchus or lung, unspecified - Malignant neoplasms	63	98.5	59.2	3,727	44.3	38.1
Alzheimer disease, unspecified	46	72	44.6	2,363	28.1	26.3
Atherosclerotic heart disease	44	68.8	40.8	2,912	34.6	31.1
Chronic obstructive pulmonary disease, unspecified	38	59.4	36.3	2,528	30.1	27.0
Acute myocardial infarction, unspecified	34	53.2	35.3	2,358	28.0	24.8
Unspecified dementia	26	40.7	25.2	3,365	40.0	37.3
Congestive heart failure	22	34.4	20.9	1,605	19.1	17.4
Stroke, not specified as haemorrhage or infarction	21	32.8	20.3	1,692	20.1	18.5
Malignant neoplasm without specification of site	15	*Unreliable / Number too small to calculate*		831	9.9	8.7
Pneumonia, unspecified	15	*Unreliable / Number too small to calculate*		1,039	12.4	11.3
Breast, unspecified - Malignant neoplasms	14	*Unreliable / Number too small to calculate*		1,118	13.3	11.5
Pancreas, unspecified - Malignant neoplasms	13	*Unreliable / Number too small to calculate*		1,056	12.6	10.8
Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	13	*Unreliable / Number too small to calculate*		837	10.0	10.0
Atherosclerotic cardiovascular disease, so described	10	*Unreliable / Number too small to calculate*		1,075	12.8	11.2
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 568 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 2016 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	568	101,220
Rate of Live Births Per 100,000	8.8	12.2
Total Low Weight Births	41	8,266
Low Weight Birth as Percent of Total Births	7.2%	8.2%
Total Live Births to Teens (age 10-19)	21	4,140
Teenage Birth Rate	7.3	7.9
Live Births to Teens Age <15	0	84
Live Births to Teens Age 15-17	3	1,346
Live Births to Teens Age 18-19	18	4,199
Total Infant Deaths	3	593
Infant Death Rate	5.3	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 475 hospital discharges from Virginia community hospitals for behavioral health conditions in 2017. The leading diagnosis for these discharges was psychoses (337). The crude BH discharge rate for the study region (7.38) was 6.4% below the Virginia rate (7.88).

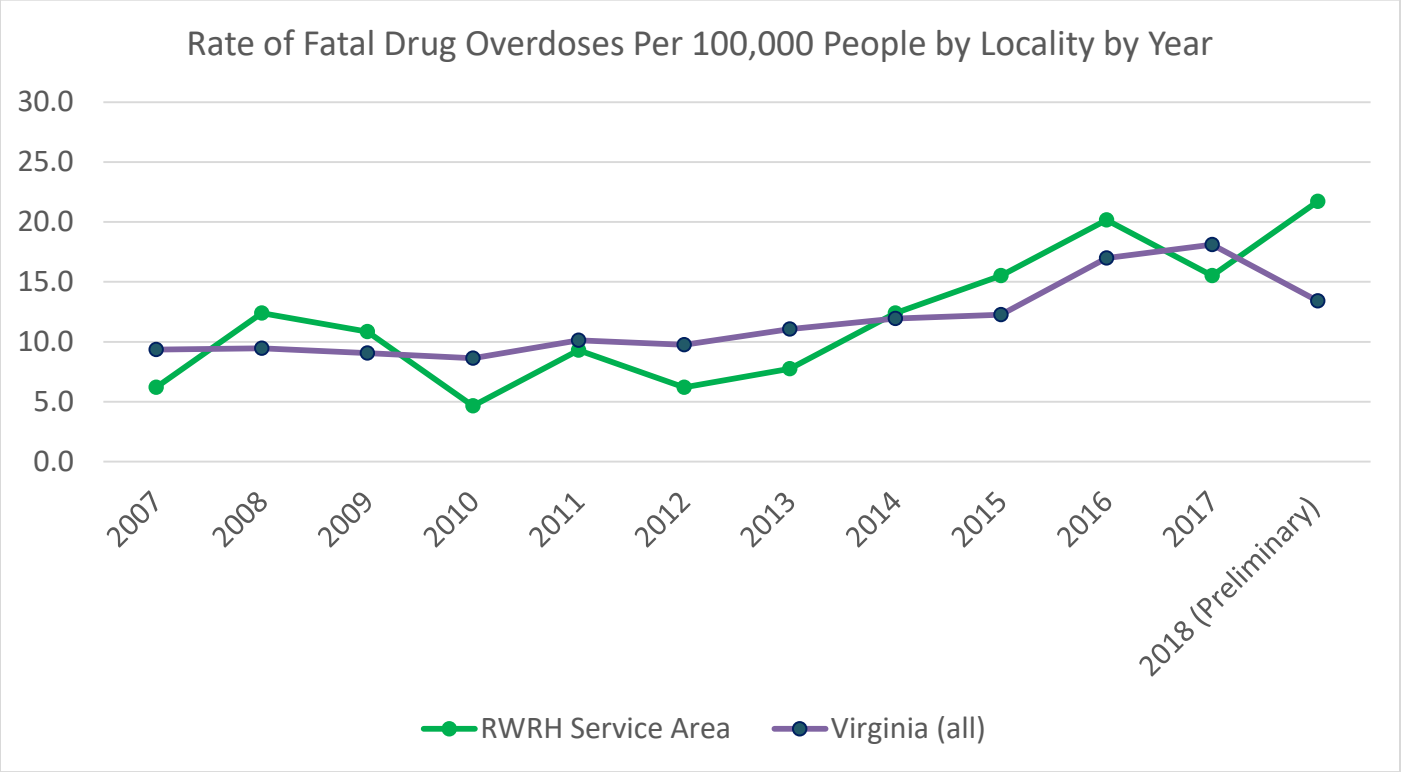
The leading causes of behavioral health hospitalization in 2017 were generally the same as in the 2011 profile reported in the 2012/2013 CHNA and the 2013 profile reported in the 2016 CHNA. A more detailed analysis of ranks and rates between the two study years is not feasible due to changes in diagnostic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

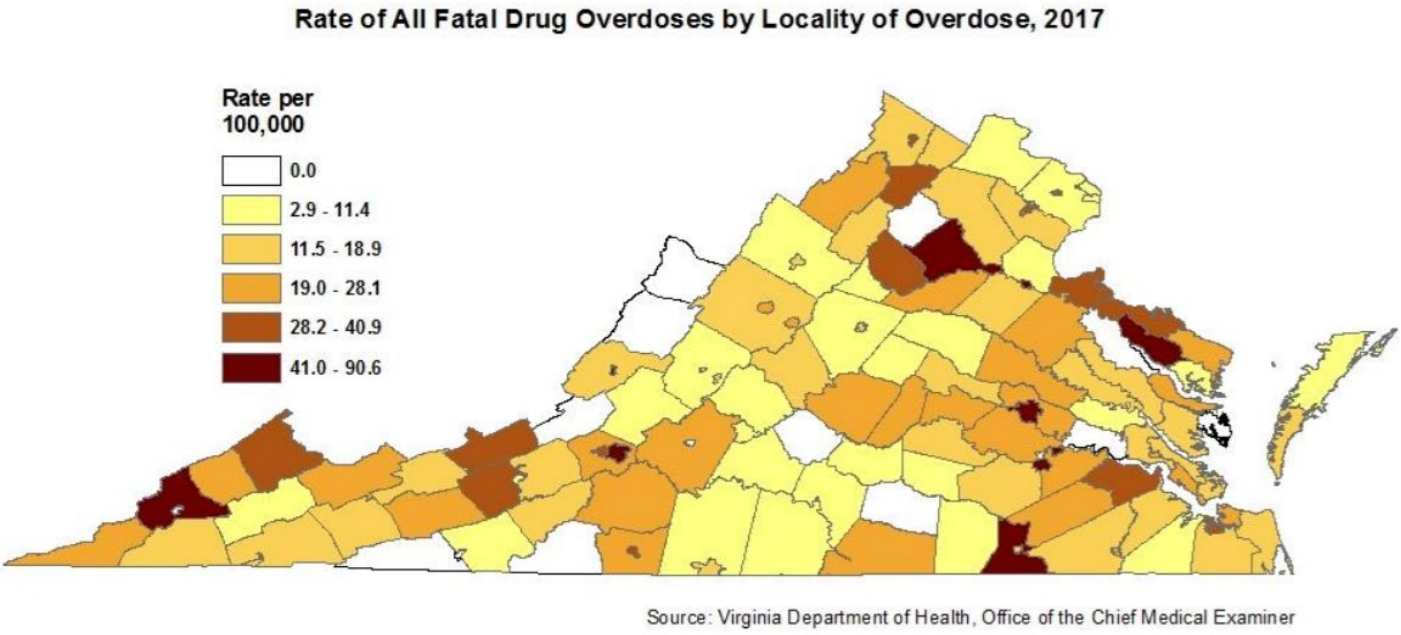
		Middle Peninsula Counties (2017)		Virginia (2017)	
DRG	DRG Description	Number of Inpatient Discharges	Crude Rate per 100,000	Number of Inpatient Discharges	Crude Rate per 100,000
	All inpatient behavioral health discharges	475	7.38	66,640	7.88
880	Acute adjustment reaction & psychosocial dysfunction	18	0.28	1,256	0.15
881	Depressive neuroses	32	0.50	4,737	0.56
882	Neuroses except depressive	8	0.12	2,149	0.25
883	Disorders of personality & impulse control	5	0.08	353	0.04
884	Organic disturbances & mental retardation	13	0.20	1,311	0.16
885	Psychoses	337	5.23	44,837	5.30
886	Behavioral & developmental disorders	1	0.02	334	0.04
887	Other mental disorder diagnoses	1	0.02	58	0.01
894	Alcohol / drug abuse or dependence, left AMA (Against Medical Advice)	1	0.02	844	0.10
895	Alcohol / drug abuse or dependence with rehabilitation therapy	0	0	873	0.10
896	Alcohol / drug abuse or dependence without rehabilitation therapy with MCC (Major Complicating Condition)	9	0.14	1,084	0.13
897	Alcohol / drug abuse or dependence without rehabilitation therapy without MCC	50	0.78	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 obesity, smoking and physical inactivity. In addition, a number of adults have chronic conditions such as diabetes. 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.**

		Gloucester County	King & Queen County	Mathews County	Middlesex County	Virginia (All)
Diabetes: % of adults that report having been diagnosed with diabetes						
	2013	9.5%	12.8%	12.0%	12.4%	9.6%
	2016	9.3%	9.7%	12.5%	9.1%	9.4%
	2019	11.9%	11.5%	13.1%	10.7%	10.0%
Obesity: % of adults that report a BMI >= 30						
	2013	28.7%	30.0%	27.9%	29.1%	28.1%
	2016	33.2%	30.0%	25.7%	31.6%	27.3%
	2019	32.3%	35.4%	27.6%	28.6%	28.8%
Excessive Drinking: % of adults that report excessive or binge drinking						
	2013	19.4%	11.8%			15.9%
	2016	17.6%	16.7%	14.2%	17.7%	16.6%
	2019	18.1%	15.3%	15.5%	14.9%	17.4%
Physical Inactivity: % of adults that report being physically inactive						
	2013	25.0%	28.6%	30.8%	21.5%	24.0%
	2016	23.7%	28.6%%	22.8%	23.4%	22.2%
	2019	22.9%	24.0%	23.0%	24.9%	21.6%
Food Insecurity: % of adults that report worrying that they will						
	2013					
	2016	9.0%	10.2%	10.7%	8.2%	11.9%
	2019	7.8%	10.1%	10.3%	6.8%	10.6%
Free School Lunch: % of children eligible to receive free lunch at school						
	2013	26.9%	26.0%	28.6%	41.4%	30.8%
	2016	27.6%	26.9%		16.9%	32.1%
	2019	35.6%	28.6%	52.6%	21.3%	41.2%

		Gloucester County	King & Queen County	Mathews County	Middlesex County	Virginia (All)
Smoking: % of adults that smoke						
	2013	21.6%%%	18.6%			18.3%
	2016	16.1%	17.0%	15.6%	15.6%	19.5%
	2019	14.9%	18.3%	15.6%	14.7%	15.3%
HIV Rate: HIV+ Individuals per 100,000 population						
	2013	102	167		181	307
	2016	123	90	197	117	320
	2019	123	74	179	120	308
Mammography: % of Female Medicare Enrollees Ages 65-74 That Had a Screening Mammogram (NOTE – changed data source in 2019)						
	2013	69.2%	63.0%	74.1%	67.2%	66.0%
	2016	68.0%	67.0%	70.0%	68.0%	63.0%
	2019	48.0%	46.0%	55.0%	51.0%	43.0%
Mental Health Provider Ratio: The number of Mental Health Providers Population Ratio						
	2013	4615:1		2991:1	10977:1	2216:1
	2016	774:1	2698:1	2139:1	1001:1	685:1
	2019	704:1		2926:1	1526:1	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	57	68	45	54	58
	2016	47	47	47	44	49
	2019	3,971	5,349	3,140	4,222	4,454
Violent Crime Rate: The number of violent crimes per 100,000 population						
	2013	66	50	139	134	233
	2016	76	73	97	125	200
	2019	114	140	40	217	207

Sources

Health Behavior data pulled through Robert Wood Johnson's countyhealthrankings.org

Diabetes: 2013 – National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation (2009 data); 2016 – CDC Diabetes Interactive Atlas (2012 data); 2019 – CDC Diabetes Interactive Atlas (2015 data).

Obesity: 2013 – National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation (2009 data); 2016 – CDC Diabetes Interactive Atlas (2012 data); 2019 – CDC Diabetes Interactive Atlas (2015 data).

Excessive Drinking: 2013 – Behavioral Risk Factor Surveillance System (BRFSS) 2005-2011; 2016 – BRFSS (2014); 2019 – BRFSS (2016)

Physical Inactivity: 2013 – National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation (2009 data); 2016 – CDC Diabetes Interactive Atlas (2012 data); 2019 – CDC Diabetes Interactive Atlas (2015 data**).**

Food Insecurity: 2013 (NA); 2016 – Map the Meal Gap (2013); 2019 – Map the Meal Gap (2016)

Free School Lunch: 2013 - National Center for Education Statistics (2011); 2016 – National Center for Education Statistics (2012-2013); 2019 – National Center for Education Statistics (2016)

Smoking: 2013- BRFSS (2005-2011); 2016 – BRFSS (2013); 2019- BRFSS (2016)

HIV: 2013 – National HIV Surveillance System (2012); 2016 – National HIV Surveillance System (2012); 2019 – National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (2015)

Mammography: 2013 – Dartmouth Atlas of Care (2010); 2016 – Dartmouth Atlas of Care (2013); 2019 – Mapping Medicare Disparities (2016)

Mental Health Provider Ratio: 2013 – HRSA Area Resource File 2011-2012; 2016 – CMS National Provider Identification (NPI) File (2015); 2019 – CMS NPI File (2018)

Preventable Hospitalizations: 2013 – Rate per 1,000, Dartmouth Atlas of Care (2010); 2016 – Rate per 1,000, Dartmouth Atlas of Care (2015); 2019 – Rate per 100,000, Mapping Medicare Disparities Tool (2016)

Violent Crime Rate: 2013 – Violent Crime Reporting, FBI (2008-2010); 2016 – Uniform Crime Reporting, FBI (2010-2012); 2019 – Uniform Crime Reporting, FBI (2014-2016)

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 5,098 nonelderly residents of the study region were uninsured, including 748 children and 4,350 adults. The estimated uninsured rates were 6% for children age 0-18, 14.3% for adults age 19-64, and 12.4% for the population age 0-64. This is a higher 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)	748	6.0%	94,398	4.9%
Adults (Age 19-64)	4,350	14.3%	606,611	11.8%
All Under 65	5,098	12.4%	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 four localities that overlap with the zip code study region have been fully designated as Medically Underserved Areas (King and Queen, Mathews and Middlesex counties). There has been a change in this from prior CHNAs. Gloucester County used to have partial designation as a Medically Underserved Area, with 1 of 8 census tract areas qualifying. However, it no longer has any designation as an MUA. 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
Gloucester County	No Designation	n/a
King and Queen County	Medically Underserved Area	61.7
Mathews County	Medically Underserved Area	57.7
Middlesex County	Medically Underserved Area	58.8
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 Kings' 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.

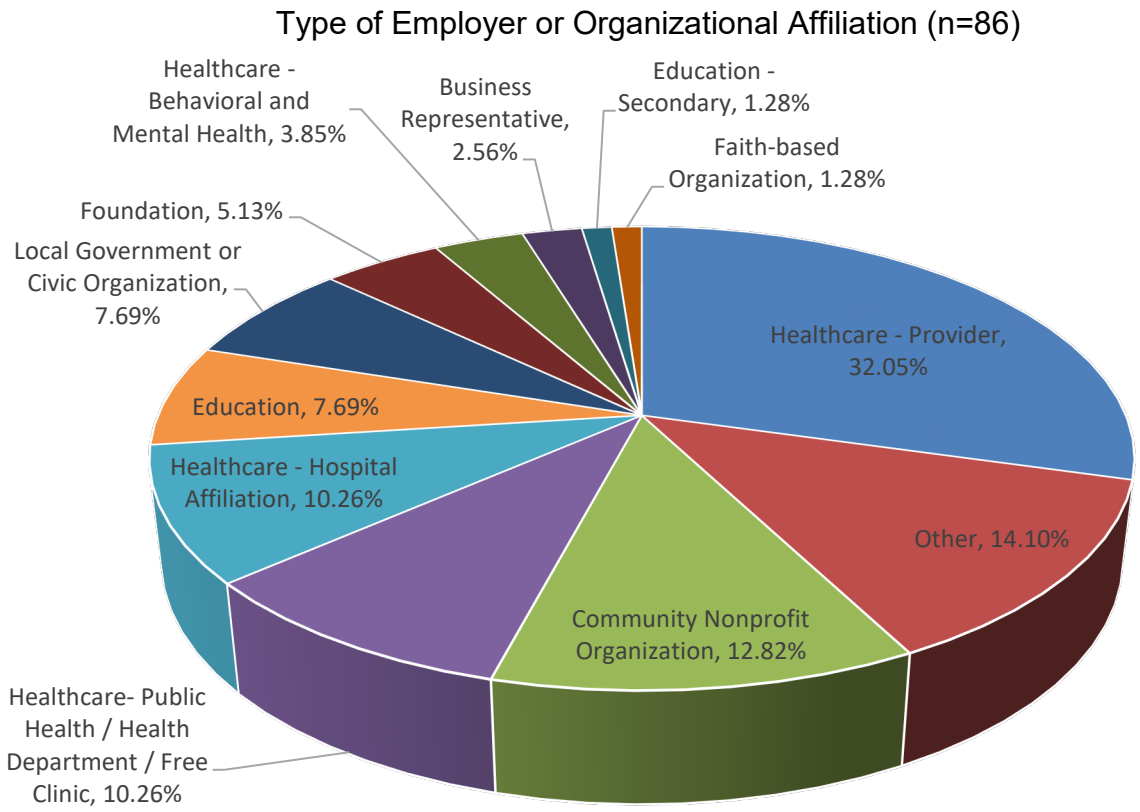
The survey was facilitated using SurveyMonkey, and online survey tool. Each survey asked respondents to identify the community they were answering for when they took the survey. This allowed the same survey to be used across multiple regions and for multiple hospitals. Once the survey was closed, each 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, 106 respondents completed the survey who identified areas within RWRH's service area as their community (86 took the stakeholder survey, and 20 took the community survey). This response size is an increase of 100% over the 2016 survey (49 responses). RWRH 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.

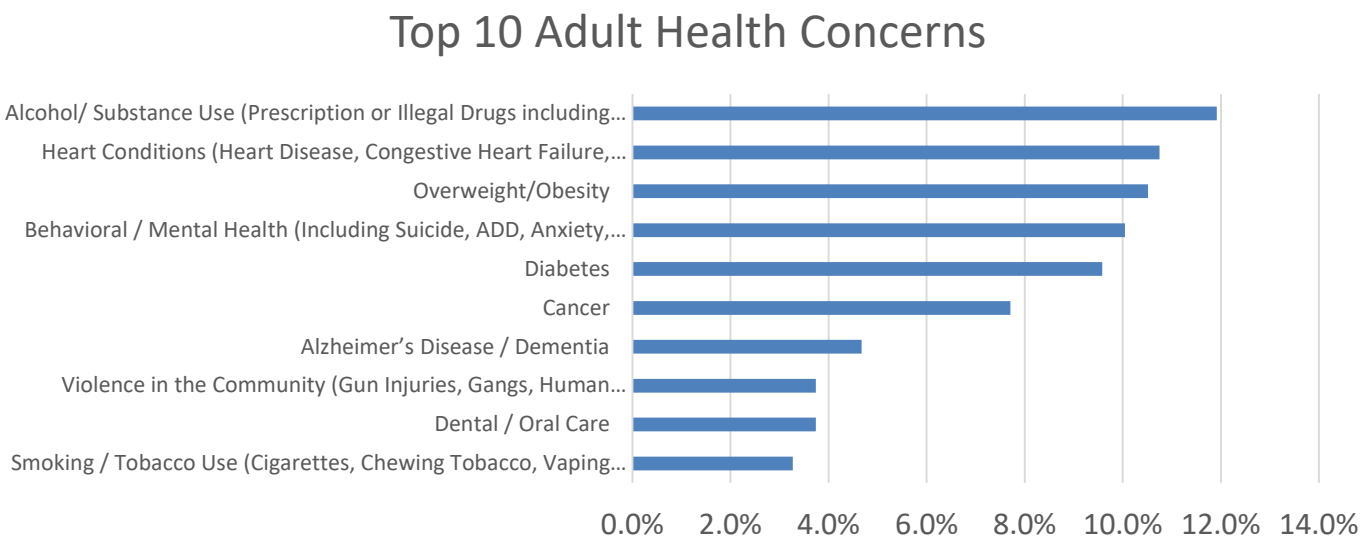
Exhibit II-A
Employer Affiliation of Survey Respondents



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.

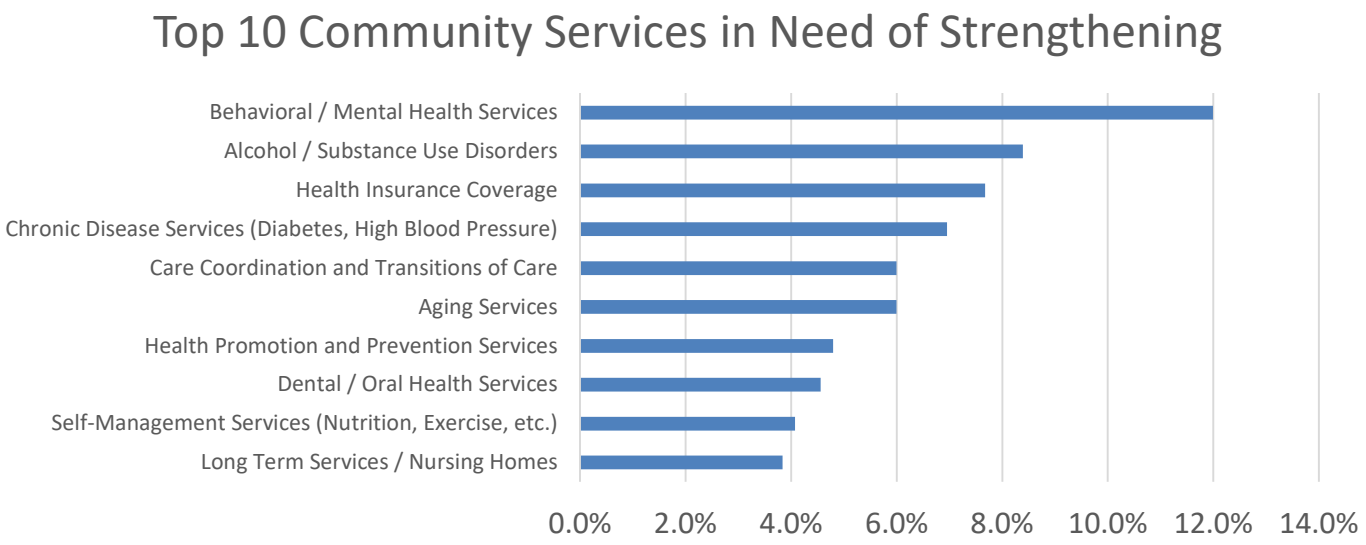
Exhibit II-B
Top Community Health Issues Facing Adults
87 respondents with up to 5 priorities each = 428 responses



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.

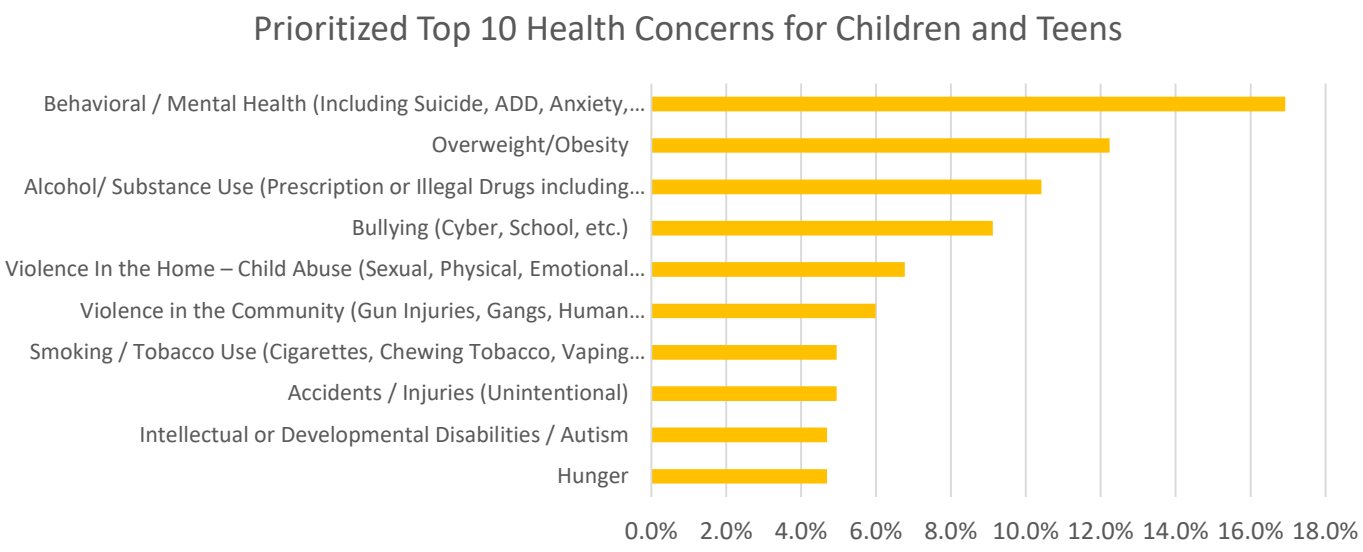
Exhibit II-C
Top Community Health Services for Adults In Need of Strengthening
70 respondents with up to 5 priorities each = 343 responses



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
79 respondents with up to 5 priorities each = 384 responses

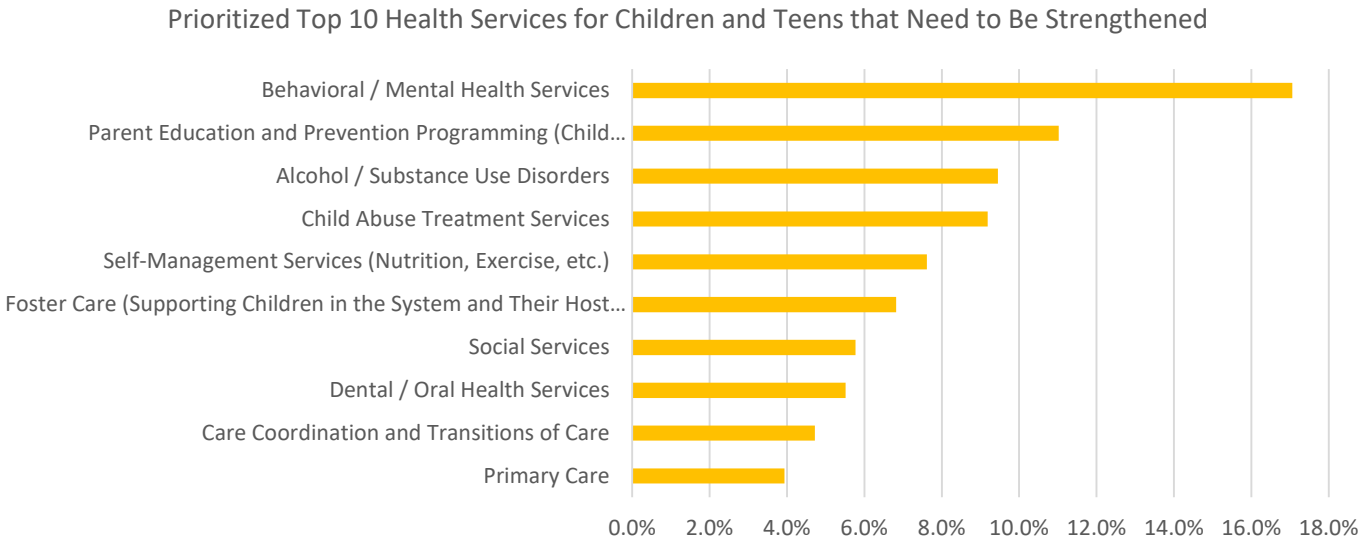


Community Health Services for Children & Teens

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

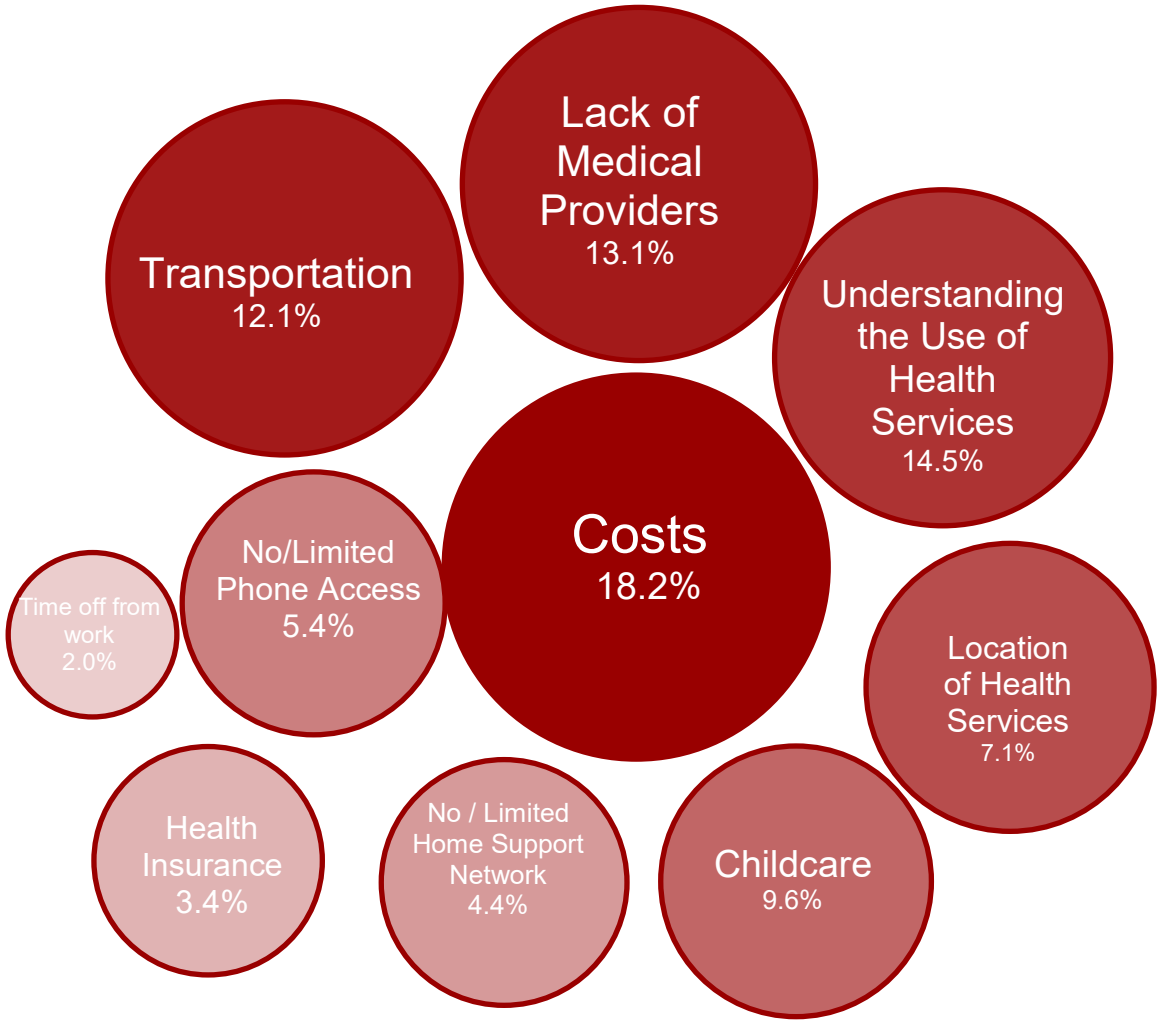
78 respondents with up to 5 priorities each = 381 responses



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.

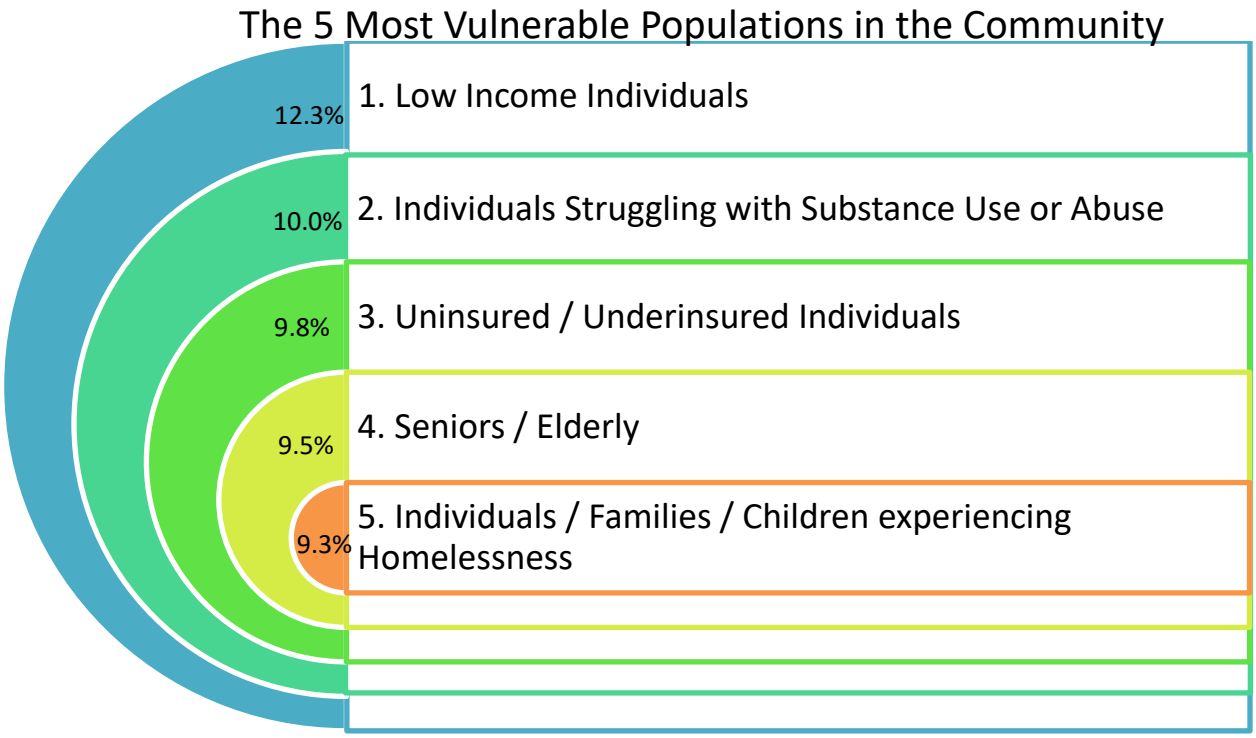
Exhibit II-F
Top Community Issues Impacting Access to Healthcare
85 respondents with up to 5 priorities each = 406 responses



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
70 respondents with up to 5 priorities each = 347 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 were six focus areas as part of the 2016 Implementation Plan for the Middle Peninsula area.

Mental Health

As in the rest of the country, mental health is perceived as an underserved health need across the Middle Peninsula and Northern Neck regions. In Virginia, the Community Services Board (CSB) system is charged with serving the uninsured and seriously mentally ill across the commonwealth. Locally, the Middle Peninsula Northern Neck Community Services Board serves the ten county region from Colonial Beach to Gloucester Point. The CSB has identified the three largest obstacles to be a lack of funding, the lack of Medicaid expansion in Virginians a lack of qualified staff (and the long term funding to support them). Riverside worked with legislators and employers in the region advocating the expansion of Medicaid which did pass in Virginia in 2018.

Healthy Lifestyle/Obesity/Diabetes

The population across the Middle Peninsula region struggles with obesity and obesity-related conditions, such as hypertension and diabetes. Riverside offered a host of community education lectures and screenings throughout the counties in collaboration with community partners covering a broad range of health topics. RWRH provides two support groups offering both weight management and diabetes education on a monthly basis at no charge to the community.

Healthy Aging

The objective defined by the multi-disciplinary group of community representatives is to promote ongoing collaboration and communication among agencies, providers and organizations. Riverside offered F.A.M.I.L.I.E.S. Counseling Program for caregivers of person's living with dementia, as well as a supported a chronic condition care management program in collaboration with Bay Rivers.

Transportation

Transportation was considered to be a critical community health issue. Without transportation, not only is someone not able to reach medical appointments, but they have limited access to grocery stores, medication and employment opportunities. Bay Transit is a part of the Regional Resource Council and is an important cornerstone in the community. RWRH continued its relationship with Bay Transit, a division of Bay Aging. There was no specific new action completed in the 2016 CHNA.

Housing

The group recognizes the important role safe and reliable housing plays in the region and wants to ensure that Bay Housing continues to be a part of community health conversations. Again, it was noted that the Regional Resource Council, which also includes Bay Housing, is an important catalyst of key communications between community organizations. In the 2016 CHNA implementation timeframe, the Northern Neck/Middle Peninsula Housing Coalition received the Capacity Building Grant through Bay Aging enabling the funding of a consultant who assisted with the completion of a strategic plan. Recommendations are complete and the next step is to seek the funding for the actual housing projects.

Middle Peninsula/Northern Neck Regional Resource Council

The process of working through the various issues continued to highlight the importance of the community working in collaboration with the existing community assets in the region. The Middle Peninsula/ Northern Neck Regional Resource Council was noted as an existing group that had the potential to continue to address all of these issues if attendance and participation was increased. Team members from Riverside attended scheduled meetings and added information to the Regional Resource Council's online directory. The organizer of the Regional Resource Council retired in the summer of 2019 and work is being directed through the individual county resource councils.

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 Walter Reed Hospital and the quality committee of the hospital compiled the list of most critical needs in the community. In addition, the strategic plan initiatives for the hospital were reviewed for alignment with the community needs assessment for 2019. Looking at both the quantitative and qualitative results and comparing them with the current community initiatives underway in the study region, the six areas of focus were confirmed as major priorities.

After the six areas of focus were identified, a review of current action steps and resources were examined and through input from the hospital leaders, the priority area was validated. Further, the leadership team of the hospital has ongoing meetings with local officials, employers and community non-profits to name a few. There will continue to be ongoing collaboration with community partners in the action steps identified and the resources allocated for the focus area.

IMPLEMENTATION STRATEGY

Strategy Process for Addressing Prioritized Health Needs

In the prioritization process, Riverside engaged with team member stakeholders who have professional knowledge of the state-of-health care in the Middle Peninsula region, including some local non-profit agencies focused on health services, RMG primary care and specialty providers, and others focused on services for the aging population.

As noted above, the hospital leadership aligned community health needs with its strategic plan to identify action steps that will significantly advance benefits to the community. Following the prioritization of health needs by the Administrative team at RWRH, the next step was to develop an implementation strategy.

Significant Health Need To Be Addressed

- Aging Services
- Transportation
- Cardiovascular Health and Heart Disease
- Chronic Diseases
- Lung Cancer
- Substance Abuse

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:

- COPD
- Stroke
- Violent Crime Rate
- Psychoses
- Food Insecurities

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:

- Smoking/Tobacco Use
- Violence in the Home/Child Abuse
- Dental/Oral Care
- Health Insurance Coverage
- Autism
- Chronic pain
- Foster Care
- Social Services

Background information, action steps and anticipated resources are noted.

Aging Services

Background:

The Middle Peninsula study region has 64,381 residents and the fastest growing age cohort is the adults age 65+ anticipated to grow by 18.3% while the overall region is estimated to grow by 2.9% by 2022. Moreover, the 2016 mortality profile exhibited that Alzheimer's disease is the second leading cause of death. In the 2016 Community Health Needs Assessment, Alzheimer's was not among the top five leading causes of death. Finally, seniors and elderly were identified as one of the top five most vulnerable populations in the community based on the qualitative survey.

Action Steps:

Through Riverside's Center for Excellence in Aging and Lifelong Health (CEALH) and the Middle Peninsula Riverside Wellness and Fitness Center, a number of community services are available for to those living with Alzheimer's and dementia, chronic diseases as well as support for their caregivers. The community resources include or will be expanded:

- **R.I.S.E.** Riverside's Introduction to Supervised Exercise program is offered to RMG patients referred by a Riverside physician at no charge. This program is also offered in the community with a charge. This program helps individuals with health conditions improve their strength, endurance, flexibility, balance and overall quality of life. The program also provides support and education on how to improve cardiovascular fitness, decrease risk of complication from chronic illness and build a healthier lifestyle.

- **F.A.M.I.L.I.E.S** RWRH will continue to promote the F.A.M.I.L.I.E.S. program supporting the caregivers of individuals living with dementia.

- **Advance Care Planning** RWRH will expand its current efforts to encourage patients' to complete their advance directive. The team members at RWRH have and will continue to receive education and training to assist patients and their family members to understand the value of documenting a patient's goals, value and belief for future medical treatment and place of care.

- **Memory Café** will be offered in the study region in partnership with Peninsula Agency on Aging in 2020.

Resources:

The Riverside Center for Excellence in Aging and Lifelong Health actively pursues grants and donation 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. Further the clinical team at Riverside Walter Reed will work to provide information and education to its team members for moving the Advance Care Planning initiative forward

with patients and caregivers. An RMG provider is currently securing a palliative care fellowship at VCU bringing extensive knowledge and expertise to the region. The Middle Peninsula Riverside Fitness and Wellness Center will continue to provide programs targeted to the aging population and expand some of their programming as appropriate.

Transportation

Background:

Riverside Walter Reed and Riverside Tappahannock along with a broad group of community members identified the important role transportation plays in the region. This need to access health care is present in the 2019 qualitative survey findings for the Middle Peninsula Study Region. The counties of King and Queen, Mathew and Middlesex are all designated as medically underserved areas. Gloucester County did not get a designation.

Action Steps:

Riverside Walter Reed administration recognizes the need to add a new bus stop at RWRH. This will be done in conjunction with Bay Transit by the end of 2020. This will provide broader access to the surrounding counties to the medical services available on the campus.
Resources:
Riverside Walter Reed will approach Bay Transit to build a covered bus stop and will contribute the financial resources to erect the shelter to include proper safety elements such as illumination during evening hours.

Cardiovascular Health and Heart Disease

Background:

Heart disease is among the top five leading causes of death in the region. It is also noted to be one of the top health concerns in the community and one of the leading diagnoses treated in the primary care practices.

Action Step:

RWRH plans to establish an Advanced Cardiovascular Diagnostic Testing Center. The center will provide advanced testing and treatment such as Stress Echo, transesophageal echo and noninvasive ventilator support.

Resources:

The hospital is actively recruiting a dedicated cardiologist and expanding its interventional rotations with the RMG cardiology group along with rotating a physician from the RMG vascular group.
Cardiac rehab is working physical therapy to develop programs that will improve health and help recover from heart disease in addition to seeking a medical director. The clinical team will also provide education to the community and its current patients about heart health and early detection.

Chronic Diseases

Background:

The study region has an older population compared to Virginia as a whole and also has higher rates of obesity, diabetes and physical inactivity, all contributors to chronic diseases. In the survey conducted with community stakeholders, chronic disease services were among the top five identified as needing strengthening.

Action Step:

RWRH will establish an outpatient destination to accommodate rheumatology (autoimmune), GI treatments, antibiotics, and non-chemotherapy related infusions. The chronic diseases that will be treated will include:

- Multiple Sclerosis
- Crohn's Disease
- Lupus
- Rheumatoid Arthritis
- Ulcerative Colitis
- Chronic Inflammatory Demyelinating Polyneuritis

Resources:

The hospital will staff the outpatient infusion with a trained clinical team providing both the professional and compassionate care to care for patients with chronic conditions. This will include both patient and caregiver support.

Neoplasms of the Lung

Background:

Lung cancer is the leading causes of death in the Middle Peninsula community mortality profile.

Action Step:

Riverside has been offering low-dose CT screenings to patients who may have an increased risk of developing lung cancer. These screenings may help Riverside physicians spot lung cancer sooner, when it is more treatable. Initially, RHS only provided those screenings to patients with commercial insurance or those who paid out-of-pocket.

Resources:

In late 2018, Riverside began participating with the PenLung registry which allows for Riverside to accept Medicare and Medicaid patients. This expanded the availability to care for a much broader population on the Middle Peninsula. The RMG physicians offer the program to patients who meet the qualifications for the screening. The cancer lung navigators are available to the patient should an abnormality or a cancer is detected.

Substance Abuse

Background:

In the last four years, the fatal overdose rate in the RWRH study region was higher than Virginia as a whole, with the exception of 2017. The Virginia Department of Health reports that fatal drug overdoses are the leading causes of unnatural death in Virginia since 2013 and that opioids have been the driving force in this increase.

Action Steps and Resources:

Several Riverside facilities have a Crisis Intervention program, where a team including members of the CSB, fire/EMS, psychiatric technicians, and behavioral health specialists come together to allow patients' psychiatric needs to be addressed while in the hospital. Riverside Health System has transitional processes in place, where individuals in various care settings (ED, IP, others) are referred to an addiction management specialist for appropriate care (an example of this would be the ED-bridge implementation). As seen in many other hospitals across the country, Riverside facilities are attempting to minimize opioid exposure through responsible and appropriate prescribing tactics such as multi-modal pain management and education to patients and providers. Riverside will also continue to partner with other organizations, such as the Community Service Board, to address related issues in 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 Walter Reed Hospital at 804-693-8800 or via the comments section on www.riversideonline.com/community_benefit.

To obtain a paper copy, write or visit Riverside Walter Reed Administration located at 7519 Hospital Drive, Gloucester, VA 23061.

Appendices

Appendix A

Specific Organizational Affiliations of Respondents *(as entered by respondents on the survey)*
WIC
CHKD
EVMS
Children's Hospital of The King's Daughters
CHKD
The Orchard--A Riverside Healthy Living Community
Mathews County School Board
Eastern Virginia Medical School
Middlesex County School Board
Riverside. Lifelong Health and Aging
Riverside Health System
Peninsula Metropolitan YMCA
Riverside Convalescent Center – Mathews
Mathews County
Access Partnership
Williamsburg Health Foundation
Grace Covenant Presbyterian Church
Bay Aging
Middlesex County Public Schools
EVMS ENT
Consortium for Infant and Child Health (CINCH)/EVMS
Riverside Health System

Riverside Health System
Virginia Career Works- Greater Peninsula
American Diabetes Association
Gloucester-Mathews Free Clinic
Olde Towne Medical & Dental Center
RWRH
Peninsula Metropolitan YMCA
Compassionate Care Hospice
Virginia Oral Health Coalition
Middle peninsula Northern Neck CSB
King and Queen Social Services
Middlesex Department of Social Services
Sentara
Riverside Tappahannock Hospital
EVMS
Bay Rivers Telehealth Alliance
VersAbility Resources
Bon Secours Mercy Health Mary Immaculate Hospital
Williamsburg Health Foundation
Virginia Peninsula Foodbank
York Juvenile Services
United Way of the Virginia Peninsula
United Way of the Virginia Peninsula
SNF/NF/ALF
Retired
DOL One Stop Career Center
We are a community based designated rural health clinic serving uninsured and under insured.

We provide training and technical assistance to health care providers, family educators and others to ensure oral health education, services and referrals are included in patient/client interactions
EVMS
Non-Profit Consortium

Appendix B

Community Health Issues Affecting Adults (Ages 18+) Ranked by Survey Respondents		
"Please check the five most important health concerns for adults in your community." Note: 87 of 106 respondents answered this question (on the stakeholder and community surveys).		
Answer Options	Response Percent	Response Count
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	11.9%	51
Heart Conditions (Heart Disease, Congestive Heart Failure, Heart Attacks, High Blood Pressure)	10.7%	46
Overweight/Obesity	10.5%	45
Behavioral / Mental Health (Including Suicide, ADD, Anxiety, Depression, etc.)	10.0%	43
Diabetes	9.6%	41
Cancer	7.7%	33
Alzheimer's Disease / Dementia	4.7%	20
Dental / Oral Care	3.7%	16
Violence in the Community (Gun Injuries, Gangs, Human Trafficking, etc.)	3.7%	16
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	3.3%	14
Accidents / Injuries (Unintentional)	2.8%	12
Chronic Pain	2.8%	12
Respiratory Diseases (Asthma, COPD, Emphysema)	2.8%	12
Hunger	2.6%	11
Neurological Conditions (Stroke, Seizures, Multiple Sclerosis, Traumatic Brain Injury, etc.)	2.3%	10
Prenatal and Pregnancy Care	1.9%	8
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	1.9%	8
Violence – Sexual and / or Domestic	1.4%	6
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	1.2%	5

Intellectual or Developmental Disabilities / Autism	1.2%	5
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	0.9%	4
Other	0.9%	4
Physical Disabilities	0.7%	3
Bullying (Cyber, Workplace, etc)	0.5%	2
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 health care disparities not make this list
I work with children so am not sure
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.
Lack of understanding of community resources that are already available to patients and are under utilized

Appendix C

Community Health Services for Adults (Ages 18+) In Need of Strengthening Ranked by Survey Respondents		
"Check the five services that you feel need to be strengthened in order to improve access, availability and quality of health and healthcare for adults (age 18+) in your community." Note: 85 of 106 respondents answered this question (on the stakeholder and community surveys).		
Answer Options	Response Percent	Response Count
Behavioral / Mental Health Services	12.0%	50
Alcohol / Substance Abuse Services	8.4%	35
Health Insurance Coverage	7.7%	32
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	7.0%	29
Care Coordination and Transitions of Care	6.0%	25
Aging Services	6.0%	25
Health Promotion and Prevention Services	4.8%	20
Dental / Oral Health Services	4.6%	19
Self-Management Services (Nutrition, Exercise, etc.)	4.1%	17
Long Term Services / Nursing Homes	3.8%	16
Social Services	3.6%	15
Home Health Services	3.4%	14
Cancer Services	3.4%	14
Telehealth / Telemedicine	3.1%	13
Domestic Violence / Sexual Assault Services	3.1%	13
Chronic Pain Management Services	3.1%	13
Hospice and Palliative Care Services	2.9%	12
Hospital Services (Inpatient, Outpatient, Emergency Care)	2.4%	10
Family Planning and Maternal Health Services	2.4%	10
Primary Care	2.2%	9
Other Community Health Services: Please share other needed community health services if they are not listed	2.2%	9
Pharmacy Services	1.4%	6
Access to Care (Availability, Language, Costs, Lack of Providers, etc.)	1.0%	4
Physical Rehabilitation Services	1.0%	4
Bereavement Support Services	0.7%	3

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.
Hospital obstetrics services-deliveries.
Women's health
I work with children
Hospice and Palliative Care also important but there are many gaps in services and in education of providers and the public.
Transportation is a critical barrier to health care for many of our patients.
In the rural areas of Eastern Virginia, access to services is essential. Through the use of telemedicine access to many services available in urban areas may be increased empowering patients to address complex issues, coordinate care across settings and sectors, and improve self-care

Appendix D

Community Health Issues Affecting Children & Teens (Age 0 - 17) Ranked by Survey Respondents		
"Please check the five most important health concerns for children and teens in your community." Note: 79 of 106 respondents answered this question (on the stakeholder and community surveys).		
Answer Options	Response Percent	Response Count
Behavioral / Mental Health (Including Suicide, ADD, Anxiety, Depression, etc.)	16.9%	65
Overweight/Obesity	12.2%	47
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	10.4%	40
Bullying (Cyber, School, etc.)	9.1%	35
Violence In the Home – Child Abuse (Sexual, Physical, Emotional or Neglect) or Exposure to Domestic Violence	6.8%	26
Violence in the Community (Gun Injuries, Gangs, Human Trafficking, etc.)	6.0%	23
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	4.9%	19
Accidents / Injuries (Unintentional)	4.9%	19
Intellectual or Developmental Disabilities / Autism	4.7%	18
Hunger	4.7%	18
Dental / Oral Care	4.2%	16
Teen Pregnancy	2.6%	10
Respiratory Diseases (Asthma, Emphysema, Cystic Fibrosis)	2.6%	10
Diabetes	2.1%	8
Sexually Transmitted Infections (HPV, Herpes, HIV/AIDS, Chlamydia, Gonorrhea, etc.)	1.8%	7
Eating Disorders	1.3%	5
Drowning / Water Safety	1.3%	5
Other	1.0%	4
Neurological Conditions (Epilepsy, Tourette Syndrome, Sleep Disorders, Seizures etc.)	0.8%	3
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	0.8%	3
Physical Disabilities	0.3%	1
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	0.3%	1
Cancer	0.3%	1
Heart Conditions (Congenital Heart Disease, Fainting, and Rhythm Abnormalities)	0	0
Chronic Pain	0	0

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.
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
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.

Appendix E

Community Health Services for Children & Teens (Age 0 - 17) In Need of Strengthening Ranked by Survey Respondents		
"Please check the five services that you feel need to be strengthened in order to improve access, availability and quality of health and healthcare for children and teens (ages 0-17) in your community." Note: 78 of 106 respondents answered this question (on the stakeholder and community surveys).		
Answer Options	Response Percent	Response Count
Behavioral / Mental Health Services	17.1%	65
Parent Education and Prevention Programming	11.0%	42
Alcohol / Substance Use Services	9.4%	36
Child Abuse Prevention and Treatment Services	9.2%	35
Self-Management Services (Nutrition, Exercise, etc.)	7.6%	29
Foster Care (Supporting children in the system and their host families)	6.8%	26
Social Services	5.8%	22
Dental / Oral Health Services	5.5%	21
Care Coordination and Transitions of Care	4.7%	18
Primary Care	3.9%	15
Public Health Services	3.7%	14
Telehealth / Telemedicine	3.4%	13
Health Insurance Coverage	3.4%	13
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	2.4%	9
Other Community Health Services: Please share other needed community health services if they are not listed	1.8%	7
Chronic Pain Management Services	1.6%	6
Home Health Services	1.3%	5
Cancer Services	0.5%	2
Bereavement Support Services	0.5%	2
Pharmacy Services	0.3%	1
Physical Rehabilitation Services	0	0

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
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
Transportation remains a barrier to health care for teens.
Water Safety/Drowning Prevention Tween/Teen Leadership Programs
Schools are a primary source of care and support for children and teens in rural areas. By improving the health infrastructure of rural schools through telemedicine, schools can be equipped to support physical, behavioral, dental and chronic disease care services, teaching children at a young age how to be healthier adults.

Appendix F

Community Issues Affecting Access to Healthcare Ranked by Survey Respondents		
"Please check the five most important issues in accessing healthcare in your community." Note: 85 of 106 respondents answered this question (from the stakeholder and community surveys).		
Answer Options	Response Percent	Response Count
Costs	18.2%	74
Understanding the Use of Health Services	14.5%	59
Lack of Medical Providers	13.1%	53
Transportation	12.1%	49
Other	10.1%	41
Childcare	9.6%	39
Location of Health Services	7.1%	29
No / Limited Phone Access	5.4%	22
No / Limited Home Support Network	4.4%	18
Health Insurance	3.4%	14
Time Off From Work	2.0%	8

Access Issues: Respondents were asked to use this space to provide any additional information on why they selected these concerns.
Lack of providers in Rural areas
Few providers of services are available in evenings or weekends making it difficult for working parents to take time off.
Lack of Medicaid Providers and that will only become more serious as additional people enroll in the Program. Also, understanding the use of health services.
These are all important. Understanding use of health services is easily a tie for the others I chose. As is child care.....
perception of issues confronting community
Stigma
Poor broadband and cellular reception in rural areas make it difficult to access services that might be available via telemedicine, which could overcome several of these access obstacles such as transportation, time off from work, etc.

Appendix G

Vulnerable Populations In Need of Additional Services or Support Ranked by Survey Respondents		
"Check what you feel the five vulnerable populations needing additional services or support in the community." Note: 81 of 106 respondents answered this question (on the stakeholder and community surveys).		
Answer Options	Response Percent	Response Count
Low Income Individuals	12.3%	49
Individuals Struggling with Substance Use or Abuse	10.0%	40
Uninsured / Underinsured Individuals	9.8%	39
Seniors / Elderly	9.5%	38
Individuals / Families / Children experiencing Homelessness	9.3%	37
Caregivers (Examples: caring for a spouse with dementia or a child with autism)	8.5%	34
Children and Teens (age 0-17 years)	7.3%	29
Immigrants or community members who are not fluent in English	5.3%	21
Individuals with Intellectual or Developmental Disabilities	4.5%	18
Unemployed Individuals	3.8%	15
Individuals Needing Hospice / End of Life Support	3.3%	13
Individuals Transitioning out of Incarceration	3.0%	12
Individuals with Physical Disabilities	2.5%	10
Victims of Human Trafficking, Sexual Violence or Domestic Violence	2.3%	9
Veterans and Their Families	2.3%	9
Migrant Workers	2.0%	8
Individuals Struggling with Literacy	2.0%	8
Other Vulnerable Populations	1.3%	5
Individuals in the LBGTQ+ community	1.3%	5

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.
Add seniors and un or underinsured
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.
The VA just terminated funding for the Veteran's connected program for rural veterans to access care in their communities. Only 8-10% of veterans in the rural areas of Eastern Virginia are enrolled in VA services at the VAMC's in Hampton or Richmond. These populations are at increased risk of not accessing health services because they are no longer being paid for.
Wow. I could have chosen several others on this list (i.e., many more than 5)!

Appendix H

Community Health Assets In Need of Strengthening Ranked by Survey Respondents		
"Please check what you feel are the five community assets that need strengthening in the community." Note: 81 of 106 respondents answered this question (on the stakeholder and community surveys).		
Answer Options	Response Percent	Response Count
Transportation	11.4%	45
Affordable Child Care	9.6%	38
Employment Opportunity/Workforce Development	8.4%	33
Affordable Housing	8.4%	33
Healthy Food Access (Fresh Fruits & Vegetables, Community Gardens, Farmers Markets, etc.)	8.1%	32
Homelessness	6.3%	25
Social Services	5.8%	23
Senior Services	5.6%	22
Neighborhood Safety	4.8%	19
Education – Kindergarten through High School	4.8%	19
Early Childhood Education	4.8%	19
Safe Play and Recreation Spaces (Playgrounds, Parks, Sports Fields)	4.3%	17
Social and Community Networks	4.1%	16
Walk-able and Bike-able Communities (Sidewalks, Bike/Walking Trails)	3.5%	14
Safety Net Food System (Food Bank, WIC, SNAP, Meals on Wheels, etc)	3.3%	13
Public Safety Services (Police, Fire, EMT)	2.5%	10
Education – Post High School	1.5%	6
Other Community Assets: share other community assets if they are not listed	1.0%	4
Public Spaces with Increased Accessibility for those with Disabilities	0.8%	3
Green Spaces	0.5%	2
Environment – Air & Water Quality	0.5%	2
Housing Affordability & Stability	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.
Affordable access to broadband
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/bike able communities also rank high up there.
health safety net

Appendix I

Respondents were asked to express any final comments or closing ideas
Thank you for asking. I'd love to help from a public health standpoint if needed.
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....
There is little vocal effective advocacy for patients ages 19-64.
Thank you for allowing me the opportunity to share my concerns
Bay Rivers Telehealth Alliance has conducted a number of Community Needs Assessments related to the provision of Telemedicine in the Northern Neck, Middle Peninsula and Eastern Shore related to Care Transitions, Geriatric Care, Rural Opioid Planning and School Based Health Services. In addition, we have developed a comprehensive data base for all of Eastern Virginia on the Veteran Population beyond the statistics of the Veterans Administration. If we can be of support in the Needs Assessment by sharing any of this information