Sentara Halifax Regional Hospital

Community Health Needs Assessment 2018






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Community Health Needs Assessment (CHNA)

2018

Table of Contents

I. Introduction

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

Our assessment includes a review of population characteristics such as age and racial and ethnic composition because demographic factors are important determinants of health. Socioeconomic factors such as education, employment and poverty are included because current research suggests that the way a person lives in their community, the challenges they face and the solutions they find, plays a substantial role in that person's ability to lead a healthy life. The assessment also looks at risk factors like obesity and smoking and at health indicators such as infant mortality and preventable hospitalizations. Community input is important and this year we have partnered with the Southside Health Department to share survey results from two survey instruments that have slightly different focus and respondent populations, as well as findings from community interviews and focus groups on health issues and barriers to achieving good health. Finally, the assessment presents the health status indicators that depict the medical conditions commonly found in the community. Each of these types of data is essential in developing a comprehensive view of community health.

The needs assessment identifies numerous health issues that our communities face. While there are many important health problems, we are focusing our efforts on the health issues listed below. Considering factors such as size and scope of the health problem, the severity and intensity of the problem, the feasibility and effectiveness of possible interventions, health disparities associated with the need, the importance the community places on addressing the need, and consistency with our mission "to improve health every day," we have identified these priority health problems in our area:

- Behavioral Health
- Heart Disease
- Metabolic Syndrome (obesity and diabetes)
- Cancer
- Stroke

Most of these health issues are continued from our previous CHNA, completed in 2015. This makes sense because these are complex, intractable health conditions, and it takes many years and concerted effort to make positive changes that are significant enough to impact outcomes for the whole community. In 2015, an implementation strategy was developed to address these problems and many programs have been developed to improve health for those who face these health challenges. The hospital has tracked progress on the implementation activities in order to evaluate the impact of these programs. A summary of the strategies employed to address health issues identified in the 2015 CHNA is included at the end of this document.

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

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

II. Community Description

The SHRH Service Area in Detail:

The service area of Sentara Halifax Regional Hospital (SHRH) comprises Halifax County as the primary service area, with Charlotte County and the western half of Mecklenburg served as well. The area encompasses the 29 zip codes displayed above, and the lives of 78,161 residents. Approximately 91% of the hospital's inpatients reside in this area. The zip codes included are listed on the next page.

County	Zip Code	Zip Code Name
Halifax	24520	Alton
Halifax	24534	Clover
Halifax	24539	Crystal Hill
Halifax	24558	Halifax
Halifax	24577	Nathalie
Halifax	24589	Scottsburg
Halifax	24592	South Boston
Halifax	24597	Vernon Hill
Halifax	24598	Virgilina
Charlotte	23923	Charlotte Court House
Charlotte	23934	Cullen
Charlotte	23937	Drakes Branch
Charlotte	23947	Keysville
Charlotte	23959	Phenix
Charlotte	23962	Randolph

County	Zip Code	Zip Code Name
Charlotte	23963	Red House
Charlotte	23964	Red Oak
Charlotte	23967	Saxe
Charlotte	23976	Wylliesburg
Mecklenburg	23915	Baskerville
Mecklenburg	23917	Boydton
Mecklenburg	23919	Bracey
Mecklenburg	23924	Chase City
Mecklenburg	23927	Clarksville
Mecklenburg	23950	La Crosse
Mecklenburg	23968	Skipwith
Mecklenburg	23970	South Hill
Mecklenburg	24529	Buffalo Junction
Mecklenburg	24580	Nelson

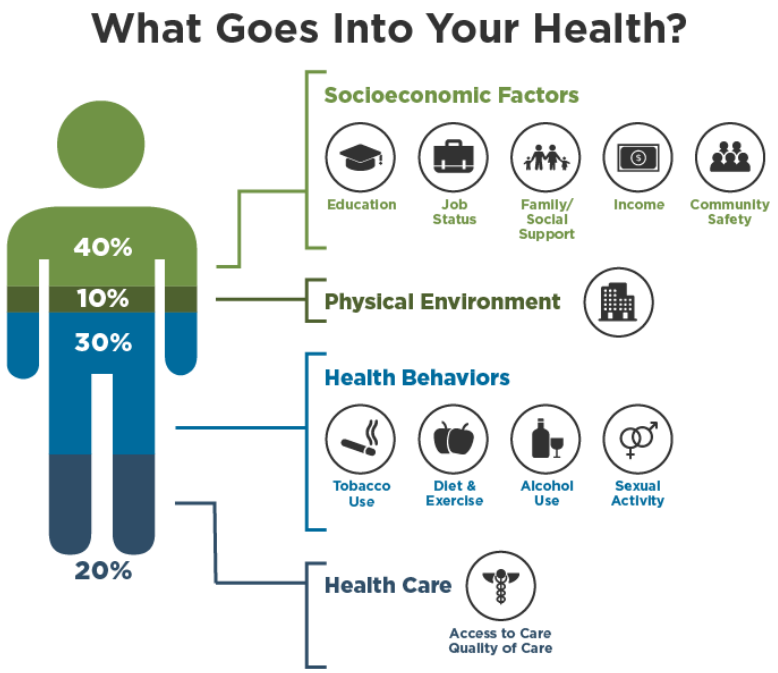
The geography of the service area distinguishes it from both Virginia as a whole and the United States in that it is an entirely rural region (designated as such by the United States Department of Agriculture classification). Halifax County is the 4th largest county in the state, and the logistical challenges faced by large geographic regions, including lack of public transportation, clustering of social, medical and educational services, and the poverty that results in 3% of the population not having access to a vehicle (US Census Bureau), makes access to services an important health challenge.

Geographic Description	Halifax County	Charlotte County	Mecklenburg County	Virginia	United States
Total Population*	35,276	12,313	30,572	8,310,301	318,558,162
Population Density/square mile*	42.5	25.8	45	202.6	87.4
Rural/Urban Designation**	RURAL			Mixed	

*US Census Bureau, 2017 Population Estimates**https://www.ers.usda.gov/webdocs/DataFiles/Rural_Definitions__18009//25601_VA.pdf

The Role of Social Determinants in health:

A growing body of research is being conducted on the ways our lifestyle opportunities, choices and constraints impact our overall health. Some have been surprised to discover that what we consider to be medical care, visits with our doctors, medication requirements and procedures to treat identified illnesses, contribute fairly little to our overall health over the course of a lifetime (20%). Much more important in determining our health are our health behaviors (like screenings, diet, exercise, sleep habits) and what we call the social determinants of health, the circumstances we live in (such as poverty, access to services, adequate housing, education and stable family structure). The following graphic depicts the impact of various factors on our health.



The following pages present some of the social determinants that influence community health in this service area.

The People, Who We Are:

Knowing the characteristics of the people who live in the service region is the first step to knowing their health status and concerns, and provides important information to use in improving community health.

	Halifax County	Charlotte County	Mecklenburg County	Virginia	United States
Total Population	35,276	12,232	30,572	8,310,301	318,558,162
Race					
White Non-Hispanic	60.7%	67.8%	61.4%	68.7%	73.3%
Black Non-Hispanic	36.8%	30.9%	35.5%	19.2%	12.6%
Hispanic	1.9%	.9%	2.6%	8.7%	17.3%
Minority Population	39%	32%	37%	31%	26.4%
Median Age	45.7 years	44.7 years	48.2 years	37.8 years	37.7 years
% of Population Aged 0 - 17	20.7%	21.7%	19.1%	22.4%	23%
% of Population Aged 65+	21.8%	20.4%	23.8%	13.3%	14.1%
Projected Population Change through 2040	-8.7%	-3%	-6.1%	+17%	

American Community Survey, US Census Bureau 2012-2017

Our Aging Population:

It is well understood that older individuals are more likely to need more healthcare services, and a variety of services which are targeted toward that population. The need for healthcare services increases with age and looking at the older population in fine detail reveals a set of likely healthcare needs as time goes on. The population of the SHRH service area is aging faster than the rest of the state, as presented in the table below. In 2020, 25% of the SHRH service area population will be aged 65+, while only 16% of the population of Virginia as a whole falls into that category. In 2030 the older population in the SHRH service area increases to 29%, while Virginia will find 19% of its population aged 65+. The trend reverses slightly by 2040, but the percentage in the SHRH area remains higher than in the whole of Virginia combined.

Additionally, the percent of the population aged 80+ and 85+ is consistently greater in the SHRH service area than in Virginia as a whole, and that difference continues through 2040. There are many reasons for this aging trend, including outmigration of young people in search of job opportunities and fewer births as a result. This is a community need addressed by Sentara's two state-of-the-art long term care facilities as well as the Sentara Halifax Orthojoint Center, Cox Rehabilitation Center, and other hospital-based programming.

The Aging Population: a Comparison of Projections for the SHRH Service Area and the State of Virginia			
2020			
Total 3 County Area % Aged 65+	25%	**Virginia % Aged 65+**	16%
Total 3 County Area % Aged 80+	6%	**Virginia % Aged 80+**	3%
Total 3 County Area % Aged 85+	3%	**Virginia % Aged 85+**	2%
2030			
Total 3 County Area % Aged 65+	29%	**Virginia % Aged 65+**	19%
Total 3 County Area % Aged 80+	8%	**Virginia % Aged 80+**	5%
Total 3 County Area % Aged 85+	3%	**Virginia % Aged 85+**	2%
2040			
Total 3 County Area % Aged 65+	28%	**Virginia % Aged 65+**	15%
Total 3 County Area % Aged 80+	9%	**Virginia % Aged 80+**	6%
Total 3 County Area % Aged 85+	4%	**Virginia % Aged 85+**	3%

The Demographics Group of the UVA Weldon Cooper Center for Public Service, June 2017: http://demographics.coopercenter.org

Maternal Demographics:

Unsupported and under-supported young families face many negative health outcomes, and predict many community challenges as time goes on, so looking at the way families begin can help us understand the current and future health of the community. Compared to Virginia, and to a lesser extent, to the US as a whole, the SHRH service area is home to a disproportionate share of young families in need of support and clearly displays the kind of racial differences that create long term health disparities.

Indicator	Halifax County	Charlotte County	Mecklenburg County	Virginia	United States*
Births w/out Early Prenatal Care	22.6%	31.7%	24%	14.8%	6.2%
Teen Births: (age 15-19, /100,000)	48.5	39	26.3	16.7	22.3
Non-Marital Births	49.6%	42.8%	56.9%	34.5%	40.3%
Births to Black Women	81.3%	59.5%	80.7%	64.7%	70.1%
Births to White Women	34%	36.8%	39.7%	25.2%	35.8%
Low Birth Weight Births: 2015	11.8%	9.7%	12%	7.9%	8.1%
Births to Black Women	20%	16.2%	16%	12.4%	13%
Births to White Women	7.2%	7.5%	7.5%	6.4%	7%

Red indicates that rates are worse, green that rates are better than comparison rates

Virginia Department of Health, Division of Health Statistics, 2015 www.vdh.virginia.gov/healthstats/

*CDC National Center for Health Statistics, 2015

Household Sustainability:

Family economic stability and sufficiency are leading indicators of community health, and predict access to preventive care, healthcare utilization and engagement in healthy lifestyle choices. Structural changes to the economy over the last 20 years have led to a high correlation between education, employment and income, the foundation of a stable household. In all categories that reference strain on the household, the SHRH service area faces larger challenges than Virginia or the United States as a whole.

Indicator	Halifax County	Charlotte County	Mecklenburg County	Virginia	United States
Educational Attainment*					
Less than High School (aged 25+)	21%	20%	20%	11.3%	13%
Bachelor's Degree	10.3%	8.3%	10.9%	21.2%	18.8%
Professional Degree	5.6%	4.7%	6.2%	15.7%	11.5%
Unemployment (Jan. 2018)**	5.2%	4.6%	5.7%	3.3%	4.1%
Single (female) Headed Households*	19%	24%	22%	18.5%	19.7%
Children in single-parent female headed households***	37%	50%	42%	30%	23%
Children in Poverty (below 100% FPL)*	25.9%	35.8%	23.5%	15.1%	21.2%
Population with Health Insurance*	85.9%	83.9%	87%	89.3%	91.4%
Public Health Insurance****	41.4%	42.7%	41.9%	26.1%	20.8%
% with Disability *	17.9%	21.3%	20.3%	11.3%	12.5%

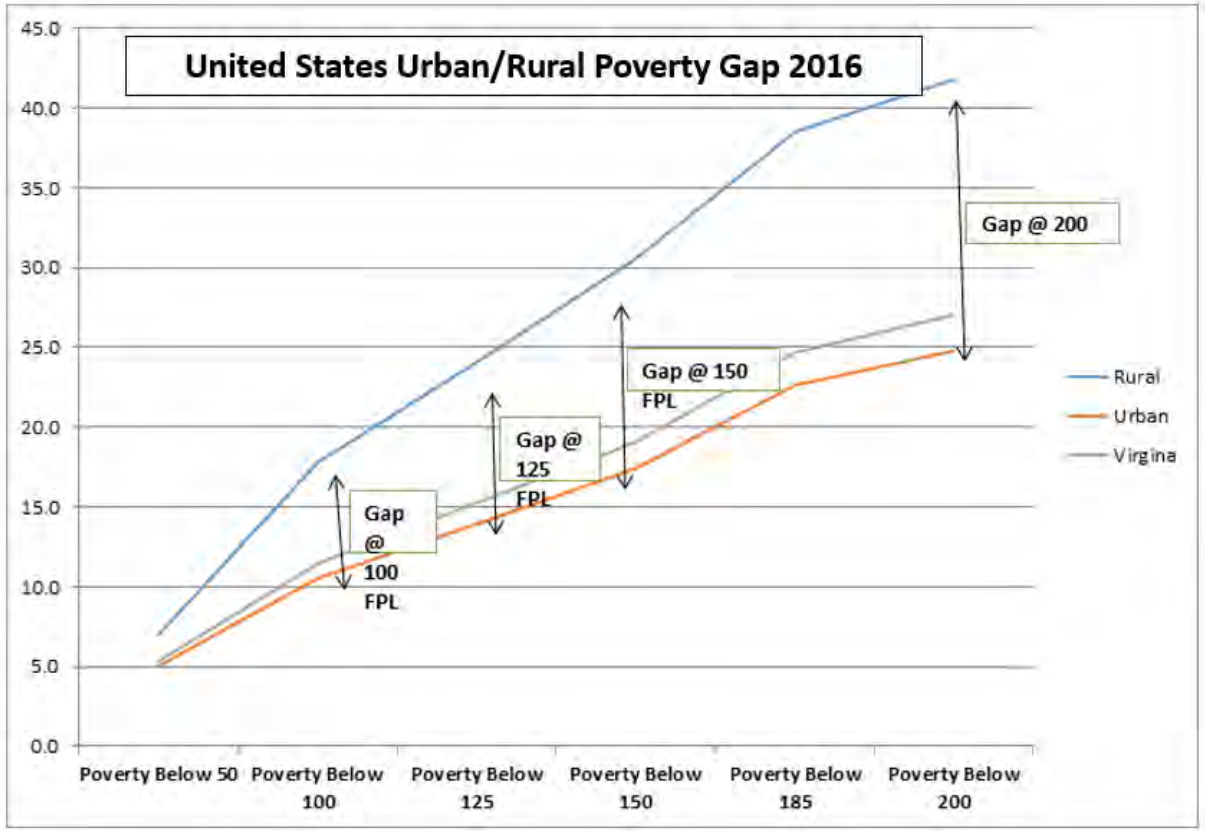
Red indicates that rates are worse, green that rates are better than comparison rates

*American Community Survey, American Factfinder 2012-2016, US Census Bureau **Bureau of Labor statistics

***County Health rankings, 2018 ****includes Medicare, Medicaid, and public exchange coverage

Poverty:

Independent of other factors, poverty is a powerful predictor of health status in any setting. The graph presented below demonstrates why it might be of particular concern to residents of the SHRH service area. The graph depicts the distribution of poverty between rural (shown in blue) and urban areas (shown in orange), with the combined and averaged level for the state of Virginia as a whole included for context. The graph shows that while only a slightly higher percent of rural dwellers in America are extremely poor, living below 50% of the federal poverty level (approximately 7% for rural vs. 5% for urban residents), the gap between rural and urban poverty grows significantly as poverty becomes less acute, but no less crippling. More than 40% of rural residents in the United States live below 200% of the federal poverty level, while only 25% of urban residents do. This disparity becomes important in policy decisions, and is applicable in understanding the generational, chronic poverty that is part of life in a rural area such as the service area of SHRH.



The poverty status of the SHRH service area mirrors the national poverty status, with 42.2% of Halifax residents living below 200% of the Federal Poverty Level, higher than Virginia's 26.8%, which includes urban dwellers. A closer look reveals another important distinction, with the poverty level of black residents of the SHRH service area significantly higher than for white individuals. The difference between white and black poverty rates is listed in the table below, with black residents experiencing more than twice the poverty rate of white SHRH residents. While the United States poverty rate disparity approaches that found in the SHRH service area, the disparity in Virginia, at 10.8%, is significantly less. Well-established racial health disparities in heart health, diabetes and hypertension are then amplified among residents of the SHRH service area.

Poverty Level: % 2016	Halifax County	Charlotte County	Mecklenburg County	Virginia	United States
100%	18.8%	24.7%	17.8%	11.4%	15.1%
100% Poverty Level: White	12.7%	20.8%	12.3%	9.1%	12.4%
100% Poverty Level: Black	28.9%	33.3%	27.3%	19.9%	26.2%
Disparity Between White and Black at 100% Federal Poverty Level	16.2%	13.3%	15%	10.8%	13.8%
200%	42.2%	52.6%	41.5%	26.8%	34%
Median Household Income	$37,001	$33,837	$40,040	$66,149	$55,322

Red indicates that rates are worse, green that rates are better than comparison rates

*American Community Survey, American Factfinder 2012-2016, US Census Bureau (Tables DP03, S1701, S1703 and S1901)

General health status:

Each year the County Health Rankings Project, funded by the Robert Wood Johnson Foundation, compiles data on various factors recognized as determinants of health, both medical and social, and compounds them into indicators that are then ranked with other localities within each state. In Virginia, 133 localities, both counties and incorporated cities, reported. The overarching indicators, health outcomes (data on medical status) and health factors (comprising medical care, social determinants, and individual behaviors) for Halifax County in 2018 are ranked at 115 and 105, respectively, in the 14th percentile, indicating that 86% of localities in Virginia reported better status.

County Health Rankings 2018					
Indicator	**Halifax County**	**Charlotte County**	**Mecklenburg County**	**Virginia**	**United States**
Health Outcomes Ranking (1 out of 133 is best) -length of life, quality of life	115	110	107		
Health Factors Ranking (1 is best) – health behaviors	105	108	98		
Clinical Care Ranking (1 is best) – medical care sufficiency and quality	62	85	86		
Diabetes Prevalence	16%	12%	16%	10%	
Diabetes Monitoring	91%	91%	88%	87%	85
Mammogram Screenings	59%	N/A	66%	64%	63
Adult Smoking	19%	20%	19%	15%	17
Premature Death (cumulative yrs. of life lost before age 75/100,000 age adjusted)	9,900	8,500	9,900	6,100	6,700
Poor or fair health – self-report	21%	21%	19%	15%	16%
Frequent Mental Distress –self report	13%	14%	12%	11%	
Food Environment Index (10.0 is best) -- access, affordability, knowledge, behavior	6.7	6.3	7.4	8.9	7.7
Physical Inactivity	28%	29%	27%	22%	23%
Exercise Opportunities	38%	21%	56%	83%	83%
Injury Deaths per 100,000 population – intentional and accidental	83	91	71	58	65

Red indicates that rates are worse, **green** that rates are better than comparison rates

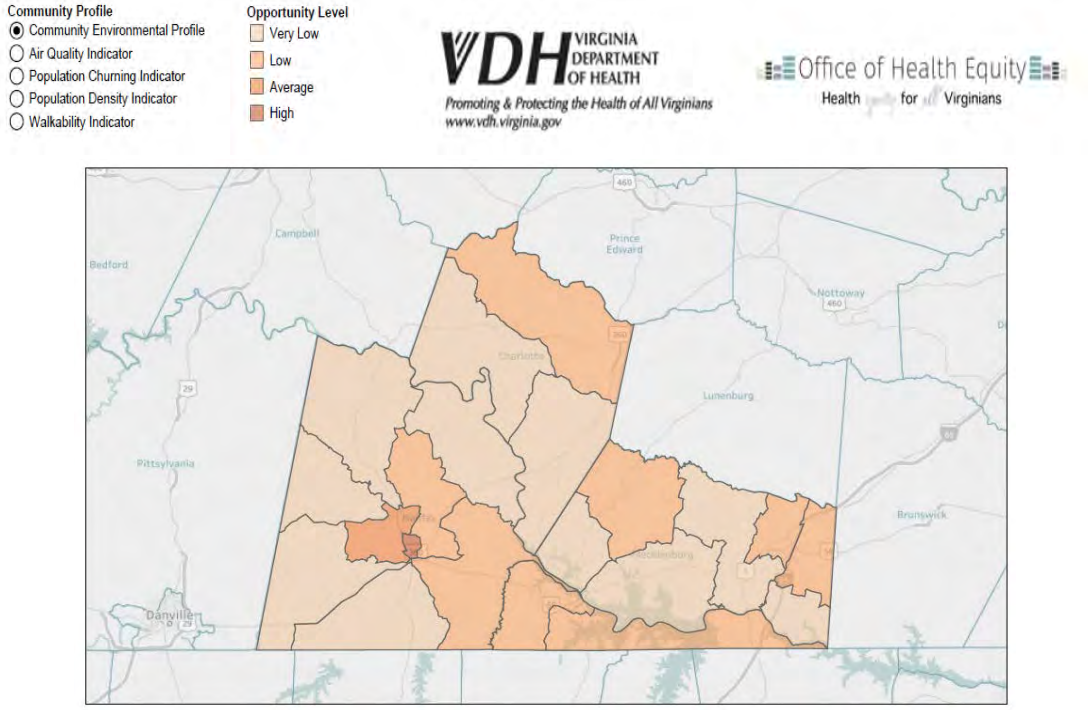
County Health Rankings 2018, a project of the Robert Wood Johnson Foundation, www.countyhealthrankings.org/app/virginia/2018

The rates of several of the individual health factors are significantly different for the three counties that make up the SHRH service area compared with the rates for Virginia as a whole. Medical conditions such as diabetes, health behaviors, such as smoking, and lack of opportunities for exercise, all combine to result in almost 1.5 times the number of years lost to premature death than in Virginia as a whole.

The Environment – How it Impacts Life in the Community:

Natural and Built Environment:

The map below represents the Virginia Department of Health's Health Opportunity Index for environmental quality. Included in the composite indicator that depicts the quality of the environment are measures of air quality, population churning (to what extent the population changes as people move into and out of the area), the density of the population, and the extent to which individuals have the opportunity for natural exercise by walking to and from destinations (the availability of sidewalks, etc.). The only area of the service region where the opportunities created by the natural and built environment positively impact health at a high level is the town of South Boston, where there are sidewalks in several sections of town, and parks and public spaces are more easily accessed. Even South Hill, the largest population center of Mecklenburg County, is not listed as a high opportunity place.



The Community Environment:

Having an active, supportive and engaged community is essential to creating the conditions that lead to improved health. Although the population is small in this region, the residents are highly engaged in matters important to the community. There were 80 invitations sent out to key stakeholders in 50 separate organizations representing service providers, policy makers and underserved communities, to participate in the online survey eliciting their input on the main health concerns for the community, and 61 recipients responded by filling out the survey. That is a 76% response rate, extremely high for survey research. Not only does SHRH appreciate their input, but we recognize the importance of their willingness to participate in efforts to enhance life in our community. Representatives of the following organizations participated in the study:

Halifax County Department of Social Services	Mecklenburg County Department of Social Services
Lake Country Area Agency on Aging	Southside Community Services Board
Town of Brookneal	Mecklenburg County Board of Supervisors
Halifax County Board of Supervisors	Mecklenburg County Public Schools
Halifax County Public Schools	Virginia Cooperative Extension
Mecklenburg County YMCA	Halifax County United Way
Swann Haven Domestic Violence Shelter	The Selah Center
Halifax County Industrial Development Authority	Optima Managed Care Community Programming
Southern Virginia Higher Education Center	Tri-County Healthy Families
Tri-County Community Action Agency	Halifax Chamber of Commerce
Clarksville Chamber of Commerce	Halifax County Commonwealth's Attorney
Halifax County Courts	Turbeville VFD
Community Memorial Hospital (VCU)	Oak Level VFD
Burnett and Snead CPAs	Virginia Realty, Inc.
State Farm Insurance	Talbert Building Supply
Brooks Lyons Funeral Homes	ACF Greenhouses, Inc.
Sentara Halifax Regional Hospital Emergency Services	Sentara Halifax Regional Hospital Social Work Department
Halifax Heart Center Physician	Central Virginia Health Services physician – Charlotte County
Sentara Halifax Family Medicine nurse practitioner	Southside Health Department

As expected, many of these organizational representatives wear many hats, with the Community Services Board respondent the pastor of a small, rural congregation, the funeral director serving on various non-profit boards of directors, etc. Additionally, organizational representatives, such as the Director of the Charlotte County Department of Social Services, participated through interviews or focus groups.

III. Community Insight

Key Stakeholder Survey Results

Asked to choose the most important health concerns among 34 health conditions, with no restrictions on the number of choices, respondents selected them as in the table below. These selections resulted in ratings closely resembling those of the previous (2015) community health needs assessment, which makes sense because many of them are complex conditions with multiple contributing factors. Improving these conditions throughout the community will take many years.

Frequency Rank	Most Important Health Problem in Community	% of Participants Selecting Item
1	Mental Health - Behavioral Health Conditions (e.g. depression, anxiety, etc.)	73%
2	Obesity	71%
3	Cancer	68%
4	Diabetes	66%
	Heart Disease	66%
5	High Blood Pressure / Hypertension	63%
6	Substance Abuse (prescription or illegal drugs)	59%
7	Dementia / Alzheimer's Disease	58%
8	Tobacco Use	53%
9	Alcohol Use	47%
	Dental/Oral Health Care	47%
10	Infant and Child Health	46%
11	Stroke	41%
12	Accidents / Injuries	37%
	Violence – Domestic Violence	37%
13	Arthritis	36%
14	Prenatal and Pregnancy Care	32%
	Respiratory Diseases (e.g., asthma, COPD, etc.)	32%
15	Chronic Pain	29%
	Hunger	29%
	Orthopedic Problems	29%
16	Drowning / Water Safety	25%
	Neurological Conditions (e.g., seizures, multiple sclerosis, traumatic brain injury, etc.)	25%
	Teen Pregnancy	25%

Frequency Rank	Most Important Health Problem in Community	% of Participants Selecting Item
17	Physical Disabilities	24%
18	Intellectual / Developmental Disabilities	22%
19	Renal (kidney) Disease	20%
	Sexually Transmitted Diseases	20%
	Violence – other than Domestic Violence	20%
20	Bullying	19%
21	Autism	17%
22	Environmental Health (e.g., pollution, mosquito control, water quality, etc.)	15%
	Infectious Diseases	15%
23	HIV / Aids	14%

A second question asked respondents to rank the community health services that most need to be strengthened. Once again the number of choices was unrestricted. The table below presents their responses. In the 2015 survey, mental and behavioral health services topped the list, with 73% of respondents listing them as in need of strengthening. Since then, the Sentara Center for Behavioral Health has implemented new programming including a crisis intervention team located in the SHRH emergency department, substance abuse counseling, an intensive outpatient program, and collaboration with the Southside Community Services Board. The result of this attention to the top-rated problems is visible in the lower percent of respondents who see the need for more services in 2018.

Frequency Rank	Community Services Needing Strengthening	% of Participants Selecting Item
1	Mental Health - Behavioral Health Services	57%
2	Aging Services	54%
3	Substance Abuse Services	52%
4	Cancer Services	48%
5	Health Care Insurance Coverage	45%
	Transportation Services	45%
6	Early Intervention Services for Children	41%
7	Dental Care / Oral Health	39%
8	Veterans Services	36%
9	Chronic Disease Services (e.g. diabetes, high blood pressure, etc.)	30%
	Health Promotion and Prevention Services	30%

Frequency Rank	Community Services Needing Strengthening	% of Participants Selecting Item
10	Chronic Pain Management Services	29%
11	Long Term Care Services	27%
	Services for Caregivers	27%
12	Food Safety Net (e.g. food bank, community gardens, school lunches, etc.)	25%
	Home Health Services	25%
	Services for Vulnerable Populations	25%
13	Domestic Violence Services	23%
14	Family Planning Services	21%
	Self-management Services (e.g. nutrition, exercise, taking medications)	21%
15	Care Coordination and Transitions of Care	20%
	Social Services	20%
16	Physical Rehabilitation	18%
	Primary Care Medical Services	18%
17	Maternal, Infant and Child Health Services	16%
18	Intellectual / Developmental Disabilities Services	13%
	School Health Services	13%
	Specialty Medical Care Services (e.g., cardiology, oncology, etc.)	13%
19	Hospice Services	11%
20	Hospital Services (e.g., inpatient, outpatient, emergency care, etc.)	9%
	Public Health Services	9%
21	Pharmacy Services	7%
	Workplace Health and Safety Services	7%
22	Public Safety Services	5%
23	Environmental Health Services	4%

Respondents were asked two questions new to the survey this year: to identify vulnerable populations and geographies where health conditions may be worse or where residents may have restricted access to care and resources, and to list community assets that can improve the level of community health by providing opportunities to engage in healthful behaviors. Respondents wrote in the answers in blank spaces. The results of those questions are presented in the two tables below and on the next page.

Vulnerable/At-Risk Populations	Vulnerable/At-Risk Geographic Regions
• Elderly • Low income • Uninsured • Children • Substance addicted individuals • Individuals with disabilities • Low educational attainment populations	• Rural regions of the service area • The entire service area • Low income housing developments • The outer edges of Halifax County

Most Important Health Assets Existing in Community	Needed Health Assets Currently Lacking in the Community
• Medical services including hospitals, primary care and other forms such as long term care • YMCA, in both Halifax and Mecklenburg Counties • State and local parks in both Halifax and Mecklenburg Counties • Rails to Trails and other walking trails • Buggs Island lake and local rivers used for kayaking and boating • Farmers' markets and local healthy food initiatives • Social services such as a domestic violence shelter	• Fitness facilities, indoor (pools, basketball courts) as well as outdoor (public track, tennis courts) • Walking/biking/running trails, although there are trails, some not convenient to access • Medical services, particularly specialty care, extended hours, and support for EMS and fire department/rescue services • Group education and support for life events, (grief, medical conditions, etc.) and pro-active such as healthy lifestyle education • Social service coordination and navigation for vulnerable populations • A designated community center with activities, facilities for sport and community meetings

Although respondents identified many vulnerabilities and needed health assets, they also saw strength in the existing medical care services and the outdoor opportunities for activity, healthy food choices and community events.

Interviews and Focus Groups:

Two Community Focus Group Sessions were carried out by the hospital to gain more in-depth insight from community stakeholders. The groups were the Chase City Chamber of Commerce, with business owners and managers, and the Halifax County Special Victims Coalition, comprising law enforcement, social service, medical staff, the public schools and lawyers who work with underserved victims of crimes. The following questions were asked. The results of the focus groups are summarized below.

- What are the most serious health problems in our community?
- Who/what groups of individuals are most impacted by these problems?

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

Topic	Key Findings
What are the most serious health problems in our community? **What are the most serious health problems in our community?**	The impact of the social determinants of health, Chronic diseases, access to care, Lack of support structures such as caregiver support, Lack of education about health conditions and how to manage them, Lack of education about local resources and how to access them, Health conditions related to aging such as: dementia/Alzheimer's disease, the need for joint replacements, cancer, and heart disease, Flu is a concern, access to and education about vaccines
Who/what groups of individuals are most impacted by these problems?	Everyone, The elderly, Those addicted to opioids and other drugs, Those vulnerable because of poverty or isolation, Children who are dependent of adults to meet their needs, Employers who have to deal with uncertain workforce, Caregivers who have been thrust into that role with no training or understanding of what they are supposed to do
What keeps people from being healthy? In other words, what are the barriers to achieving good health?	The continuing loss of resources to provide services to those in need, The expectation that more can be done with less, Closing down places to treat addiction as models of care and payment models have changed, Transportation is a huge barrier, Lifestyle opportunities like access to exercise and access to healthy food
What is being done in the community to improve health and to reduce the barriers? What resources exist in the community?	Exercise classes at Community Memorial Hospital and the local YMCAs, Community education classes and seminars on different health topics, Health screenings such as blood pressure and glucose screening at community events, P.E. classes for school children, Healthy Families program, Counseling services offered by the CSB and others
What more can be done to improve health, particularly for those individuals and groups most in need?	Solutions have to be individual, not one-size fits all, Hospitals need to work together on things to reach more people, Transportation for treatments, Being given medication to take home upon release from the hospital would save a trip and make it more likely that people would take the medicine they need, More choices needed in providers, with more specialists

Subject Matter Experts representing collaborating partners in our service area were interviewed to get additional insight for this report.

The interviews were conducted with:

- The Health Directors of Southside (Halifax and Mecklenburg Counties) and Piedmont (Charlotte County) health districts
- The Director of the Lake Country Area Agency on Aging
- The Assistant Director of the Halifax County Department of Social Services
- The Director of Behavioral Health Services at the Southside Community Services Board (Halifax and Mecklenburg)
- The Director of the Charlotte County Department of Social Services

The results of these interviews are summarized below.

- All interviewees agreed that the strain on social, medical and other services is increasing at a time when resources are dwindling.
- The directors of social service agencies agreed that they are seeing more people newly in need of service as people who used to be considered middle class and self-sufficient now need assistance.
- All agreed that the outlook is bleak unless something changes.
- One health director commented that our 2015 CHNA and implementation plan was good, and hit on all the standard medical concerns, but that now it is time to take it further with community involvement in creating community-based solutions through the formation of health coalitions and partnerships.
- All agreed that the aging population is going to provide an increasing strain on available services in the coming years.
- One interviewee commented that the community is suffering from charity fatigue, and that the local, private donation sources are no longer as willing to give, which impacts their organization's ability to fulfill their mission, given the cuts to government funding.
- Specific social determinants were cited by different interviewees according to the focus of their work. The director of the Lake Country Area Agency on Aging spoke of the need for more affordable housing for the elderly. The director of behavioral health for the Southside Community Services Board spoke of the need for more services to combat opioid addiction, and gave examples of treatment options that had closed down as funding models have changed over the last 20 years. The social service agency administrators discussed the impact of opioids and growing poverty on the structure and viability of the families in their care.
- In every interview, the actual, medical issues that might have been expected to take center stage were overwhelmed by the interviewee's desire to talk about the impact of socioeconomic factors that determine health.

Additional Community Input:

SHRH was joined by the **Southside Health District**, which also conducted a community needs assessment, which was distributed more broadly than the SHRH survey, with 532 respondents and a population health focus rather than a focus on medical care; the results of that survey are summarized below. The top 5 responses for improving the quality of life in the community, the top 5 responses for most important health issues to affect the community, and a measure of the respondent's confidence in his or her ability to enhance life in their communities are presented.

What Would Improve the Quality of Life Where You Live?			
Rank	**Item**	**% responses**	**# responses**
1	More jobs and healthier economy	73.1	389
2	More programs and support for youth outside of school	51.6	275
3	Improved education	51.5	274
4	Access to healthcare for everyone	34.2	182
5	Access to mental health services for everyone	32.2	171

Responses below are grouped by type of challenge rather than by physiological system involved (such as heart, lungs, etc.) Therefore, the first choice of chronic conditions reflects the provider and self-management resources needed that are common to all such conditions.

From the Following List: What do you think are the 3 most important health issues that affect your community?			
Rank	**Item**	**% responses**	**# responses**
1	Chronic diseases (e.g., obesity, diabetes, heart disease, high blood pressure, stroke, cancer)	61.2	326
2	Substance use (e.g., tobacco use, alcohol and drug abuse)	51.6	275
3	Nutrition (healthy food and eating habits, food allergies)	41.2	219
4	Aging problems (e.g., arthritis, hearing/vision loss, Alzheimer's disease/dementia)	38.6	205
5	Mental health issues and suicide (depression, anxiety, stress)	29.1	155

A surprising 95% of individuals responded that they can make a difference in their communities, in spite of the socio-economic and cultural pressures they face.

Survey Respondents Reporting their Ability to Improve their Communities	
Confidence in Ability	**Percent of Respondents**
Strongly Agree	28
Agree	67.1
Disagree	4.5
Strongly Disagree	.6

Respondents were also asked to build on the previous question and provide strategies that would encourage them to engage in community building. Most respondents suggested the need for gathering places, educational and interactive programming to give residents tools to pursue health and community development, and opportunities to work together for community benefit. A special focus on programming for youth was featured, and the need for financial resources was emphasized.

Clearly, the definition of community health is broader than simply medical care. As more is known about the role of social determinants of health, more opportunities will arise to influence population health through engaging in community building approaches to care. Beyond the scope of SHRH alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact.

IV. Health Status Indicators

In addition to the input of the community, an important clue to community health needs resides in the "hard" data, the statistics on death, disease and treatment that are routinely collected and reported by a number of agencies. Below are the health status indicators used in this report.

Leading Causes of Death:

The following table presents the leading causes of death in the SHRH service area in 2015, the most recent data available. The data have been made comparable by adjusting each data point for age at the time of death and to account for the differences in population size by converting the numbers to the proportion of a population size of 100,000.

The table blow indicates that while the total number of individuals residing in the SHRH service area who would have died in 2015 per 100,000 in population was 881.1, that number was 720.1 for Virginia as a whole, which means that a significantly higher proportion of residents of the SHRH service area died compared to residents in Virginia as a whole. This agrees with the higher cumulative number of years of life lost to premature death, discussed on page 13. Breaking out the individual causes of death gets us closer to the underlying causes, and to working on possible solutions. It is important to note that in some cases, the actual number of deaths is small, making any larger analysis statistically unstable.

	Total Number of Deaths					Rate of Death per 100,000 Population				
Leading Cause of Death	SHRH Service Area	Halifax County	Charlotte County	Mecklenburg County	VA	SHRH Service Area	Halifax County	Charlotte County	Mecklenburg County	VA
Total Deaths	1,046	463	150	433	62,995	1328.3	1323.2	1236.7	1401.7	748.9
Cancer Deaths	241	107	34	100	14,317	306	305.8	280.3	323.7	170.2
Heart Disease Deaths	233	101	32	100	13,461	295.9	288.6	263.8	323.7	160
Cerebrovascular Disease Deaths	68	28	8	32	3,305	86.4	80	66	103.6	39.3
Chronic Obstructive Pulmonary Disease Deaths (COPD)	41	18	2	21	3,106	52.1	51.4	16.5	68	36.9
Accident Injury Deaths	55	24	14	17	3,358	69.8	68.6	115.4	55	39.9
Alzheimer's Disease Deaths	32	8	7	17	2,354	40.6	22.9	57.7	55	28
Diabetes mellitus Deaths	37	10	6	21	1,999	47	28.6	49.5	68	23.8
Nephritis and Nephrosis Deaths	34	20	4	10	1,454	43.2	57.2	33	32.4	17.3

Red indicates that rates are worse, green that rates are better than comparison rates

Virginia Department of Health, Virginia Population Health Profile 2016

Cancers cause the highest death rate in the service area, as for Virginia as a whole, followed by heart disease. It is worth noting that in the 2015 CHNA, heart disease was the leading cause of death. Looking at each of the eight leading causes of death, the SHRH service area rate of death is higher than the Virginia rate. For each cause of death, a higher proportion of SHRH service area residents die than residents of the state as a whole.

Health concerns of particular interest to SHRH service area residents:

The Community Health Needs Assessment (CHNA) conducted by SHRH in 2015 produced a list of health concerns based on input from survey participants, senior leaders of SHRH, and the "hard data" including the leading causes of death. The 4 most frequently cited concerns: heart disease, cancer, mental/behavioral health and diabetes, were chosen to have spotlight focus and to be the main areas addressed in efforts to improve the health of the community. The development of community and hospital-based programming to address these health concerns is an ongoing effort, and many programs have been developed since the last CHNA in 2015. It should be noted, though, that many of the disease statistics presented below are from before newer programs became established, due to the lag in health statistics data. Care should be taken in making generalizations about these health conditions. The impact of current programming will be more apparent with the next CHNA in 2021.

Health Concerns Continuing from 2015 CHNA:

Heart Disease:*

- The rate of heart disease deaths per 100,000: SHRH service area in 2015 (using 2013 data): 183.1, Virginia as a whole – 151.8
  2018 (using 2015 data): 295.9, Virginia as a whole -- 160
- Discharges after preventable hospitalizations (PQI discharges) per 100,000: SHRH service area -- 259.8, Virginia as a whole -- 231

Diabetes:*

- The rate of diabetes deaths per 100,000: SHRH service area in 2015 (using 2013 data): 33.9, Virginia as a whole – 18.3
  2018 (using 2015 data): 47, Virginia as a whole – 23.8
- Discharges after preventable hospitalizations (PQI discharges) per 100,000: SHRH service area -- 182.8, Virginia as a whole – 106.2

Mental Health and Depression:**

- Frequent Mental Distress (self-report): SHRH service area -- 13% of respondents, Virginia as a whole – 11% of respondents
- The number of poor mental health days in the previous month: SHRH service area -- 3.8 days, Virginia as a whole – 3.3 days
- Rating on Key Stakeholder Survey: most salient health concern, ranked 1 of 34 items

Cancer:*

- The rate of cancer deaths per 100,000: SHRH service area – 207.4, Virginia as a whole – 199.3
- The rate of cancer diagnosis at local site: SHRH service area – 43.1%, Virginia as a whole – 45%
- The percent of adults who smoke: SHRH service area – 23%, Virginia as a whole – 19%**
- The percent of adults who have had a Colonoscopy Screening: SHRH service area – 65%, Virginia as a whole – 72%**

*VDH, chronic disease surveillance system, Division of Health Statistics, 2015 (most recent available)

**Adult Behavioral Risk Factor Survey, VDH Population Health Profile 2016, data: 2014 (most recent available)

Cancer in More Detail:

The 2 tables presented below and on the next page show the incidence of the leading types of cancer and the mortality rate for those same types.

Cancer Incidence Age Adjusted per 100,000					
Site of Cancer	SHRH Service Area	Charlotte County	Halifax County	Mecklenburg County	Virginia
Breast (female)	114.4	114.0	126.6	101.3	126.9
Cervix Uteri	9.5	not available	not available	not available	6.3
Ovary	8.2	not available	not available	not available	10.9
Prostate	117.8	98.9	114.4	128.5	107.6
Lung and Bronchus	88.8	79.8	80.2	101.6	73.2
Colon and Rectum	50.2	84.5	49.0	39.0	41.1
Melanoma of the Skin	17.3	not available	not available	25.6	24.6
Oral Cavity/Pharynx	20.6	not available	22.6	14.7	16.6
All Sites	480.1	503.4	455.1	499.3	459.1

Red indicates that rates are worse, green that rates are better than comparison rates

Virginia Department of Health, Division of Health Statistics 2015

Cancer Mortality Age Adjusted per 100,000					
Site of Cancer	SHRH Service Area	Charlotte County	Halifax County	Mecklenburg County	Virginia
Breast (female)	30.9	28.6	30.5	32.4	28.1
Cervix Uteri	4.4	4.6	4.5	4.2	3.5
Ovary	8.0	9.1	7.2	8.5	8.7
Prostate	39.0	37.8	40.1	38.4	32.5
Lung and Bronchus	54.7	59.6	51.6	56.5	54.5
Colon and Rectum	22.1	25.6	21.9	21.0	21.0
Melanoma of the Skin	2.2	1.6	2.6	1.9	2.7
Oral Cavity/Pharynx	3.6	3.6	2.9	3.8	3.1
All Sites	207.4	214.5	201.1	212.1	199.3

Red indicates that rates are worse, green that rates are better than comparison rates

Virginia Department of Health, Division of Health Statistics 2015

Percent of Cancers Identified at Early Stage		
Site of Cancer	SHRH Service Area	Virginia
Breast (female)	62.6	64.1
Cervix Uteri	46.6	42.0
Ovary	16.3	14.1
Prostate	76.3	79.2
Lung and Bronchus	16.5	18.9
Colon and Rectum	36.1	38.0
Melanoma of the Skin	81.5	76.9
Oral Cavity/Pharynx	38.6	30.7
All Sites	43.1	45.0

Red indicates that rates are worse, green that rates are better than comparison rates

Virginia Department of Health, Division of Health Statistics 2015

SHRH has been working to develop both screening opportunities in the communities we serve and diagnostic and treatment options to address the importance of this set of diseases in our communities. The addition of low-dose CT lung cancer scanning is a very success modality for early detection of lung cancers before they are detectable by conventional means, public awareness efforts and free screening opportunities encourage people to pay attention to the issues and the importance of early detection, and patient navigation services for radiation diagnostics makes the path between screening and treatment easier for patients and families to understand and to complete.

Preventive Quality Indicators (PQI) Discharges:

The Agency for Healthcare Research and Quality (AHRQ), part of the Health and Human Services Administration, is devoted to conducting and funding research designed to understand how to make Healthcare provision safer and more effective. Researchers there have created a measure of healthcare quality based on the number of inpatient admissions/discharges for conditions that could be managed with appropriate outpatient care. The higher the number, the more room for improvement there is in the quality of primary care that is being provided for a number of conditions (http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx). The table below presents the PQI score for the SHRH service area compared to the State of Virginia as a whole. One thing to remember when looking at the table is that the SHRH service area has a higher (8.6% higher) proportion of elderly residents than Virginia as a whole, so may be expected to have a higher incidence of the diseases that comprise the PQI index, which consists of mostly chronic diseases that affect the elderly. Rates have been standardized per 100,000 for ease of comparison.

SHRH Preventable Quality Index (PQI) Report with Comparisons to Virginia as a Whole						
Locality	**Total PQI Discharges**	**Community Acquired Pneumonia**	**Congestive Heart Failure**	**COPD or asthma (older adult aged 40+)**	**Diabetes**	**Urinary Tract Infection**
Virginia	778.7	99.9	231	134.3	106.2	82
SHRH Service Area	961.2	102.8	259.8	212.6	182.8	58
Difference	**182.5**	**2.9**	**28.8**	**78.3**	**76.6**	**-24**
Trend Rates: 2014-2016	**Rate of Change in PQI Discharges**					
Virginia	-5%	-13%	6%	-11%	-12%	-9%
SHRH Service Area	-10%	9%	-7%	-19%	-21%	-11%
Difference	**5%**	**4%**	**13%**	**8%**	**9%**	**2%**

Red indicates that rates are worse, green that rates are better than comparison rates

PQI data provided by Community Health Solutions using 2016 data, standardized per 100,000 population

The table presents areas where SHRH and the state are making progress in addressing the challenges of preventable hospitalizations in progress toward quality care under the **Rate of Change in PQI Discharges** title. The table shows that for 4 out of 5 conditions, the SHRH service area experiences a higher level of hospitalization for these chronic illnesses, with urinary tract infections being the exception. However, it is also true that SHRH has made significant progress in addressing these unnecessary hospitalizations, and in 4 out of 5 cases, has made more progress than the State as a whole. This table demonstrates the seriousness of SHRH's intent to improve the health of the community, and the success of our efforts.

Incidence of Health Problems, Chronic Disease:

The Behavioral Risk Factor Surveillance System (BRFSS) is a national health factors database operated by the CDC using sampling of residents of localities on various key components of health, incidence of chronic disease, risky behaviors, and health care screenings. The table below presents the chronic disease incidence that was reported in 2014, the most recent data available. Once again, note that the numbers represent a sample of residents of the SHRH service area, and generalized conclusions must be made with caution.

Percent of Population Ever Told by a Healthcare Professional that they have a Chronic Condition			
Chronic Condition	**Halifax County**	**Charlotte County**	**Mecklenburg County**
Arthritis	32.4	33	35.0
Asthma	16.1	12.5	15.7
COPD (Chronic Obstructive Pulmonary Disease)	10.7	8.3	11.4
Diabetes	18.8	16.4	19.6
Heart Attack	9.4	8.1	5.9
Heart Disease	4.6	7.4	6.1
Overweight/Obese	72.7	77.5	70.6
Pre-diabetic	9.4	10.6	10.0
Skin Cancer	5.0	5.5	7.0
Stroke	4.2	2.9	3.8

Incidence of Health Problems, Communicable Disease:

The data on sexually transmitted diseases is presented both as the raw number of cases and the rates per 100,000 in population. The rates are included to ease comparisons, but the raw numbers are included to prevent conclusions based on extremely small numbers of cases. For each disease, the incidence across the service area is mixed, with some counties having lower incidence and some having higher. The service area column combines what are sometimes extremely low numbers of cases, to create a more viable, but still unstable, comparison.

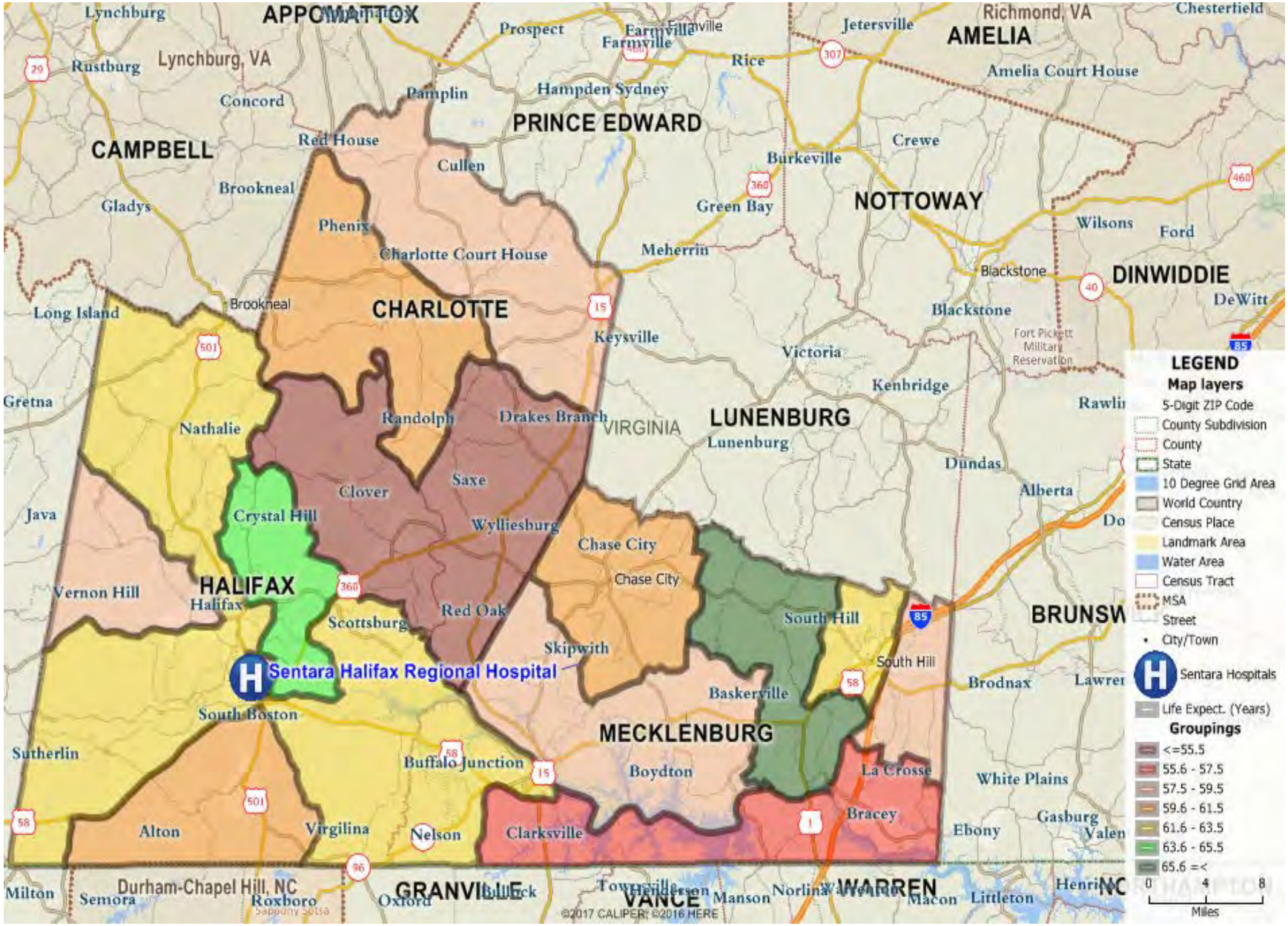
Sexually Transmitted Disease 2016: Number of Cases/Rates per 100,000					
Sexually Transmitted Disease	SHRH Service Area	Halifax County	Charlotte County	Mecklenburg County	Virginia
Early Syphilis	2 / 2.55	0 / 0	1 / 8.1	1 / 3.2	6306 / 7.8
Chlamydia	313 / 400.5	142 / 399.1	36 / 292.3	135 / 430.7	331096 / 408.8
Gonorrhea	91 / 116.4	52 / 146.1	10 / 81.1	29 / 92.5	79642 / 98.3
HIV/Aids	8 / 10.2	6 / 17.1	1 / 8.2	1 / 3.2	9753 / 12.0

Red indicates that rates are worse, green that rates are better than comparison rates

Virginia Department of Health, Population Health Profile 2016

Virginia Department of Health (VDH) Disability-free Life Expectancy Map:

The VDH has created a map as part of their project to visualize the health of all Virginians that shows how long, on average, a resident of the service area can expect to live a healthy, disability-free life. The map is presented on the following page. Disability is defined as any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). The very dark area in the north of Halifax County and into Charlotte County has the earliest onset of disability, with the average age at disability less than 56 years. The reddish area on the southern border of Mecklenburg County experiences the second earliest onset, with residents on average living less than 58 years before experiencing disability. The areas with the longest disability-free life expectancy are in Halifax County at the town of South Boston, and in Mecklenburg County to the east of South Hill. Considering determinants of health such as walkability (the availability of sidewalks, parks and other opportunities for exercise) the availability of fresh, nutritious food (grocery stores), the closeness of services such as medical care and social services, the disability-free life expectancy map makes sense. Where those things are concentrated, it is easier to live a healthier lifestyle and to live longer without disability. This is especially true in a rural area with a large geographical footprint and without public transportation.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Prospect
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Red House
Cullen
Brookneal
Gladys
Phenix
Charlotte Court House
CHARLOTTE
Long Island
Keysville
Meherrin
Green Bay
Burkeville
Crewe
NOTTOWAY
Jetersville
Richmond, VA
Chesterfield
AMELIA
Amelia Court House
Wilsons
Ford
Blackstone
DINWIDDIE
DeWitt
Fort Pickett Military Reservation
Victoria
Kenbridge
LUNENBURG
Lunenburg
VIRGINIA
Gretna
Nathalie
Randolph
Drakes Branch
Dundas
Alberta
Java
Crystal Hill
Clover
Saxe
Wylliesburg
Chase City
HALIFAX
Halifax
Vernon Hill
Scottsburg
Red Oak
Skipwith
South Hill
Sentara Halifax Regional Hospital
South Boston
Baskerville
Brodnax
MECKLENBURG
Sutherlin
Buffalo Junction
Boydton
La Crosse
White Plains
Bracey
Ebony
Alton
Virgilina
Nelson
Clarksville
Gasburg
Milton
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Finally, we present the fourth quarter report for the CHNA currently in effect for the SHRH service area. Strategies to address each of the four health concerns that were selected in 2015 are divided into public awareness/community education, screening and diagnosis, and treatment and care. Tracking SHRH efforts in these different categories makes clear how much energy and effort are going into programming that targets the community in community settings as well as in the hospital. While many of these strategies will continue through the 2018 CHNA, some may be altered or deleted, and others will be added as new opportunities and capacity are developed.

Sentara Community Health Needs Assessment Implementation Strategy

2017 Progress Report

Hospital: _Sentara Halifax Regional Hospital (SHRH)____

Quarter (please indicate): ☐First Quarter ☐Second Quarter ☐Third Quarter ☒Year End

In support of community health needs assessment and related implementation strategies, Sentara will measure the progress toward the community health needs assessment implementation strategies selected by each hospital on a quarterly basis.

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

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

Reports should be emailed to Laura Armstrong-Brauer at lrarmstr@sentara.com within 15 days of the close of each quarter.

Health Problem	Three Year Implementation Strategies	Progress
All		
Problem #1 **Cardiac Disease**	**Public Awareness/Education:** 1—public awareness media events will be scheduled for February to mark Heart Health Month and throughout the year as appropriate	**Public Awareness/Education throughout the year:** **TV segments:** Cardiac Symptoms and care: Feb.

Health Problem	Three Year Implementation Strategies	Progress
Overall Outcome: there will be a decrease in deaths due to cardiac disease over a 5-year period.	**Screening/Diagnosis:** 2-- There will be a 10% increase in the number of cardiac-related lab services performed annually, resulting in higher levels of detection. Baseline in 2016—10,600 3-- There will be a 5% annual increase in the number of cardiac screening procedures performed, including echocardiograms, stress tests and holter monitors. 4—Pocket EKG events will be held at least 3 x annually, with at least 30 attendees at each session 5-- At least 50 PAD screenings will be offered at community events annually. **Care:** 6-- There will be a 5% increase in the number of cardiac medication prescriptions sourced annually by MedAssist, indicating success in reaching those in need of financial assistance. 7-- Cardiac Care/Cardiac Rehab group will be offered at least 6 x annually 8-- SHRH will educate and offer services to help employees recognize and manage job-related stress	Atrial Fibrillation: Feb. Valvular Heart Disease: June **Newspaper full page articles w/Color Photos:** Deep Vein Thrombosis: Jan. Atrial Fibrillation: Feb. Chronic Venous Disease: Feb. **Health Nite Out:** Healthy Heart Lifestyle Changes: Feb. – 60 attendees Heart Health – Symptoms and Care: Feb. – 120 attendees **Speakers:** Heart Health – Feb. – 50 attended Mental health after heart failure – Feb. 63 attended **Breakfast Club radio segment:** Deep vein thrombosis – Feb. **Life & Health Newsletter:** Heart risk profiler, blood pressure – Feb. delivered to 31,000 homes **On-hold messages:** Blood pressure, cholesterol – Feb. **Community events:** Lake Fest in Clarksville – 3,000 walked through inflatable heart and got printed information. Close to 20,000 saw the heart and booth and had access to print material. **Screening/Diagnosis:** 2 – number of lab tests more than met 10% increase goal, with 76% increase. 3 – 2485 Echoes, 1071 stress tests, 1095 holter monitors for the year, 4% increase over 2016, which had declined from 2015. 4 – 124 individuals were screened through 4 Pocket EKG events 5 – 64 PAD screenings were held at 2 events **Care:** **6 –** while the total number of the 6 most common cardiac medications rose by 6%, the number of patients could not

Health Problem	Three Year Implementation Strategies	Progress
		be duplicated so it is not a good proxy for increased patient outreach. Will discontinue this measure. 7 – Cardiac rehab group was offered 6 times, with 11 unduplicated patients attending. 8 – Pastoral care discontinued events for employees mid-year, but employees are allowed to use cardiac rehab fitness equipment at times to get fit and reduce stress.
Problem #2 **Diabetes** Overall Outcomes: The ratio of controlled to uncontrolled diabetic patients of SHRH primary care providers will increase, and the number of Emergency Department (ED) visits due to uncontrolled diabetes will decline over the course of 3 years.	**Public Awareness/Education:** 1-- Increase patient/public education about risks, management and self-care. 2-- Educate MedAssist patients on diabetes self-care. 3-- Provide patient education at PCPs with diabetes educator on-site for specific events. 4-- At least 50 patients annually will complete diabetes self-care classes. 5-- At least one public education event annually will focus on diabetes. **Screening/Diagnosis:** 6-- Initiate POC A1c testing performed in PCPs to educate, monitor and assist patients at risk. A smoother process with no extra trip to campus to get results will increase follow up. 7-- Track lab tests for on-site (as opposed to community event-based) diabetic screening/diagnosis to demonstrate increased screening. Baseline screenings for 2016: total 11,267 (387 DAT) 8-- Provide at least 200 blood glucose tests (with counseling) at community events annually. **Care:** 9-- Maintain at least 80% PCP patients with A1c levels less than 8. The target for tracking has changed to be patients with levels less than 9. The current number reflects that change. 10-- Track the number of prescription requests for insulin by MedAssist patients to demonstrate increase in patients identified and brought into care.	**Public Awareness/Education throughout the year:** **Printed information** was selected by diabetes educator for distribution to diabetic patients enrolled in MedAssist medication assistance program. PCPs are distributing diabetic tool kits to new-onset diabetic patients and to patients who struggle with control. 2-page spread in Life & Health newsletter reached 31,000 homes – risks, symptoms, self-care **Speaking engagements**: Senior engagement group – 48 attendees Dollar General Employee Health Fair – 122 attendees **TV segment:** Diabetes educator on self-care **On-hold messages**: -- April, symptoms, diagnosis and care **Screening/Diagnosis:** **Diabetes educator at Pocket EKG events:** 138 individuals received blood glucose testing and individual education at PEKG events 27 received blood glucose testing at North Halifax Marathon **POC A1c testing** implemented at PCP offices for new onset and uncontrolled diabetics. 2018 will be first full year of that service. **On-site lab A1c testing**: A decline in total on-site (both lab and DAT) A1c testing could be attributable to the implementation of POC A1c testing. The number of tests was down 17.5%. **Care:**

Health Problem	Three Year Implementation Strategies	Progress
		58 individuals completed the diabetic care class in 2017, meeting goal. **The percent of patients** with A1c less than 8 hovered just over 80% (82 Q1, 81 Q2) with 88% and 87% below 9 for Q3 and Q4 respectively. The change in tracking reflects new standards. **A grant was received** to fund diabetic Medicare patients who fall into the donut hole and can't afford their insulin. Each will receive up to $500 to pay specifically for insulin.
Problem #3 Mental Health and Depression Overall Outcome: A continuum of care will be developed to address this #1 reported need in the CHNA survey	**Public Awareness/Education:** 1—At least 3 public awareness events will be produced annually that address mental health topics **Screening/Diagnosis:** 2-- A valid and reliable depression screening tool will be made available at primary care practices for use as appropriate with patients who exhibit symptoms of depression. 3-- 80% of appropriate Emergency Department staff will be trained in suicide recognition and intervention. **Care:** 4-- The number of patients requiring TDOs seen in the Emergency Department will decrease as more patients can access medications and tele-psychiatry services. 5-- A continuum of care for psychiatric patients will be developed that will provide consistent and comprehensive care for patients who comply with recommendations.	**Public Awareness/Education:** **Speakers:** Mental health after heart failure – Feb. 60 attendees Panel members at Special Victims Coalition all-day seminar on Recognizing and Handling Mentally Ill Clients – March – 100 attended **TV segments / Sentara Website / SHRH Facebook Page:** Depression -- July Domestic Violence – July **Newspaper articles (full page, color, 18,000 distribution):** Domestic Violence Depression What is Addiction? **On hold messages:** Mental health issues throughout month of May Anxiety for month of September **Radio Interview:** Sentara Counselor on domestic violence and anxiety – Sept. **Screening/Diagnosis:** Corporate has decided to put "de-escalation lite" online in Onelink training, appropriate staff will be trained. Depression screening tool is under review by corporate. We will adopt it for use in physician practices when finalized. **Care:**

Health Problem	Three Year Implementation Strategies	Progress
		Sentara Behavioral Health: • Added a substance abuse counselor • Implemented tele psychiatry • Is fully staffed for the first time • Implemented counseling at remote PCP offices • Implemented an intensive outpatient program • Is licensed and beginning to implement a partial hospitalization program • Has established collaborations with the local CSB including a crisis stabilization unit at SHRH ED **TDO number for 2017: 175** This is up 12% from 2016 (total 156). The increase may be the result of more access leading to more self-recognition rather than more mental illness.
Problem #4 **Cancer** Overall Outcomes: The number and percent of cancers identified in early stages (stage 1 and 2) will increase. The number of cancer deaths will decrease over a 5-year period.	**Public Awareness/Education:** 1-- SHRH will work with community organizations to sponsor at least two events promoting cancer awareness and early detection annually. **Screening/Diagnosis:** 2-- 50 men will receive no-cost prostate screening at free community health events annually. 3-- The new low-dose CT for lung cancer service will be online by the end of 2016. **Care:** 4-- 40 women annually will benefit from the EWL program. 5-- SLT will evaluate possible partnership with a Center for Excellence oncology services provider. 6-- Throughout the course of the term of the CHNA, at least one grant will be submitted seeking patient navigator funding.	**Public Awareness/Education:** **TV segments:** GI symptoms and care -- March Colon cancer awareness -- March **Newspaper articles (full color, 1/2 page):** Colon health – diet, etc. – March Colonoscopy -- March **Newsletter (glossy, 8 page, distributed to 31,000 homes):** Patient testimonials on the importance of screening – June New low dose CT scanning program for lung cancer Breast cancer symptoms and screening Colon cancer awareness and screening **On-hold messages:** Colon cancer awareness – March Cancer survivorship – June Prostate screening and pain management for cancer patients – Sept. **Social Media:** Sentara's tobacco cessation program Childhood cancer awareness month

Health Problem	Three Year Implementation Strategies	Progress
		Sentara tobacco cessation program promoted at PCP offices and with printed info and book marks distributed at community events. **Community events:** Annual Walk for Hope with local cancer association: Sept. Walking team, speaker, inflatable colon which 100+ toured and hundreds were given printed information, community partnership donation to Halifax County Cancer Assn. Cancer survivors lunch – June, 45 attended **Screening/Diagnosis:** **Colonoscopies**: 1,725, increasing by 29% through the year **Screening mammograms**: 3,644, increasing by 11.6% through the year **Prostate screening** – free event in Sept. 48 men screened **Low Dose CT** scanning for lung cancer implemented in Q3 with 30 screens, Q4 34, a 13% increase. **Care:** Imaging services navigator position created and filled. In addition to navigation services, navigator has speaking engagements and community events. 61 women enrolled in Every Woman's Life cancer diagnostic program. Sadly, the grant for this program has been discontinued for the 2018 – 2019 year. SLT continuing to seek Center for Excellence partner for cancer services.

The information presented in this CHNA reveals a rural community facing a number of health challenges resulting from geographic constraints, demographic forces and cultural beliefs and choices based on generations of behavior. The same challenges can be found in countless rural communities throughout the country. Sentara Healthcare and Sentara Halifax Regional Hospital are committed to finding innovative, responsive and successful strategies to address these challenges, to fulfill our mission to improve health every day.