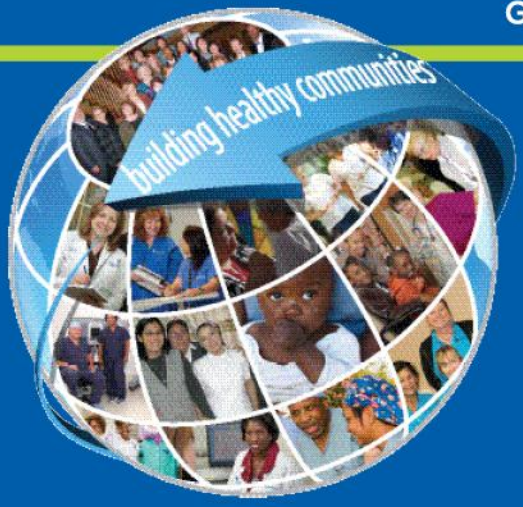


BON SECOURS HEALTH SYSTEM

Community Health Needs Assessment

Bon Secours Richmond Community Hospital

Table of Contents

Executive Summary

Bon Secours Richmond Community Hospital is a 104-bed facility licensed in the state of Virginia, serving approximately 851,230 residents primarily from the counties of Chesterfield, Hanover, Henrico; and the cities of Petersburg and Richmond.

The Mission of Bon Secours Health System is to bring compassion to health care and to be Good Help to Those in Need®, especially those who are poor and dying. As a system of caregivers, we commit ourselves to help bring people and communities to health and wholeness as part of the healing ministry of Jesus Christ and the Catholic Church.

Over the period of one year, a Community Health Needs Assessment was conducted for Richmond Community Hospital that included secondary data, surveys, and key informant focus groups and representatives of our community with a knowledge of public health, the broad interests of the communities we serve, individuals with special knowledge of the medically underserved, as well as people in vulnerable populations and people with chronic diseases.

The Assessment determined that the most significant health needs of our service area may be grouped into three broad categories:

- Health Promotion and Prevention
- Access to health care
- Support Services (e.g. social services, transportation, etc.)

The Assessment further identified significant health needs in our service area to be:

- Adult and Childhood Obesity
- Aging Services
- Behavioral Health
- Cancer Early Detection and Screening
- Chronic Disease Prevention and Management
- Dental Care / Oral Health
- Heart Disease & Stroke Prevention and Treatment
- Maternal Health
- Transportation
- Uninsured Adults and Children

Collectively, these health concerns may be arranged as depicted below:

Health Promotion & Prevention	Access to Health Care	Support Services
Adult & Childhood Obesity		
Cancer Early Detection & Screening		
Chronic Disease Prevention		
Heart Disease & Stroke Prevention	Heart Disease & Stroke Treatment	
	Behavioral Health	
	Uninsured Adults & Children	
	Dental Care/Oral Health	
		Maternal Health
		Aging Services
		Transportation

In this report we have identified community-wide resources that, together, can help to improve the health of our community. We will work with many of these health facilities and organizations to develop plans and programs to improve the health of our community.

If you would like additional information on this Community Health Needs Assessment please contact us at CHNA@bshsi.org.

BON SECOURS FACILITY DESCRIPTION AND VISION

The roots of Richmond Community Hospital run deep, originating in the vision of Dr. Sarah Garland Jones, the first woman and African-American to be licensed as a physician in the Commonwealth of Virginia. Dr. Jones and other area physicians opened the first facility in Richmond designed to serve African-American patients in historic Jackson Ward in 1895.

Meanwhile, across the Atlantic in 1824, twelve young women formed the congregation of the Sisters of Bon Secours to nurse the sick and dying in their homes. In 1881, the Sisters arrived in the U.S. to continue their work, and in 1966 they established their presence in Richmond, Virginia, with the opening of St. Mary's Hospital.

In 1995, the stories of Richmond Community Hospital and Bon Secours became intertwined when Bon Secours Health System acquired the hospital, which by then had moved to the present location of 1500 N. 28th Street in historic Church Hill. Today, Bon Secours Richmond Community Hospital continues the legacy of its founders by providing "good help to those in need." The hospital has been honored as a top performer for Emergency Room patient satisfaction and earned recognition for improvements in patient care and safety from the Institute for Health Care Improvement.

Richmond Community Hospital's Emergency Department is a proud recipient of the Emergency Nurses Association® Lantern Award for exceptional practice and innovative performance in in the core areas of leadership, practice, education, advocacy and research; as well as the Pathways to Excellence Award granted by the American Nurses Credentialing Center.

Richmomd Community Hospital offers a dedicated 40-bed unit for acute psychiatric treatment and stabilization, including 24-hour emergency psychiatric evaluation. The physicians treat a wide range of medical conditions, but also believe in treating the whole person. The Mission is to deliver compassionate, quality health care to every patient, every time.

SECTION I

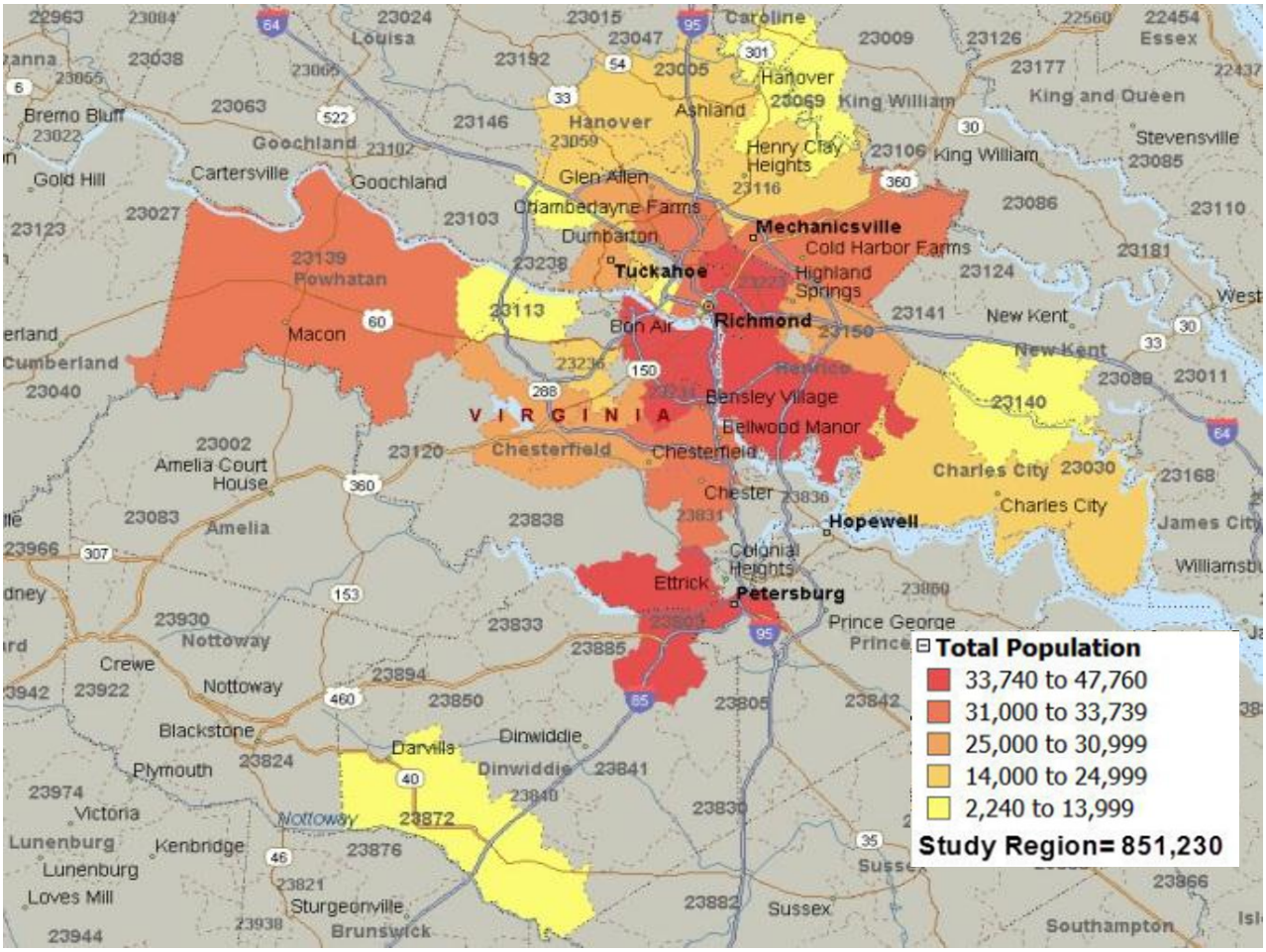
BON SECOURS RICHMOND COMMUNITY HOSPITAL SERVICE AREA AND DESCRIPTION OF COMMUNITY SERVED

The Richmond Community Hospital service area extends through much of the Richmond metropolitan area, including the heritage of downtown Richmond. It is uniquely located in Richmond's East End, a historic area of Richmond with great diversity and culture. This locale is of great significance to Richmond Community Hospital in its efforts to address a variety of health needs in East End neighborhoods, including Richmond's Promise Neighborhood: The East End Achievement Zone (EEAZ). These communities within the service area provide many qualities of life, but there are also many health issues that require attention to maintain all aspects of community health.

The Richmond Community Hospital service area consists of 34 zip codes that fall mostly in the counties of Chesterfield, Hanover, Henrico; and the cities of Petersburg and Richmond.[1] The map below depicts the Primary Service Area (PSA) and the Secondary Service (SSA). A PSA represents the area that accounts for the top 75% of health provision, while the SSA accounts for the following 15% of health provision. The geographic context of the area is a significant aspect since the area consists of a variety of localities throughout the Richmond Metropolitan Area. Consequently, there are some health factors that are prevalent throughout the area but others are uniquely tied to particular localities. The service area covers a large and diverse section of Virginia, so it is not surprising that the needs assessment bears out many state trends. It is also important to note that the region includes other hospital facilities and service providers whose service areas overlap.

[1] The study region is comprised of zip codes that overlap with the hospital's primary service and/or secondary service area.

Figure 1. Richmond Community Hospital Study Area



(Map created by Community Health Solutions for the Community Health Needs Assessment 2012)

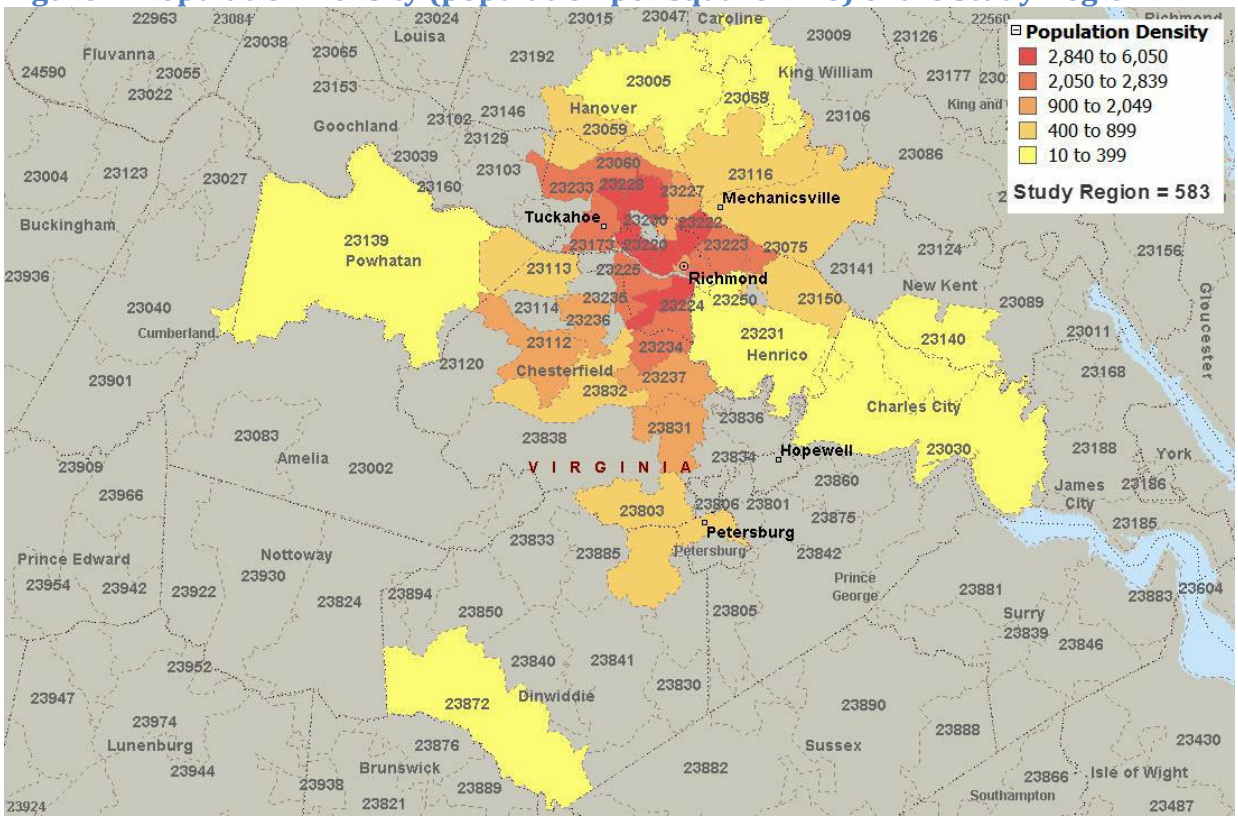
Demographic Profile

The health of a community is largely connected to the demographics and social aspects of its residents, which can be useful indicator of health concerns. The study region for Richmond Community Hospital contained 851,230 people as of 2010, of which 52% are female and 48% male—a population that is expected to grow to 890,905 by 2015. Compared to the Commonwealth of Virginia as a whole, this region is more densely populated (583.0 people per sq. mile) and is proportionately more Black/African American (32%). It is helpful to note that the service area for Richmond Community is

expansive in part because it is one of the few facilities providing acute psychological treatment, constituting 40 dedicated beds within the acute care facility.

The median household income of the community is $56,631, just under the median income in Virginia of $60,034. The study region also has lower income levels (29% are Low Income Households with income less than $35,000). This section provides a brief summary of the demographic trends of the study region but the demography is discussed further in the results

Figure 2. Population Density (population per square mile) of the Study Region



(Map created by Community Health Solutions for the Community Health Needs Assessment 2012)
(This map shows a count rather than a rate. Rates are not mapped at the zip code level because in multiple zip codes the population is too small to support rate-based comparison.)

SECTION II

DESCRIPTION OF PROCESS AND METHODS USED TO CONDUCT THE ASSESSMENT

Background

Bon Secours Richmond (BSR) Richmond Community Hospital, a Catholic, not-for-profit hospital, embraces its responsibility to provide community benefit. In order to assure that we offer Good Help to Those in Need, we have traditionally identified unmet community needs in several ways. Each facility has its own Community Advisory Board that gives voice to health care related concerns from across the service area. BSR staff also provides leadership in numerous coalitions, commissions, committees, partnerships and task forces to observe and address issues of health access and disparity.

Historically, Bon Secours Richmond has also conducted more formal inquiries using either internal staff and/or external consulting groups to analyze available internal and secondary data to inform community benefit strategy. More recently, Congress enacted the Patient Protection and Affordable Care Act (PPACA) in 2010, which requires not-for-profit hospitals to complete a community health needs assessment every three years. This process and resulting document, while designed to meet the regulatory requirements, is strongly rooted in our own commitment to transparency and collaboration.

Summary of Community Health Needs Assessment (CHNA) 2012 Method

BSR contracted with Community Health Solutions (CHS), a local Healthcare Consultant who was recommended by the Virginia Hospital and Healthcare Association (VHHA) to assist with data collection and analysis. Becky Clay Christenson, of The Clay Christensen Group, facilitated conversation to prioritize and vet findings from the initial data collection. Jason W. Smith, PhD, consulted on the CHNA and implementation strategy process, documenting method, analyzing data, and synthesizing components into a public document.

The CHNA was conducted during Fiscal Year 2013 (September 1, 2012 to August 31, 2013.) in order to prepare documents by the end of the fiscal year. It was determined that existing secondary data, augmented by a key informant survey, would be used to identify and prioritize health indicators. An executive summary and report was then presented to system leadership from Mission and Business Development. Findings were then presented to the Memorial Regional/Richmond Community Senior Operations Team for further review

and comment. Finally, a presentation was made to the Bon Secours Richmond Health System Board for final approval prior to being made available to the public.

Secondary Data

The core of the secondary data analysis was conducted by CHS in order to develop a Community Health Indicator Profile. The analysis intentionally did not include every possible indicator, but instead focused on key metrics that provide a broad insight into community health. Availability of data sources was also considered in selection of content. In many cases, results can be considered in comparison to Virginia averages. Foundational source of data include: Alteryx, Inc.; Virginia Department of Health; hospital discharge data from Virginia Health Information, Inc.; Health Resources and Administration data.[2]

In other cases, data was only readily available at the state or national levels and synthetic estimates were created by CHS in order to further develop the community profile.[3] CHS developed statistical models to produce estimates where local data was not available. This analysis was based on the CDC's Behavioral Risk Factor Surveillance Survey; the Virginia Foundation for Youth's Market Decisions' 2010 Obesity Survey; a report produced for Virginia Healthcare Foundation by Urban Institute; and local demographic characteristics obtained by Alteryx, Inc. Because the data is extrapolated, meaningful comparisons to state and national averages cannot be made.

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[2] Unless otherwise noted, demographic data used in the report were acquired from Alteryx, Inc., a commercial vendor of such data. The Virginia Department of Health was the source for all of the birth and death data included in the report. Virginia Health Information, Inc. was the source of the hospital discharge data included in the report. Virginia Hospital Information (VHI) requires the following statement to be included in all reports utilizing its data: *VHI has provided non-confidential patient level information used in this report which was compiled in accordance with Virginia law. VHI has no authority to independently verify this data. By accepting this report the requester agrees to assume all risks that may be associated with or arise from the use of inaccurately submitted data. VHI edits data received and is responsible for the accuracy of assembling this information, but does not represent that the subsequent use of this data was appropriate or endorse or support any conclusions or inferences that may be drawn from the use of this data.*

[3] In addition, Community Health Solutions produced a number of indicators using '*synthetic estimation methods*.' Synthetic estimation methods can be used when there are no readily available sources of local data to produce a community health indicator. Synthetic estimation begins with analysis of national and state survey data to develop estimates of the number of people with a particular health status (e.g. asthma, diabetes, uninsured) at the national or state level. The national and state data are then applied to local demographic data to produce estimates of health status in a local area. These kinds of synthetic estimates are subject to error. They are instructive for planning, but it is not possible for Community Health Solutions to guarantee their accuracy.

Community Survey

An essential part of the Community Health Needs Assessment was hearing from citizens and community leaders who served as key informants. An electronic survey using Survey Monkey was developed and administered to 412 community members and partners by CHS.

Individuals were invited to participate based on their ability to represent: underserved, low-income and minority population needs; needs of chronically ill patients; and awareness of healthcare needs in their respective communities. A total of 141 (34%) responded, though not all participants completed each question. Participants represented over 60 agencies from across the primary service area, including concerned citizens, faith community leaders, free clinics, physicians, elected officials and governmental servants.

Participants were asked to share their viewpoints on:

- Important health concerns in the community;
- Significant service gaps in the community;
- Ideas for addressing concerns and service gaps.

To gauge importance of various health concerns, respondents were asked to identify issues of community concern from a list modified from topics in Healthy People 2010. Respondents were able to enter additional concerns in an open-ended response item. Participants were also asked to review a list of services typically important to addressing health concerns. Respondents were then asked to indicate services that needed to be strengthened in terms of availability, access, or quality. Open-ended response items were provided for participants to indicate additional service gaps in the community and ideas for addressing concerns and service gaps.

SECTION III

IDENTIFIED HEALTH NEEDS

Community Feedback Survey

In the assessment of the needs of the community, it is imperative to consider the health concerns and gaps from the prospective of the community through direct response. This study uses a variety of data sources that provide insight to community health. But by gathering responses from the community, it can reveal whether the data is aligned with the community perceptions and potentially fill gaps in data if particular health concerns are consistently voiced. This section lists the Top Five health concerns and service gaps that the community has identified through survey responses. Throughout the remainder of the Community Needs Report, quotations from community individuals are highlighted, representing the voice of the community for particular health concerns.

Community Health Concerns

Survey respondents were asked to review a list of common community health issues. The list of issues draws from the topics in *Healthy People 2010*, with some refinements. The survey asked respondents to identify from the list what they view as important health concerns in the community. Respondents were also invited to identify additional issues not already defined on the list. *Table 1* provides the Top Five Important Community Health Concerns Identified by Survey Respondents. (*When interpreting the survey results, please note that while the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.)*

Table 1

Top 5 Important Community Health Concerns Identified by Survey Respondents		
Answer Options	**Response Percent**	**Response Count**
Adult Obesity	76%	107
Diabetes	67%	95
Mental Illness	63%	89
Heart Disease & Stroke	60%	84
Childhood Obesity	56%	79

Community Service Gaps

Survey respondents were asked to review a list of community services that are typically important for addressing the health needs of a community. Respondents were asked to identify from the list any services they think needed strengthening in terms of availability, access, or quality. Respondents were also invited to identify additional service gaps not already defined on the list. *Table 2* below provides the Top Five Important Community Service Gaps Identified by Survey Respondents. (*When interpreting the results please note that the relative number of responses received is not a definitive measure of the relative importance of one issue compared to another.)*

Table 2

Top 5 Important Community Service Gaps Identified by Survey Respondents		
Answer Options	**Response Percent**	**Response Count**
Health Care Coverage	55%	77
Patient Self-Management (e.g. nutrition, exercise, taking medications)	53%	75
Transportation	52%	73
Aging Services	50%	70
Early Detection and Screening	50%	70

Community Indicator Profile and Risk Factor Estimates

This section of the report provides a quantitative profile of the study region based on a wide array of community health indicators. To produce the profile, Community Health Solutions analyzed data from multiple sources. By design, the analysis does not include every possible indicator of community health. The analysis is focused on a set of indicators that provide broad insight into community health, and for which there were readily available data sources.

The results of this profile can be used to evaluate community health status compared to the Commonwealth of Virginia overall. The results can also be helpful for determining the number of people affected by specific health concerns. In addition, the results can be used alongside the Community Insight Survey results and the zip code level maps to help inform action plans for community health improvement. This section includes seven indicator profiles and three risk factor profiles as follows:

Community Indicator Profiles

1. Demographic Trend Profile
2. Demographic Snapshot
3. Mortality Profile
4. Maternal and Infant Health Profile
5. Preventable Hospitalization Profile
6. Behavioral Health Hospital Discharge Profile
7. Medically Underserved Profile

Risk Factor Estimates

1. Adult Health Risk Factor Profile
2. Child Health Risk Factor Profile
3. Uninsured Profile

1. Demographic Trend Profile

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

As shown in *Table 3*, as of 2010, the study region included approximately 851,230 people. The population is expected to grow to 890,905 by 2015. It is projected that growth will occur in most age groups, including a 21% increase in the seniors age 65+ populations. Focusing on racial background, growth is projected across all populations, including a 17% increase in the Asian population. The Hispanic population is also expected to grow by 28%

Table 3

Demographic Trend, Study Region, 2000-2015				
Indicators	**2000 Census**	**2010 Estimate**	**2015 Projection**	**% Change 2010 -2015**
Total Population	754,416	851,230	890,905	5%
Population Density (per Sq. Mile)	516.7	583.0	610.2	5%
Total Households	298,421	327,170	339,373	4%
Children Age 0-17	191,445	201,465	203,335	1%
Adults Age 18-29	120,328	141,691	141,584	0%
Adults Age 30-44	189,196	178,364	181,817	2%
Adults Age 45-64	170,206	223,441	235,763	6%
Seniors Age 65+	83,226	106,240	128,406	21%
Asian	15,758	26,409	30,967	17%
Black/African American	247,374	268,973	280,787	4%
White	469,182	518,836	538,768	4%
Other or Multi-Race	22,105	37,013	40,432	9%
Hispanic Ethnicity[4]	17,795	42,104	53,784	28%

Source: Community Health Solutions analysis of data from Alteryx, Inc.

[4] Classification of ethnicity; therefore Hispanic individuals are also included in the race categories.

2. Demographic Snapshot

Community health is driven in large 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. *Table 4* presents a snapshot of key demographics of the study region. As of 2010, the study region included an estimated 851,230 people, nearly 11% of Virginia's population. Compared to the Commonwealth of Virginia as a whole, the study region is more densely populated and proportionately more Black/African American.

Table 4

Demographic Snapshot, 2010		
Indicators	**Study Region**	**Virginia**
Population Rates		
Population Density (pop. per sq. mile)	583.0	197.8
Children Age 0-17 pct. of Total Pop.	24%	23%
Adults Age 18-29 pct. of Total Pop.	17%	17%
Adults Age 30-44 pct. of Total Pop.	21%	20%
Adults Age 45-64 pct. of Total Pop.	26%	26%
Seniors Age 65+ pct. of Total Pop.	12%	13%
Male pct. of Total Pop.	48%	49%
Female pct. of Total Pop.	52%	51%
Asian pct. of Total Pop.	3%	5%
Black/African American pct. of Total Pop.	32%	19%
White pct. of Total Pop.	61%	70%
Other or Multi-Race pct. of Total Pop.	4%	5%
Hispanic Ethnicity pct. of Total Pop.	5%	7%
Per Capita Income	$30,449	$32,872
Median Household Income	$56,631	$60,034
Low Income Households (Households with Income <$35,000) pct. of Total Households	29%	22%
Pop. Age 25+ Without a High School Diploma pct. of Total Pop. Age 25+	13%	13%

Source: Community Health Solutions analysis of data from Alteryx, Inc

3. Mortality Profile

As shown in *Table 5*, the study region had 6,567 total deaths in 2010. The leading causes of death were malignant neoplasms (cancer) (1,501), heart disease (1,476) and cerebrovascular disease (stroke) (407). When compared to statewide rates, the incidence of death by cerebrovascular disease (stroke) is 16.9% greater in the study region. The mortality rate for the remaining diseases is either somewhat greater than or slightly better than the statewide mortality rates.[5] (*Figure 3 shows the geographic distribution of cancer deaths by zip code.)*

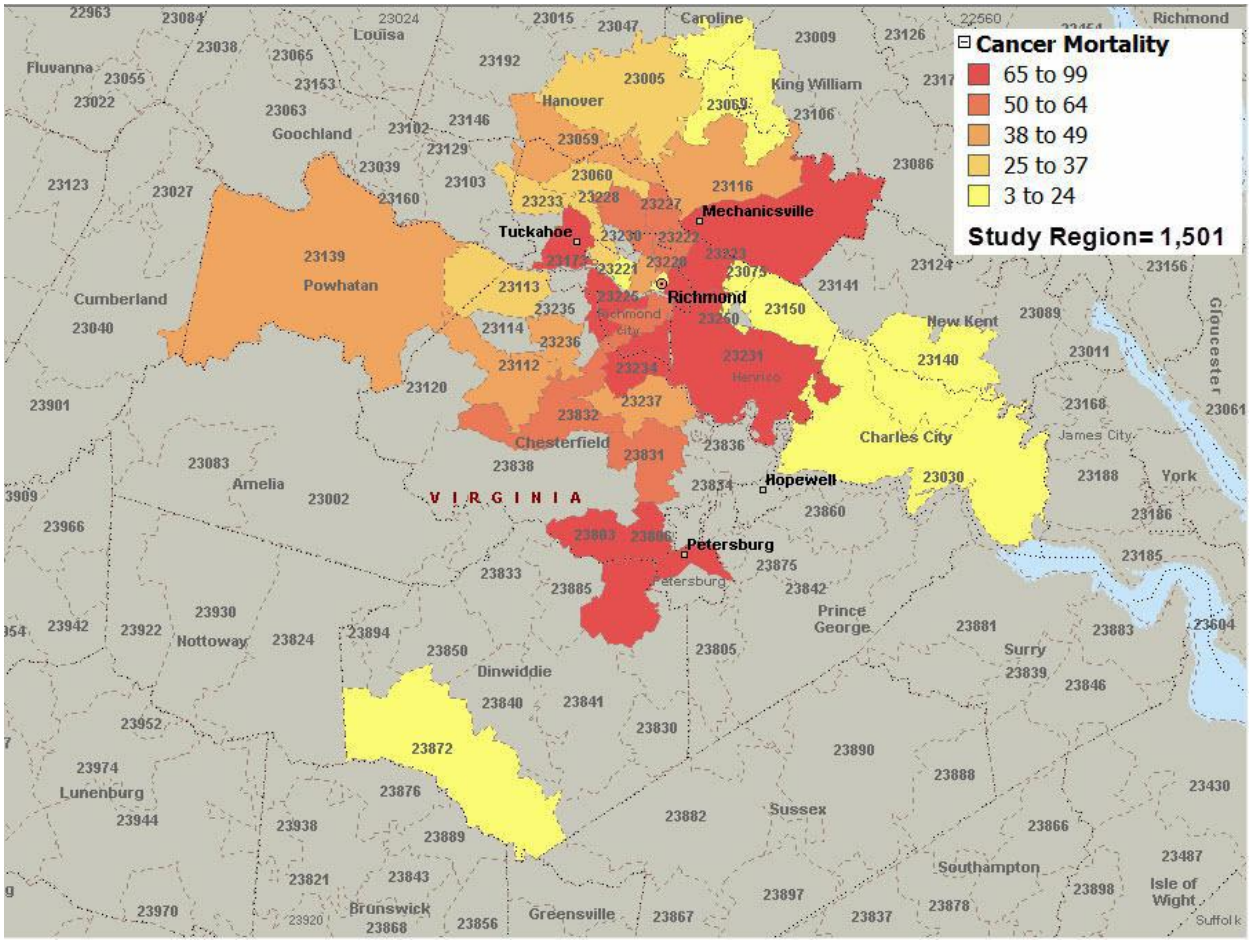
Table 5

Mortality Profile, 2010		
Indicators	**Study Region**	**Virginia**
Total Deaths		
Deaths by All Causes	6,567	58,841
Deaths by Top 5 Causes		
Malignant Neoplasms (Cancer) Deaths	1,501	13,958
Heart Disease Deaths	1,476	13,332
Cerebrovascular Disease (Stroke) Deaths	407	3,259
Chronic Lower Respiratory Disease Deaths	279	2,957
Unintentional Injury Deaths	271	2,571
Deaths per 100,000 by Top 5 Causes		
Malignant Neoplasms (Cancer) Deaths	176.3	175.3
Heart Disease Deaths	173.4	167.4
Cerebrovascular Disease (Stroke) Deaths	47.8	40.9
Chronic Lower Respiratory Disease Deaths	32.8	37.1
Unintentional Injury Deaths	31.8	32.3

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

[5] Age-adjusted death rates were not calculated for this study because the study region is defined by zip codes, and available data are not structured to support calculation of age-adjusted death rates at the zip code level. Age-group death rates are used as an alternative.

Figure 3. Malignant Neoplasms (Cancer) Deaths



(Map created by Community Health Solutions in delivery of the Community Health Needs Assessment 2012)

(This map shows a count rather than a rate. Rates are not mapped at the zip code level because in multiple zip codes the population is too small to support rate-based comparison.

4. Maternal and Infant Health Profile

The study region had 11,040 total live births in 2010. As shown in *Table 6,* 1,098 (10%) were born with low birth weight, 1,168 (11%) were births with late prenatal care, 5,006 (45%) were non-marital births and 867 were births to teens, with most (616) involving older teens age 18 or 19. Compared to Virginia as a whole, the study region had higher rates of low weight births and non-marital births. However, the study region also had a lower rate of late prenatal care births. (*Figure 4 shows the geographic distribution of low weight births by zip code.)*

Table 6

Maternal and Infant Health Profile, 2010		
Indicators	**Study Region**	**Virginia**
Rates		
Live Birth Rate per 1,000 Population	13.0	12.9
Low Weight Births pct. of Total Live Births	10%	8%
Late Prenatal Care (No Prenatal Care in First 13 Weeks) pct. of Total Live Births	11%	15%
Non-Marital Births pct. of Total Live Births	45%	35%

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

Table 7 shows counts and rates of infant mortality and teen pregnancy for the cities/counties that overlap the study region. The five-year infant mortality rates were higher than the statewide rate for the cities of Petersburg and Richmond. It was not possible to calculate teen pregnancies or five-year infant mortality rates at the zip code level.[6]

Table 7

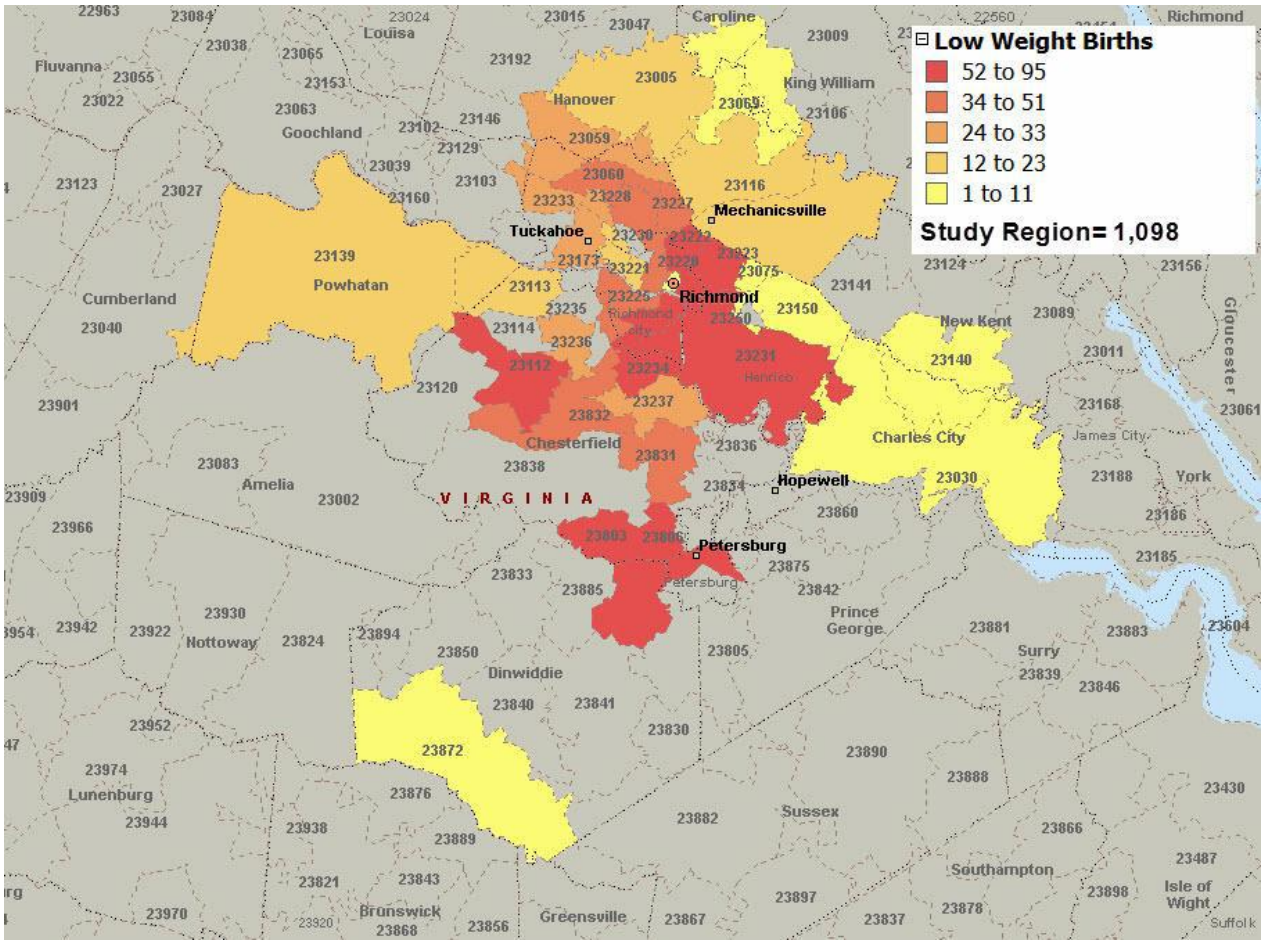
Infant Mortality and Teen Pregnancy, 2010

Indicators	Virginia	Chesterfield County	Hanover County	Henrico County	Petersburg City of	Richmond City of
Counts						
Total Infant Deaths (2010)	695	22	4	19	12	38
Total Teenage (age 10-19) Pregnancies	10,970	314	85	317	189	624
Rates						
Five-Year Average Infant Mortality Rate per 1,000 Live Births	7.1	5.8	5	6.7	12.2	12.3
Teenage (age 10-19) Pregnancy Rate per 1,000 Teenage Female Population	21.1	13.1	11.7	16.3	100.4	47.8

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

[6] Infant mortality and teen pregnancy rates were not calculated for this study region because the study region is defined by zip codes and available data are not structured to support calculation of rates at the zip code level. City/county level rates are provided as an alternative.

Figure 4. Low Weight Births, 2010



(Map created by Community Health Solutions in delivery of the Community Health Needs Assessment 2012)

(This map shows a count rather than a rate. Rates are not mapped at the zip code level because in multiple zip codes the population is too small to support rate-based comparison.)

5. Preventable Hospitalization Profile

The Agency for Healthcare Research and Quality (AHRQ) identifies a defined set of conditions (called Prevention Quality Indicators, or 'PQIs') for which hospitalization should be avoidable with proper outpatient health care.[7] High rates of hospitalization for these conditions indicate potential gaps in access to quality outpatient services for community residents.

Community Voice

"Too many people after 40 don't get regular physicals and too many women don't get regular check-ups especially since the #1 killer of women is heart attacks."

[7] The PQI definitions are detailed in their specification of ICD-9 diagnosis codes and procedure codes. Not every hospital admission for congestive heart failure, bacterial pneumonia, etc. is included in the PQI definition; only those meeting the detailed specifications. Low birth weight is one of the PQI indicators, but for the purpose of this report, low birth weight is included in the Maternal and Infant Health Profile. Also, there are three diabetes-related PQI indicators, which have been combined into one for the report. For more information, visit the AHRQ website at www.qualityindicators.ahrq.gov/pqi_overview.htm

Table 8 shows the Top 5 PQI Hospital Indicators in the study region. Residents of the study region had 8,640 PQI hospital discharges in 2010, with most involving seniors age 65+. The highest counts by diagnosis were for congestive heart failure (2,237), diabetes (1,470) and bacterial pneumonia (1,163).[8] When compared to statewide rates, the incidence of hospitalization for diabetes is 23.2% greater in the study region. Adult asthma is 42.8% greater when compared to the study region. Bacterial pneumonia is 26.7% lower than the study region. (*Figure 5 shows the geographic distribution of PQI discharges by zip code.)*

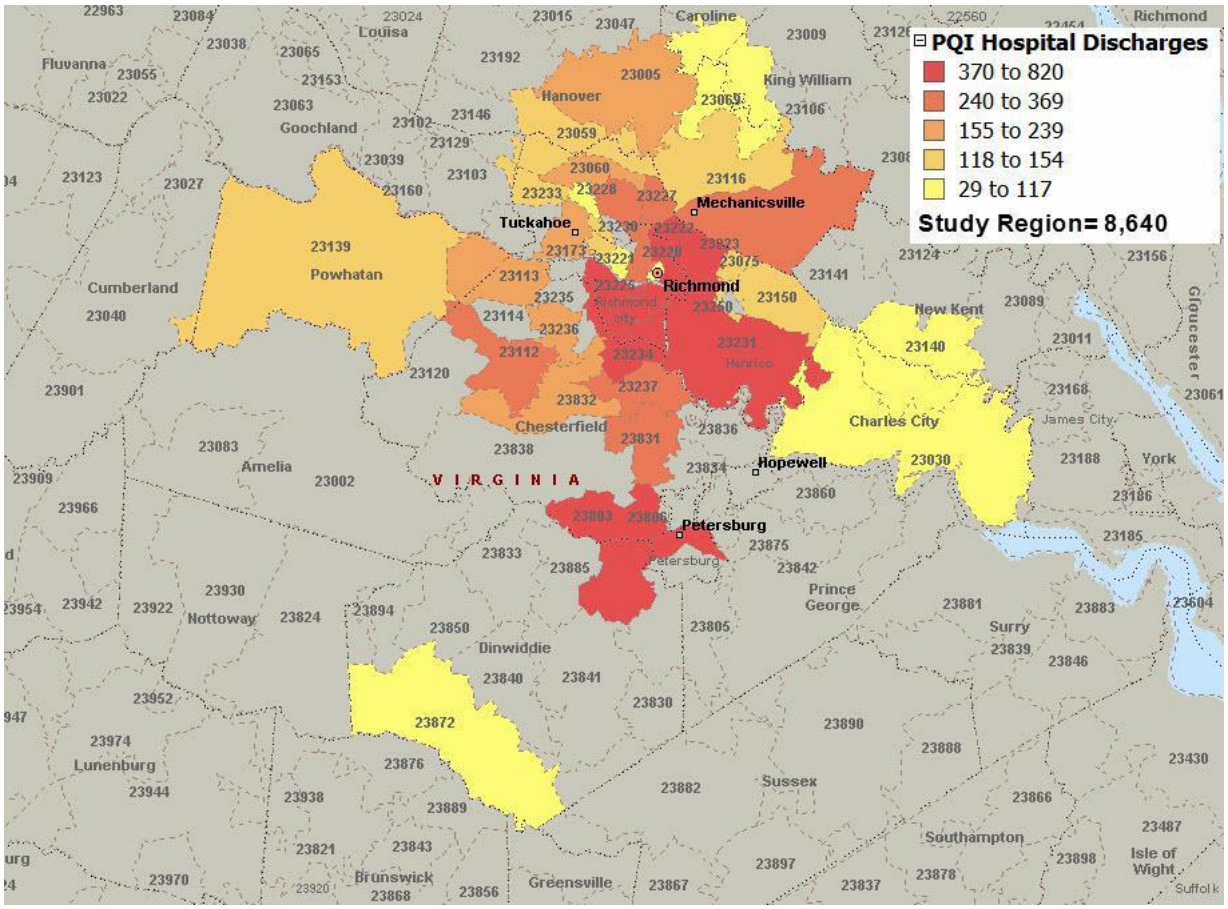
Table 8

Prevention Quality Indicator Hospital Discharges, 2010		
Indicators	**Study Region**	**Virginia**
Top 5 PQI Discharges by Diagnosis	**8,640**	**81,070**
Congestive Heart Failure	2,237	19,062
Diabetes	1,470	11,166
Bacterial Pneumonia	1,163	14,845
Urinary Tract Infection	1,157	10,331
Adult Asthma	964	6,313
Top 5 PQI Discharges per 100,000		
Congestive Heart Failure	262.8	239.4
Diabetes	172.7	140.2
Bacterial Pneumonia	136.6	186.4
Urinary Tract Infection	135.9	129.7
Adult Asthma	113.2	79.3

Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information, Inc.

[8] Data include discharges from Virginia hospitals reporting to Virginia Health Information, Inc. These data do not include discharges from state behavioral health facilities.

Figure 5. Prevention Quality Indicator (PQI) Hospital Discharges, 2010



(Map created by Community Health Solutions in delivery of the Community Health Needs Assessment 2012)

(This map shows a count rather than a rate. Rates are not mapped at the zip code level because in multiple zip codes the population is too small to support rate-based comparison.)

6. Behavioral Health Hospital Discharge Profile

Behavioral health (BH) hospitalizations provide another important indicator of community health status. *Table 9* shows the Top Five behavioral health hospital discharges for study region residents in 2010. Residents of the study region had 15,878 hospital discharges from Virginia hospitals for behavioral health conditions in 2010.[9] The leading diagnoses for these discharges were affective psychoses (3,833), schizophrenic disorders (1,893) and non-dependent abuse of drugs (1,648). When compared to the statewide rates, the incidence of behavioral health discharges is significantly higher for four of the top five diagnoses. The incidence of schizophrenic disorders is 125% greater than the statewide rate, followed by other psychosocial circumstances at 103%. Non-dependent abuse of drugs has an incident rate 50% greater than statewide rates and affective psychoses are at 34.6%. The incidence of general symptoms is actually lower than the statewide rate by 2.3%. (*Figure 6 shows the geographic distribution of behavioral health discharges by zip code.)*

Community Voice

"There is no doubt in my mind that the biggest health problem in Hanover County is mental health."

[9] Data include discharges from Virginia hospitals reporting to Virginia Health Information, Inc. These data do not include discharges from state behavioral health facilities.

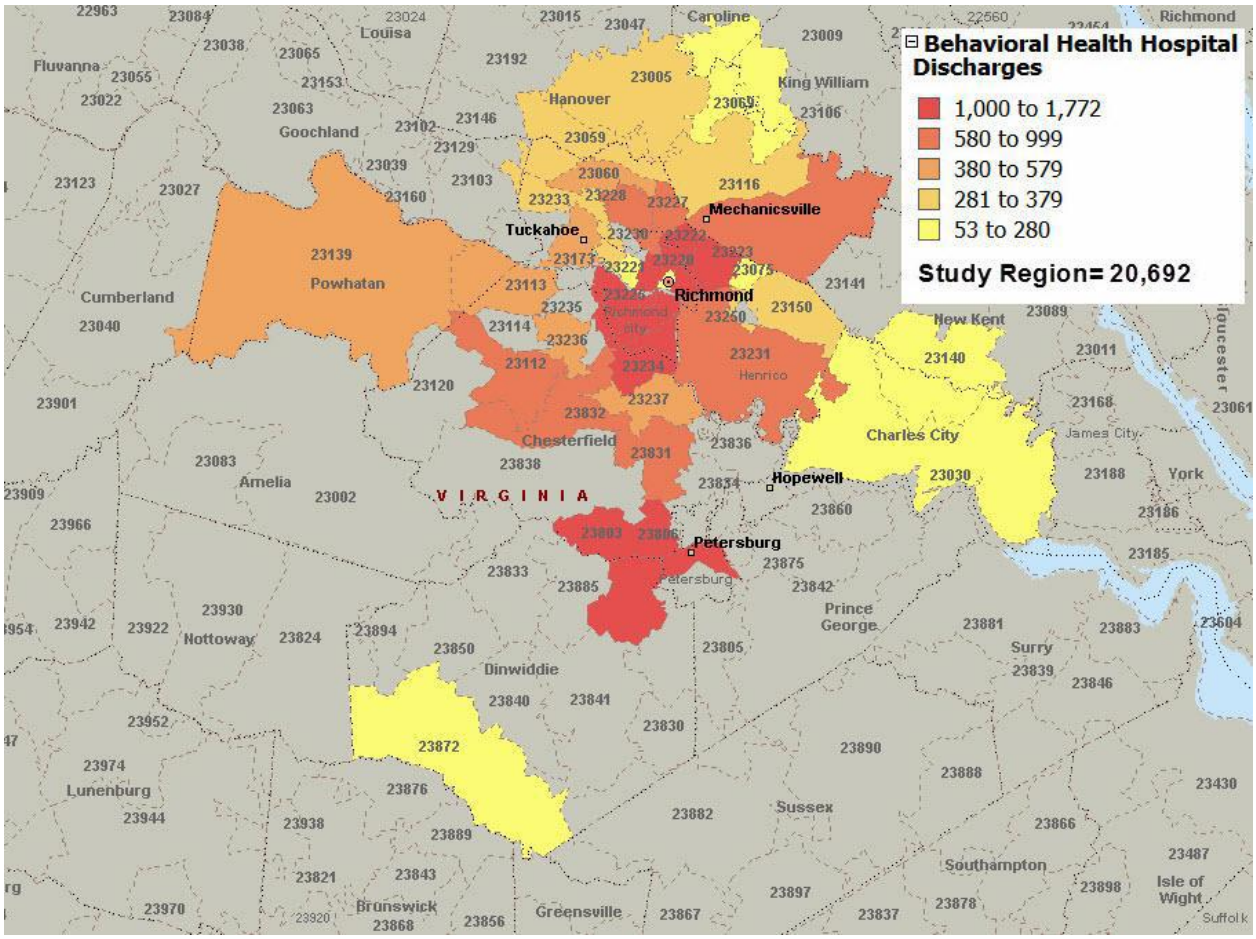
Table 9

Behavioral Health Hospital Discharges, 2010		
Indicators	**Study Region**	**Virginia**
BH Discharges by Top 5 Diagnoses	**20,692**	**125,414**
Affective Psychoses[10]	5,232	33,098
Schizophrenic Disorders	2,481	9,754
Non-Dependent Abuse of Drugs	2,011	12,770
Other Psychosocial Circumstances	1,926	8,047
General Symptoms	1,868	16,957
Top 5 BH Discharges per 100,000		
Affective Psychoses	614.6	415.6
Schizophrenic Disorders	291.5	122.5
Non-Dependent Abuse of Drugs	236.2	160.3
Other Psychosocial Circumstances	226.3	101.0
General Symptoms	219.4	212.9

Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information, Inc.

[10] Includes major depressive, bipolar affective and manic depressive disorders.

Figure 6. Behavioral Health Hospital Discharges, 2010



(Map created by Community Health Solutions in delivery of the Community Health Needs Assessment 2012)

(This map shows a count rather than a rate. Rates are not mapped at the zip code level because in multiple zip codes the population is too small to support rate-based comparison.)

7. 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+.

Community Voice

"Provide incentive motivation to medical, dental, and mental health providers to serve the underserved population."

As shown in *Table 10*, four of the five localities that overlap the study region have been designated as MUAs/MUPs. All of the City of Petersburg has been designated as an MUA/MUP. Parts of Chesterfield County, Henrico County, and the City of Richmond have been designated as MUAs/MUPs. For a more detailed description, visit the U.S. Health Resources and Service Administration designation webpage at http://muafind.hrsa.gov/.

Table 10

Medically Underserved Areas		
Locality	**MUA/MUP Designation**	**Census Tracts**
Chesterfield County	Partial	2 of 88 Census Tracts
Hanover County	None	---
Henrico County	Partial	2 of 76 Census Tracts
Petersburg, City of	Full	17 of 17 Census Tracts
Richmond, City of	Partial	14 of 73 Census Tracts

Source: Community Health Solutions analysis of hospital discharge from Virginia Health Information, Inc.

Risk Factor Estimates

Risk factors are an important aspect of the community health profile because they are factors that can influence particular health trends. These areas could be potentially successful issues to address through work in the community to help mitigate the risk factors, helping to create a healthier community.

Community Voice

"Adequate patient education opportunities (especially as it relates to nutrition and diabetes) for the poor would be a significant contribution to the community we serve."

1. Adult Health Risk Factor Profile

This section examines health risks for adults based on synthetic estimates developed by Community Health Solutions.[11] As shown in *Table 11*, the estimates indicate that substantial numbers of adults in the study region may have health risks related to nutrition, weight, physical activity, alcohol and tobacco. In addition, substantial numbers of adults may have chronic conditions such as high cholesterol, high blood pressure, arthritis, asthma and diabetes.

[11] Synthetic estimates are used when there are no primary sources of data available at the local level. In this case, synthetic estimates were developed by using national and state survey results to predict the prevalence of the listed conditions in the local population. The survey data came from the CDC's Behavioral Risk Factor Surveillance Survey. Local demographics estimates were obtained from Alteryx, Inc. The statistical model to produce the estimates was developed by Community Health Solutions.

Table 11

Adult Health Risk Factors (Estimates) 2010		
Indicators	**Study Region Estimates (count)**	**Study Region Estimates (percent)**
Estimated adults age 18+	649,741	100%
Estimated to…		
Eat Less Than Five Servings of Fruits and Vegetables Per Day	500,619	77%
Be Overweight or Obese	384,954	59%
Have High Cholesterol (told by a doctor or other health professional)	186,179	29%
Have High Blood Pressure (told by a doctor or other health professional)	182,326	28%
Have Arthritis (told by a doctor other health professional)	176,771	27%
Have No Physical Activity in the Past 30 Days	155,480	24%
Be a Smoker	146,836	23%
Be Limited in any Activities because of Physical, Mental or Emotional Problems	118,370	18%
Have Fair or Poor Health Status	101,638	16%
Be at Risk of Binge Drinking	95,577	15%
Have Asthma (told by a doctor or other health professional)	84,332	13%
Have Diabetes (told by a doctor or other health professional)	54,885	8%

Source: Community Health Solutions synthetic estimates.

2. Child Health Risk Factor Profile

> **Community Voice**
>
> *"There needs to be health education for the school systems to improve meals at school. Parental education as far as nutrition needs to be improved too."*

This section examines health risks for children based on synthetic estimates developed by Community Health Solutions. The particular health risk indicators involve nutrition, physical activity and weight. These risks have received increasing attention as the population of American children has become more sedentary, more prone to unhealthy eating and more likely to develop unhealthy body weight. The long-term implications of these trends are serious, as these factors place children at higher risk for chronic disease both now and in adulthood.

Table 12 shows the list of selected child health risk estimates for children age 10-17 in the study region. These estimates are based on statewide and regional survey data from a recent household survey on childhood obesity commissioned by the Virginia Foundation for Healthy Youth.[12] The results of the survey were published in May 2010. The estimates were produced by applying the regional estimates for Central Virginia to the study region population estimates for 2010. Assuming that the survey estimates for Central Virginia reflect the behaviors of children in the study region today, it is estimated that large numbers of children in the study region are not meeting recommendations for healthy eating, physical activity and healthy weight. (*Note: Figure 7 shows the geographic distribution of estimated child obesity age 10-17 by zip code.)*

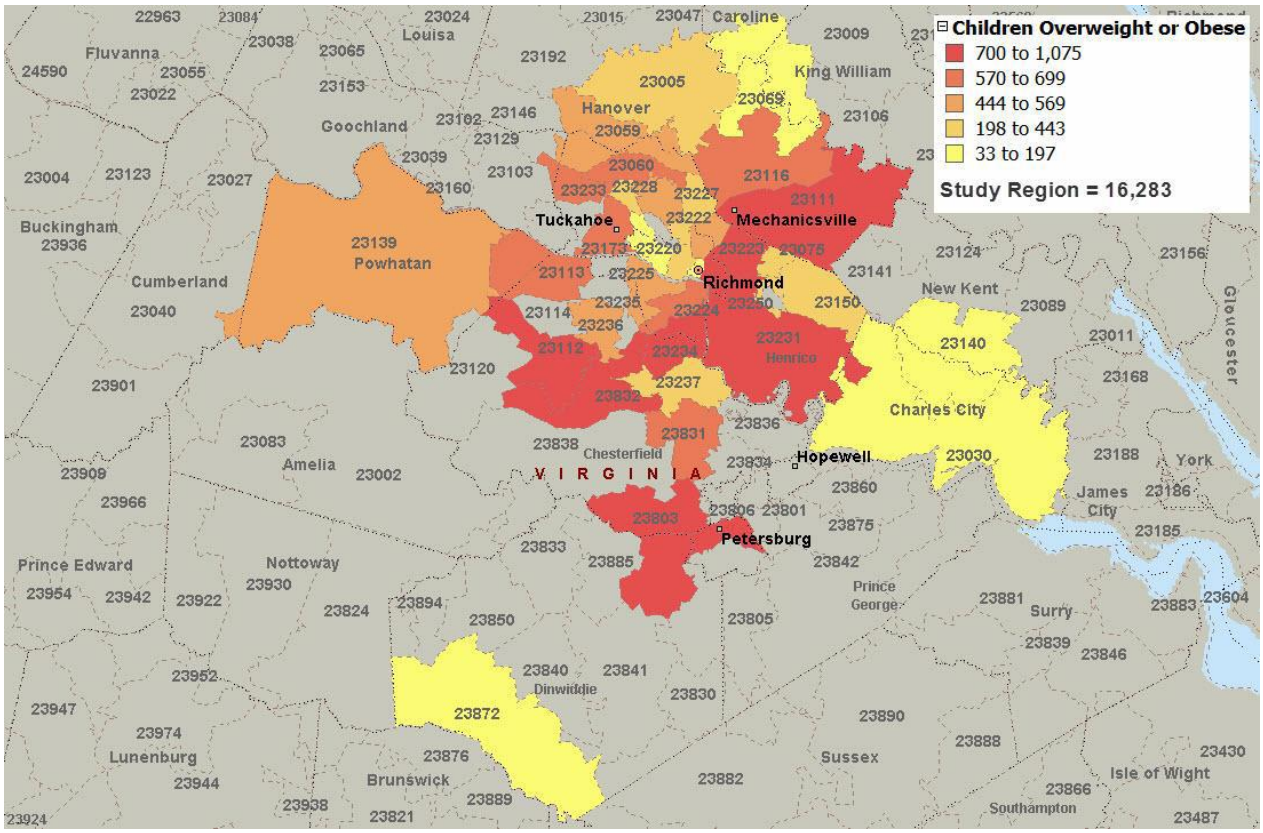
[12] Synthetic estimates are used when there are no primary sources of data available at the local level. In this case, synthetic estimates were developed by using state and regional survey results to predict the prevalence of the listed conditions in the local population. The survey data came from Market Decisions' *2010 Obesity Survey* commissioned by Virginia Foundation for Healthy Youth. Local demographic estimates were obtained from Alteryx, Inc. The statistical model to produce the estimates was developed by Community Health Solutions.

Table 12

Child Health Risk Factors (Estimates) 2010		
Indicators	**Study Region Estimates (count)**	**Study Region Estimates (percent)**
Estimated Children Age 10-17	88,694	100%
Estimated to…		
Drink soda or eat chips or candy one or more days per week	81,598	92%
Eat less than the recommended intake of fruits and vegetables	78,051	88%
Be less physically active than recommended	30,156	34%
Watch television three or more hours per day	21,393	24%
Be overweight or obese	16,283	18%
Play video/computer games three or more hours per day	14,191	16%

Source: Community Health Solutions synthetic estimates.

Figure 7. Estimated Children Age 10-17 Overweight or Obese, 2010



(Map created by Community Health Solutions in delivery of the Community Health Needs Assessment 2012)

(This map shows a count rather than a rate. Rates are not mapped at the zip code level because in multiple zip codes the population is too small to support rate-based comparison.)

3. Uninsured Profile

Community Voice

"We need more providers that accept Medicaid and providers willing to help undocumented children who do not qualify for Medicaid and can't afford other insurance coverage."

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. *Table 13* shows synthetic estimates of the number of uninsured individuals in the study region as of 2010.[13] An estimated 120,978 (16%) nonelderly residents of the study region were uninsured. This includes an estimated 20,206 children and 100,772 adults. Among both children and adults, the large majority of uninsured residents were estimated to have incomes from 0-200% of the federal poverty level (FPL).[14] (*Note: Figure 8 shows the geographic distribution of uninsured population by zip code.)*

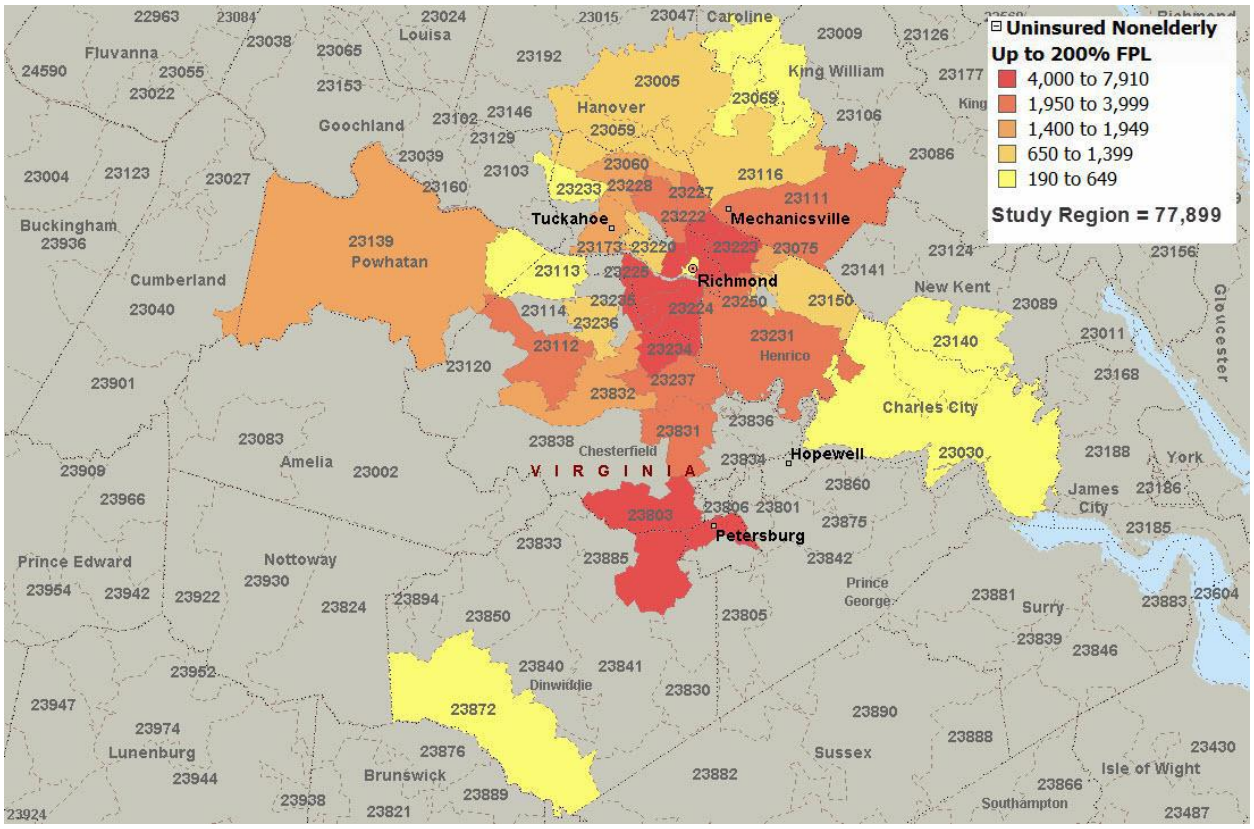
[13] Synthetic estimates are used when there are no primary sources of data available at the local level. In this case, synthetic estimates were developed by using state survey results to predict the prevalence of the listed conditions in the local population. The statewide uninsured estimates were obtained from a report produced for the Virginia Health Care Foundation by Urban Institute. Local demographic estimates were obtained from Alteryx, Inc. The statistical model to produce the estimates was developed by Community Health Solutions. The estimates do not explicitly account for either undocumented populations or acute drops in income due to the recession.

[14] Two hundred percent of the federal poverty level is defined as an annual income of $44,700 for a family of four. http://aspe.hhs.gov/poverty/11poverty.shtml

Table 13

Uninsured (Estimates) 2010	
Indicators	**Study Region**
Estimated Uninsured Counts	
Uninsured Nonelderly Age 0-64	120,978
Uninsured Children Age 0-18	20,206
Uninsured Children 0-200% Federal Poverty Level (FPL)	14,410
Uninsured Children <100% FPL	10,251
Uninsured Children 101-200% FPL	4,160
Uninsured Children 201-300% FPL	2,413
Uninsured Children 301%+ FPL	3,383
Uninsured Adults Age 19-64	100,772
Uninsured Adults 0-200% FPL	63,488
Uninsured Adults <100% FPL	34,785
Uninsured Adults 101-200% FPL	28,703
Uninsured Adults 201-300% FPL	17,614
Uninsured Adults 301%+ FPL	19,670
Uninsured Adults 19-64 under 133% FPL	44,257
Uninsured Adults 19-64 and 133-300% FPL	36,845
Estimated Uninsured Rates	
Uninsured Nonelderly Percent	16%
Uninsured Children Percent	10%
Uninsured Adults Percent	19%

Figure 8. Estimated Uninsured Nonelderly Age 0-64, 0-200% Federal Poverty Level, 2010



(Map created by Community Health Solutions in delivery of the Community Health Needs Assessment 2012)

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SECTION IV

PRIORITY NEEDS

The CHNA method described above sets a strong foundation for prioritizing community need. Secondary data analysis contained herein, as well as survey data reflecting the perspectives of key informants on needs and service gaps, was then vetted with internal and external audiences to help confirm initial findings and establish priorities. The approach taken when presenting and obtaining feedback varied based on group composition, but several guiding questions helped to frame the interaction with each group:

1) Prevalence: How many people are affected?
2) Mortality: How severe is the issue?
3) Community Will: How important is the issue to community members?
4) Health Disparity: Are some populations disproportionately vulnerable?
5) System Alignment: Does the hospital have capacity to help impact change?

Multiple meetings were conducted with various constituents to assist in prioritizing needs and receiving feedback on the Community Health Needs Assessment. Two of the meetings warrant additional description because of their unique contribution to the process.

The Bon Secours Richmond CHNA Community Review session covered all four hospitals, and was facilitated by Becky Clay Christensen with The Clay Christensen Group. This review included: Medical Directors and Associate Medical Director covering Health Departments for four jurisdictions; Health Department Registered Nurses from two jurisdictions; a Chief Operating Officer of a Free Clinic; an Executive Director of a Federally Qualified Health Center; an Executive Director for Community Health Services; a Director of Richmond Promise Neighborhoods. In addition to these community health leaders, the following internal leaders also participated: the Senior Vice President of Sponsorship for Bon Secours Richmond; the Administrative Director for Community Health Services; the Administrative Director for Advocacy; Manager for Evaluation and Sustainability; Manager for Community Nutrition; two Healthy Community Liaisons.

After hearing a presentation on initial findings, which included secondary and survey data, this group discussed and made “dot choices” to help prioritize issues by distributing dots on issues from the report and raised by the group.

The Health Reform East End group is also important to note. In keeping with Catholic social teaching and the mission of the hospital system, Richmond Community Hospital sought to insure that analysis of community-level indicators did not eclipse issues experienced in neighborhoods experiencing economic challenges. This group reviewed the information with particular interest in a neighborhood that has been identified as focal area for health outreach because of its disproportionate vulnerable based on several criteria.

Two priorities were identified through this thorough, multifaceted process including:

- Adult and Childhood Obesity
- Mental Illness

The results of the assessment, input from the community and discussion among internal leaders led to the following priorities:

- Adult and Childhood Obesity
- Aging Services
- Behavioral Health
- Cancer Early Detection and Screening
- Chronic Disease Prevention and Management
- Dental Care / Oral Health
- Heart Disease & Stroke Prevention and Treatment
- Maternal Health
- Transportation
- Uninsured Adults and Children

An Implementation Plan specific to Richmond Community Hospital follows.

SECTION V

DESCRIPTION OF EXISTING HEALTH CARE FACILITIES AND OTHER RESOURCES AVAILABLE WITHIN THE COMMUNITY SERVED TO MEET IDENTIFIED NEEDS:

Our Work and Commitment

A list of existing Bon Secours Community Programs addressing priority areas identified for Richmond Community Hospital follows:

Health Promotion and Prevention

i. Healthy Communities Initiative: *Improve community health in target neighborhoods through community organizing and resource alignment. Helps neighbors help neighbors by assisting with identifying and prioritizing need and facilitation of strategic partnerships to build community capacity for sustained health and quality of life gains. Serves residents of Richmond's East End and applies principles to regional efforts.*

ii. Faith Community Health Ministry: *Mobilizes and equips faith community nurses, other allied health professionals and lay health ministers. Serves individuals and communities interested in promoting health and wellness for the whole person within their respective faith community in Central Virginia.*

iii. Community Nutrition Services: *Improves community health, particularly in vulnerable communities, through nutrition counseling, healthy eating classes, and advocacy for food access. Serves communities within a 60-mile radius of the City of Richmond.*

iv. Healthy Beginnings: *Reduce infant mortality in the City of Richmond's East End (Zip 23223) through education, resources, and better access to prenatal care. Serves new, expectant mothers, and pre-conceptual women in the East End.*

v. Love and Learn: *Strengthen families within the community by providing free or discounted classes to assist individuals and families in gaining vital parenting skills. Serves new and expectant parents in a 60-mile radius of City of Richmond including Tappahannock and Kilmarnock. Some services have associated fees, though inability to does not exclude anyone.*

vi. Movin' Mania: *An awareness campaign, highlighting childhood obesity and connecting families to nutrition education and physical activity resources within Bon Secours and the community. Serves families in Central Virginia and beyond.*

vii. Heart Aware: *Focuses on prevention and early detection of heart disease by providing health lectures health screenings, healthy cooking and physical activity demonstrations. Primarily serves adults over 30 years of age in Central Virginia.*

viii. Senior Outreach: *Enhance health and wellbeing of seniors through community outreach, advocacy and support. The program provides information, educational opportunities, activities and linkages with community resources to maintain optimal health, wellbeing and independence. Serves seniors within a 60-mile radius of the City of Richmond.*

Access to Health Care

i. Bon Secours Care Card: *To serve uninsured and underinsured patients with ease and dignity as they access health care. Serves individuals who qualify for Bon Secours Health System Financial Assistance Plan and are not eligible for government sponsored insurance.*

ii. Care-A-Van: *Improve access to health care services for the uninsured through mobile neighborhood health clinics that provide free, primary, urgent, and preventative health care. Nutrition and chronic disease management consultation are also provided. Serves uninsured and vulnerable populations in a 60-mile radius of the City of Richmond, Northern Neck, Middle Peninsula and Hampton Roads areas.*

iii. St. Joseph's Outreach Clinic*: Increase access to care for uninsured and underinsured patients. Nutrition and chronic disease management consultation are also provided. Serves Medicaid and Medicare patients, Spanish-speaking patients and working uninsured in a 60-mile radius of the City of Richmond.*

iv. Every Woman's Life: *Reduce breast and cervical* cancer *through early screening exams, free mammograms, breast exams, Pap tests and cervical screenings. Serves women between 40-64 years of age in a 60-mile radius of the City of Richmond, who are residents of Virginia, are uninsured or underinsured, and meet income guidelines. Women 18-39 years of age with symptoms may also be served.*

v. Healthy Beginnings: *Reduce infant mortality in the City of Richmond's East End (Zip 23223) through education, resources, and better access to prenatal care. Serves new, expectant mothers, and pre-conceptual women in the East End.*

vi. CARMA (Controlling Asthma in the Richmond Metropolitan Area): *Improve the management of asthma in children through care coordination, home visits and education for children and their families. Serves children 2-18 years of age and families in a 60-mile radius of the City of Richmond.*

vii. Noah's Children: *Central Virginia's only pediatric palliative care and hospice program. Provide comprehensive care, through an interdisciplinary team approach for mind, body and spirit of infants, children and adolescents who have been diagnosed with a life-threatening illness and their families. Serves children 0-17 years of age and families with physician referral in a 60-mile radius of City of Richmond.*

viii. Bon Secours Richmond Diabetes Treatment Center: *Enables persons with diabetes to achieve long-term control of their blood sugar and reduce the possibility of developing diabetic complications. Serves adults and children with diabetes, gestational diabetes, and their families. Provides bariatric counseling in the Richmond metropolitan area, and as far east as Urbanna, the Northern Neck and Williamsburg, north to Fredericksburg, west to Farmville. Fees associated with some services, though inability to pay does not exclude anyone.*

ix. Cross Cultural Services: *Supports culturally competent care and access by providing interpreter training, medical Spanish, and education about cultural diversity and health to Bon Secours staff and community groups. Serves culturally and linguistically diverse populations needing health care and all Bon Secours Virginia employees.*

x. Hospice and Palliative Care: *Provide respite and bereavement support to end-of-life patients and their families.*

xi. Bon Secours Richmond Bereavement Center: *Provides support services for those suffering loss. Serves the community at large.*

xii. Bon Secours Richmond Cullither Brain Tumor Quality of Life:
Provides supports and education to patients with brain tumors and their families. Serves the community at large.

Our Community's Assets

While we are committed to advancing this work and making an impact on community health, we know that impacting community health will require alignment of community-wide efforts. Therefore, Bon Secours is committed to strategic partnerships that promise to achieve more than we could on our own. Bon Secours is also committed to building capacity in other nonprofits and community efforts through sponsorship and volunteerism. A list of

partners and other identified community resources that are well positioned to impact the identified needs follows:

Health Promotion and Prevention / Support Services

i. Area Congregations Together in Service: *Provides financial support to keep Richmond residents stably housed and to prevent homelessness.*

ii. Commonwealth Catholic Charities: *Provides social services, immigration services and financial services to the community at large.*

iii. Anna Julia Cooper School: *Faith-based middle school in Richmond's East End, serving youth with limited resources.*

iv. Better Housing Coalition: *Supports affordable housing; Partnership has an emphasis on Richmond's East End.*

v. Challenge Discovery*: Provides bullying prevention and substance abuse counseling; Partnership has an emphasis on Richmond's East End.*

vi. Chef Mamusu: *Cooking school for girls; Partnership has an emphasis on Richmond's East End.*

vii. Family Lifeline: *A home visiting program seeking to enhance family functioning through intensive case management with Community Health Nurse, Outreach Worker, and Mental Health Clinicians providing support, access to healthcare and medical services, as well as mental health assessment. Partnership has an emphasis on Richmond's East End.*

viii. Friends Association: *Provides quality childcare and development in an underserved part of Richmond; Partnership has an emphasis on Richmond's East End.*

ix. Habitat for Humanity: *Improves access to affordable home ownership; Partnerships across the region with an emphasis on Richmond's East End.*

x. Junior League: *Support of efforts at an elementary school in the Richmond Promise Neighborhood area; Partnership has an emphasis on Richmond's East End*.

xi. Local Initiatives Support Corporation (LISC*): Supports economic development in vulnerable communities; Partnership has an emphasis on Richmond's East End.*

xii. Peter Paul Development Center: *A community center in Richmond's East End with child, youth, and adult services, including a Senior Center Adult Day Care; Partnership has an emphasis on Richmond's East End*.

xiii. Promise Neighborhood Consortium: *A neighborhood–level, cradle-to-career effort that takes a holistic approach to community engaged*

neighborhood development; Partnership has an emphasis on Richmond's East End.

xiv. Richmond Cycling Corps*: Changes lives and encourages physical activity of youth living in public housing, via cycling; Partnership has an emphasis on Richmond's East End*.

xv. Richmond Hill: *An ecumenical Christian fellowship and residential community committed to the wellbeing of Richmond residents; Partnership has an emphasis on Richmond's East End.*

xvi. Richmond Redevelopment and Housing Authority: *Partnership has an emphasis on Richmond's East End.*

xvii. Salvation Army Boys and Girls Club*: The Club emphasizes life-skills training and serves more than 500 members with a daily participation of 150; Partnership has an emphasis on Richmond's East End.*

xviii. Senior Outreach - Sr. Ambassador Council: *Provides community leadership and service opportunities, education, and social networking; Partnership has an emphasis on Richmond's East End.*

xix. Seventh District Health and Wellness Initiative: *Seeks to connect each East End resident to a medical home and reduce obesity through nutrition education and physical activity opportunities; Partnership has an emphasis on Richmond's East End.*

xx. Sports Backers/Richmond Strikers: *Provides social development and physical activity opportunities to inner-city youth, via soccer; Partnership has an emphasis on Richmond's East End.*

xxi. Tricycle Gardens: *Improves healthy food access through urban agriculture, education and urban farm stands; Partnership has an emphasis on Richmond's East End.*

xxii. Women Infant and Children (WIC*): Provide breastfeeding education during pregnancy and breastfeeding support after deliver; Partnership has an emphasis on Richmond's East End*.

xxiii. YMCA: *Youth development and physical activity programing; Partnership has an emphasis on Richmond's East End*.

xxiv. YWCA: *Community support services; Partnership has an emphasis on Richmond's East End.*

xxv. Hanover Safe Place: *Provides services to victims of sexual or domestic violence and promotes violence prevention*.

xxvi. Hilliard House: *Assists homeless women and their children to build their capacity to live productively within the community.*

xxvii. Circle Center Adult Day Services: *Alternative to in-home care, assisted living or nursing home care.*

xxviii. Commonwealth Parenting: *Resource for parenting education.*

xxix. Faces of Hope*: Addresses childhood obesity through nutrition education and physical activity.*

xxx. Faison School for Autism: *School addressing the unique learning needs of children diagnosed with autism*.

xxxi. Fit 4 Kids: *Program to address childhood obesity via collaborations with schools and Out of School Time programs*.

xxxii. Hanover Tavern Foundation: *Support of historic gardens, civic education, historic preservation, and cultural enrichment*.

xxxiii. Higher Achievement*: rigorous afterschool and summer academic programs aimed to close the opportunity gap for middle school youth in at-risk communities*.

xxxiv. Legal Information Network for Cancer (LINC*): Provides assistance and referral to legal, financial, and community resources for cancer patients and their families.*

xxxv. Older Dominion Partnership: *Collaboration of organizations to plan for aging Virginians.*

xxxvi. Excel VCU: *Literacy efforts for children; Partnership has an emphasis on Richmond's East End*.

xxxvii. Rebuilding Together Richmond: *Helps lower income seniors and people with disabilities stay in their homes via home repair*.

xxxviii. Partnership for Non-Profit Excellence: *Develops the capacity of nonprofits through education, information sharing and civic engagement.*

xxxix. Prevent Blindness Mid Atlantic: *Promotes eye health and safety through education, prevention, and promotion of a continuum of vision care.*

xl. Science Museum of Virginia: *Promotes Science, Technology, Engineering, Math and Healthcare (STEMH) interests within the region.*

xli. Senior Connections: *Capital Area Agency on Aging with home and community-based services for seniors age 55 and older, caregivers and persons with disabilities.*

xlii. Senior Navigator: *A one-stop source of information and access to community programs and services for seniors.*

xliii. Virginia Literacy Foundation: *Provides funding and technical support to private, volunteer literacy organizations throughout Virginia via challenge grants, training, and direct consultation*.

xliv. Virginia Recreation and Parks: *Improves access to quality places and physical activity opportunities.*

xlv. Virginia Supportive Housing: *Provides permanent housing to the homeless.*

xlvi. Voices for Children: *Statewide, privately funded, non-partisan policy resea*rch *and practices that improve the lives of children*.

Access to Health Care

i. Access Now: *Volunteer Specialty network for free clinic patients.*

ii. Dental Van: *Partnership with the City of Richmond to provide emergency, adult dental care.*

iii. Child Savers: *Mental health services for children; Partnership has an emphasis on Richmond's East End.*

iv. Family Lifeline: *A home visiting program seeking to enhance family functioning through intensive case management with Community Health Nurse, Outreach Worker, and Mental Health Clinicians providing support, access to healthcare and medical services, as well as mental health assessment. Partnership has an emphasis on Richmond's East End.*

v. Creighton Court Resource Center: *Partnership with the Richmond City Health Department and Richmond Redevelopment & Housing Authority to deliver health screenings, checkups, health education, nutrition, parenting classes, budget management community resource information to an underserved community; Partnership has an emphasis on Richmond's East End.*

vi. Richmond City Health District: *Support of programs addressing the needs of vulnerable populations – includes prevention and access.*

vii. Virginia Commonwealth University Sickle Cell: *Addressing sickle cell anemia in high incident populations; Partnership has an emphasis on Richmond's East End.*

viii. Virginia Asthma Coalition: *Organizations and individuals devoted to reducing the morbidity and mortality associated with asthma; Partnership has an emphasis on Richmond's East End.*

ix. Federally Qualified Health Centers (2): *Improving access to care for underserved populations; Partnership has an emphasis on Richmond's East End.*

x. Free Clinics (6): *Financial and in-kind support for CrossOver, Fan Free, Goochland, Center for High Blood Pressure, Hanover Interfaith, Powhatan and Pathways.*

xi. Healing Place: *Provides substance abuse rehab for homeless men.*

xii. Respite Program*: Post discharge continuing care facility for the homeless: funded by the Daily planet, FQHC.*

xiii. Medical Society of Virginia: *Medication assistance program for Care-A-Vans and St. Joseph's Outreach Clinic.*

xiv. Ronald McDonald House: *Guest house for Virginia Commonwealth University Medical Center patients and families.*

xv. Shepherd's Center of Chesterfield: *An interfaith ministry of seniors volunteering to improve the lives of other seniors, including medical transportation services.*

xvi. Virginia Healthcare Foundation: *Promotes and funds local public-private partnerships that increase access to primary health care* services for medically underserved and uninsured Virginians.

xvii. Virginia Home: *Private, non-profit providing nursing, therapeutic and residential care to adult Virginians with irreversible disabilities.*

Needs Not Addressed

Dental Care/Oral Health

Dental Care was identified in the CHNA community survey as a gap. Oral health is important because it can impact general health. Multiple community organizations are engaged in providing dental care services to the uninsured. They include Virginia Commonwealth University's School of Dentistry, Daily Planet, FQHC, Vernon J. Harris Dental Clinic, CrossOver Ministry and Goochland Free Clinic and Family Services. As such Bon Secours will not be addressing dental needs at this time.

Transportation

Other community organizations are better positioned to provide transportation. The Greater Richmond Transit Authority (GRTC) serves the City of Richmond and Henrico County. They have 186 buses and 40 routes. Each bus is equipped with a wheel chair lift. GRTC serves the Richmond Community Hospital campus.

GRTC CARE service provides curb-to-curb public transportation to disabled individuals who may not be reasonably able to use the GRTC fixed route bus. It is also available for persons aged 80 or older.

Richmond Community Hospital provides limited patient transportation. Patients who reside within a 10-mile radius of the hospital may utilize the patient transport van to reach the hospital campus. This service includes behavioral health patients.

Lack of adequate transportation can be a barrier to accessing health care services. The Bon Secours Care-A-Van is a mobile health outreach program providing primary care services in local neighborhoods in the Richmond Community Hospital service area. The Care-A-Van contributes to the elimination of transportation as a barrier to care for uninsured patients.

Next Steps

The public documentation of the triennial needs assessment and implementation plan is a snapshot in time in a continuous improvement process. As such, we have already identified some areas for continued work over the next three years, to improve our effectiveness and prepare for anticipated requirements for the next reporting cycle.

- Develop specific, measurable, and attainable goals using community-level indicators
- Further align external partnerships according to prioritized needs
- Increase community capacity to address health needs through strategic investment and accountability
- Develop a plan to evaluate and report on program outcomes and overall community health impact

APPENDIX

1. The Community Health Needs Assessment was developed by Community Health Solutions. The link to their website appears below.

   http://www.communityhealthsolutions.net/index.html

2. The Community Health Needs Assessment Community Survey was created and administered by Community Health Solutions. It was available electronically through survey monkey and in paper. A copy of the survey is attached.

   Bon Secours Richmond_Community

3. Technical writing and consultation was provided by: Jason W. Smith, PhD. A copy of his CV is attached.

   Jason W. Smith, PhD.pdf