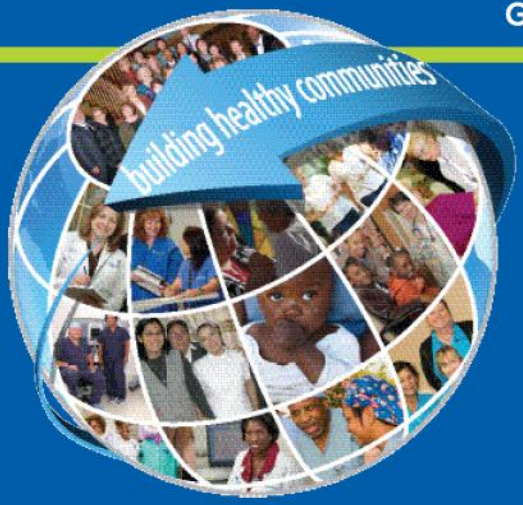



BON SECOURS HEALTH SYSTEM

# Community Health Needs Assessment

## Bon Secours St. Francis Medical Center


## Table of Contents


# Executive Summary

St. Francis Medical Center is part of the Bon Secours Richmond Health System. Bon Secours St. Francis Medical Center is a 130 bed facility licensed in the state of Virginia and serving approximately 893,861 residents of the following communities and cities: Amelia, Chesterfield, Hanover, Henrico, Nottoway, Powhatan and Prince George counties; and the cities of Colonial Heights, 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 St. Francis Medical Center 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

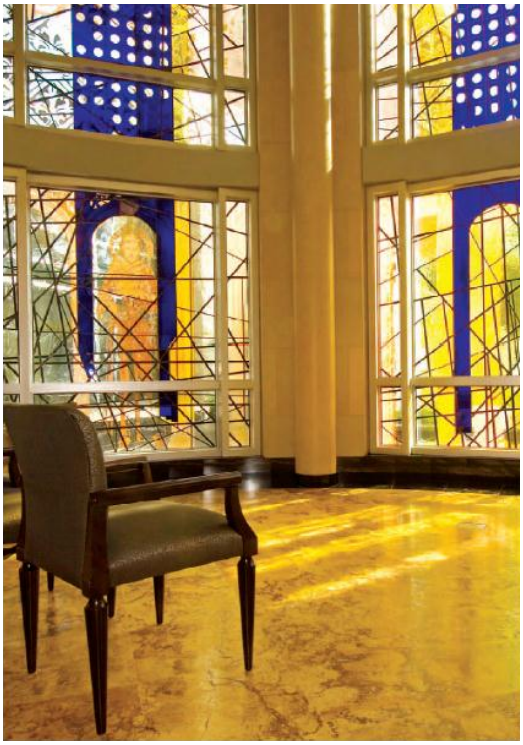

Collectively, these health concerns may be arranged as depicted below:

| 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 CHNA@bshsi.org.

**BON SECOURS ST. FRANCIS MEDICAL CENTER DESCRIPTION AND VISION**



Completed in 2005, St. Francis Medical Center is a state-of-the-art facility offering the latest in digital technology, including patient rooms wired for the Internet. Our peaceful setting provides a restful and contemplative environment for patients, families, staff and the community. The Chapel, prayer gardens, fountains and walking paths are designed to enhance the spiritual aspects of healing, to fulfill our Mission of bringing people and communities to health and wholeness.

In this serene setting with an atmosphere of hope and compassion, the Bon Secours Cancer Institute at St. Francis offers services in radiation, medical and surgical oncology, diagnostic services, infusion therapy, palliative care and patient/family education services.

Fully accredited by the Joint Commission (JCAHO), our service offerings include all types of surgery, women's services, 24-hour onsite neonatology, 24-hour emergency care, cardiology, orthopedics, oncology, urology, pediatric services, cardiac catheterization, MRI/CT, diagnostic imaging and nuclear medicine. St. Francis Medical Center has been honored with the Pathway to Excellence™ designation by the American Nurses Credentialing Center. St. Francis Medical Center also received national recognition from the American Heart Association/American Stroke Association for excellence in stroke care. The Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award and Target: Stroke Honor Roll designation are awarded to hospitals that have implemented standards of protocol for treating stroke patients.

## SECTION I

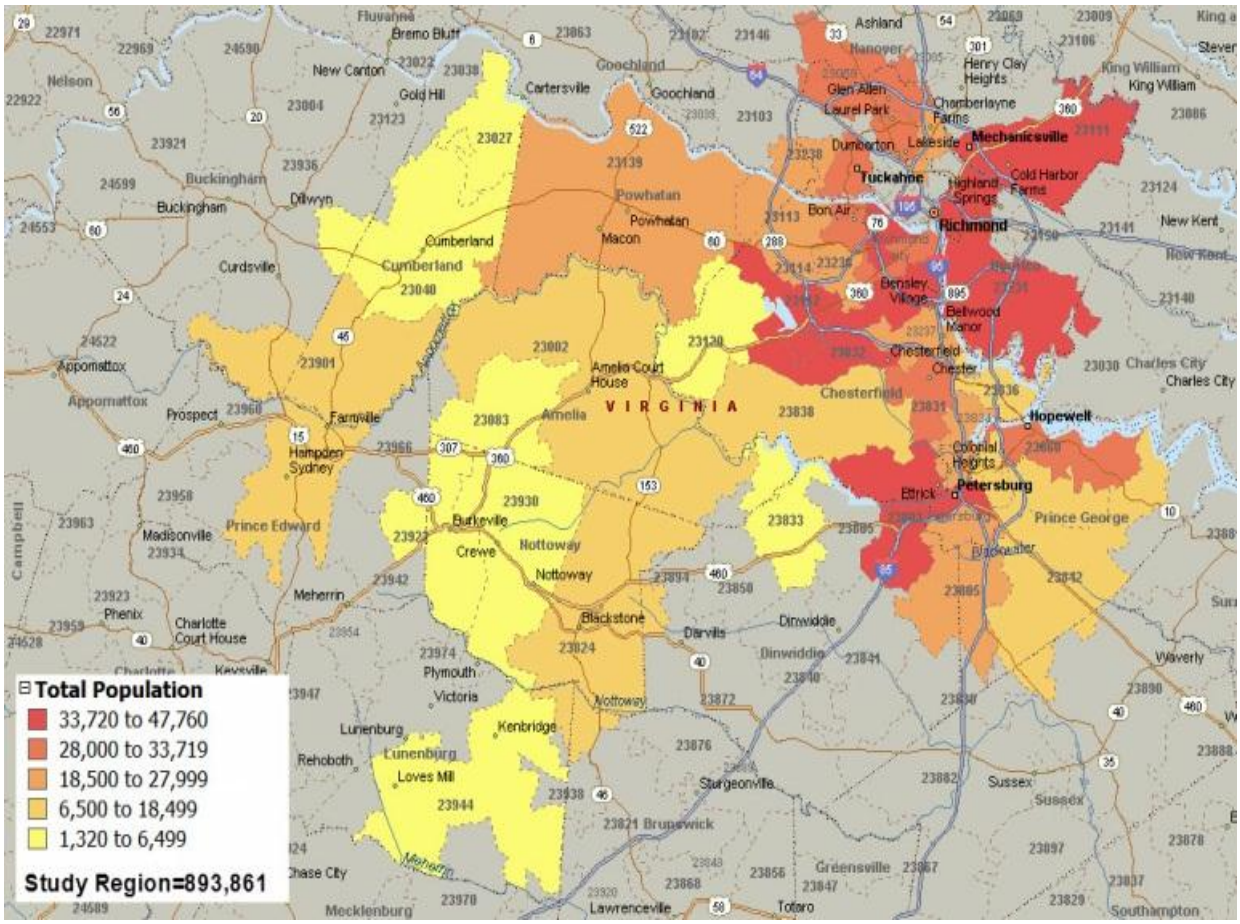
### BON SECOURS FACILITY SERVICE AREA AND DESCRIPTION OF COMMUNITY SERVED

The St. Francis Medical Center service area extends across much of central Virginia, containing the heritage of downtown Richmond, suburban communities of Chesterfield and Henrico counties and the pleasures of rural life in counties such as Powhatan and Amelia. These localities provide many qualities of life, but there are also many health issues that require attention to maintain all aspects of community health.

The St. Francis Medical Center service area consists of 41 zip codes that fall mostly in the counties of Amelia, Chesterfield, Hanover, Henrico, Nottoway, Powhatan and Prince George counties; and the cities of Colonial Heights, Hopewell, Petersburg and Richmond.[1] The map below depicts the Primary Service Area (PSA) and the Secondary Service (SSA). A PSA represents the area which 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 wide variety of localities, from very urban and dense to rural. 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 the hospital's primary service and/or secondary service area.

## Figure 1. St. Francis Medical Center Study Area




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

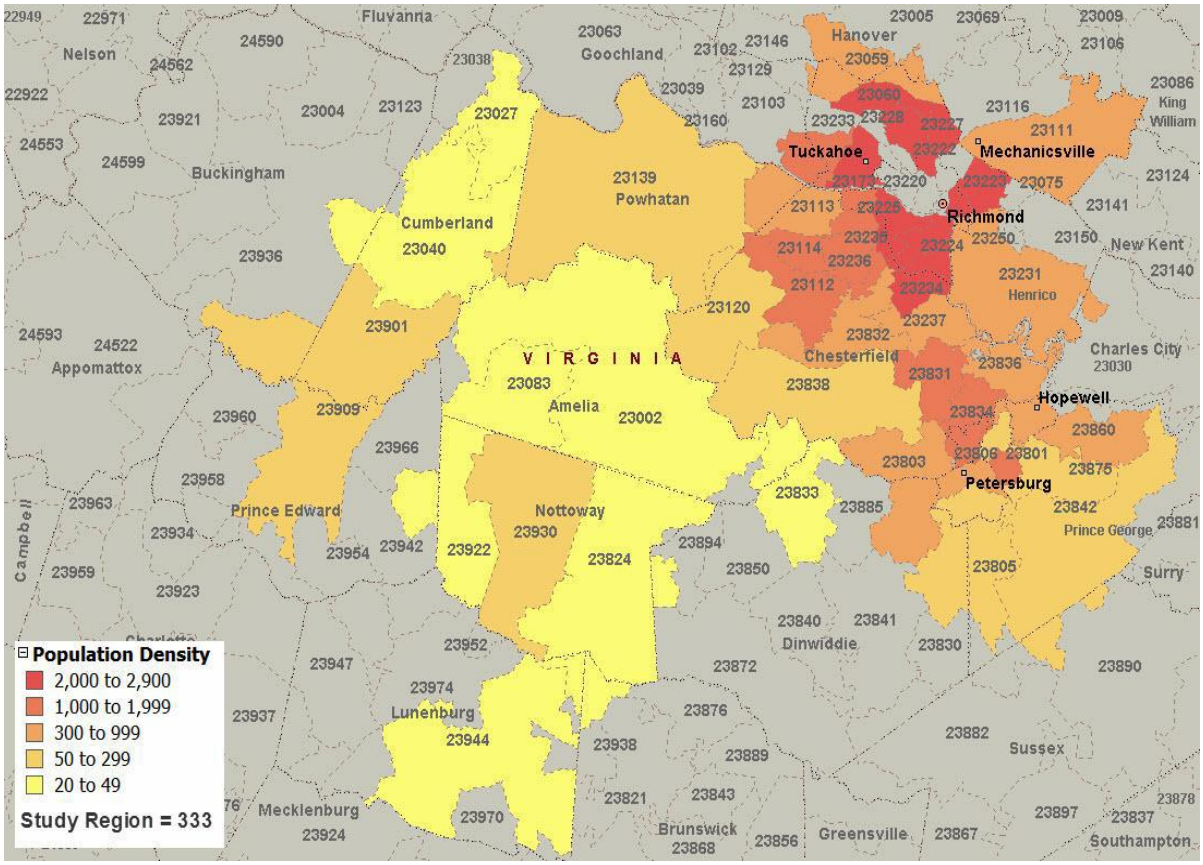
*(This map shows a count rather than a rate. Rates are not mapped at the zip code level because in multiple zip codes the population is too small to support rate-based comparison.)*

### *Demographic Profile*

The health of a community is largely connected to the demographics and social aspects of its residents, which can be useful indicators of health concerns. The St. Francis Medical Center study area contained 893,861 people as of 2010, of which 52% are female and 48% male—a population that is expected to grow to 941,278 by 2015. Compared to the Commonwealth of Virginia as a whole, this region is more densely populated (332.7 people per sq. mile) and is proportionately more Black/African American (31%).

The median household income of the community is $57,621, just under the median income in Virginia of $60,034. The study region also has higher levels of low-income households (28% are Low Income Households with income less than $35,000), and proportionately more adults age 25+ without a high school education. This section provides a brief summary of the demographic trends within the study region; demography is also 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) St. Francis Medical Center, a Catholic, not-for profit hospital, embraces its responsibility to reinvest earnings to provide lasting community benefit. In order to assure that we are 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 that 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 and post public 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. Initial CHNA reports for each hospital were then compared to other publicly available health assessments and community-based research that was conducted during the contracted needs assessment


process. 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 are able to be considered in comparison to Virginia averages. Foundational sources 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 were 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 are 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 424 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 (33%) 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 individuals in the community are integrated into the report, 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 | 74% | 104 |
| Diabetes | 65% | 92 |
| Mental Illness | 62% | 87 |
| Heart Disease & Stroke | 60% | 85 |
| 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 need 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 |
| Transportation | 52% | 73 |
| Aging Services | 51% | 72 |
| Patient Self-Management (e.g. nutrition, exercise, taking medications) | 51% | 72 |
| Health Education | 49% | 69 |


**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 are 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 893,861 people. The population is expected to grow to 941,278 by 2015. It is projected that growth will occur in most age groups, including a 23% increase in the seniors age 65+ populations. Growth is projected across all racial populations, including a 19% increase in the Asian population and 29% in the Hispanic population.

***Table 3***

| Demographic Trend, Study Region, 2000-2015 | | | | |
|---|---|---|---|---|
| **Indicators** | **2000 Census** | **2010 Estimate** | **2015 Projection** | **% Change 2010 - 2015** |
| Total Population | 783,165 | 893,861 | 941,278 | 5% |
| Population Density (per Sq. Mile ) | 291.5 | 332.7 | 350.4 | 5% |
| Total Households | 302,158 | 338,399 | 354,795 | 5% |
| Children Age 0-17 | 202,785 | 213,345 | 212,059 | -1% |
| Adults Age 18-29 | 116,613 | 143,557 | 147,662 | 3% |
| Adults Age 30-44 | 191,764 | 181,674 | 185,162 | 2% |
| Adults Age 45-64 | 182,069 | 241,216 | 255,674 | 6% |
| Seniors Age 65+ | 89,914 | 114,028 | 140,721 | 23% |
| Asian | 14,617 | 24,602 | 29,251 | 19% |
| Black/African American | 242,278 | 274,067 | 290,989 | 6% |
| White | 503,809 | 556,916 | 578,646 | 4% |
| Other or Multi-Race | 22,460 | 38,277 | 42,442 | 11% |
| Hispanic Ethnicity[4] | 19,241 | 45,000 | 58,116 | 29% |

*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

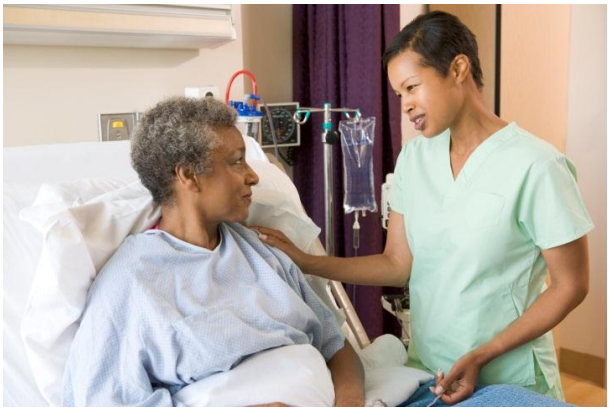
Community health is strongly related to community demographics. The age, sex, race, ethnicity, income and education status of a population are strong predictors of community health status and community health needs. *Table 4* presents a snapshot of key demographics of the study region. As of 2010, the study region included an estimated 893,861 people, 11.2% 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. The study region has lower income levels and slightly more adults age 25+ without a high school diploma.

*Table 4*

| Demographic Snapshot, 2010 | | |
|---|---|---|
| **Indicators** | **Study Region** | **Virginia** |
| **Population Rates** | | |
| Population Density (pop. per sq. mile) | 332.7 | 197.8 |
| Children Age 0-17 pct. of Total Pop. | 24% | 23% |
| Adults Age 18-29 pct. of Total Pop. | 16% | 17% |
| Adults Age 30-44 pct. of Total Pop. | 20% | 20% |
| Adults Age 45-64 pct. of Total Pop. | 27% | 26% |
| Seniors Age 65+ pct. of Total Pop. | 13% | 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. | 31% | 19% |
| White pct. of Total Pop. | 62% | 70% |
| Other or Multi-Race pct. of Total Pop. | 4% | 5% |
| Hispanic Ethnicity pct. of Total Pop. | 5% | 7% |
| Per Capita Income | $29,954 | $32,872 |
| Median Household Income | $57,621 | $60,034 |
| Low Income Households (Households with Income <$35,000) pct. of Total Households | 28% | 22% |
| Pop. Age 25+ Without a High School Diploma pct. of Total | 14% | 13% |

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

## 3. Mortality Profile



As shown in *Table 5*, the study region had 7,136 total deaths in 2010. The leading causes of death were malignant neoplasms (cancer) (1,660), heart disease (1,638) and cerebrovascular disease (stroke) (448).When compared to statewide rates, the incidence of death by cerebrovascular disease (stroke) is 22.5% greater in the study region. The mortality rate for the remaining diseases is either slightly greater than or slightly better than statewide mortality rates[5]. (*Figure 3 shows the geographic distribution of cancer deaths by zip code.)*

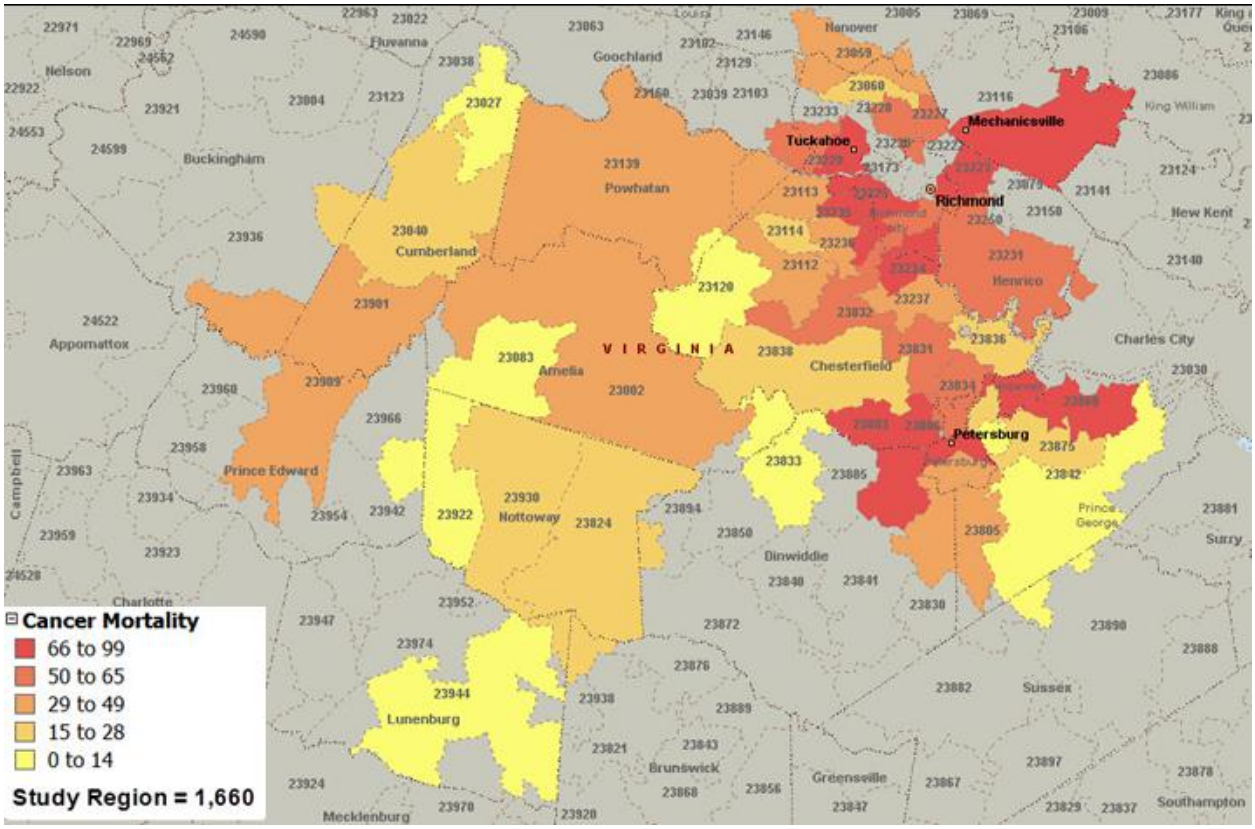
*Table 5*

| Mortality Profile, 2010 | | |
|---|---|---|
| **Indicators** | **Study Region** | **Virginia** |
| **Total Deaths** | | |
| Deaths by All Causes | 7,136 | 58,841 |
| **Deaths by Top 5 Causes** | | |
| Malignant Neoplasms (Cancer) Deaths | 1,660 | 13,958 |
| Heart Disease Deaths | 1,638 | 13,332 |
| Cerebrovascular Disease (Stroke) Deaths | 448 | 3,259 |
| Chronic Lower Respiratory Disease Deaths | 332 | 2,957 |
| Unintentional Injury Deaths | 291 | 2,571 |
| **Deaths per 100,000 by Top 5 Causes** | | |
| Malignant Neoplasms (Cancer) Deaths | 185.7 | 175.3 |
| Heart Disease Deaths | 183.2 | 167.4 |
| Cerebrovascular Disease (Stroke) Deaths | 50.1 | 40.9 |
| Chronic Lower Respiratory Disease Deaths | 37.1 | 37.1 |
| Unintentional Injury Deaths | 32.6 | 32.3 |

[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.

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

## 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 11,471 total live births in 2010. As shown in *Table 6,* 1,125 (10%) were born with low birth weight, 1,202 (10%) were births with late prenatal care, 5,205 (45%) were non-marital births and 962 were births to teens, with most (690) 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 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 | 12.8 | 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 | 10% | 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. Teen pregnancy rates were higher than the statewide rates for the counties of Amelia and Nottoway; and 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]

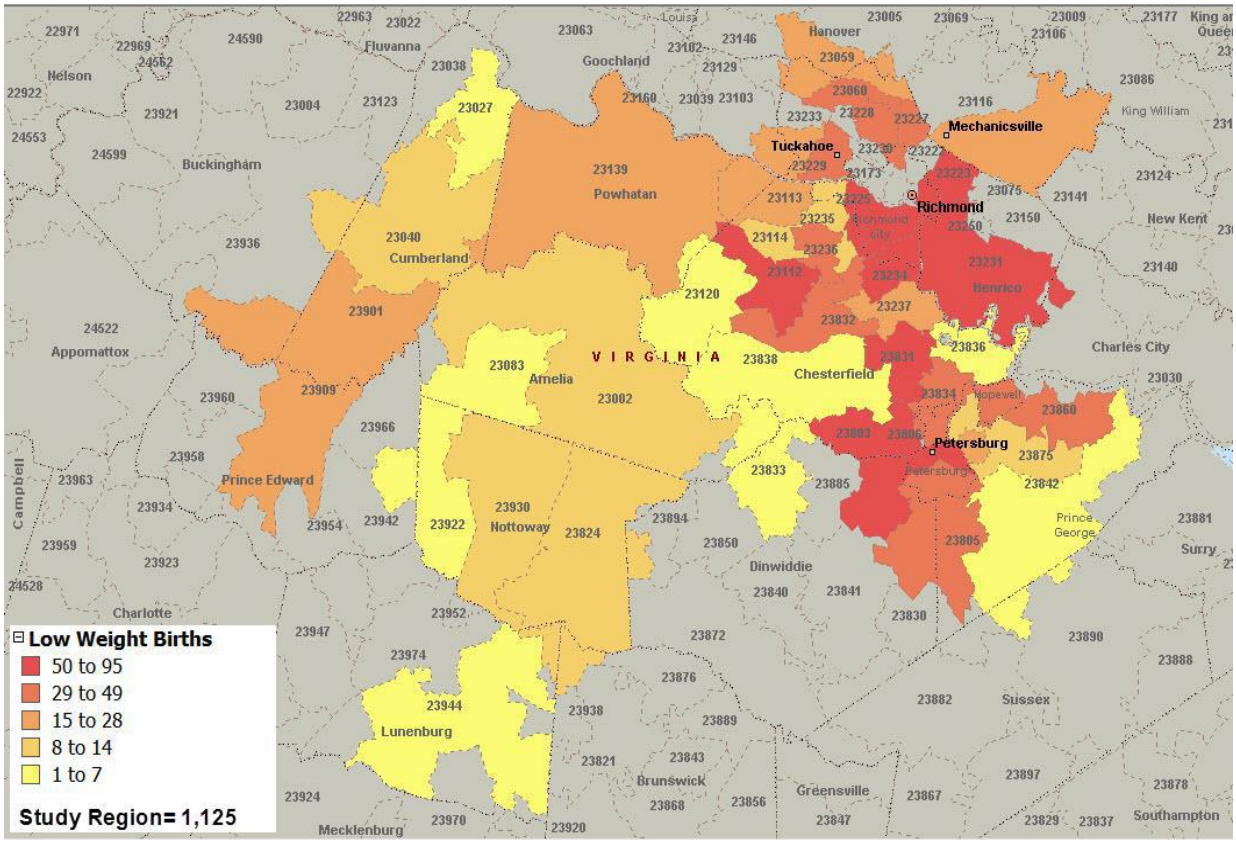
[6] Infant mortality and teen pregnancy rates were not calculated for this study region because the study region is defined by zip codes and available data are not structured to support calculation of rates at the zip code level. City/county level rates are provided as an alternative.


*Table 7*

| Infant Mortality and Teen Pregnancy, 2010 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicators** | **Virginia** | **Amelia County** | **Chesterfield County** | **Colonial Heights, City of** | **Hanover County** | **Henrico County** | **Hopewell, City of** | **Nottoway County** | **Powhatan County** | **Prince George County** | **Petersburg, City of** | **Richmond, City of** |
| **Counts** | | | | | | | | | | | | |
| Total Infant Deaths (2010) | 698 | 2 | 22 | 1 | 4 | 19 | 5 | 1 | 3 | 2 | 12 | 38 |
| Total Teenage (10-19) Pregnancies | 10,970 | 20 | 314 | 40 | 85 | 317 | 74 | 22 | 20 | 43 | 189 | 624 |
| **Rates** | | | | | | | | | | | | |
| Five-Year Average Infant Mortality Rate per 1,000 Live Births | 7.1 | 3.9 | 5.8 | 7.4 | 5.0 | 6.7 | 9.1 | 5.8 | 6.5 | 5.4 | 12.2 | 12.3 |
| Teenage (10-19) Pregnancy Rate per 1,000 Teenage Female Population | 21.1 | 25.9 | 13.1 | 35.5 | 11.7 | 16.3 | 49.7 | 24.7 | 11.2 | 18.6 | 100.4 | 47.8 |

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

## 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."*

*Table 8* shows the Top Five PQI Hospital Indicators in the study region. Residents of the study region had 9,654 PQI hospital discharges in 2010, with most involving seniors age 65+. The highest counts by diagnosis were for congestive heart failure (2,448), diabetes (1,517) and bacterial pneumonia (1,326).[8] When compared to statewide rates, the incidence of hospitalization for diabetes is 21.0% greater in the study region while the incidence of hospitalization for bacterial pneumonia is 25.7% lower. Other PQI discharges are either somewhat greater or slightly better than the statewide rates. (*Figure 5 shows the geographic distribution of PQI discharges by zip code.)*

[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

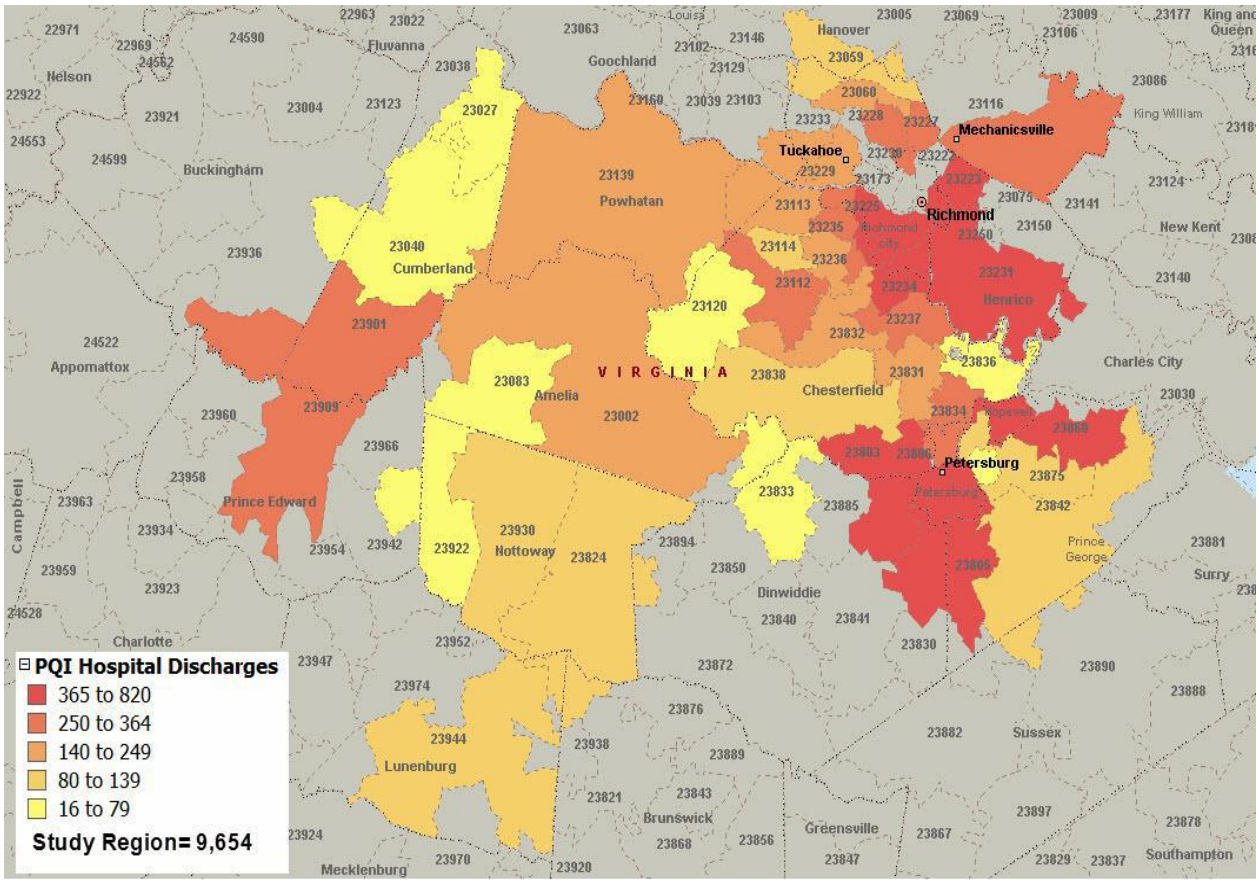
[8] Data include discharges from Virginia hospitals reporting to Virginia Health Information, Inc. These data do not include discharges from state behavioral health facilities.


*Table 8*

| Prevention Quality Indicator Hospital Discharges, 2010 | | |
|---|---|---|
| **Indicators** | **Study Region** | **Virginia** |
| **Top 5 PQI Discharges by Diagnosis** | **9,654** | **81,070** |
| Congestive Heart Failure | 2,448 | 19,062 |
| Diabetes | 1,517 | 11,166 |
| Bacterial Pneumonia | 1,326 | 14,845 |
| Urinary Tract Infection | 1,300 | 10,331 |
| Chronic Obstructive Pulmonary Diseases | 1,017 | 10,448 |
| **Discharges per 100,000 for Top 5 PQI Diagnoses** | | |
| Congestive Heart Failure | 273.9 | 239.4 |
| Diabetes | 169.7 | 140.2 |
| Bacterial Pneumonia | 148.3 | 186.4 |
| Urinary Tract Infection | 145.4 | 129.7 |
| Chronic Obstructive Pulmonary Diseases | 113.8 | 131.2 |

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

## 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 21,744 hospital discharges from Virginia hospitals for behavioral health conditions in 2010.[9] The leading diagnoses for these discharges were affective psychoses (5,688), general symptoms (2,283) and schizophrenic disorders (2,204). When compared to the statewide rates, the incidence of behavioral health discharges is significantly higher for each of the top five diagnoses. Other psychosocial circumstances has the greatest variance at 117% higher than the statewide rate, followed by schizophrenic disorders at 101% and affective psychoses at 53.1% (*Figure 6 shows the geographic distribution of behavioral health discharges by zip code.)*

*Table 9*

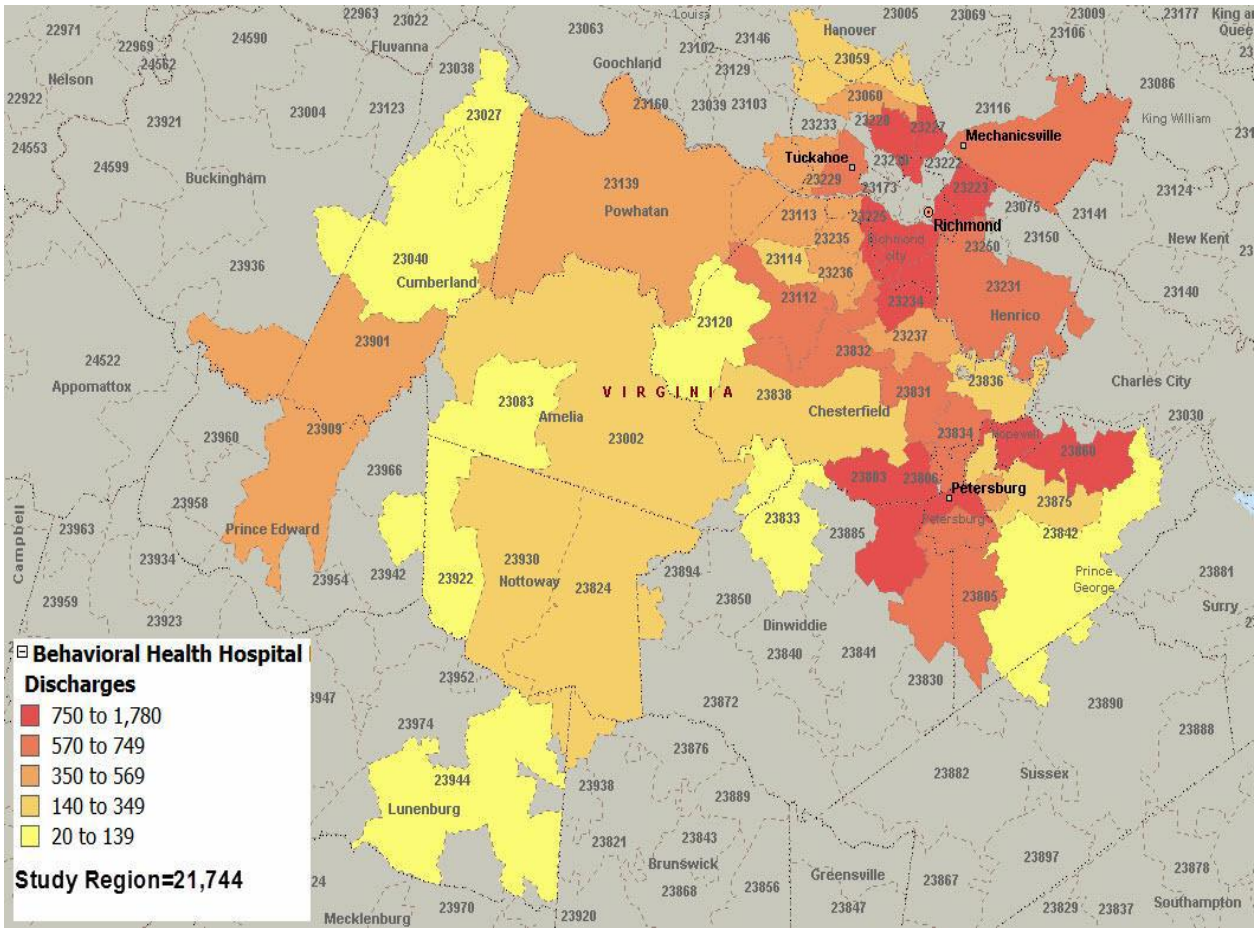
| Behavioral Health Hospital Discharges, 2010 | | |
|---|---|---|
| **Indicators** | **Study Region** | **Virginia** |
| **BH Discharges by Top 5 Diagnoses** | **21,744** | **125,414** |
| Affective Psychoses[10] | 5,688 | 33,098 |
| General Symptoms | 2,283 | 16,957 |
| Schizophrenic Disorders | 2,204 | 9,754 |
| Non-Dependent Abuse of Drugs | 2,121 | 12,770 |
| Other Psychosocial Circumstances | 1,960 | 8,047 |
| **BH Discharges per 100,000 for Top 5 Diagnoses** | | |
| Affective Psychoses | 636.3 | 415.6 |
| General Symptoms | 255.4 | 212.9 |
| Schizophrenic Disorders | 246.6 | 122.5 |
| Non-Dependent Abuse of Drugs | 237.3 | 160.3 |
| Other Psychosocial Circumstances | 219.3 | 101.0 |

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

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

[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

> **Community Voice**
>
> *"Provide incentive/motivation to medical, dental, and mental health providers to serve the underserved population."*

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+.

As shown in *Table 10*, six of the eight localities that overlap the study region have been designated as MUAs/MUPs. All of Amelia County, Nottoway County, and the City of Petersburg have been designated. Parts of Chesterfield County, Henrico County, and the City of Richmond have been designated. 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** |
| Amelia County | Full | 10 of 10 Census Tracts |
| Chesterfield County | Partial | 2 of 88 Census Tracts |
| Hanover County | None | --- |
| Henrico County | Partial | 2 of 76 Census Tracts |
| Nottoway County | Full | 14 of 14 Census Tracts |
| Prince George County | None | --- |
| Petersburg, City of | Full | 17 of 17 Census Tracts |
| Richmond, City of | Partial | 14 of 73 Census Tracts |
| Colonial Heights, City of | None | ---- |
| Hopewell, City of | None | ---- |
| Powhatan, City of | Full | 5 of 5 Census Tracts |

***Source: Community Health Solutions analysis of hospital discharge data 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.

**1. Adult Health Risk Factor Profile**

> **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."*

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+ | 680,478 | 100% |
| **Estimated to…** | | |
| Eat Less Than Five Servings of Fruits and Vegetables Per Day | 523,799 | 77% |
| Be Overweight or Obese | 404,001 | 59% |
| Have High Cholesterol (told by a doctor or other health professional) | 199,299 | 29% |
| Have High Blood Pressure (told by a doctor or other health professional) | 192,531 | 28% |
| Have Arthritis (told by a doctor other health professional) | 189,153 | 28% |
| Have No Physical Activity in the Past 30 Days | 161,738 | 24% |
| Be a Smoker | 152,823 | 22% |
| Be Limited in any Activities because of Physical, Mental or Emotional Problems | 125,990 | 19% |
| Have Fair or Poor Health Status | 106,151 | 16% |
| Be at Risk of Binge Drinking | 99,030 | 15% |
| Have Asthma (told by a doctor or other health professional) | 87,729 | 13% |
| Have Diabetes (told by a doctor or other health professional) | 57,395 | 8% |

*Source: Community Health Solutions synthetic estimates.*


## 2. Child Health Risk Factor Profile

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.

**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."*

*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.)*

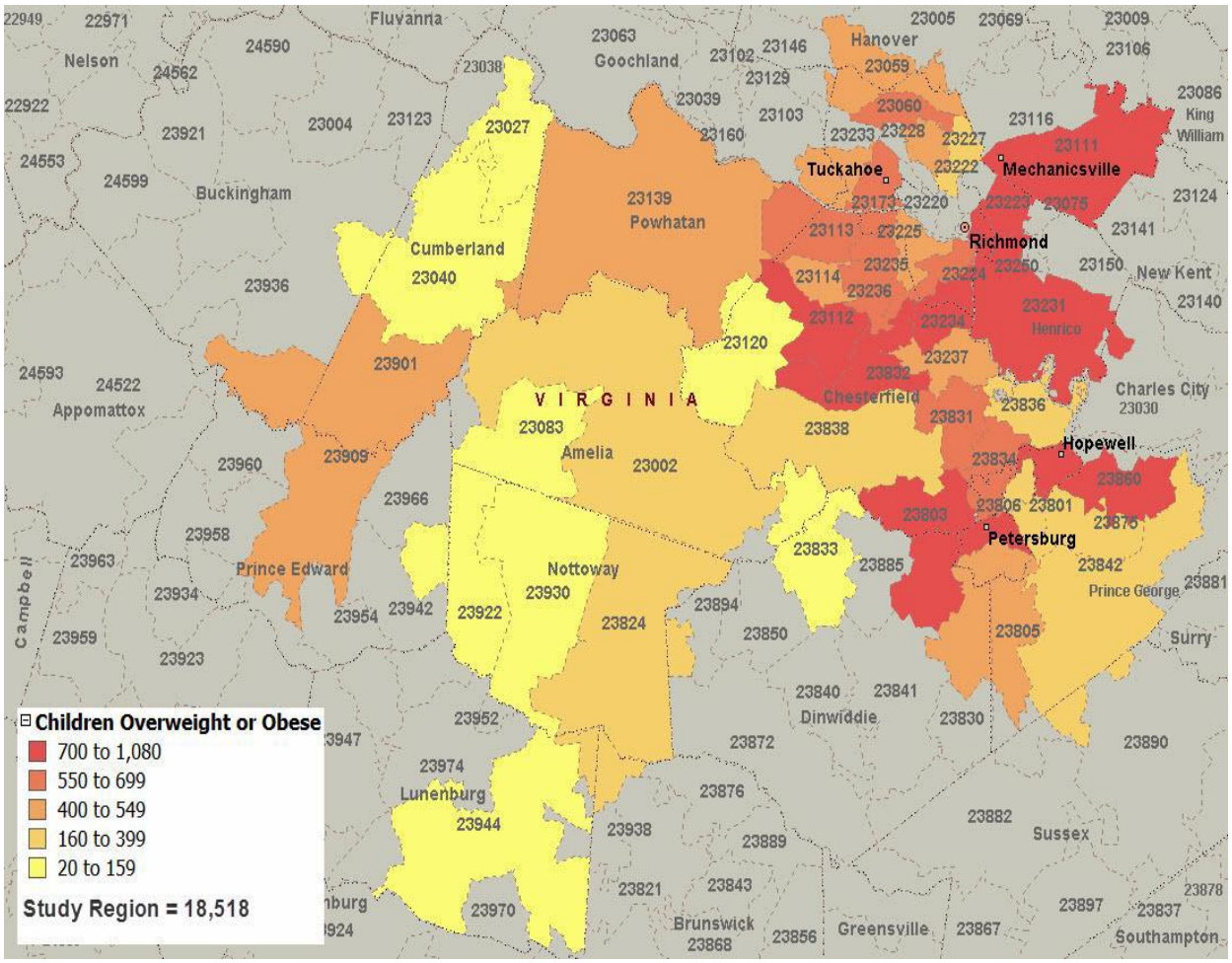
[12] Synthetic estimates are used when there are no primary sources of data available at the local level. In this case, synthetic estimates were developed by using state and regional survey results to predict the prevalence of the listed conditions in the local population. The survey data came from Market 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 | 96,171 | 100% |
| **Estimated to…** | | |
| Drink soda or eat chips or candy one or more days per week | 88,477 | 92% |
| Eat less than the recommended intake of fruits and vegetables | 84,630 | 88% |
| Be less physically active than recommended | 32,698 | 34% |
| Watch television three or more hours per day | 23,483 | 24% |
| Be overweight or obese | 18,518 | 19% |
| Play video/computer games three or more hours per day | 15,387 | 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 124,219 (16%) nonelderly residents of the study region were uninsured. This includes an estimated 21,173 children and 103,046 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 the 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.

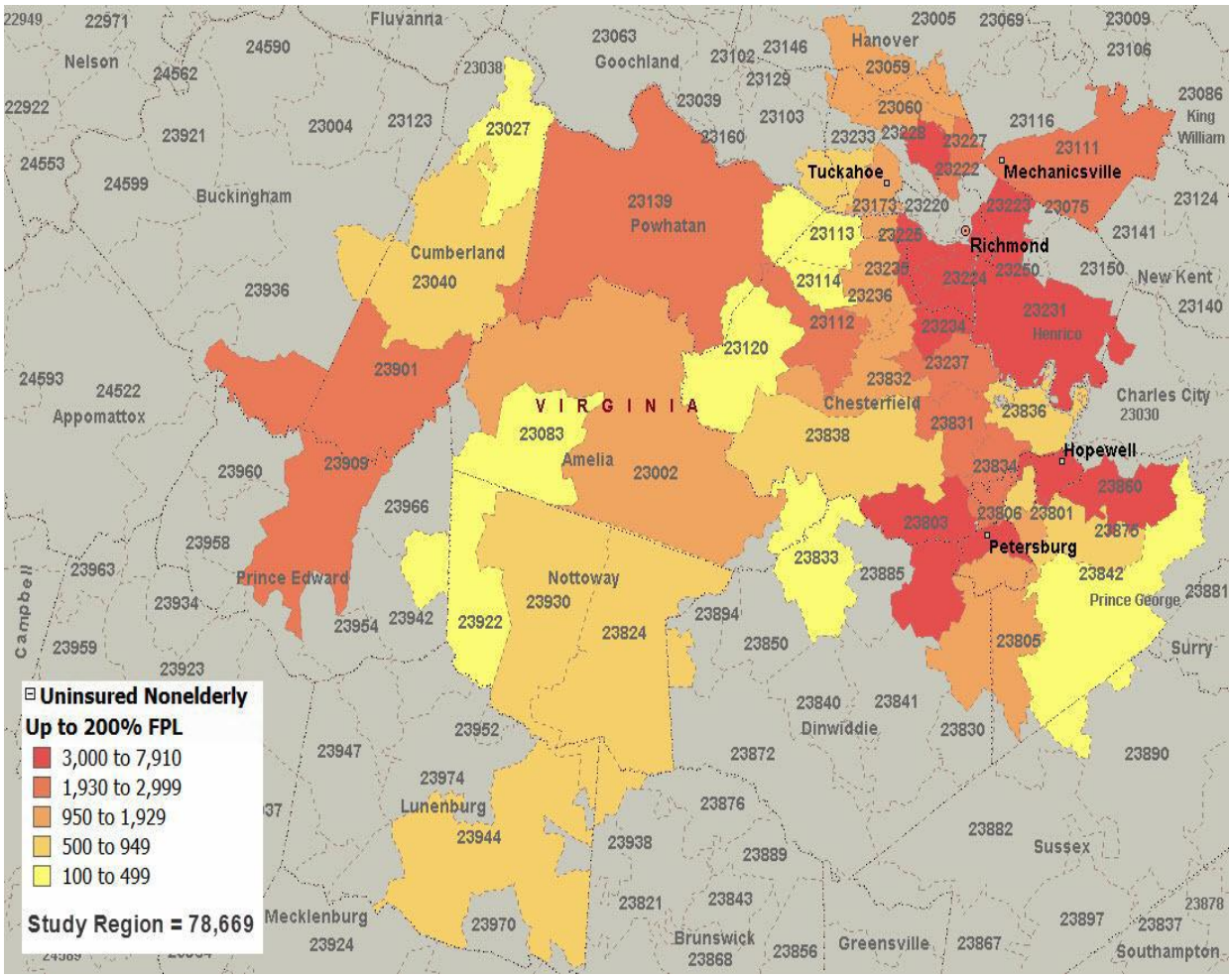
[14] Two hundred percent of the federal poverty level is defined as an annual income of $44,700 for a family of four. http://aspe.hhs.gov/poverty/11poverty.shtml


*Table 13*

| Uninsured (Estimates) 2010 | |
|---|---|
| **Indicators** | **Study Region** |
| **Estimated Uninsured Counts** | |
| Uninsured Nonelderly Age 0-64 | 124,219 |
| Uninsured Children Age 0-18 | 21,173 |
| Uninsured Children 0-200% Federal Poverty Level (FPL) | 14,989 |
| Uninsured Children <100% FPL | 10,381 |
| Uninsured Children 101-200% FPL | 4,608 |
| Uninsured Children 201-300% FPL | 2,617 |
| Uninsured Children 301%+ FPL | 3,567 |
| Uninsured Adults Age 19-64 | 103,046 |
| Uninsured Adults 0-200% FPL | 63,680 |
| Uninsured Adults <100% FPL | 32,871 |
| Uninsured Adults 101-200% FPL | 30,809 |
| Uninsured Adults 201-300% FPL | 18,724 |
| Uninsured Adults 301%+ FPL | 20,642 |
| Uninsured Adults 19-64 under 133% FPL | 43,038 |
| Uninsured Adults 19-64 and 133-300% FPL | 39,366 |
| **Estimated Uninsured Rates** | |
| Uninsured Nonelderly Percent | 16% |
| Uninsured Children Percent | 9% |
| Uninsured Adults Percent | 19% |

*Source: Community Health Solutions synthetic estimates.*

## 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. One of the meetings warrants additional description because of its unique contribution to the process.

The Bon Secours Richmond CHNA Community Review session covered all four hospitals, and was facilitated by Becky Clay Christensen. This review included: Medical Directors and Associate Medical Director covering Health Departments for four jurisdictions; Health Department Registered Nurses from two jurisdictions; the Chief Operating Officer of a Free Clinic; the Executive Director of a Federally Qualified Health Center; the Executive Director for Community Health Services; the 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; a Manager for Evaluation and Sustainability; a 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.


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

Some of these priorities are shared by other Bon Secours Richmond facilities as the service areas overlap and the need is associated with multiple hospitals. Additional priorities are addressed by a single facility due to a particular core competency or a need in a specific zip code.

An Implementation Plan specific to St. Francis Medical Center follows.


**SECTION V**

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

*Our Work and Commitment*

A list of existing Bon Secours Community Programs addressing priority areas identified for St. Francis Medical Center 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 within 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 the City of Richmond including Tappahannock and Kilmarnock. Some services have associated fees, though inability to pay 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 well-being of seniors through community outreach, advocacy and support. The program provides information, educational opportunities, activities and linkages with community resources to maintain optimal health, well-being and independence. Serves senior within a 60-mile radius of the City of Richmond.*

ix. Bon Secours Richmond Safe Landings: *Volunteers provide non-clinical assistance and home support to vulnerable populations.*

**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: *Improves access to health care services for the uninsured through mobile 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 City of Richmond, Northern Neck, Middle Peninsula and Hampton Roads areas.*

iii. St. Joseph's Outreach Clinic*: Increases access to care for uninsured and underinsured patients. Nutrition and chronic disease management consultation is also provided. Serves Medicaid and Medicare patients, Spanish-speaking patients and working uninsured in a 60-mile radius 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: *Reduces 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): *Improves the management of asthma in children through care coordination 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 and palliative care and hospice program Provides 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 the 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: *Provides 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.*

Bon Secours Richmond Cullither Brain Tumor Quality of Life: *Provides support 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*): Provides 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 cares, 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) efforts 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: *State-wide, privately-funded, non-partisan policy research 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 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-Van and St. Joseph's Outreach Center.*


xiv. Ronald McDonald House: *Guest house for patients and families.*
xv. Shepherds Center of Chesterfield: *An interfaith ministry of senior 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, the 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 this need at this time.

*Transportation*

Community organizations are well positioned to provide this service. The Shepherd's Center of Chesterfield is a non-profit, interfaith organization. A pool of drivers volunteer their time making it possible to get to medical appointments for those who do not drive, do not have a car or do not have access to public transportation. Prescriptions can also be picked up on the return trip.

Public transportation is available via taxi. The Greater Richmond Transit Company (GRTC) bus service does not currently extend as far as St. Francis Medical Center.

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 St. Francis 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. Those areas include:

- Develop specific, measurable, and attainable goals using community-level indicators
- 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