Bon Secours


# 2022 Community Health Needs Assessment

Bon Secours Richmond

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## Bon Secours Richmond Health System Adopted by the Richmond Board of Trustees, September 27, 2022

As a ministry of which Bon Secours Richmond Health System is a member, Bon Secours Mercy Health has been committed to the communities it serves for nearly two centuries. This long-standing commitment has evolved intentionally, based on our communities' most pressing health needs.

Every three years we evaluate those needs through a comprehensive Community Health Needs Assessment (CHNA) process. The most recent assessments, completed Bon Secours Richmond Health System, and community partners, include quantitative and qualitative data that guide both our community investment, community benefit, and strategic planning. The following document is a detailed CHNA for the Bon Secours Richmond Health System.

Bon Secours is dedicated to our Mission of extending the compassionate ministry of Jesus by improving the health and well-being of our communities and by brining good help to those in need, especially people who are poor, dying, and underserved. Bon Secours Richmond Health System has identified the greatest needs in our community by listening to the voices of the community. This ensures our resources for outreach, prevention, education, and wellness are directed towards opportunities where the greatest impact can be realized.

Written comments regarding the health needs that have been identified in the current CHNA should be directed to Bon Secours Richmond Health System.

**Bon Secours Richmond Market**

5875 Bremo Road, MOB South, Suite 710, Richmond, Virginia 23226

Bonsecours.com

# Table of Contents

# 2022 Community Health Needs Assessment

A 2022 CHNA and corresponding Implementation Plan were prepared for Bon Secours Richmond Health System for fiscal year ending December 2022. Both documents were made available to the public and posted online.

For further information or to obtain a hard copy of this Community Health Needs Assessment (CHNA), please contact:

Becky Clay Christensen at Rebecca_Christensen@bshsi.org or
Kerrissa MacPherson at kerrissa_macpherson@bshsi.org

This Community Health Needs Assessment can also be found at:
https://www.bonsecours.com/about-us/community-commitment/community-health-needs-assessment

# Executive Summary

## Overview

The true health of a community is defined by living conditions, opportunities, and a variety of social determinants.

This Community Health Needs Assessment (CHNA) examines qualitative input provided by community members, nonprofit leaders, public health and government agency leaders, physicians and advanced practice clinicians, Bon Secours associates, and a diverse Community Health Advisory Council. This qualitative input has been coupled with quantitative publicly accessible data on health and social conditions in the area. Together the information forms a snapshot of important areas of health concern. In order to obtain input from the community, four initiatives were advanced: a Community Health Advisory Council was convened, a community engagement survey was conducted, several community conversations were held, and multiple interviews were performed with key informant community leaders with expertise in a variety of sectors. Quantitative data from various sources was collected and analyzed.

The Bon Secours Richmond Health System includes seven acute hospital facilities serving the entire Bon Secours Richmond market area.

The Bon Secours Richmond Health System facilities are listed below:

- Memorial Regional Medical Center
- Rappahannock General Hospital
- Richmond Community Hospital
- Southern Virginia Medical Center
- Southside Medical Center
- St. Mary's Hospital
- St. Francis Medical Center

## Significant health needs

After analyzing the qualitative and quantitative feedback from the community engagement process, the following five significant health needs were identified.

1. Chronic Disease and Prevention
2. Mental Health
3. Violence and Trauma
4. Social and Economic Disparity
5. Engagement and Inclusion

In addition to the significant health needs identified, the community engagement process identified the following overarching values as integral to our ability to impact the prioritized health need:

1. Fostering an environment of justice
2. Facilitating access, opportunity, and belonging
3. Listening, learning, and collaborative action
4. Addressing systemic issues and root causes

The below five needs have been selected as the 2022 prioritized health needs.

## Prioritized Health Needs

1. Chronic Disease and Prevention
2. Mental Health
3. Violence and Trauma
4. Social and Economic Disparity
5. Engagement and Inclusion

## Resources Available

Bon Secours is committed to addressing the prioritized needs identified in our 2022 Community Health Needs Assessment process and to making a measurable impact on community health across Bon Secours Richmond. True impact comes when strategic partnerships are formed, and when collaborations are built that can achieve greater results collectively. Bon Secours is committed to forming intentional relationships focused on building a healthier community and to breaking down barriers to coordinated patient care. Bon Secours partners or collaborates with over one hundred (100) organizations across the geographic footprint of Bon Secours Richmond to help patients connect to community support outside of the acute or outpatient setting (See Appendix D for additional information).

## Feedback

Feedback can be submitted via a survey link for Bon Secours Hospitals at: https://www.bonsecours.com/about-us/community-commitment/community-health-needs-assessment

Feedback can also be submitted via email to: Rebecca_Christensen@bshsi.org or kerrissa_macpherson@bshsi.org

# Our Mission

Our mission is to extend the compassionate ministry of Jesus by improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved.

# Our Vision

Inspired by God's hope for the world, we will be a ministry where associates want to work, clinicians want to practice, people seek wellness and communities thrive.

# Our Values

## Human Dignity

We commit to upholding the sacredness of life
and being respectful and inclusive of everyone.

## Integrity

We commit to acting ethically and modeling right relationships
in all of our individual and organizational encounters.

## Compassion

We commit to accompanying those we serve with mercy and
tenderness, recognizing that "being with" is as important as "doing for."

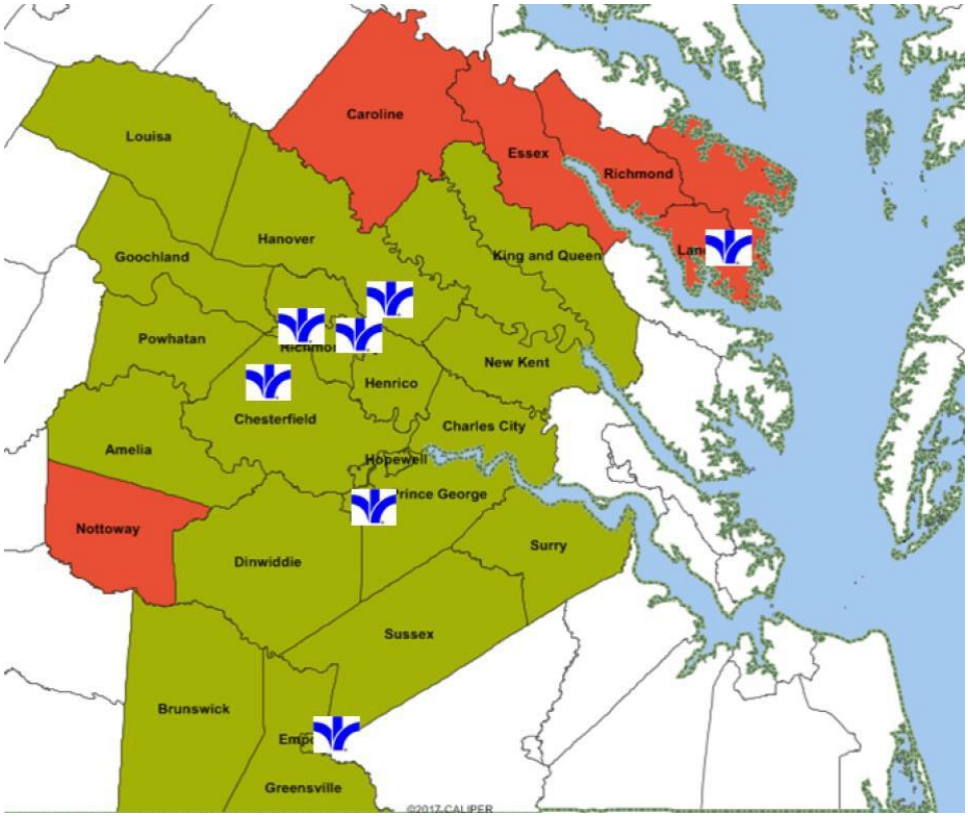
## Stewardship

We commit to promoting the responsible use of all human
and financial resources, including Earth itself.

## Service

We commit to providing the highest quality in every dimension of our ministry.

# Bon Secours Richmond Service Area




**24 Counties & Cities Served (Primary Service Area)**

Amelia County, Brunswick County, Chesterfield County, Colonial Heights City, Dinwiddie County, Emporia City, Goochland County, Greensville County, Hanover County, Henrico County, Hopewell City, King and Queen County, King William County, Lancaster County, Middlesex County, New Kent County, Northumberland County, Petersburg City, Powhatan County, Prince George County, Richmond City, Southampton County, Surry County, Sussex County

# Facilities Description

The Bon Secours Richmond Health System includes seven acute hospital facilities serving the entire Bon Secours Richmond market area.

The Bon Secours Richmond Health System facilities are listed below:

**Memorial Regional Medical Center**

Richmond Memorial Hospital (RMH) was chartered in 1947 in the Ginter Park Community to accommodate the shortage of hospital facilities after World War II. Since 1998, Memorial Regional Medical Center has provided a continuation of RMH's commitment and preserved its monumental importance. Memorial Regional Medical Center is an acute care facility licensed for 225 beds, serving residents primarily from the counties of Hanover, Henrico, King and Queen, King William, New Kent, and Richmond City.

**Rappahannock General Hospital**

Rappahannock General Hospital was acquired by Bon Secours Health System on December 31, 2014. Over the past eight years, Rappahannock General Hospital has grown into a critical access hospital with 25 licensed beds in acute care and 10 licensed beds in behavioral health. Rappahannock General Hospital primarily serves residents in the counties of Lancaster, Middlesex, and Northumberland.

**Richmond Community Hospital**

In 1895, Richmond Community Hospital opened as the first facility in Richmond designed to serve African American patients in historic Jackson Ward. 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 is an acute care facility licensed for 104 beds. The Richmond Community Hospital service area extends through much of the Richmond metropolitan area, including downtown Richmond. It is uniquely located in Richmond's East End, an historic area of Richmond with great diversity and culture. The Richmond Community Hospital service area falls mostly in the City of Richmond and also serves residents primarily from the counties of Chesterfield, Hanover, and Henrico.

**Southern Virginia Medical Center**

Southern Virginia Medical Center is an 80-bed acute care hospital, primarily serving more than 50,000 residents of Emporia and Greensville, and the surrounding counties of Brunswick, Southampton, and Sussex. Southern Virginia Medical Center was acquired by Bon Secours Mercy Health on January 1, 2020.

**Southside Medical Center**

Southside Medical Center is a 300-bed facility located on a 50-acre campus with nearly 400 physicians representing more than 40 specialties. Southside Medical Center primarily serves the communities of Petersburg, Hopewell, Colonial Heights, Fort Lee and Chester and the counties of Prince George, Dinwiddie, Sussex, Surry, and Southern Chesterfield.

**St. Mary's Hospital**

St Mary's Hospital opened in 1966 with a unique vision for the time, allowing patients of all colors and religions to receive treatment there. Fifty years later, St. Mary's has grown into an acute care facility licensed for 391 beds. The St. Mary's Hospital serves residents primarily from the counties of Chesterfield, Goochland, Hanover, Henrico, and Richmond City. While its core is based in the Richmond metropolitan area, its services reach into the surrounding rural counties.

**St. Francis Medical Center**

St. Francis Medical Center was completed in 2005 and is a state-of-the-art acute care facility licensed for 130 beds. The St. Francis Medical Center service area extends across much of central Virginia, including downtown Richmond, suburban communities of Chesterfield and Henrico counties and rural counties such as Powhatan and Amelia.

## Community Served by the Hospital

Bon Secours Richmond Health System provides compassionate medical care through a network of hospitals, primary and specialty care practices, ambulatory care sites and continuing care facilities across a diverse 24-locality region. Over 9,000 associates and 420 employed providers care for patients throughout the urban, suburban, and rural geography that makes up the CHNA Service Area. In addition to the 7 acute hospitals mentioned above, Bon Secours also provides services to the community through the following four freestanding emergency departments: Westchester Emergency Center, Short Pump Emergency Center, Chester Emergency Center, and Southside Emergency Care Center.

Combined, the 24-locality service area consists of nearly 1.4 million people, and is comprised of 57% Non-Hispanic White, 29% Non-Hispanic Black, 6% Hispanic or Latino, 4% Asian, 4% Two or more races, and <1% Native American. The population is 51% Female, 49% Male. Additionally, 62% of residents are between the ages of 18-64, 22% are between the ages of 0-17, and 16% are 65 years and older.

## JOINT CHNA

This is a "joint CHNA report," within the meaning of Treas. Reg. §1.501(r)-3(b)(6)(v), by and for Bon Secours Richmond Health System, including Memorial Regional Medical Center, Rappahannock General Hospital, Richmond Community Hospital, Southern Virginia Medical Center, Southside Medical Center, St. Mary's Hospital, and St. Francis Medical Center. This report reflects the hospitals' collaborative efforts to conduct an assessment of the health needs of the community they serve. Each of the hospitals included in this joint CHNA report define its community to be the same as the other included hospitals. This assessment included seeking and receiving input from that community.

**Collaborating Partners**

Bon Secours Richmond partnered with a diverse mix of nonprofits, government agencies, and public health entities to collect qualitative and quantitative data for the 2022 CHNA. A complete list of collaborating partners, along with their level of participation, can be found in the comprehensive list of organizations providing input later in this document.

# Methods of Collecting Information and Prioritizing Needs

## Community Engagement Survey

A survey to assess community health needs was conducted as part of the CHNA process during a six-month period between October 2021 and April 2022. One thousand three hundred and seventy (1,370) individuals responded. The survey was offered in Spanish and English. One thousand three hundred and fifty-seven (1,357) individuals completed the survey in English and thirteen (13) individuals in Spanish. Individuals were asked to "Please choose the TOP 5 health issues you think should be addressed in your community:" from a list of 13 health issues. Respondents were also asked "On a scale of 1 - 6 (1 having little impact, and 6 having significant impact), how do each of the underlying causes below impact the health needs of the community."

Survey respondents from the entire Bon Secours Richmond Service Area identified the top three priorities that needed to be addressed as (Figure 1):

1. Mental Health and Suicide
2. Chronic Diseases
3. Substance/Drug Abuse

When discussing underlying causes, COVID-19, Stress/Trauma, and Community Violence & Crime rose to the top. When the results were broken down by specific populations, the respondents self-identifying as Black also emphasized Institutional Racism, and the respondents that chose to complete the survey in Spanish also emphasized Language Barriers (Figure 2). The top survey responses from each question are listed below:

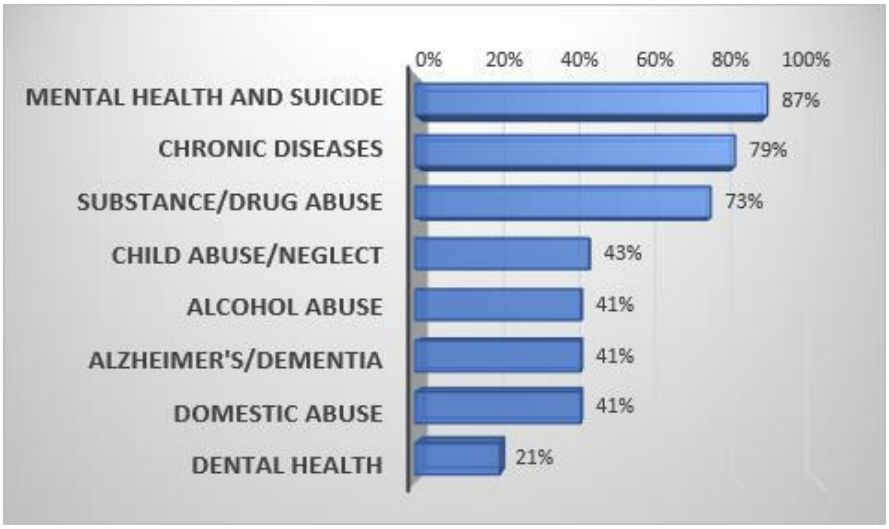



Figure 1. Top 5 Health Issues Facing Community – Survey Responses.

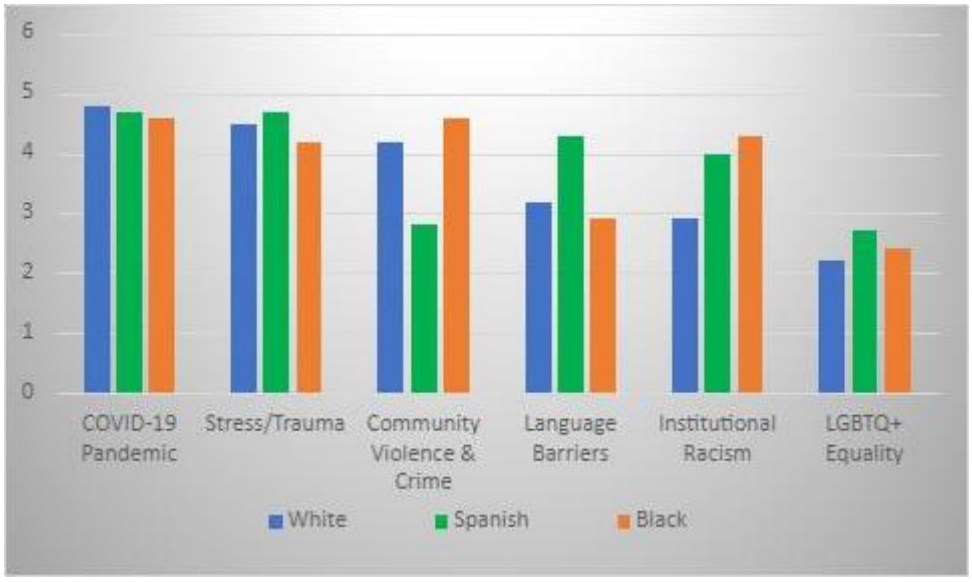



Figure 2. Underlying Causes Health Issues Facing Community – Survey Responses. (Note: Results sorted by self-identified race of respondents. Spanish results reflect respondents that chose to complete the survey in Spanish.)

A copy of the full survey is available in English in Appendix A. Variance between the Spanish speaking responses and English speaking responses is highlighted in Appendix B.

**Community Health Advisory Council**

To assist Bon Secours Richmond Community Health leaders in interpreting this data from the survey, a Community Health Advisory Council was convened. This Community Health Advisory Council was a diverse and representative mix of nonprofit and other agency leaders from across the Bon Secours Richmond Health System market. The Community Health Advisory Council was reflective of the CHNA service area in gender, race, and geography and provided an inclusive perspective on the community served by Bon Secours hospitals. The Community Health Advisory Council met three times, focusing on interpreting survey results, identifying significant and prioritized needs, and emphasizing the overarching values that will enable successful implementation of programs and collaborations to address prioritized needs. The conversation in this space was deep and nuanced, examining systemic, cultural and bias-driven attitudes and behaviors that have impacted progress in dealing with the social determinants of health.

**Community Conversations**

Five Community Conversations occurred in March of 2022 as part of the CHNA process in which over 75 individuals (total) participated. Three community conversations were geographically specific, with in-person community conversation opportunities offered in the East End of Richmond, in Petersburg City, and in Kilmarnock in the Northern Neck. Two of the community conversations were virtual and offered via Zoom, drawing attendees from across the Bon Secours Richmond service area and providing an opportunity to offer qualitative feedback in a COVID-safe environment. Overall, the racial and geographical diversity of the participants represented a healthy mix of the region's residents. The sample skewed towards wealthier participants with more education than the region overall, and there were more females than males represented.

The purpose of these conversations was to elicit feedback from community members about publicly available health data describing health conditions in the service areas and to review the survey results to further explore the findings. Geographically specific publicly available data as well as a sampling of the survey results were presented to the attendees and they were asked, "What are 3 health issues that could be affected over the next 2 years?" They were also asked, "What root causes contribute to this health issue? (i.e., social determinants, racism, inequities, etc.), What is currently being done to help address this health issue?" and "Where are there gaps?"

Responses from attendees at the community conversations were in line with survey results, with a significant focus on Mental Health, Suicide, Trauma, and Chronic Health Conditions. There was also substantial dialogue about social and economic disparity and the importance of engagement and inclusion with community partners and with the community at large. A detailed report and prioritization images from the community conversations are presented in Appendix C. (For a list of community partners, please see Appendix D).

**Key Informant Interviews**

To dive more deeply into root causes and to increase qualitative data collection, the Bon Secours Richmond Community Health team completed over ten key informant interviews. These key informant interviews were with a wide variety of community, nonprofit, and government leaders with diverse areas of expertise, including transportation, maternal and child health, housing, the Latinx community, and other areas that were viewed as top health issues by survey respondents. These conversations with key leaders helped interpret and clarify the results of the survey and the Community Conversations into categories and themes that could be discussed with the Community Health Advisory Council. For more information about the questions asked in the key informant interviews, please see Appendix E.

**Feedback on Previous CHNAs**

As part of the community engagement planningprocess, feedback was also solicited regarding the 2019 CHNA and Implementation Plan, both of which are posted online and available in hard copy upon request. No feedback was received.

**Significant Health Needs**

After analyzing survey responses, community conversations, information from key informant interviews, and feedback from the community advisory council, five (5) significant health needs were identified.

1. Chronic Disease and Prevention
2. Mental Health
3. Violence and Trauma
4. Social and Economic Disparity
5. Engagement and Inclusion

In addition to the significant health needs identified, the community engagement process identified the following overarching values as integral to our ability to impact the prioritized health need:

1. Fostering an environment of justice
2. Facilitating access, opportunity, and belonging
3. Listening, learning, and collaborative action
4. Addressing systemic issues and root causes

**Prioritized Health Needs**

1. Chronic Disease and Prevention
2. Mental Health
3. Violence and Trauma
4. Social and Economic Disparity
5. Engagement and Inclusion

# Resources Available

Bon Secours is committed to addressing the prioritized needs identified in our 2022 Community Health Needs Assessment process and to making a measurable impact on community health across Bon Secours Richmond. True impact comes when strategic partnerships are formed, and when collaborations are built that can achieve greater results collectively. Bon Secours is committed to forming relationships to build a healthier community and to building capacity in other nonprofits through investments, volunteerism and through breaking down barriers to coordinated patient care. The list below provides a representative but not exhaustive list of existing resources that collaborate with Bon Secours or support Bon Secours patients. While each prioritized need below is currently being addressed to some capacity, there remains an inadequacy of services to meet the needs of the community completely. For a more extensive list of community partners that support the needs of Bon Secours patients, please see Appendix D.

## Chronic Disease and Prevention

- **Bon Secours Care-A-Van and IVNA** – Mobile health and vaccine clinics for the underserved at sites across metro Richmond*
- **Greater Richmond Health Safety Net Collaborative** – Partnerships across the entire Bon Secours Richmond service area with free clinics and FQHCs that provide primary care services to the uninsured
- **Shalom Farms** – Healthy produce distribution to underserved communities, including uninsured Bon Secours patients

## Mental Health

- **Bon Secours Richmond Cullather Brain Tumor Quality of Life Center** – Mental Health support and education to patients with brain tumors
- **Child Savers** – Clinical treatment, education and training services focused on the mental well-being of children
- **Family Lifeline** – Home visiting program with intensive case management including mental health clinicians

## Violence and Trauma

- **Bon Secours Violence Response Team** – Clinical team providing care to patients 24/7 who have been victims of child abuse, sexual assault, domestic violence, elder abuse, human trafficking, and strangulation *
- **Safe Harbor** – Comprehensive services and support for those who are experiencing or have experienced domestic violence, sexual violence, or human trafficking
- **Stop Child Abuse Now (SCAN)** – Organization focused on preventing and treating child abuse and neglect

## Social and Economic Disparity

- **GRTC (Greater Richmond Transit Authority)** – Serves the City of Richmond, Chesterfield County and Henrico County with public transportation
- **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
- **Sacred Heart Center** – Supports Latinx youth, adults and families through comprehensive educational classes, mentorship, and social, financial, and legal support programming

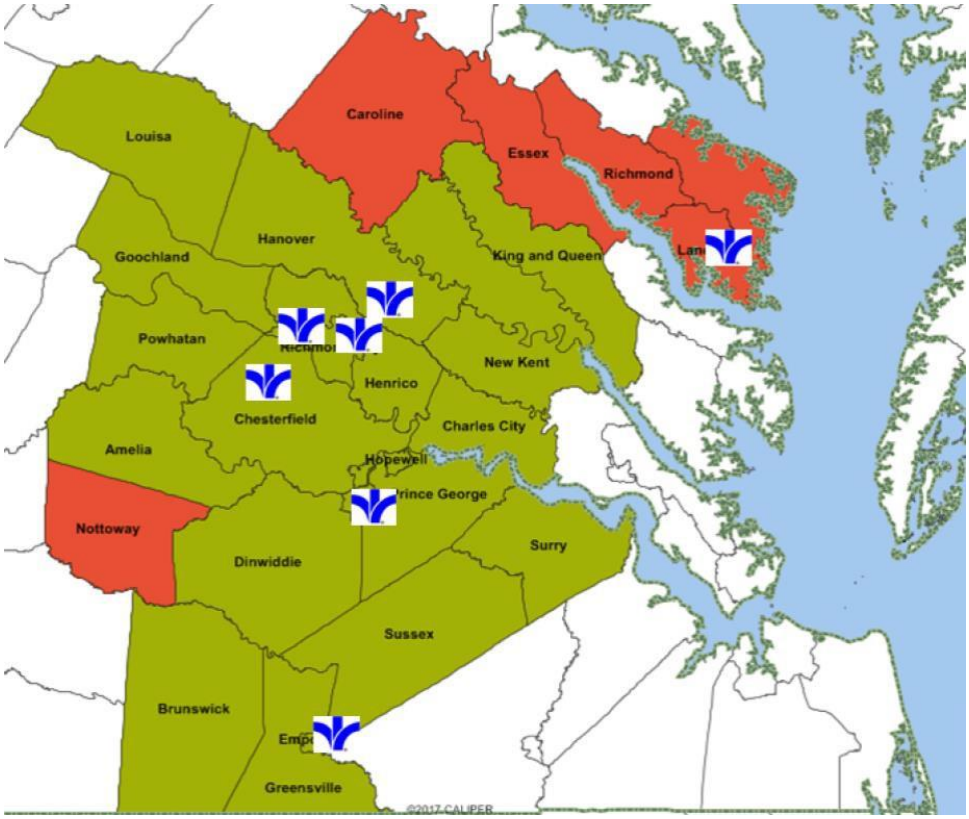
## Engagement and Inclusion

- **Partnership for Housing Affordability** – A cross-county collaboration focused on implementing solutions to increase housing opportunities across the Richmond region
- **Virginia Poverty Law Center** – Leads and coordinates efforts to seek justice in civil legal matters for lower income Virginians
- **University of Richmond Bonner Center for Civic Engagement** – Volunteering, community-based learning and research focused on community relationships and impacting the community

*Part of Bon Secours Richmond Community Health Initiatives

Appendix D contains a more comprehensive listing of Bon Secours community partners, highlighting the collaborations already in process in areas that impact our prioritized health needs.

# Information and Data Considered in Identifying Potential Need




## Demographics Data Profile

The health of a community is largely connected to the demographics and social aspects of its residents, which can be a useful indicator of health concerns. Demographic studies of a population are based on factors such as age, race, sex, economic status, education levels, and employment rates, among others. The physical environment in which individuals live, learn, work, play, and grow old also has a great impact on their health and quality of life. These cultural and environmental conditions are also known as ‘Social Determinants of Health’.

## Race and Ethnicity Demographics

**Indicator Description:**

This indicator shows race and ethnicity percentages among the population of the CHNA Service Area.

**Indicator Importance:**

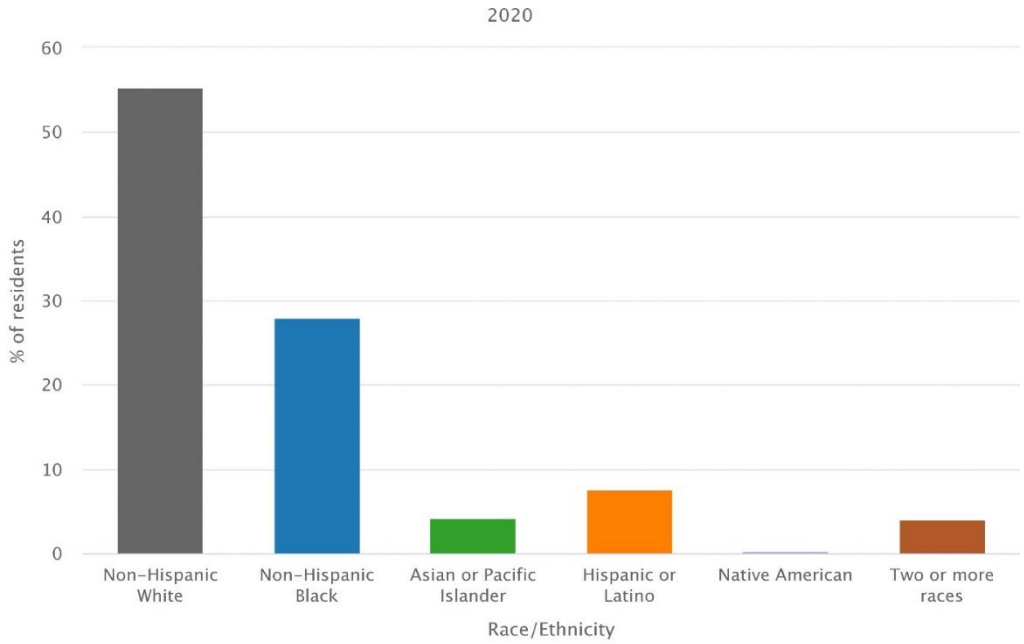
The race and ethnicity composition of a population provides vital information about the overall health of a community.

**What the data shows:**

This data represents persons who self-selected these categories on the 2020 Census. It is important to note that while the Census is meant to capture all individuals living in our communities, it often underrepresents the most vulnerable persons.

Non-Hispanic White is the largest resident population followed by Non-Hispanic Black for the CHNA Service Area.

## Demographics by Race/Ethnicity




**Created on Metopio** | https://metop.io | **Data source:** American Community Survey (Table B01001)
**Demographics:** Percent of residents within each major demographic group. Use this topic to explore age, gender, and racial/ethnic breakdowns. This topic is expressed as a percent; to see a breakdown of all residents (pie or area chart), use Population (POP).

## Age Demographics and Projections

**Indicator Description:**

This indicator shows age distribution within the localities in the CHNA Service Area.

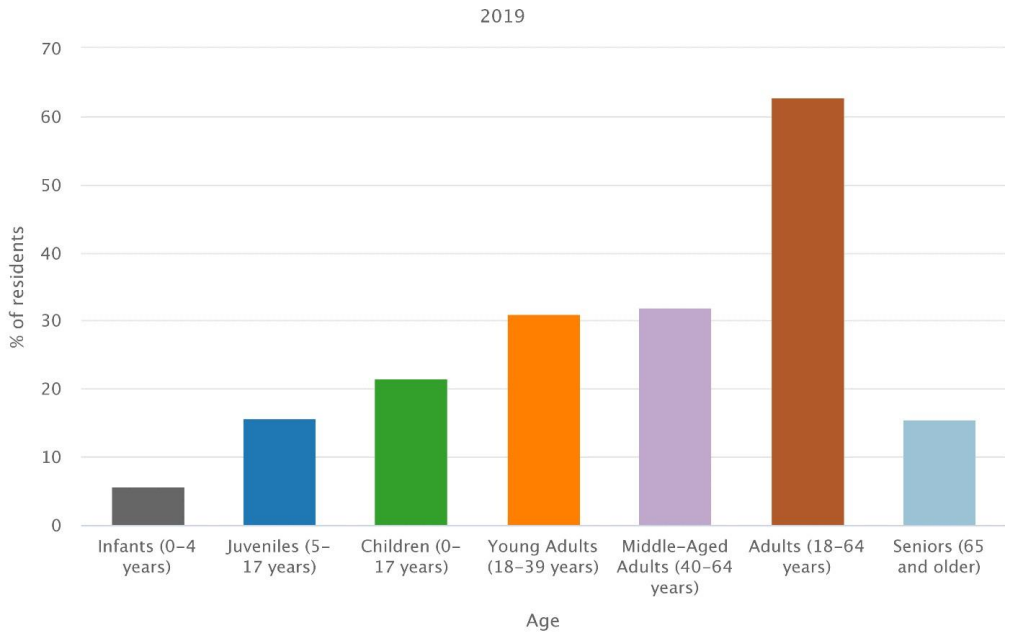
**Indicator Importance:**

Understanding the age structure of a population is important in planning for the future of a community. Communities with a large aging population will have significantly different needs than communities with a large youth population.

**What the data shows:**

- While the largest population in the CHNA Service Area is 18-64 years old, there are a significant number of 45–64-year old's who will be moving into the 65+ category over the next 10 years.

## Demographics by Age




**Created on Metopio** | https://metop.io | **Data source:** American Community Survey (Table B01001)
**Demographics:** Percent of residents within each major demographic group. Use this topic to explore age, gender, and racial/ethnic breakdowns. This topic is expressed as a percent; to see a breakdown of all residents (pie or area chart), use Population (POP).

## Income Demographics

**Indicator Description:**

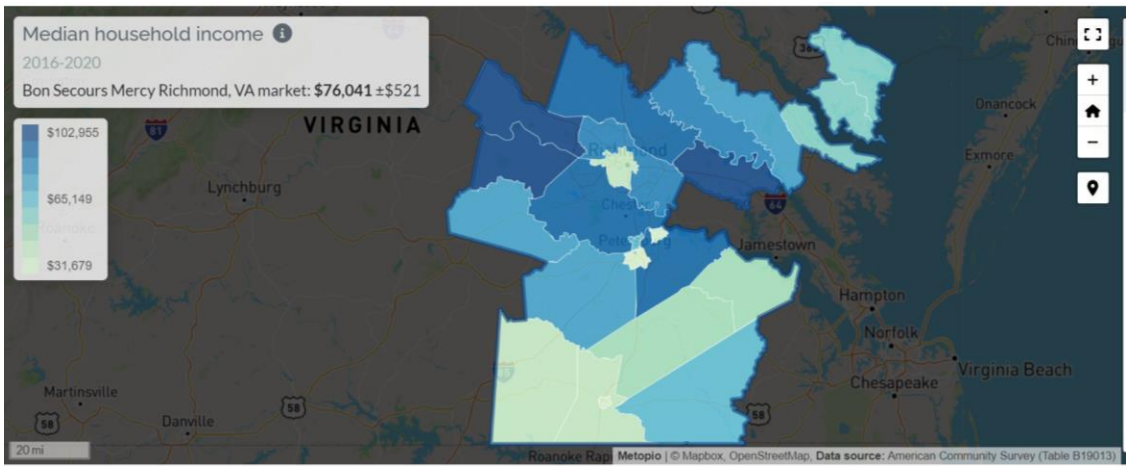
This indicator shows the median household income. Household income is defined as the sum of money received over a calendar year by all household members 15 years and older.

**Indicator Importance:**

Median household income is an important determinant of health. Communities with higher poverty rates often experience poorer health. Higher median household incomes are often associated with higher educated residents and lower unemployment rates.

**What the data shows:**

- Household living in the cities represented in the CHNA Service Area on average have lower median household income when compared to the counties in the same CHNA Service Area.
- The median household income in the State of Virginia is $80,517 compared to the CHNA Service Area of $76,041



## Poverty Rate

**Indicator Description:**

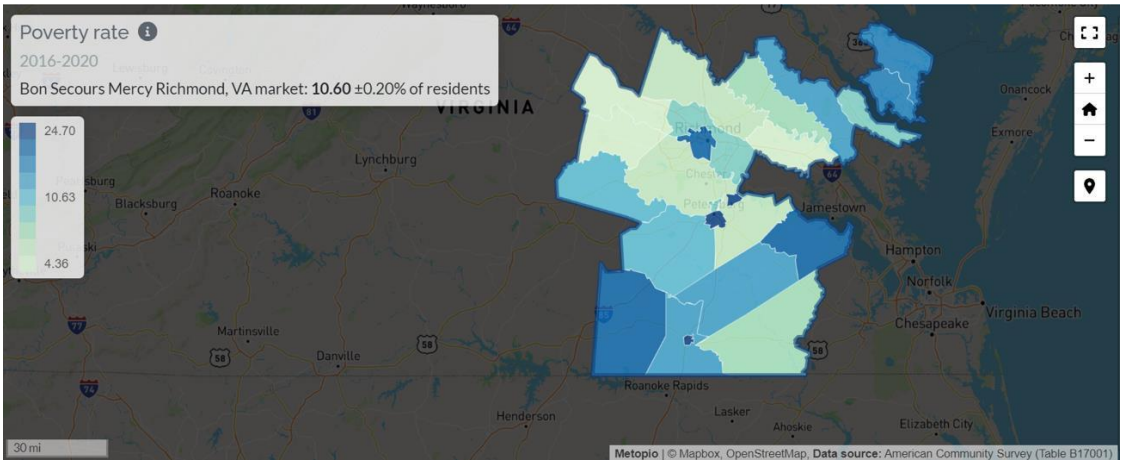
This indicator shows the percentage of individuals living below the federal poverty level.

**Indicator Importance:**

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Communities with higher poverty rates often experience poorer economic conditions. Poverty is an underlying root cause of poorer health.

**What the data shows:**

- The Virginia state value is 10.01% of people living below poverty level
- While the CHNA Service Area value is 10.60% and slightly above the state average, Virginia and the CHNA Service Area both fall below the national average of 12.84%



## High School Graduation (Educational Attainment)

**Indicator Description:**

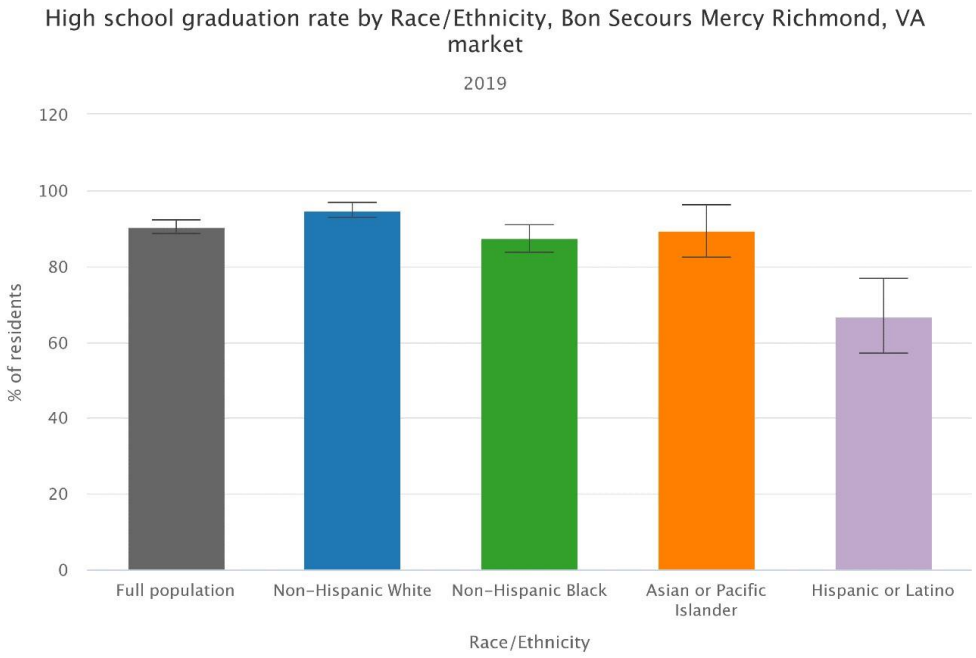
This indicator shows the percentage of residents 25 years or older with at least a high school diploma.

**Indicator Importance:**

High School graduation is a critical measure of overall health. Obtaining a high school diploma leads to increased employment opportunities, higher wages, and economic stability.

**What the data shows:**

- Although the CHNA Service Area rate is nearly the same as the state average, there is a significant disparity among the Hispanic or Latino population when compared to other races and ethnicities.
- As a state, Virginia has a slightly higher high school graduation rate at 90.34% than the national average of 88.53%




**Created on Metopio** | https://metop.io | **Data source:** American Community Survey (Table B15002)
**High school graduation rate:** Residents 25 or older with at least a high school degree: including GED and any higher education

## Population Totals

**Indicator Description:**

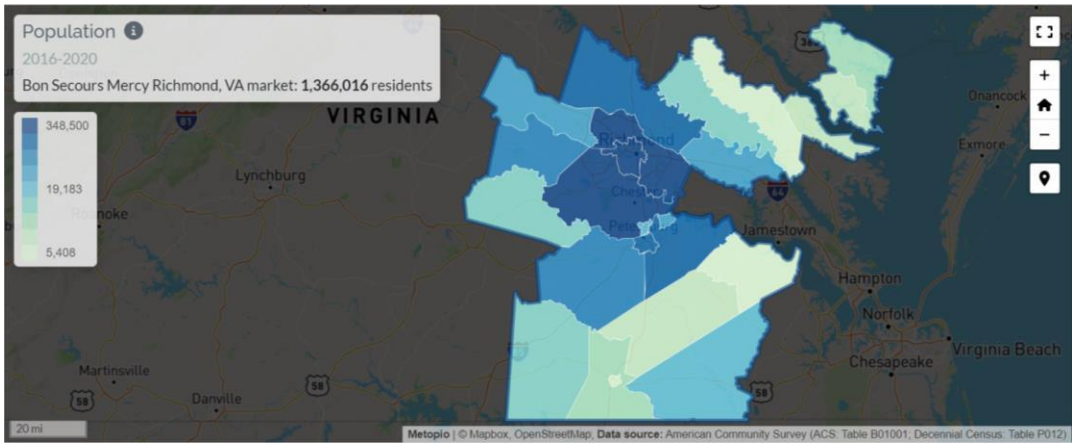
This indicator shows the total population for each locality in the CHNA Service Area.

**Indicator Importance:**

Population totals are important for determining rates of health conditions.

**What the data shows:**

- The population for the total CHNA Service Area is 1,398,607 as calculated in the 2020 Census
- The highest population density surrounds the Metro Richmond area while the lowest population density occurs in more rural localities



## Life Expectancy

**Indicator Description:**

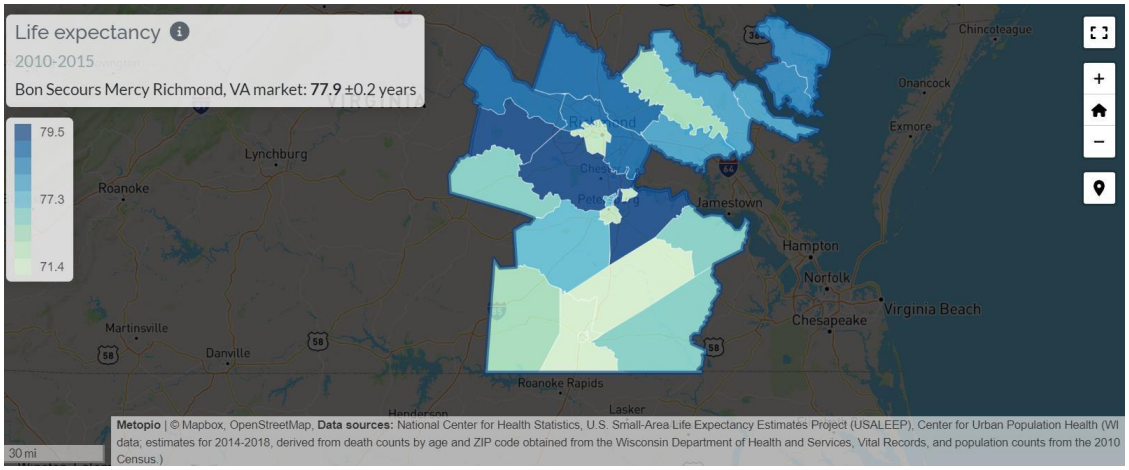
This indicator shows the estimated life expectancy in years of residents living in the CHNA Service Area.

**Indicator Importance:**

This data represents the average number of years a person is expected to live, based on the locality where they live.

**What the data shows:**

- Darker shaded regions are associated with a higher estimated life expectancy. Conversely, lighter shaded regions are associated with a lower estimated life expectancy.
- The urban and rural localities in the CHNA Service Area have lower life expectancy than the surrounding suburban areas.
- Life expectancy rates often trend conversely to poverty level rates.




**Information and data sources: federal, state or local health or other departments or agencies; community input**

In surveying publicly accessible data, a variety of sources were used, including Metopio, the Virginia Department of Health, and Homeward. Metopio data utilized statistics from the American Community Survey (2020), the National Center for Health Statistics, the National Vital Statistics System, Feeding America, the Environmental Protection Agency, and the FBI Crime Data Portal, in addition to other sources. For a list of information and data sources including links, please see Appendix F.

## Organizations Providing Input

| Organization providing input | Nature and extent of input | Medically under-served, low income or minority populations represented by organization |
|---|---|---|
| Access Now | Town Hall Participant | Medically under-served, low-income and minority populations |
| Bay Area Agency on Aging | Key Informant Interview, Town Hall Participant | Low-income |
| Bon Secours Richmond Health System Associates & Providers | Town Hall Participant | Medically under-served, low-income and minority populations |
| Boys and Girls Club of Metro Richmond | Town Hall Participant | Low-income and minority populations |
| The Cameron Foundation | Community Advisory Council | Medically under-served, low-income and minority populations |
| CancerLINC | Town Hall Participant | Medically under-served and low-income |
| Center for Public Health Practice & Research | Town Hall Participant | Medically under-served, low-income and minority populations |
| Chesterfield County Commissioner Office | Town Hall Participant | Low-income |
| Chesterfield County Department of Transportation | Key Informant Interview | Low-income |
| Child Savers | Town Hall Participant | Medically under-served, low-income and minority populations |
| City of Petersburg | Town Hall Participant | Medically under-served, low-income and minority populations |
| Community Foundation For A Greater Richmond | Community Advisory Council | Medically under-served, low-income and minority populations |
| Congregational Health Partner | Key Informant Interview, Town Hall Participant | Low-income and minority populations |

| Organization providing input | Nature and extent of input | Medically under-served, low income or minority populations represented by organization |
|---|---|---|
| Community Advocates | Town Hall Participant, Community Advisory Council | Medically under-served, low-income and minority populations |
| Crater Health District | Town Hall Participant | Medically under-served, low-income and minority populations |
| Flagler Housing and Homeless Services at St. Joseph's Villa | Town Hall Participant | Low-income and minority populations |
| Gateway Homes | Town Hall Participant | Low-income |
| Greater Richmond and Surrounding Counties Community Members | Town Hall Participant | Medically under-served, low-income and minority populations |
| Here for the Girls, Inc. | Town Hall Participant | Low-income and minority populations |
| Honoring Choices, RVA | Town Hall Participant | Medically under-served |
| Latinos en Virginia Empowerment Center | Key Informant Interview, Town Hall Participant | Low-income and minority populations |
| Maggie Walker Community Land Trust | Town Hall Participant | Low-income and minority populations |
| Miriam's House | Town Hall Participant | Low-income and minority populations |
| Neighborhood Resource Center of Greater Fulton | Key Informant Interview, Town Hall Participant | Medically under-served, low-income and minority populations |
| Nurture RVA | Town Hall Participant | Medically under-served, low-income and minority populations |
| Pathways – VA Inc | Town Hall Participant | Medically under-served, low-income and minority populations |
| Peter Paul Development Center | Community Advisory Council | Low-income and minority populations |

| Organization providing input | Nature and extent of input | Medically under-served, low income or minority populations represented by organization |
|---|---|---|
| Petersburg Community Pediatrician | Key Informant Interview | Medically under-served, low-income and minority populations |
| Petersburg Police Department | Town Hall Participant | Low-income and minority populations |
| Postpartum Support Virginia | Town Hall Participant | Medically under-served, low-income and minority populations |
| Private Practice Psychotherapist | Town Hall Participant | Medically under-served, low-income and minority populations |
| RBC Wealth Management Branch | Town Hall Participant | Low-income |
| Reynolds Community College | Key Informant Interview | Low-income |
| Richmond Academy of Medicine | Town Hall Participant | Medically under-served, low-income and minority populations |
| Richmond Association of Realtors | Key Informant Interview | Low-income and minority populations |
| Richmond City & Henrico Health District(s) | Key Informant Interview, Town Hall Participant | Medically under-served, low-income and minority populations |
| Richmond City Public School | Key Informant Interview | Low-income and minority populations |
| Richmond Symphony | Town Hall Participant | Low-income and minority populations |
| RVA Rapid Transit | Community Advisory Council | Low-income and minority populations |
| Ronald McDonald House Charities of Richmond | Town Hall Participant | Medically under-served, low-income and minority populations |

| Organization providing input | Nature and extent of input | Medically under-served, low income or minority populations represented by organization |
|---|---|---|
| Urban Baby Beginnings | Key Informant Interview, Town Hall Participant | Medically under-served, low-income and minority populations |
| Virginia Career Works Crater Region | Town Hall Participant | Low-income and minority populations |
| Virginia Department of Social Services | Town Hall Participant | Low-income and minority populations |
| Virginia Information Technologies Agency | Town Hall Participant | Low-income |
| Virginia State University | Town Hall Participant | Low-income and minority populations |
| Virginia Supportive Housing | Town Hall Participant | Low-income and minority populations |
| YMCA of Greater Richmond | Town Hall Participant | Low-income and minority populations |

# Access to Health Care Profile

## Adults with a primary care physician

**Indicator Description:**

This indicator shows the rate of primary care providers per 100,000 residents

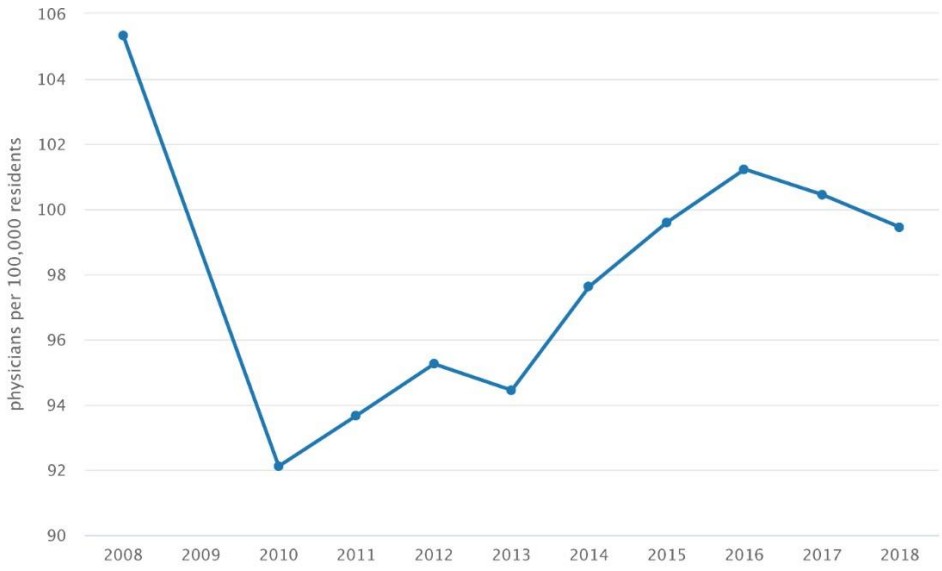
**Indicator Importance:**

Access to a health care provider on a regular basis helps to increase preventative screenings, identify potential health concerns, and improves overall quality of life.

**What the data shows:**

- While the rate of primary care providers per 100,000 residents increased from 2010 to 2016, there is a noticeable decline in primary care providers in the service area as the population continues to grow

## Adults with a primary care physician (PCP) Per Capita




Created on Metopio | https://metop.io | **Data sources:** Health Resources & Services Administration (HRSA) (Area Health Resource File, via the Health Data Warehouse), Health Resour
**Primary care providers (PCP) per capita:** Number of physicians in primary care (general practice, internal medicine, obstetrics and gynecology, or pediatrics) per 100,000 residents. Includes hospital residents. Excludes federal physicians and physicians age 75 or older.

## Persons without health insurance

**Indicator Description:**

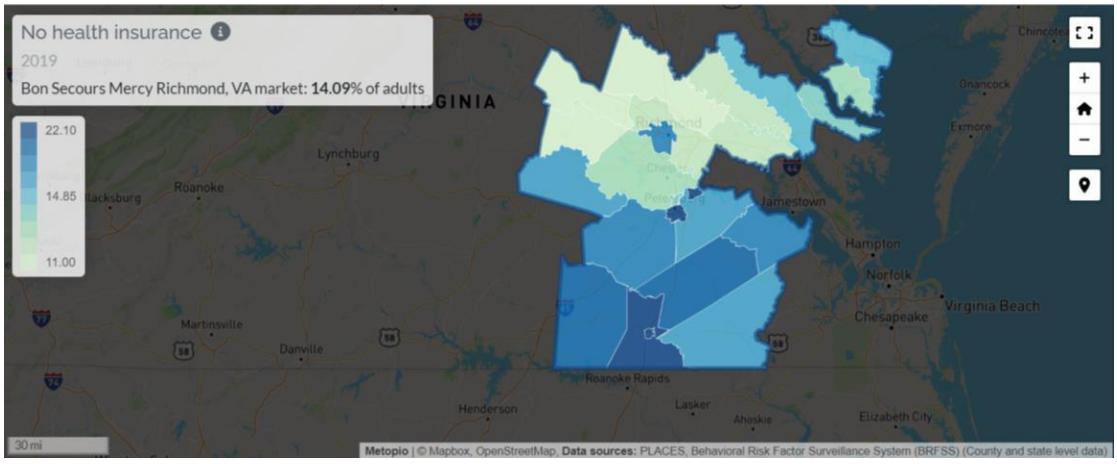
This indicator shows the percentage of persons aged 0-64 years that have any type of health insurance coverage.

**Indicator Importance:**

Individuals without health insurance are less likely to seek medical care and treatment due to high costs and socioeconomic barriers. While there are several safety net resources within the CHNA Service Area, there are still significant access challenges based on medical conditions and patient needs.

**What the data shows:**

- The overall uninsured rate in the CHNA Service area is 14.09% of adults
- The uninsured rate is significantly higher in the urban and rural localities than in the suburban localities



# Health Conditions and Disease Data Profile

## Leading Causes of Death

**Indicator Description:**

These indicators show the leading causes of death in the CHNA Service Area

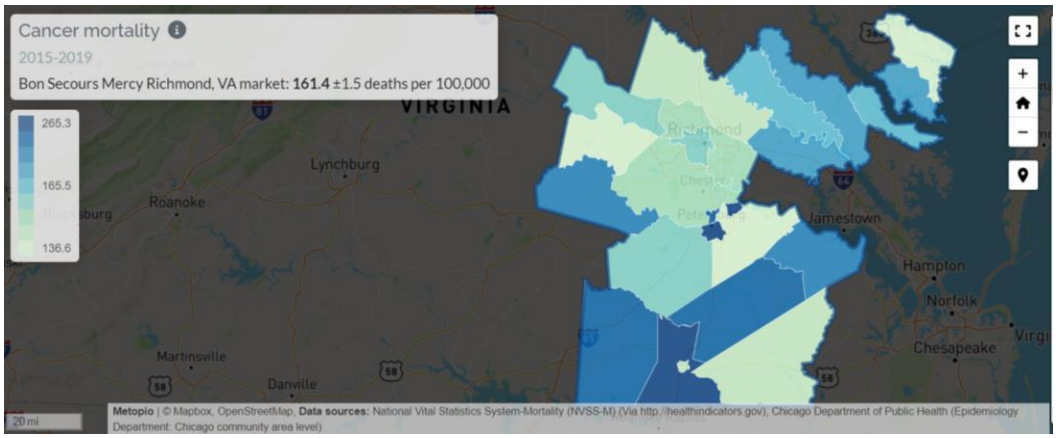
**Indicator Importance:**

Determining the specific leading causes of death is an important factor in understanding the overall health of communities.

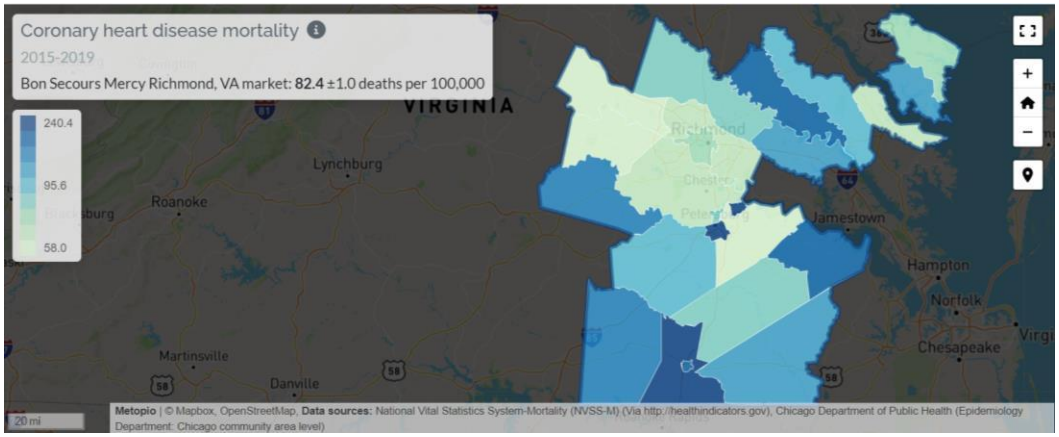
**What the data shows:**

The leading causes of death in both the CHNA Service Area include Cancer, Heart Disease, Stroke, Chronic lower respiratory disease, and Unintentional Injuries

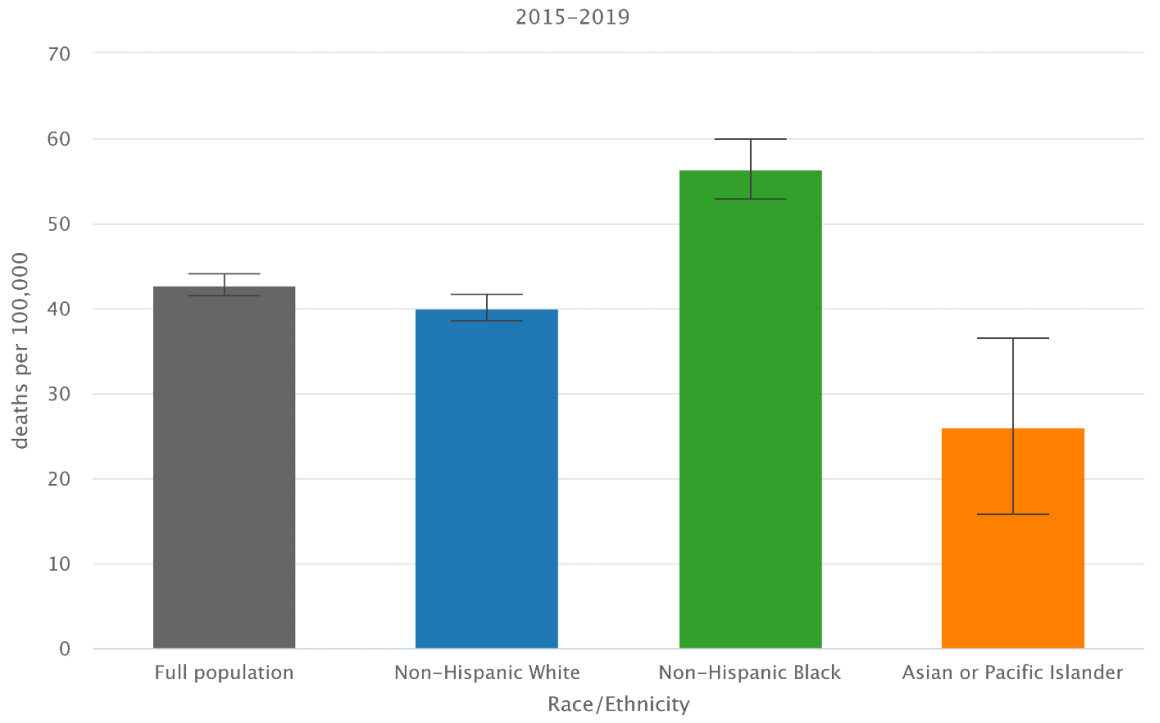
### Cancer



## Heart Disease

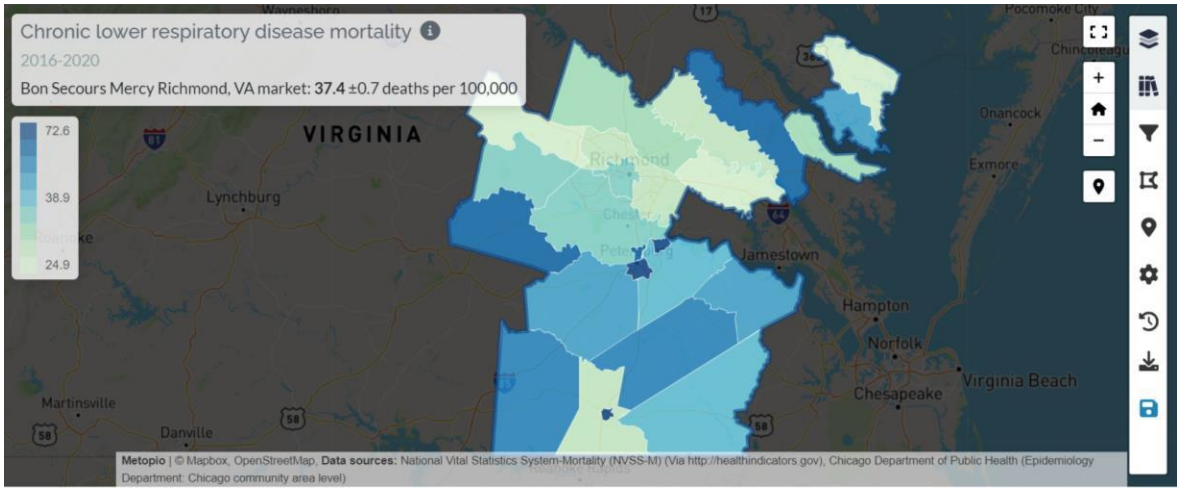



## Stroke Mortality by Race/Ethnicity

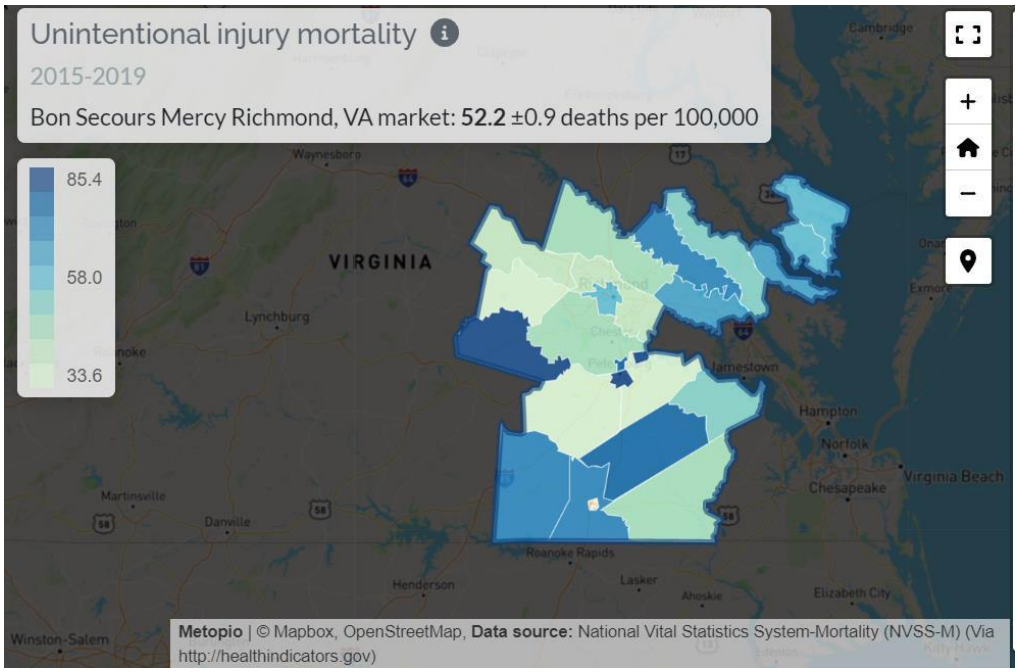



**Created on Metopio** | https://metop.io | **Data sources:** National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Departmen
**Stroke mortality:** Deaths per 100,000 residents due to stroke (ICD-10 codes I60-I69).

## Chronic Lower Respiratory Disease




## Unintentional Injuries



## Drug Overdose Mortality by Race/Ethnicity

**Indicator Description:**

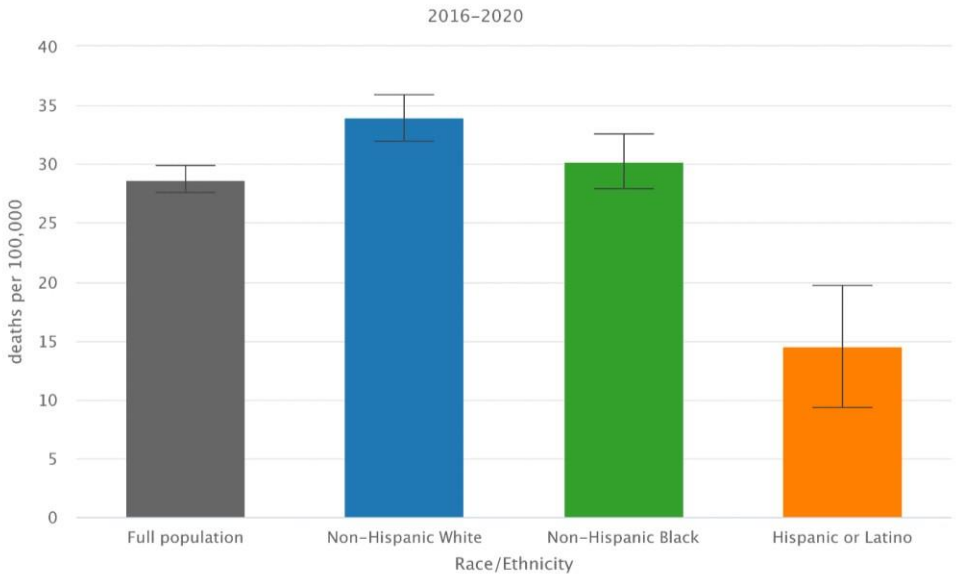
This indicator shows the rate of drug overdose deaths per 100,000 in the CHNA Service Area.

**Indicator Importance:**

Communities with a high rate of drug overdose deaths have a higher concentration of drug use and higher susceptibility to crime than communities with a low rate of drug overdose deaths.

**What the data shows:**

- The mortality rate for the CHNA Service Area (28.71 per 100,000) is significantly higher than the rate in Virginia (19.32 per 100,000) and the United State (22.43 per 100,000)
- Additionally, the rates for both Non-Hispanic White and Non-Hispanic Black are higher than the CHNA Service Area average.




**Created on Metopio** | https://metop.io | **Data sources:** National Vital Statistics System–Mortality (NVSS–M) (CDC Wonder), Chicago Department of Public Health (Epidemiology Depar
**Drug overdose mortality:** Deaths per 100,000 residents due to drug poisoning (such as overdose), whether accidental or intentional. The increase during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here. Age–adjusted.

## Mortality Rate Due to Suicide

**Indicator Description:**

This indicator shows the death rate per 100,000 persons due to suicide.

**Indicator Importance:**

The number of deaths due to suicide is a strong indicator of the overall health of a community. Communities that experience a higher rate of suicides are more likely to have a higher rate of depression, anxiety, and other behavioral health issues than communities with a low rate of suicide deaths.

**What the data shows:**

- Suicide mortality continues to be at an alarming level across the United State and is slightly higher in the CHNA Service Area compared to Virginia and the United States


Created on Metopio | https://metop.io | **Data sources:** National Vital Statistics System–Mortality (NVSS–M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Departm
**Suicide mortality:** Deaths per 100,000 residents due to suicide (ICD–10 codes *U03, X60–X84, Y87.0). In the United States, decisions about whether deaths are listed as suicides on death certificates are usually made by a coroner or medical examiner. The definition of suicide is "death arising from an act inflicted upon oneself with the intent to kill oneself."

## Adult Obesity

**Indicator Description:**

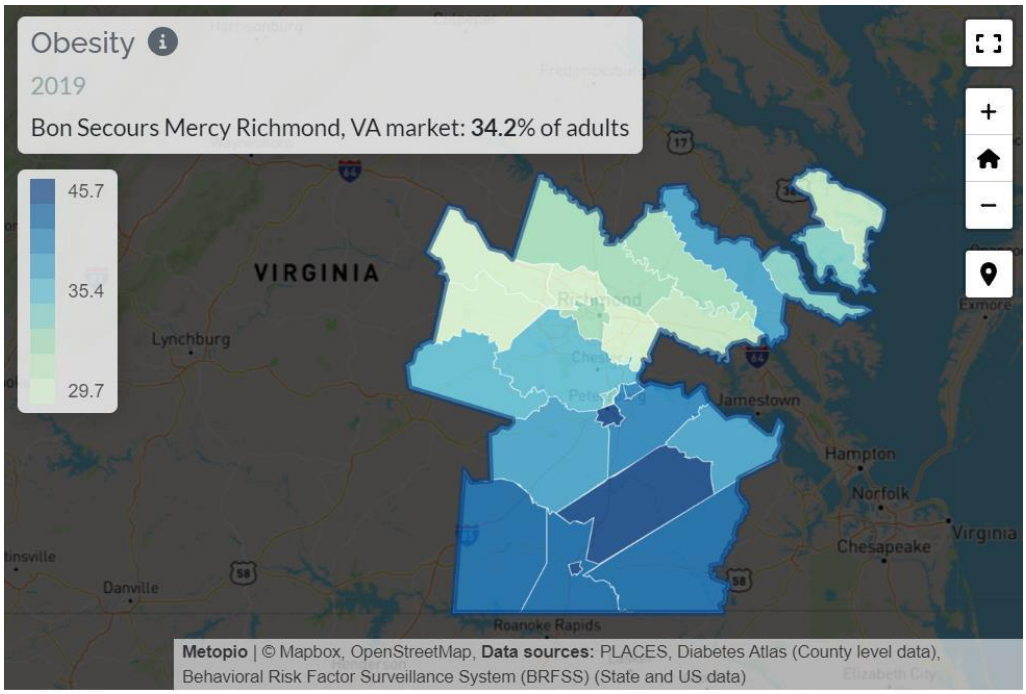
This indicator shows the percentage of adults who are obese according to the Body Mass Index (BMI).

**Indicator Importance:**

A high BMI is an overall indicator of poor individual and community health. Being overweight or obese puts individuals at a higher risk of developing many chronic diseases.

**What the data shows:**

- While a BMI between 25-29.9 is considered overweight, a BMI equal to 30 is considered obese
- Every locality in the CHNA Service area has a significant percentage of adults who are obese, with higher obesity in the southern Virginia localities



## Infant Mortality Rate by Race/Ethnicity

**Indicator Description:**

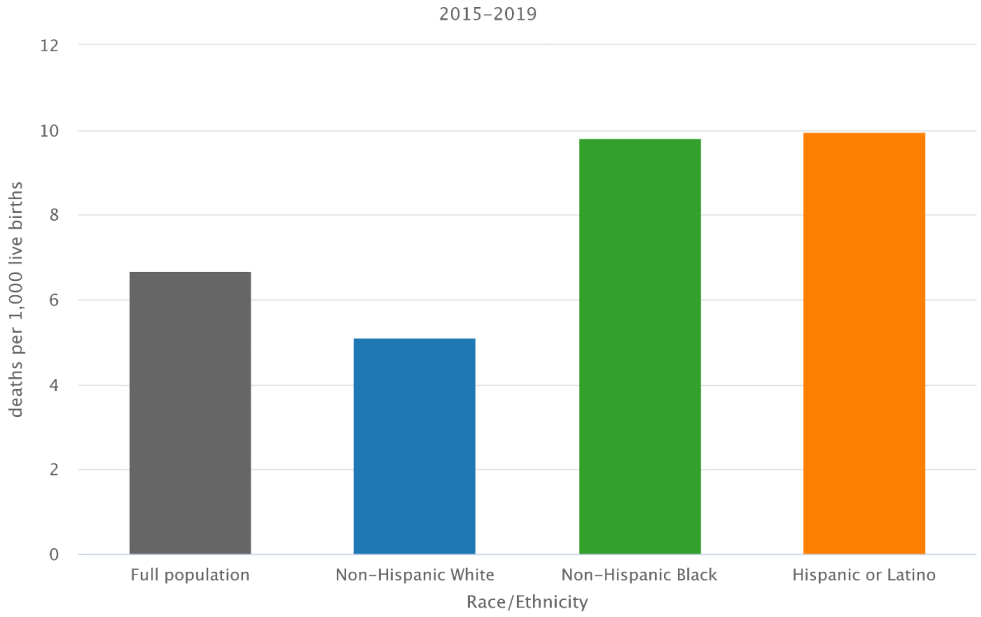
This indicator shows the mortality rate in deaths per 1,000 live births for infants within their first year of life.

**Indicator Importance:**

The infant mortality rate is a common indicator of overall health status of a community. Common reasons for infant death include birth defects, preterm delivery, low birth weight, Sudden Infant Death Syndrome (SIDS) and maternal complications during pregnancy.

**What the data shows:**

- Significant disparity exists among Non-Hispanic Black and Hispanic or Latino populations within the CHNA Service Area




**Created on Metopio** | https://metop.io | **Data sources:** National Vital Statistics System–Natality (NVSS–N) (CDC Wonder; counties and states, excluding Wisconsir
**Infant mortality:** Rate of postneonatal deaths (in the first year of life). Stratifications by race/ethnicity are of the mother.

## Very Low Birth Weight

**Indicator Description:**

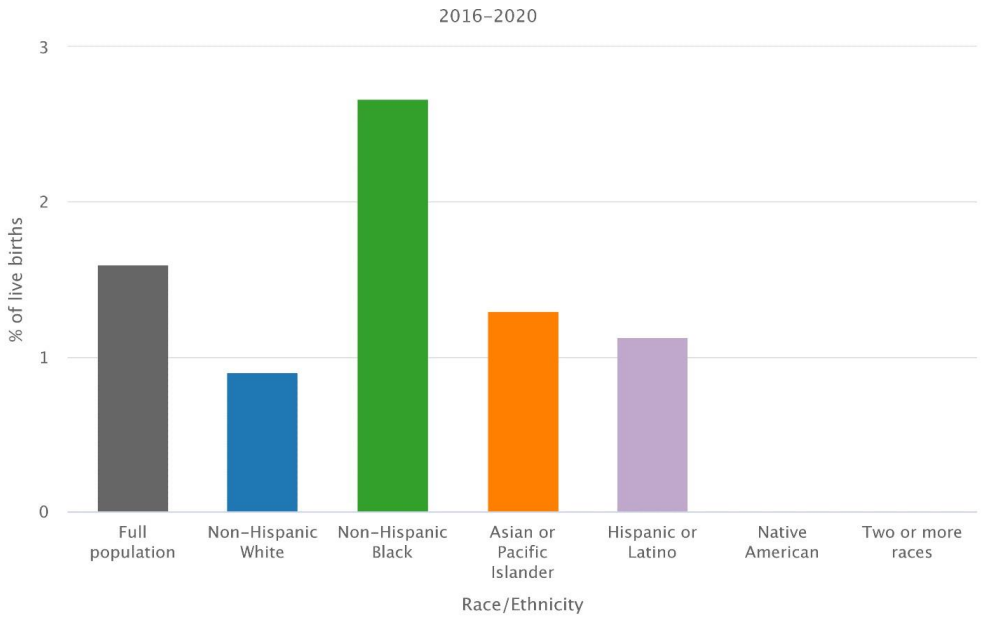
This indicator shows the percentage of very low birth weights among all newborns. Newborns weighing less than 1500 grams (3 pounds, 4 ounces) are considered to have a very low birth weight.

**Indicator Importance:**

Very low birth weight is a leading cause of infant mortality in communities. Babies born with very low birth weight typically experience more health problems than normal birth weight babies.

**What the data shows:**

- Disparities in very low birth weight babies' pattern that of infant mortality with Non-Hispanic Black having the highest percentage in the CHNA Service Area




**Created on Metopio** | https://metop.io | **Data sources:** National Vital Statistics System–Natality (NVSS–N) (via CDC wonder (2016–2020 data averages)), National
**Very low birth weight:** Percent of live births with a birth weight of less than 1,500 grams (3 lbs, 4 oz).

## Teen Birth Rate

**Indicator Description:**

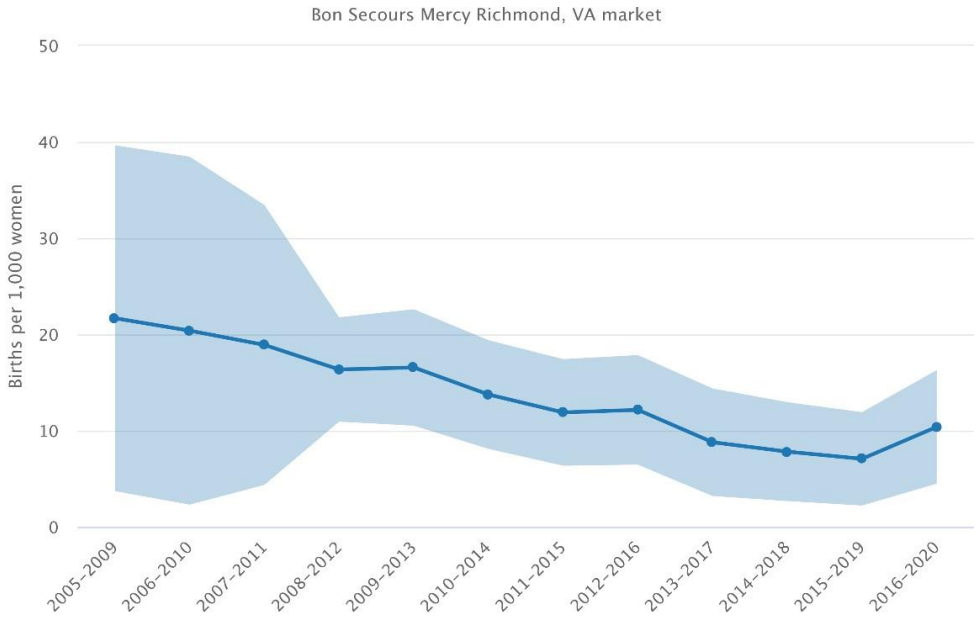
This indicator shows the rate of pregnancies per 1,000 females ages 15 to 19.

**Indicator Importance**:

Teen pregnancies have significant social and economic impacts on individuals and communities. Teen pregnancy leads to increased risk of high school dropout and increased socioeconomic burden.

**What the data shows:**

- Teen birth rates have been trending positively, decreasing since 2005. The five-year average of 2016-2020 shows a slight increase compared to prior years




**Created on Metopio** | https://metop.io | **Data source:** American Community Survey (Table B13002)
**Teen birth rate:** Women age 15–19 with a birth in the past year, per 1,000 women age 15–19. Does not include births to women below age 15.

## COVID-19 Case Fatality

**Indicator Description:**

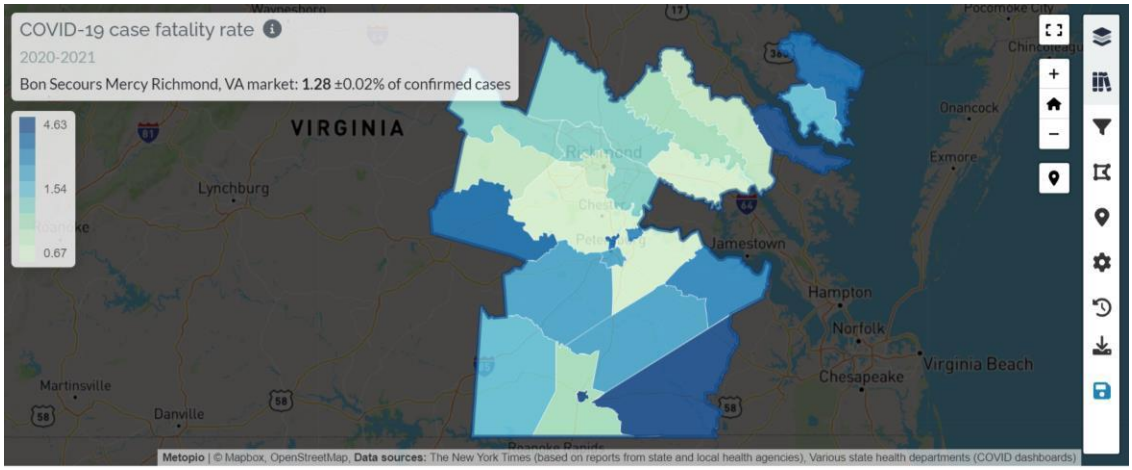
This indicator shows the percent of COVID-19 fatalities relative to confirmed cases.

**Indicator Importance:**

This indicator brings awareness to the overall public health response, vaccinations, and access to healthcare during the COVID-19 pandemic.

**What the data shows:**

- The rate of COVID-19 fatalities is higher in the most rural localities in the CHNA Service Area
- Areas with high access to medical services and public health services have the lowest case fatality rate



## Other Health Behaviors and Social Determinants

### Food Insecurity

**Indicator Description:**

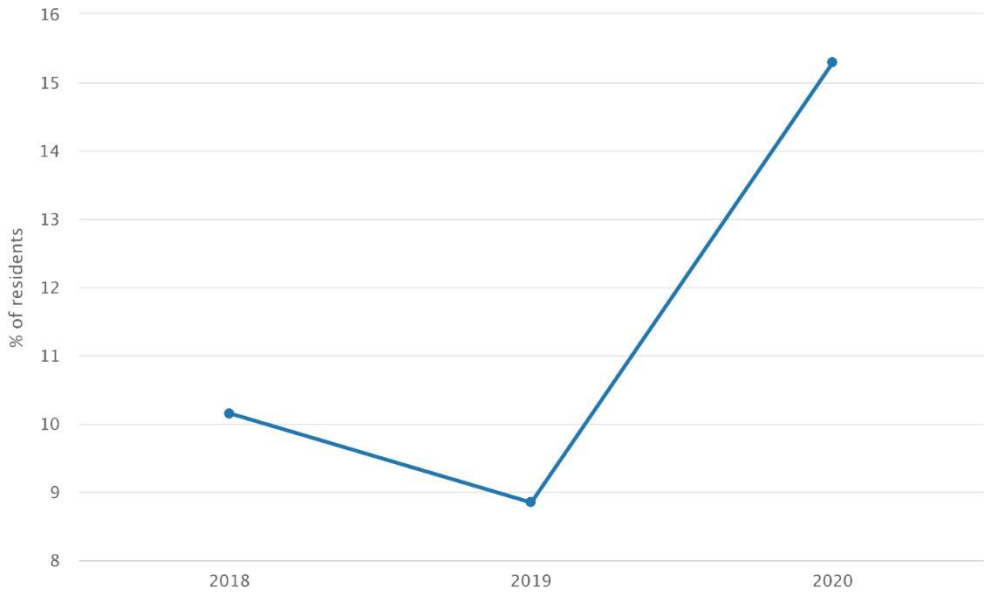
This indicator shows the percentage of residents who at some points have had uncertain or limited access to adequate food.

**Indicator Importance:**

The lack of access to healthy and affordable foods is a significant barrier to a community's overall health. Individuals who do not have local access to a grocery store are less likely to develop healthy eating habits for themselves and their families, which can lead to several chronic health issues such as heart disease, diabetes, and obesity.

**What the data shows:**

- The sharp increase in food insecurity pictured below is an estimated value as a result of the COVID-19 pandemic
- While food insecurity exists in every locality within the CHNA Service Area, it disproportionally impacts rural localities and areas of high poverty and high unemployment




**Created on Metopio** | https://metop.io | **Data source:** Feeding America (Map the Meal Gap 2020)
**Food Insecurity:** Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. 2020 data is a projection based on 11.5% national unemployment and 16.5% national poverty rate.

## Homelessness

**Indicator Description:**

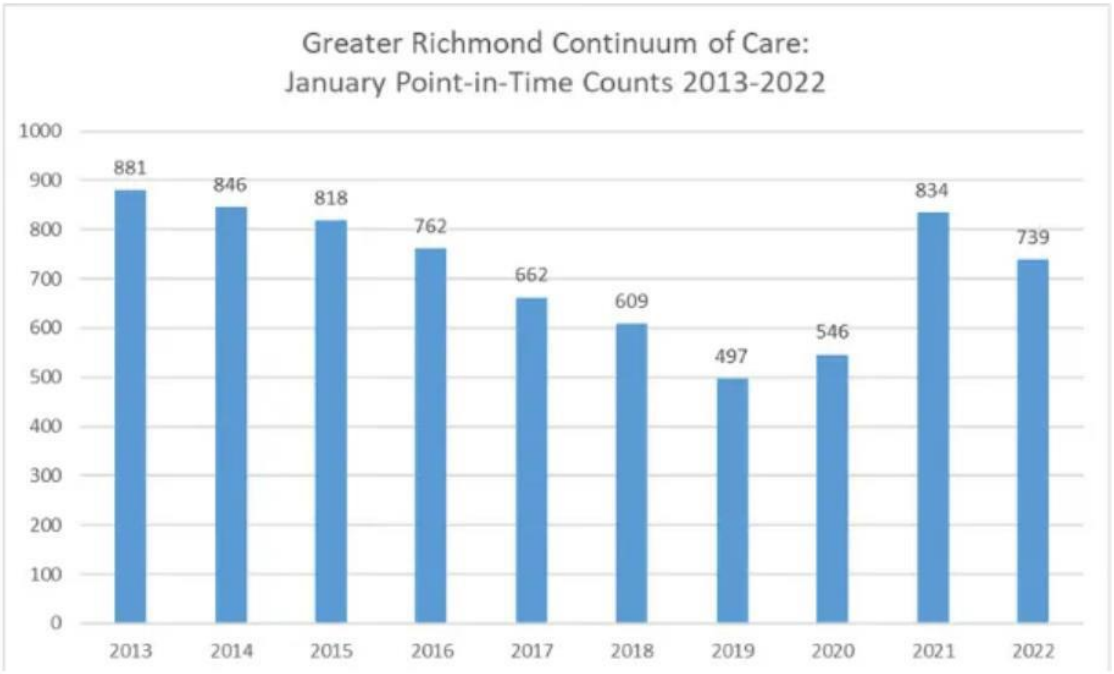
It is important to note that there are many definitions of homelessness. The first indicator shows a table of the number of adults who were experiencing homelessness on any given night in the Greater Richmond Area. In this case, an individual who is experiencing homelessness lacks a regular and adequate nighttime residence and includes those who are living in a shelter. The second indicator shows a map of the population living in shelters for the homeless, group homes, treatment centers, workers' living quarters, natural disaster recovery centers, religious group quarters, and other group quarters.

**Indicator Importance:**

As housing is a basic human necessity, those who experience homelessness are at a much higher risk for poor/inadequate health, severe financial burden, and overall poor quality of life.

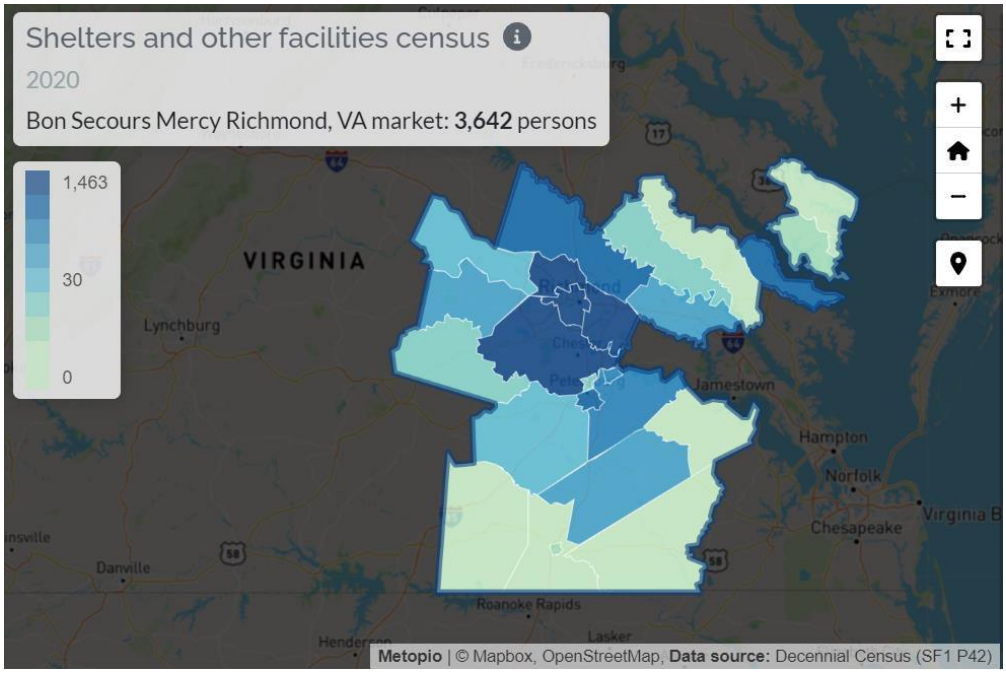
**What the data shows:**

- The Point-In-Time count shows a significant increase in homeless individuals following the COVID-19
- While homelessness is a reality in all geographic regions, higher rates of homelessness tend to exist in more urban areas




Homeward (http://homewardva.org/)

PIT count totals for sheltered and unsheltered people over the past five years. Note that no count was conducted in July 2020. The unsheltered count in January 2021 was an observation-only count.



## Aggravated Assault/Battery Rate

**Indicator Description:**

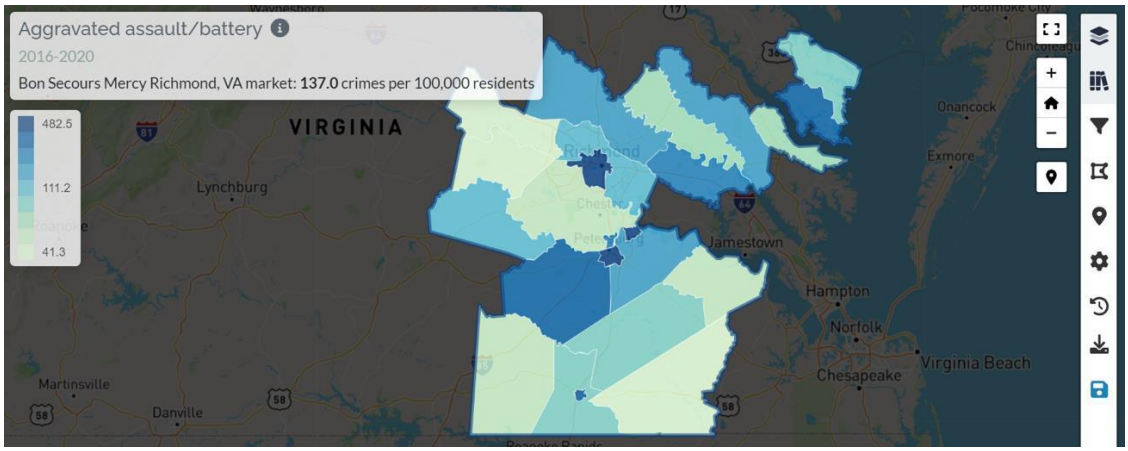
This indicator is the percentage of aggravated assault and/or aggravated battery per 100,000 residents.

**Indicator Importance:**

Assault and battery are important indicators of overall community violence and crime and brings awareness to continued incidents of domestic violence within the community. Aggravated assault is defined as an unlawful attack by one person upon another, wherein the offender displays a weapon in a threatening manner. Aggravated battery is defined as the physical attack itself, wherein the offender uses a weapon, or the victim suffers obvious severe or aggravated bodily injury involving apparent broken bones, loss of teeth, possible internal injury, severe laceration, or loss of consciousness.

**What the data shows:**

- While urban localities often experience the highest rate of violence and crime, certain suburban and rural localities throughout the CHNA Service Area also have high levels of assult and battery



## Particulate Matter Environmental Justice Index

**Indicator Description:**

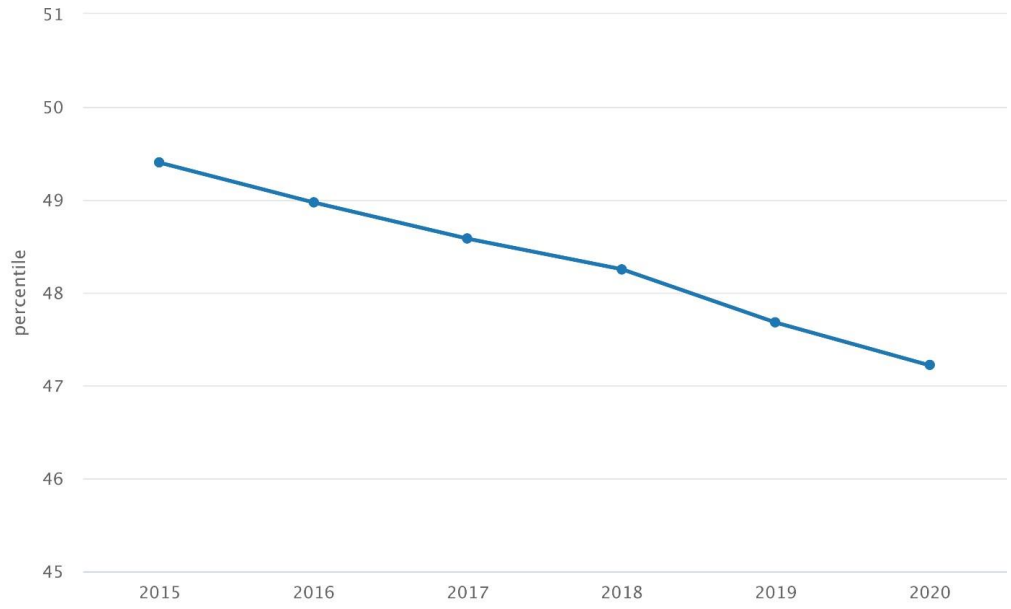
This indicator shows the weighted vulnerability to particulate matter in the air.

**Indicator importance:**

Weighting by the vulnerability of residents can provide a better estimate of the disproportionate impact of environmental hazards on a community.

**What the data shows:**

- The localities in the CHNA Service Area have experienced a positive decline in environmental risk since 2015
- Urban and rural areas are disproportionately at higher risk and vulnerability of environmental air hazards




**Created on Metopio** | https://metop.io | **Data source:** Environmental Protection Agency (EPA) (EJSCREEN)
**Particulate matter Environmental Justice Index:** Weighted index of vulnerability to particulate matter. Measures exposure to PM 2.5 in the air, weighted by population vulnerability and reported as a percentile nationally, where 0 = lowest exposure, and 100 = highest exposure. Weighting by the vulnerability of residents can provide a better estimate of the disproportionate impact of environmental hazards.

## Water Polluting Sites Environmental Justice Index

**Indicator Description:**

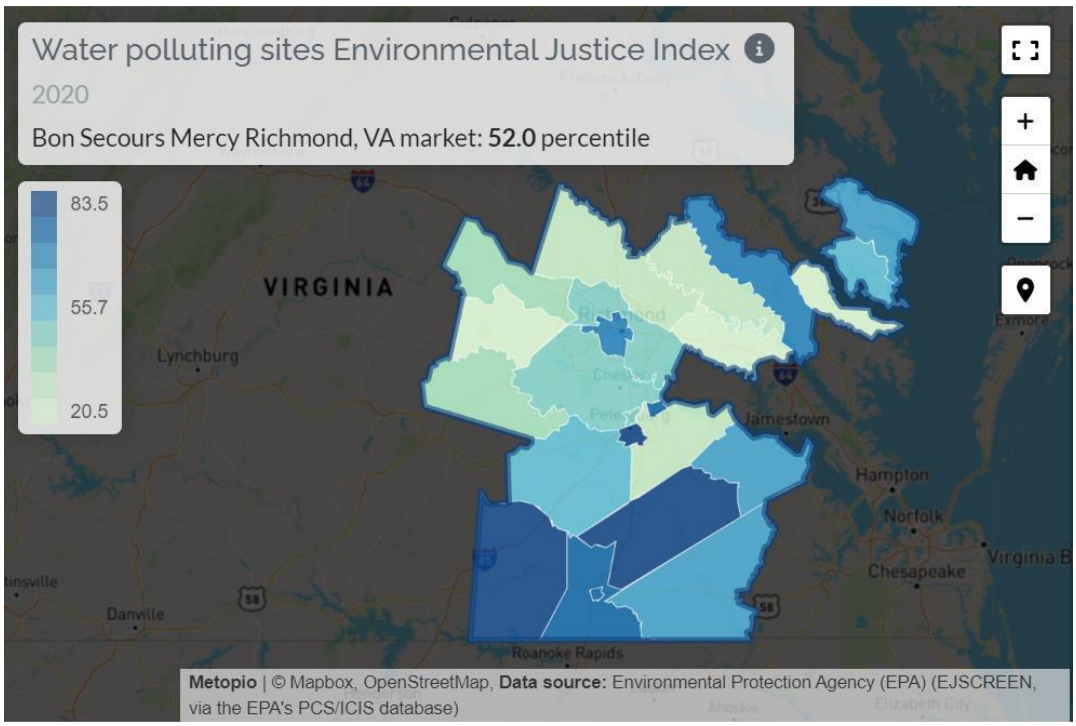
This indicator shows the weighted vulnerability to water polluting sites.

**Indicator importance:**

Weighting by the vulnerability of residents can provide a better estimate of the disproportionate impact of environmental hazards on a community.

**What the data shows:**

- Urban and rural areas are disproportionately at higher risk and vulnerability to environmental water hazards



## No Exercise

**Indicator Description:**

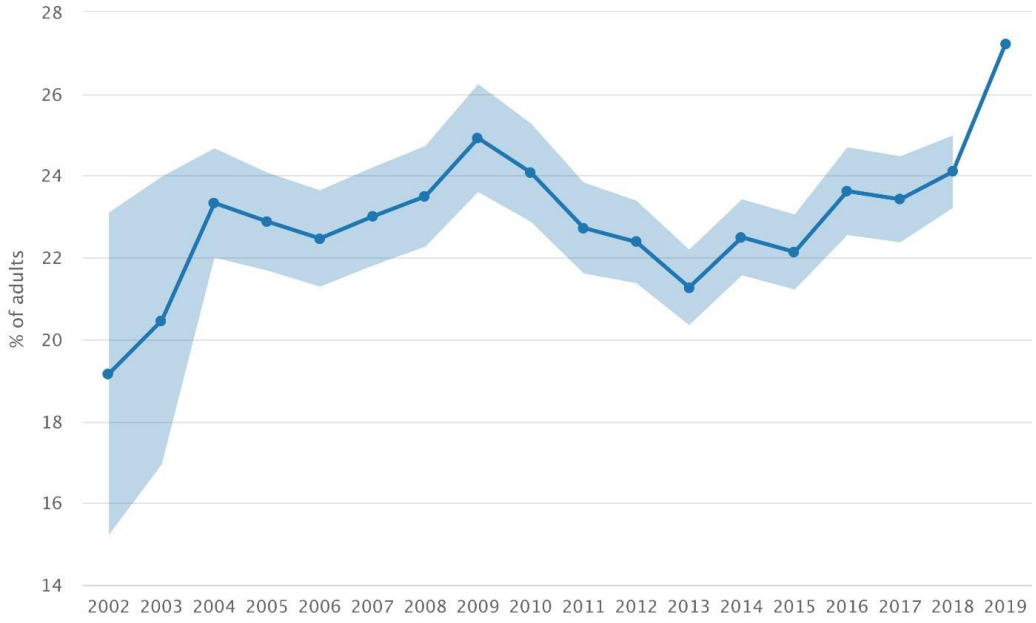
This indicator shows the percentage of adults who reported having no physical activity outside of their regular job in the past month.

**Indicator Importance:**

Individuals who engage in more frequent physical activity have an overall increased health status, as regular exercise has been linked to numerous health benefits.

**What the data shows:**

- Since 2013, the percentage of adults with no exercise has steadily increased with a more significant increase in 2019




**Created on Metopio** | https://metop.io | **Data sources:** Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Diabetes Atlas (County level data), PLACES
**No exercise:** Percent of resident adults aged 18 and older who answered "no" to the following question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

## Severe Housing Cost Burden

**Indicator Description:**

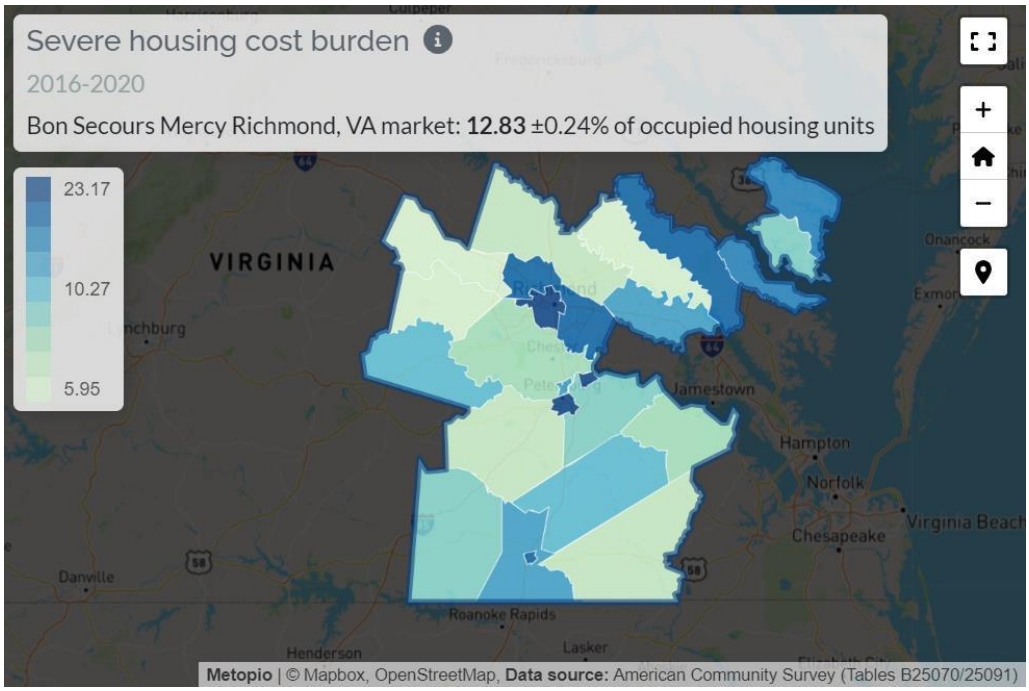
This indicator reflects the percentage of renters who are spending 50% or more of their household income on rent. This includes both renters and owners.

**Indicator Importance:**

Renters who spend a higher percentage of household income on rent are likely to have increased financial hardship. The more income spent on housing, the less income is available for other necessities such as food, transportation, and medical care.

**What the data shows:**

- The severe housing cost burden is higher in urban localities compared to rural localities
- It is important to also note the higher housing cost burden in the localities that make up the Northern Neck



## Social Engagement Index

**Indicator Description:**

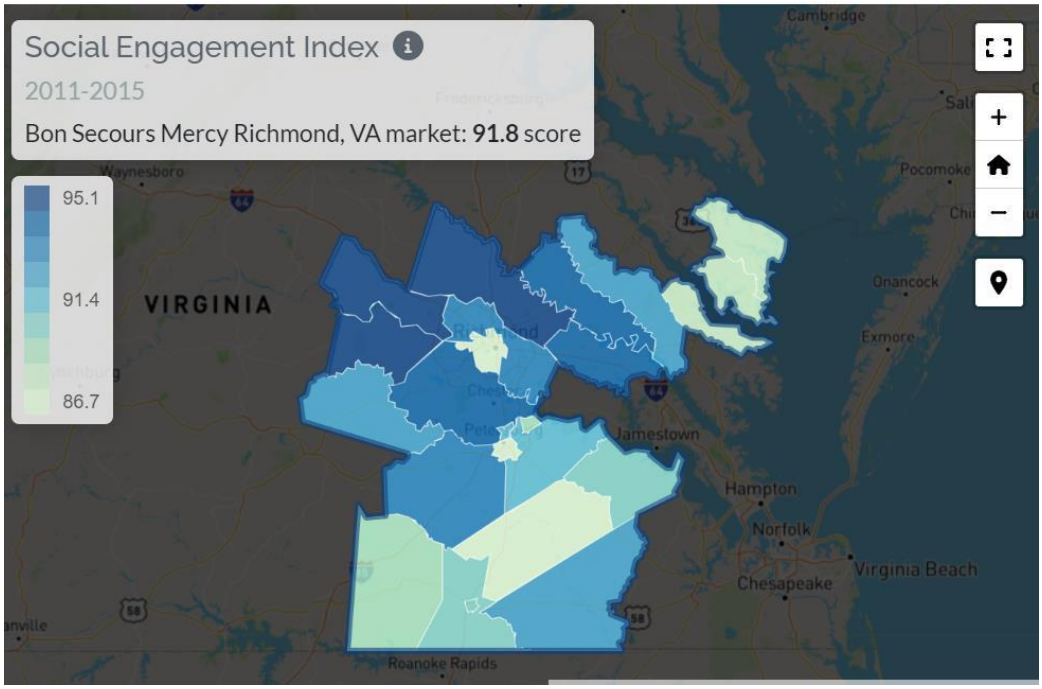
This indicator is an index school that measures the elements of civic engagement and social isolation, especially those who are affected by the built environment.

**Indicator Importance:**

The indicator also suggests information about neighborhood resiliency (five-year change in rent prices, how often residents move, and housing vacancy) and barriers to social engagement (disconnected youth, proportion of seniors living alone, residents with cognitive and ambulatory disabilities, limited English proficiency, and residents reporting poor mental health)

**What the data shows:**

- Residents living in urban localities in the CHNA Service Area are experincing slightly less social engagement than those in the suburban localities



## Binge Drinking in the Past 30 Days

**Indicator Description:**

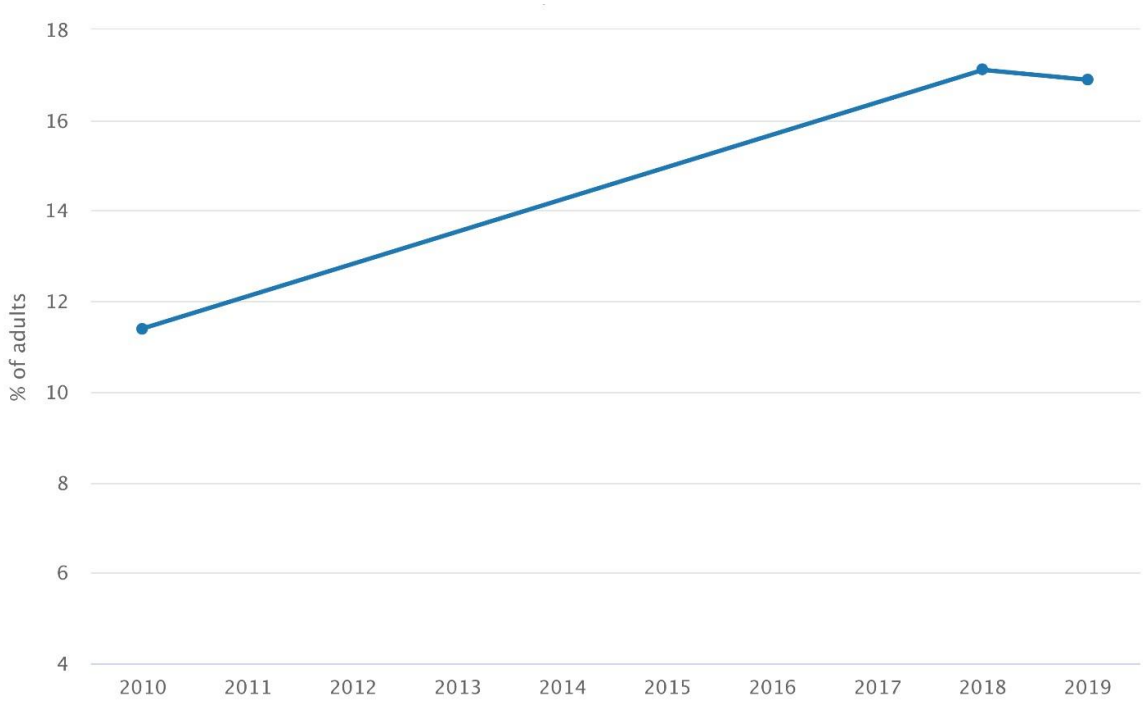
This indicator shows the percent of adults who have participated in binge drinking in the last 30 days. Male binge drinking is defined as five or more drinks on one occasion. Female binge drinking is four or more drinks on one occasion.

**Indicator Importance:**

Binge drinking can lead to alcohol abuse which is associated with many negative health outcomes as well as increased alcohol-related traffic accidents, employment difficulties, legal concerns, and other financial challenges.

**What the data shows:**

- While the percentage of adults who reported binge drinking in the last 30 days has slightly increased since 2010, it appears to have leveled off around 17% in 2018 and 2019




**Created on Metopio** | https://metop.io | **Data sources:** PLACES, Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data)
**Binge drinking:** Percent of adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Alcohol use is likely seriously underreported, so these estimates are an extreme lower bound on actual binge drinking prevalence.

# Significant Community Identified Health Needs

## Social Determinant of Health – Community Level Needs that Impact Health and Wellbeing

### Social and Economic Disparity

**Capacity and adequacy of service levels**

The 2022 CHNA community engagement, data collection, and analysis process identified significant opportunities to address existing social and economic disparities throughout the CHNA Service Area. As a not-for-profit health system, Bon Secours partners with many community-based organizations whose core missions are to address social determinants of health in the community with the goal of reducing social and economic disparity. Additionally, many Bon Secours programs and initiatives are intentionally designed to support individuals and families who experience social and economic disparity.

**Current service providers or resources**

In addition to the representative community partners listed earlier in this document, Bon Secours directly invests in other community-based partner organizations. These investments allow partner organizations to expand their capacity to reduce disparities in the community. For a listing of Bon Secours community partners, please see Appendix D.

### Engagement and Inclusion

**Capacity and adequacy of service levels**

The 2022 CHNA community engagement, data collection, and analysis process identified significant opportunities to have intentional, regularly occurring, and authentic engagement with the community. This engagement should also emphasize the diversity of the CHNA Service Area in an inclusive way, focusing on the assets of the community and what it looks like to work together to create an environment of justice. As a not-for-profit health system, Bon Secours partners with many community-based organizations whose core missions are to create opportunities for historically marginalized and underserved communities to have their voice be heard and to collectively drive change.

**Current service providers or resources**

In addition to the representative community partners listed earlier in this document, Bon Secours directly invests in other community-based partner organizations. These investments allow partner organizations to connect with and access individual voices that are often unrepresented or underrepresented in the CHNA process. For a listing of Bon Secours community partners, please see Appendix D.

# Social Health Need – Individual Level Non-Clinical Needs

## Violence and Trauma

**Capacity and adequacy of service levels**

The 2022 CHNA community engagement, data collection, and analysis process identified significant opportunities to address existing and increasing violence and trauma throughout the CHNA Service Area. In addition to Bon Secours emergency departments, acute hospital facilities, and outpatient medical resources, Bon Secours has a nationally respected Violence Response Team that has been serving the CHNA Service Area for over twenty (20) years. This team is comprised of Forensic Nurses and Advocates working to address all forms of violence as well as to address the increase in violence observed since the beginning of the COVID-19 pandemic.

**Current service providers or resources**

In addition to the representative community partners listed earlier in this document, Bon Secours directly invests in other community-based partner organizations. These investments allow partner organizations to expand their capacity to address violence and trauma in the community. For a listing of Bon Secours community partners, please see Appendix D.

# Significant Clinical Health Needs

## Chronic Disease and Prevention

**Capacity and adequacy of service levels**

The 2022 CHNA community engagement, data collection, and analysis process identified significant opportunities to address ongoing Chronic Diseases and the importance of increasing Prevention efforts. In addition to Bon Secours emergency departments, acute hospital facilities, and outpatient medical resources, Bon Secours has a robust community health department that brings primary and specialty care services into underserved communities.

**Current service providers or resources**

In addition to the representative community partners listed earlier in this document, Bon Secours directly invests in other community-based partner organizations. These investments allow partner organizations to expand their clinical capacity for serving the most vulnerable, and to improve care coordination and patient transitions across the continuum of care. For a listing of Bon Secours community partners, please see Appendix D.

## Mental Health

**Capacity and adequacy of service levels**

The 2022 CHNA community engagement, data collection, and analysis process identified significant opportunities to address existing and emerging Mental Health needs. In addition to Bon Secours emergency departments, acute hospital facilities, and outpatient medical resources, Bon Secours is increasingly focused on the delivery of services as part of the communities' response to the mental health crisis.

**Current service providers or resources**

In addition to the representative community partners listed earlier in this document, Bon Secours directly invests in other community-based partner organizations. These investments allow partner organizations to expand their clinical capacity for serving the most vulnerable, and to address aspects of Mental Health care that are not traditionally provided in the acute or outpatient setting. For a listing of Bon Secours community partners, please see Appendix D.

# Prioritization of Health Needs

The following prioritization of health issues and root causes was the culmination of a yearlong CHNA engagement process. Chronic Disease and Prevention, Mental Health, Violence and Trauma, Social and Economic Disparity, and Engagement and Inclusion are the five prioritized needs for the 2023-2025 CHNA. While there are current service providers addressing each of these five focus areas, many service providers are at capacity. These needs were prioritized in an effort to meet the needs of the community more adequately. Prioritization Methodology and Results Conversations with the CHNA Advisory Council, community members, and community leaders reaffirmed the survey findings and identified significant linkages between identified health needs. Additionally, the four overarching values of 1) fostering and environment of justice, 2) facilitating access, opportunity, and belonging, 3) listening, learning, and collaborative action, and 4) addressing system issues and root causes were identified as significant considerations towards the successful addressing of prioritized needs.

Leaders within the Community Health Division at Bon Secours Richmond Health System grouped the identified needs into the following five (5) categories based on the feedback provided by the community, then presented the five (5) categories to the CHNA Advisory Council. The Advisory Council reaffirmed the five (5) categories as critical and tangible focus areas needing improvement over the next 3 years.

These five categories were then shared with the Bon Secours Richmond Senior Leadership Team where further affirmation was received. The Leadership Team was asked the following questions and discussion led to improvement planning:

1. Where does our existing work align with these themes identified in the new CHNA structure?
2. Where are there gaps where we need to enhance our work?
3. What areas should we prioritize in the next 3 years?

Further prioritization of health needs within each category will be outlined through a separate multisector implementation plan.

Based on the above information and processes, the prioritized health needs of the community served by the hospitals are listed below:

# Prioritized Social Determinants of Health Needs

**Social and Economic Disparity**

Social determinants of health were identified by the community as root causes of health needs in the CHNA Service Area. The interconnectedness of social determinants with one another led to the group prioritization of social and economic disparities as a prioritized health need.

**Engagement and Inclusion**

Throughout the engagement process there were many conversations about whose voice was absent in the survey process, at community conversations, and in key informant interviews. These conversations led to the prioritization of authentic and frequent community engagement that ensures inclusion of all voices in the improvement process.

# Prioritized Social Health Needs

**Violence and Trauma**

Trauma has continued to be a prioritized theme since the 2016 CHNA. Throughout the CHNA engagement process, particularly during the community conversations and key informant interviews, community members and key informants identified trauma and violence as two of the most important health needs that are drivers of many other health needs. Additionally, available data suggests a significant increase in violence (both community violence and interpersonal violence) since the beginning of the COVID-19 pandemic.

# Prioritized Clinical Health Needs

**Chronic Disease and Prevention**

An overwhelming focus on Chronic Disease and the need for increased prevention and education were top results of both the survey and the community conversation prioritization process. As leading causes of death in our community, Chronic Diseases are multifaceted and require tremendous attention and resources to address. The community engaged throughout the CHNA process is passionate about growing the current momentum in the region to address these health needs.

**Mental Health**

Mental health was the number one need identified in the engagement survey and a critical component of every community conversation. During the key informant interview process, the interviewers asked the interviewees about root cause health issues and nearly every conversation resulted in the identification of mental health as a root cause of poor health outcomes.

# Resources Available to Meet Prioritized Needs

Representative existing Bon Secours Richmond healthcare facilities and other resources within the community that are available to help meet the prioritized needs are listed below. Community resources are listed in Appendix D, categorized by each prioritized need.

## Prioritized Social Determinants of Health Needs

### Social and Economic Disparity

**Bon Secours Financial Assistance Team** - The Bon Secours Financial Assistance Program helps uninsured patients who do not qualify for government-sponsored health insurance and cannot afford to pay for their medical care. Insured patients may also qualify for assistance, based on family income, family size, and medical needs.

**Bon Secours Community Benefit Investments** – Between 2019 and 2022, Bon Secours provided over $14 million through community benefit investments to community partners serving the uninsured and underinsured populations.

### Engagement and Inclusion

**Bon Secours Sarah Garland Jones Center** – This healthy living center promotes well-being and community engagement in Richmond's East End.

## Prioritized Social Health Needs

### Violence and Trauma

**Bon Secours Violence Response Team** – This program provides care to patients 24/7 who have been victims of child abuse, sexual assault, domestic violence, elder abuse, human trafficking, and strangulation.

**Bon Secours Hospital Emergency Departments, Freestanding Emergency Departments** – Bon Secours Richmond includes 7 acute facility hospitals with Emergency Departments as well as 4 freestanding Emergency Departments.

## Prioritized Clinical Health Needs

### Chronic Disease and Prevention

**Bon Secours Care-A-Van** – Mobile health clinics that provide free, primary, urgent, and preventative health care to uninsured and vulnerable populations in a 60-mile radius of the City of Richmond.

**Bon Secours Community Nutrition** – Improves community health, particularly in vulnerable communities, through nutrition counseling, healthy eating classes, and advocacy for food access.

**Bon Secours Program for Diabetes Health** – Addresses the needs of those living with diabetes, utilizing an across the continuum program that provides inpatient diabetes management through a Clinical Nurse Specialist team and ambulatory diabetes education by teams of RNs/RDs embedded within primary care practices.

**Bon Secours Every Woman's Life** -–This program provides breast and cervical cancer screening and early detection, clinical breast exams, mammograms, pelvic exams, and Pap smears.

**Bon Secours Instructive Visiting Nurse Association (IVNA)** – IVNA is an Immunization and Wellness Program that provides over 12,000 flu shots per year, in addition to other immunizations and wellness services, to the Greater Richmond community

**Bon Secours Medical Group** – Four hundred and fifty six (456) physicians and advanced practice clinicians and associated staff providing primary and specialty medical care to the CHNA service area in one hundred and fifty two (152) locations.

**Bon Secours Prenatal Education** – Team of Prenatal Educators providing low or no-cost community education about childbirth, breastfeeding, postpartum care, newborn care and safety, and more.

## Mental Health

**Bon Secours Behavioral Health Center at Richmond Community Hospital** – Opening at the end of 2022 in response to previous CHNA feedback, a two story, 25,000 square foot behavioral health facility is being built. This facility will contain a behavioral health partial hospitalization program (PHP), programming from the Bon Secours Mobile Assessment Response Team (BSMART) and a behavioral health tele-consult call center.

**Bon Secours Cullather Brain Tumor Qualify of Life Center** – Provides support and education to patients with brain tumors and their families.

**Bon Secours Hospital Emergency Departments, Freestanding Emergency Departments** – Bon Secours Richmond includes 7 acute facility hospitals with Emergency Departments as well as 4 freestanding Emergency Departments.

**Bon Secours Hospital Inpatient Mental Health Care** – Across the CHNA service area within hospital settings, there are designated beds for acute psychiatric treatment and stabilization.

**Bon Secours Medical Group** – Four hundred and fifty-six (456) physicians and advanced practice clinicians and associated staff providing primary and specialty medical care to the CHNA service area in one hundred and fifty-two (152) locations.

See Appendix D for a list of healthcare facilities, programs, organizations, and other resources within the community addressing these significant health needs.

# Progress on Health Priorities Identified in the 2019-2021 Community Health Needs Assessment

## Chronic Disease

| Initiative | Impact |
|---|---|
| Objective #1: Support community partners providing high-quality clinical services to the uninsured and underinsured populations through investment and advocacy.<br><br>Activities included: supporting area safety net clinics to enhance chronic disease management services, wellness services, and increase patient coordination, and ensure uninsured patients were connected to medical homes. | Provided over $2.1 million through community benefit investments to community partners serving the uninsured and underinsured populations. This enabled safety net providers to ensure uninsured patients were connected to appropriate and ongoing care, reduced unnecessary readmissions, and enhance the continuum of care services available to the most vulnerable patients in our communities. |
| Objective #2: Provide direct health services to the uninsured through community health programs, medical group practices, and inpatient and outpatient services.<br><br>Activities included: caring for thousands of uninsured patients through our Care-A-Van mobile health program, IVNA program, and EWL program | Provided over $10.5 million in primary care services to the uninsured through nearly 40,000 patient visits and administration of over 50,000 flu shots and childhood immunizations. These services ensured timely access to care for patients, prevented unnecessary hospitalizations, and led to the development of two new fixed locations for our primary care and prevention work – one in the Manchester community and one in the East End community – both in Richmond City. |

# Behavioral Health

| Initiative | Impact |
|---|---|
| Objective #1: Support regional community partners working to increase quality behavioral health services through investment and advocacy.<br><br>Activities included: partnering with area non-profits who provided comprehensive behavioral health services to uninsured patients, advocating for increased substance abuse and alcohol and drug abuse programs, supporting homeless individuals and families, and increasing school partnerships | Provided over $1.4 million to community partners through community benefit investments working to improve behavioral health services. These investments led to more equitable access to behavioral health services, expanded the capacity of the safety net, and worked to ensure that all individuals and families experiencing homelessness had access to stable housing. |
| Objective #2: Enhance the scope and quality of behavioral health services available to the community through traditional healthcare models.<br><br>Activities included: increasing asing depression screening, follow-up, and treatment, increasing non-opiate treatment options, launching new services through our emergency department and exploring new outpatient service options | Provided nearly $7.5 million in direct services to the victims of violence through the Violence Response Team and incorporated new strategies across our CHNA service area. The increased awareness and investment have lead to new strategies across our medical groups primary care footprint as well as new behavioral health strategies for patients presenting to the emergency departments or needing outpatient treatment. |

## Social Determinants of Health

| Initiative | Impact |
|---|---|
| Objective #1: Collaborate with and support community partners working to address social, economic, and environmental factors that influence health through investment and advocacy.<br><br>Activities included: building affordable housing units that offset displacement, expanding homeownership opportunities, closing the education gap, supporting early childhood education, enhancing the built environment, and promoting place-making, supporting living-wage job initiatives, and advocating for greater food access and education | Provided nearly $5 million to community partners through community benefit investments working to address economic equity and educational achievement gaps. These investments and strategic partnerships have increased the housing stock, provided low-income renters with affordable units, put children on a path to success, enhanced and revitalized neighborhoods, and improved access to healthy and affordable foods. |
| Objective #2: Increase screenings and coordination of resources to support individuals with needs related to the social determinants of health.<br><br>Activities Included: Hiring our first Community Health Worker, implementing meaningful social determinants screenings, and launching a new platform that will allow us to have closed loop referrals. | Screened nearly 800 Care-A-Van patients through social determinants of health screening tool and connected them to area resources. Launched Unite VA social needs referral platform to connect patients to resources. |

## Stress and Trauma

| Initiative | Impact |
|---|---|
| Objective #1: Support community partners who are collaborating to promote safer, supportive communities through investments and advocacy.<br><br>Activities included: supported comprehensive case management services, programs caring for victims, survivors, and at-risk youth of domestic and sexual violence, and ensured communities have thriving trauma-informed community networks. | Provided nearly $2.5 million to community partners through community benefit investments working to promote safer, supportive communities. These investments worked to address the impacts of trauma and adverse childhood experiences, and expanded cross-sector education, and awareness towards reducing the rate of domestic abuse and child abuse and neglect. |
| Objective #2: Enhance programs that provide direct services to individuals and families who have experienced stress and trauma.<br><br>Activities included: Expanding the forensic nursing program to include violence response intervention advocates, and increased counseling services. | Provided over 9000 patient visits through Violence Response Team programs to individuals and families who have experienced stress and trauma. These services ensured that all victims of violence, abuse, and stress had access to high-quality, timely, forensic nurses and advocates through our violence response team |

# Appendix A

Full Copy of the CHNA Community Survey (in English)

We believe that the true health of a community is defined by living conditions and economic and social opportunities. Where you live, work, play and serve has a direct impact on your health. As a part of our continued learning, we are conducting a Community Health Needs Assessment for our Greater Richmond and South Richmond Regions. As part of this engagement, we are listening and learning from a variety of people, including community residents, leaders and policy makers. We will be following up with virtual and in person community engagement events to dig deeper into identified community needs and look forward to your participation.

We are asking you to provide your opinions on health and social needs facing your community to inform the development of an improvement strategy so that Bon Secours can best support the community. This survey will be shared with the public, but no information collected from this survey will be used to identify you. We ask that all survey participants be 18 years or older. If you have any questions regarding this survey, please contact Madelyn Eubanks at Madelyn_Eubanks@bshsi.org.

On behalf of the Bon Secours Mercy Health, we thank you in advance for assisting in this effort.

1. Please choose the TOP 5 health issues you think should be addressed in your community:

- [ ] Alcohol Abuse
- [ ] Alzheimer's/Dementia
- [ ] Asthma
- [ ] Chronic Diseases (i.e. Obesity, Diabetes, Heart Disease, Stroke, Cancer, COPD)
- [ ] Child Abuse/Neglect
- [ ] Dental Health
- [ ] Domestic Abuse
- [ ] Infant & Maternal Mortality
- [ ] Mental Health & Suicide
- [ ] Substance/Drug Abuse
- [ ] Sexually transmitted infections including HIV/AIDS
- [ ] Teen Pregnancy
- [ ] Unintentional Injuries

Other (please specify)

2. In your opinion, please select the TOP 5 health issues that have become more apparent due to the COVID-19 pandemic:

- [ ] Alcohol Abuse
- [ ] Alzheimer's/Dementia
- [ ] Asthma
- [ ] Chronic Diseases (i.e. Obesity, Diabetes, Heart Disease, Stroke, Cancer, COPD)
- [ ] Child Abuse/Neglect
- [ ] Dental Health
- [ ] Domestic Abuse
- [ ] Infant & Maternal Mortality
- [ ] Mental Health & Suicide
- [ ] Substance/Drug Abuse
- [ ] Sexually transmitted infections including HIV/AIDS
- [ ] Teen Pregnancy
- [ ] Unintentional Injuries

Other (please specify)

### 3. Please choose the TOP 5 causes of poor health in your community:

- [ ] Insufficient access to healthcare services
- [ ] Insufficient access to healthy & affordable food
- [ ] Insufficient access to Social Services
- [ ] Insufficient availability of jobs with fair wages
- [ ] Insufficient community voice
- [ ] Insufficient education/school system
- [ ] Insufficient health education
- [ ] Insufficient health services for persons with disabilities
- [ ] Insufficient health services for senior citizens
- [ ] Insufficient housing opportunities
- [ ] Insufficient natural environment (i.e. air and water quality)
- [ ] Insufficient outdoor spaces (i.e. parks)
- [ ] Insufficient physical activity opportunities
- [ ] Insufficient recognition and confrontation of institutional racism
- [ ] Insufficient resources for homeless individuals
- [ ] Insufficient resources for individuals in poverty
- [ ] Insufficient transportation options

Other health issues/causes not listed above:

### 4. On a scale of 1 - 6 (1 having little impact, and 6 having significant impact), how do each of the underlying causes below impact the health needs of the community?

| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Community violence & crime (i.e. assault, gun violence, rape, drugs, prostitution, theft) | ○ | ○ | ○ | ○ | ○ | ○ |
| COVID-19 Pandemic | ○ | ○ | ○ | ○ | ○ | ○ |
| Language barriers = inequitable access to healthcare services | ○ | ○ | ○ | ○ | ○ | ○ |
| LGBTQ+ equality | ○ | ○ | ○ | ○ | ○ | ○ |
| Institutional Racism | ○ | ○ | ○ | ○ | ○ | ○ |
| Stress/trauma | ○ | ○ | ○ | ○ | ○ | ○ |

### 5. Within the past year, where did you go most often for health care?

- ○ Hospital/Emergency Room
- ○ Private Doctor's Office
- ○ Free Clinic
- ○ Urgent Care Center (i.e. Patient First)
- ○ Local Health Department
- ○ Telehealth or Virtual Health
- ○ I did not receive health care services in the past 12 months.

Other (please specify):

### 6. What is the PRIMARY source of your health care coverage? Is it …

- [ ] A plan purchased through an employer or union (includes plans purchased through another person's employer)
- [ ] A plan that you or another family member buys on your own
- [ ] Medicare
- [ ] Medicaid or other state program
- [ ] TRICARE (formerly CHAMPUS), VA, or Military
- [ ] Alaska Native, Indian Health Service, Tribal Health Services
- [ ] Some other source
- [ ] None (no coverage)
- [ ] Don't know/Not sure

### 7. Please provide the zip code where you primarily work, play or serve:

### 8. What county/city do you currently reside/live in?

Other (please specify):

### 9. Please choose what best describes you:

- [ ] Male
- [ ] Female
- [ ] Transgender Female /Trans woman
- [ ] Transgender Male/ Trans man
- [ ] Gender Variant/Non-Conforming/Non-Binary
- [ ] Prefer not to answer

Prefer to self-describe:

### 10. Please choose your age group:

- ◯ 18-24 years old
- ◯ 25-34 years old
- ◯ 35-44 years old
- ◯ 45-54 years old
- ◯ 55-64 years old
- ◯ 65- 74 years old
- ◯ 75 years or older

11. Please choose the ethnicity below that best represents you:

- ◯ Hispanic/Latino
- ◯ Not Hispanic/Latino
- ◯ Unavailable/Unknown
- ◯ Prefer not to answer

12. Please choose the race below that best represents you (select as many as apply):

- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ White (non-Hispanic)
- ☐ Two or more races
- ☐ Unavailable/Unknown
- ☐ Prefer not to answer
- ☐ Other (please specify):

13. What is your highest level of education completed?

- ◯ Less than High School diploma
- ◯ High School diploma or GED
- ◯ Some college
- ◯ Associates degree, Technical degree, or Trade school
- ◯ Bachelor's Degree
- ◯ Graduate Degree or Higher
- ◯ Prefer not to answer

14. What is your average combined household income?

- ◯ $0 - $24,999
- ◯ $25,000 - $49,999
- ◯ $50,000 - $74,999
- ◯ $75,000 - $99,999
- ◯ $100,000 - $124,999
- ◯ $125,000 – $149,999
- ◯ $150,000 – $174,999
- ◯ $175,000 - $199,999
- ◯ $200,000 and higher
- ◯ Prefer not to answer

Thank you so much for taking the time to complete the survey. If you are interested in participating in a focus group, please provide your contact information below. You will be entered to win a prize valued at $100!

15. Following this survey, we will be holding virtual and in person focus groups to discuss results and dig deeper into identified community needs. If you are willing to participate, please complete the below form. You will be entered to win a prize valued at $100!

| | |
|---|---|
| Name | |
| Email Address | |
| Phone Number | |

# Appendix B

Variance in the Spanish Survey Results

# Variance in the Spanish Survey Results

Most of the results of the Spanish speaking survey respondents were statistically similar to the results of the English-speaking respondents.

One variance was about the significance of Dental Health as a top Health Issue facing their community.

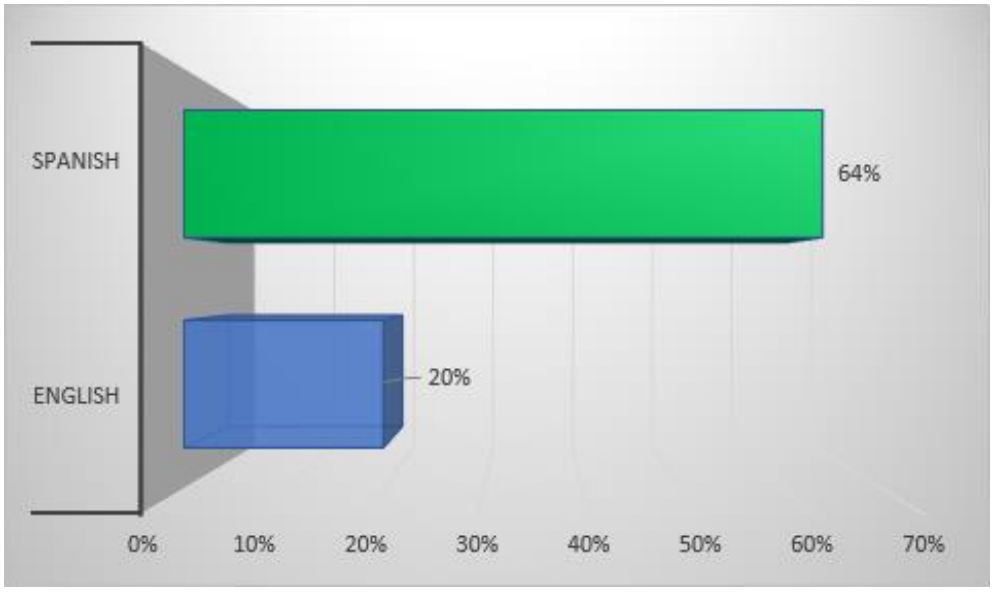



Figure 3. Percentage of Spanish respondents and English respondents identifying Dental Health as a “Top 5” health issue facing their community.

Spanish speaking respondents viewed dental health as a more significant community health issue than did English speakers.

# Appendix C

Additional Information from Community Conversation Town Halls

# Additional Information from Community Conversation Town Halls


Figure 4. Image from an In-Person Community Conversation, March 2022.

Over 75 individuals in total attended the five (5) community conversations offered across the CHNA Service Area.

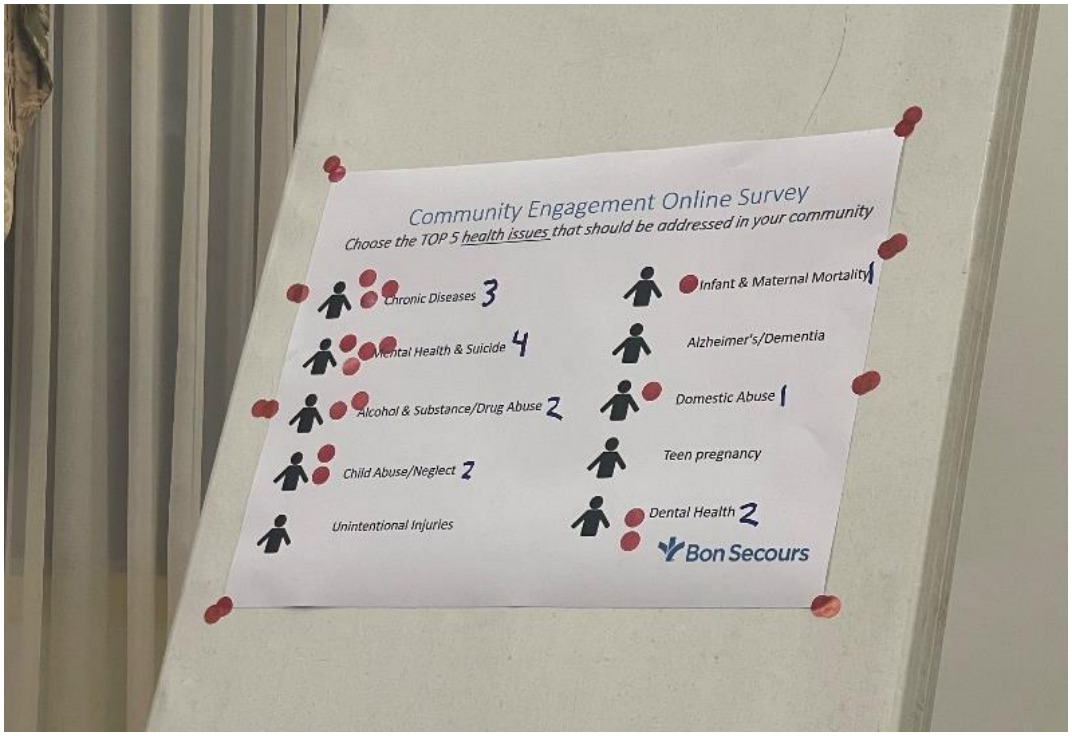



Figure 5. Image from a Community Conversation Need Prioritization.

This image features a representative example of an interactive activity in which attendees prioritized health issues that they thought should be addressed.

At all five (5) Community Conversations, Mental Health & Suicide, Chronic Diseases, and various forms of Abuse (Alcohol and Substance Abuse/Drug Abuse, Child Abuse/Neglect, Domestic Abuse) were consistently referenced. Dental Health and Maternal/Infant Mortality were referenced as well, in addition to extended dialogue about community violence and underlying root causes of health issues.

# Appendix D

Resources Available to Meet Identified Needs

# Resources Available to Meet Identified Needs

Bon Secours is committed to addressing the prioritized needs identified in our 2022 Community Health Needs Assessment process and to making a measurable impact on community health across Bon Secours Richmond. True impact comes when strategic partnerships are formed, and when collaborations are built that can achieve greater results collectively. Bon Secours is committed to forming relationships to build a healthier community and to building capacity in other nonprofits through investments, volunteerism, and by breaking down barriers to coordinated patient care. The list below provides a representative but not exhaustive list of existing resources that collaborate with Bon Secours or support Bon Secours patients. While each prioritized need below is currently being addressed to some capacity, there remains an inadequacy of services to meet the needs of the community completely.

## Prioritized Social Determinants of Health Needs

**Social and Economic Disparity**

- Area Congregations Together in Service (ACTS): ACTS provides funds, support and other resources to those living in the Greater Richmond area who are at risk of losing their housing, utilities or transportation. Those served by ACTS do not qualify through government prevention assistance due to eligibility requirements and often fall through the cracks.
- Armstrong Priorities Freshman Academy - Armstrong Priorities Freshman Academy will identify entering ninth grade students at Armstrong High School below grade level and will provide instruction in math and English to bring them up to grade level by the tenth grade.
- Anna Julia Cooper School - Faith-based middle school in Richmond's East End, serving youth with limited resources.
- Better Housing Coalition: The Better Housing Coalition works to ensure that every citizen in the Richmond region, regardless of their economic status, has good choices in where they live, and opportunities to reach their fullest potential.
- Bon Secours Financial Assistance - The Bon Secours Financial Assistance Program helps uninsured patients who do not qualify for government-sponsored health insurance and cannot afford to pay for their medical care. Insured patients may also qualify for assistance, based on family income, family size, and medical needs. To offset the cost of health care, no uninsured Bon Secours patient will be billed more than the average insurance reimbursement received from our insured patients. This reflects our ongoing commitment to the communities we serve and our Mission to bring Good Help to Those in Need®.
- Bon Secours Community Benefit Investments – Provides over $3.5 million through community benefit investments to community partners serving the uninsured and underinsured populations annually.

- Children's Home Society of Virginia: Children's Home Society of Virginia is a full-service, private, nonprofit 501(c)(3), non-sectarian licensed child-placing agency, and one of Virginia's oldest adoption agencies.
- Church Hill Activities & Tutoring (CHAT) - CHAT serves the youth of the East End of Richmond and equips them with the heart, head and hands to make transformative life decisions.
- Coalition for Smart Transit - The RVA Coalition for Smart Transit was organized to be an independent and city-wide advocacy and education organization on mass transit issues. This organization believes that how we get around our city is everyone's business, and everyone should have a voice.
- Commonwealth Catholic Charities - Provides quality compassionate human services to all people, especially the most vulnerable, regardless of faith.
- Commonwealth Parenting - Resource for parenting education.
- Cristo Rey Richmond High School: Cristo Rey Richmond is a Catholic learning community that educates young people of limited economic means to become men and women of faith, purpose and service. Through a rigorous college preparatory curriculum, integrated with relevant work study experience, students graduate ready to succeed in college and in life.
- Enrichmond Foundation: Serves the people, parks, and public space of the City of Richmond. Since 1990, Enrichmond has enacted their mission by supporting The Department of Parks, Recreation, and Community Facilities through citizen involvement, education, and fundraising.
- Excel VCU - Literacy efforts for children; Partnership has an emphasis on Richmond's East End.
- Faison School for Autism - School addressing the unique learning needs of children diagnosed with autism.
- FRIENDS Association for Children- Provides quality childcare and development in an underserved part of Richmond; Partnership has an emphasis on Richmond's East End.
- GRASP - Our goal is to ensure that every student has an equal opportunity for continuing education after high school, regardless of financial or social circumstances.
- GRTC (Greater Richmond Transit Authority - Serves the City of Richmond, Chesterfield County and Henrico County. Newly redesigned bus routes with the launch of PULSE BRT.
- GRTC CARE - Provides curb-to-curb public transportation to disabled individuals who may not be reasonably able to use the GRTC fixed route bus.
- The Hanover Center for Trades and Technology - Strives to create effective partnerships among students, parents, staff, and the community that enables students to become workplace ready and develop into life-long learners prepared to succeed in a competitive and ever-changing world.

- Henrico County Public Schools Career & Technical Education - Students who complete CTE programs are prepared for successful transition into postsecondary education and work. Opportunities are available for students to earn college credit through selected courses and to prepare for licensure and/or industry certifications related to their programs of study.
- Higher Achievement: By leveraging the power of communities, Higher Achievement provides a rigorous year-round learning environment, caring role models, and a culture of high expectations, resulting in college-bound scholars with the character, confidence, and skills to succeed.
- Homeward: Planning and coordinating organization for homeless services in the greater Richmond region. Homeward's mission is to prevent, reduce, and end homelessness by facilitating creative solutions through the collaboration, coordination, and cooperation of regional resources and services.
- Housing Families First: Provides families experiencing homelessness with the tools to achieve housing stability. The goal is not only to assist families in finding permanent housing, but also to ensure that each family has access to the supportive services necessary to sustain housing in the long run.
- Neighborhood Resource Center (NRC): NRC was founded to build relationships, advocate for positive change, share resources, and develop skills to enhance residents' lives through programs and partnerships in the Greater Fulton area of Richmond.
- NextUp RVA: NextUp provides a free, coordinated system of after-school programs for Richmond middle schools.
- Northern Neck Family YMCA: Youth development and physical activity programming
- Maggie Walker Community Land Trust: The Maggie Walker CLT seeks to develop and maintain permanently affordable homeownership opportunities for low and moderate income households.
- Partnership for Non-Profit Excellence - Develops the capacity of nonprofits through education, information sharing and civic engagement.
- Partnership for Smarter Growth - An organization focused on educating and engaging the communities in the Richmond region to work together to improve our quality of life by guiding where and how we grow, including transportation services.
- 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.
- project:HOMES: Improving the safety, accessibility & energy efficiency of existing houses and building high quality affordable housing throughout Central Virginia. project:HOMES serves low-income individuals and families by making critical home-safety repairs, accessibility modifications and implementing energy conservation measures in their homes.
- Shepherd's Center of Chesterfield - An interfaith ministry of senior volunteering to improve the lives of other seniors, including medical transportation services.
- Reach Out and Read - Preparing America's youngest children to succeed in school by partnering with doctors to prescribe books and encourage families to reach together.

- Richmond Hill, Inc- Armstrong Leadership Program: Richmond Hill is an ecumenical Christian fellowship and residential community who serve as stewards of an urban retreat center within the setting of a historic monastery. The Armstrong Leadership Program provides students with leadership training, personal development, mentoring, service projects, career and college preparation, weekend retreats, and cultural enrichment.
- Richmond Metropolitan Habitat for Humanity (RMHFH): RMHFH is a non-profit, non-proselytizing Christian housing ministry committed to making affordable and safe housing a reality for low-income families
- Richmond Metropolitan Transportation Authority - The mission of the RMTA is to build and operate a variety of public facilities and offer public services, especially transportation related, within the Richmond metropolitan area, each of which is operated and financed primarily by user fees.
- Richmond Opportunities, Inc.: Richmond Opportunities, Inc. (ROI) supports community transformation by creating pathways to self-sufficiency for people residing in Richmond's public housing communities.
- RideFinders - RideFinders offers real-time ride matching with interested commuters in your area that share similar work locations and hours.
- Robinson Theater Community Arts Center (RTCAC): RTCAC is a multi-purpose facility that exists to inspire, encourage, and restore health community life to the residents of the North Church Hill area of Richmond.
- RVA Rapid Transit - RVA Rapid Transit's mission is to connect all people of the Richmond region as we educate, organize, and advocate for the design, construction, and operation of a first-class metro-area rapid transit system.
- Supervisors - For the counties represented in the Bon Secours Richmond CHNA Service Area.
- 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.
- Science Museum of Virginia - Promotes Science, Technology, Engineering, Math and Healthcare (STEMH) career interests within the region.
- School Superintendents - For Public Schools
- Side by Side VA, Inc: Side by Side is dedicated to creating supportive communities where Virginia's LGBTQ+ youth can define themselves, belong, and flourish.
- SwimRVA: SwimRVA works to build social bridges through aquatics that cross physical, racial, and economic barriers. SwimRVA serves as a catalyst for water safety, health and fitness, sports tourism, competitive aquatics, and possibility, for all Richmonders.
- Virginia Community Development Corporation (VCDC): VCDC serves as a leader in the development of innovative affordable housing and revitalization of Virginia's communities by acting as a catalyst for creative and profitable private sector investments and by empowering non-profit and other providers throughout the Commonwealth.

- Virginia Home for Boys and Girls: Virginia Home for Boys and Girls (VHBG) is a nonprofit organization that has been serving children in crisis since 1846. VHBG works to help children across Virginia with emotional and behavioral health concerns by facilitating the healing process using a relationship-based, cognitive behavioral approach.
- Virginia LISC: Virginia LISC works with community organizations to revitalize under-served Richmond-area neighborhoods, leading to physical improvements, safer streets, increased property values and highly engaged residents. Virginia LISC supports community development organizations with grants, loans and expertise to help them construct businesses, community centers and affordable homes in low and moderate income neighborhoods.
- Virginia Literacy Foundation - Provides funding and technical support to private, volunteer literacy organizations throughout Virginia via challenge grants, training and direct consultation.
- Virginia Supportive Housing (VSH): VSH seeks to end homelessness by providing permanent housing and supportive services. Founded in 1988, VSH was the first non-profit organization in Virginia to develop and provide permanent supportive housing for homeless single adults.
- United Way of Greater Richmond & Petersburg - Through coalition building, regional leadership, program investments, and fundraising, United Way mobilizes the caring power of our community to advance the common good. We focus on the building blocks of a good life, including education.
- YMCA of Greater Richmond - Youth development and physical activity programming.
- YWCA Richmond- YWCA Richmond helps women, children and families in the community of Richmond, Virginia through programs to eliminate racism and empower women.

**Engagement and Inclusion**

Bon Secours Sarah Garland Jones Center – Focused on improving the health and well-being of Richmond's East End, the Sarah Garland Jones Center is a healthy living center that promotes a variety of age appropriate and subject-focused community programming. The East End community is also invited to utilize the kitchen and meeting rooms for community needs.

Partnership for Housing Affordability – Richmond regional housing framework for Chesterfield County, Hanover County, Henrico County, the City of Richmond, and the Town of Ashland. The Partnership enables local officials and community representatives to implement solutions that will increase housing opportunities across the region.

RVA Rapid Transit - Advocacy for frequent and far-reaching transit in the Richmond region.

Sacred Heart Center - Sacred Heart Center offers many programs to the Latino community including English as a Second Language, GED Prep in Spanish, Plaza Comunitaria – Spanish Literacy, Citizenship, Pasitos Exitosos: First Steps to Success – a bilingual school-readiness program, College & Career Bound, Cielito Lindo summer camp, Latino Leadership Institute and more.

University of Richmond Bonner Center for Civic Engagement - Volunteering, community-based learning and research focused on community relationships and impacting the Richmond community. University of Richmond is home to one of the largest Bonner Scholars Programs in the country.

Virginia Interfaith Center - Engaging people of faith and goodwill to advocate for economic, racial, and social justice in Virginia's policies and practices through education, prayer and action.

Virginia Poverty Law Center - Virginia Poverty Law Center uses advocacy, education, and litigation to break down systemic barriers that keep low-income Virginians in the cycle of poverty.

Virginia Center for Inclusive Communities - Through workshops, retreats, and customized programs that raise knowledge, motivation, and skills, VCIC develops leaders who work together to achieve success throughout the Commonwealth.

Voices for Virginia's Children – Through championing public policies that improve the lives of Virginia's children, Voices for Virginia's Children identifies unmet needs and threats to child well-being, recommends sound policy solutions, provides objective input to policymakers, and educates and mobilizes leaders and concerned citizens to support policy initiatives.

## Prioritized Social Health Needs

**Violence and Trauma**

- Bon Secours Violence Response Team - This program provides care to patients 24/7 who have been victims of child abuse, sexual assault, domestic violence, elder abuse, human trafficking, and strangulation.
- Bon Secours Hospital Emergency Departments, Freestanding Emergency Departments - Bon Secours Richmond includes 7 acute facility hospitals with Emergency Departments as well as 4 freestanding Emergency Departments.
- Challenge Discovery - Provides bullying prevention and substance abuse counseling; Partnership has an emphasis on Richmond's East End.
- Child Savers - Mental health services for children; Partnership has an emphasis on Richmond's East End.
- Comfort Zone Camp - Comfort Zone Camp is a nonprofit 501(c)3 bereavement camp that transforms the lives of children who have experienced the death of a parent, sibling, or primary caregiver.
- 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.
- Full Circle Grief Center: Provides comprehensive professional bereavement support to children, adults, families, and communities in the Greater Richmond area. Full Circle offers grief counseling groups, consulting services and bereavement educational programs.

- Greater Richmond SCAN: SCAN works to prevent and treat child abuse and neglect throughout the Greater Richmond area by protecting children, promoting positive parenting, strengthening families and creating a community that values and cares for its children.
- Hanover Safe Place - Provides services to victims of sexual or domestic violence and promotes violence prevention.
- The Haven - The Haven Shelter & Services, Inc., provides advocacy and shelter for identified victims of partner abuse and sexual assault as well as provides support services to victims and their families within their service area, which includes Westmoreland, Richmond, Essex, Lancaster and Northumberland Counties.
- Healing Place/CARITAS - Provides substance abuse rehab for homeless men and women.
- Hilliard House/Housing Families First - Assists homeless women and their children to build their capacity to live productively within the community.
- Jails and Juvenile Detention in Chesterfield County, Henrico County, and Richmond City, Northern Neck Regional Jail, Pamunkey Regional Jail, and Federal Correctional Complex in Petersburg – Partnering with the Bon Secours Violence Response Team to promote the best possible outcomes for patients experiencing violence and/or trauma.
- Latinos en Virginia Empowerment Center - Provides education, advocacy, and support to Spanish-speaking individuals affected by violence in Virginia in order to ensure that they can access services that empower them to become happy, healthy, and self-sufficient.
- Multi-disciplinary/Sexual Assault/Domestic Violence Response Taskforces in Charles City County, Chesterfield County, Colonial Heights, Fort Lee/Kenner Army Hospital, Goochland County, Hanover County, Henrico County, Hopewell City, King William County, King & Queen County, Louisa County, New Kent County, Northumberland County, Petersburg County, Powhatan County, Richmond City, Richmond County, & Westmoreland County – Partnering with the Bon Secours Violence Response Team to promote the best possible outcomes for patients experiencing violence and/or trauma.
- Richmond Behavioral Health Authority - Provides services in four major behavioral health areas: Mental Health; Intellectual Disabilities; Substance Use Disorders; and Access, Emergency & Medical Services.
- Safe Harbor - Offers comprehensive services and support for those who are experiencing or have experienced domestic violence, sexual violence, or human trafficking. Working from a trauma-informed and empowerment-focused lens, Safe Harbor seeks to help clients understand and address the impact of trauma and build resilience.
- Stop Child Abuse Now (SCAN) - SCAN's mission is to prevent and treat child abuse and neglect throughout the Greater Richmond area by protecting children, promoting positive parenting, strengthening families and creating a community that values and cares for its children.

- United Methodist Family Services (UMFS) - Offers a network of flexible community-based services. Mentoring, community respite, visitation, community-based clinical support and parent coaching are just a few of the formal and informal offerings to support at-risk families.
- Voices for Children - Statewide, privately funded non-partisan policy research and practices that improve the lives of children.

## Prioritized Clinical Health Needs

**Chronic Disease & Prevention**

- Access Now -Volunteer Specialty network for free clinic patients.
- Bay Aging: A premier provider of programs and services for people of all ages in the Northern Neck Region. Formed in 1978, Bay Aging is diverse in the programs it offers through three major divisions: Community Living, Bay Transit, and Bay Family Housing.
- Bon Secours 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.
- Bon Secours Community Nutrition Services - Improves community health, particularly in vulnerable communities, through nutrition counseling, healthy eating classes, and advocacy for food access.
- Bon Secours Program for Diabetes Health - Addresses the needs of those living with diabetes, utilizing an across the continuum program that provides inpatient diabetes management through a Clinical Nurse Specialist team and ambulatory diabetes education by teams of RNs/RDs embedded within primary care practices.
- Bon Secours Every Woman's Life - This program provides breast and cervical cancer screening and early detection, clinical breast exams, mammograms, pelvic exams, and Pap smears.
- Bon Secours Instructive Visiting Nurse Association (IVNA) - IVNA is an Immunization and Wellness Program that provides over 12,000 flu shots per year, in addition to other immunizations and wellness services, to the Greater Richmond community
- Bon Secours Medical Group - Four hundred and fifty-six (456) physicians and advanced practice clinicians and associated staff providing primary and specialty medical care to the CHNA service area in one hundred and fifty-two (152) locations.
- Bon Secours Prenatal Education – Team of Prenatal Educators providing low or no-cost community education about childbirth, breastfeeding, postpartum care, and newborn care and safety, and more.
- Bon Secours Saint Francis Family Medicine Clinic – Patient Centered Medical Home that offers complete primary care for newborns, children, and adults, as well as comprehensive obstetrics and gynecological services. This clinic provides care to many patients referred from the Bon Secours Care-A-Van.

- 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 and community resource information to an underserved community.
- Eastern Virginia Care Transitions Partnerships: Coordinating and delivering quality care and prevention services to older adults living in the Northern Neck Region.
- Free Clinics (6) and FQHCs (3) - CrossOver Health Ministry, Health Brigade, Goochland Cares, Hanover Interfaith Clinics, Free Clinic of Powhatan, Northern Neck - Middlesex Free Health Clinic. Capital Area Health Network, Daily Planet, and Central Virginia Health Services. Provide primary care services to the uninsured.
- Greater Richmond Fit4Kids: Non-profit organization dedicated to improving children's health and reducing the prevalence of childhood obesity in the Richmond region. Greater Richmond Fit4Kids offers innovative programs that promote physical activity and healthy eating in schools, community organizations, and beyond.
- 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.
- Medical Society of Virginia - Physician led organization providing medication assistance programs for uninsured patients.
- Metropolitan Richmond Sports Backers: Seek to inspire people from all corners of the Greater Richmond community to live actively.
- Middle Peninsula/Northern Neck Community Services Board: Serves the ten counties of the Middle Peninsula and Northern Neck providing services related to early intervention, intellectual disabilities, mental health, prevention and substance use.
- National Alliance on Mental Illness of Virginia - The National Alliance on Mental Illness of Virginia (NAMI Virginia) was created in 1984 to provide support, education, and advocacy for individuals and families in Virginia affected by mental illness. Along with our community-based affiliates, we provide education, support, information, training, and resources, and engage in systems change policy advocacy.
- Regional Health Districts: Chesterfield County Health Department, Chickahominy Health District, Goochland County Health Department, Henrico County Health Department, Richmond City Health District, Three Rivers Health District, Crater Health District - Support of programs addressing the needs of vulnerable populations – includes prevention and access.
- 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.
- Shalom Farms - Grow healthy produce distributed to underserved communities.

  Provide learning opportunities for children and adults, on growing food, overcoming barriers to cooking and eating nutritionally.
- SOAR365 (formerly Greater Richmond ARC): In partnership with families, SOAR365 creates life-fulfilling opportunities for individuals with disabilities.

- The Faces of Hope of Virginia, Inc: Strive to educate children and their families about healthy options and encourage personal empowerment to make significant strides toward preventing and fighting childhood and adult obesity.
- 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.
- Virginia Commonwealth University – Chronic disease education and treatment.
- Virginia Healthcare Foundation - Promotes and funds local public-private partnerships that increase access to primary health care services for medically underserved and uninsured Virginians.

**Mental Health**

- Bon Secours Behavioral Health Center at Richmond Community Hospital – Opening at the end of 2022 in response to previous CHNA feedback, a two story, 25,000 square foot behavioral health facility will open. This facility will contain a behavioral health partial hospitalization program (PHP), programming from the Bon Secours Mobile Assessment Response Team (BSMART) and a behavioral health tele-consult call center.
- Bon Secours Richmond Cullather Brain Tumor Quality of Life Center - Provides supports and education to patients with brain tumors and their families. Serves the community at large.
- Bon Secours Hospital Emergency Departments, Freestanding Emergency Departments – Bon Secours Richmond includes 7 acute facility hospitals with Emergency Departments as well as 4 freestanding Emergency Departments.
- Bon Secours Hospital Inpatient Mental Health Care – Across the CHNA service area within hospital settings, there are designated beds for acute psychiatric treatment and stabilization.
- Bon Secours Medical Group – Four hundred and fifty-six (456) physicians and advanced practice clinicians and associated staff providing primary and specialty medical care to the CHNA service area. The Medical Group has fifty-three (53) primary care offices and ninety-nine (99) specialty offices, for a total of one hundred and fifty-two (152) locations.
- Challenge Discovery Projects - Challenge Discovery Projects provides direct services to over 1,600 at-risk youth in Richmond. Committed to improving the emotional health and well-being of children and their families through programs that promote self-worth and positive, healthy relationships. Partnership has an emphasis on Richmond's East End.
- Child Savers – Provide a fundamental commitment to the mental well-being of children and the positive bond between adult and child. ChildSavers supports this with clinical treatment and education and training services. Partnership has an emphasis on Richmond's East End.
- Comfort Zone Camp - Comfort Zone Camp is a nonprofit 501(c)3 bereavement camp that transforms the lives of children who have experienced the death of a parent, sibling, or primary caregiver.

- 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.
- Hanover Safe Place - Provides services to victims of sexual or domestic violence and promotes violence prevention.
- Healing Place/CARITAS - Provides substance abuse rehab for homeless men and women.
- Hilliard House/Housing Families First - Assists homeless women and their children to build their capacity to live productively within the community.
- Middle Peninsula/Northern Neck Community Services Board: Serves the ten counties of the Middle Peninsula and Northern Neck providing services related to early intervention, intellectual disabilities, mental health, prevention and substance use.
- Virginia Supportive Housing - Provides permanent housing to the homeless.
- Voices for Children - Statewide, privately funded non-partisan policy research and practices that improve the lives of children.
- Real Life - REAL LIFE serves individuals who have been impacted by incarceration, homelessness, or substance use disorder by giving them an opportunity to overcome their personal and community barriers that hinder their pathway to a Thriving Life.
- Richmond Behavioral Health Authority - Provides services in four major behavioral health areas: Mental Health; Intellectual Disabilities; Substance Use Disorders; and Access, Emergency & Medical Services.
- Rx Partnership: Rx Partnership increases medication access for vulnerable Virginians and strengthens the health safety net.
- Safe Harbor - Offers comprehensive services and support for those who are experiencing or have experienced domestic violence, sexual violence, or human trafficking. Working from a trauma-informed and empowerment-focused lens, Safe Harbor seeks to help clients understand and address the impact of trauma and build resilience.
- United Methodist Family Services (UMFS) - Offers a network of flexible community-based services. Mentoring, community respite, visitation, community-based clinical support and parent coaching are just a few of the formal and informal offerings to support at-risk families.

## Needs Not Prioritized

The following needs are important to the community but were not directly prioritized in this CHNA due to limited resources and/or existing partners working to address these needs:

1. Dental Health: CrossOver Healthcare Ministry's dental program provides preventative cleaning, patient education, and screenings. Additionally, they provide fillings, extractions, and dentures all at low or no cost to uninsured patients throughout the region. The Capital Area Health Network and the Daily Planet are two Federally Qualified Health Centers that provide comprehensive dental care to uninsured patients on a sliding fee scale. Virginia Commonwealth University also has a dental care program for low-income uninsured and underinsured individuals.
2. Sexually transmitted infections including HIV/AIDS: Local and state health departments provide STI/HIV prevention programs, Pre-Exposure Prophylaxis for HIV (PrEP) and ongoing case management services. In addition to the health departments, Virginia Commonwealth University, Richmond Behavioral Health Authority, Health Brigade, the Minority Health Consortium, and the Daily Planet all provide HIV/AIDS services throughout the region.
3. Infant & Maternal mortality: Many local health departments provide reproductive health and family planning services as well as a group care program called Centering Pregnancy. The Health departments also house the WIC (Women, Infants, and Children) supplemental food program. Urban Baby Beginnings is a non-profit that provides several resources through their Community Cares program as well as birthing support, early childhood development, maternal mental health, and workforce development services.
4. Alzheimer's/Dementia: There are several resources available through assisted living facilities across the region. Additionally, the Rick Sharp Alzheimer's Foundation and the Greater Richmond Chapter of the Alzheimer's Association are two organizations working to educate individuals and families as well as connect them to resources in the community. The Memory Center is adjacent to Bon Secours St. Francis Medical Center and provides comprehensive care to those living with Alzheimer's and dementia.

# Appendix E

Key Informant Interview Script/Questions

# Key Informant Interview Script/Questions

2022 CHNA Sample Key Informant Interview Script

INTERVIEWER NAME: _____

RECORDER NAME: _____

DATE: _____

INTERVIEWEE NAME: _____

ORGANIZATION: _____

TITLE: _____

Hello, my name is _____. I am a representative of Bon Secours Richmond and am working with the Community Benefit team on the 2022 Community Health Needs Assessment. Also, with me is _____from _____.

Thank you for taking your time to meet with us and agreeing to participate in the Community Health Needs Assessment. As part of the assessment we are interviewing Community Leaders and Representatives as a way of understanding and identifying the priority health needs of our entire Bon Secours Richmond service area, which includes the Northern Neck, Petersburg, and Southern Virginia . We plan for this conversation to take about 45-60 minutes. We have a set of questions we will be asking. Both _____and I will be recording your selections and comments, so that the information may be combined with the responses of the other interview participants. Please note: As required by the IRS Community Health Needs Assessment (CHNA) guidelines, the CHNA which will be made publicly available and posted on the hospital's website. We will be acknowledging the participation of community leaders and representatives by industry grouping. Your responses will be summarized and aggregated with others and your name will not be linked to specific responses or comments.

Are you comfortable with what I have said so far, or do you have additional questions?

- What part of your organization's mission are you the most passionate about? How does that play out in your daily work?
- What do you think are the biggest community and/or health issues facing the Richmond community (Greater Richmond, Petersburg/Southern Virginia, Northern Neck)? (Please feel free to think broadly here!)
- Based on your professional experience and expertise, what do you think are some of the root causes of these issues? (If they ask for an example, suggest that they look under the surface for environmental or systemic issues that have challenged the community)
- What other issues are facing your clients (instead, what about people you serve)? Would they identify the same root causes?

- What's already being  done to address this issue?  What seems to be working?  Where has there been progress?
- How is it helping to foster an environment of justice? How does the work present in an environment of justice?
- Thinking with a 3 year time frame (through 2025), what actionable, measurable steps do you think would help to address or chip away at the issues or root causes?
  - Could you suggest a doable/achievable in the short or medium term implementation idea? Can you suggest one doable action?
  - Could you suggest an "if I had a magic wand" implementation idea?
- Are there innovative individuals or organizations working in these implementation areas already with whom Bon Secours could partner? Would you be willing to connect us to them? Can you name individuals or organizations who are making progress in this area?
- Is there anything we should be discussing today that we haven't discussed?
- Do you have any questions for us before we conclude this interview?
- How might you want to be involved with any sort of action plan?

Thank you for your time. We appreciate your participation and willingness to share your and your constituents' concerns. The complete Community Health Needs Assessment is anticipated to be posted on the Bon Secours Richmond website in early 2023. Thank you again for your participation.

# Appendix F

Information and data sources

# Information and data sources

## Public health departments

| Public Health Departments | Date of Data/ Information |
|---|---|
| Health Resources & Services Administration (HRSA) (Area Health Resource File, via the Health Data Warehouse), Health Resources & Services Administration (HRSA) (American Medical Association Primary Care Physician Data), Number of physicians in primary care (general practice, internal medicine, obstetrics and gynecology, or pediatrics) per 100,000 residents. Includes hospital residents. Excludes federal physicians and physicians age 75 or older. | 2008-2018 |
| PLACES, Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data), Percent of resident adults aged 18 to 64 years who report having no current health insurance coverage. | 2019 |
| American Community Survey (Table B01001), Percent of residents within each major racial/ethnic demographic group. | 2020 |
| **Median household income INC in Bon Secours Mercy Richmond, VA market**<br>Income in the past 12 months.<br>Data source: American Community Survey (Table B19013) | 2019 |
| **High school graduation rate EDB in Bon Secours Mercy Richmond, VA market % of residents**<br>Residents 25 or older with at least a high school degree: including GED and any higher education<br>Data source: American Community Survey (Table B15002) | 2019 |

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| **Population POP in Bon Secours Mercy Richmond, VA market residents**<br><br>Average population over the time period.<br><br>Data source: American Community Survey (ACS: Table B01001; Decennial Census: Table P012) | **2016-2020** |
| **Life expectancy LEX in Bon Secours Mercy Richmond, VA market**<br><br>Years<br><br>Life expectancy at birth, or at the start of the specified age bracket. This is equal to the average age at death of all people born in this place, or all people who have lived to the start of the specified age bracket.<br><br>Data sources: Center for Urban Population Health (WI data; estimates for 2014-2018, derived from death counts by age and ZIP code obtained from the Wisconsin Department of Health and Services, Vital Records, and population counts from the 2010 Census.), National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project (USALEEP) | 2010-2015 |
| **Cancer mortality MYZ in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 100,000<br><br>Deaths per 100,000 residents due to cancer (ICD-10 codes C00-C97). Cancer generally gets you if nothing else does, so higher values may merely indicate better overall health. This indicator is not a good measure of the burden of cancer in a community, because it is complicated by other causes of death (especially in the elderly); instead, use CCR (cancer diagnoses).<br><br>Data sources: National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) | 2015-2019 |
| **Poverty rate POV in Bon Secours Mercy Richmond, VA market**<br><br>% of residents<br><br>Percent of residents in families that are in poverty (below the Federal Poverty Level).<br><br>Data source: American Community Survey (Table B17001) | 2019 |

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| **Coronary heart disease mortality MYG in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 100,000<br><br>Deaths per 100,000 residents related to coronary heart disease (ICD-10 codes I20-I25). Specifically, ischemic heart diseases (acute myocardial infarction, other acute ischemic heart diseases, and other forms of chronic ischemic heart disease).<br><br>Data sources: National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) | **2015-2019** |
| **Chronic obstructive pulmonary disease (COPD) LNG in Bon Secours Mercy Richmond, VA market**<br><br>% of adults<br><br>Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis.<br><br>Data sources: PLACES, Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data) | 2019 |
| **Unintentional injury mortality MYV in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 100,000<br><br>Deaths per 100,000 residents with an underlying cause of unintentional injury, excluding motor vehicle injuries (ICD-10 codes *U01-*U02, V01-X59, Y10-36, Y85-86, Y87.1, Y89).<br><br>Data source: National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov) | 2015-2019 |

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| **Drug overdose mortality MYJ in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 100,000<br><br>Deaths per 100,000 residents due to drug poisoning (such as overdose), whether accidental or intentional. The increase during the 2010s is largely due to the opioid overdose epidemic, but other drugs are also included here. Age-adjusted.<br><br>Data sources: National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) | **2016-2020** |
| **Stroke mortality MYX in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 100,000<br><br>Deaths per 100,000 residents due to stroke (ICD-10 codes I60-I69).<br><br>Data sources: National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) | 2015-2019 |
| **Suicide mortality SUI in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 100,000<br><br>Deaths per 100,000 residents due to suicide (ICD-10 codes *U03, X60-X84, Y87.0). In the United States, decisions about whether deaths are listed as suicides on death certificates are usually made by a coroner or medical examiner. The definition of suicide is "death arising from an act inflicted upon oneself with the intent to kill oneself."<br><br>Data sources: National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) | 2008-2014 |

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| **Obesity OBE in Bon Secours Mercy Richmond, VA market**<br><br>% of adults<br><br>Percent of resident adults aged 18 and older who are obese (have a body mass index (BMI) ≥30.0 kg/m² calculated from self-reported weight and height). Excludes those with abnormal height or weight and pregnant women.<br><br>Data sources: Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Diabetes Atlas (County level data), PLACES | **2019** |
| **Infant mortality IFM in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 1,000 live births<br><br>Rate of postneonatal deaths (in the first year of life). Stratifications by race/ethnicity are of the mother.<br><br>Data sources: National Vital Statistics System-Natality (NVSS-N) (CDC Wonder; counties and states, excluding Wisconsin), Wisconsin Department of Health Services (WISH (Wisconsin data only)), University of Texas System (Texas zip code data) | 2015-2019 |
| **Very low birth weight VLW in Bon Secours Mercy Richmond, VA market**<br><br>% of live births<br><br>Percent of live births with a birth weight of less than 1,500 grams (3 lbs, 4 oz).<br><br>Data sources: National Vital Statistics System-Natality (NVSS-N) (via CDC wonder (2016-2020 data averages)), National Vital Statistics System-Natality (NVSS-N) (Via CDC Wonder and Health Indicators Warehouse (through 2014)) | 2016-2020 |

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| **Food insecurity FAI in Bon Secours Mercy Richmond, VA market**<br><br>% of residents<br><br>Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. 2020 data is a projection based on 11.5% national unemployment and 16.5% national poverty rate.<br><br>Data source: Feeding America (Map the Meal Gap 2020) | **2018-2020** |
| **Shelters and other facilities census SHL in Bon Secours Mercy Richmond, VA market**<br><br>Persons<br><br>Population living in shelters for the homeless, group homes, treatment centers, workers' living quarters, natural disaster recovery centers, religious group quarters, and other group quarters.<br><br>Data source: Decennial Census (SF1 P42) | 2020 |
| **Particulate matter Environmental Justice Index EJO in Bon Secours Mercy Richmond, VA market**<br><br>Percentile<br><br>Weighted index of vulnerability to particulate matter. Measures exposure to PM 2.5 in the air, weighted by population vulnerability and reported as a percentile nationally, where 0 = lowest exposure, and 100 = highest exposure. Weighting by the vulnerability of residents can provide a better estimate of the disproportionate impact of environmental hazards.<br><br>Data source: Environmental Protection Agency (EPA) (EJSCREEN) | 2015-2020 |

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| **Water polluting sites Environmental Justice Index EJJ in Bon Secours Mercy Richmond, VA market**<br><br>Percentile<br><br>Weighted index of vulnerability to water polluting sites. Measures proximity to water polluting sites, weighted by population vulnerability and reported as a percentile nationally, where 0 = lowest exposure, and 100 = highest exposure. Weighting by the vulnerability of residents can provide a better estimate of the disproportionate impact of environmental hazards.<br><br>Data source: Environmental Protection Agency (EPA) (EJSCREEN, via the EPA's PCS/ICIS database) | **2015-2020** |
| **No exercise EXR in Bon Secours Mercy Richmond, VA market**<br><br>% of adults<br><br>Percent of resident adults aged 18 and older who answered “no” to the following question: “During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?”<br><br>Data sources: Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Diabetes Atlas (County level data), PLACES | 2002-2019 |
| **Severe housing cost burden HBS in Bon Secours Mercy Richmond, VA market**<br><br>% of occupied housing units<br><br>Households spending more than 50% of income on housing are considered severely housing cost-burdened. Includes both renters (rent) and owners (mortgage and other owner costs). For renters, costs include any utilities or fees that the renter must pay, but do not include insurance or building fees.<br><br>Data source: American Community Survey (Tables B25070/25091) | 2011-2019 |

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| **Binge drinking BNG in Bon Secours Mercy Richmond, VA market**<br><br>% of adults<br><br>Percent of adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Alcohol use is likely seriously underreported, so these estimates are an extreme lower bound on actual binge drinking prevalence.<br><br>Data sources: PLACES, Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data) | 2010-2019 |
| **Aggravated assault/battery in Bon Secours Mercy Richmond, VA market**<br><br>Crimes per 100,000 residents<br><br>Aggravated assault and aggravated battery crimes (yearly rate). Per the Chicago definitions, aggravated assault is an unlawful attack by one person upon another, wherein the offender displays a weapon in a threatening manner. Aggravated battery is the physical attack itself, wherein the offender uses a weapon or the victim suffers obvious severe or aggravated bodily injury involving apparent broken bones, loss of teeth, possible internal injury, severe laceration, or loss of consciousness. Some cities switch their definitions of assault and battery, but by reporting them together these rates are comparable across cities that use the FBI's Uniform Crime Reporting classifications.<br><br>Data sources: FBI Crime Data Explorer, City of Milwaukee, New York City Police Department (NYPD), Crime data portal | 2019 |

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| **Chronic lower respiratory disease mortality in Bon Secours Mercy Richmond, VA market**<br><br>Deaths per 100,000<br>Deaths per 100,000 residents due to chronic lower respiratory disease (ICD-10 codes J40-J47). The primary disease in this category is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Also includes asthma and bronchiectasis.<br><br>Data sources: National Vital Statistics System-Mortality (NVSS-M) (Via http://healthindicators.gov), Chicago Department of Public Health (Epidemiology Department: Chicago community area level) | **2020** |
| **Teen birth rate TBR in Bon Secours Mercy Richmond, VA market**<br><br>Births per 1,000 women<br><br>Women age 15-19 with a birth in the past year, per 1,000 women age 15-19. Does not include births to women below age 15.<br><br>Data source: American Community Survey (Table B13002) | 2005-2020 |
| **Social Engagement Index SGX in Bon Secours Mercy Richmond, VA market**<br><br>Score<br><br>The Social Engagement Index is a composite score measuring elements of civic engagement and social isolation, especially those that are affected by the built environment. It incorporates information about neighborhood resiliency (five-year change in rent prices, how often residents move, and housing vacancy) and barriers to social engagement (disconnected youth, proportion of seniors living alone, residents with cognitive and ambulatory disabilities, limited English proficiency, and residents reporting poor mental health). Higher values indicate more social engagement.<br><br>Data source: Metopio | 2011-2015 |

# Board Approval

The Bon Secours Richmond Health System 2022 Community Health Needs Assessment was approved by the Richmond Market Board on September 27th, 2022.

Board Signature: _____ Shannon Sinclair, Chair

Date: 9/27/2022

For further information or to obtain a hard copy of this Community Health Needs Assessment (CHNA) please contact:

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Bon Secours CHNA Website: https://www.bonsecours.com/about-us/community-commitment/community-health-needs-assessment