

# 2018 Community Health Needs Assessment Report

## Obici Healthcare Foundation Service Area Western Tidewater, Virginia

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Obici Healthcare Foundation

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# Introduction



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## Project Overview

### Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Obici Healthcare Foundation. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Obici Healthcare Foundation by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.



## Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

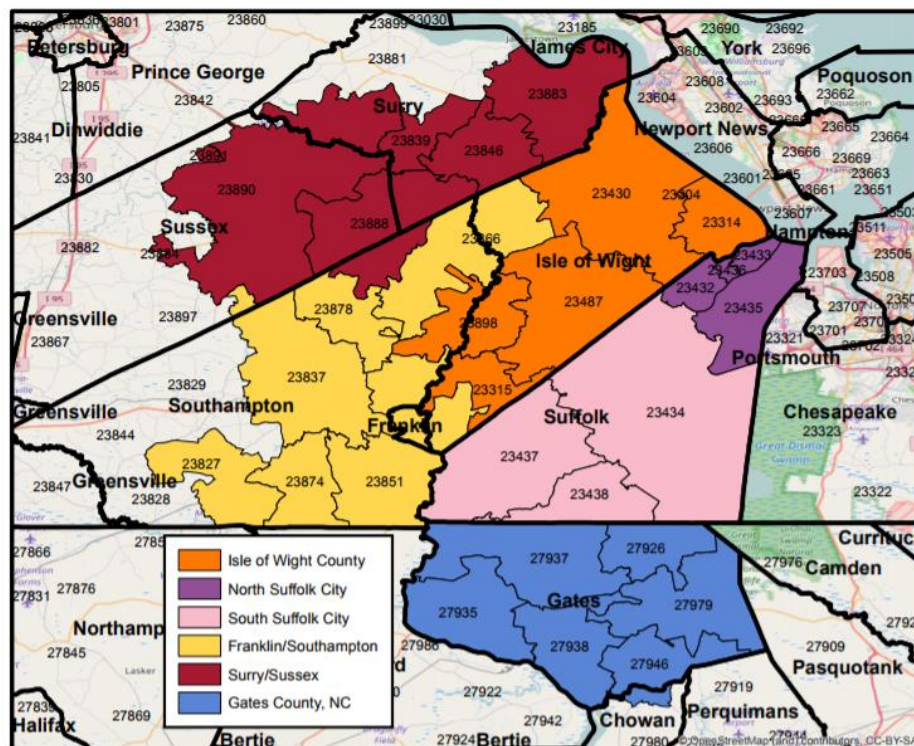
### PRC Community Health Survey

#### *Survey Instrument*

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Obici Healthcare Foundation and PRC.

#### *Community Defined for This Assessment*

The study area for the survey effort (referred to as the “OHF Service Area” in this report) is defined as the combined area incorporating Isle of Wight County, Suffolk City, Franklin City, portions of Southampton County, portions of Surry and Sussex counties, and Gates County in North Carolina. This community definition is illustrated in the following map.



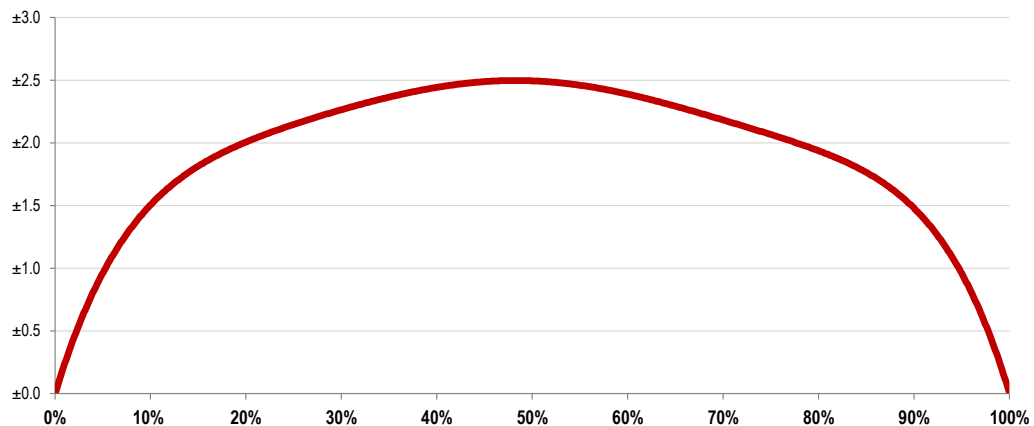
### Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a stratified random sample of 1,500 individuals age 18 and older in the OHF Service Area, including 350 each in Isle of Wight County and North Suffolk City; 500 in South Suffolk City; and 100 each in Franklin City/Southampton County, Surry/Sussex counties, and Gates County (NC). Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the OHF Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 1,500 respondents is  $\pm 2.5\%$  at the 95 percent confidence level.

### Expected Error Ranges for a Sample of 1,500 Respondents at the 95 Percent Level of Confidence



- Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.
- Examples:
- If 10% of the sample of 1,500 respondents answered a certain question with a "yes," it can be asserted that between 8.5% and 11.5% ( $10\% \pm 1.5\%$ ) of the total population would offer this response.
  - If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 47.5% and 52.5% ( $50\% \pm 2.5\%$ ) of the total population would respond "yes" if asked this question.

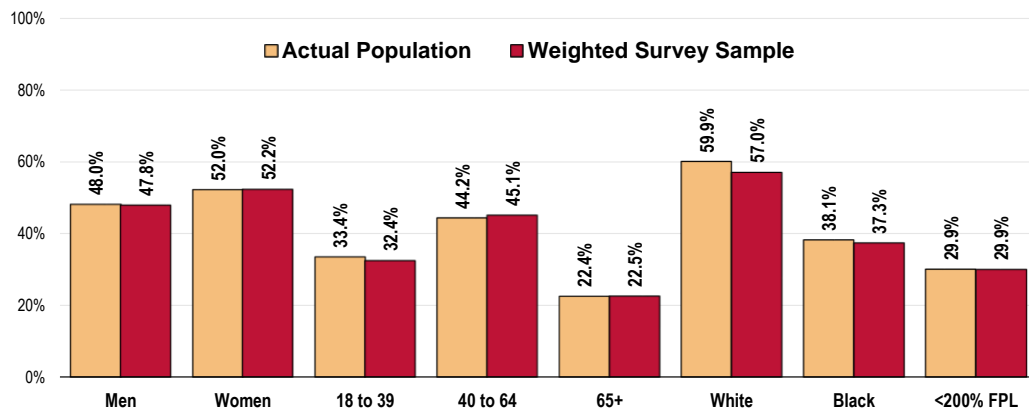
### Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the

geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the OHF Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

### Population & Survey Sample Characteristics (OHF Service Area, 2017)



Sources:   
 • Census 2010, Summary File 3 (SF 3). US Census Bureau.   
 • 2017 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2017 guidelines place the poverty threshold for a family of four at \$24,400 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

### Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Obici Healthcare Foundation; this list included names and contact information for physicians, public health representatives, other health providers, social services providers, educators, and a variety of other church and community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 67 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Church Leader	8	1
Community Leader	95	25
Educator	31	10
Other Health Provider	37	18
Physician	1	1
Public Health Representative	15	8
Social Services Provider	8	4

Final participation included representatives of the organizations outlined below.

- Albemarle Regional Health Services
- Alzheimer's Association
- Bon Secours Health System
- Catholic Charities of Eastern Virginia
- CCEVA, Obici Life Coach Program
- City of Franklin
- City of Suffolk
- County Government
- Cross Management Corporation
- Eastern Virginia Medical School Endocrine and Metabolic Disorders

- Eastern Virginia Medical School  
Strelitz Diabetes Center of  
Western Tidewater
- ForKids, Inc.
- Franklin City Health Department  
Medical Assistance Program
- Franklin Southampton Economic  
Development, Inc.
- Gates County Aging and Adult  
Services
- Girls on the Run Hampton Roads
- Healthy Suffolk
- Horizon Health Services, Inc.
- Isle of Wight County Schools
- Lakeland High School
- Local Government Commission
- Nursing CAP, Inc.
- Rx Partnership (RxP)
- School System
- Sentara Obici Hospital
- Smart Beginnings Western  
Tidewater
- Southampton County Board of  
Supervisors
- Southampton County Public  
Schools
- Southampton County,  
Department of Social Services
- Southampton Memorial Hospital
- Suffolk Christian Church
- Suffolk City Council
- Suffolk Department of Social  
Services
- Suffolk Family YMCA
- Suffolk Meals on Wheels
- Surry County Public Schools
- Surry Department of Social  
Services
- Sussex County Middle School,  
Principal
- Western Tidewater Free Clinic
- Western Tidewater Health District

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

**Minority/medically underserved populations represented:**

*African-Americans, children/adolescents, disabled, elderly, Hispanics, HIV/AIDS, homeless, low-income, Medicare/Medicaid, mentally ill, pregnant, rural population, substance abusers, uninsured/underinsured.*

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

*NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area. Thus, these findings are based on perceptions and not facts.*

## Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the OHF Service Area (roughly the Western Tidewater region) were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- Sentara Obici Hospital Discharge Data
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect the entirety of the cities and counties that encompass the OHF Service Area.

## Benchmark Data

### *Virginia and North Carolina Risk Factor Data*

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

### *Nationwide Risk Factor Data*

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2017 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

### *Healthy People 2020*

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:



- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

### **Virginia Health Opportunity Index (HOI)**

The Virginia Health Opportunity Index (HOI) is a product of the Virginia Department of Health Office of Minority Health and Health Equity that “scores” each census tract in Virginia as to the level of opportunity that exists for its residents. The HOI consists of 13 indicators that act as building blocks; each indicator is conceived as an indication of the opportunity to live a long and healthy life in each area. These indicators were chosen based on social determinants of health and are organized into these four profiles of opportunity: **Economic Opportunity Profile** (including the indicators of air quality, population churning, population density, and walkability), **Consumer Opportunity Profile** (including affordability, education, food accessibility, and material deprivation), **Community Environment Profile** (employment accessibility, income inequality, and job participation), and **Wellness Opportunity Profile** (access to care and segregation). The data are then combined into a single index of information in an interactive, web-based format.



The HOI is remarkably predictive of health outcomes and, as such, plays a complementary role to this Community Health Needs Assessment. Where applicable and possible, HOI-related charts are included in an effort to provide a more robust picture of community health in the Obici Healthcare Foundation Service Area.

Throughout this report, PRC highlights select survey findings, segmented by service area geographies that share similar opportunity levels as determined by the HOI. This will demonstrate where correlations exist (and don't exist) with these social determinant groupings.

### **Determining Significance**

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.



## Summary of Findings

### Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

Areas of Opportunity Identified Through This Assessment	
<b>Access to Healthcare Services</b>	<ul style="list-style-type: none"> <li>• Primary Care Physician Ratio</li> <li>• Access to the Internet for Personal Use</li> <li>• Emergency Room Utilization</li> </ul>
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• Cancer is a leading cause of death.</li> <li>• Cancer Deaths               <ul style="list-style-type: none"> <li>◦ Including Prostate Cancer and Female Breast Cancer Deaths</li> </ul> </li> <li>• Cancer (Non-Skin) Prevalence</li> <li>• Cervical Cancer Screening [Age 21-65]</li> </ul>
<b>Diabetes</b>	<ul style="list-style-type: none"> <li>• Diabetes Deaths</li> <li>• Diabetes Prevalence</li> <li>• Prevalence of Borderline/Pre-Diabetes</li> <li>• <i>Diabetes ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Heart Disease &amp; Stroke</b>	<ul style="list-style-type: none"> <li>• Cardiovascular disease is a leading cause of death.</li> <li>• Stroke Deaths</li> <li>• High Blood Pressure Prevalence</li> <li>• High Blood Cholesterol Prevalence</li> <li>• Overall Cardiovascular Risk</li> <li>• <i>Heart Disease &amp; Stroke ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Infant Health &amp; Family Planning</b>	<ul style="list-style-type: none"> <li>• Low-Weight Births</li> <li>• Infant Mortality</li> <li>• Teen Births</li> </ul>
<b>Injury &amp; Violence</b>	<ul style="list-style-type: none"> <li>• Motor Vehicle Crash Deaths</li> </ul>
<b>Kidney Disease</b>	<ul style="list-style-type: none"> <li>• Kidney Disease Deaths</li> <li>• Kidney Disease Prevalence</li> </ul>

—continued on next page—

<b>Areas of Opportunity (continued)</b>	
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• Seeking Professional Help</li> <li>• <i>Mental Health ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Nutrition, Physical Activity, &amp; Weight</b>	<ul style="list-style-type: none"> <li>• Overweight &amp; Obesity [Adults]</li> <li>• Sugar-Sweetened Beverages</li> <li>• Low Food Access</li> <li>• Trying to Lose Weight [Overweight Adults]</li> <li>• Access to Recreation/Fitness Facilities</li> <li>• <i>Nutrition, Physical Activity &amp; Weight ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Oral Health</b>	<ul style="list-style-type: none"> <li>• <i>Oral Health ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Potentially Disabling Conditions</b>	<ul style="list-style-type: none"> <li>• Multiple Chronic Conditions</li> <li>• Arthritis/Rheumatism Prevalence [Age 50+]</li> <li>• Caregiver</li> </ul>
<b>Respiratory Diseases</b>	<ul style="list-style-type: none"> <li>• Asthma Prevalence [Adults]</li> <li>• Chronic Obstructive Pulmonary Disease (COPD) Prevalence</li> <li>• Flu Vaccination [Age 65+]</li> <li>• Pneumonia Vaccination [Age 65+]</li> </ul>
<b>Sexually Transmitted Diseases</b>	<ul style="list-style-type: none"> <li>• Gonorrhea Incidence</li> <li>• Chlamydia Incidence</li> </ul>
<b>Substance Abuse</b>	<ul style="list-style-type: none"> <li>• Sought Help for Alcohol/Drug Issues</li> <li>• <i>Substance Abuse ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>

## Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the OHF Service Area, including comparisons among the individual city/county areas. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

### Reading the Summary Tables

■ In the following charts, OHF Service Area results are shown in the larger, blue column. For survey-derived indicators, this column represents the ZIP Code–defined Obici Healthcare Foundation service area; for data from secondary sources, this column represents findings for the combined cities/counties as a whole. *Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

■ The green columns [to the left of the OHF Service Area column] provide comparisons among the 6 city/county areas (and the combined Suffolk City), identifying differences for each as “better than” (☀️), “worse than” (🌧️), or “similar to” (☁️) the combined opposing areas.

■ The columns to the right of the OHF Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the OHF Service Area compares favorably (☀️), unfavorably (🌧️), or comparably (☁️) to these external data.

*Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.*

#### Survey Data Indicators:

Note that survey data reflect the ZIP Code–defined OHF Service Area.

#### Other (Secondary) Data

Indicators: Secondary data reflect city/county-level data.

Social Determinants	Each Sub-Area vs. Others							OHF Service Area	OHF Service Area vs. Benchmarks			
	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County		vs. VA	vs. NC	vs. US	vs. HP2020
Linguistically Isolated Population (Percent)	0.2			0.4	0.0	0.0	0.5	<b>0.3</b>	2.8	3.0	4.6	
Population in Poverty (Percent)	11.7			11.6	17.5	16.7	14.2	<b>13.0</b>	11.5	17.4	15.5	
Population Below 200% FPL (Percent)	24.1			27.1	38.9	38.6	38.4	<b>29.3</b>	26.8	38.5	34.3	
Children Below 200% FPL (Percent)	34.6			38.1	48.4	51.7	57.3	<b>40.0</b>	33.8	48.9	43.9	
No High School Diploma (Age 25+, Percent)	13.7			12.5	19.6	25.5	15.4	<b>15.5</b>	11.7	14.2	13.4	
Unemployment Rate (Age 16+, Percent)	4.3			4.7	4.5	6.0	5.2	<b>4.7</b>	4.0	5.1	4.9	
% Worry/Stress Over Rent/Mortgage in Past Year	21.1	23.9	24.8	24.5	30.3	18.8	21.3	<b>23.8</b>		30.8		
% Low Health Literacy	17.9	14.4	18.7	17.1	27.5	14.1	17.3	<b>18.4</b>		23.3		

Each Sub-Area vs. Others

Social Determinants (continued)	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% Have Access to the Internet	91.5	91.2	85.5	87.6	78.4	77.3	82.6
% Have a Smartphone	81.5	85.6	79.2	81.6	69.4	68.8	63.6
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.							

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
86.3			91.9	
77.8			72.2	
better     similar     worse				

Each Sub-Area vs. Others

Overall Health	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% "Fair/Poor" Overall Health	16.0	15.9	20.0	18.5	17.4	25.2	16.3
% Multiple Chronic Conditions	63.3	67.0	66.1	66.4	70.0	84.3	62.3
% Activity Limitations	25.9	28.0	23.6	25.3	13.1	22.8	26.8
% Caregiver to a Friend/Family Member	25.2	26.2	28.3	27.5	22.1	13.6	22.2
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.							

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
18.1	15.2	19.3	18.1	
67.1			56.8	
23.9	17.6	21.6	25.0	
25.0			20.8	
better     similar     worse				

Each Sub-Area vs. Others

Access to Health Services	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% [Age 18-64] Lack Health Insurance	7.7	8.3	8.0	8.1	22.0	5.7	11.5
% Difficulty Accessing Healthcare in Past Year (Composite)	35.2	39.0	38.2	38.5	42.8	45.2	39.8
% Difficulty Finding Physician in Past Year	6.3	13.3	6.8	9.3	11.5	10.2	5.5
% Difficulty Getting Appointment in Past Year	17.8	13.1	15.2	14.4	17.9	18.8	13.8
% Cost Prevented Physician Visit in Past Year	7.8	10.0	9.9	9.9	17.2	8.7	16.3
% Transportation Hindered Dr Visit in Past Year	4.6	4.0	7.3	6.1	6.5	10.3	7.1
% Inconvenient Hrs Prevented Dr Visit in Past Year	15.1	9.6	7.6	8.3	18.0	15.1	9.2
% Language/Culture Prevented Care in Past Year	0.8	0.2	0.2	0.2	1.5	1.6	1.4
% Cost Prevented Getting Prescription in Past Year	6.3	16.9	15.8	16.3	19.4	10.4	14.7
% Skipped Prescription Doses to Save Costs	7.0	16.9	10.2	12.7	13.4	20.0	17.1

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
9.8	15.8	19.1	13.7	0.0
38.8			43.2	
8.6			13.4	
15.9			17.5	
10.7			15.4	
6.1			8.3	
11.6			12.5	
0.7			1.2	
13.8			14.9	
12.3			15.3	

Access to Health Services (continued)	Each Sub-Area vs. Others						
	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% Difficulty Getting Child's Healthcare in Past Year	3.3	2.9	1.4	2.1			
Primary Care Doctors per 100,000	55.5			96.8	52.7	21.6	8.7
% Have a Specific Source of Ongoing Care	82.9	78.5	81.9	80.7	71.9	68.7	82.1
% Have Had Routine Checkup in Past Year	73.5	77.0	80.0	78.9	80.4	83.4	78.4
% Child Has Had Checkup in Past Year	84.3	83.5	98.8	91.8			
% Two or More ER Visits in Past Year	8.1	11.6	13.7	13.0	9.5	25.1	9.4
% Rate Local Healthcare "Fair/Poor"	11.1	9.6	7.2	8.0	12.4	24.6	23.8
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>							

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
2.3			5.6	
72.6	86.0	80.0	87.8	
79.4			74.0	95.0
78.1	75.0	73.5	68.3	
87.9			87.1	
11.9			9.3	
11.6			16.2	
<p> better     similar     worse</p>				

Cancer	Each Sub-Area vs. Others						OHF Service Area	OHF Service Area vs. Benchmarks				
	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex		Gates County	vs. VA	vs. NC	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	158.3			177.0	174.8	204.5	158.1	<b>173.8</b>	161.0	167.2	161.0	161.4
Lung Cancer (Age-Adjusted Death Rate)								<b>44.2</b>	42.2	47.6	42.0	45.5
Prostate Cancer (Age-Adjusted Death Rate)								<b>31.5</b>	19.4	20.0	19.0	21.8
Female Breast Cancer (Age-Adjusted Death Rate)								<b>29.0</b>	21.7	21.0	20.6	20.7
Colorectal Cancer (Age-Adjusted Death Rate)								<b>14.5</b>	14.0	14.0	14.4	14.5
Female Breast Cancer Incidence Rate	143.3			140.7	141.9	122.2	82.8	<b>139.5</b>	125.5	128.4	123.4	
Prostate Cancer Incidence Rate	117.2			140.9	141.8	153.0	112.2	<b>137.0</b>	116.5	130.2	123.4	
Lung Cancer Incidence Rate	63.0			68.3	69.6	79.1	51.8	<b>68.7</b>	62.1	70.7	62.6	
Colorectal Cancer Incidence Rate	35.3			44.8	44.4	47.9	32.1	<b>42.9</b>	37.5	38.4	40.6	
% Cancer (Other Than Skin)	8.6	9.0	9.7	9.4	5.0	4.7	16.5	<b>8.9</b>	6.2	7.3	7.1	



Each Sub-Area vs. Others

	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% Skin Cancer	9.7	7.9	5.7	6.5	6.5	2.7	3.6
% [Women 50-74] Mammogram in Past 2 Years	78.1	89.1	84.6	86.4			81.4
% [Women 21-65] Pap Smear in Past 3 Years	71.8	79.4	85.3	83.1			
% [Age 50-75] Colorectal Cancer Screening	83.1	87.7	85.7	86.4	71.7	83.8	91.9

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
6.8	5.7	7.1	8.5	
82.4	80.0	80.7	77.0	81.1
81.2	85.2	85.8	73.5	93.0
84.2	69.1	70.8	76.4	70.5

better    similar    worse

Each Sub-Area vs. Others

	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
Alzheimer's Disease (Age-Adjusted Death Rate)	19.4			37.4	17.0		

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OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
28.5	22.0	31.0	26.1	

better    similar    worse

Each Sub-Area vs. Others

Diabetes	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
Diabetes (Age-Adjusted Death Rate)	24.7			29.0	20.5	38.2	43.2
% Diabetes/High Blood Sugar	17.6	18.0	16.6	17.1	22.6	27.2	14.3
% Borderline/Pre-Diabetes	14.3	12.2	11.3	11.6	12.7	11.2	8.3
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	62.3	60.3	57.7	58.7	53.6	58.4	58.0
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>							

OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
28.5	19.6	23.0	21.1	20.5
18.4	10.4	10.7	13.3	
12.1			9.5	
58.9			50.0	
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Heart Disease & Stroke	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
Diseases of the Heart (Age-Adjusted Death Rate)	166.4			193.0	157.7	212.0	156.4
Stroke (Age-Adjusted Death Rate)	32.6			41.4	61.3	60.9	
% Heart Disease (Heart Attack, Angina, Coronary Disease)	6.6	4.4	6.5	5.7	6.5	11.5	15.7

OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
180.2	155.8	162.1	168.0	156.9
44.2	37.9	43.4	36.8	34.8
7.2			8.0	

Each Sub-Area vs. Others

Heart Disease & Stroke (continued)	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% Stroke	3.8	3.6	1.7	2.4	4.5	4.2	3.9
% Blood Pressure Checked in Past 2 Years	93.4	97.0	97.9	97.6	92.8	93.7	93.5
% Told Have High Blood Pressure (Ever)	42.5	43.6	46.7	45.5	65.6	52.8	42.7
% [HBP] Taking Action to Control High Blood Pressure	95.5	95.3	92.0	93.1	82.2		
% Cholesterol Checked in Past 5 Years	88.8	95.8	93.6	94.4	91.3	92.8	88.5
% Told Have High Cholesterol (Ever)	39.9	44.4	39.0	41.0	31.0	48.0	44.8
% [HBC] Taking Action to Control High Blood Cholesterol	85.6	84.8	86.0	85.5			90.2
% 1+ Cardiovascular Risk Factor	86.4	91.1	88.8	89.7	98.7	96.9	86.8






Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.












OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
<b>3.2</b>	3.1	3.7	4.6	
<b>95.5</b>			90.4	92.6
<b>47.6</b>	33.2	35.2	37.0	26.9
<b>92.5</b>			93.8	
<b>92.1</b>	81.1	81.7	85.1	82.1
<b>40.3</b>			36.2	13.5
<b>87.5</b>			87.3	
<b>90.3</b>			87.2	



















better    similar    worse
















Each Sub-Area vs. Others

HIV	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
HIV/AIDS (Age-Adjusted Death Rate)							
HIV Prevalence Rate	 160.6			 334.2	 247.1	 397.2	 131.1
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>							






















OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
3.0	 1.9	 3.1	 2.7	 3.3
289.6	 314.5	 326.3	 353.2	 22.1
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Immunization & Infectious Diseases	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% [Age 65+] Flu Vaccine in Past Year	 77.8	 77.6	 63.2	 68.3		 55.6	
% [High-Risk 18-64] Flu Vaccine in Past Year	 42.5	 58.3	 76.4	 69.4			
% [Age 65+] Pneumonia Vaccine Ever	 77.8	 86.7	 71.3	 76.8		 71.5	
% [High-Risk 18-64] Pneumonia Vaccine Ever	 40.0	 53.5	 59.3	 57.1			
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>							













OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
68.3	 61.5	 70.5	 76.8	 70.0
57.7			 55.7	 70.0
75.9	 74.3	 73.6	 82.7	 90.0
47.0			 39.9	 60.0
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Infant Health & Family Planning	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
No Prenatal Care in First Trimester (Percent)	 13.1			 14.2	 22.4	 19.1	
Low Birthweight Births (Percent)	 8.1			 9.9	 11.3	 11.3	 10.1
Infant Death Rate	 7.1			 7.6	 13.4	 10.6	
Births to Teenagers Under Age 20 (Percent)	 8.9			 7.9	 7.6	 14.6	
Births to Unwed Mothers (Percent)	 36.9			 37.9	 57.4	 59.9	






























Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

OHF Service Area vs. Benchmarks



























OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
15.8	 13.2			 22.1
9.9	 8.3	 9.1	 8.2	 7.8
8.7	 7.1	 6.1	 6.5	 6.0
9.0	 7.3			
42.7	 34.6			

 better     similar     worse

Each Sub-Area vs. Others

Injury & Violence	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
Unintentional Injury (Age-Adjusted Death Rate)	 34.8			 34.6	 56.5		 59.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)							
[65+] Falls (Age-Adjusted Death Rate)							
% [Age 45+] Fell in the Past Year	 25.4	 23.5	 26.6	 25.5	 30.5	 23.7	 32.3
Firearm-Related Deaths (Age-Adjusted Death Rate)							
Homicide (Age-Adjusted Death Rate)							
Violent Crime Rate	 135.9			 313.6	 223.3	 218.2	
% Victim of Violent Crime in Past 5 Years	 0.8	 5.9	 1.1	 2.9	 0.0	 2.8	 0.0
% Victim of Domestic Violence (Ever)	 9.3	 10.3	 8.8	 9.3	 11.9	 3.6	 9.0

OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
<b>39.2</b>	 37.1	 45.0	 41.0	 36.4
<b>12.9</b>	 8.8	 13.6	 10.6	 12.4
<b>45.1</b>	 62.6	 69.5	 59.0	 47.0
<b>26.5</b>			 31.6	
<b>10.7</b>	 10.5	 12.1	 10.6	 9.3
<b>6.0</b>	 4.6	 6.3	 5.6	 5.5
<b>250.1</b>	 201.1	 353.6	 395.5	
<b>1.8</b>			 3.7	
<b>9.2</b>			 14.2	

Each Sub-Area vs. Others

Injury & Violence (continued)	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% Child [Age 5-17] "Always" Wears Bicycle Helmet	44.3	60.3	43.4	50.8			
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	97.2	98.5	99.4	99.0			
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.							

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
49.9			48.8	
98.7			85.6	
better     similar     worse				

Each Sub-Area vs. Others

Kidney Disease	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
Kidney Disease (Age-Adjusted Death Rate)	17.6			19.8	24.5		
% Kidney Disease	3.2	3.8	3.8	3.8	4.5	8.5	1.6
Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.							

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
20.1	17.2	16.3	13.3	
3.9	2.3	2.8	3.8	
better     similar     worse				

Each Sub-Area vs. Others

Mental Health	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% "Fair/Poor" Mental Health	11.6	7.5	11.2	9.8	6.9	8.6	8.5
% Diagnosed Depression	16.9	12.2	20.0	17.1	9.1	20.2	12.3
% Symptoms of Chronic Depression (2+ Years)	24.8	23.9	36.5	31.8	22.8	30.0	27.7
% Typical Day Is "Extremely/Very" Stressful	11.3	6.8	12.3	10.3	6.3	5.3	5.7
Suicide (Age-Adjusted Death Rate)							
% Taking Rx/Receiving Mental Health Trtmt	11.4	15.3	18.0	16.9	6.1	7.9	10.0
% Have Ever Sought Help for Mental Health	24.3	25.9	29.5	28.1	14.7	21.4	21.1
% [Those With Diagnosed Depression] Seeking Help							
% Unable to Get Mental Health Svcs in Past Yr	2.0	0.9	2.8	2.1	1.5	2.8	0.0

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

OHF Service Area vs. Benchmarks

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
9.7			13.0	
15.9	15.7	18.8	21.6	
28.6			31.4	
9.3			13.4	
11.2	12.7	13.0	13.0	10.2
13.2			13.9	
24.6			30.8	
91.1			87.1	
1.9			6.8	

better    similar    worse



Nutrition, Physical Activity & Weight	Each Sub-Area vs. Others							OHF Service Area	OHF Service Area vs. Benchmarks			
	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County		vs. VA	vs. NC	vs. US	vs. HP2020
% Food Insecure	16.1	20.3	24.1	22.7	12.6	17.0	18.0	19.2		27.9		
% Eat 5+ Servings of Fruit or Vegetables per Day	30.8	30.7	28.4	29.3	42.3	40.6	18.1	31.1		33.5		
% "Very/Somewhat" Difficult to Buy Fresh Produce	15.7	16.2	17.2	16.8	27.7	36.1	29.9	20.2		22.1		
% 7+ Sugar-Sweetened Drinks in Past Week	36.0	36.2	34.4	35.1	47.2	31.2	44.6	37.3		29.0		
Population With Low Food Access (Percent)	26.8			26.7	34.9	44.8	0.0	30.1	20.4	23.6	22.4	
% No Leisure-Time Physical Activity	22.7	20.9	22.5	21.9	38.1	20.2	28.3	24.4	25.2	26.2	26.2	32.6
% Meeting Physical Activity Guidelines	20.2	24.3	29.5	27.5	5.0	27.3	24.2	22.8	22.1	18.9	22.8	20.1
Recreation/Fitness Facilities per 100,000	11.3			9.5	3.7	10.5	0.0	9.0	12.3	11.3	10.5	
% Overweight (BMI 25+)	79.8	81.8	78.8	79.9	84.8	86.6	75.9	80.6	64.1	65.9	67.8	
% Healthy Weight (BMI 18.5-24.9)	19.1	17.1	18.8	18.2	14.9	13.3	24.2	18.1	34.0	32.7	30.3	33.9

Each Sub-Area vs. Others

Nutrition, Physical Activity & Weight (continued)	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% [Overweights] Trying to Lose Weight	53.0	58.0	63.5	61.4	39.1	48.1	43.3
% Obese (BMI 30+)	46.1	42.3	47.3	45.4	43.3	59.7	36.9
% Medical Advice on Weight in Past Year	31.9	32.2	28.2	29.7	29.8	31.4	31.8
% [Overweights] Counseled About Weight in Past Year	37.5	37.2	32.9	34.6	34.7	35.9	37.5
% Child [Age 5-17] Healthy Weight	61.1	63.0	47.7	55.2			
% Children [Age 5-17] Overweight (85th Percentile)	29.8	27.2	40.8	34.1			
% Children [Age 5-17] Obese (95th Percentile)	18.7	20.3	23.7	22.0			
% Child [Age 2-17] Physically Active 1+ Hours per Day	54.5	52.1	48.8	50.2			
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>							

OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
54.4			61.3	
45.6	29.2	30.1	32.8	30.5
30.5			24.2	
35.6			29.0	
57.1			58.4	
33.6			33.0	
20.1			20.4	14.5
59.0			50.5	
<p> better     similar     worse</p>				

Each Sub-Area vs. Others

Oral Health	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% Have Dental Insurance	74.1	74.2	76.3	75.5	64.6	70.7	55.7
% [Age 18+] Dental Visit in Past Year	66.8	74.7	71.1	72.5	67.1	57.9	56.8
% Child [Age 2-17] Dental Visit in Past Year	92.0	86.6	80.0	82.9			

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
72.0			59.9	
68.4	69.3	64.2	59.7	49.0
85.5			87.0	49.0

better    similar    worse

Each Sub-Area vs. Others

Potentially Disabling Conditions	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% [50+] Arthritis/Rheumatism	44.9	44.0	39.5	41.2	45.2	50.5	49.2
% [50+] Osteoporosis	10.5	10.0	9.5	9.7	9.0	9.0	12.3
% Sciatica/Chronic Back Pain	20.6	28.5	19.9	23.2	23.2	29.5	27.6
% Eye Exam in Past 2 Years	60.2	67.1	64.9	65.7	53.7	54.0	49.2

OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
44.0			38.3	
10.0			9.4	5.3
23.3			22.8	
60.9			55.3	

Each Sub-Area vs. Others

Respiratory Diseases	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
CLRD (Age-Adjusted Death Rate)	40.3			37.1	44.5	60.9	51.0
Pneumonia/Influenza (Age-Adjusted Death Rate)							
% [Adult] Currently Has Asthma	7.3	12.5	11.7	12.0	8.3	24.0	7.5
% [Child 0-17] Currently Has Asthma	18.5	5.1	15.1	10.7			
% COPD (Lung Disease)	13.0	14.6	8.6	10.8	13.3	25.0	10.7
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>							

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
40.0	36.6	45.6	41.4	
13.6	16.6	18.1	15.4	
10.9	7.9	8.2	11.8	
11.6			9.3	
12.6	5.8	7.4	8.6	
	better	similar	worse	

Each Sub-Area vs. Others

Sexually Transmitted Diseases	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
Chlamydia Incidence Rate	434.7			664.9	661.3	565.3	291.9
Gonorrhea Incidence Rate	95.4			191.3	227.9	113.1	34.3

OHF Service Area	OHF Service Area vs. Benchmarks			
	vs. VA	vs. NC	vs. US	vs. HP2020
604.0	435.8	478.6	456.1	
167.9	99.9	146.4	110.7	

Substance Abuse	Each Sub-Area vs. Others							OHF Service Area	OHF Service Area vs. Benchmarks			
	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County		vs. VA	vs. NC	vs. US	vs. HP2020
Drug-Induced Deaths (Age-Adjusted Death Rate)								9.5	11.8	14.8	15.8	11.3
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)								9.6	9.1	10.4	10.5	8.2
% Current Drinker	54.9	55.4	45.2	49.0	40.6	46.3	27.8	47.5	54.0	46.2	55.0	
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	14.2	15.0	13.1	13.8	8.5	5.6	8.1	12.3			20.0	24.4
% Excessive Drinker	17.7	20.5	16.7	18.1	16.8	6.1	9.1	16.4			22.5	25.4
% Drinking & Driving in Past Month	1.9	0.4	0.5	0.5	0.0	0.0	1.0	0.8			5.2	
% Illicit Drug Use in Past Month	0.4	0.2	1.3	0.9	0.2	0.0	8.4	1.2			2.5	7.1
% Have Used Marijuana/Hashish in Past 30 Days	2.1	3.3	1.0	1.9	0.2	2.2	10.5	2.4			8.5	
% Ever Sought Help for Alcohol or Drug Problem	1.7	0.4	0.9	0.7	0.0	0.0	5.5	1.2			3.4	
% Life Negatively Affected by Substance Abuse	37.7	34.3	25.8	29.0	35.5	28.6	35.4	32.3			37.3	

Each Sub-Area vs. Others

Tobacco Use	Isle of Wight Co	North Suffolk	South Suffolk	Suffolk City	Franklin/Southampton	Surry/Sussex	Gates County
% Current Smoker	8.6	16.7	7.9	11.2	10.2	15.6	20.9
% Someone Smokes at Home	13.2	8.1	7.9	8.0	6.9	17.2	13.2
% [Nonsmokers] Someone Smokes in the Home	10.5	4.3	5.6	5.1	5.4	4.6	1.8
% [Household With Children] Someone Smokes in the Home							
% [Smokers] Have Quit Smoking 1+ Days in Past Year							
% [Smokers] Received Advice to Quit Smoking							
% Currently Use Electronic Cigarettes	2.6	6.1	4.3	5.0	6.5	0.8	2.8
% Use Smokeless Tobacco	4.5	5.6	3.4	4.2	6.1	4.8	1.5
% Smoke Cigars	6.5	4.5	1.7	2.7	0.0	4.5	4.1
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>							

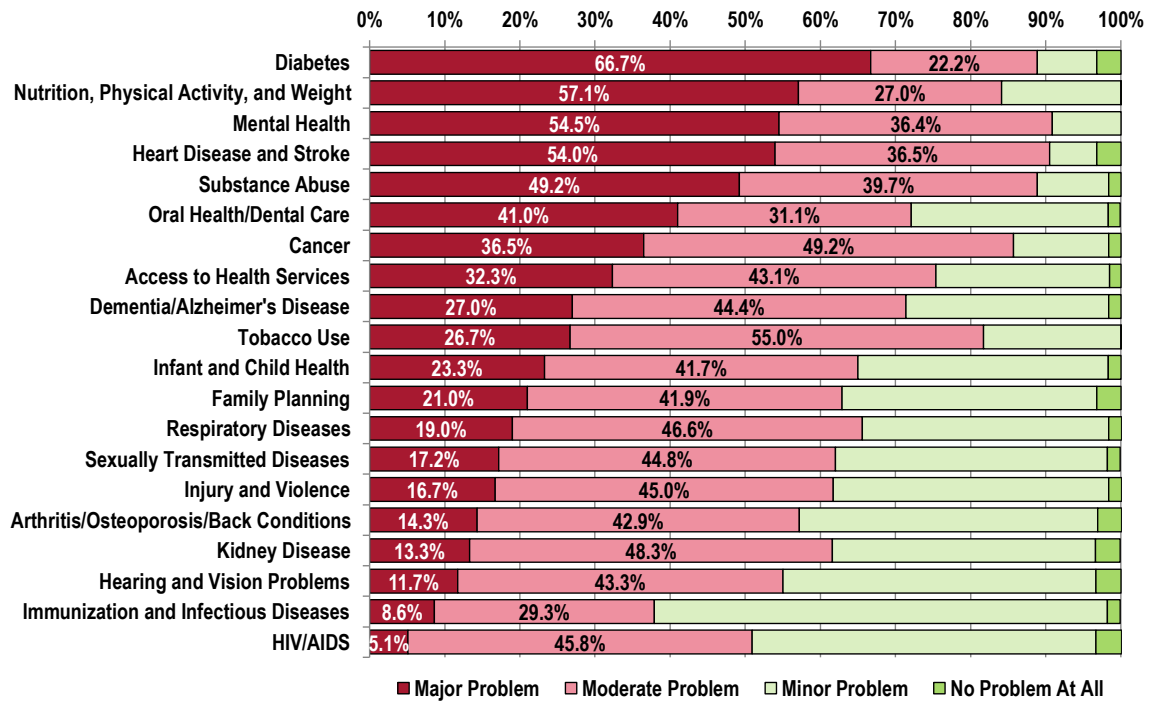
OHF Service Area vs. Benchmarks

OHF Service Area	vs. VA	vs. NC	vs. US	vs. HP2020
11.5	16.5	19.0	11.0	12.0
10.0			10.7	
6.2			4.0	
11.6			7.2	
59.4			34.7	80.0
77.7			58.0	
4.1			3.8	
4.4	4.4	4.9	4.4	0.3
3.5			7.5	0.2
<p> better     similar     worse</p>				

### Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)

### Key Informants: Relative Position of Health Topics as Problems in the Community



# Community Description



**Professional Research Consultants, Inc.**



## Population Characteristics

### Total Population

The cities and counties that contain the OHF Service Area, the focus of this Community Health Needs Assessment, encompass over 2,000 square miles and house a total population of 167,478 residents, according to latest census estimates. (Note that these figures reflect the entirety of Southampton, Surry, and Sussex counties.)

**Total Population**  
(Estimated Population, 2011–2015)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Isle of Wight County	35,740	315.62	113.24
Suffolk City	86,184	400.19	215.36
Franklin City/Southampton County	26,867	607.35	44.24
Surry/Sussex Counties	18,687	769.17	24.3
Gates County (NC)	11,724	340.44	34.44
OHF Service Area	167,478	2,092.34	80.04
Virginia	8,256,630	39,491.68	209.07
North Carolina	9,845,333	48,617.25	202.51
United States	316,515,021	3,532,070.45	89.61

Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved October 2017 from Community Commons at <http://www.chna.org>.

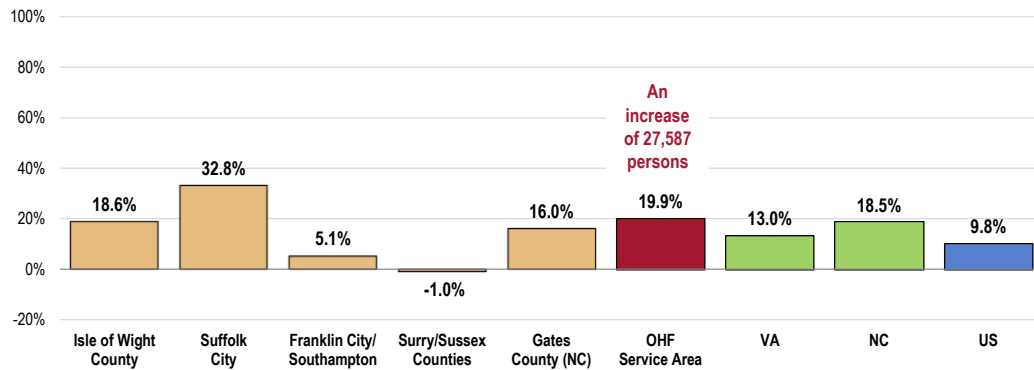
### Population Change 2000-2010

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

**Between the 2000 and 2010 US Censuses, the population of the OHF Service Area increased by 27,587 persons, or 19.9%.**

- A greater proportional increase than seen across either state as well as the nation.
- Note the great disparity in population change when viewed by individual community: Suffolk City experienced a population increase of 32.8%, while the combined Surry/Sussex County community decreased by 1.0%.

### Change in Total Population (Percentage Change Between 2000 and 2010)



Sources: 

- Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- US Census Bureau Decennial Census (2000-2010).

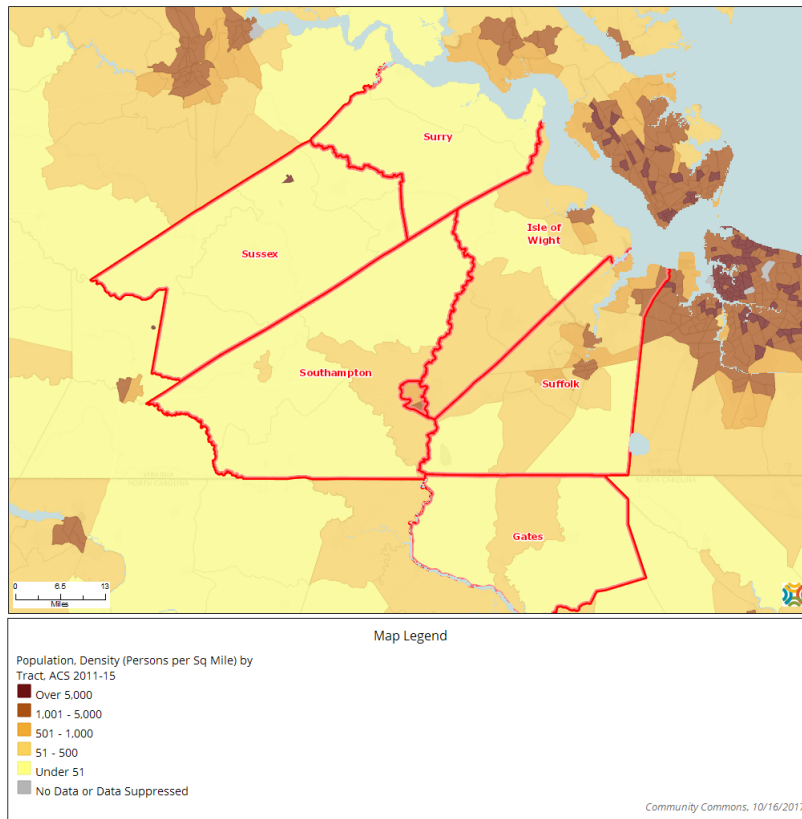
 Notes: 

- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

### Population Density

This map provides a visual illustration of 2011-2015 population density by census tract.

### Population Density by Tract, ACS 2011-2015

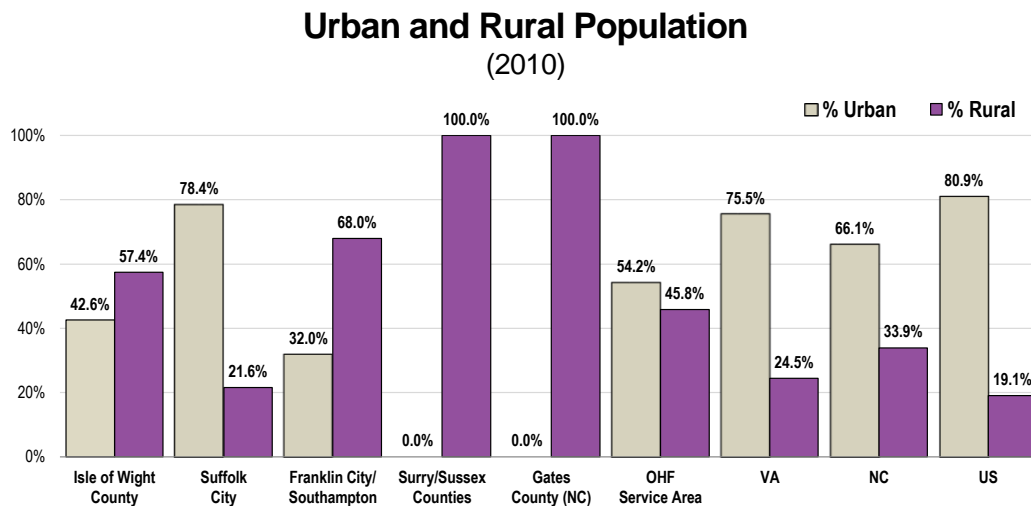


## Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

**The OHF Service Area is divided between urban and rural identifications, with 54.2% of the population living in areas designated as urban and 45.8% as rural.**

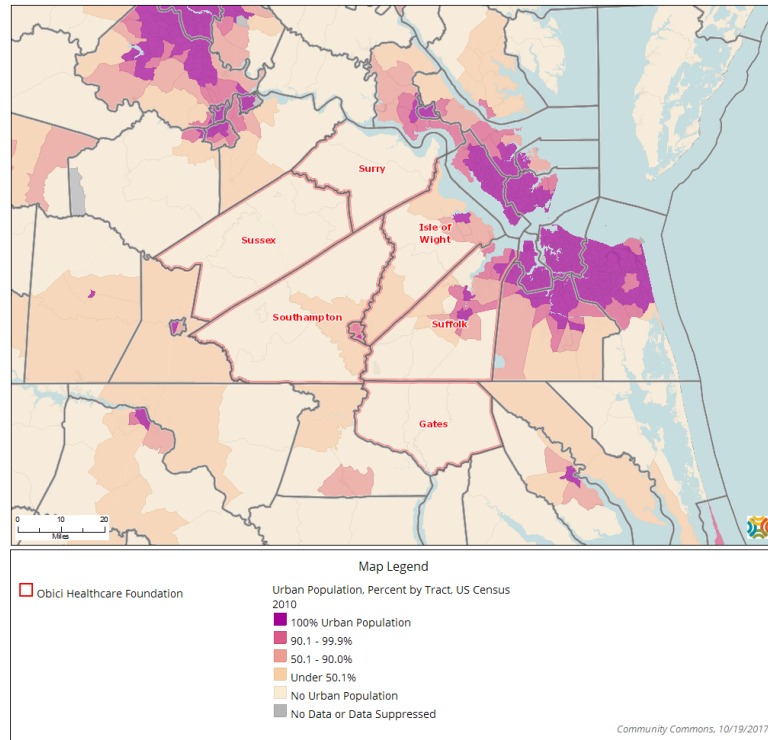
- Note that both states and the US overall are more likely to be categorized as urban.
- In the OHF Service Area, Suffolk City is largely urban, while Surry/Sussex, and Gates (North Carolina) counties are entirely rural.



- Sources:
- US Census Bureau Decennial Census (2010).
  - Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

- Note the following map, outlining the urban population in the OHF Service Area census tracts as of 2010.

### Urban Population, Percent by Tract, US Census 2010



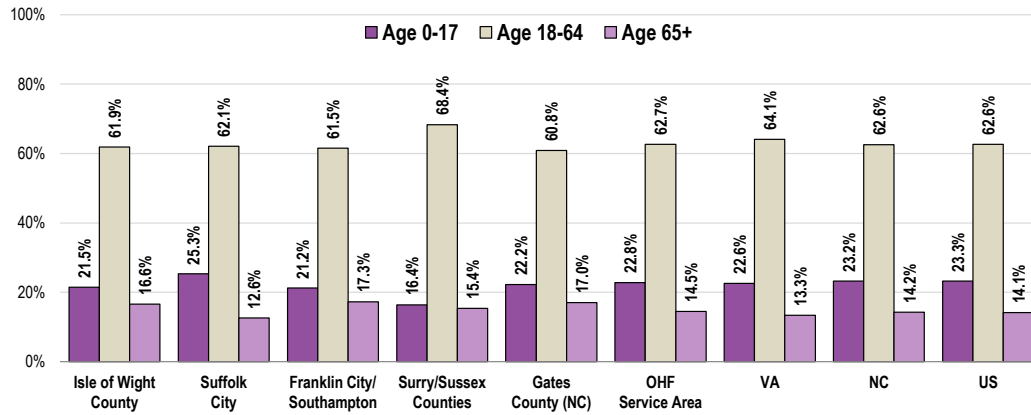
## Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

**In the OHF Service Area, 22.8% of the population are infants, children, or adolescents (age 0-17); another 62.7% are age 18 to 64, while 14.5% are age 65 and older.**

- This distribution is generally similar to that found across Virginia, North Carolina, and the US overall.
- Note the larger 65+ populations outside of Suffolk City.

### Total Population by Age Groups, Percent (2011–2015)

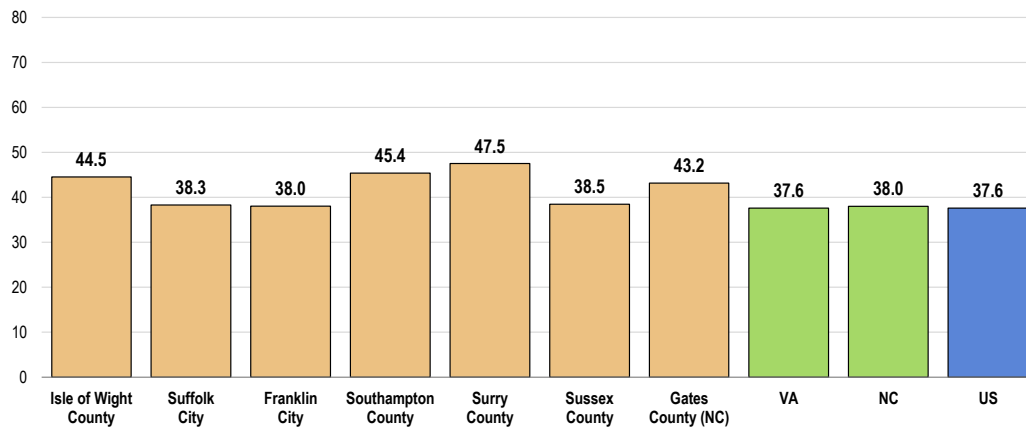


Sources:   
 • US Census Bureau American Community Survey 5-year estimates.   
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.

### Median Age

Many counties in the OHF Service Area are “older” than both Virginia and North Carolina and the nation in that the median age is older (especially Isle of Wight, Southampton, Surry, and Gates counties).

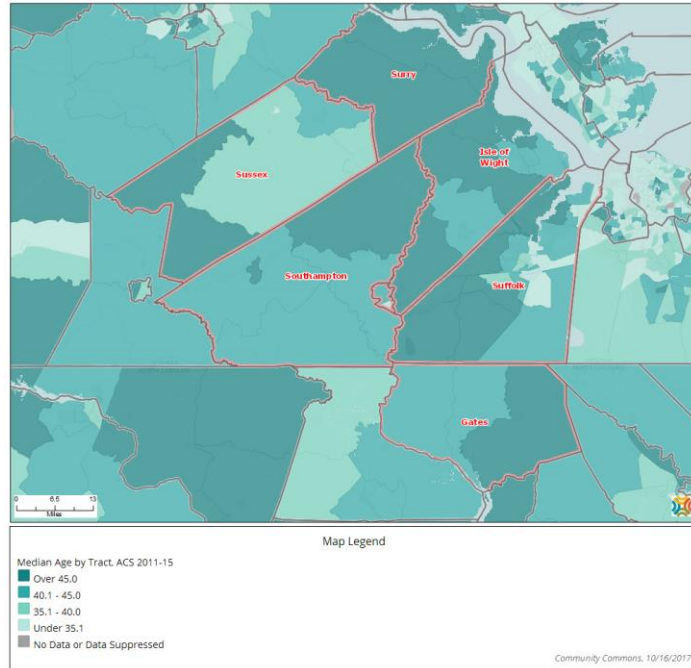
### Median Age (2011–2015)



Sources:   
 • US Census Bureau American Community Survey 5-year estimates.   
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.

- The following map provides an illustration of the median age in the OHF Service Area, segmented by census tract.

Median Age by Census Tract, ACS 2011-2015



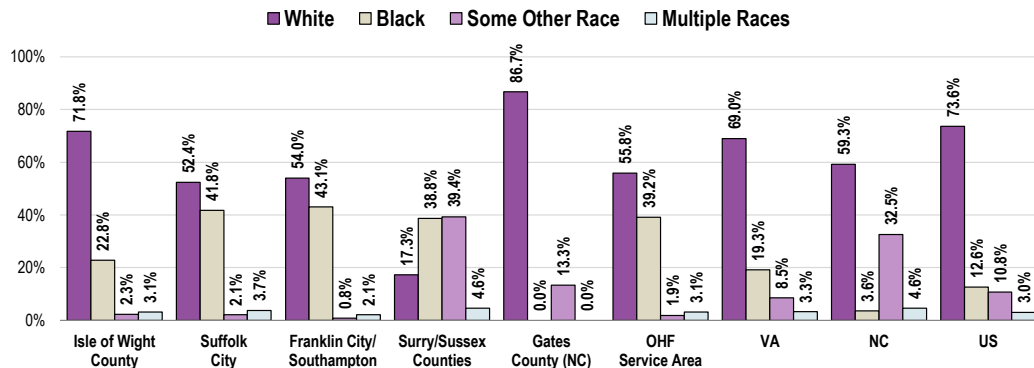
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 55.8% of OHF Service Area residents are White and 39.2% are Black.

- African Americans make up a much greater proportion of the population than found for either state or for the nation as a whole.
- Note the considerable range in race distribution when viewed among the OHF Service Area's individual communities.

Total Population by Race Alone, Percent (2011–2015)



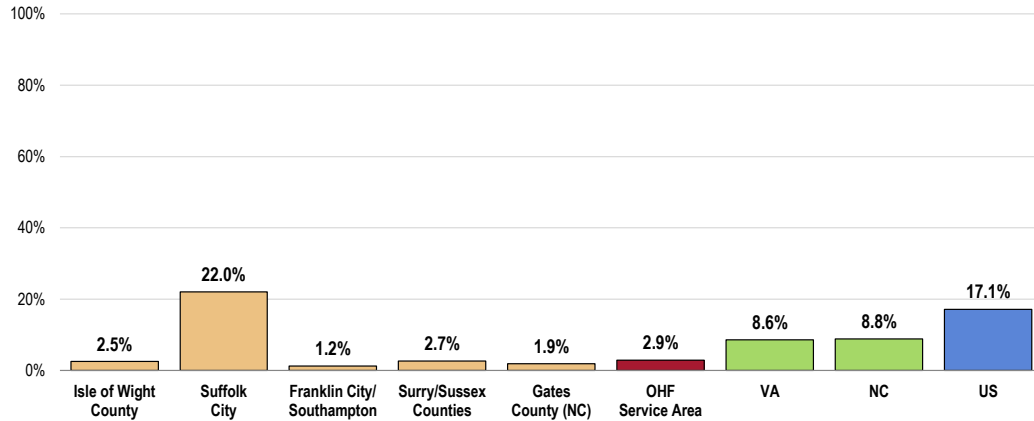
Sources: • US Census Bureau American Community Survey 5-year estimates.  
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.

### Ethnicity

A total of 2.9% of OHF Service Area residents are Hispanic or Latino.

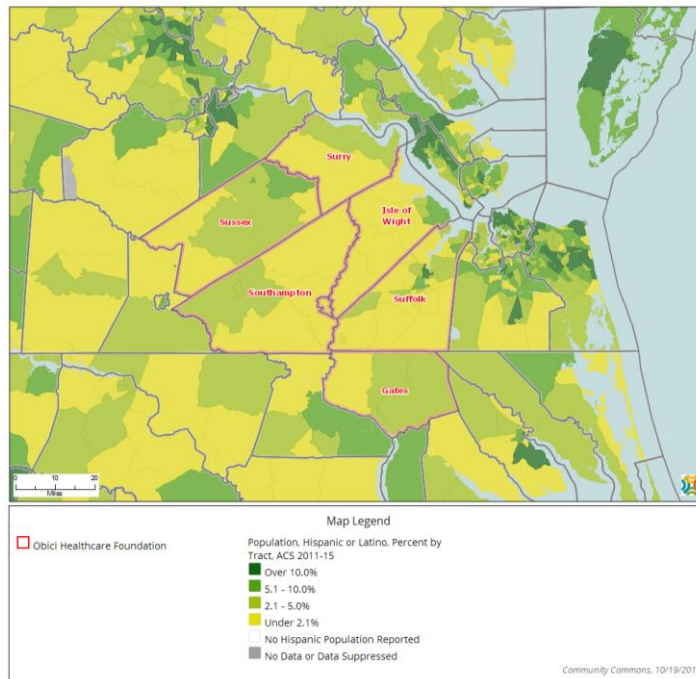
- Lower than both state percentages and especially the US percentage.
- In the OHF Service Area, most Hispanics/Latinos live in Suffolk City.

### Hispanic Population (2011–2015)



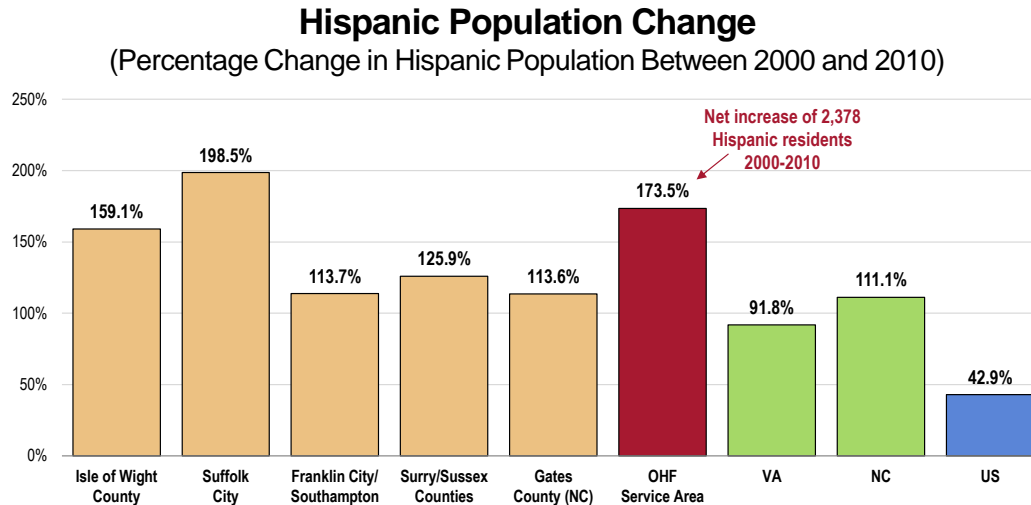
- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

### Population, Hispanic or Latino, Percent by Tract, ACS 2011-2015



**Between 2000 and 2010, the Hispanic population in the OHF Service Area increased by 2,378 residents, or 173.5%.**

- Much higher (in terms of percentage growth) than found for Virginia, North Carolina, or especially the nation as a whole
- The Hispanic population increase varies considerably by area and is highest in Suffolk City (198.5%).



Sources:

- US Census Bureau Decennial Census (2000-2010).
- Retrieved October 2017 from Community Commons at <http://www.chna.org>.

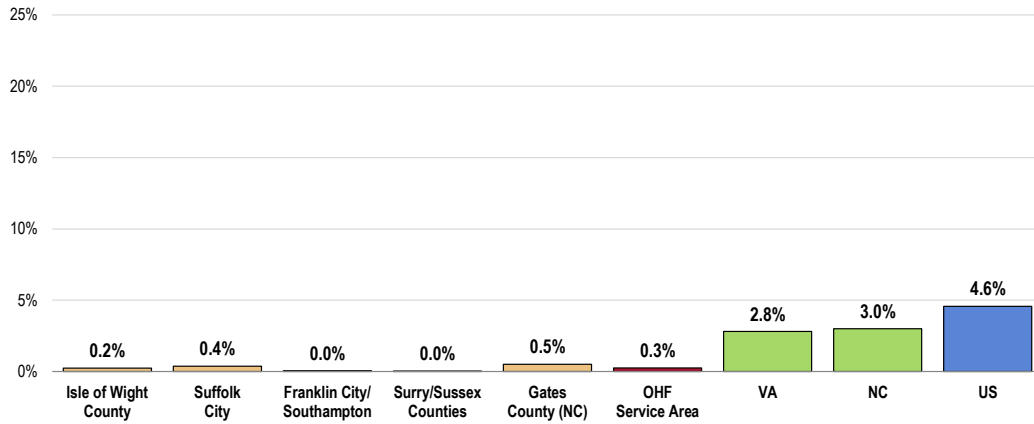
## Linguistic Isolation

Just 0.3% of the OHF Service Area population age 5 and older lives in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English “very well”).

- Well below both states as well as the US proportion.
- Highest (0.5%) in Gates County.



## Linguistically Isolated Population (2011–2015)



Sources:

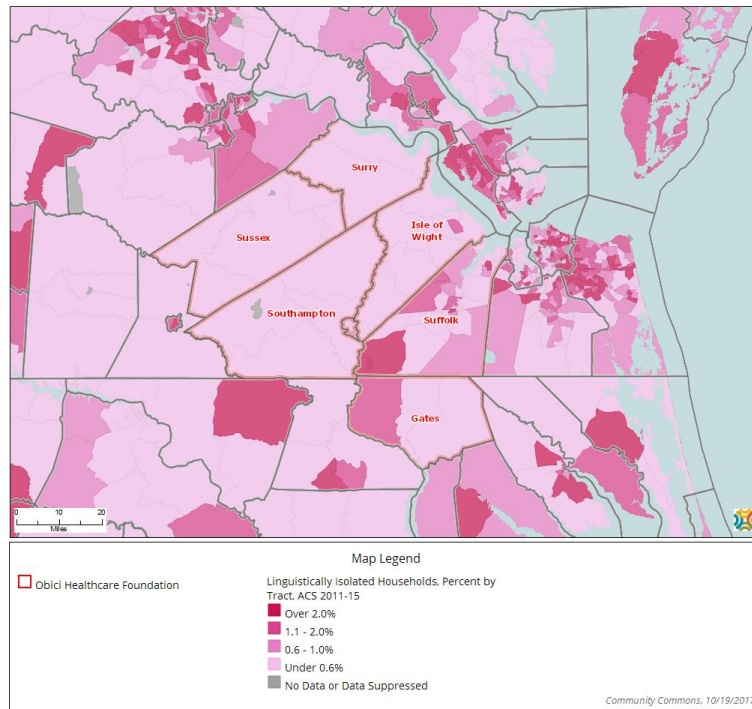
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved October 2017 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."

- Note the following map illustrating linguistic isolation in the OHF Service Area.

### Population in Linguistically Isolated Households, Percent by Tract, ACS 2011-2015



## Social Determinants of Health

### About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

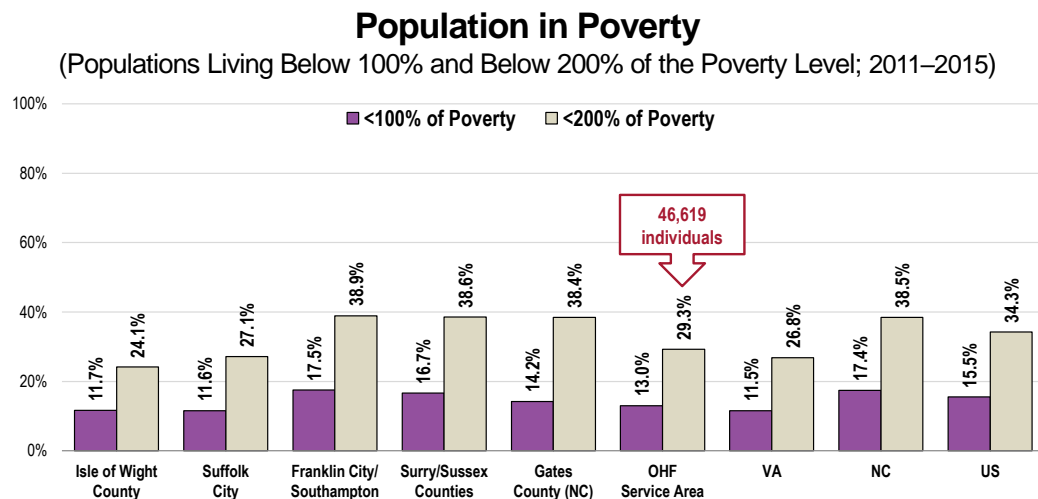
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Poverty

The latest census estimate shows **13.0%** of the OHF Service Area population living below the federal poverty level.

In all, **29.3%** of OHF Service Area residents (an estimated **46,619 individuals**) live below 200% of the federal poverty level.

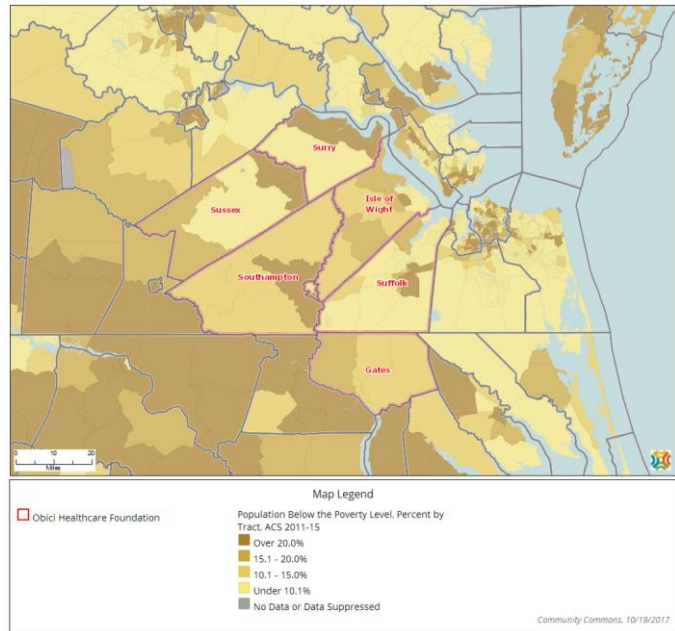
- A comparable proportion to that reported in Virginia but lower than North Carolina and US figures.
- The prevalence is favorably low in Isle of Wight County and Suffolk City.



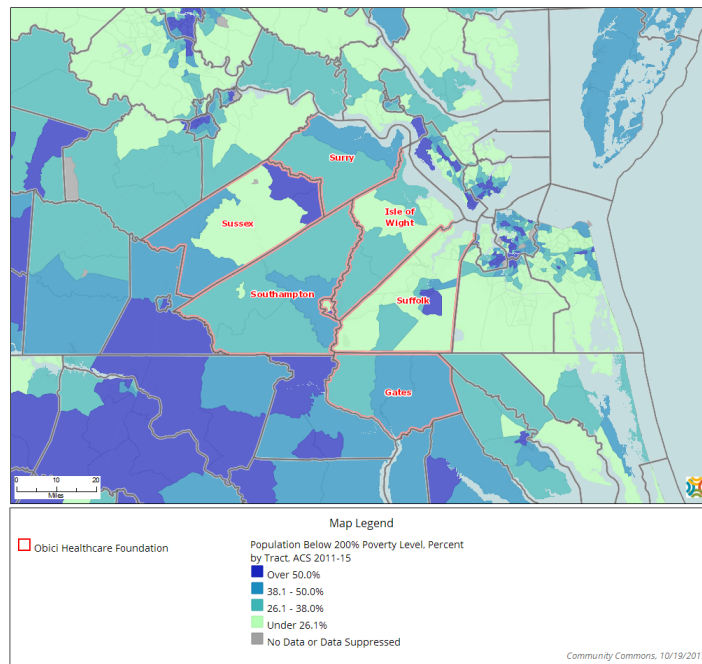
- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- Note the following maps of poverty designation by census tract in the region.

### Population Below the Poverty Level, Percent by Tract, ACS 2011-2015



### Population Below 200% Poverty Level, Percent by Tract, ACS 2011-2015

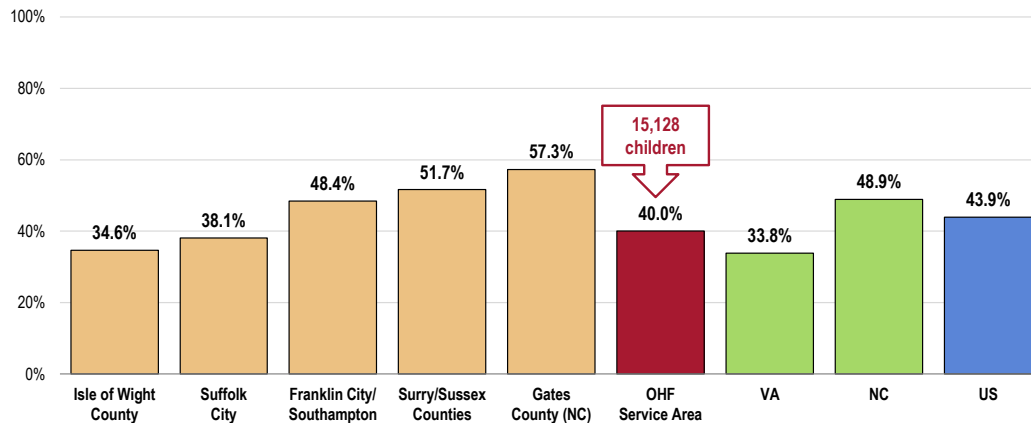


### Children in Low-Income Households

Additionally, 40.0% of OHF Service Area children age 0-17 (representing an estimated 15,128 children) live below the 200% poverty threshold.

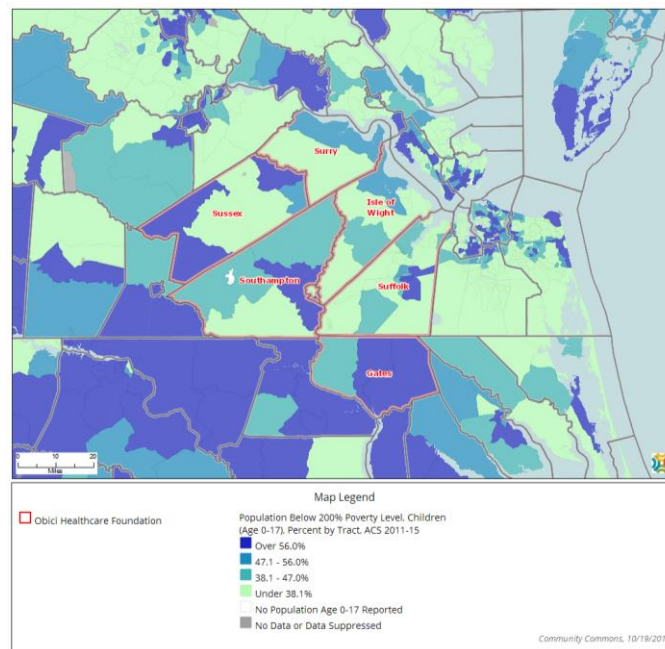
- Above the Virginia percentage (but below the North Carolina percentage).
- Similar to the US percentage.
- Especially high in Gates County; lowest in Isle of Wight County and Suffolk City.

**Percent of Children in Low-Income Households**  
(Children 0-17 Living Below 200% of the Poverty Level, 2011–2015)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

### Children Living Below 200% Poverty Level, Percent by Tract, ACS 2011-2015



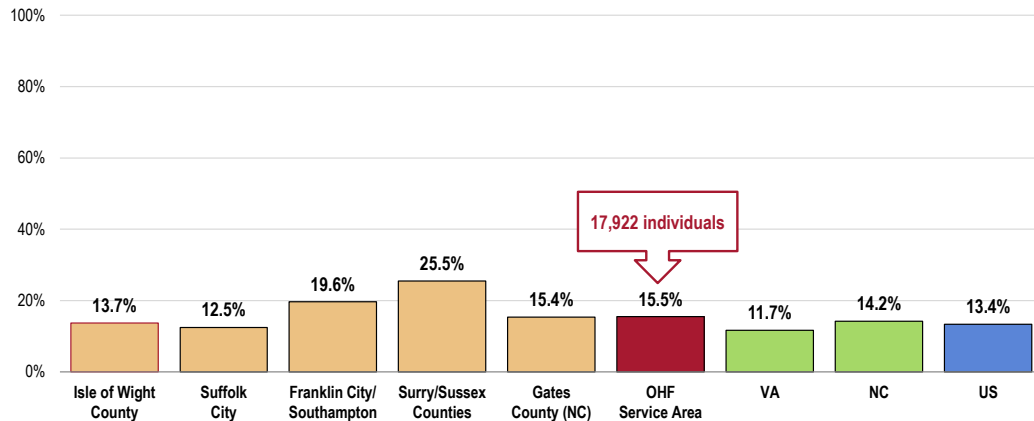
## Education

Among the OHF Service Area population age 25 and older, an estimated 15.5% (nearly 18,000 people) do not have a high school education.

- Statistically higher than the Virginia percentage but comparable to the North Carolina and US proportions.
- The prevalence is highest in Franklin City/Southampton and Surry/Sussex counties.

### Population With No High School Diploma

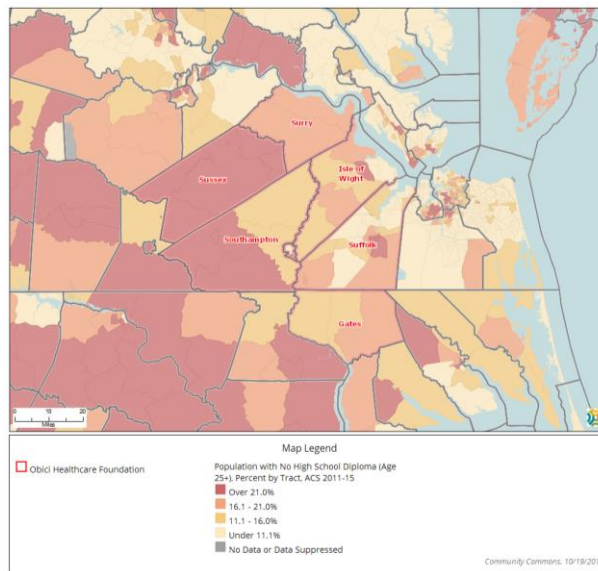
(Population Age 25+ Without a High School Diploma or Equivalent, 2011–2015)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

- Note the following map depicting the area population without a high school diploma.

### Population With No HS Diploma (Age 25+), Percent by Tract, ACS 2011-2015



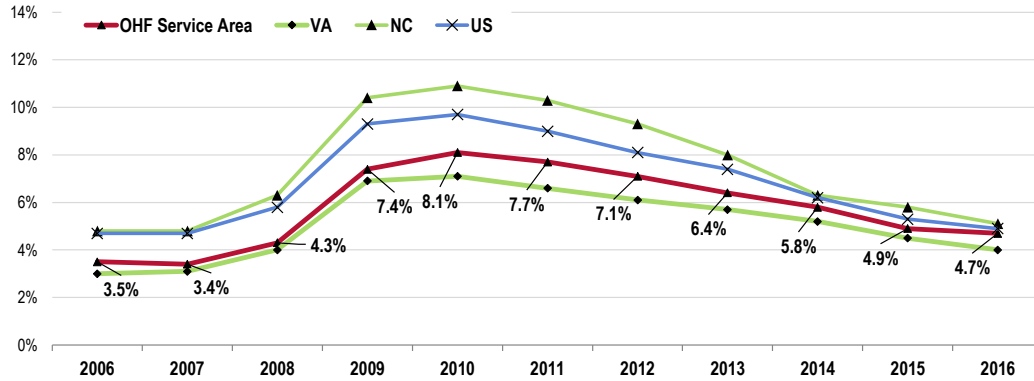
## Employment

According to data derived from the US Department of Labor, the unemployment rate in the OHF Service Area as of 2016 was 4.7%.

- Statistically comparable to the rates in both states and the US..

### Unemployment Rate

(Percent of Non-Institutionalized Population Age 16+ Unemployed, Not Seasonally-Adjusted)

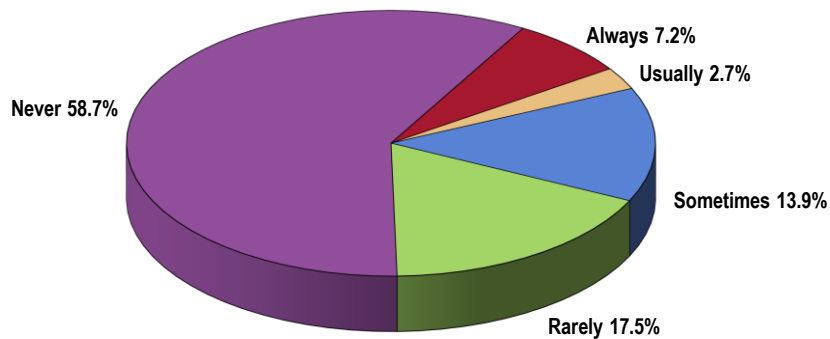


Sources: • US Department of Labor, Bureau of Labor Statistics.  
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

## Housing Insecurity

While most surveyed adults rarely, if ever, worry about the cost of housing, a considerable share (23.8%) reported that they were “sometimes,” “usually,” or “always” worried or stressed about having enough money to pay their rent or mortgage in the past year.

### Frequency of Worry or Stress Over Paying Rent/Mortgage in the Past Year (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]  
 Notes: • Asked of all respondents.

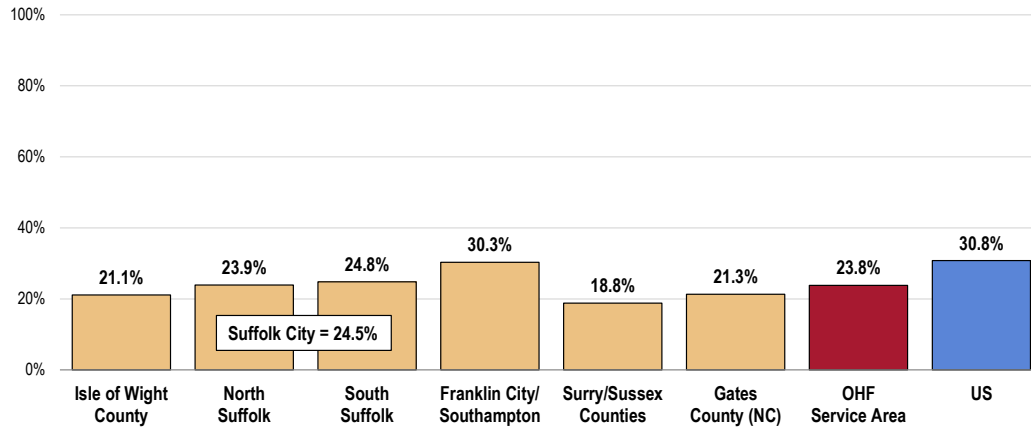
NOTE:

Differences noted in the text represent significant differences determined through statistical testing.

Where sample sizes permit, community-level data are provided.

- Compared to the US prevalence, the OHF Service Area proportion of adults who worried about paying for rent or mortgage in the past year is more favorable.
- Housing insecurity does not vary significantly by community in the OHF Service Area.

### “Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year

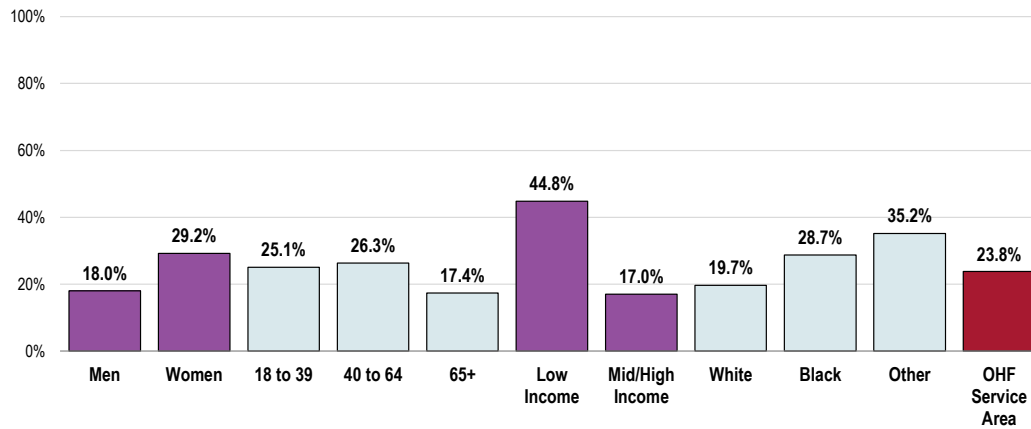


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- Adults more likely to report housing insecurity include women, adults under 65, residents living at lower incomes especially, Blacks, and residents of Other races/ethnicities.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by sex, age groupings, income (based on poverty status), and race/ethnicity.

### “Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year (OHF Service Area, 2017)



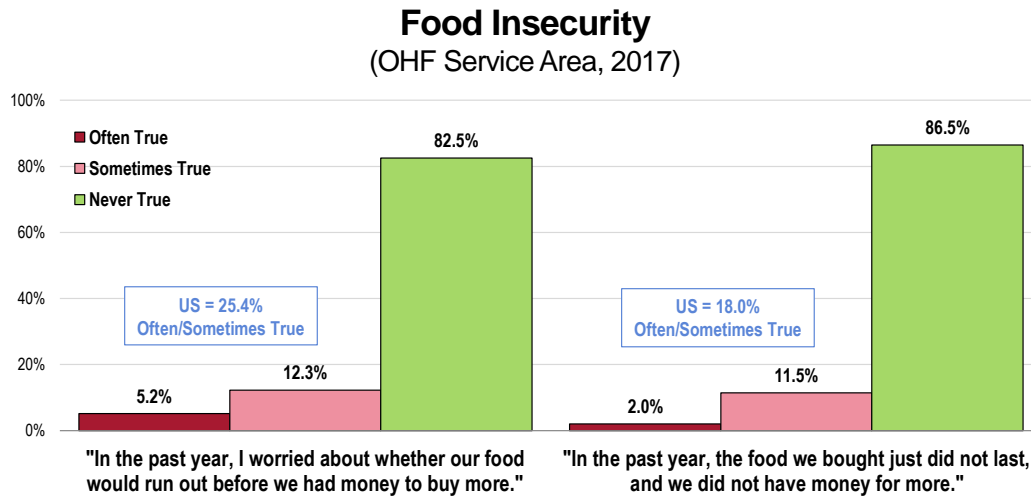
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



## Food Insecurity

In the past year, 17.5% of OHF Service Area adults “often” or “sometimes” worried about whether their food would run out before they had money to buy more.

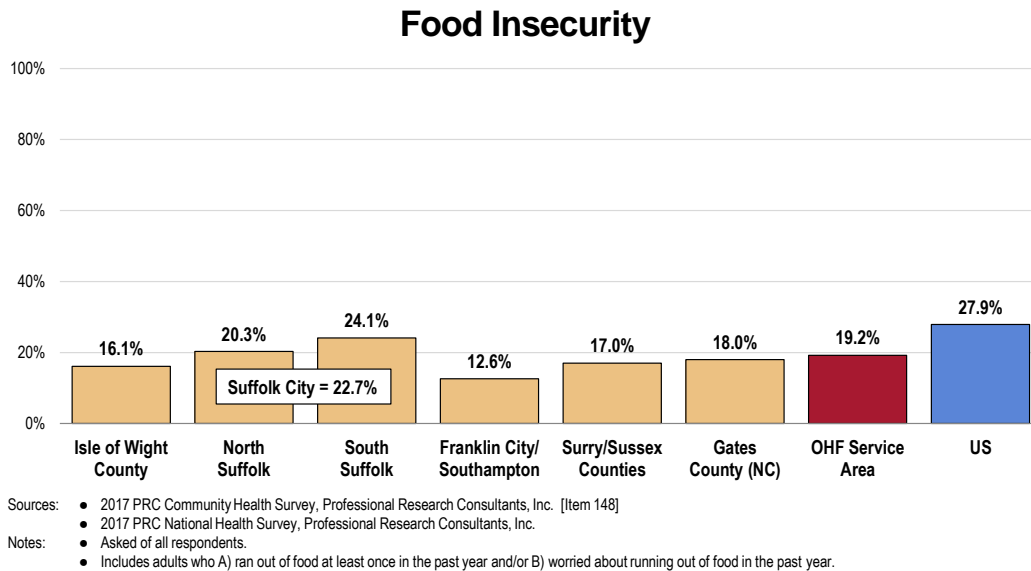
Another 13.5% report a time in the past year (“often” or “sometimes”) when the food they bought just did not last, and they did not have money to get more.



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87-88]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Reflects the total sample of respondents.

**Overall, 19.2% of community residents are determined to be “food insecure,” having run out of food in the past year and/or been worried about running out of food.**

- More favorable than the US prevalence.
- Unfavorably high in Suffolk City, especially South Suffolk.



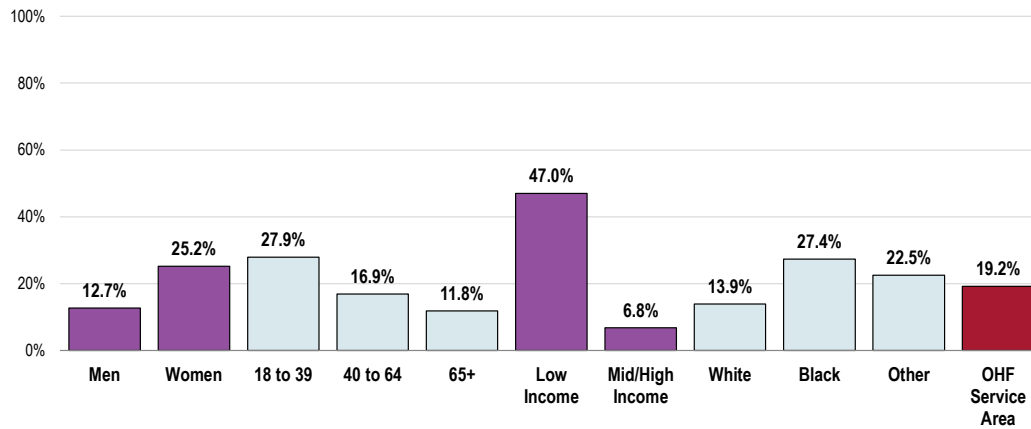
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.  
 • Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.



Adults more likely to be affected by food insecurity include:

- Women.
- Young adults (negative correlation with age).
- Residents living at lower incomes especially.
- Blacks and Other race/ethnicity residents.

### Food Insecurity (OHF Service Area, 2017)



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

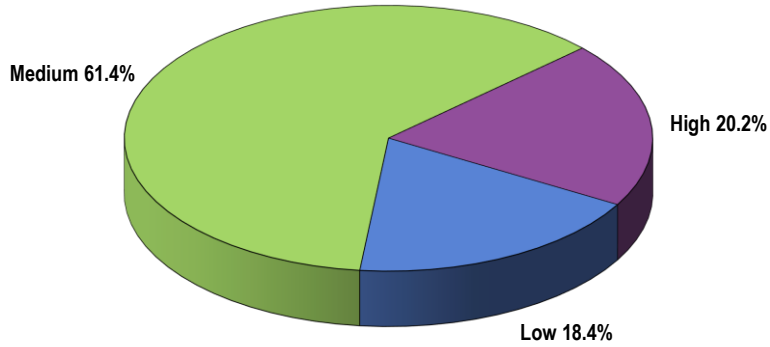
## Health Literacy

### Population With Low Health Literacy

A total of 18.4% of OHF Service Area adults are found to have low health literacy.

Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

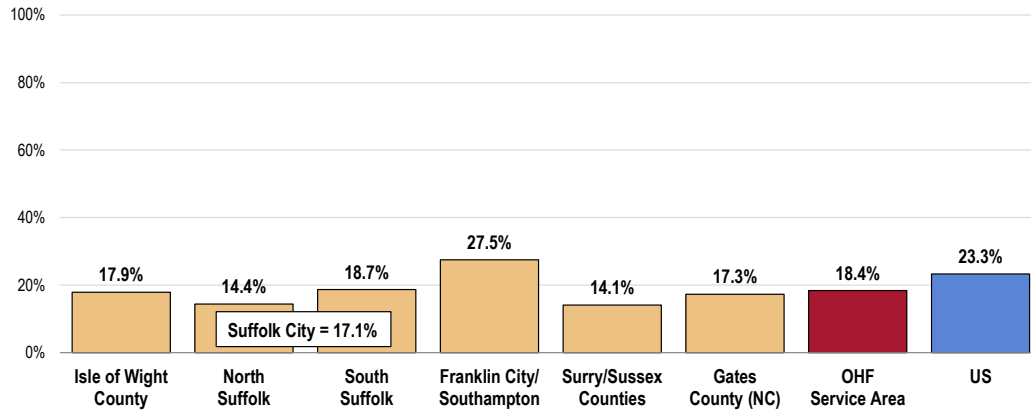
**Level of Health Literacy**  
(OHF Service Area, 2017)



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
- Notes:
- Asked of all respondents.
  - Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

- Lower than national findings.
- The prevalence is unfavorably high in Franklin City/Southampton.

### Low Health Literacy

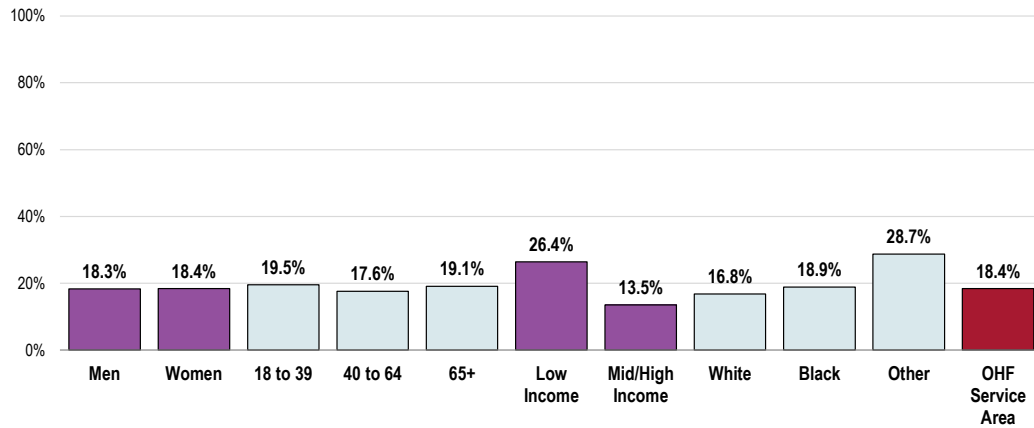


- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

These local adults are more likely to have low levels of health literacy:

- Low-income residents.
- Adults of Other race/ethnicity.

### Low Health Literacy (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 178]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

## Understanding Health Information

Respondents were read:

"You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor's office, in clinics, and many other places.

How often is health information written in a way that is easy for you to understand?

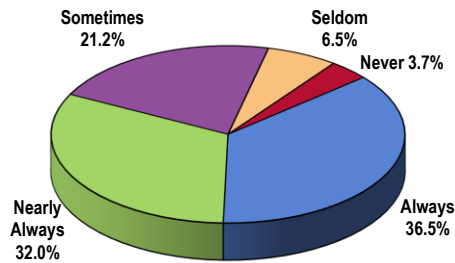
How often is health information spoken in a way that is easy for you to understand?"

The following individual measures are used to determine the health literacy levels described above.

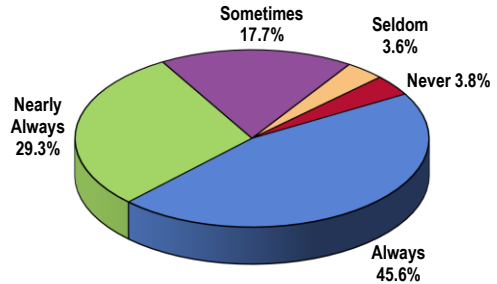
### Written & Spoken Information

While a majority of OHF Service Area adults generally find health information to be easy to understand, 10.2% experience some difficulty with written health information and 7.4% experience some difficulty with spoken health information (responding "seldom" or "never" easy to understand).

### Frequency With Which Health Information Is \_\_\_\_\_ in a Way That is Easy to Understand (OHF Service Area, 2017)



Written



Spoken

Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 74, 76]  
 Notes: • Asked of all respondents.

### Reading Health Information & Completing Health Forms

Respondents were read:

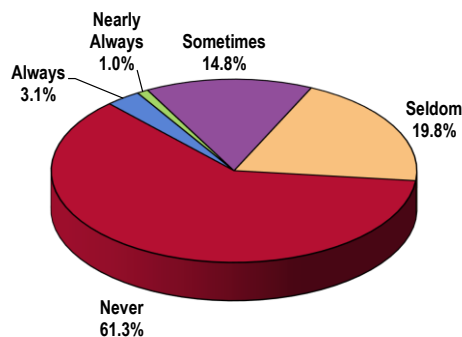
"People who might help you read health information include family members, friends, caregivers, doctors, nurses, or other health professionals. How often do you need to have someone help you read health information?"

**A total of 4.1% of OHF Service Area adults "always" or "nearly always" need to have someone help them read health information.**

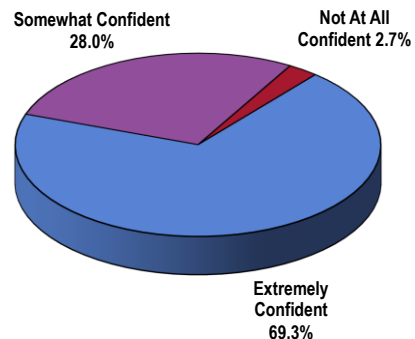
**A total of 2.7% of adults are "not at all confident" in their ability to fill out health forms by themselves.**

"Health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and health care. In general, how confident are you in your ability to fill out health forms yourself?"

### Frequency of Needing Help Reading Health Information (OHF Service Area, 2017)



### Confidence in Ability to Fill Out Health Forms (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 75, 77]  
 Notes: • Asked of all respondents.  
 • In this case, health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

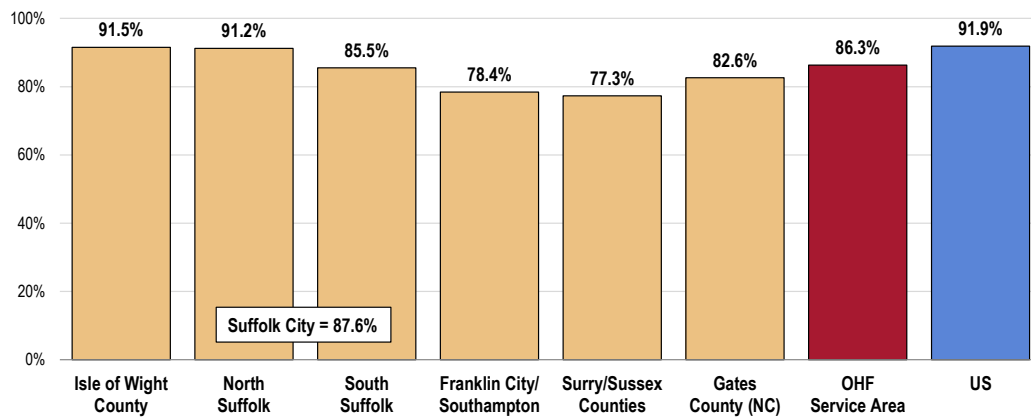
## Internet Access and Smartphones

### Personal Use of the Internet

A majority of OHF Service Area survey respondents (86.3%) have access to the Internet for personal use.

- This prevalence is less favorable than the US benchmark.
- By area, adults in Franklin City/Southampton County and Surry/Sussex counties were less likely to report having Internet for personal use.

#### Have Access to the Internet for Personal Use

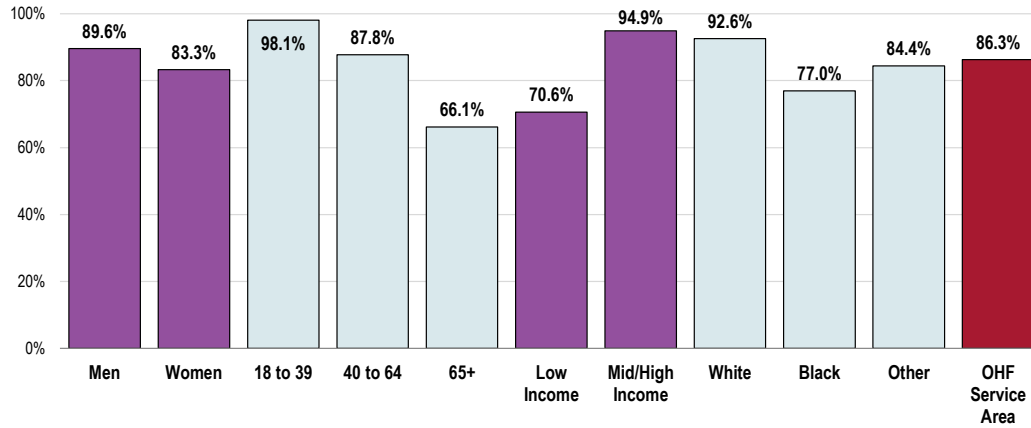


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

OHF Service Area adults less likely to have access to the Internet for personal use include:

- Women.
- Older residents (negative correlation with age).
- Respondents in low-income households.
- Blacks and Other race/ethnicity adults.

### Have Access to the Internet for Personal Use (OHF Service Area, 2017)



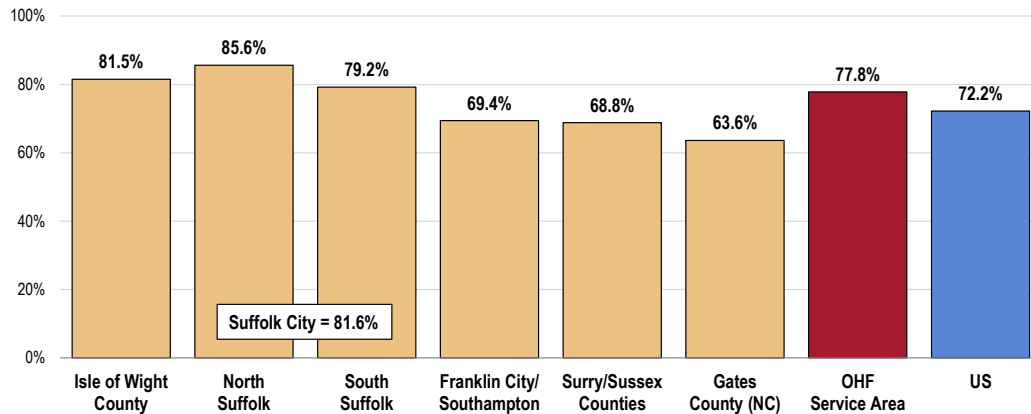
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 308]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Smartphones

More than three in four OHF Service Area residents (77.8%) have a smartphone.

- More favorable than the US prevalence.
- The prevalence is markedly lower in Franklin City/Southampton County, Surry/Sussex counties, and Gates County.

### Have a Smartphone

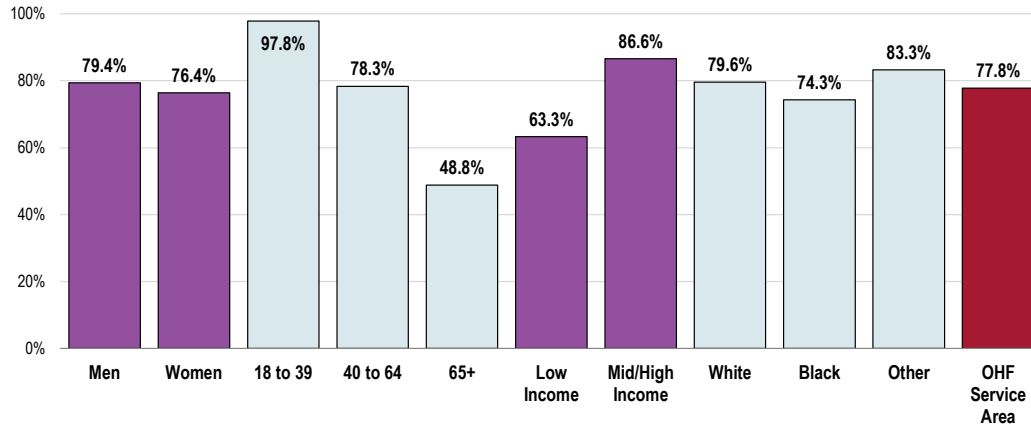


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

These area residents are less likely to own smartphones:

- Older residents (negative correlation with age).
- Adults in low-income households.
- Blacks.

### Have a Smartphone (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

# General Health Status



Professional Research Consultants, Inc.



## Overall Health Status

### Evaluation of Health Status

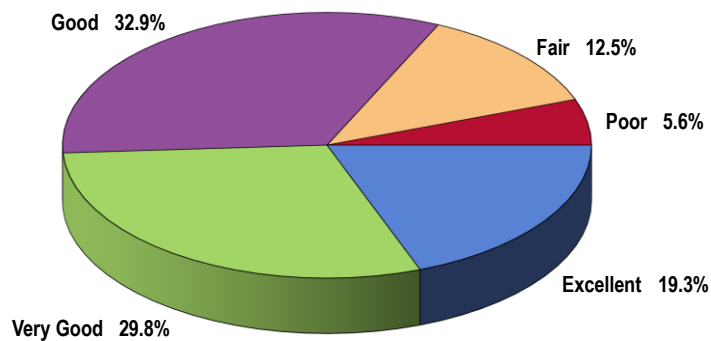
A total of 49.1% of OHF Service Area adults rate their overall health as “excellent” or “very good.”

- Another 32.9% gave “good” ratings of their overall health.

The initial inquiry of the PRC Community Health Survey asked respondents the following:

“Would you say that in general your health is: excellent, very good, good, fair, or poor?”

### Self-Reported Health Status (OHF Service Area, 2017)

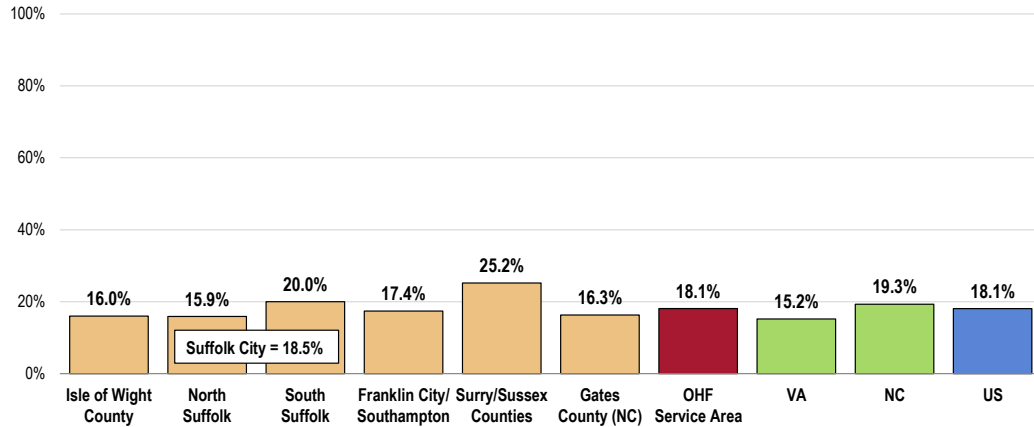


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
Notes: • Asked of all respondents.

However, 18.1% of OHF Service Area adults believe that their overall health is “fair” or “poor.”

- Higher than the Virginia prevalence but comparable to North Carolina and the US.
- Statistically comparable findings by community.

### Experience “Fair” or “Poor” Overall Health



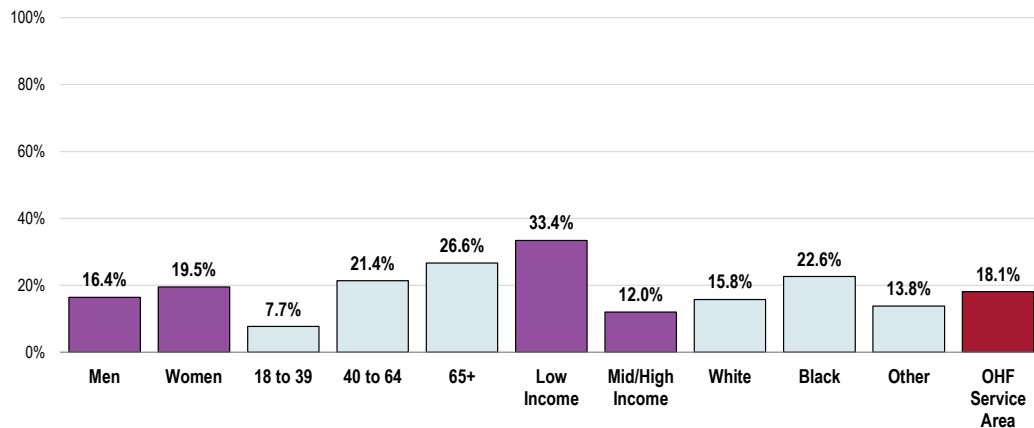
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Adults more likely to report experiencing “fair” or “poor” overall health include:

- Older residents (positive correlation with age).
- Residents living at lower incomes.
- Blacks.

### Experience “Fair” or “Poor” Overall Health (OHF Service Area, 2017)

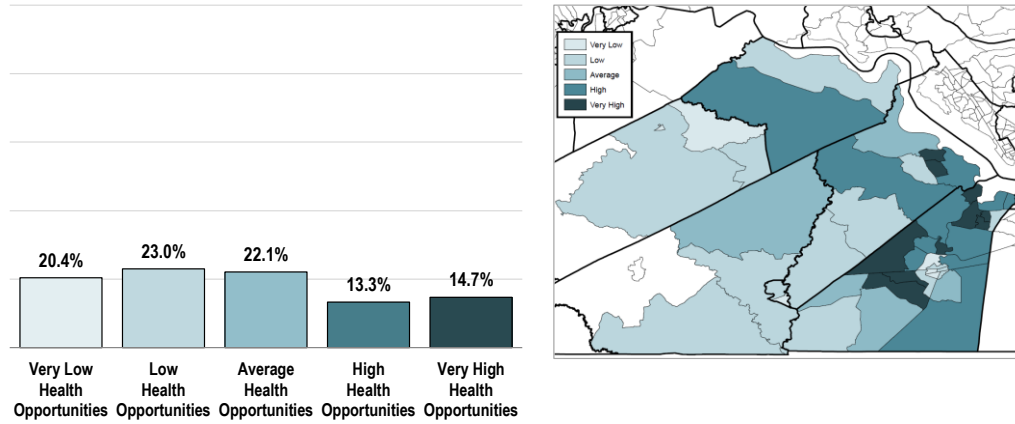


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Throughout this report, segmentation by the Virginia Health Opportunity Index (HOI) is provided for select indicators (grouping service area census tracts with similar opportunity levels). These charts show any correlation between the illustrated indicator and the level of opportunity that exists for residents (as defined by the Virginia HOI project).

In areas with average or lower health opportunities, the proportion of respondents giving “fair” or “poor” ratings of their health is higher than among those with more health opportunities.

### Experience “Fair” or “Poor” Overall Health (OHF Service Area by Health Opportunity Index Classification)



Sources: ● PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
 Notes: ● Asked of all respondents.

## Activity Limitations

### About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
  - **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
  - **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

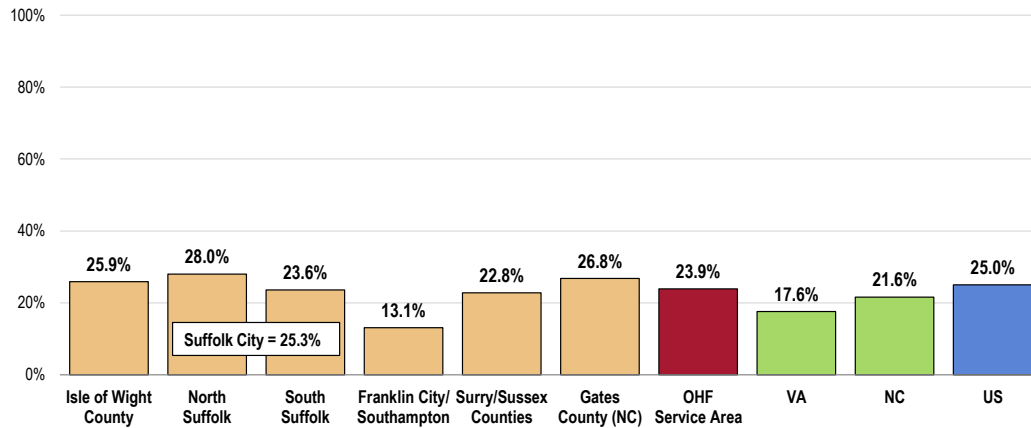
**A total of 23.9% of OHF Service Area adults are limited in some way in some activities, due to a physical, mental, or emotional problem.**

- Less favorable than the prevalence reported in Virginia but comparable to North Carolina and US results.
- Favorably low in the Franklin City/Southampton community.

#### RELATED ISSUE:

See also *Potentially Disabling Conditions in the Death, Disease & Chronic Conditions* section of this report.

### Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources:
 

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

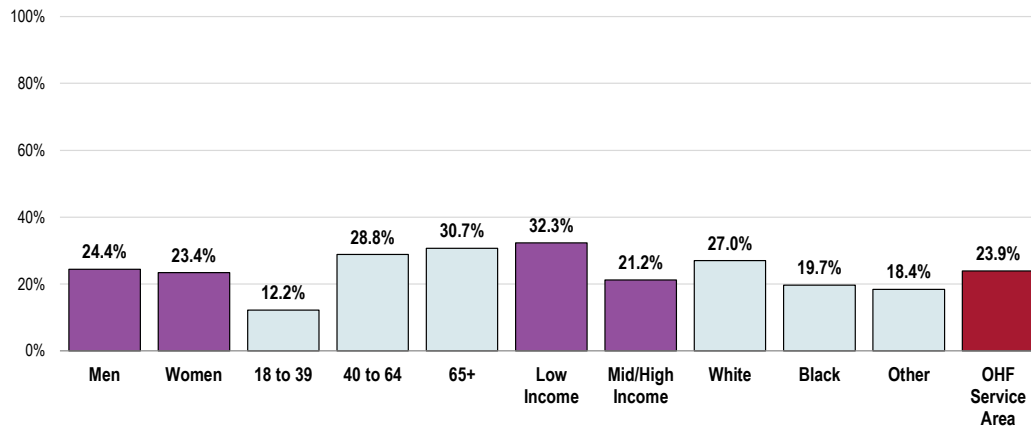
 Notes:
 

- Asked of all respondents.

In looking at responses by key demographic characteristics, these adults are statistically more likely to report some type of activity limitation:

- Adults age 40 and older (note the positive correlation with age).
- Residents in low-income households.
- Whites.

### Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (OHF Service Area, 2017)



Sources:
 

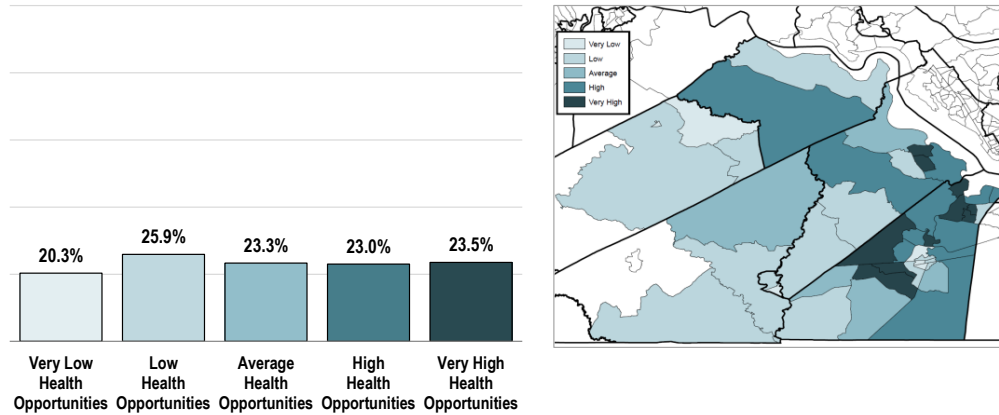
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]

 Notes:
 

- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Examining findings by Health Opportunities Index classification shows no clear correlation.

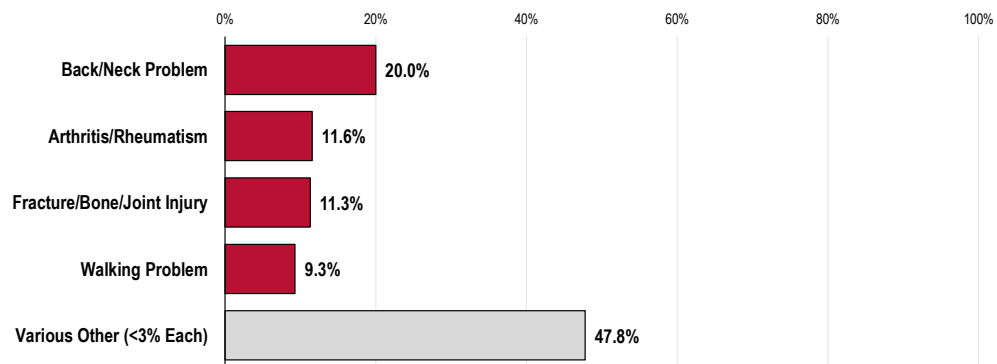
### Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]  
Notes: • Asked of all respondents.

Among persons reporting activity limitations, these are most often attributed to musculo-skeletal issues, such as back/neck problems, arthritis/rheumatism, fractures or bone/joint injuries, or difficulty walking.

### Type of Problem That Limits Activities (Among Those Reporting Activity Limitations; OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 110]  
Notes: • Asked of those respondents reporting activity limitations.

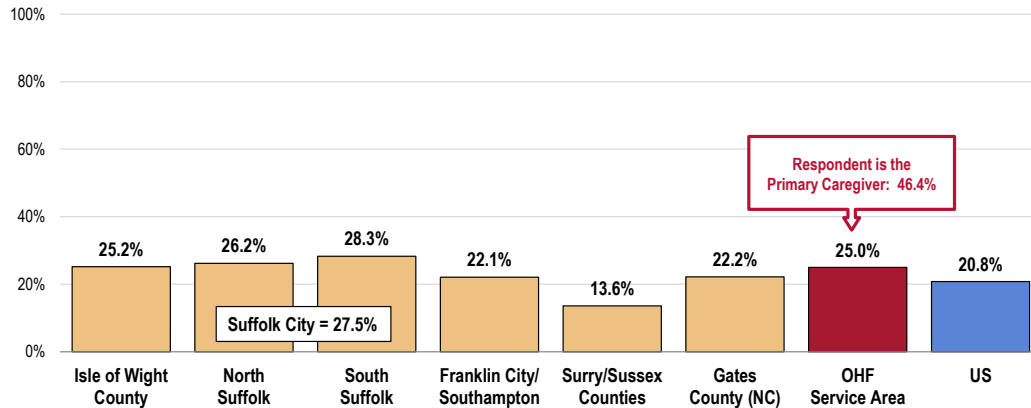
## Caregiving

A total of 25.0% of OHF Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

- Higher than the national finding.
- Highest in Suffolk City, especially South Suffolk; lowest in Surry/Sussex counties.

Of these adults, 46.4% are the **primary** caregiver for the individual receiving care.

### Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability

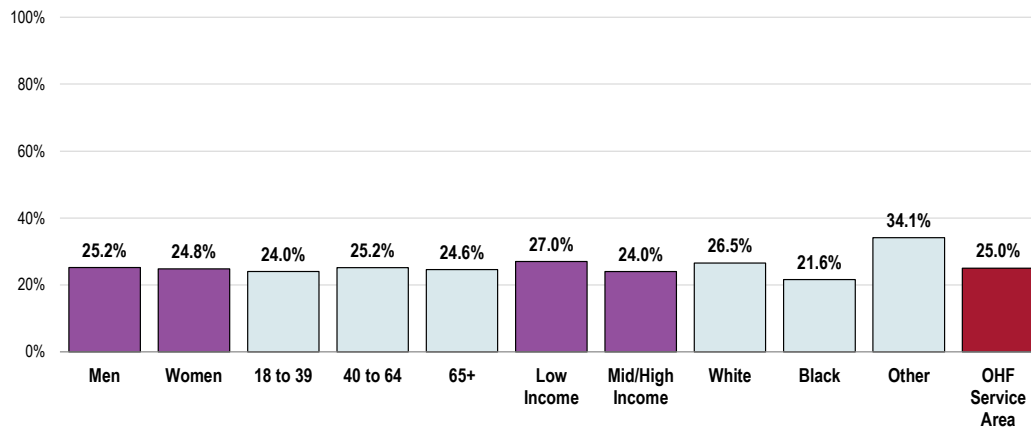


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 111, 113]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

- The prevalence of caregivers in the community is notably higher among residents of Other race/ethnicities.

### Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability (OHF Service Area, 2017)

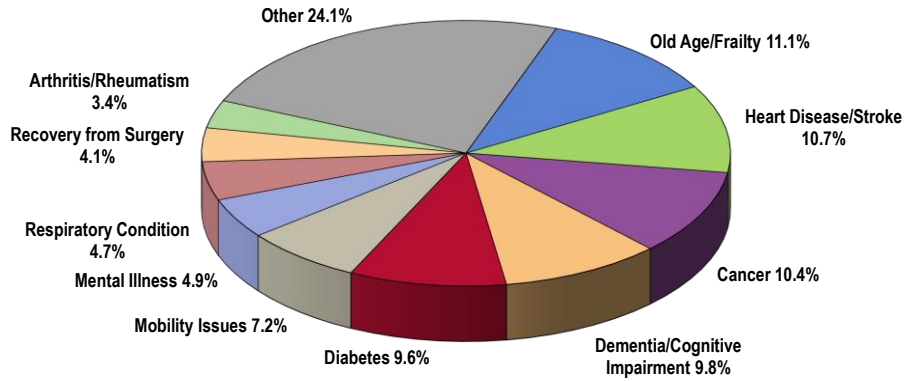


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 111]

Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

For those who provide care or assistance, the top health issues affecting those receiving their care include **old age/frailty** (mentioned by 11.1%), **heart disease/stroke** (10.7%), **cancer** (10.4%), **dementia/cognitive impairment** (9.8%), and **diabetes** (9.6%).

**Primary Health Issue of Person Receiving Care or Assistance**  
 (Among Caregivers Providing Regular Care to a Friend/Family Member;  
 OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 112]  
 Notes: • Asked of those respondents reporting providing regular care or assistance to a friend or family member with a health problem, long-term illness, or disability.



## Mental Health

### About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

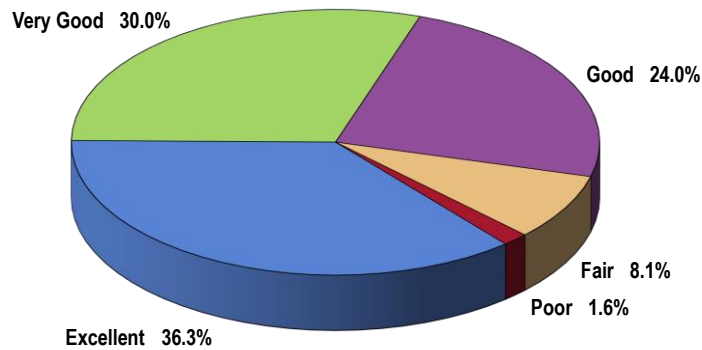
## Evaluation of Mental Health Status

A total of 66.3% of OHF Service Area adults rate their overall mental health as “excellent” or “very good.”

- Another 24.0% gave “good” ratings of their own mental health status.

“Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?”

### Self-Reported Mental Health Status (OHF Service Area, 2017)

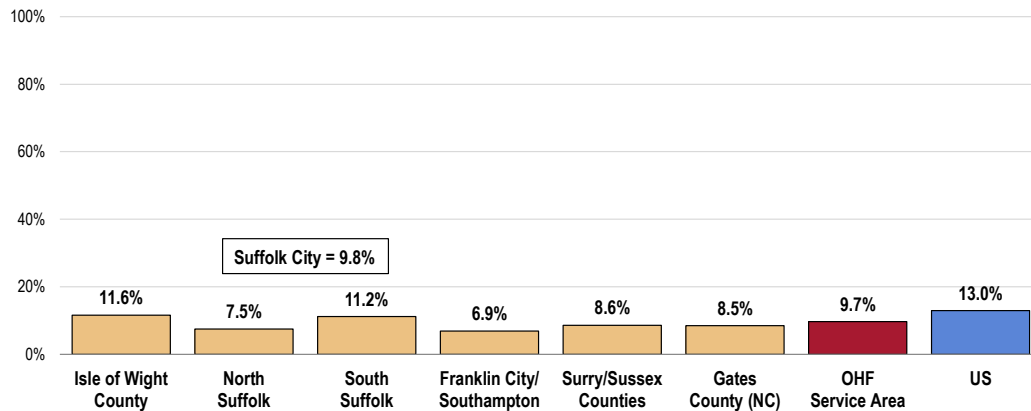


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]  
Notes: • Asked of all respondents.

A total of 9.7% of OHF Service Area adults, however, believe that their overall mental health is “fair” or “poor.”

- More favorable than the “fair/poor” response reported nationally.
- Statistically comparable findings by community.

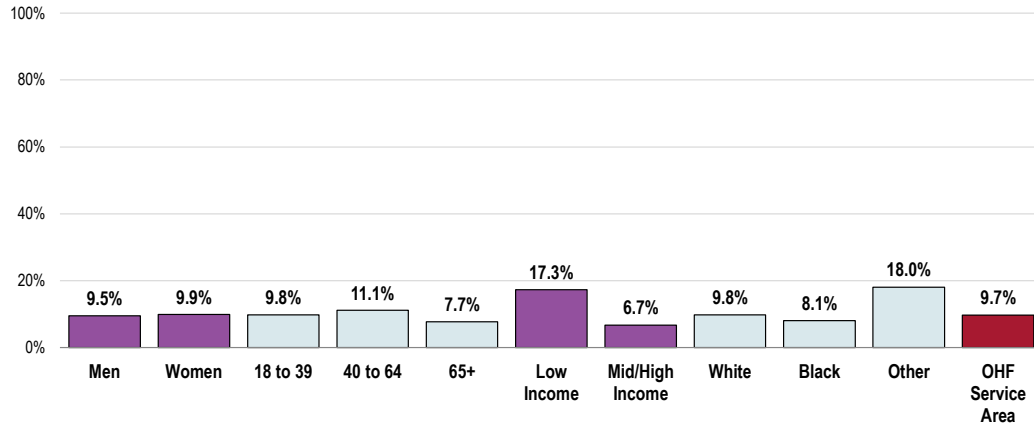
### Experience “Fair” or “Poor” Mental Health



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]  
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

- Adults age 40 to 64, those in low-income households, and residents of Other race/ethnicities are more likely to report experiencing “fair/poor” mental health than their demographic counterparts.

### Experience “Fair” or “Poor” Mental Health (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

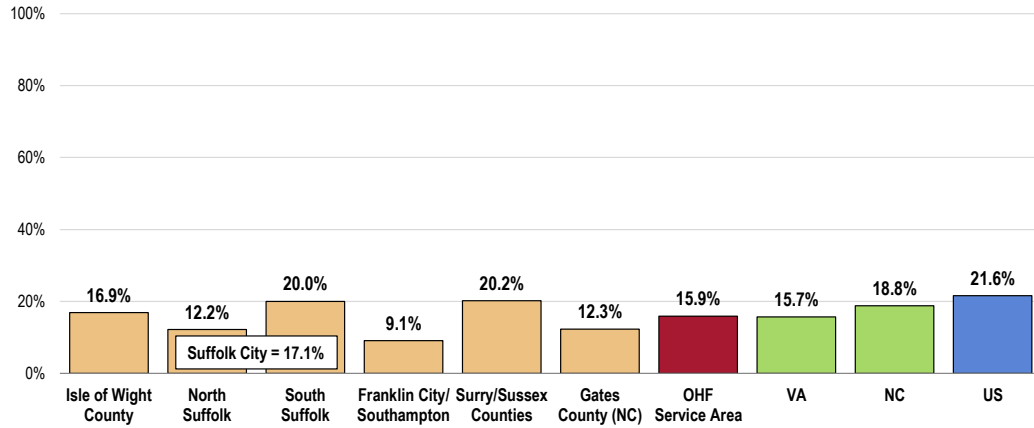
## Depression

### Diagnosed Depression

A total of 15.9% of OHF Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Similar to the Virginia finding but more favorable than North Carolina and the US.
- Unfavorably high in South Suffolk; lowest in North Suffolk and Franklin City/Southampton.

### Have Been Diagnosed With a Depressive Disorder

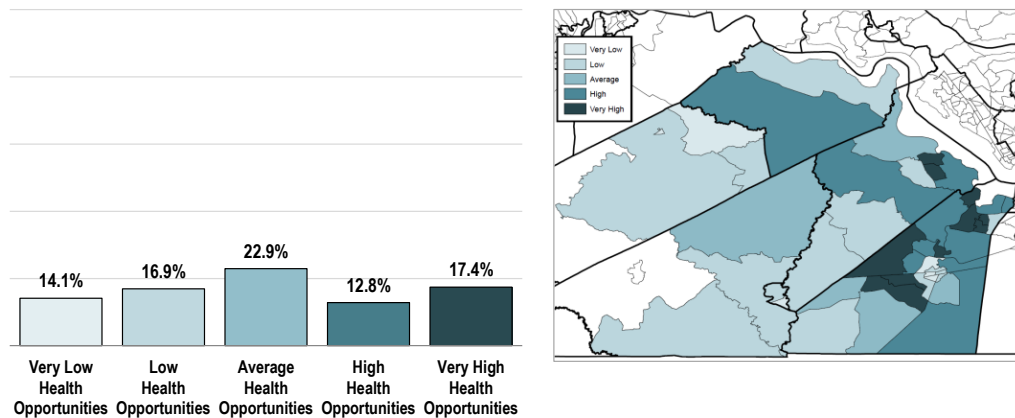


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.  
 • Depressive disorders include depression, major depression, dysthymia, or minor depression.

Note the following chart illustrating diagnoses of depressive disorder in the OHF Service Area, segmented by the Virginia HOI classifications.

### Have Been Diagnosed With a Depressive Disorder (OHF Service Area by Health Opportunity Index Classification)



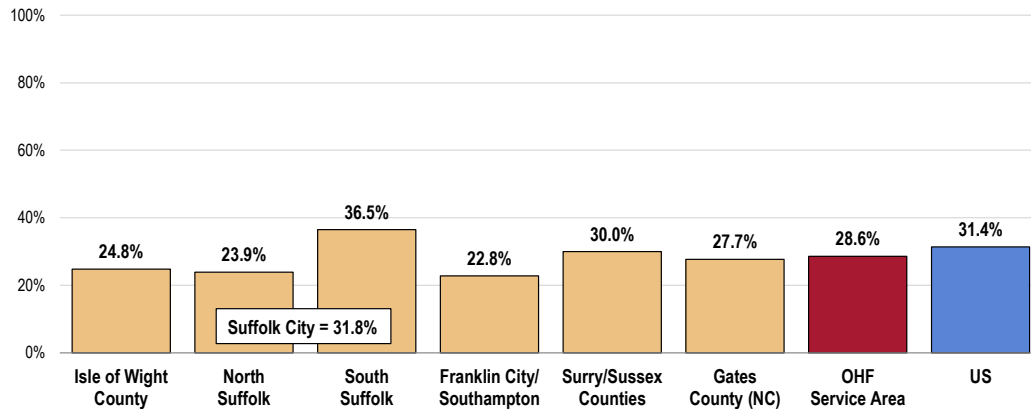
Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]  
 Notes: • Asked of all respondents.

### Symptoms of Chronic Depression

A total of 28.6% of OHF Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

- Similar to the national findings.
- Unfavorably high in Suffolk City, especially South Suffolk.

### Have Experienced Symptoms of Chronic Depression

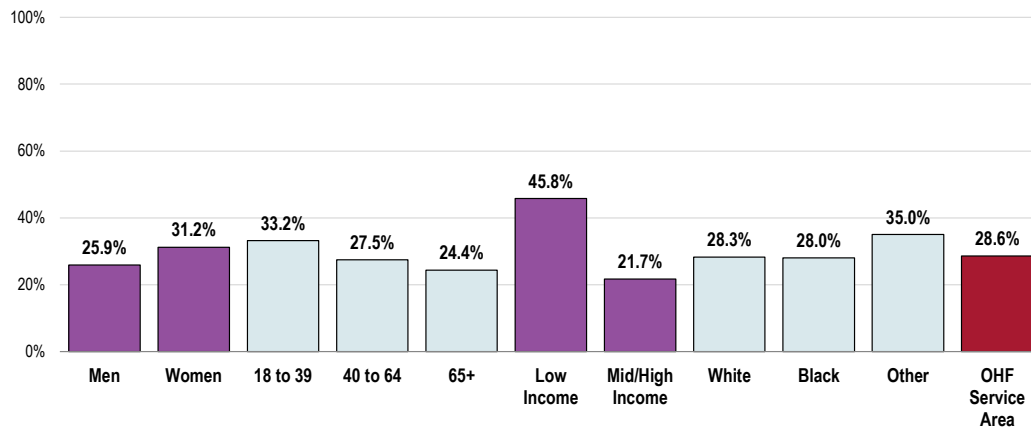


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.  
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

- The prevalence of chronic depression is higher among women and especially adults with lower incomes.

### Have Experienced Symptoms of Chronic Depression (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]

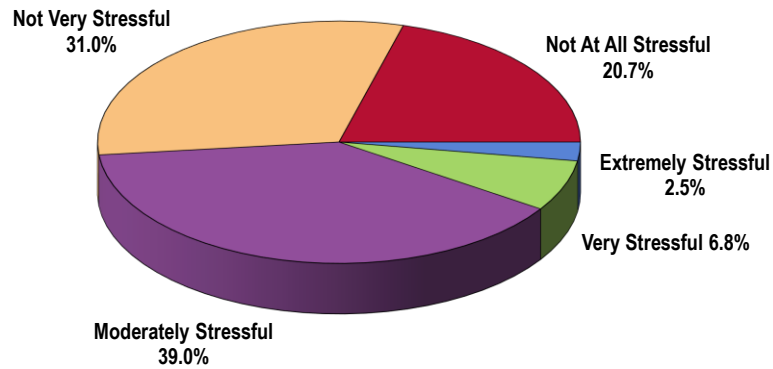
Notes: • Asked of all respondents.  
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Stress

More than half of OHF Service Area adults consider a typical day to be “not very stressful” (31.0%) or “not at all stressful” (20.7%).

- Another 39.0% of survey respondents characterize a typical day as “moderately stressful.”

**Perceived Level of Stress On a Typical Day**  
(OHF Service Area, 2017)

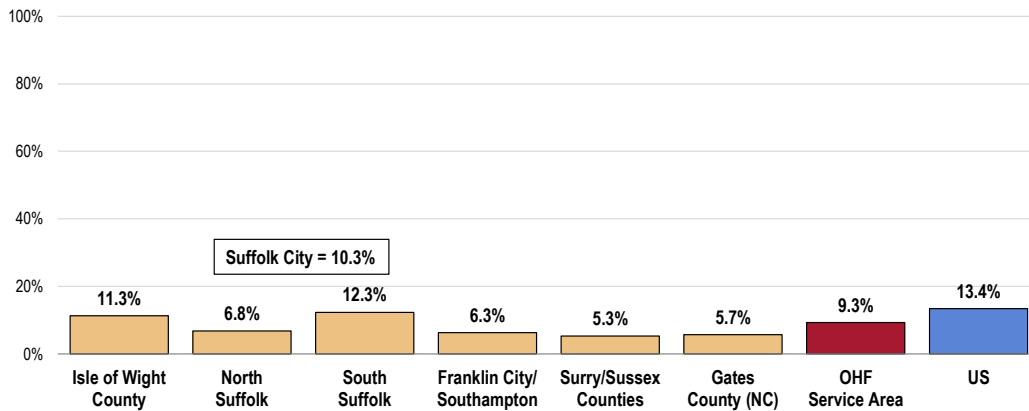


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]  
Notes: • Asked of all respondents.

In contrast, 9.3% of OHF Service Area adults experience “very” or “extremely” stressful days on a regular basis.

- More favorable than national findings.
- Statistically high in South Suffolk.

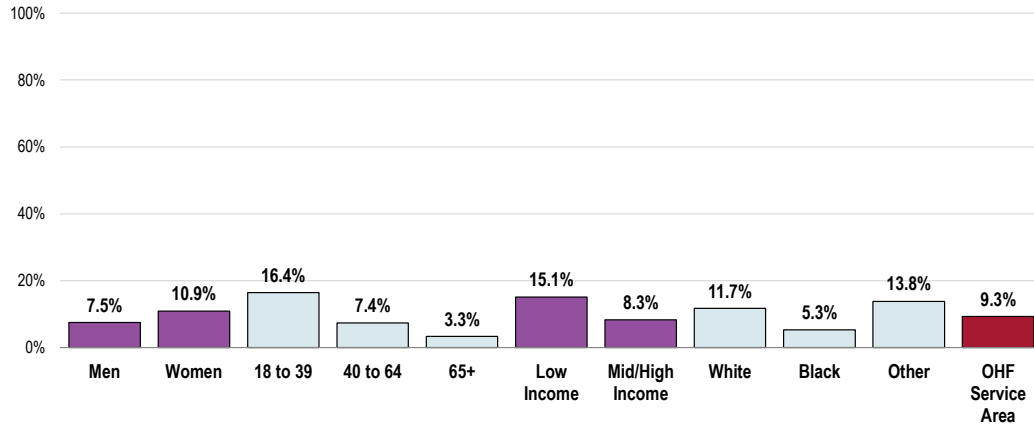
**Perceive Most Days As “Extremely” or “Very” Stressful**



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]  
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

- Note that high stress levels are more prevalent among women, adults under age 65 (negative correlation with age), low-income residents, Whites, and Other race/ethnicity residents.

### Perceive Most Days as “Extremely” or “Very” Stressful (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]

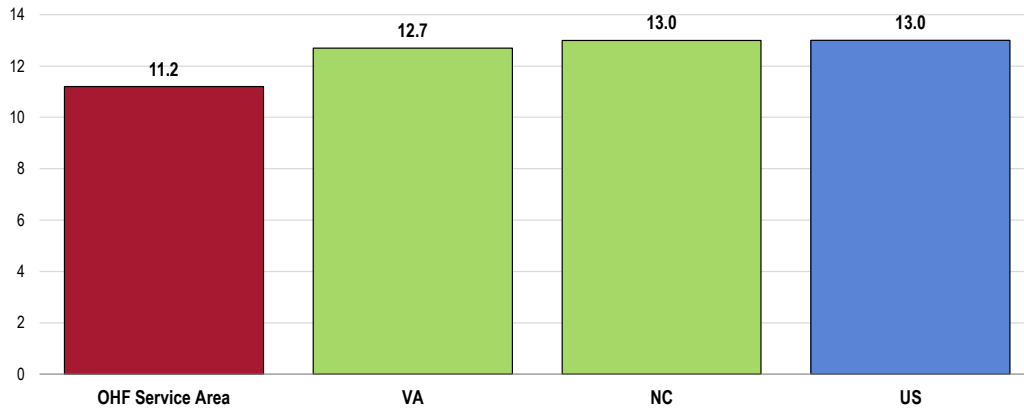
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Suicide

**Between 2013 and 2015, there was an annual average age-adjusted suicide rate of 11.2 deaths per 100,000 population in the OHF Service Area.**

- Similar to the Virginia rate but lower than the North Carolina rate.
- Lower than the national rate.
- Similar to the Healthy People 2020 target of 10.2 or lower.

### Suicide: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 10.2 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

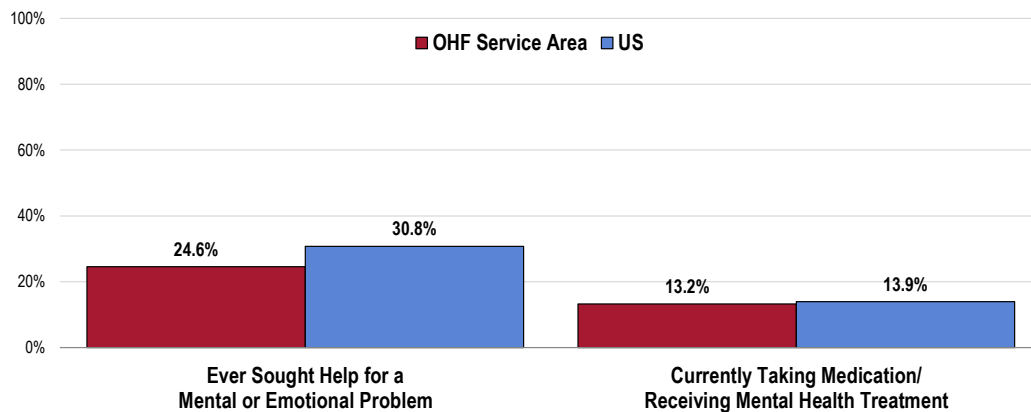
### Mental Health Treatment

A total of 24.6% of OHF Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

A total of 13.2% are currently taking medication or receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

- Compared to national findings, a lower proportion of area residents have sought help for a mental or emotional problem (a similar proportion is receiving treatment).

### Mental Health Treatment



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 103-104]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Reflects the total sample of respondents.

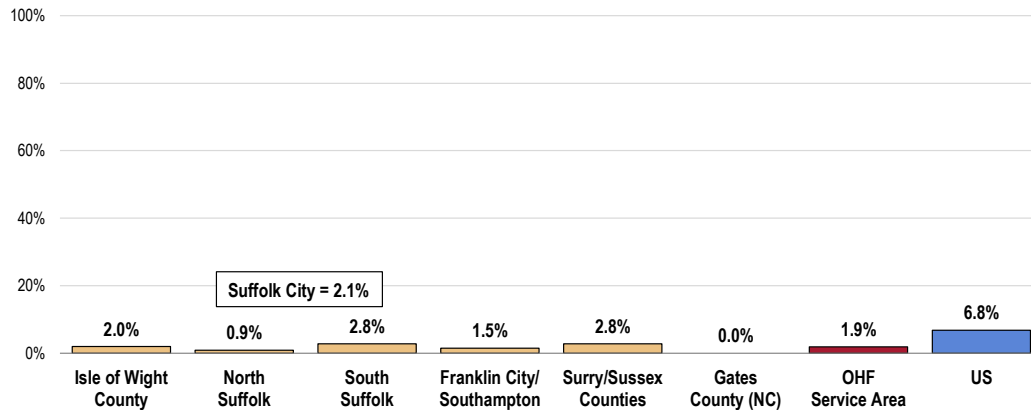


### Difficulty Accessing Mental Health Services

A total of 1.9% of OHF Service Area adults report a time in the past year when they needed mental health services, but were not able to get them.

- Well below the national finding.
- Note the null response in Gates County.

### Unable to Get Mental Health Services When Needed in the Past Year



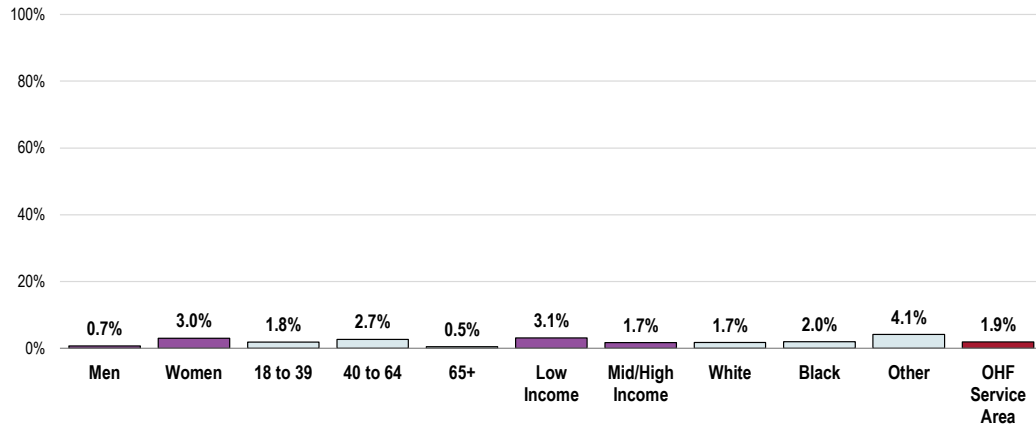
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

Among the 30 persons citing difficulties accessing mental health services in the past year, these are predominantly attributed to **cost** or **physician availability**.

Note that access difficulty is notably more prevalent among:

- Women.
- Adults age 40 to 64.
- Low-income residents.

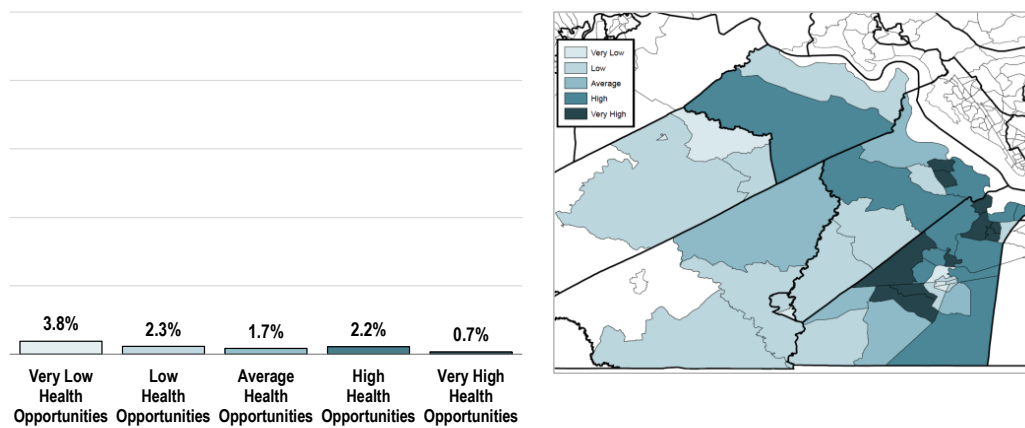
### Unable to Get Mental Health Services When Needed in the Past Year (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Note that access difficulty is notably more prevalent among residents in areas with very low health opportunities.

### Unable to Get Mental Health Services When Needed in the Past Year (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]  
 Notes: • Asked of all respondents.

## Key Informant Input: Mental Health

The greatest share of key informants taking part in an online survey characterized *Mental Health* as a “major problem” in the community.

### Perceptions of Mental Health as a Problem in the Community (Key Informants, 2017)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” the following represent what key informants see as the main challenges for persons with mental illness:

#### Access to Care/Services

*Few resources other than Western Tidewater Community Services Board and our inpatient psychiatric unit at Sentara Obici Hospital. Outpatient services are very limited. – Other Health Provider*

*Mental health needs more crisis interventions in our area. Patients cannot get appointments for days and often need to be seen immediately. People need to get involved in purposeful work or activities to make them feel worthy. Watching too much TV, I feel, adds to depression and anxiety. The news alone can make you feel hopeless, vulnerable, and depressed. – Public Health Representative*

*Lack of available resources, and this issue has a great stigma associated with it. Workplaces ignore it. Healthcare does not cover much; if you have a heart attack or stroke, you get more healthcare than if you have a mental health issue. Mental health issues go undiagnosed lots of times. – Community Leader*

*I see patients in Western Tidewater. Many have mental health disorders and do not have ready access to care, so they are underserved. They would benefit from more access to counseling, specifically. – Physician*

*No direct access to resources. Not being able to afford care. Not knowing where to go for help. Insurance not covering the cost of care or medications. – Community Leader*

*A lot more work needs to be done to help the mentally ill to have places for treatment and hospitalization specific for mental health. – Community Leader*

*Patients complain that they have a hard time getting into Western Tidewater Community Services Board to get medications. – Other Health Provider*

*Access to appropriate care at appropriate phases of the disease. – Other Health Provider*

*Access to care. Minimal preventative services available. Patient has to be in crisis for intervention. Young individuals lack coping strategies. – Other Health Provider*

*Not enough access to care. – Other Health Provider*

*No services. – Other Health Provider*

*Access to care. – Educator*

**Lack of Providers**

*Limited number of qualified professionals and facilities to treat and admit those with these types of illnesses. Admission facilities are desperately few and far between. – Other Health Provider*

*Western Tidewater does not have enough providers, specifically for low- or no-income people and families. – Community Leader*

*Mental health is one of the greatest problems faced across our state. There are not enough providers and mental health resources to ease the problem. – Public Health Representative*

*The only major provider in Western Tidewater is the Western Tidewater Community Services Board. Many individuals need mental health services, and there are few providers in this community. A psychiatrist is much needed in our area to serve the insured and underinsured. – Public Health Representative*

*Access to mental healthcare providers for diagnosis, prevention, and medication necessary is limited without insurance. Hospitals are flooded with mental health issues, resulting in temporary treatment. – Other Health Provider*

*Lack of geriatricians, adult day-care centers, respite providers. – Other Health Provider*

*Lack of mental health professionals. Our area, as well as treatment centers. – Community Leader*

**Denial/Stigma**

*Stigma, lack of education, and awareness about mental health and treatment options. Limited service providers, cost and insurance coverage. – Community Leader*

*The perceived stigma associated with mental health is deterring people from seeking treatment in our community. – Other Health Provider*

*Stigma. – Community Leader*

**Co-Occurrences**

*Opioid crisis, depression, anxiety, and more serious behavioral health issues that go unidentified and untreated. Medication-access challenges, transportation, access to providers, ability to make referrals. – Other Health Provider*

**Disease Management**

*The people who need the help are not being engaged in a manner that promotes long-term progress. We're only able to address the episode at hand, and this is not helping the community. – Other Health Provider*

# Death, Disease & Chronic Conditions

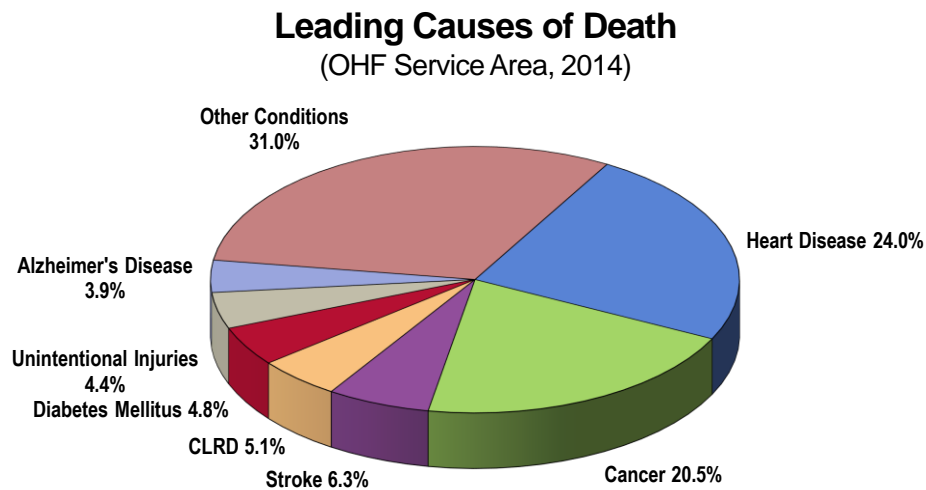


Professional Research Consultants, Inc.

## Leading Causes of Death

### Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for half of all deaths in the OHF Service Area in 2014.



- Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• CLRD is chronic lower respiratory disease.

### Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, Virginia, North Carolina, and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines 2013-2015 annual average age-adjusted death rates per 100,000 population for selected causes of death in the OHF Service Area.

Each of these is discussed in greater detail in subsequent sections of this report.

For infant mortality data, see [Birth Outcomes & Risks](#) in the [Births](#) section of this report.

## Age-Adjusted Death Rates for Selected Causes (2013–2015 Deaths per 100,000 Population)

	OHF Service Area	VA	NC	US	HP2020
<b>Diseases of the Heart</b>	180.2	155.8	162.1	168.0	156.9*
<b>Malignant Neoplasms (Cancers)</b>	173.8	161.0	167.2	161.0	161.4
<b>Falls (Age 65+)</b>	45.1	62.6	69.5	59.0	47.0
<b>Cerebrovascular Disease (Stroke)</b>	44.2	37.9	43.4	36.8	34.8
<b>Chronic Lower Respiratory Disease (CLRD)</b>	40.0	36.6	45.6	41.4	n/a
<b>Unintentional Injuries</b>	39.2	37.1	45.0	41.0	36.4
<b>Alzheimer's Disease</b>	28.5	22.0	31.0	26.1	n/a
<b>Diabetes</b>	28.5	19.6	23.0	21.1	20.5*
<b>Kidney Disease</b>	20.1	17.2	16.3	13.3	n/a
<b>Pneumonia/Influenza</b>	13.6	16.6	18.1	15.4	n/a
<b>Motor Vehicle Deaths</b>	12.9	8.8	13.6	10.6	12.4
<b>Intentional Self-Harm (Suicide)</b>	11.2	12.7	13.0	13.0	10.2
<b>Firearm-Related</b>	10.7	10.5	12.1	10.6	9.3
<b>Cirrhosis/Liver Disease</b>	9.6	9.1	10.4	10.5	8.2
<b>Drug-Induced</b>	9.5	11.8	14.8	15.8	11.3
<b>Homicide/Legal Intervention</b>	6.0	4.6	6.3	5.6	5.5
<b>HIV/AIDS</b>	3.0	1.9	3.1	2.7	3.3

Sources: 

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.

- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.

Note: 

- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.

- \*The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

## Cardiovascular Disease

### About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Heart Disease & Stroke Deaths

### Heart Disease Deaths

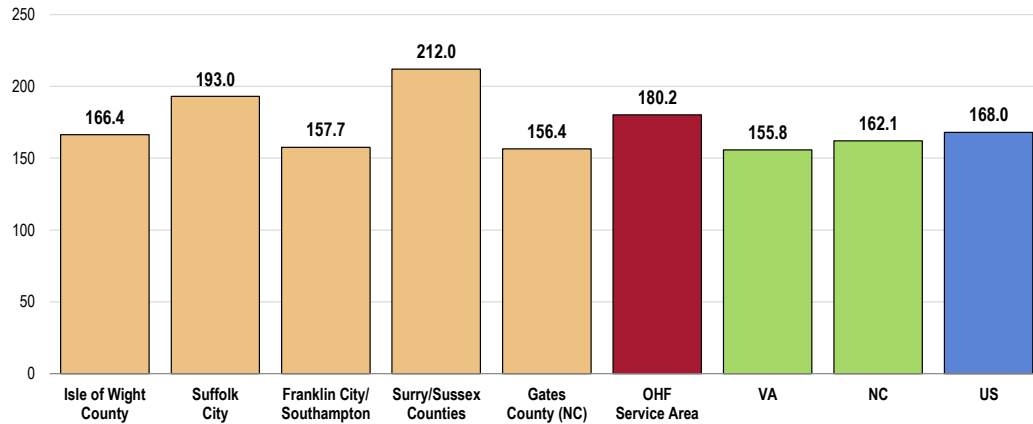
**Between 2013 and 2015 there was an annual average age-adjusted heart disease mortality rate of 180.2 deaths per 100,000 population in the OHF Service Area.**

- Statistically comparable to the statewide and national rates.
- Comparable to the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).
- Unfavorably high in the Surry/Sussex County area.

The greatest share of cardiovascular deaths is attributed to heart disease.



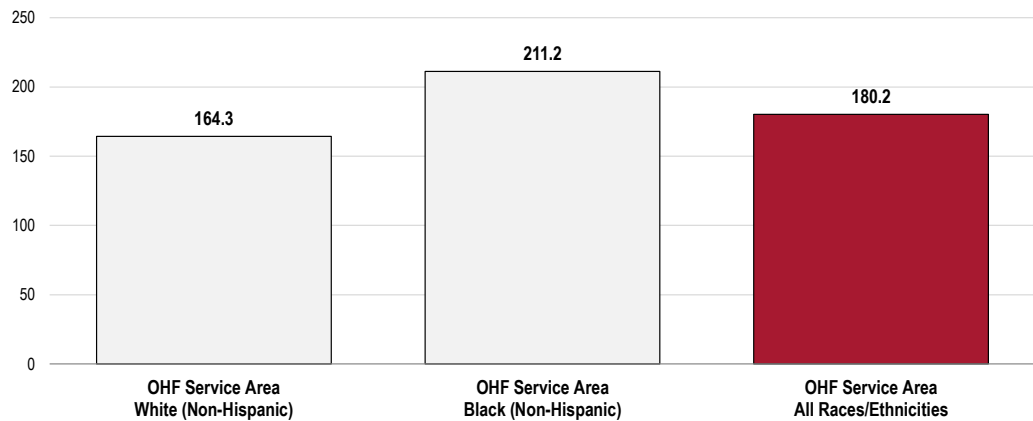
### Heart Disease: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 156.9 or Lower (Adjusted)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

- By race, the heart disease mortality rate is notably higher among Non-Hispanic Blacks when compared with Non-Hispanic Whites in the OHF Service Area.

### Heart Disease: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 156.9 or Lower (Adjusted)



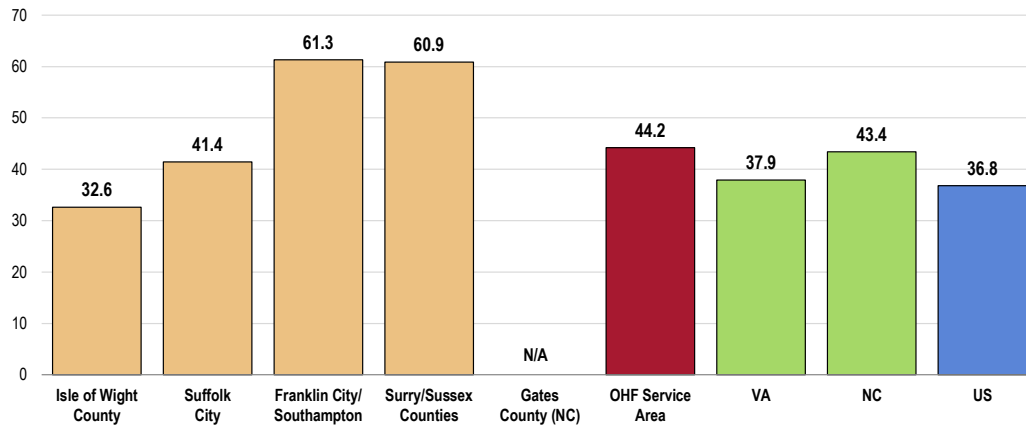
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

### Stroke Deaths

Between 2013 and 2015, there was an annual average age-adjusted stroke mortality rate of 44.2 deaths per 100,000 population in the OHF Service Area.

- Similar to both state rates but higher than the US rate.
- Fails to satisfy the Healthy People 2020 target of 34.8 or lower.
- Highest in the Franklin City/Southampton and Surry/Sussex County combined areas.

**Stroke: Age-Adjusted Mortality**  
(2013–2015 Annual Average Deaths per 100,000 Population)  
Healthy People 2020 Target = 34.8 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- Stroke mortality is higher among Blacks than Whites in the OHF Service Area.

**Stroke: Age-Adjusted Mortality by Race**  
(2013–2015 Annual Average Deaths per 100,000 Population)  
Healthy People 2020 Target = 34.8 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

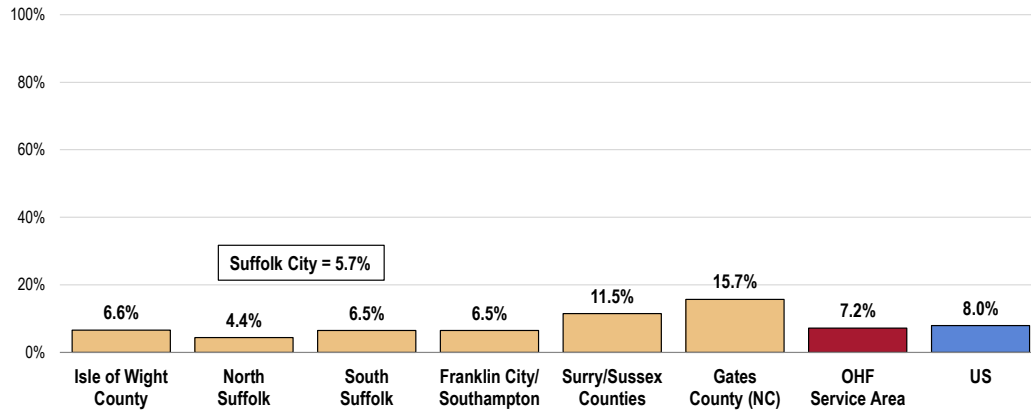
## Prevalence of Heart Disease & Stroke

### Prevalence of Heart Disease

A total of 7.2% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

- Similar to the national prevalence.
- Unfavorably high in Gates County; lowest in Suffolk City, especially North Suffolk.

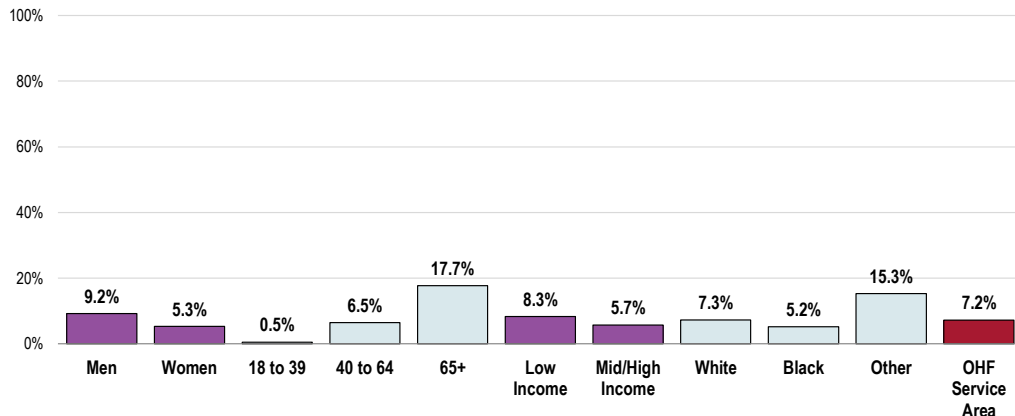
### Prevalence of Heart Disease



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - Includes diagnoses of heart attack, angina, or coronary heart disease.

- Adults more likely to have been diagnosed with chronic heart disease include men, older adults (positive correlation with age), and Other race/ethnicities.

### Prevalence of Heart Disease (OHF Service Area, 2017)



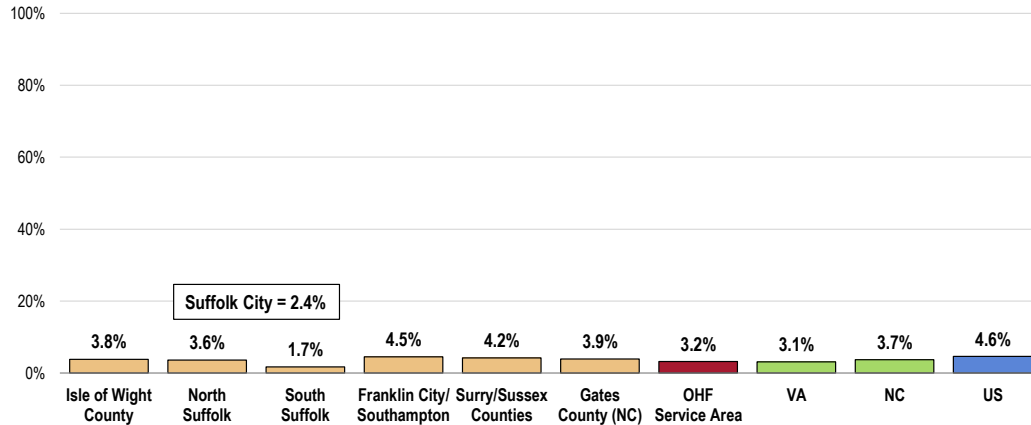
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
- Notes:
- Asked of all respondents.
  - Includes diagnoses of heart attack, angina, or coronary heart disease.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Prevalence of Stroke

A total of 3.2% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to statewide and national findings.
- Favorably low in South Suffolk.

### Prevalence of Stroke



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
- Notes:
- Asked of all respondents.

## Cardiovascular Risk Factors

### About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## High Blood Pressure

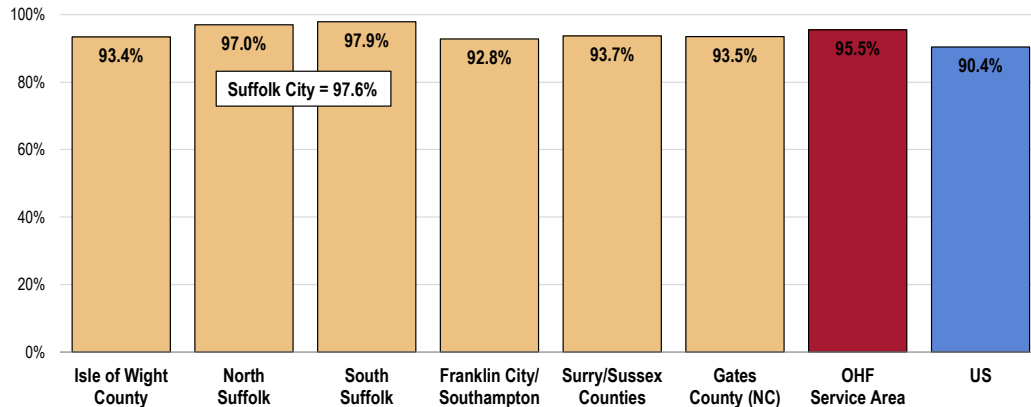
### High Blood Pressure Testing

A total of 95.5% of OHF Service Area adults have had their blood pressure tested within the past two years.

- Higher than the national findings.
- Satisfies the Healthy People 2020 target (92.6% or higher).
- Favorably high in Suffolk City.

## Have Had Blood Pressure Checked in the Past Two Years

Healthy People 2020 Target = 92.6% or Higher



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 42]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-4]  
 Notes: • Asked of all respondents.

### Prevalence of High Blood Pressure

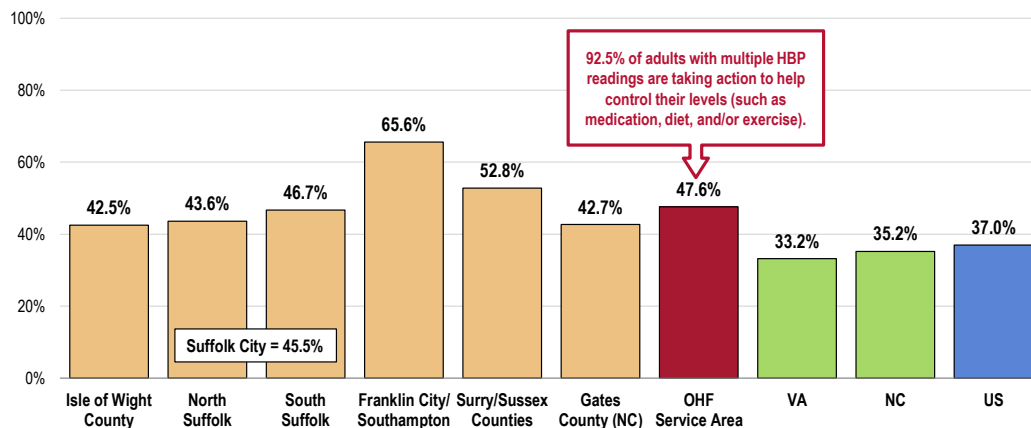
A total of 47.6% of OHF Service Area adults have been told at some point that their blood pressure was high.

- Much higher than the state and national percentages.
- Far from satisfying the Healthy People 2020 target (26.9% or lower).
- Markedly higher in Franklin City/Southampton.

Among adults with multiple high blood pressure readings, 92.5% are taking action to lower their blood pressure (such as medication, change in diet, and/or exercise).

### Prevalence of High Blood Pressure

Healthy People 2020 Target = 26.9% or Lower



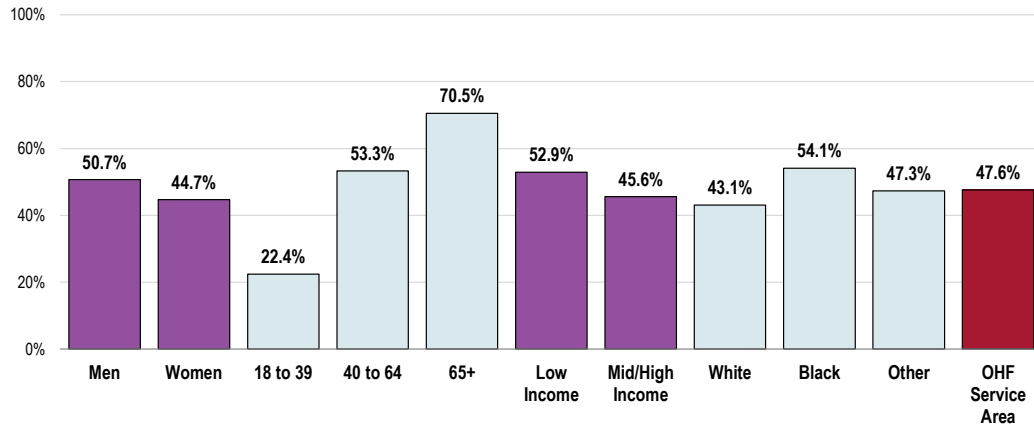
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 41, 129]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]  
 Notes: • Asked of all respondents.

High blood pressure is more prevalent among:

- Men.
- Adults age 40 and older, and especially those age 65+.
- Low-income residents.
- Blacks.

### Prevalence of High Blood Pressure (OHF Service Area, 2017)

Healthy People 2020 Target = 26.9% or Lower



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 129]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]

Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### High Blood Cholesterol

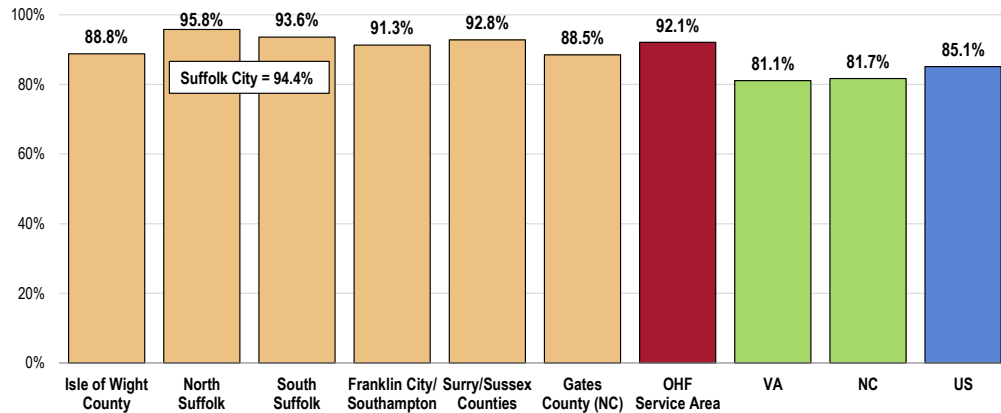
#### Blood Cholesterol Testing

**A total of 92.1% of OHF Service Area adults have had their blood cholesterol checked within the past five years.**

- Higher than the state and national proportions.
- Satisfies the Healthy People 2020 target (82.1% or higher).

## Have Had Blood Cholesterol Levels Checked in the Past Five Years

Healthy People 2020 Target = 82.1% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 45]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-6]
- Notes:
- Asked of all respondents.

### Prevalence of High Blood Cholesterol

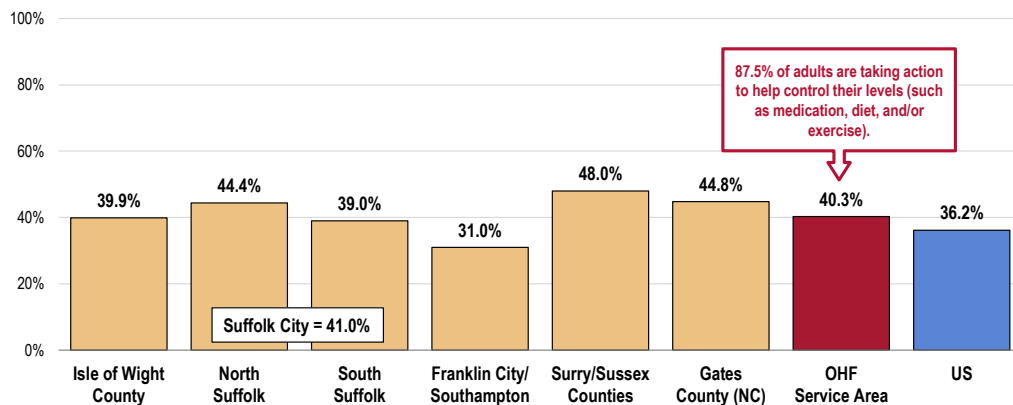
A total of 40.3% of adults have been told by a health professional that their cholesterol level was high.

- Higher than the national prevalence.
- Three times the Healthy People 2020 target (13.5% or lower).
- Favorably low in the Franklin City/Southampton area.

Among adults with high blood cholesterol readings, 87.5% are taking action to lower their numbers (such as medication, change in diet, and/or exercise).

### Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower

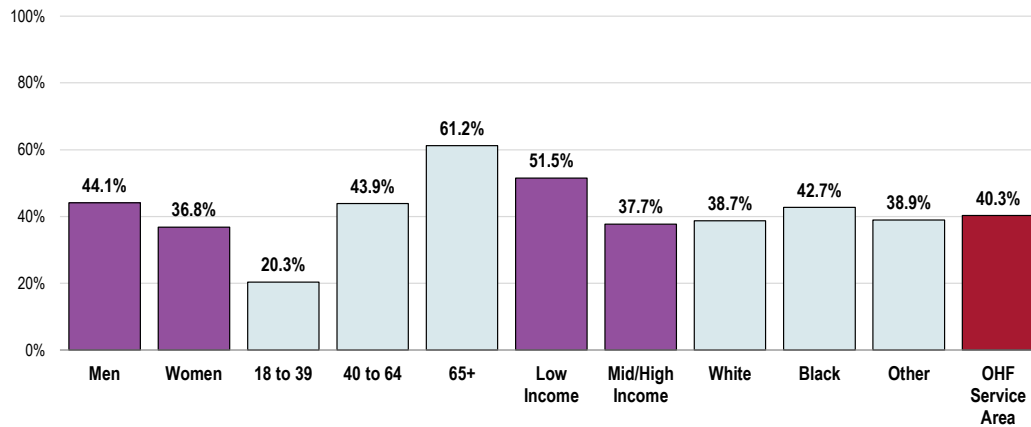


- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 44, 130]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
- Notes:
- Asked of all respondents.

Further note the following:

- OHF Service Area men are more likely than women to report high blood cholesterol levels.
- There is a strong correlation between age and high blood cholesterol.
- There is a higher prevalence among low-income adults.

**Prevalence of High Blood Cholesterol**  
 (OHF Service Area, 2017)  
 Healthy People 2020 Target = 13.5% or Lower



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 130]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



### About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
  - High Blood Cholesterol
  - Tobacco Use
  - Physical Inactivity
  - Poor Nutrition
  - Overweight/Obesity
  - Diabetes
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

**Poor nutrition.** People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

**Lack of physical activity.** People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

**Tobacco use.** Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US.

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

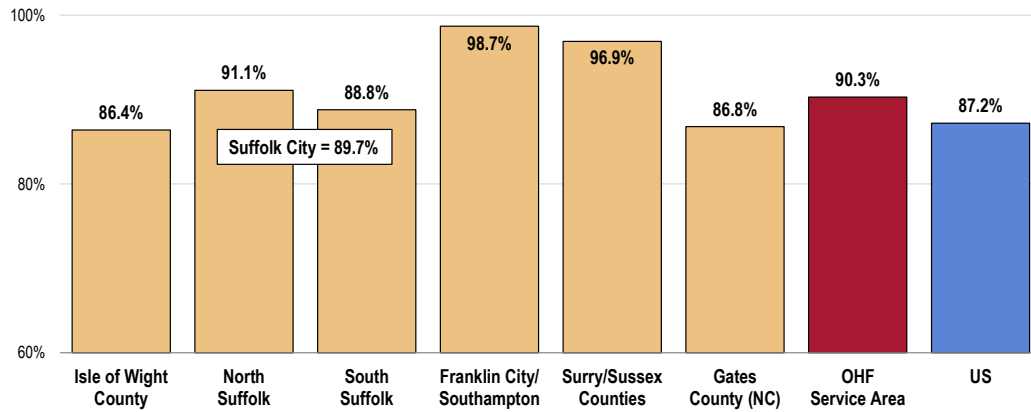
### Total Cardiovascular Risk

**A total of 90.3% of OHF Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.**

- Notably higher than national findings.
- Ranging considerably by area (highest in the Franklin City/Southampton and Surry/Sussex County areas).

RELATED ISSUE:  
See also *Nutrition, Physical Activity, Weight Status, and Tobacco Use* in the **Modifiable Health Risks** section of this report.

### Present One or More Cardiovascular Risks or Behaviors

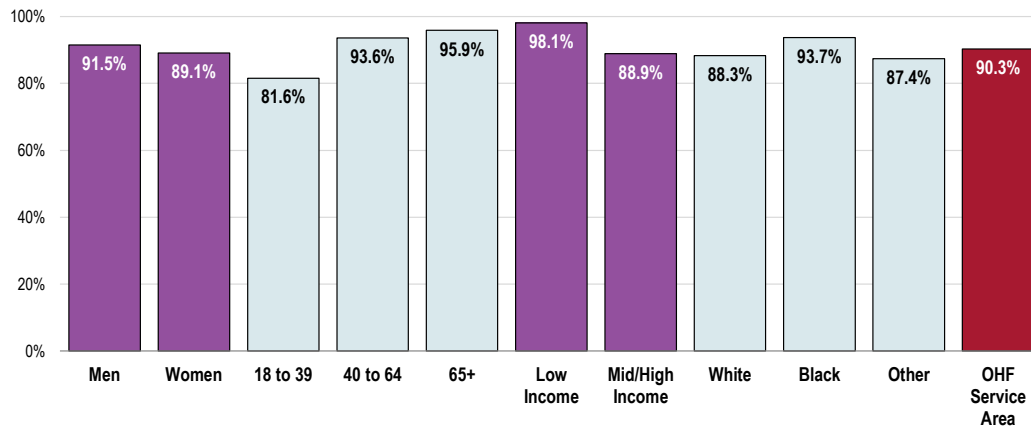


- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.

Adults more likely to exhibit cardiovascular risk factors include:

- Adults age 40 and older, especially seniors (age 65+).
- Residents in low-income households.

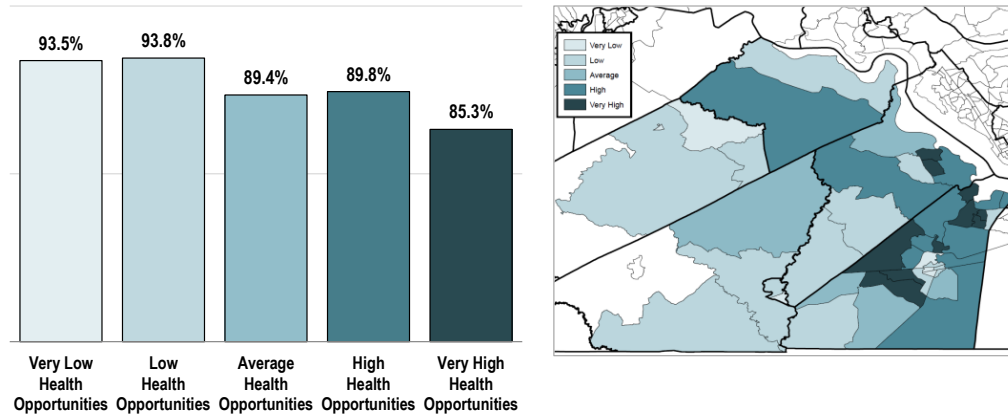
### Present One or More Cardiovascular Risks or Behaviors (OHF Service Area, 2017)



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]
  - Asked of all respondents.
- Notes:
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Adults in areas with lower health opportunities are much more likely to exhibit one or more cardiovascular risk factors.

### Present One or More Cardiovascular Risks or Behaviors (OHF Service Area by Health Opportunity Index Classification)

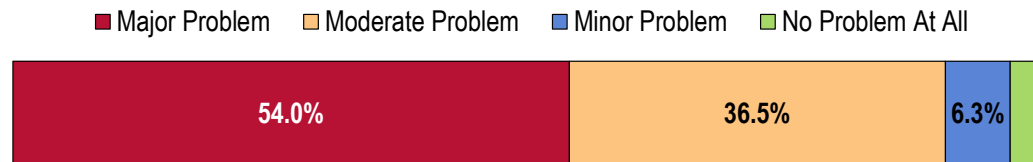


Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]  
Notes: • Asked of all respondents.

### Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a “major problem” in the community.

### Perceptions of Heart Disease and Stroke as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### Prevalence/Incidence

*Heart disease and stroke are a major problem due to the prevalence of heart disease. This is exacerbated by the diets many individuals have and unhealthy food choices. – Social Services Provider*

*Heart disease and stroke are major concerns in our community; we need to improve overall cardiovascular health and eliminate the disparities associated with cardiovascular disease and stroke. – Other Health Provider*

*Many patients come to the emergency room with heart-related problems: strokes, congestive heart failure, and coronary artery disease. – Other Health Provider*

*Statistics (both local and statewide for counties) bear out that this is a prevailing problem. There is also a direct correlation with the current patient population being seen by Horizon Health Services. Also, given the socioeconomic indicators for the area, heart disease ranks as top health indicator. (Poverty, unemployment, uninsured status.) – Public Health Representative*

*From collected VDH health data, I am able to note that heart disease and stroke is a major health issue in Western Tidewater. Many of the individuals who live in this community lead sedentary lifestyles and do not eat healthy foods. Many of our communities are food deserts, and healthy food is not cheap or easy to obtain. These people are underinsured, and it is difficult to receive health services without insurance or money for co-pays. Not only can they not pay for the physician, they cannot afford the prescribed medications. – Public Health Representative*

*The number of patients with these conditions as reported via several statewide studies and surveys. The number of patients on medication for this condition as filled through RxP (Rx Partnership). – Other Health Provider*

*Statistics point to the incidence. Contributing factors, diet and sedentary lifestyles. High blood pressure. – Community Leader*

*Prevalence, non-compliance with treatment, significant co-morbidity. – Other Health Provider*

### **Leading Cause of Death**

*Statistics state that heart disease is one of the top causes of death. More and more people are being placed on statin medications to try to lower the incidence of a heart attack. Many people do not maintain a heart-healthy diet. – Public Health Representative*

*GP4H Chronic Disease Prevention and Management Council identifies heart disease as one of the leading causes of death in Gates County. – Other Health Provider*

*Major cause of morbidity and mortality, especially in those with metabolic disease, diabetes. – Physician*

*Number-one killer in the US adult population. Same in my community. – Community Leader*

### **Nutrition**

*Many patients don't have a very good understanding or teaching of the right diet to have and don't exercise enough to prevent major health problems. – Other Health Provider*

*"Nutritional" eating habits are not conducive to reducing heart disease. – Other Health Provider*

*The unhealthy eating habits of overweight and obese individuals, who then continue the same generational eating habits for their children. – Other Health Provider*

*Nutritional and genetic. – Other Health Provider*

### **Lifestyle**

*Lifestyle and behavioral choices. Food desert, lack of access to/awareness of healthy preparation of fresh vegetables and fruits. Familial history, genetic predilection for the disease. – Other Health Provider*

*Lifestyle might contribute to the number of people with this disease. – Community Leader*

### **Obesity**

*Diet, obesity, sedentary behaviors. – Community Leader*

*Weight, health, bad habits. – Community Leader*

### **Contributing Factors**

*Family history, poor dietary habits, too many processed foods consumed, fast food, obesity, and cigarette smoking. People have become lazy. – Public Health Representative*

### **Diagnosis/Treatment**

*Testing. – Community Leader*

## Cancer

### About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
  - Cervical cancer (using Pap tests)
  - Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

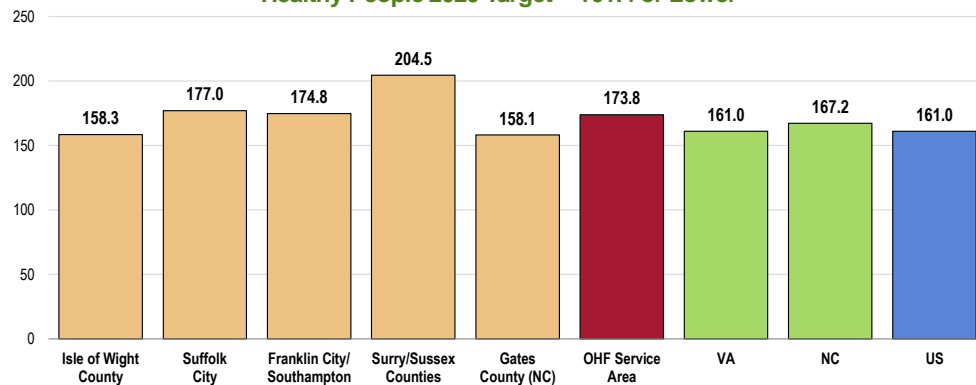
## Age-Adjusted Cancer Deaths

### All Cancer Deaths

**Between 2013 and 2015, there was an annual average age-adjusted cancer mortality rate of 173.8 deaths per 100,000 population in the OHF Service Area.**

- Comparable to the statewide and national rates.
- Comparable to the Healthy People 2020 target of 161.4 or lower.
- Despite variation, rates are statistically comparable when viewed by community.

### Cancer: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 161.4 or Lower



Sources: 

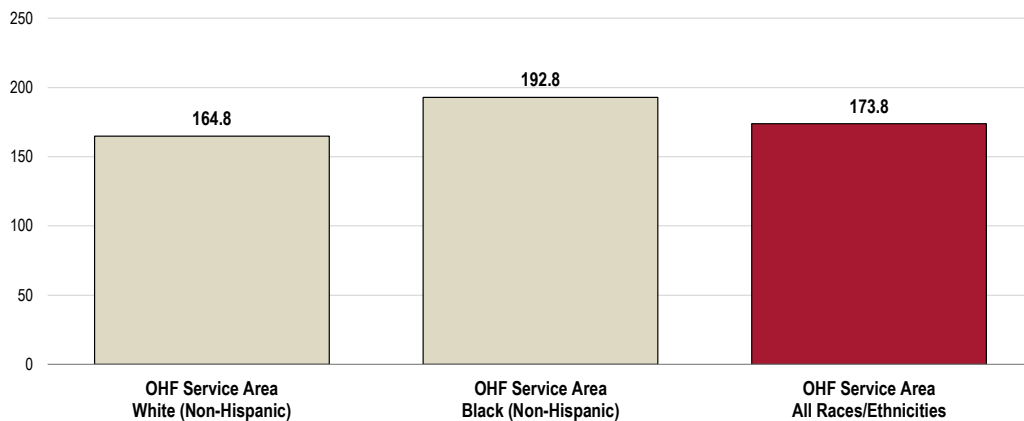
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes: 

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The cancer mortality rate is higher among Blacks than Whites in the OHF Service Area.

### Cancer: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 161.4 or Lower



Sources: 

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes: 

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Cancer Deaths by Site

**Lung cancer is by far the leading cause of cancer deaths in the OHF Service Area.**

Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both sexes).

As evident in the following chart (referencing 2013-2015 annual average age-adjusted death rates):

- The OHF Service Area **lung cancer** and **colorectal cancer** death rates are similar to the respective state and national rates.
- The OHF Service Area **prostate cancer** and **female breast cancer** death rates are both worse than state and US rates.
- Note that the OHF Service Area prostate and female breast cancer death rates detailed below fail to satisfy the related Healthy People 2020 targets (the lung and colorectal cancer rates are similar).

**Age-Adjusted Cancer Death Rates by Site**  
(2013–2015 Annual Average Deaths per 100,000 Population)

	OHF Service Area	VA	NC	US	HP2020
<b>ALL CANCERS</b>	<b>173.8</b>	<b>161.0</b>	<b>167.2</b>	<b>161.0</b>	<b>161.4</b>
<b>Lung Cancer</b>	<b>44.2</b>	<b>42.2</b>	<b>47.6</b>	<b>42.0</b>	<b>45.5</b>
<b>Prostate Cancer</b>	<b>31.5</b>	<b>19.4</b>	<b>20.0</b>	<b>19.0</b>	<b>21.8</b>
<b>Female Breast Cancer</b>	<b>29.0</b>	<b>21.7</b>	<b>21.0</b>	<b>20.6</b>	<b>20.7</b>
<b>Colorectal Cancer</b>	<b>14.5</b>	<b>14.0</b>	<b>14.0</b>	<b>14.4</b>	<b>14.5</b>

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

## Cancer Incidence

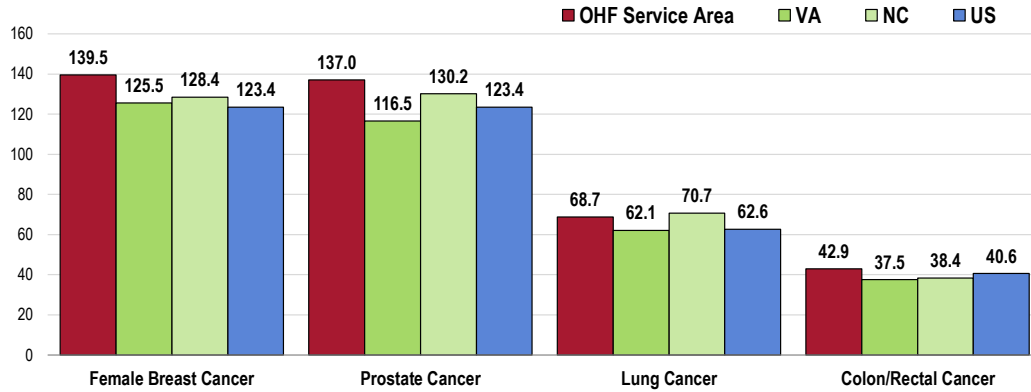
Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted.

**The 2009-2013 OHF Service Area annual average age-adjusted female breast cancer, prostate cancer, lung cancer, and colorectal cancer incidence rates are similar to both state and US rates.**

Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

It is usually expressed as cases per 100,000 population per year.

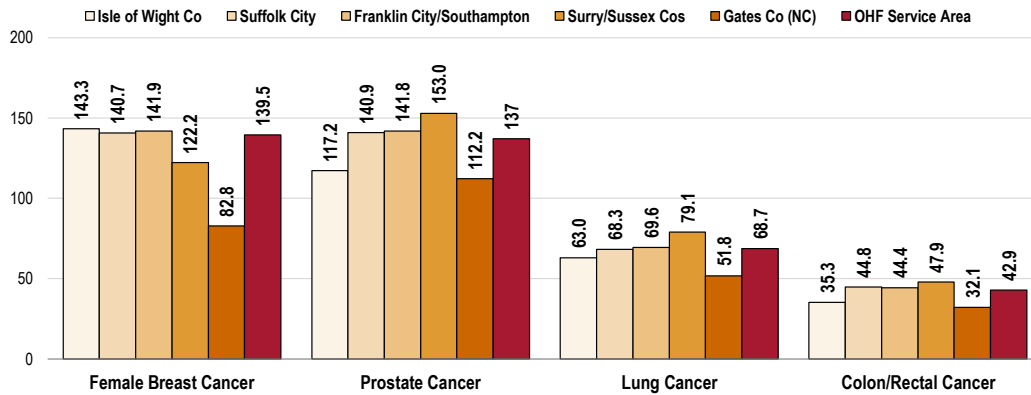
### Cancer Incidence Rates by Site (Annual Average Age-Adjusted Incidence per 100,000 Population, 2009–2013)



Sources: • State Cancer Profiles.  
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

- By area, Gates County reports the lowest incidence rates for each site.

### Cancer Incidence Rates by Site (Annual Average Age-Adjusted Incidence per 100,000 Population, 2009–2013)

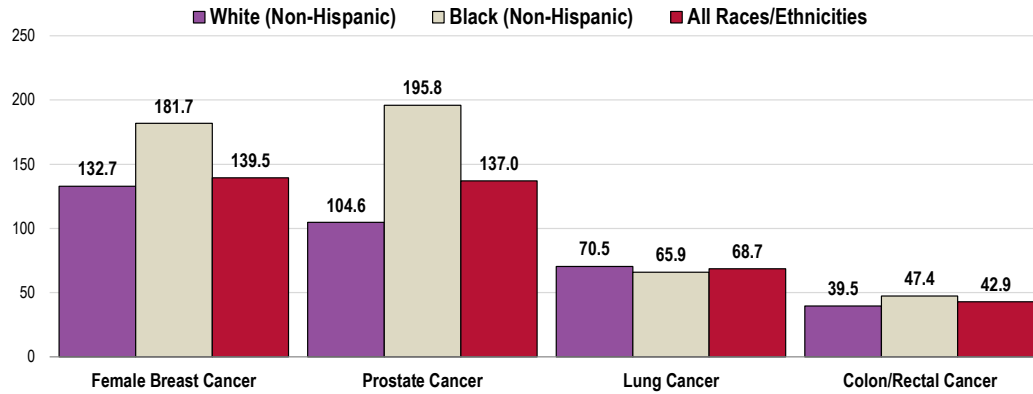


Sources: • State Cancer Profiles.  
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

- By available race data, Non-Hispanic Blacks experience a notably higher female breast cancer, prostate cancer, and colorectal cancer incidence than Non-Hispanic Whites in the OHF Service Area.



### Cancer Incidence Rates by Site and Race/Ethnicity (Annual Average Age-Adjusted Incidence per 100,000 Population, OHF Service Area 2009–2013)



Sources: • State Cancer Profiles.  
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

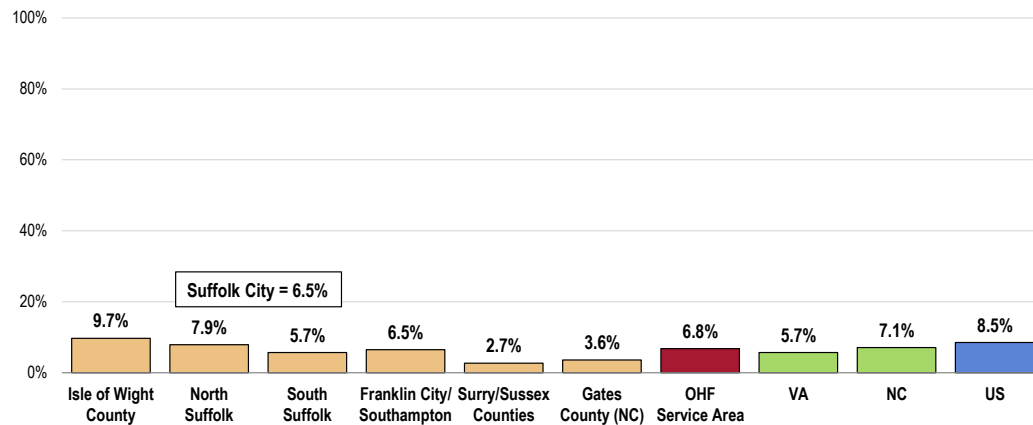
## Prevalence of Cancer

### Skin Cancer

A total of 6.8% of surveyed OHF Service Area adults report having been diagnosed with skin cancer.

- Similar to what is found statewide (both Virginia and North Carolina) and nationally.
- Particularly high in Isle of Wight County; lowest in the combined Surry/Sussex County area.

### Prevalence of Skin Cancer



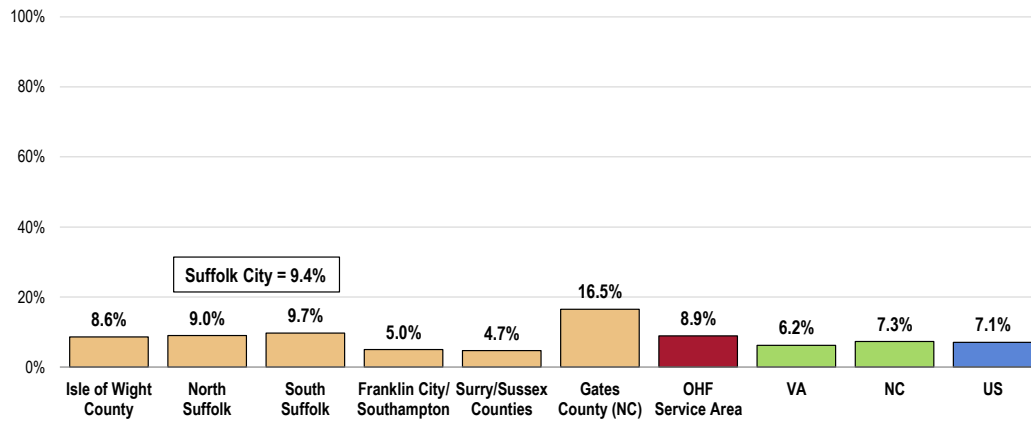
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 28]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

### Other Cancer

A total of 8.9% of survey respondents have been diagnosed with some type of (non-skin) cancer.

- Worse than both state proportions.
- Comparable to the US proportion.
- Particularly high in Gates County.

### Prevalence of Cancer (Other Than Skin Cancer)



Sources:

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 27]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:

- Asked of all respondents.

**RELATED ISSUE:**

See also *Nutrition, Physical Activity, Weight Status, and Tobacco Use* in the **Modifiable Health Risks** section of this report.

### Cancer Risk

#### About Cancer Risk

Reducing the nation’s cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

### Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

## Female Breast Cancer Screening

### About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

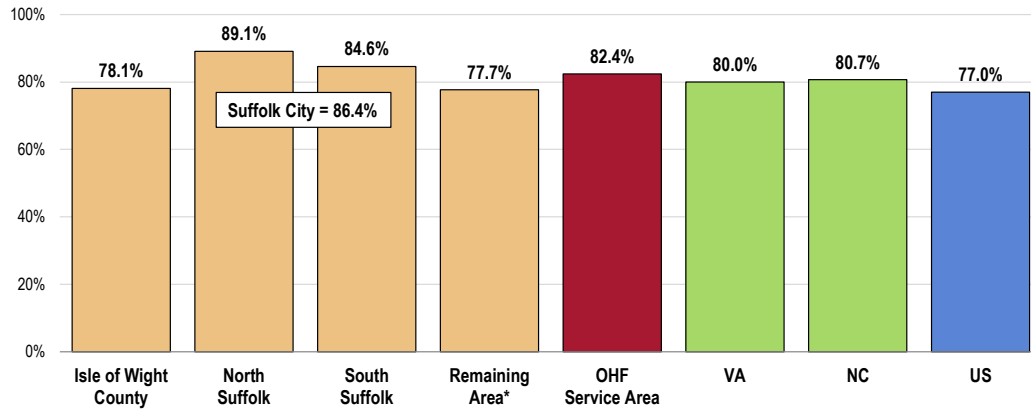
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

### *Mammography*

**Among women age 50-74, 82.4% have had a mammogram within the past 2 years.**

- Similar to statewide and national findings.
- Similar to the Healthy People 2020 target (81.1% or higher).
- Highest (best) among North Suffolk women age 50-74.

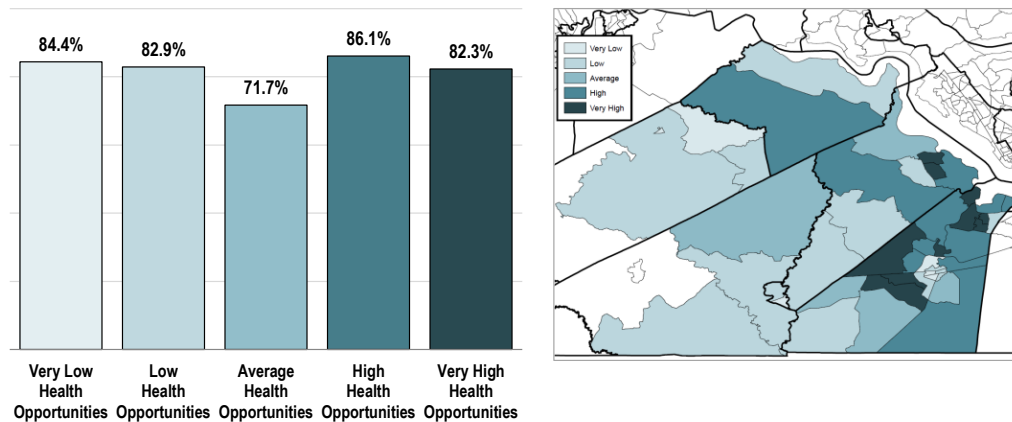
## Have Had a Mammogram in the Past Two Years (Among Women Age 50-74) Healthy People 2020 Target = 81.1% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 133]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-17]
- Notes:
- Reflects female respondents 50-74.
  - \*Franklin City/Southampton, and Surry/Sussex counties, and Gates County were combined in order to provide a more robust sample size for this indicator.

Examining findings for mammograms by the Virginia HOI classification shows no clear correlation.

## Have Had a Mammogram in the Past Two Years (OHF Service Area Women 50-74 by Health Opportunity Index Classification)



- Sources:
- PRC Community Health Survey, Professional Research Consultants, Inc. [Item 133]
- Notes:
- Reflects female respondents 50-74.

## Cervical Cancer Screenings

### About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

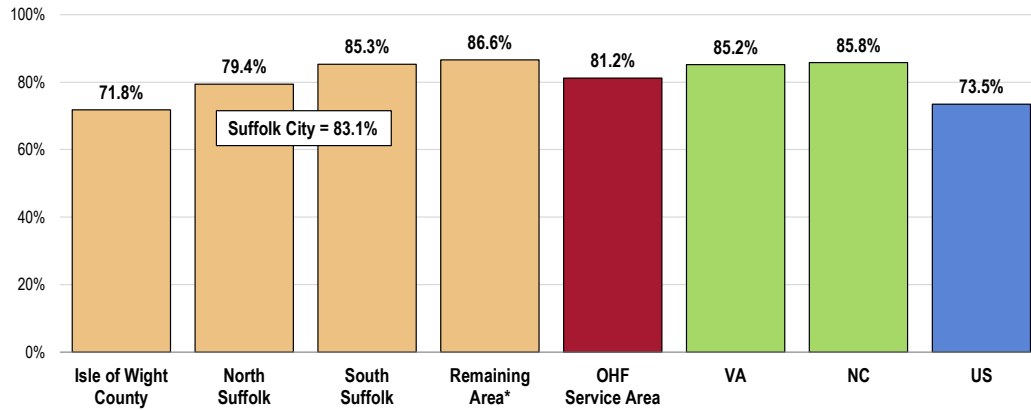
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

### *Pap Smear Testing*

**Among OHF Service Area women age 21 to 65, 81.2% have had a Pap smear within the past 3 years.**

- Lower than both state figures.
- Higher than national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).
- Unfavorably low among women in Isle of Wight County.

## Have Had a Pap Smear in the Past Three Years (Among Women Age 21-65) Healthy People 2020 Target = 93.0% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 134]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-15]
- Notes:
- Reflects female respondents age 21 to 65.
  - \*Franklin City/Southampton, Surry/Sussex counties, and Gates County were combined in order to provide a more robust sample size for this indicator.

## Colorectal Cancer Screenings

### About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (fecal occult blood testing, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

### Colorectal Cancer Screening

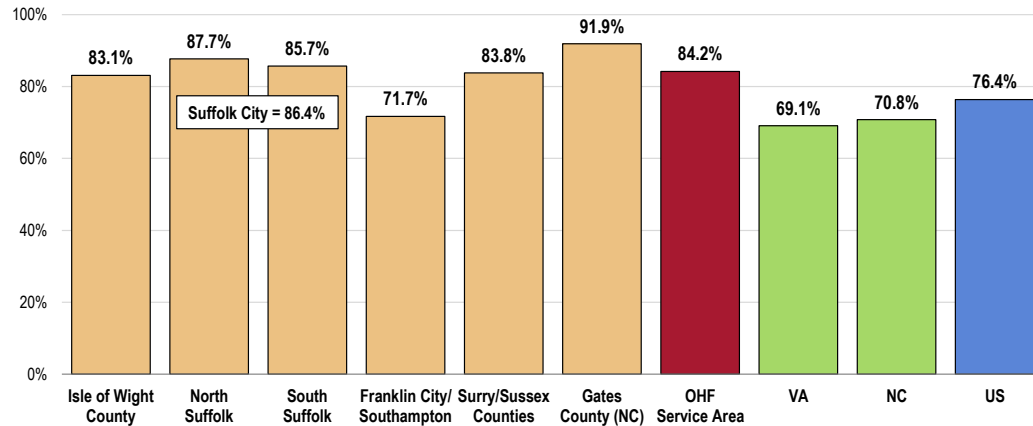
Among adults age 50-75, 84.2% have had an appropriate colorectal cancer screening.

- More favorable than state and national findings.
- Satisfies the Healthy People 2020 target (70.5% or higher).
- Lowest among residents of the Franklin City/Southampton area.

"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

## Have Had a Colorectal Cancer Screening (Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 137]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-16]
- Notes:
- Asked of all respondents age 50 through 75.
  - In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

### Key Informant Input: Cancer

Nearly half of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.

### Perceptions of Cancer as a Problem in the Community (Key Informants, 2017)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



- Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Prevalence/Incidence

*I believe it is a major problem due to the vast number of individuals diagnosed with the disease.*  
– Social Services Provider

*There appears to be a high rate of cancer in the community and limited awareness about treatment options.* – Community Leader

*Statistics indicate that Western Tidewater has one of the highest rates of breast cancer per 1,000 population.* – Public Health Representative

*Numbers of citizens that have been diagnosed.* – Community Leader

*Seems to be more widespread than ever.* – Community Leader

*I have parents and grandparents who died from cancer, and I have been threatened by cancer.*  
– Educator

*BRFSS data, morbidity and mortality rates, professional and personal, familial experiences with those diagnosed.* – Other Health Provider

### Diagnosis/Treatment

*Individuals not scheduling various screenings that could identify cancer in the early stages.*  
– Community Leader

*Lack of testing.* – Community Leader

### Impact on Families/Caregivers

*Cancer touches everyone in some way. Employees at work, family members, people you exercise with. Cancer is one of the highest expenditures in our healthcare for Suffolk City workers.* – Community Leader

*There is a cancer support group in the county of employment. This indicates that the disease affects families as a whole.* – Social Services Provider

### Affordable Care/Services

*Cancer is very expensive to treat, and a lot of the insurance options don't provide adequate coverage.*  
– Community Leader

### Environmental Contributors

*Water and the businesses in the area with waste/chemicals that go into water. International Paper, CIBA, Smithfield Foods.* – Community Leader

### Leading Cause of Death

*In accordance with our 2015 SOTCH Report, cancer is the leading cause of death in Gates County. Data was collected from NC State Center for Health Statistics, October 2014, Age-Adjusted Death Rates per 100,000 Population. 2010-2014 Gates County rate was 165.4, and state rate was 171.8. Cancer was identified as a priority in Gates County's 2014-2016 Community Health Action Plan. Our objective by 2016 was to secure two cancer-focused partnerships to provide three educational forums targeting prostate and/or breast cancers. Our target number of individuals to reach for awareness was 450. In the 2016 Community Health Assessment, cancer is identified on the county watch list as chronic health concern. Cancer mortality rate is increasing for total cancer; incidence rate is up for lung and breast, but mortality is down for both; colon cancer mortality is up significantly. GP4H established Cancer Support Group that meets monthly for our citizens. Attendees have cancer, or are a survivor or caregiver.* – Other Health Provider

### Lifestyle

*Diet and lifestyle, tobacco use.* – Community Leader



## Respiratory Disease

### About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

**Asthma.** The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

## Age-Adjusted Respiratory Disease Deaths

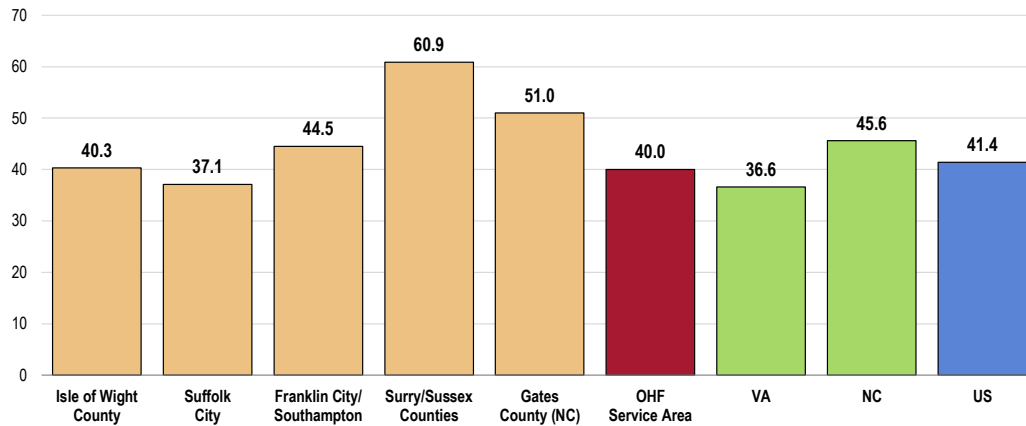
### Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2013 and 2015, there was an annual average age-adjusted CLRD mortality rate of 40.0 deaths per 100,000 population in the OHF Service Area.

- Statistically comparable to state and US rates.
- Unfavorably high in Surry/Sussex counties; lowest in Suffolk City.

Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

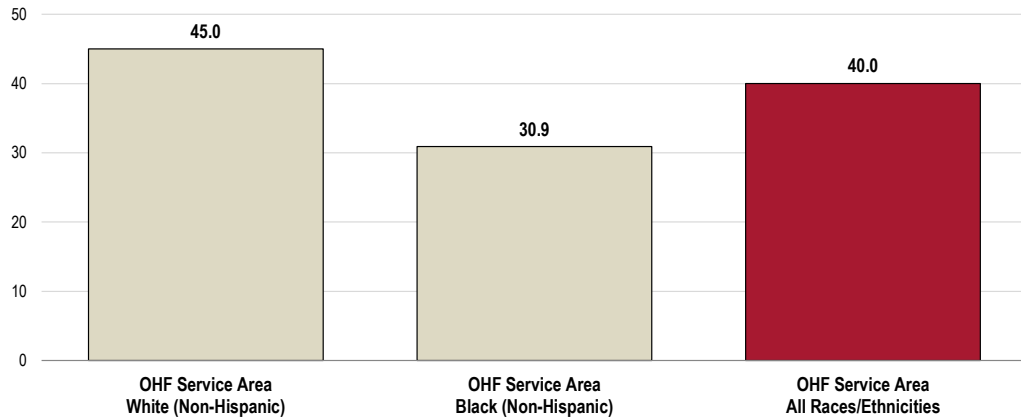
**CLRD: Age-Adjusted Mortality**  
(2013–2015 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - CLRD is chronic lower respiratory disease.

- CLRD mortality is notably higher among Non-Hispanic Whites in the OHF Service Area.

### CLRD: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - CLRD is chronic lower respiratory disease.

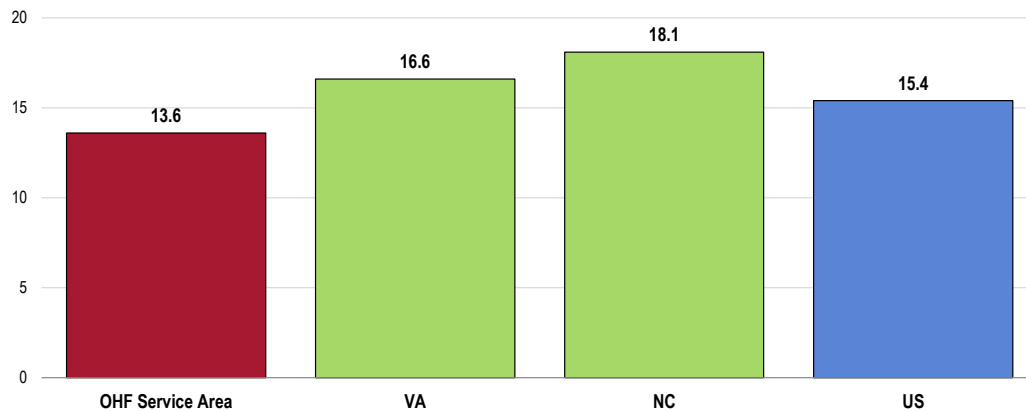
### Pneumonia/Influenza Deaths

Between 2013 and 2015, the OHF Service Area reported an annual average age-adjusted pneumonia/influenza mortality rate of 13.6 deaths per 100,000 population.

- Lower than reported across Virginia and North Carolina.
- Comparable to the US rate.

For prevalence of vaccinations for pneumonia and influenza, see also *Immunization & Infectious Diseases* in the *Infectious Disease* section of this report.

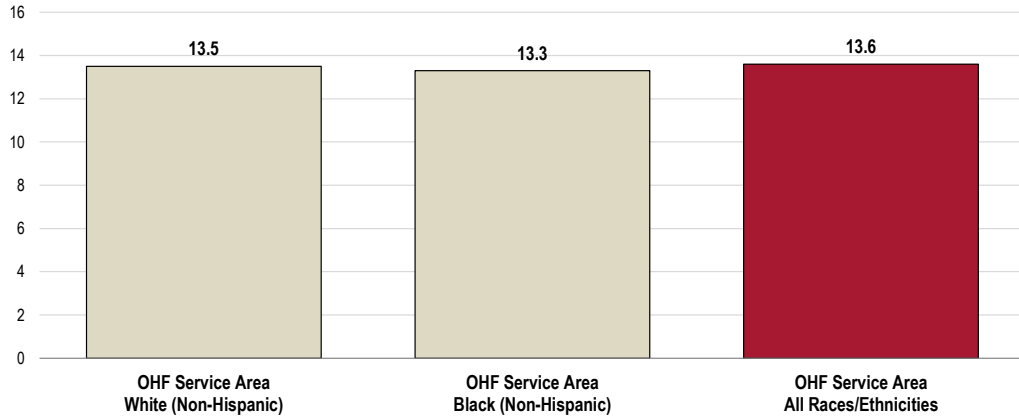
### Pneumonia/Influenza: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The pneumonia/influenza mortality rate in the OHF Service Area does not vary significantly by available race, as shown.

### Pneumonia/Influenza: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Asthma

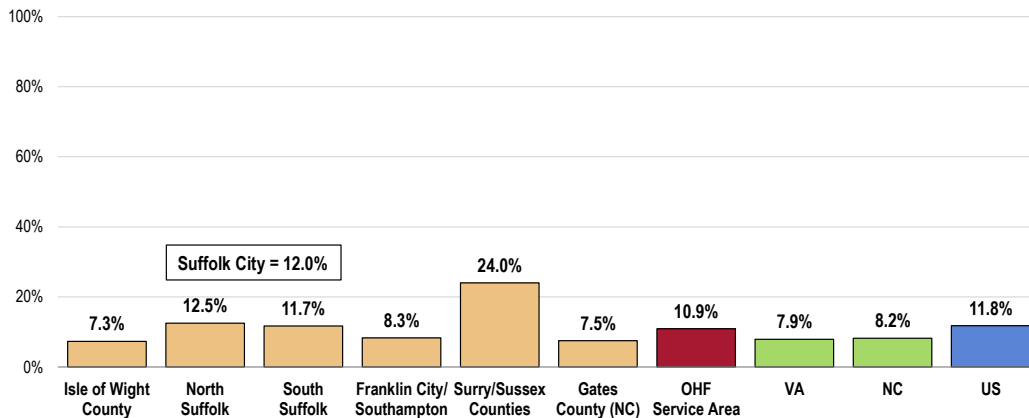
#### Adults

**A total of 10.9% of OHF Service Area adults currently suffer from asthma.**

- Higher than the statewide figures.
- Similar to the national prevalence.
- Markedly high in the Surry/Sussex County population.

Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

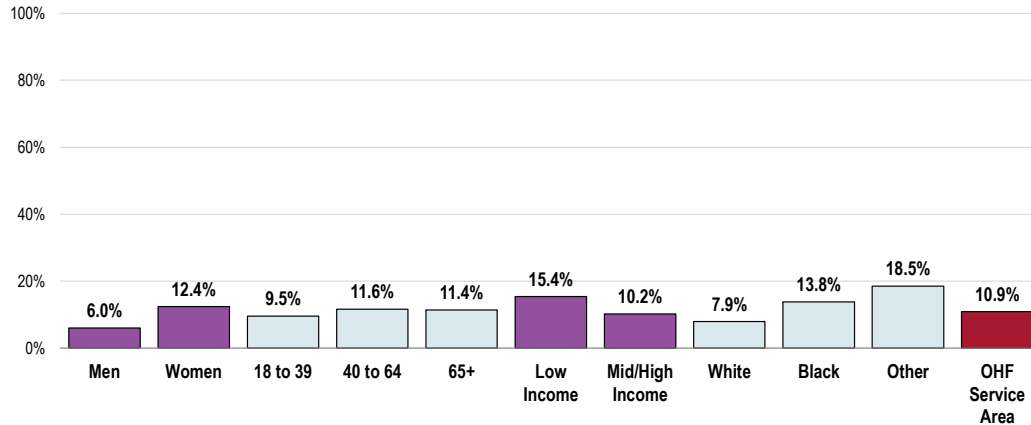
### Adult Asthma: Current Prevalence



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.  
 Notes: • Asked of all respondents.  
 • Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

- OHF Service Area women, low-income residents, Blacks, and Other race/ethnicities are more likely to suffer from asthma.

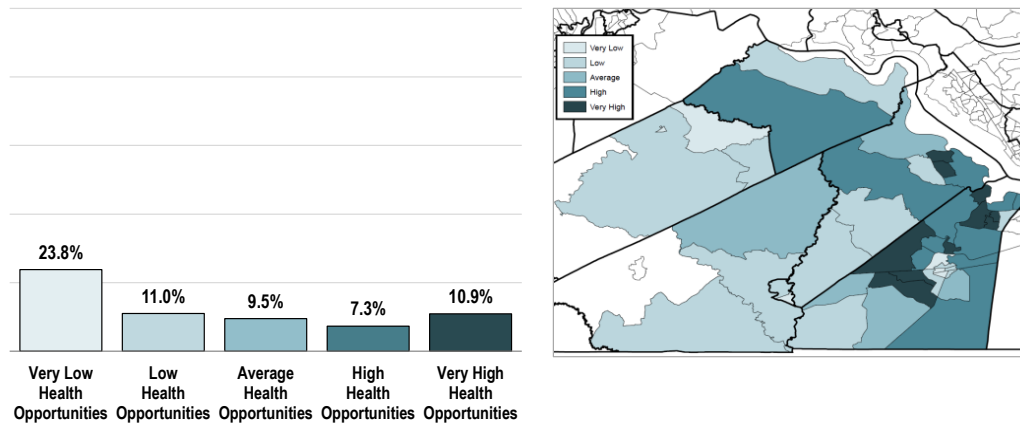
### Currently Have Asthma (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Note that OHF Service Area residents in the lowest HOI classification exhibit the highest prevalence of asthma (23.8%).

### Current Asthma (OHF Service Area by Health Opportunity Index Classification)



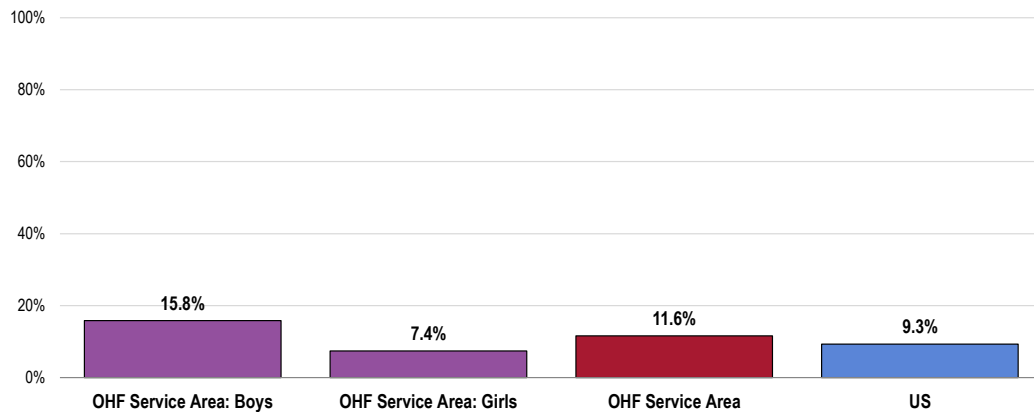
Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]  
 Notes: • Asked of all respondents.

## Children

Among OHF Service Area children under age 18, 11.6% currently have asthma.

- Statistically comparable to national findings.
- The disparity by child's gender is statistically significant: the current asthma prevalence is notably higher among boys in the OHF Service Area.

### Childhood Asthma: Current Prevalence (Among Parents of Children Age 0-17)



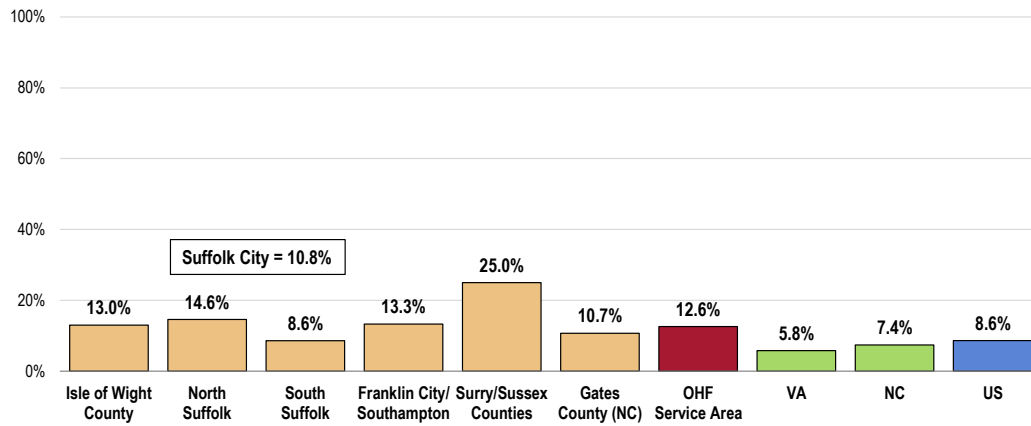
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 139]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents with children 0 to 17 in the household.
  - Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

## Chronic Obstructive Pulmonary Disease (COPD)

A total of 12.6% of OHF Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Markedly higher than the state and national figures.
- Highest in the Surry/Sussex County community.

## Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources:

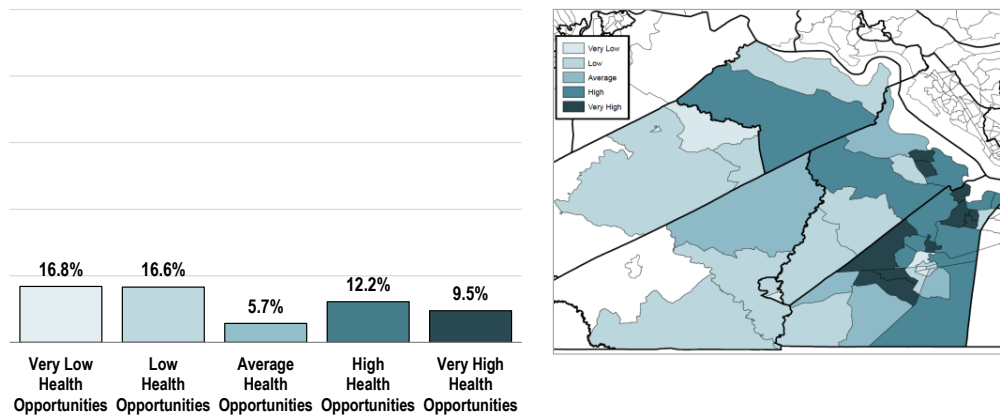
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:

- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Note the higher levels of COPD among OHF Service Area residents with the lowest health opportunities.

## Prevalence of Chronic Obstructive Pulmonary Disease (COPD) (OHF Service Area by Health Opportunity Index Classification)



Sources:

- PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]

Notes:

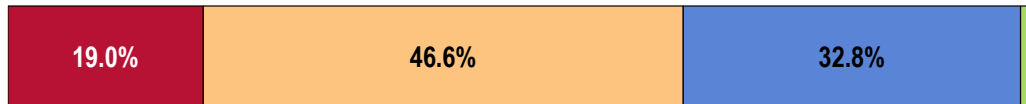
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

## Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a “moderate problem” in the community.

### Perceptions of Respiratory Diseases as a Problem in the Community (Key Informants, 2017)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### *Environmental Contributors*

*Proximity to shipyards and number of residents employed at those sites. Smoking and tobacco use.*  
– Other Health Provider

*Air quality data, number of people with asthma. Emergency room visits, medication usage for inhalers.*  
– Other Health Provider

#### *Access to Care/Services*

*Access to care and to medications for the uninsured.* – Other Health Provider

#### *Affordable Care/Services*

*Cost of service and medications.* – Community Leader

#### *Allergies*

*As a school division, we find that parents/citizens have to seek out resources and guidelines for their children/family with seasonal and genetic allergies. We are assisting with more and more families sending children to the schools with seizure disorders (from pre-K to high school).* – Educator

#### *Prevalence/Incidence*

*Review of our internal statistics from annual reporting to federal government supports this. Over 500 patients served with a diagnosis of a selected disease of the respiratory system, such as asthma or COPD.* – Public Health Representative



## Injury & Violence

### About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

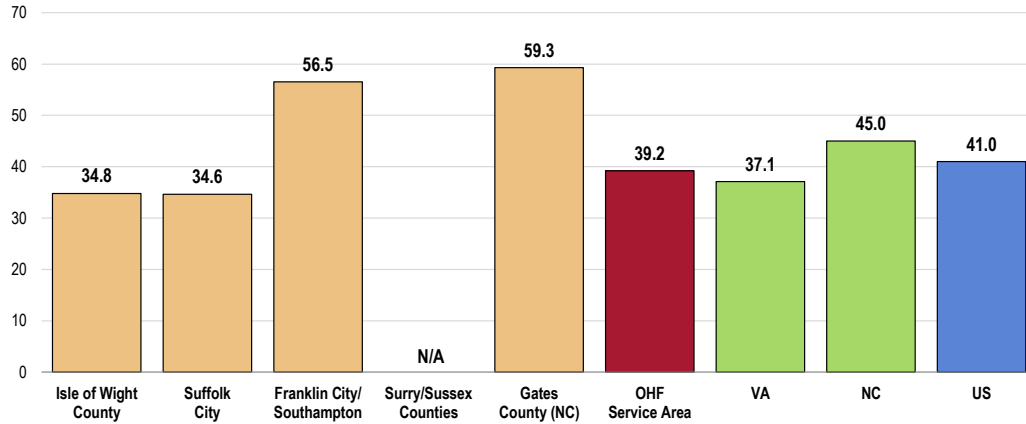
## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

**Between 2013 and 2015, there was an annual average age-adjusted unintentional injury mortality rate of 39.2 deaths per 100,000 population in the OHF Service Area.**

- Statistically comparable to the state and US mortality rates.
- Comparable to the Healthy People 2020 target (36.4 or lower).
- Higher in the Franklin City/Southampton and Gates County populations.

### Unintentional Injuries: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower



Sources: 

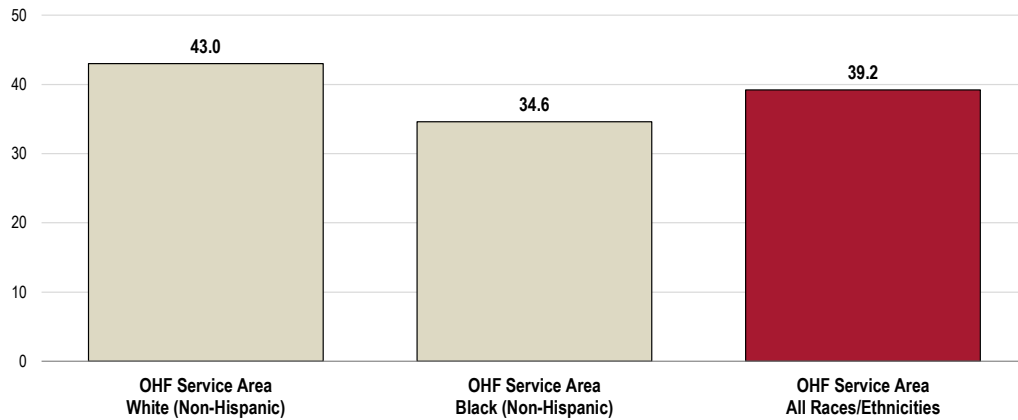
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]

Notes: 

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The mortality rate is notably higher among Whites when compared with Blacks in the OHF Service Area.

### Unintentional Injuries: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower



Sources: 

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]

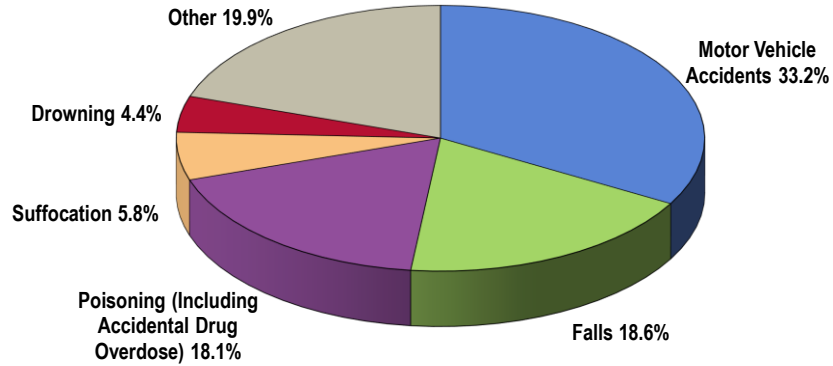
Notes: 

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Leading Causes of Accidental Death

Motor vehicle accidents, falls, poisoning (including accidental drug overdose), suffocation, and drowning accounted for most accidental deaths in the OHF Service Area between 2013 and 2015.

### Leading Causes of Accidental Death (OHF Service Area, 2013–2015)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

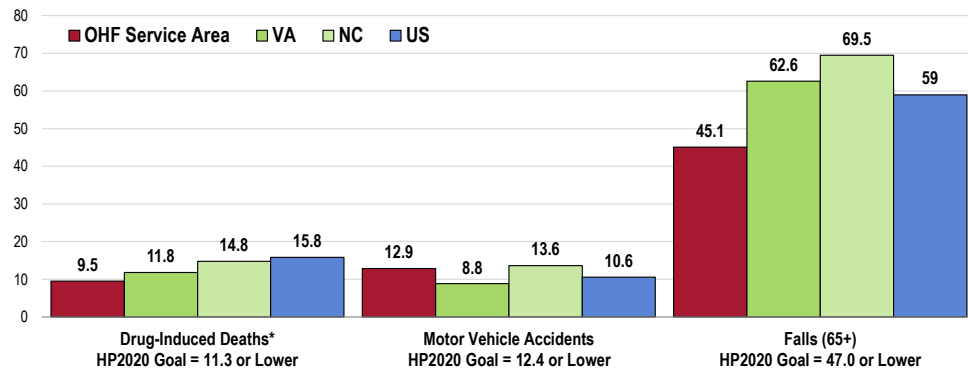
### Selected Injury Deaths

The following chart outlines mortality rates for drug-induced deaths (both intentional and unintentional overdoses), motor vehicle crashes, and falls (among adults age 65 and older).

The OHF Service Area annual average age-adjusted motor vehicle accident mortality rate is worse than the related Virginia and US rates.

### Select Injury Death Rates

(By Cause of Death; 2013–2015 Annual Average Deaths per 100,000 Population)



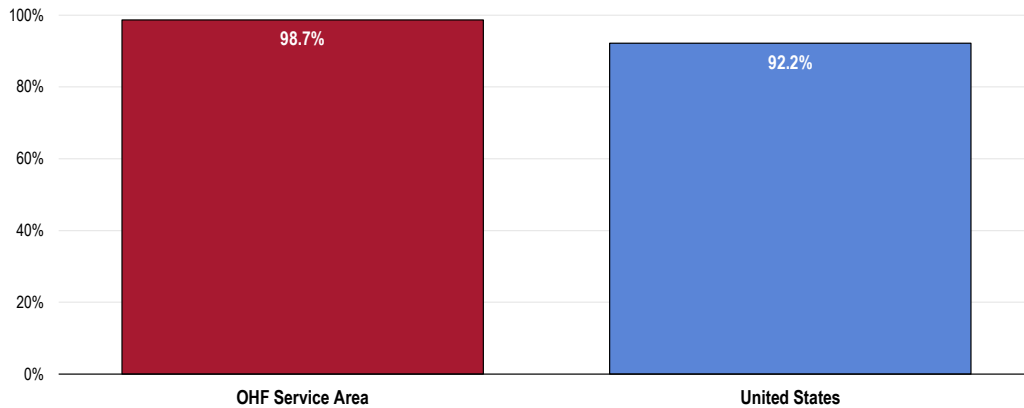
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1, IVP-23.2, SA-12]  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
• \*Drug-induced deaths include both intentional and unintentional drug overdoses.

### Child Safety Belt/Restraint Usage

Nearly all OHF Service Area respondents with children under 18 at home (98.7%) report that their child “always” wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

- Higher than what is found nationally.

#### Child “Always” Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle (Among Parents of Children Age 0-17)



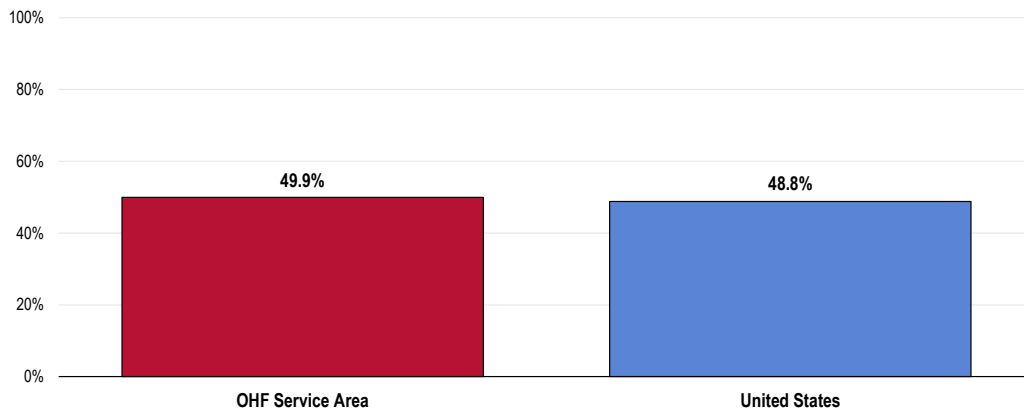
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 312]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children 0 to 17 in the household.

### Bicycle Safety

Half (49.9%) of area children age 5 to 17 “always” wear a helmet when riding a bicycle.

- Comparable to the US prevalence.

#### Child “Always” Wears a Helmet When Riding a Bicycle (Among Parents of Children Age 5-17)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 311]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children age 5 to 17 at home.

## Falls

### Falls

Each year, an estimated one-third of older adults fall, and the likelihood of falling increases substantially with advancing age. In 2005, a total of 15,802 persons age ≥65 years died as a result of injuries from falls.

Falls are the leading cause of fatal and nonfatal injuries for persons aged ≥65 years ... In 2006, approximately 1.8 million persons aged ≥65 years (nearly 5% of all persons in that age group) sustained some type of recent fall-related injury. Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

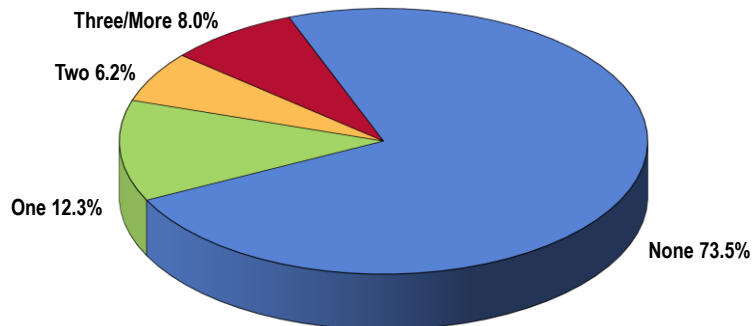
In addition, fall-related medical treatment places a burden on US healthcare services. In 2000, direct medical costs for fall-related injuries totaled approximately \$19 billion. A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of daily living as a result, and among them, 58.5% were expected to require help for at least 6 months.

Modifiable fall risk factors include muscle weakness, gait and balance problems, poor vision, use of psychoactive medications, and home hazards. Falls among older adults can be reduced through evidence-based fall-prevention programs that address these modifiable risk factors. Most effective interventions focus on exercise, alone or as part of a multifaceted approach that includes medication management, vision correction, and home modifications.

- Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC

**Among surveyed OHF Service Area adults age 45 and older, 26.5% fell at least once in the past year, including 8.0% who fell three or more times.**

**Number of Falls in Past 12 Months**  
(Among Adults Age 45 and Older; OHF Service Area, 2017)

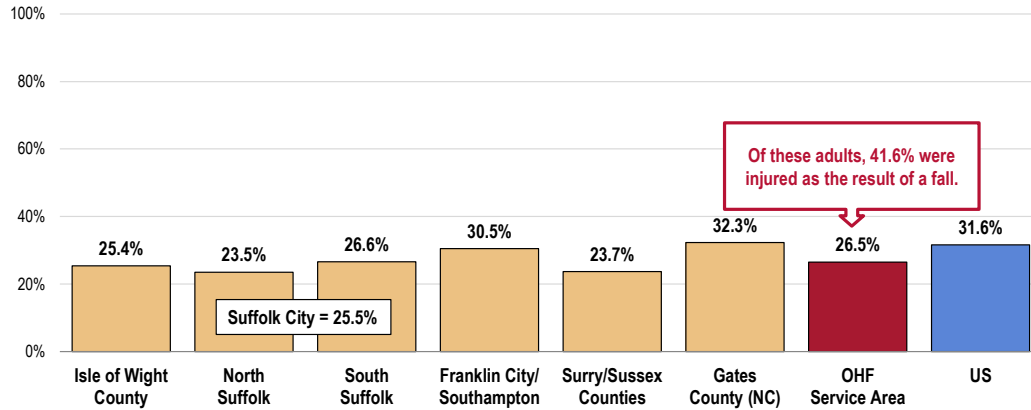


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 107]  
Notes: • Asked of all respondents age 45+.

- The prevalence of adults age 45+ who fell at least once in the past year is lower than the national proportion.

Among those who fell in the past year, 41.6% were injured as a result of the fall.

### Fell One or More Times in the Past Year (Among Respondents Age 45 and Older)

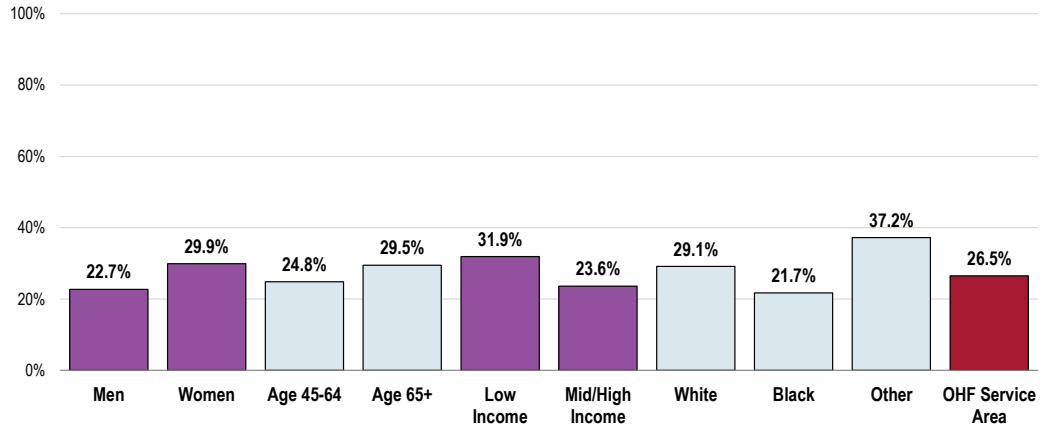


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 107-108]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of those respondents age 45 and older.

These OHF Service Area population groups (age 45+) were more likely to have fallen in the past year:

- Women.
- Residents age 65 and older.
- Those in low-income households.
- Whites and people of Other racial/ethnic designations.

### Fell One or More Times in the Past Year (Among Respondents Age 45 and Older; OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 107]  
 Notes: • Asked of those respondents age 45 and older.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

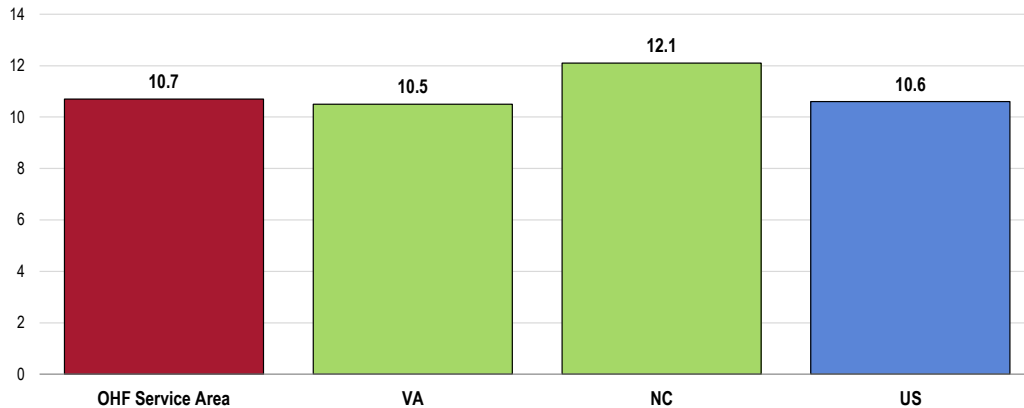
### Firearm Safety

#### Age-Adjusted Firearm-Related Deaths

Between 2013 and 2015, firearms in the OHF Service Area contributed to an annual average age-adjusted rate of 10.7 deaths per 100,000 population.

- Comparable to the state and US rates.
- Comparable to the Healthy People 2020 objective (9.3 or lower).

### Firearms-Related Deaths: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 9.3 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Intentional Injury (Violence)

### Age-Adjusted Homicide Deaths

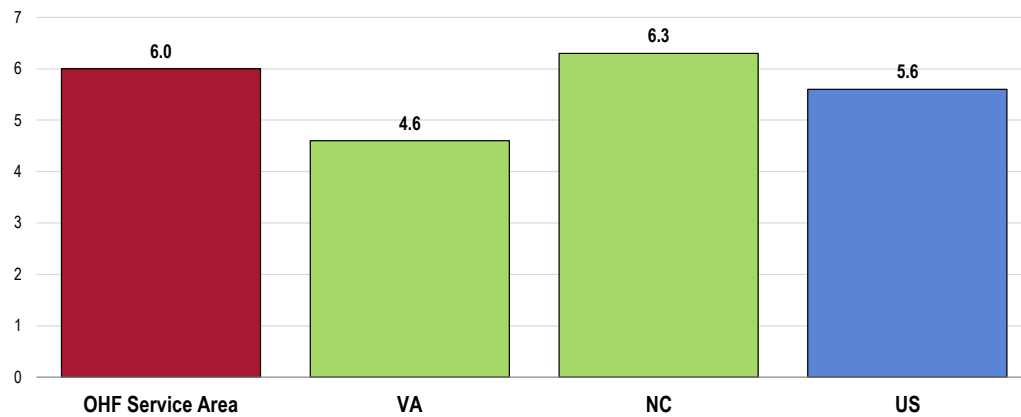
Between 2013 and 2015, there was an annual average age-adjusted homicide rate of 6.0 deaths per 100,000 population in the OHF Service Area.

RELATED ISSUE:

See also *Mental Health: Suicide* in the **General Health Status** section of this report.

- Higher than the Virginia rate but comparable to the North Carolina rate.
- Comparable to the national rate.
- Comparable to the Healthy People 2020 target of 5.5 or lower.

**Homicide: Age-Adjusted Mortality**  
(2013–2015 Annual Average Deaths per 100,000 Population)  
Healthy People 2020 Target = 5.5 or Lower

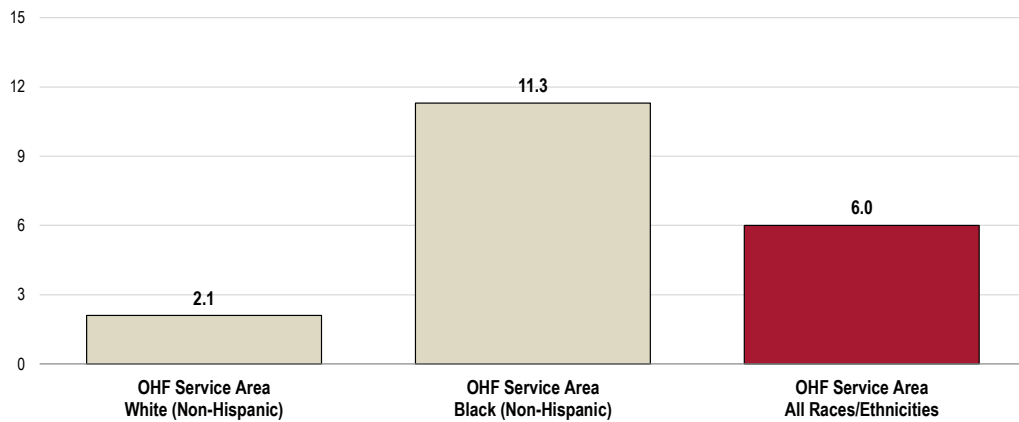


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The homicide rate is significantly higher among Blacks in the OHF Service Area.



### Homicide: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 5.5 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Violent Crime

#### Violent Crime Rates

**Between 2010 and 2012, there were a reported 250.1 violent crimes per 100,000 population in the OHF Service Area.**

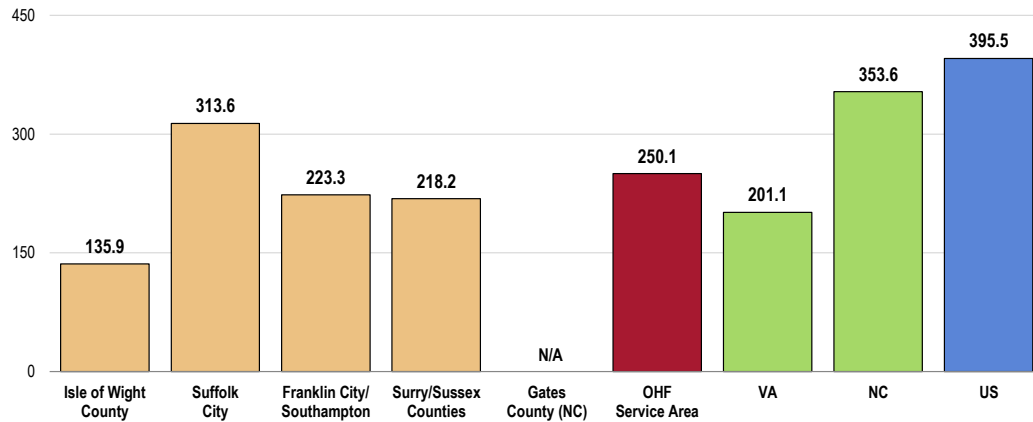
- Higher than the Virginia rate for the same period, but well below the North Carolina rate.
- Well below the national rate.
- Highest in Suffolk City.

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

### Violent Crime

(Rate per 100,000 Population, 2010–2012)



Sources: 

- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Retrieved October 2017 from Community Commons at <http://www.chna.org>.

 Notes: 

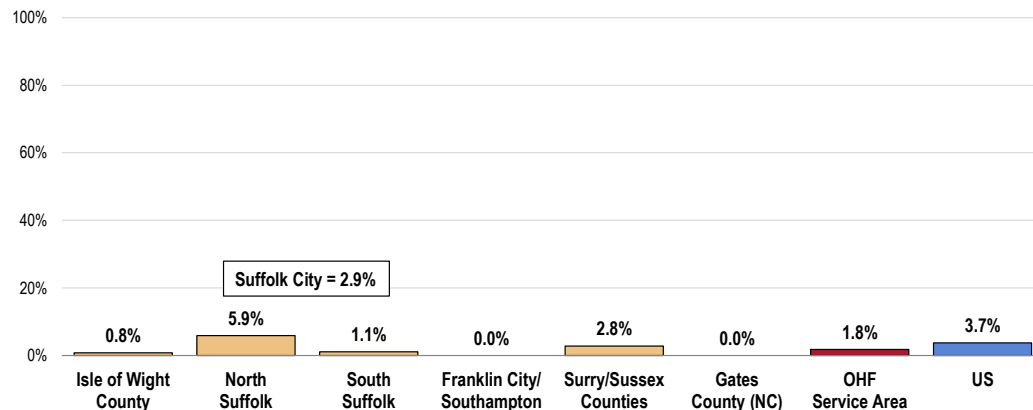
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

#### Community Violence

A total of 1.8% of surveyed OHF Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

- Half the national percentage.
- Markedly higher in North Suffolk.

### Victim of a Violent Crime in the Past Five Years



Sources: 

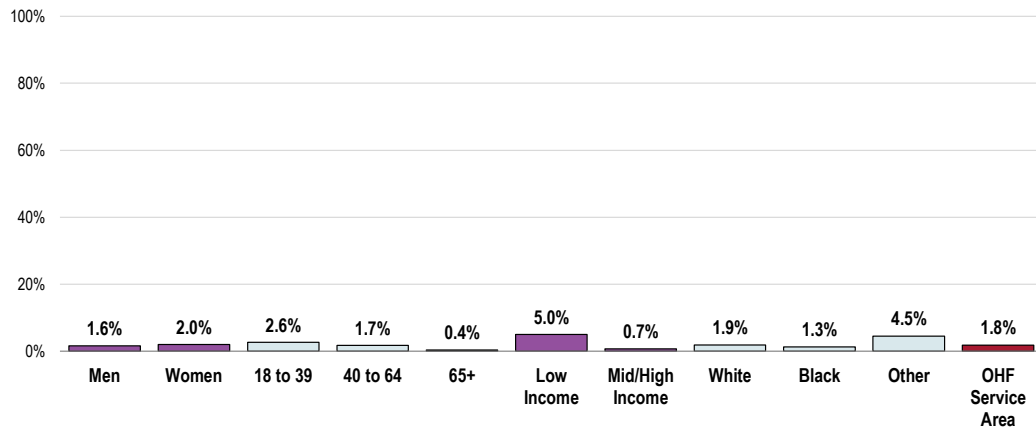
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

 Notes: 

- Asked of all respondents.

- Reports of violence are higher among younger residents (negative correlation with age), those in the lower income category, and Other race/ethnicity adults.

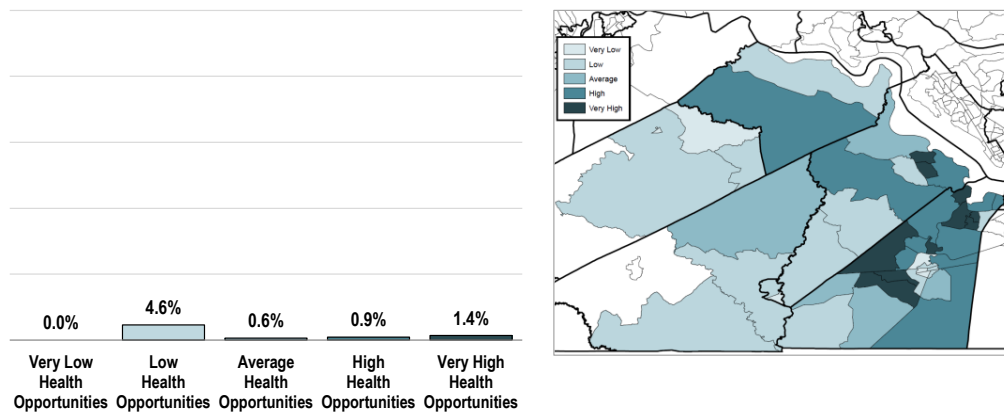
### Victim of a Violent Crime in the Past Five Years (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Reports of violence are highest in the OHF Service Area population with low health opportunities.

### Victim of a Violent Crime in the Past Five Years (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]  
 Notes: • Asked of all respondents.

**Family Violence**

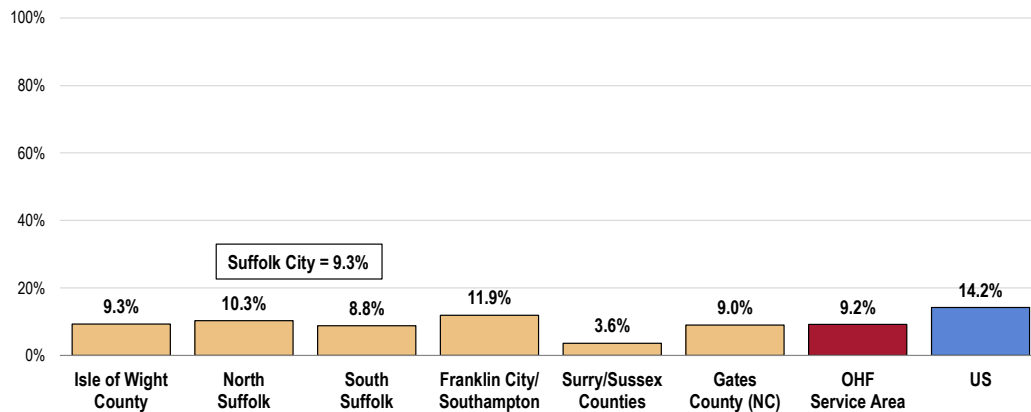
**A total of 9.2% of OHF Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.**

- More favorable than national findings.
- Favorably low in the Surry/Sussex County area.

Respondents were read:

"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

**Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner**

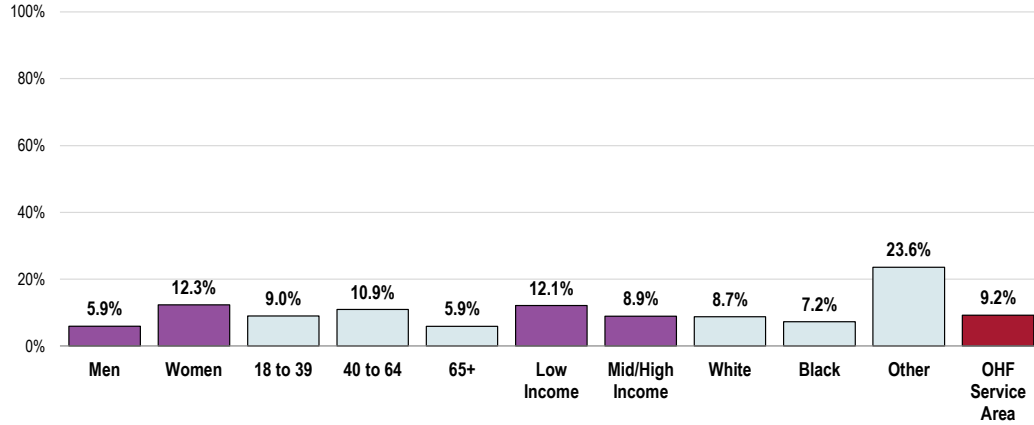


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

Reports of domestic violence are also notably higher among:

- Women.
- Adults between the ages of 40 and 64.
- Those with lower incomes.
- Respondents of Other race/ethnicity.

### Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner (OHF Service Area, 2017)

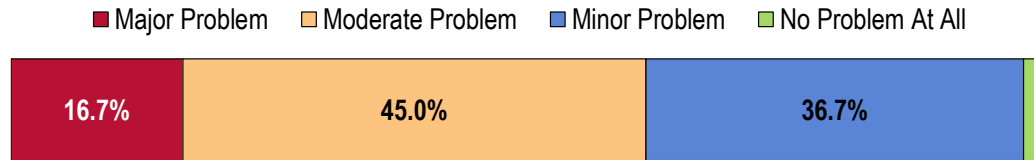


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a "moderate problem" in the community.

### Perceptions of Injury and Violence as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### **Contributing Factors**

*Drugs, poverty, and lack of people wanting to work to better themselves. Also, lack of jobs. – Educator*

*Education, jobs. – Community Leader*

*Gangs, poverty, crime in general. – Other Health Provider*

### **Prevalence/Incidence**

*2% higher than the national average, and it continues to grow. – Other Health Provider*

*Too much violence that causes injury, lack of caring by public. – Community Leader*

### **Society Norms**

*Societal norms now see law enforcement as the enemy. Lack of positive alternatives. Poverty.*

*Decreased access to mental health/behavioral healthcare services. – Other Health Provider*

## Diabetes

### About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

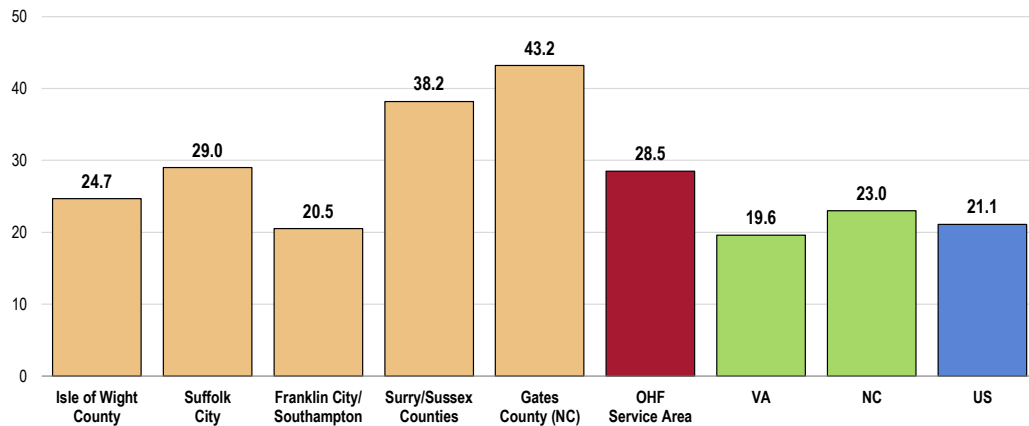
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Age-Adjusted Diabetes Deaths

**Between 2013 and 2015, there was an annual average age-adjusted diabetes mortality rate of 28.5 deaths per 100,000 population in the OHF Service Area.**

- Less favorable than that found statewide (Virginia or North Carolina) or nationally.
- Fails to satisfy the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).
- Particularly high in the Surry/Sussex County area and in Gates County.

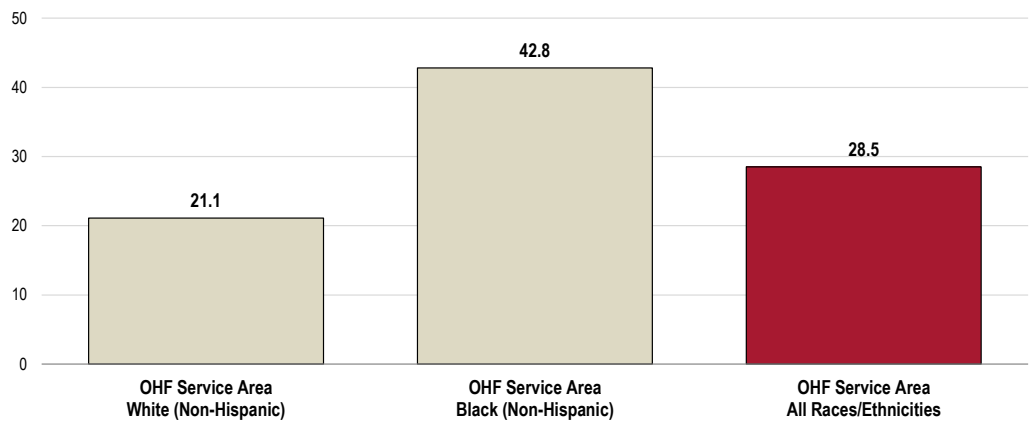
### Diabetes: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 20.5 or Lower (Adjusted)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

- The diabetes mortality rate in the OHF Service Area is notably higher among Blacks than among Whites.

### Diabetes: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 20.5 or Lower (Adjusted)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.



## Prevalence of Diabetes

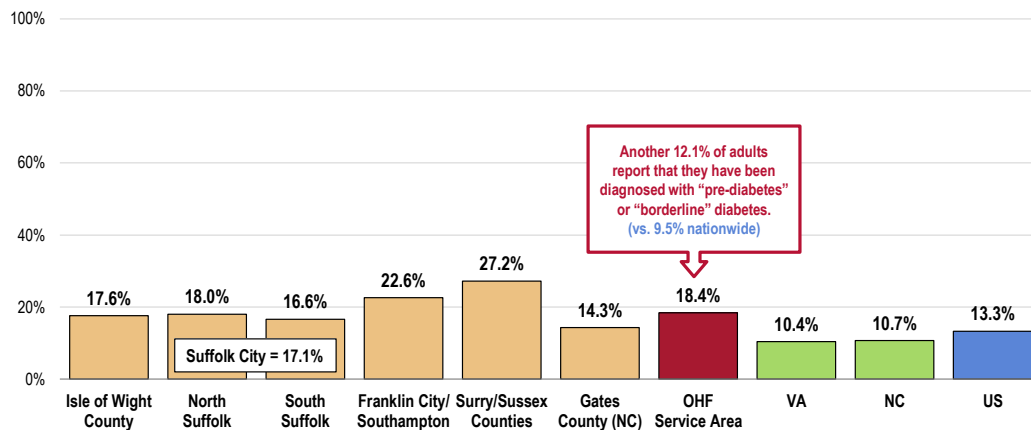
A total of 18.4% of OHF Service Area adults report having been diagnosed with diabetes.

- Much worse than the state and US proportions.
- Especially high in the Surry/Sussex County combined area.

In addition to the prevalence of diagnosed diabetes referenced above, another 12.1% of OHF Service Area adults report that they have “pre-diabetes” or “borderline diabetes.”

- Higher than the US prevalence.
- Similar findings by area (not shown).

### Prevalence of Diabetes



Sources:
 

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.

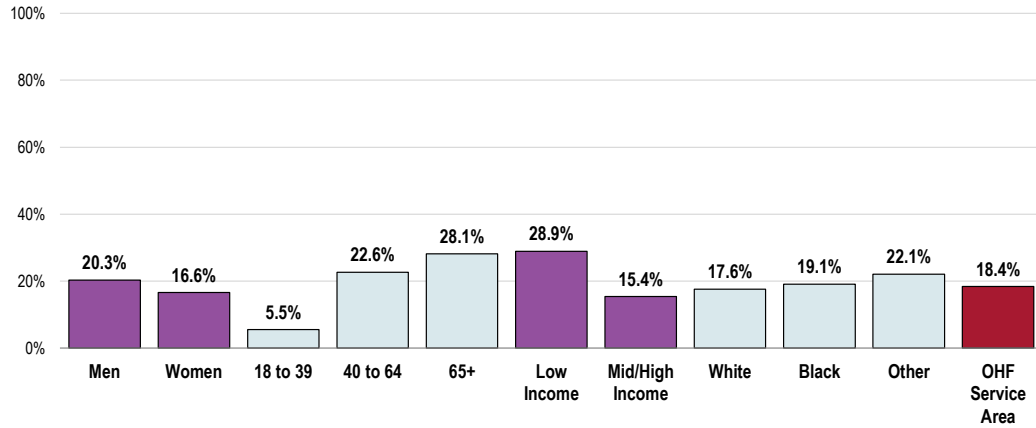
 Notes:
 

- Asked of all respondents.

A higher prevalence of diagnosed diabetes (excluding pre-diabetes or borderline diabetes) is reported among:

- Low-income residents.
- Older adults (note the strong positive correlation between diabetes and age, with 28.1% of seniors diagnosed with diabetes).

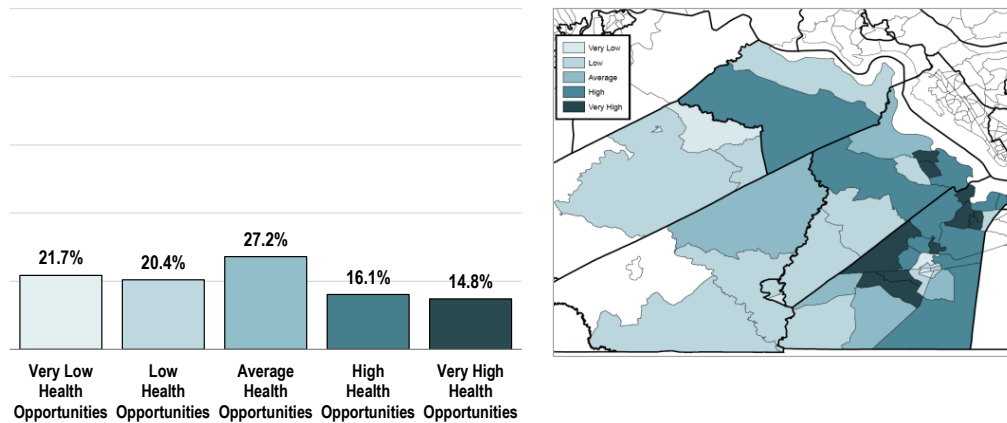
### Prevalence of Diabetes (OHF Service Area, 2017)



Sources: ● 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]  
 Notes: ● Asked of all respondents.  
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 ● Excludes gestational diabetes (occurring only during pregnancy).

The prevalence of diabetes in the OHF Service Area is higher in the population with average or lower health opportunities.

### Prevalence of Diabetes (OHF Service Area by Health Opportunity Index Classification)



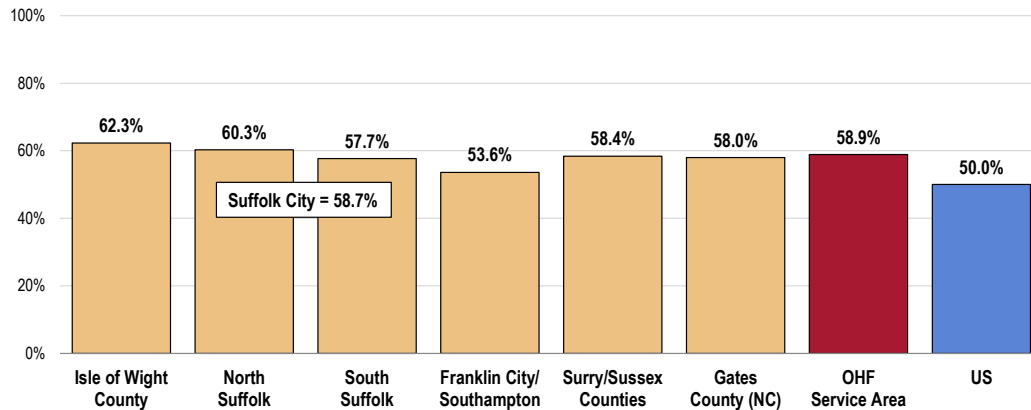
Sources: ● PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]  
 Notes: ● Asked of all respondents.

### Diabetes Testing

Of area adults who have not been diagnosed with diabetes, 58.9% report having had their blood sugar level tested within the past three years.

- Well above the national proportion.
- Statistically similar by community.

### Have Had Blood Sugar Tested in the Past Three Years (Among Nondiabetics)

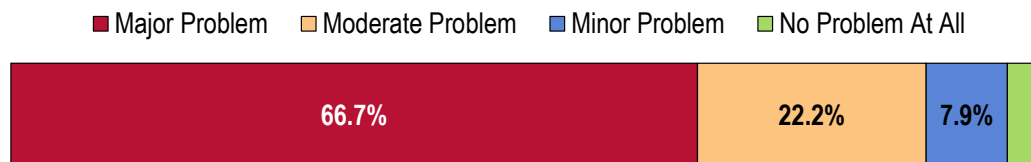


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 37]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of respondents who have not been diagnosed with diabetes.

### Key Informant Input: Diabetes

Two in three key informants taking part in an online survey characterized *Diabetes* as a “major problem” in the community.

### Perceptions of Diabetes as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” the biggest challenges for people with diabetes are seen as:

### Cost/Affordability

*Western Tidewater lies within the "Diabetes Belt" in Virginia. People with diabetes have medical expenditures that are approximately 2.3 times higher than the expenditures would be in the absence of diabetes. Approximately \$1 in \$10 healthcare dollars is attributed to diabetes. Adults with diabetes die of heart disease 2-4 times more than people without diabetes, and the risk of stroke is 2-4 times higher in diabetic patients. Diabetes is the leading cause of new cases of blindness among adults 20-74 years of age. It is the leading cause of kidney failure, and more than 60% of non-accident-related lower limb amputations in the United States are among people who have diabetes. Indirect costs relate to increased absenteeism, reduced productivity, unemployment due to disability, and early mortality. Although there are opportunities for patients to receive care, there is a need in the community for a diabetes case manager to educate and assist people with care. – Public Health Representative*

*Cost of care, ability to get care, education. – Community Leader*

*Test and cost of treatment. – Community Leader*

*Lack of funds to achieve medicines. Non-compliance to physician orders. Lack of access to nutritional meals. – Other Health Provider*

*Healthcare expenditure for diabetes is high for Suffolk City employees. Know lots of people who have it. Family members have it. I don't, and I don't want to develop it. – Community Leader*

*Cost and accessibility of healthy foods. – Other Health Provider*

*Unable to afford medications. – Other Health Provider*

### Health Education/Awareness

*Education about the disease and the proper care for individual with the disease. – Community Leader*

*There is a lack of awareness about Type 1 diabetes; however, there are more diagnoses each year. For Type 2 diabetes, there is a lack of education about how to be well-managed. – Community Leader*

*Our community has a genetic disposition toward diabetes. There are little to no educational resources in place to address lifestyle changes. – Educator*

*Maybe not taking advantage of diabetes prevention or management classes in the county.*

*Transportation or other issues may be contributed. – Social Services Provider*

*Resources may be available but our citizens may not always take advantage or come out to community programs. – Other Health Provider*

*Understanding the contributors to disease (i.e. diet, exercise). Understanding the management of the disease and significance of controlling the disease. Community has a general lack of understanding the seriousness of diabetes and the long-term effects. Consequently, many health education classes are poorly attended. – Public Health Representative*

*Nutrition education. – Educator*

### Nutrition

*Poor nutrition and lack of exercise. Too many people, young and old, are spending too much time sitting. Professionals are sitting in front of a computer or at a desk eating, snacking, and looking for the next break to eat again. – Public Health Representative*

*Nutrition choices and sedentary behaviors. – Community Leader*

*Diet, education about healthy eating. Obesity, lack of awareness about effects and amounts of sugar in the diet. – Community Leader*

*Diet. – Social Services Provider*

### Access to Care/Services

*Access to care, awareness of available resources. Familial history of the disease and inexperience with effective preventative measures that individuals are motivated by. – Other Health Provider*

*Access to care, family-oriented approach to patient care, lifestyle changes. Poverty and access to diet education and good food. – Physician*

*Access to insulin. Other diabetes medications can be accessed more easily. Lifestyle modification programs in conjunction with regular clinic visits and medication access. – Other Health Provider*

### **Access to Healthy Food**

*The biggest challenge is access to affordable, healthy, and/or natural foods. – Social Services Provider*  
*Ingrained culture of eating unhealthy foods. Access to fresh fruits and vegetables. – Other Health Provider*

*Not enough health foods like fruits and vegetables in the areas where diabetics live. – Other Health Provider*

### **Disease Management**

*Diabetes is a major concern in our community. One of the major challenges with diabetes in our community is self-management. We need our patients to take ownership for their health and become proactive members of the healthcare team. We believe this could be done by educating our patients on healthy eating, active living, and proper medical management. – Other Health Provider*

*Biggest challenge is patients being non-compliant with management of diabetes, diet, medication, and follow-up care. – Other Health Provider*

### **Prevalence/Incidence**

*Diabetes is one of the top diagnoses, according to statistics and the task force on diabetes at Obici Hospital. There are so many challenges to providing medicine, education and access to providers that make this a complex and difficult disease to manage. – Public Health Representative*

*Diabetes prevalence in Western Tidewater, 11-15%, exceeds the prevalence in Virginia, 10%. There is limited access to diabetes education and specialty care. – Public Health Representative*

### **Diagnosis/Treatment**

*Undiagnosed, lacking providers, non-compliant with treatment, limited access to appropriate foods, co-morbidity with so many other health issues. – Other Health Provider*

## Alzheimer's Disease

### About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

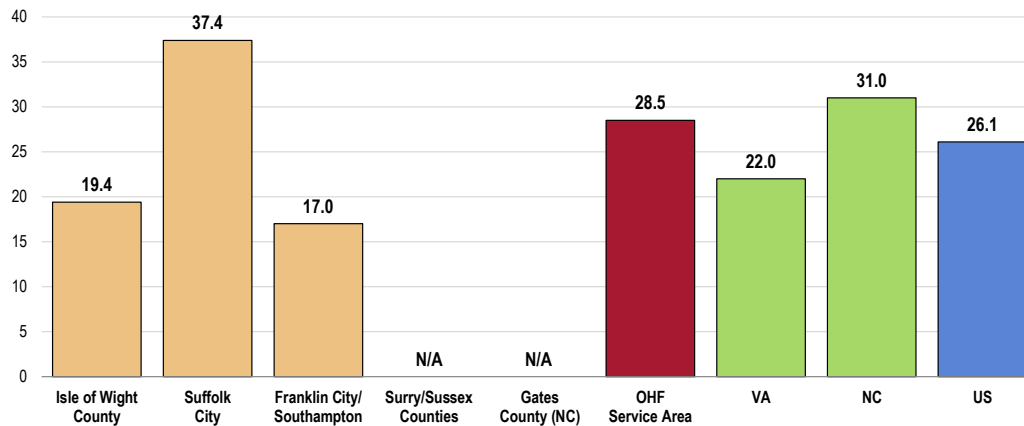
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Age-Adjusted Alzheimer's Disease Deaths

Between 2013 and 2015, there was an annual average age-adjusted Alzheimer's disease mortality rate of 28.5 deaths per 100,000 population in the OHF Service Area.

- Higher than the Virginia rate but similar to the North Carolina rate.
- Similar to the national rate.
- The mortality rate is markedly higher in Suffolk City.

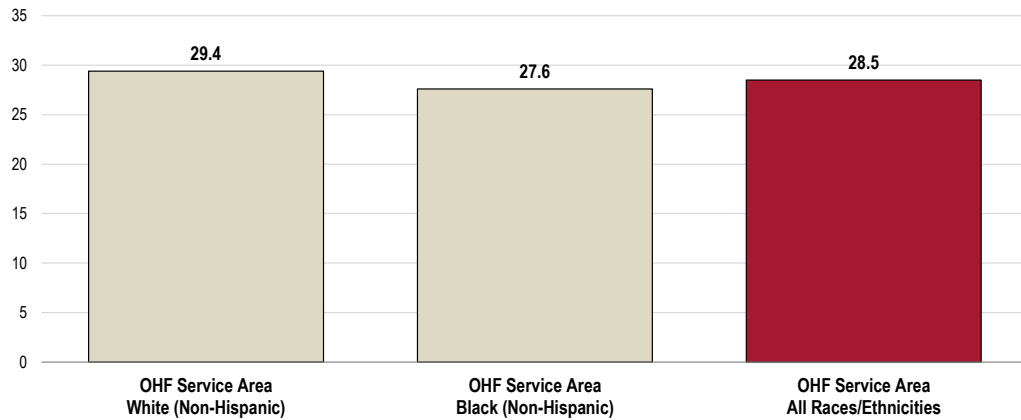
### Alzheimer's Disease: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The Alzheimer's disease mortality rate does not vary significantly between Whites and Blacks in the OHF Service Area.

### Alzheimer's Disease: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population)

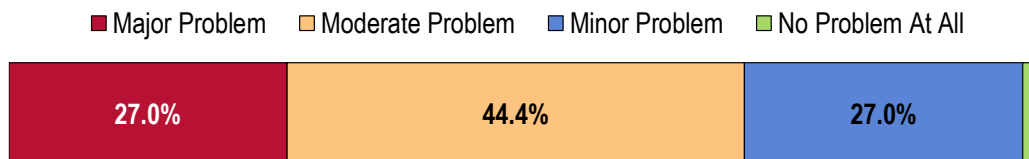


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Key Informant Input: Dementias, Including Alzheimer’s Disease

Key informants taking part in an online survey are most likely to consider *Dementias, Including Alzheimer’s Disease* as a “moderate problem” in the community.

### Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### Prevalence/Incidence

*There are a growing number of early-diagnosed Alzheimer's patients and many at a much earlier age. There are not enough resources to properly care for those patients with later stages of their disease, and it is not safe for them to continue to live at home. It takes a significant amount of financial resources to adequately provide care for them. – Public Health Representative*

*It seems to affect more people at an earlier age. – Community Leader*

*There are way too many people that I know who are currently suffering from it or have died from it. – Educator*

*I have friends who have relatives with Alzheimer's, and my grandmother had dementia. – Educator*

**Impact on Families/Caregivers**

*There aren't a lot of accessible options for caregivers in this area. The cost associated with home health care may not be covered by insurance, leaving family members to carry the burden of taking care of a loved one. Assisted living facilities are cost-prohibitive to many families. – Community Leader*

*No resources for families who are trying to work and take care of a family member with dementia or Alzheimer's disease. – Social Services Provider*

*Many individuals are affected by this disease in our area. It is life-changing, not only to the individual with dementia, but to the other family members. It is hard to find caregivers, as well as the cost of providing care. – Community Leader*

**Health Education/Awareness**

*Education and resources appear to be limited to an increasing number of residents in the area receiving this diagnosis. Again, financial means is a real roadblock for most, limiting access to memory centers. – Other Health Provider*

**Access to Care/Services**

*Price and lack of resources for care. – Community Leader*



# Kidney Disease

## About Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

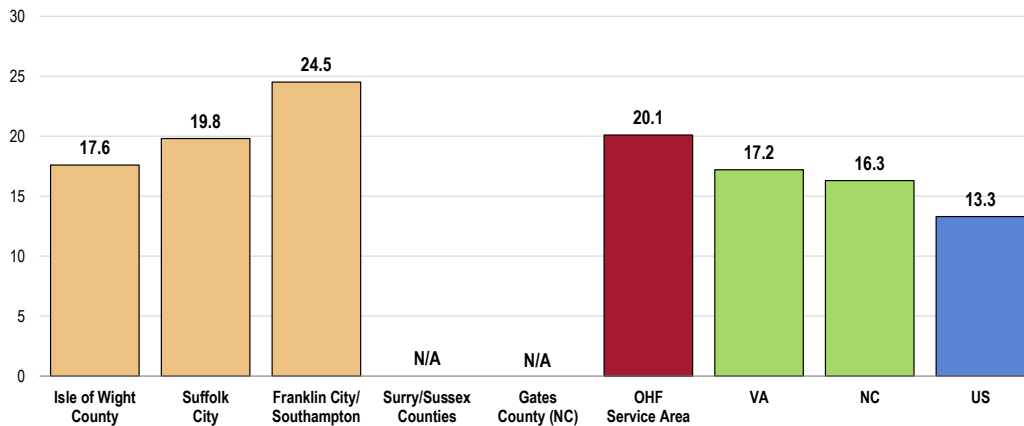
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Kidney Disease Deaths

Between 2013 and 2015, there was an annual average age-adjusted kidney disease mortality rate of 20.1 deaths per 100,000 population in the OHF Service Area.

- Comparable to the Virginia mortality rate but higher than the North Carolina rate.
- Higher than the national rate.
- Notably high in the Franklin City/Southampton County community.

**Kidney Disease: Age-Adjusted Mortality**  
(2013–2015 Annual Average Deaths per 100,000 Population)



Sources:
 

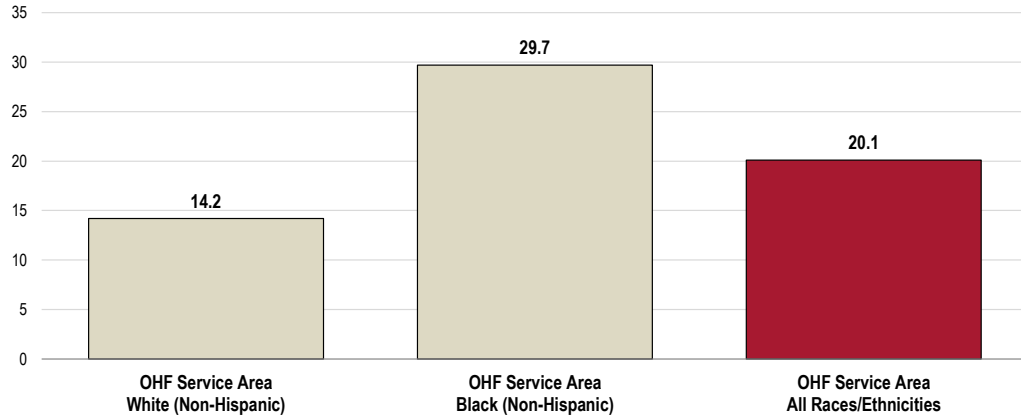
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.

 Notes:
 

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The kidney disease mortality rate in the OHF Service Area is twice as high among Blacks as among Whites.

### Kidney Disease: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population)



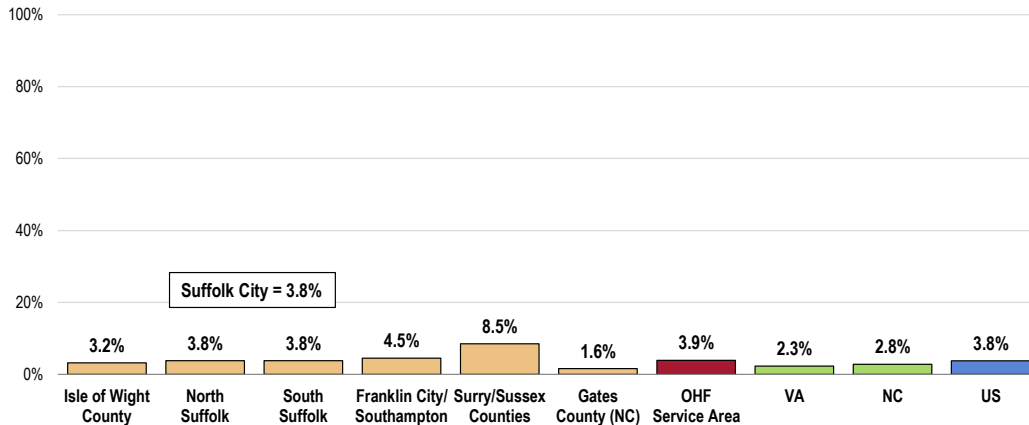
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Prevalence of Kidney Disease

A total of 3.9% of area adults report having been diagnosed with kidney disease.

- Above both state proportions.
- Similar to the US proportion.
- Statistically similar by area.

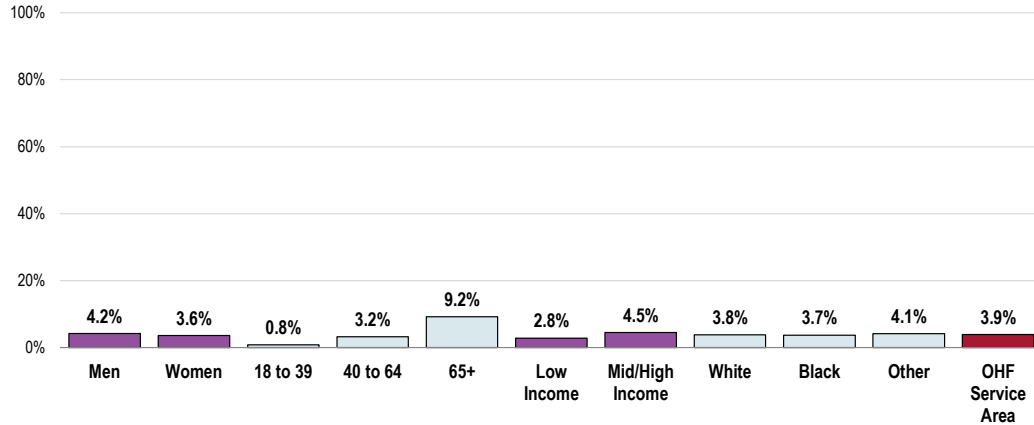
### Prevalence of Kidney Disease



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- Note the positive correlation between kidney disease and age in the OHF Service Area.

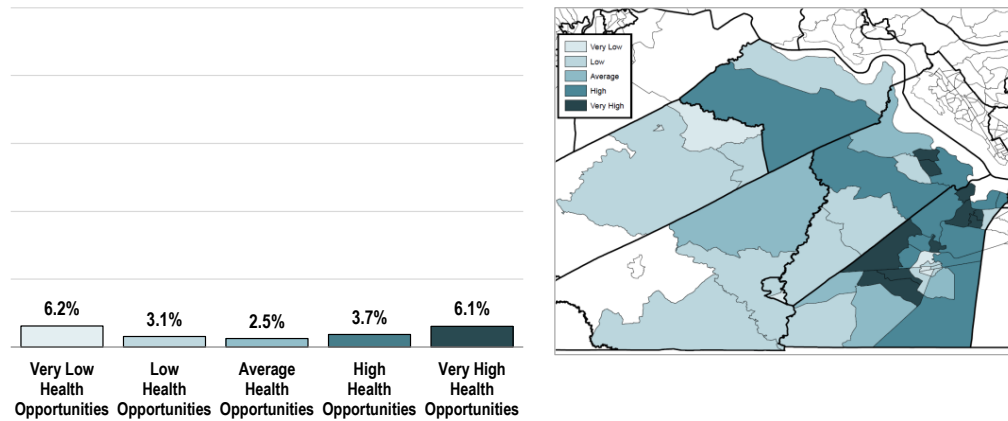
### Prevalence of Kidney Disease (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

- Examining findings by HOI category shows no clear correlation, with the highest prevalence levels at either end of the scale.

### Prevalence of Kidney Disease (OHF Service Area by Health Opportunity Index Classification)



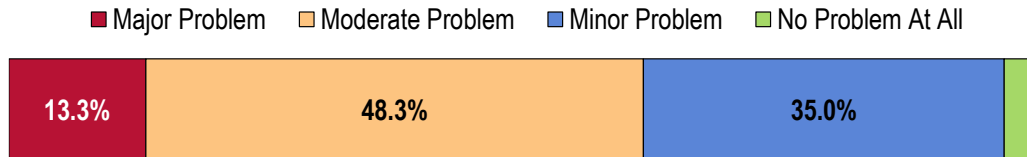
Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]  
 Notes: • Asked of all respondents.

## Key Informant Input: Kidney Disease

Nearly half of key informants taking part in an online survey characterized *Kidney Disease* as a “moderate problem” in the community.

### Perceptions of Kidney Disease as a Problem in the Community

(Key Informants, 2017)



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: ● Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### *Prevalence/Incidence*

*Many patients that come through the emergency department are on dialysis. Makes me believe there is a problem in the community. – Other Health Provider*

*Comparatively, Gates County has a large number of residents who have to access kidney dialysis. This requires a vehicle ride up to one hour one way. This is a quality-of-life issue. It would be beneficial to have a dialysis center in Gates County. – Other Health Provider*

#### *Diagnosis/Treatment*

*Chronic kidney disease is a major concern in our community. Because there are no symptoms, it can often be undetected until advanced disease. Hypertension and diabetes are major risk factors for the development of chronic kidney disease, and these diseases are prevalent in our community. – Other Health Provider*

## Potentially Disabling Conditions

### Arthritis, Osteoporosis & Chronic Back Conditions

#### About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than \$128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least \$50 billion each year on low back pain. Low back pain is the:

- 2<sup>nd</sup> leading cause of lost work time (after the common cold).
- 3<sup>rd</sup> most common reason to undergo a surgical procedure.
- 5<sup>th</sup> most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

#### **Over 4 in 10 OHF Service Area adults age 50 and older (44.0%) report suffering from arthritis or rheumatism.**

- Less favorable than that found nationwide.

#### **A total of 10.0% of OHF Service Area adults age 50 and older have osteoporosis.**

- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.

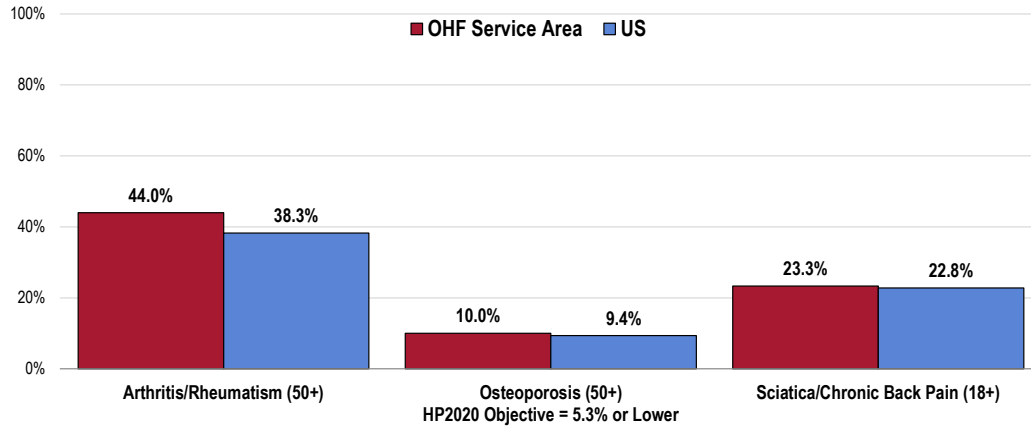
#### **A total of 23.3% of OHF Service Area adults (18 and older) suffer from chronic back pain or sciatica.**

- Comparable to that found nationwide.

#### RELATED ISSUE:

See also *Overall Health Status: Activity Limitations in the General Health Status* section of this report.

### Prevalence of Potentially Disabling Conditions

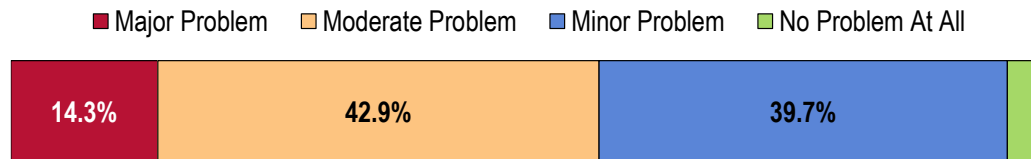


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 26, 141-142]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]  
 Notes: • The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

### Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

A plurality of key informants taking part in an online survey characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a “moderate problem” in the community.

### Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to:

#### Access to Care/Services

*Diagnosis is limited to the resources available, the ability of the clinician, and the financial resources of the patient. Transportation to physician offices for a good portion of the Western Tidewater patients is very limited. – Other Health Provider*

#### Comorbidities

*Secondary to obesity and sedentary lifestyles. – Other Health Provider*

#### Affordable Care/Services

*There are a lot of patients that need orthopedic services but are unable to be seen by a doctor because they do not have the money that orthopedic doctors are asking for up front. – Other Health Provider*

**Prevalence/Incidence**

*Back injuries for the City of Suffolk employees are prevalent. Many healthcare dollars are spent on back issues. – Community Leader*

**Vision & Hearing Impairment****About Vision**

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**About Hearing & Other Sensory or Communication Disorders**

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

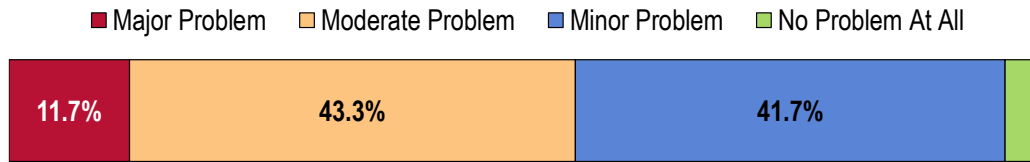
As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Key Informant Input: Vision & Hearing

Key informants taking part in an online survey most often characterized *Vision & Hearing* as a “moderate problem” in the community, followed closely by the prevalence of informants giving “minor problem” ratings of the issue.

### Perceptions of Vision and Hearing as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### *Affordable Care/Services*

*Multiple former International Paper employees with hearing impairments without the means to obtain proper exams including adequate hearing aids. Service for hearing aids is extremely limited, even for those who may be able to afford devices, but devices specific to the patient's exact hearing deficiencies seems to be very inadequate. – Other Health Provider*

*There is a great need for ophthalmology referrals for the uninsured. – Other Health Provider*

*Non-insured individuals cannot afford vision screenings and/or glasses. – Social Services Provider*

*Testing and cost. – Community Leader*

#### *Access to Care/Services*

*Access to care, costs. – Community Leader*

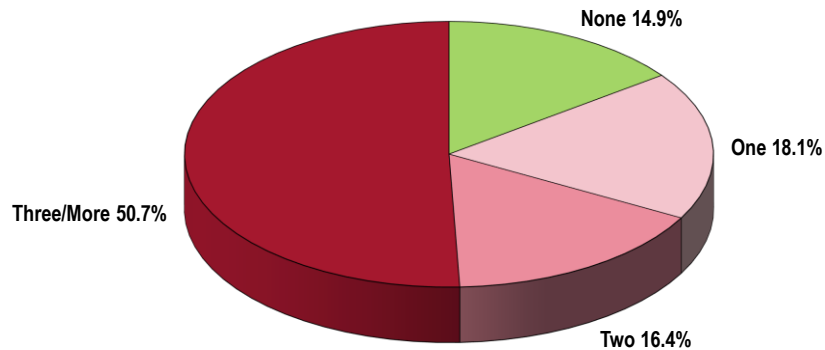


## Multiple Chronic Conditions

Among OHF Service Area survey respondents, most report currently having at least one chronic health condition, including 18.1% with one condition, 16.4% with two conditions, and half (50.7%) with three or more chronic conditions.

For the purposes of this assessment, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression. Multiple chronic conditions are concurrent conditions.

**Number of Current Chronic Conditions**  
(OHF Service Area, 2017)

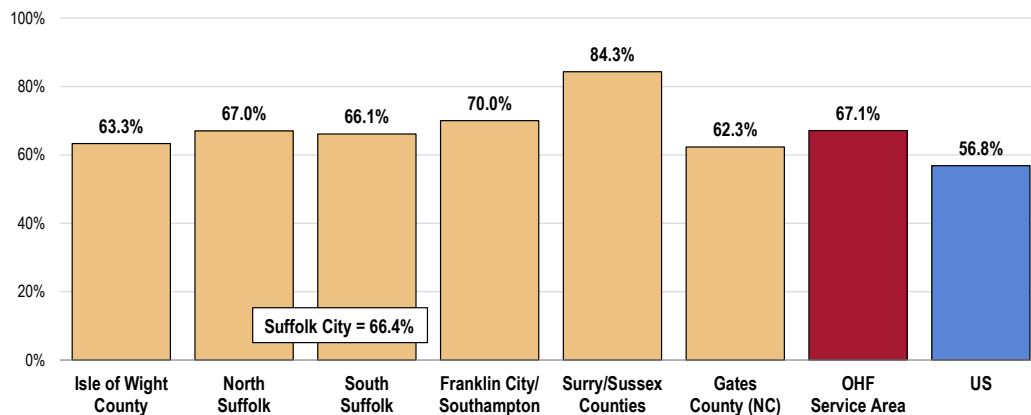


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]  
Notes: • Asked of all respondents.

• In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

- The prevalence of multiple chronic conditions among OHF Service Area residents (67.1%) is less favorable than the US prevalence.
- Viewed by area, the prevalence is markedly high among Surry/Sussex County adults.

## Currently Suffer From Multiple Chronic Conditions



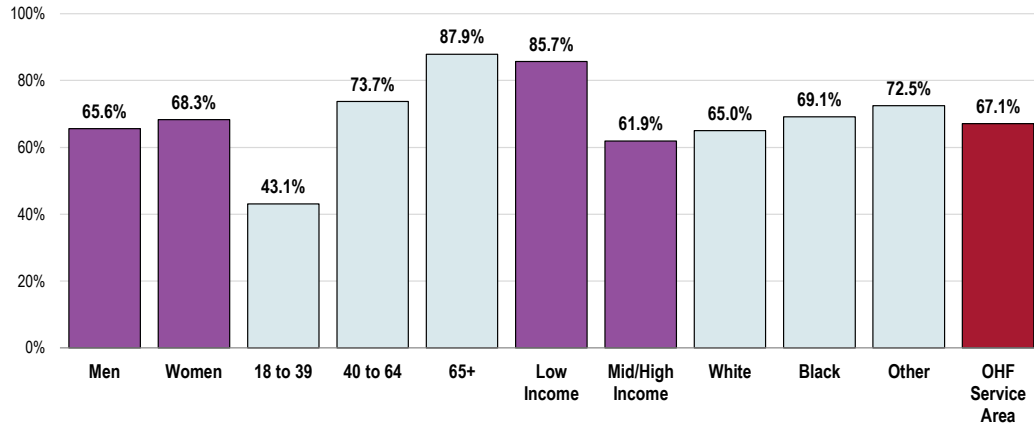
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]  
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.  
• In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

The following population segments are more likely to report suffering from multiple chronic conditions:

- Older residents (note the positive correlation with age).
- Adults in low-income households.

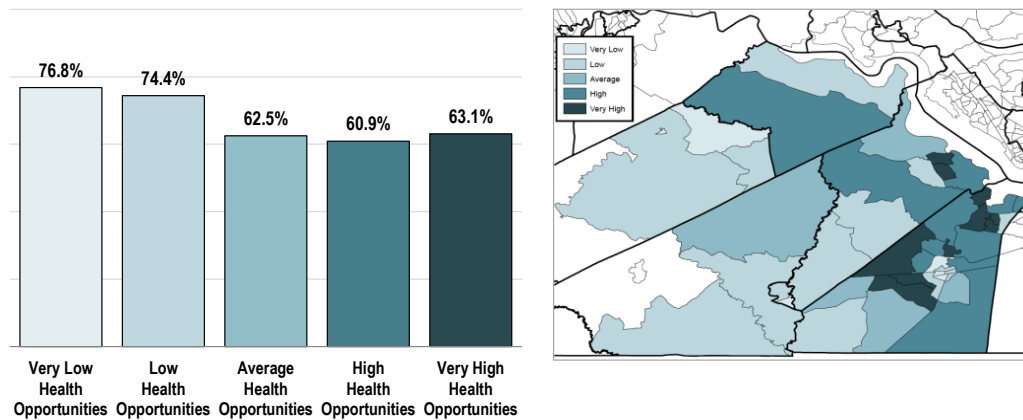
### Currently Suffer From Multiple Chronic Conditions (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Examined by HOI classification, the proportion of residents with multiple chronic conditions is notably higher in populations with low health opportunities.

### Multiple Chronic Conditions (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 197]  
 Notes: • Asked of all respondents.

# Infectious Disease



**Professional Research Consultants, Inc.**

## Influenza & Pneumonia Vaccination

### About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Flu Vaccination

Among OHF Service Area seniors, 68.3% received a flu shot within the past year.

- Higher than the Virginia finding; similar to the North Carolina percentage.
- Lower than the national finding.
- Similar to the Healthy People 2020 target (70.0% or higher).
- The percentage is highest in Isle of Wight County and North Suffolk, lowest in the Franklin City/Southampton/Gates County population (*combined in order to provide a more robust sample size for this indicator*).

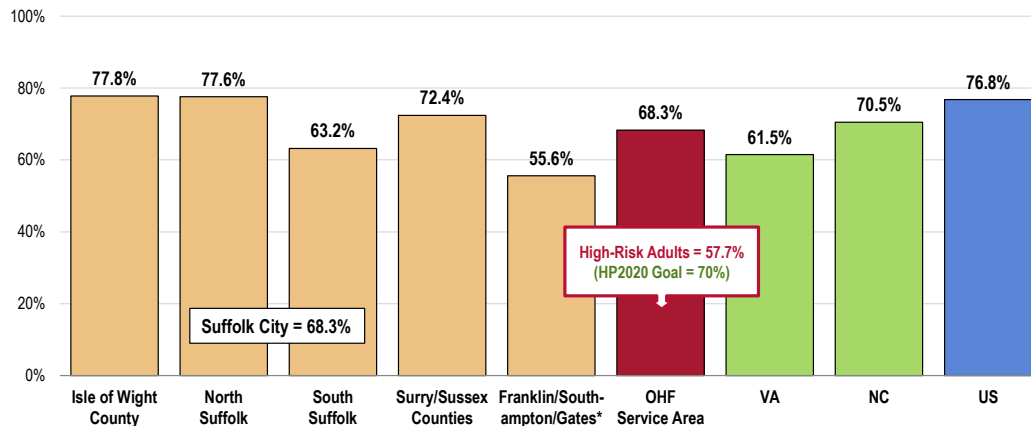
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes, or respiratory disease.

A total of 57.7% of high-risk adults age 18 to 64 received a flu shot within the past year.

### Older Adults: Have Had a Flu Vaccination in the Past Year

(Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 143-144]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.12]
- Notes:
- Reflects respondents 65 and older.
  - \*High-Risk\* includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes, or respiratory disease.
  - \*Franklin City/Southampton and Gates County were combined in order to provide a more robust sample size for this indicator.

## Pneumonia Vaccination

Among OHF Service Area adults age 65 and older, 75.9% have received a pneumonia vaccination at some point in their lives.

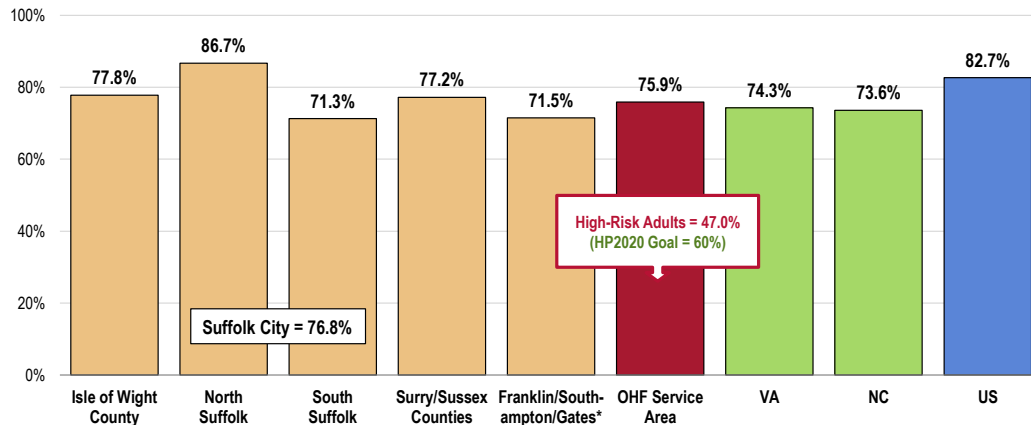
- Comparable to the findings in both states.
- Below the national finding.
- Fails to satisfy the Healthy People 2020 target of 90.0% or higher.
- Highest in North Suffolk.

A total of 47.0% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

### Older Adults: Have Ever Had a Pneumonia Vaccine

(Among Adults Age 65+)

Healthy People 2020 Target = 90.0% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 145-146]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives IID-13.1, IID-13.2]
- Notes:
- Reflects respondents 65 and older.
  - "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
  - \*Franklin City/Southampton and Gates County were combined in order to provide a more robust sample size for this indicator.

## HIV

### About Human Immunodeficiency Virus (HIV)

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

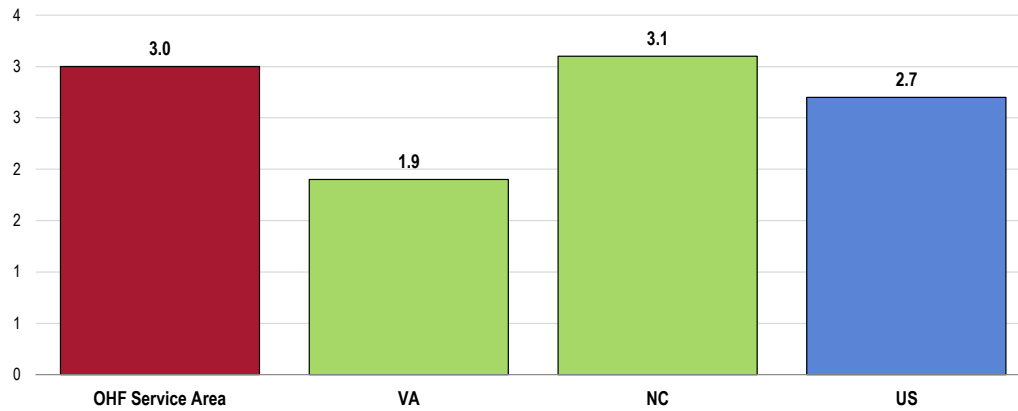
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted HIV/AIDS Deaths

Between 2004 and 2014, there was an annual average age-adjusted HIV/AIDS mortality rate of 3.0 deaths per 100,000 population in the OHF Service Area.

- Higher than the Virginia mortality rate, comparable to the North Carolina rate.
- Similar to the rate reported nationally.
- Satisfies the Healthy People 2020 target (3.3 or lower).

**HIV/AIDS: Age-Adjusted Mortality**  
(2004–2014 Annual Average Deaths per 100,000 Population)  
Healthy People 2020 Target = 3.3 or Lower



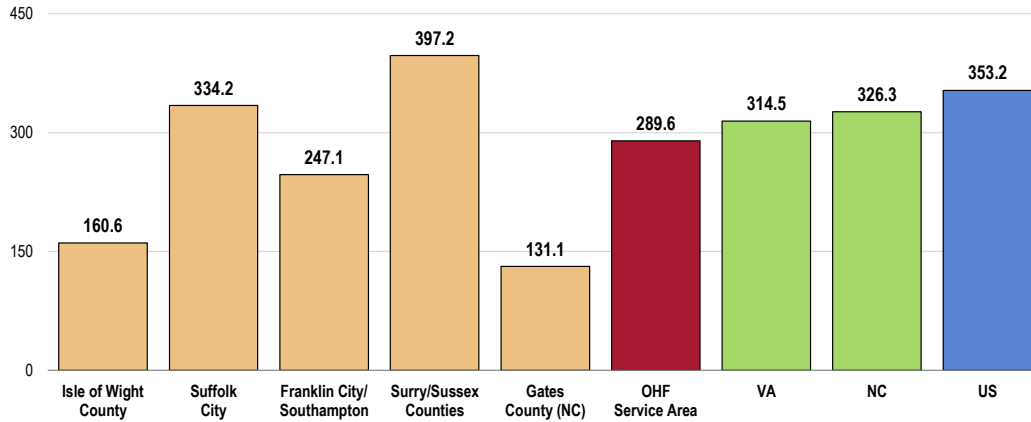
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## HIV Prevalence

In 2013, there was a prevalence of 289.6 HIV cases per 100,000 population in the OHF Service Area.

- Comparable to the statewide percentages.
- More favorable than the national prevalence.
- Ranging considerably by area; highest in Suffolk City and Surry/Sussex counties.

### HIV Prevalence (Prevalence Rate of HIV per 100,000 Population, 2013)



Sources: 

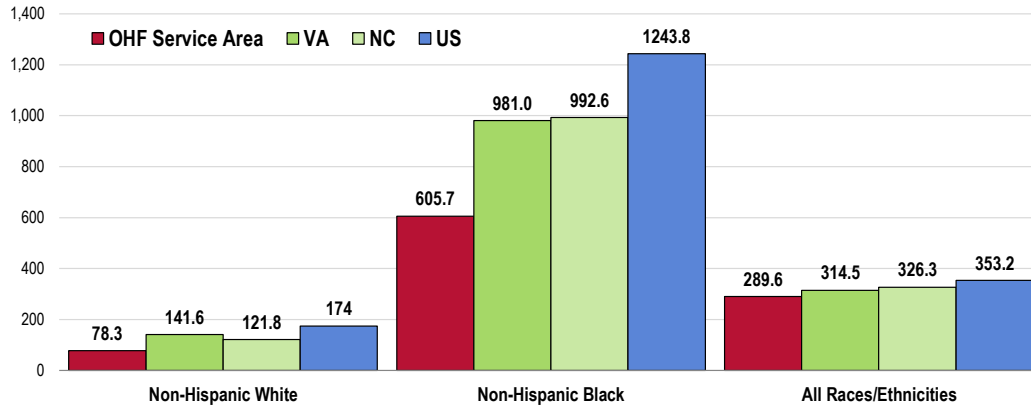
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved October 2017 from Community Commons at <http://www.chna.org>.

  
 Notes: 

- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

- By race and ethnicity, HIV/AIDS prevalence in the OHF Service Area is particularly high among Blacks, although to a lesser degree than found in either state or nationally.

### HIV Prevalence by Race/Ethnicity (Rate per 100,000 Population, 2013)



Sources: 

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved October 2017 from Community Commons at <http://www.chna.org>.

  
 Notes: 

- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

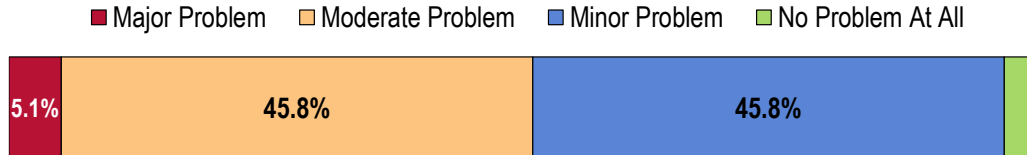


## Key Informant Input: HIV/AIDS

Key informants taking part in an online survey were divided between “moderate” and “minor” ratings of the community’s HIV/AIDS issue.

### Perceptions of HIV/AIDS as a Problem in the Community

(Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### *Risky Sexual Behaviors*

Many patients do not practice safe sex. – Other Health Provider

#### *Diagnosis/Treatment*

Testing and awareness. – Community Leader

## Sexually Transmitted Diseases

### About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

**Biological Factors.** STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

**Social, Economic, and Behavioral Factors.** The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Chlamydia & Gonorrhea

**In 2014, the chlamydia incidence rate in the OHF Service Area was 604.0 cases per 100,000 population.**

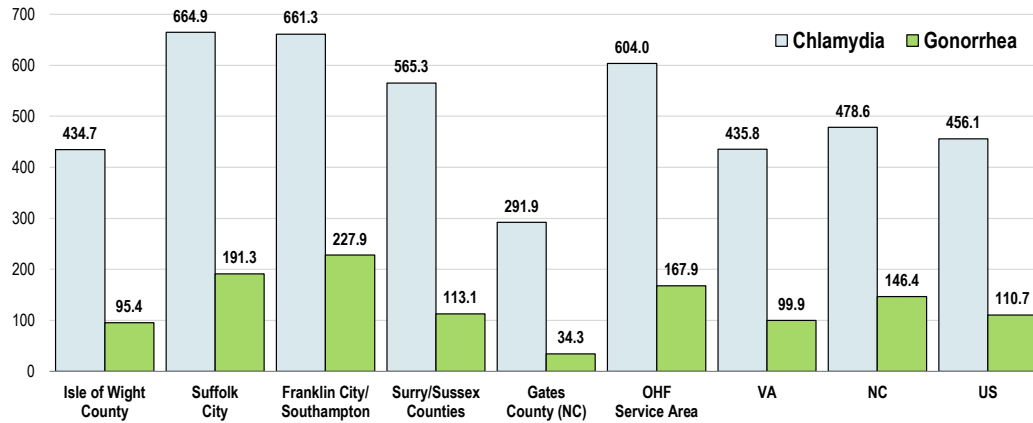
- Notably higher than state and national incidence rates.
- Lowest in Isle of Wight and Gates counties.

**The OHF Service Area gonorrhea incidence rate in 2014 was 167.9 cases per 100,000 population.**

- Notably higher than the Virginia and US incidence rates.
- Similar to the North Carolina rate.

- Unfavorably high in Suffolk City and the Franklin City/Southampton area.

### Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2014)



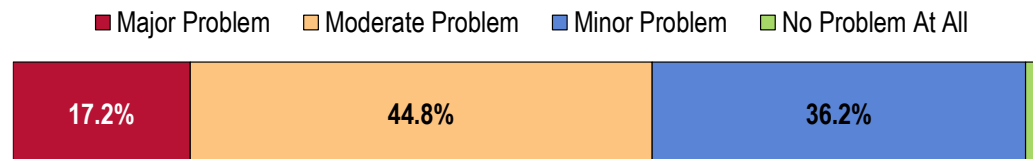
Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.  
 • Retrieved October 2017 from Community Commons at <http://www.chna.org>.

Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

### Key Informant Input: Sexually Transmitted Diseases

A plurality of key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a “moderate problem” in the community.

### Perceptions of Sexually Transmitted Diseases as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### *Prevalence/Incidence*

*Sexually transmitted diseases are transmitted by individuals not thinking that one can contract a disease if they practice safe sex. STDs are prevalent and, while resources are present, the prevalence and incidence rates are somewhat high. – Other Health Provider*

*STDs seem to be on the rise and uncontrolled, according to the local health department. – Public Health Representative*

*Historically, Western Tidewater has been a major area for the spread of STDs/STIs—syphilis, in particular. – Social Services Provider*

*We have a large number of people using the emergency department to get checked for STDs. Most are the ages of 16-40. – Other Health Provider*

*According to VDH statistics, sexually transmitted diseases are rising in Virginia and in Western Tidewater. – Public Health Representative*

### *Contributing Factors*

*Crime, risk-loving teens, lack of education. – Other Health Provider*

*Education. – Community Leader*

## Immunization & Infectious Diseases

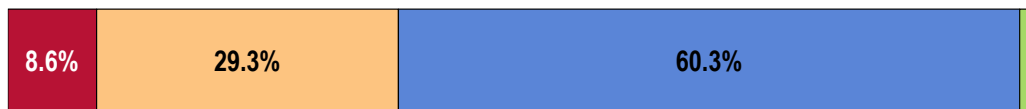
### Key Informant Input: Immunization & Infectious Diseases

A total of 6 in 10 key informants taking part in an online survey characterized *Immunization & Infectious Diseases* as a “minor problem” in the community.

### Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2017)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### *Diagnosis/Treatment*

*Patients are not seeing their primary care provider as often as they should to keep up with shots (and/or get shots at all) to prevent diseases. – Other Health Provider*

*Need to make more immunizations in medications for these types of diseases. – Community Leader*

#### *Affordable Care/Services*

*Low-income families with no or poor insurance, who don't know what avenues are available to them. – Community Leader*

# Births



Professional Research Consultants, Inc.

## Prenatal Care

### About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

Early and continuous prenatal care is the best assurance of infant health.

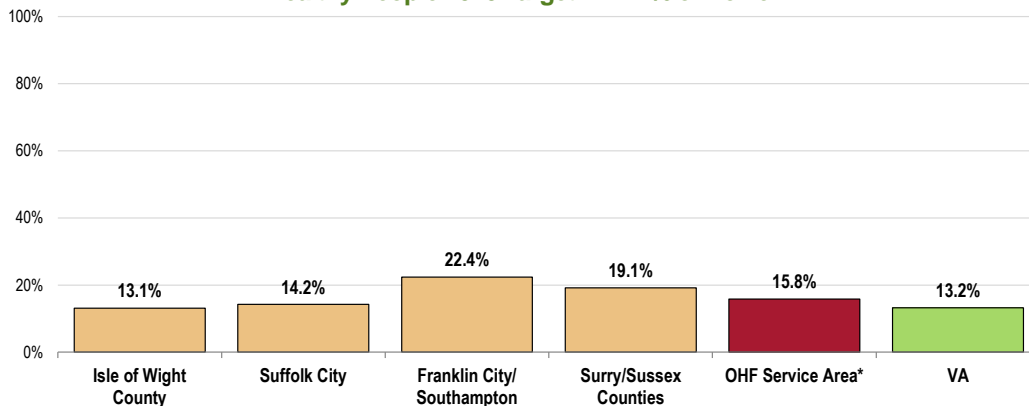
**In 2013, 15.8% of all OHF Service Area births did not receive prenatal care in the first trimester of pregnancy.**

- Less favorable than the Virginia proportion.
- Satisfies the Healthy People 2020 target (22.1% or lower).
- Particularly high in Franklin City/Southampton County.

### Lack of Prenatal Care in the First Trimester

(Percentage of Live Births, 2013)

Healthy People 2020 Target = 22.1% or Lower



- Sources:
- Sentara Obici datafile 9/30/16
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.
  - \*Excludes Gates County data.

## Birth Outcomes & Risks

### Low-Weight Births

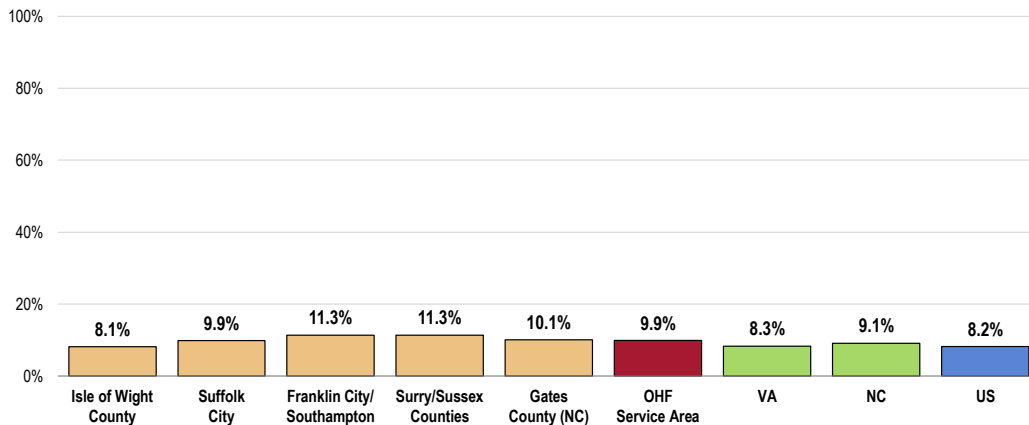
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

**A total of 9.9% of 2006–2012 OHF Service Area births were low-weight.**

- Worse than the Virginia and US proportions.
- Similar to the North Carolina proportion.
- Fails to satisfy the Healthy People 2020 target (7.8% or lower).
- Lowest (more favorable) in Isle of Wight County.

**Low-Weight Births**  
(Percent of Live Births, 2006–2012)  
**Healthy People 2020 Target = 7.8% or Lower**



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted October 2017.

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]

Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

### Infant Mortality

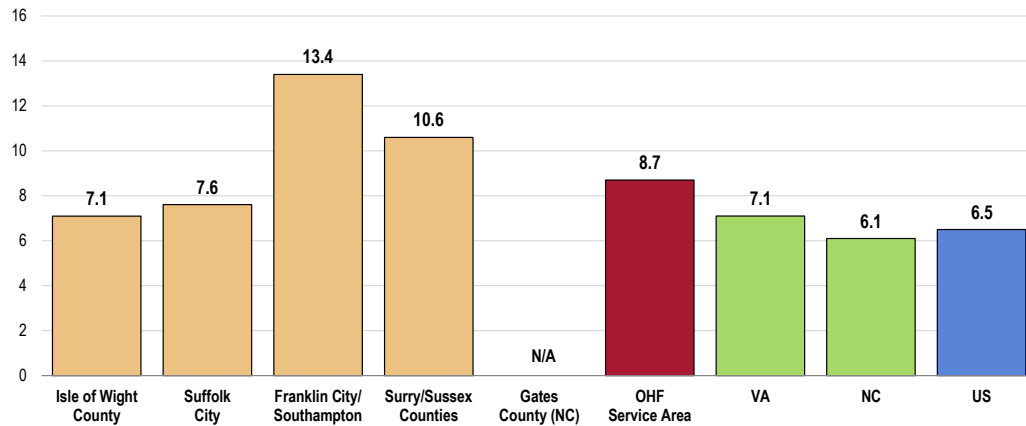
**Between 2006 and 2010, there was an annual average of 8.7 infant deaths per 1,000 live births.**

- Worse than the state and US mortality rates.
- Fails to satisfy the Healthy People 2020 target of 6.0 per 1,000 live births or lower.
- Highest in Franklin City/Southampton County.

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.



### Infant Mortality Rate (Annual Average Infant Deaths per 1,000 Live Births, 2006–2010) Healthy People 2020 Target = 6.0 or Lower

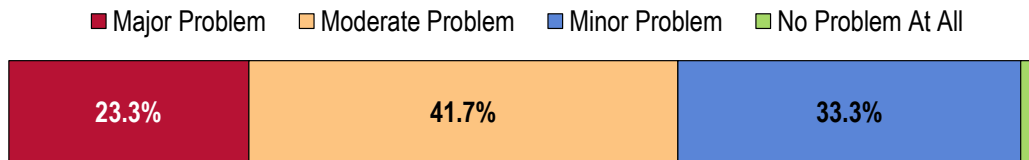


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted October 2017.  
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]  
Notes: ● Infant deaths include deaths of children under 1 year old.  
● This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

### Key Informant Input: Infant & Child Health

Key informants taking part in an online survey generally characterized *Infant & Child Health* as a “moderate problem” in the community.

### Perceptions of Infant and Child Health as a Problem in the Community (Key Informants, 2017)



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: ● Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### Health Education/Awareness

Many parents are children themselves and, therefore, don't know how to take care of infants and small children. There are also many grandparents taking care of their grandchildren and are not in good physical health or don't have the resources to care for them as they should be. – Educator

*Has to do more with the education of the parent(s). Community health departments are not available 24/7, so some parents do not seek medical attention early when needed for fear of a bill they can't pay. Education is necessary, but most don't understand that even a Walgreens pharmacist can provide over-the-counter suggestions when appropriate to prevent escalation or exacerbation of the illness.*  
– Other Health Provider

*The level of education of parents in this community.* – Community Leader

*We need to make sure that children grow up with a solid foundation, including access to healthcare and food programs.* – Community Leader

### **Infant Mortality Rates**

*Infant and child mortality rates, especially in the Franklin and Southampton localities. These areas have a higher incident of low birthweight babies.* – Public Health Representative

*Studies for region regarding infant mortality, obesity, and such.* – Other Health Provider

## Family Planning

### Births to Teen Mothers

#### About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

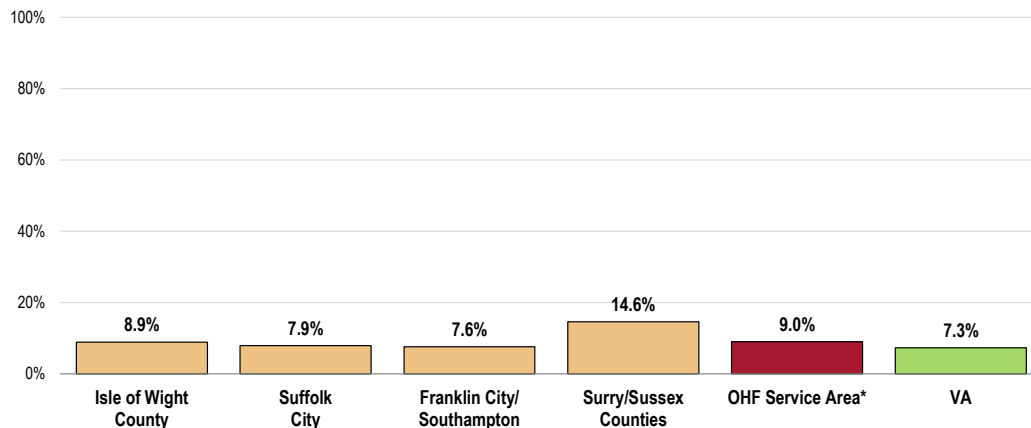
Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**In 2013, there was an annual average of 9.0% births to women under age 20 (data excludes Gates County).**

- Higher than the Virginia proportion.
- Unfavorably high in Surry/Sussex counties.

**Births to Teenagers (Under 20)**  
(Percent of Births to Women Under Age 20, 2013)



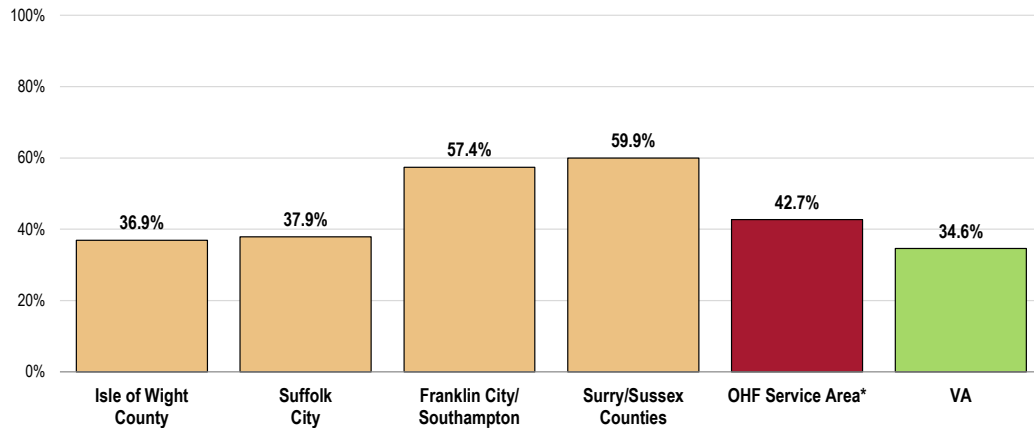
- Sources:
- Sentara Obici datafile 9/30/16
- Notes:
- This indicator reports the percentage of live births to women under the age of 20. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.
  - \*Excludes Gates County data.

## Unwed Mothers

In 2013, 42.7% of live births in the OHF Service Area were to unwed mothers.

- Higher than the Virginia proportion.
- Highest among live births in Franklin City/Southampton County and Surry/Sussex counties.

### Births to Unwed Mothers (Percent of Live Births, 2013)



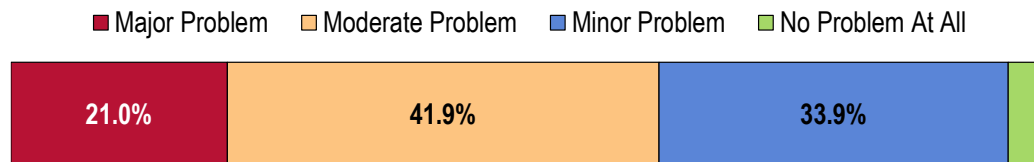
Sources: • Sentara Obici datafile 9/30/16  
 Notes: • This indicator reports the percentage of live births.  
 • \*Excludes Gates County data.

## Key Informant Input: Family Planning

Key informants taking part in an online survey largely characterized *Family Planning* as a “moderate problem” in the community.

### Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### **Health Education/Awareness**

*Education. – Community Leader*

*Limited access to education and services available. – Community Leader*

### **Single Parent Families**

*Too many children are born to single moms or unmarried couples. – Public Health Representative*

*Too many unwed mothers. – Community Leader*

### **Teen Pregnancy**

*The data indicates that there are higher-than-state averages of unplanned pregnancies and single mothers under the age of 18. – Educator*

*Pregnancy among teens. Drug abuse and pregnancy. – Other Health Provider*

### **Socioeconomic Status**

*Health inequities; social determinants of health; generational norms of the impoverished; unsuccessful educational efforts to foster behavioral changes. – Other Health Provider*

### **Access to Services**

*Maternal health access to care. Limited available resources for most vulnerable pregnant women.*

*– Public Health Representative*

### **Denial/Stigma**

*Access to services can be limited, due to stigma. – Other Health Provider*

# Modifiable Health Risks



Professional Research Consultants, Inc.

## Nutrition

### About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

**Social Determinants of Diet.** Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

**Physical Determinants of Diet.** Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

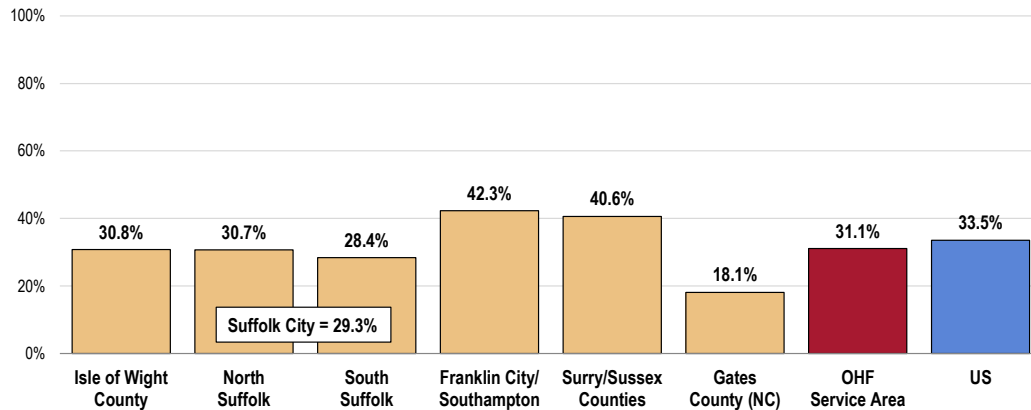
## Daily Recommendation of Fruits/Vegetables

A total of 31.1% of OHF Service Area adults report eating five or more servings of fruits and/or vegetables per day.

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

- Comparable to national findings.
- Highest in Franklin City/Southampton County and Surry/Sussex counties; especially low in Gates County.

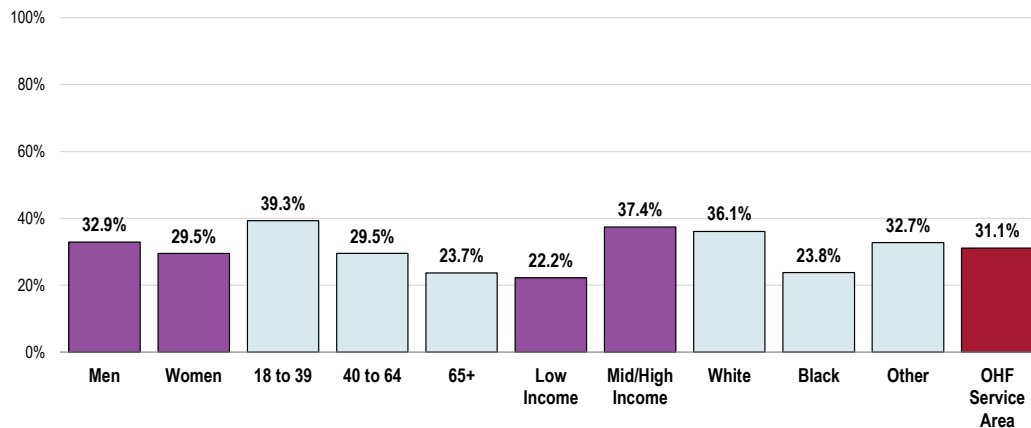
### Consume Five or More Servings of Fruits/Vegetables Per Day



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - For this issue, respondents were asked to recall their food intake on the previous day.

- Older residents are less likely to get the recommended servings of daily fruits/vegetables (negative correlation with age), as are low-income adults and Blacks.

### Consume Five or More Servings of Fruits/Vegetables Per Day (OHF Service Area, 2017)



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - For this issue, respondents were asked to recall their food intake on the previous day.



## Access to Fresh Produce

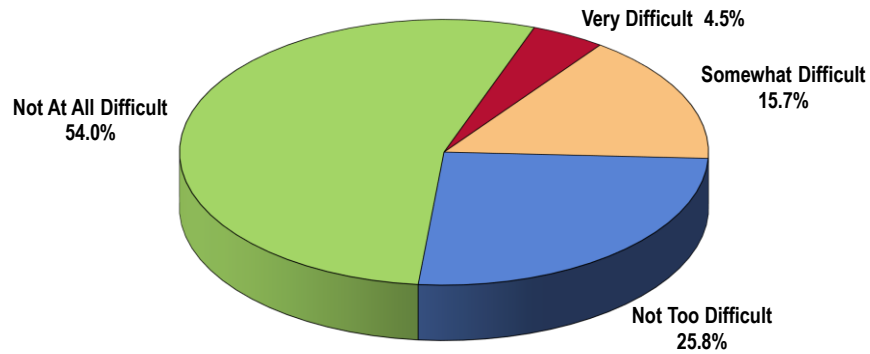
### Difficulty Accessing Fresh Produce

While most report little or no difficulty, 20.2% of OHF Service Area adults find it “very” or “somewhat” difficult to access affordable fresh fruits and vegetables.

Respondents were asked:

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?”

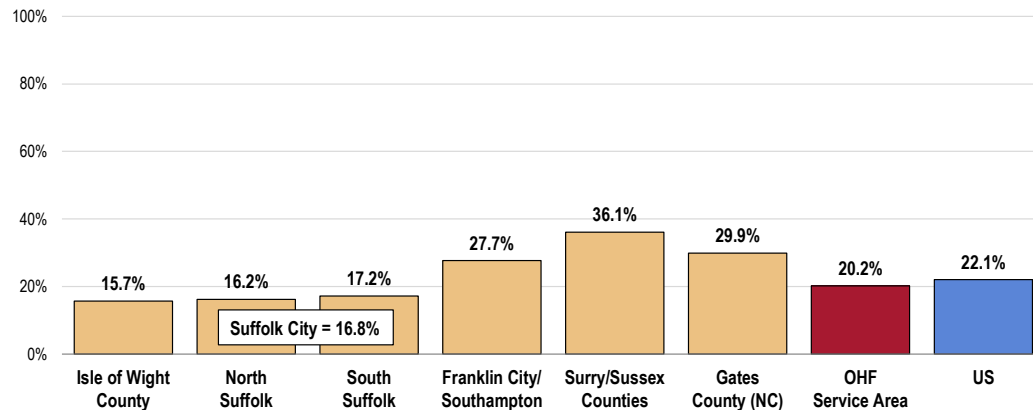
### Level of Difficulty Finding Fresh Produce at an Affordable Price (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]  
Notes: • Asked of all respondents.

- Similar to national findings.
- Difficulty is highest in Surry/Sussex and Gates counties.

### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce

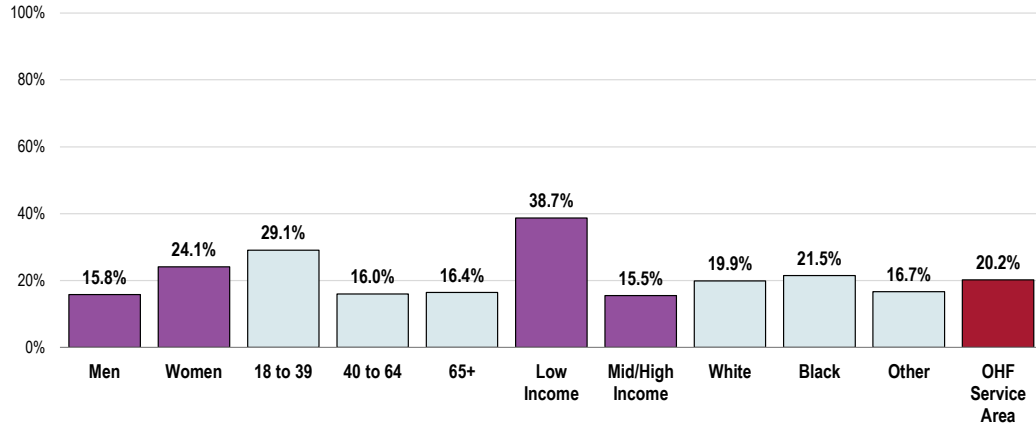


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]  
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

Those more likely to report difficulty getting fresh fruits and vegetables include:

- Women.
- Young adults (under age 40).
- Lower-income residents especially.

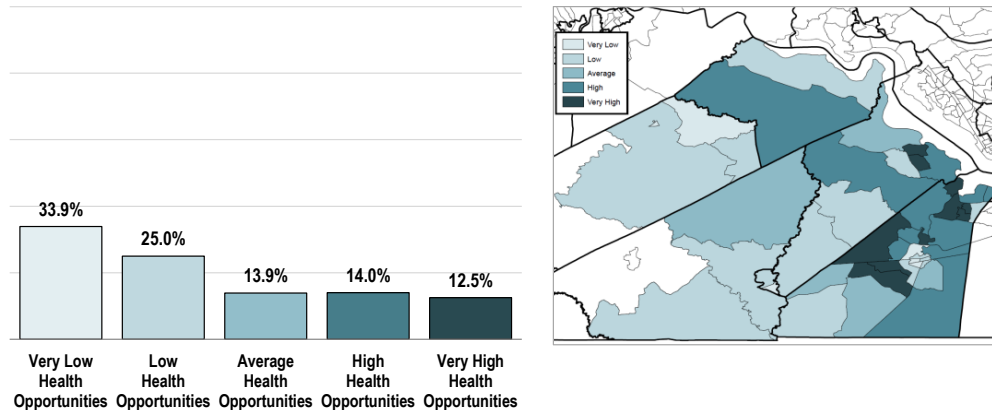
### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Viewed by HOI categorization, difficulty accessing affordable fresh produce is more often noted among residents with low health opportunities.

### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]  
 Notes: • Asked of all respondents.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

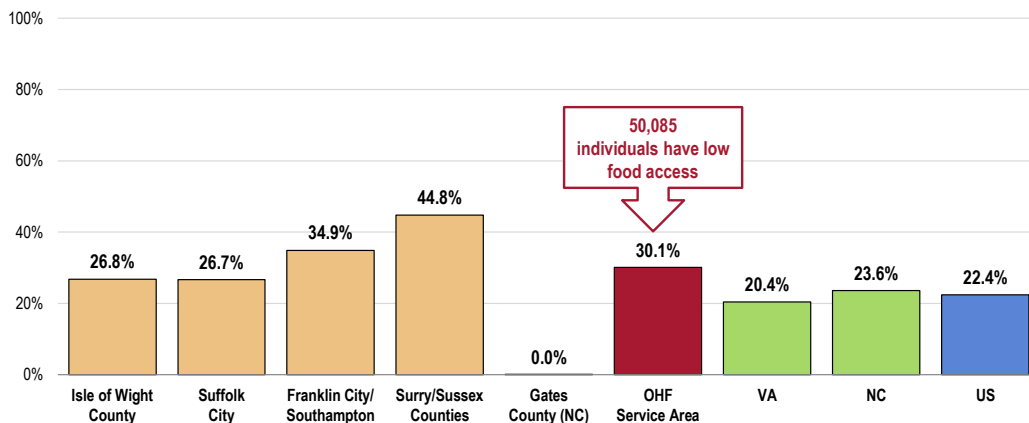
### Low Food Access (Food Deserts)

US Department of Agriculture data show that 30.1% of the OHF Service Area population (representing over 50,000 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Less favorable than statewide and national findings.
- Highest in Franklin City/Southampton County and Surry/Sussex counties.

### Population With Low Food Access

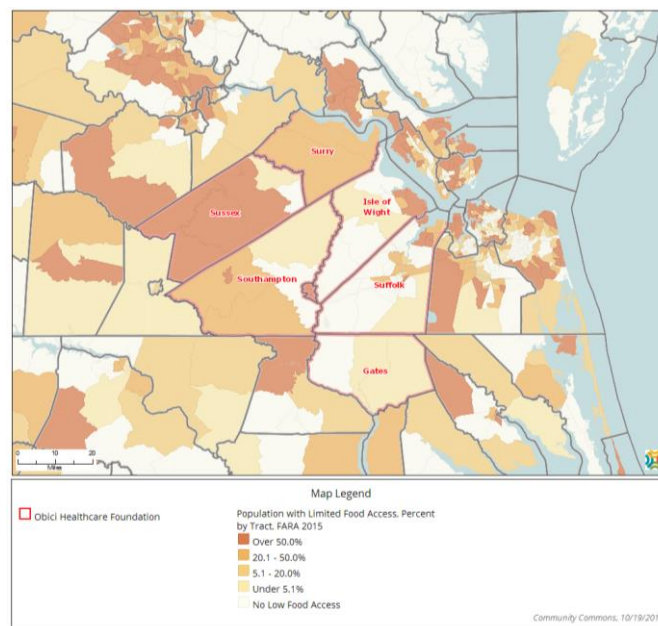
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)



- Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
  - Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts by census tract.

### Population With Limited Food Access, Percent by Tract, FARA 2015

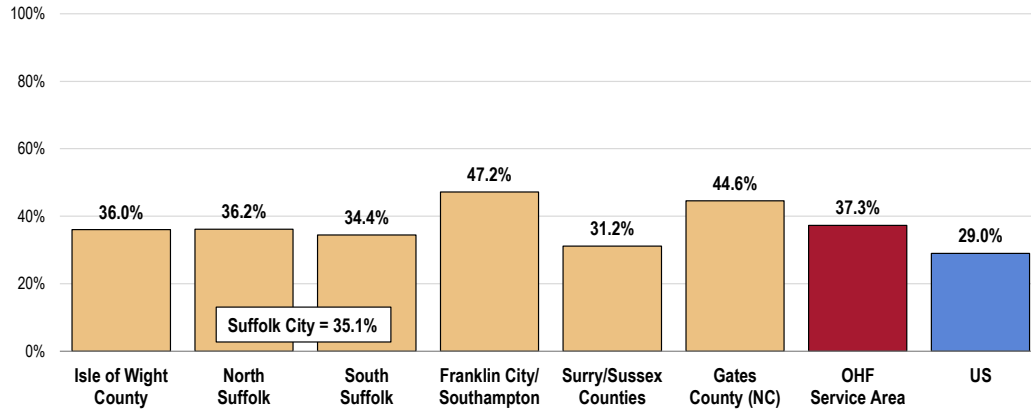


### Sugar-Sweetened Beverages

A total of 37.3% of OHF Service Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

- Well above the national findings.
- Statistically high in Franklin City/Southampton county.

### Had Seven or More Sugar-Sweetened Beverages in the Past Week



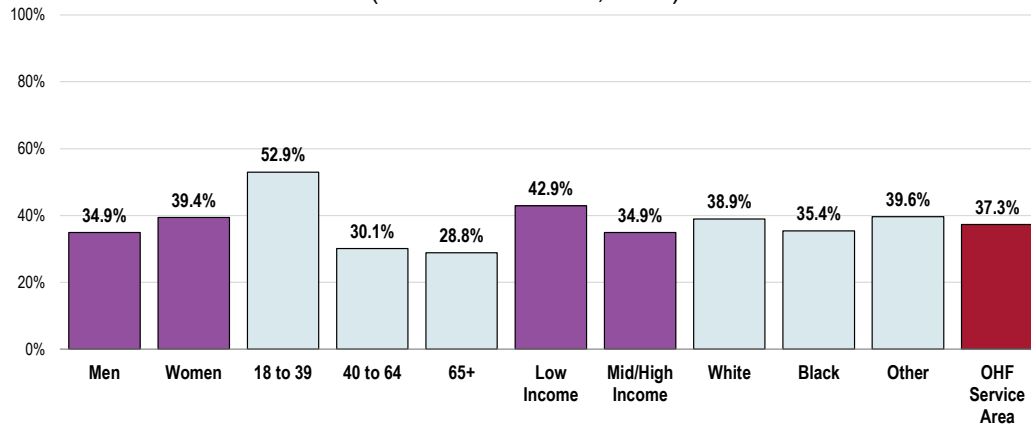
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 313]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Those more likely to consume this level of sugar-sweetened beverages include:

- Young adults especially.
- Lower-income residents.

### Had Seven or More Sugar-Sweetened Beverages in the Past Week (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 313]

Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Physical Activity

### About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Leisure-Time Physical Activity

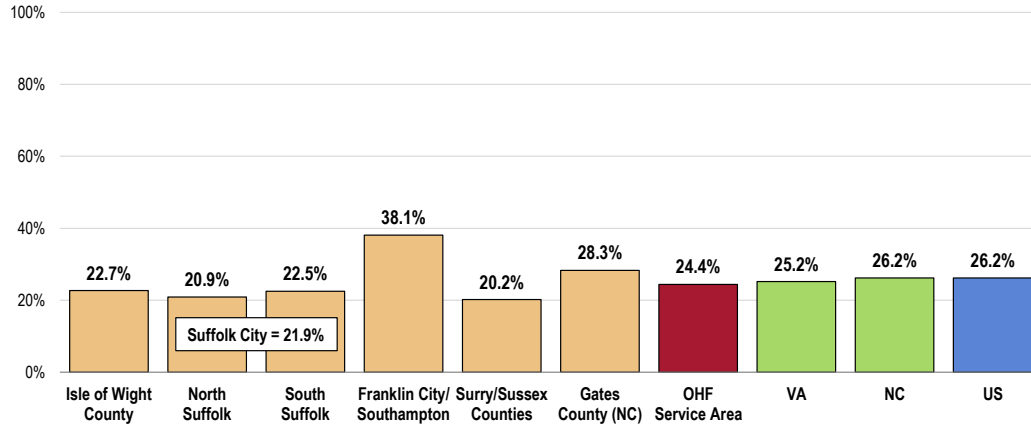
**A total of 24.4% of OHF Service Area adults report no leisure-time physical activity in the past month.**

- Comparable to state and national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

- Less favorable in Franklin City/Southampton County.

### No Leisure-Time Physical Activity in the Past Month Healthy People 2020 Target = 32.6% or Lower



Sources:
 

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 89]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]

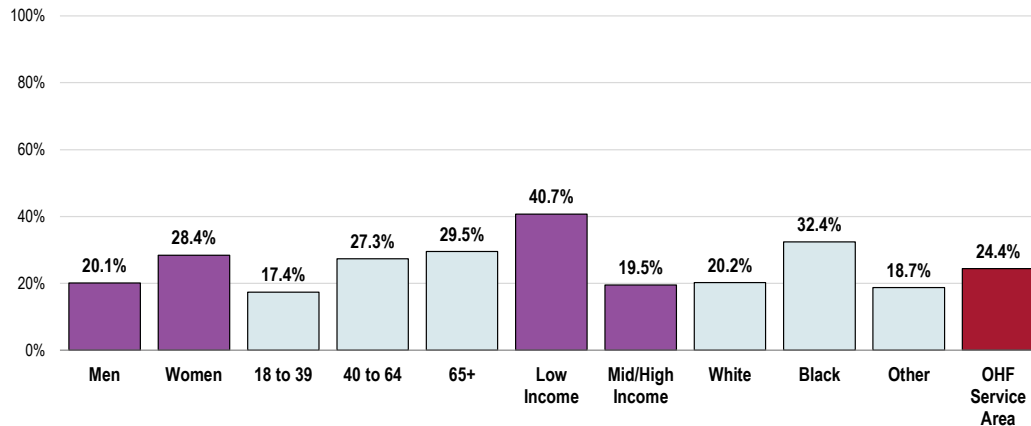
 Notes:
 

- Asked of all respondents.

Lack of leisure-time physical activity in the area is higher among:

- Women.
- Adults age 40 and older (positive correlation with age).
- Lower-income residents.
- Black adults.

### No Leisure-Time Physical Activity in the Past Month (OHF Service Area, 2017) Healthy People 2020 Target = 32.6% or Lower



Sources:
 

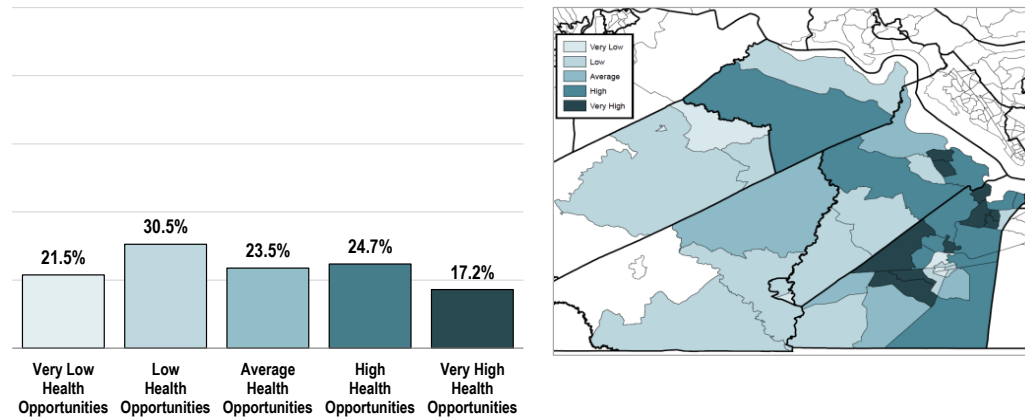
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 89]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]

 Notes:
 

- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Examining findings by HOI classification, those with “low” health opportunities appear to be the most inactive.

### Lack of Leisure-Time Physical Activity (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 89]  
Notes: • Asked of all respondents.

## Activity Levels

### Adults

#### Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. [www.cdc.gov/physicalactivity](http://www.cdc.gov/physicalactivity)
- Learn more about CDC’s efforts to promote walking by visiting <http://www.cdc.gov/vitalsigns/walking>.

Survey respondents were asked about the types of physical activities they engaged in during the past month, as well as the frequency and duration of these activities.

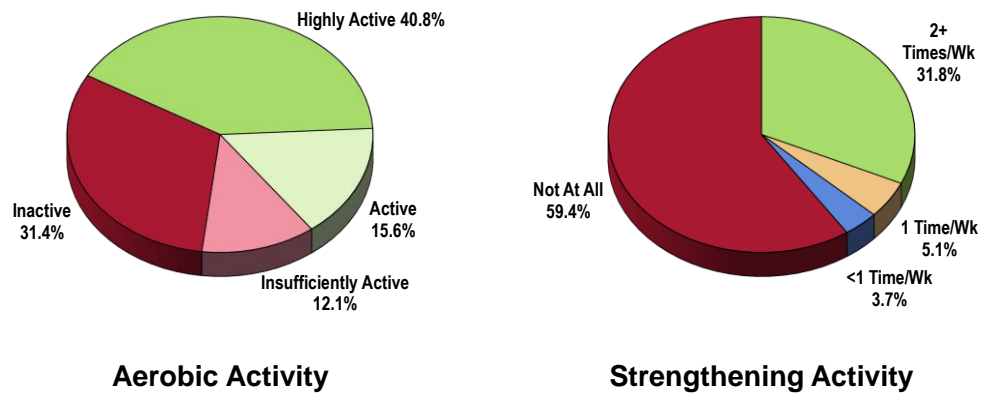
- “Inactive” includes those reporting no aerobic physical activity in the past month.
- “Insufficiently active” includes those with the equivalent of 1-150 minutes of aerobic physical activity per week.
- “Active” includes those with 150-300 minutes of weekly aerobic physical activity.
- “Highly active” includes those with >300 minutes of weekly aerobic physical activity.

### Aerobic & Strengthening Physical Activity

Based on reported physical activity intensity, frequency, and duration over the past month, 43.5% of OHF Service Area adults are found to be “insufficiently active” or “inactive.”

A total of 59.4% of OHF Service Area adults do not participate in any types of physical activities or exercises to strengthen their muscles.

**Participation in Physical Activities**  
(OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 96, 154]  
 Notes: • Reflects the total sample of respondents.  
 • In this case, “inactive” aerobic activity represents those adults participating in no aerobic activity in the past week; “insufficiently active” reflects those respondents with 1-149 minutes of aerobic activity in the past week; “active” adults are those with 150-300 minutes of aerobic activity per week; and “highly active” adults participate in 301+ minutes of aerobic activity weekly.

### Recommended Levels of Physical Activity

A total of 22.8% of OHF Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

- Similar to the Virginia prevalence and more favorable than that in North Carolina.
- Identical to national findings.
- Satisfies the Healthy People 2020 target (20.1% or higher).
- Exceptionally low in Franklin City/Southampton County.

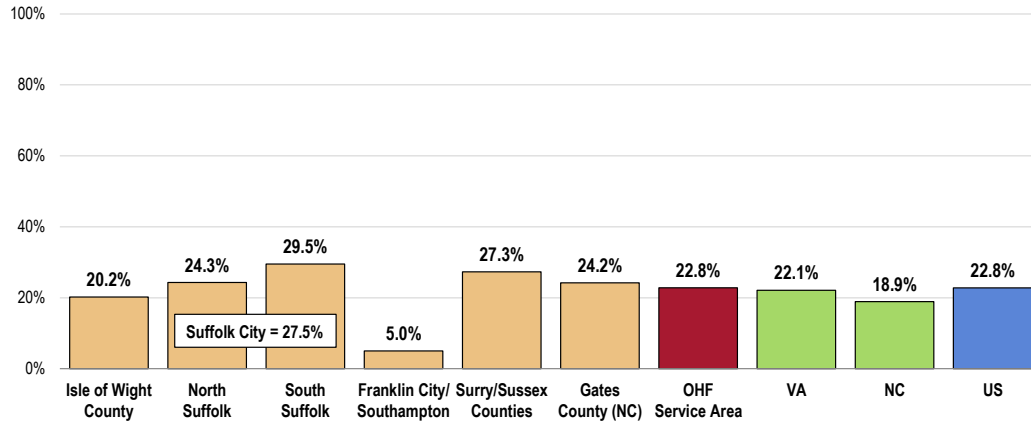
“Meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activities:

**Aerobic** activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

**Strengthening** activity is at least 2 sessions per week of exercise designed to strengthen muscles.



### Meets Physical Activity Recommendations Healthy People 2020 Target = 20.1% or Higher



Sources:

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-2.4]

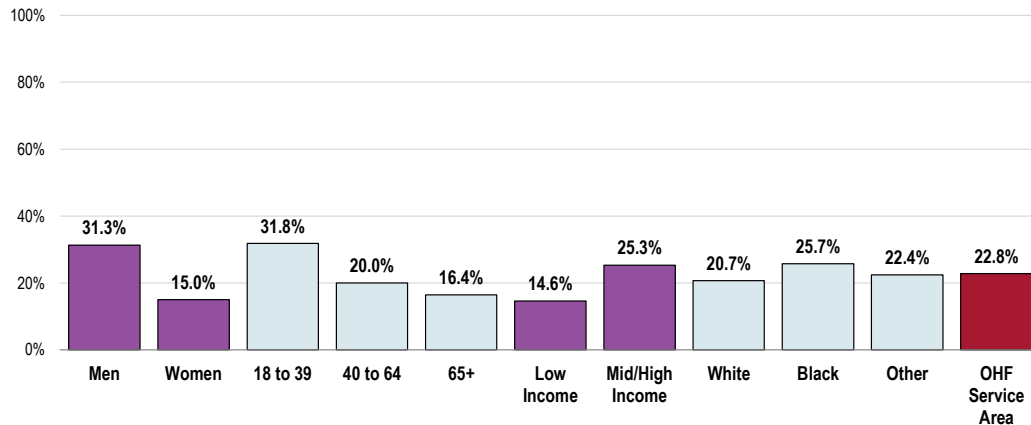
Notes:

- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Those less likely to meet physical activity requirements include:

- Women.
- Older adults (negative correlation with age).
- Residents in low-income households.

### Meets Physical Activity Recommendations (OHF Service Area, 2017) Healthy People 2020 Target = 20.1% or Higher



Sources:

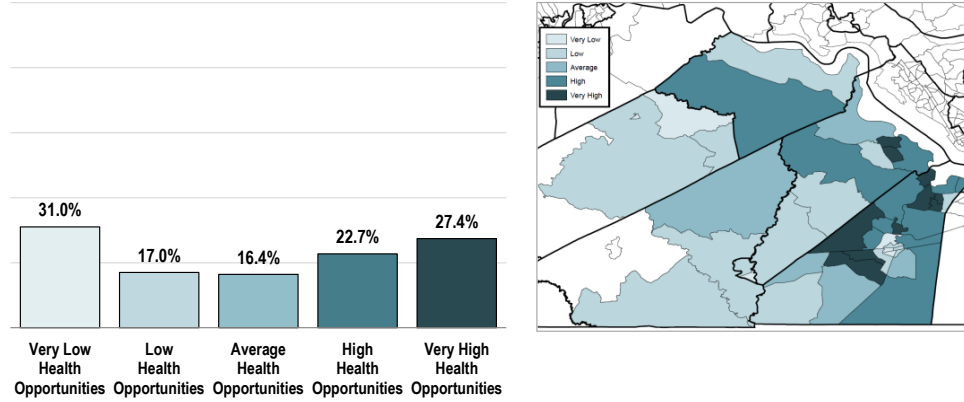
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-2.4]

Notes:

- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Examining findings by HOI classification shows no clear correlation.

### Meets Physical Activity Recommendations (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]  
 Notes: • Asked of all respondents.

## Children

### Recommended Levels of Physical Activity

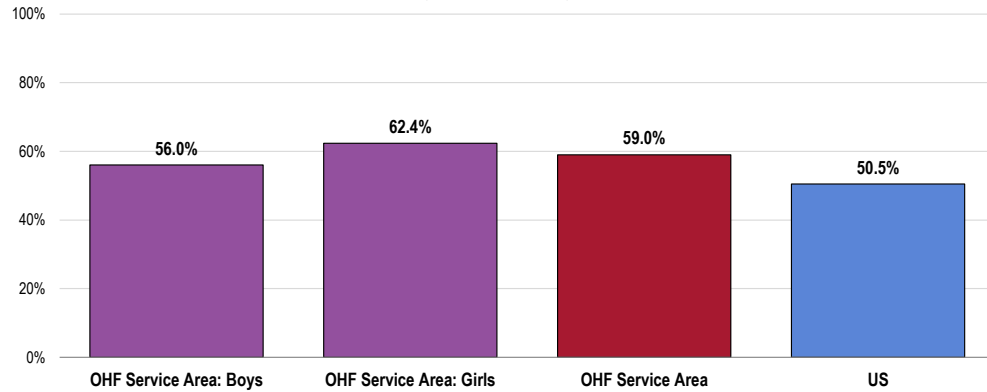
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. [www.cdc.gov/physicalactivity](http://www.cdc.gov/physicalactivity)

**Among OHF Service Area children age 2 to 17, 59.0% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).**

- More favorable than found nationally.
- Findings are comparable by child's gender.

### Child Is Physically Active for One or More Hours per Day (Among Children Age 2-17)



Sources: 

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

  
 Notes: 

- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

### Access to Physical Activity

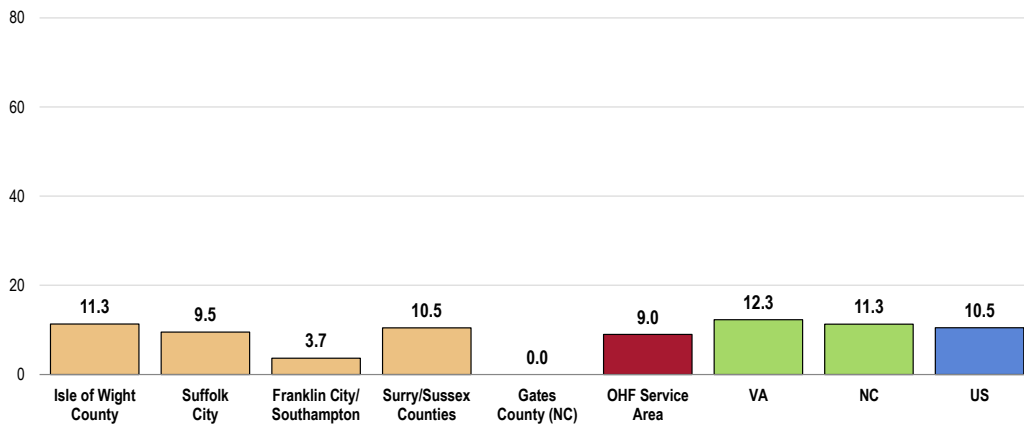
In 2015, there were 9.0 recreation/fitness facilities for every 100,000 population in the OHF Service Area.

- Below the state and national rates.
- Lowest in Franklin City/Southampton County and Gates County.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

### Population With Recreation & Fitness Facility Access (Number of Recreation & Fitness Facilities per 100,000 Population, 2015)



Sources: 

- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Retrieved October 2017 from Community Commons at <http://www.chna.org>.

  
 Notes: 

- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities"*. Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

## Weight Status

### About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared ( $m^2$ ). To estimate BMI using pounds and inches, use:  $[\text{weight (pounds)}/\text{height squared (inches}^2)] \times 703$ .

In this report, overweight is defined as a BMI of 25.0 to 29.9  $kg/m^2$  and obesity as a BMI  $\geq 30$   $kg/m^2$ . The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25  $kg/m^2$ . The increase in mortality, however, tends to be modest until a BMI of 30  $kg/m^2$  is reached. For persons with a BMI  $\geq 30$   $kg/m^2$ , mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25  $kg/m^2$ .

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

### Adult Weight Status

Classification of Overweight and Obesity by BMI	BMI ( $kg/m^2$ )
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	$\geq 30.0$

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

### Overweight Status

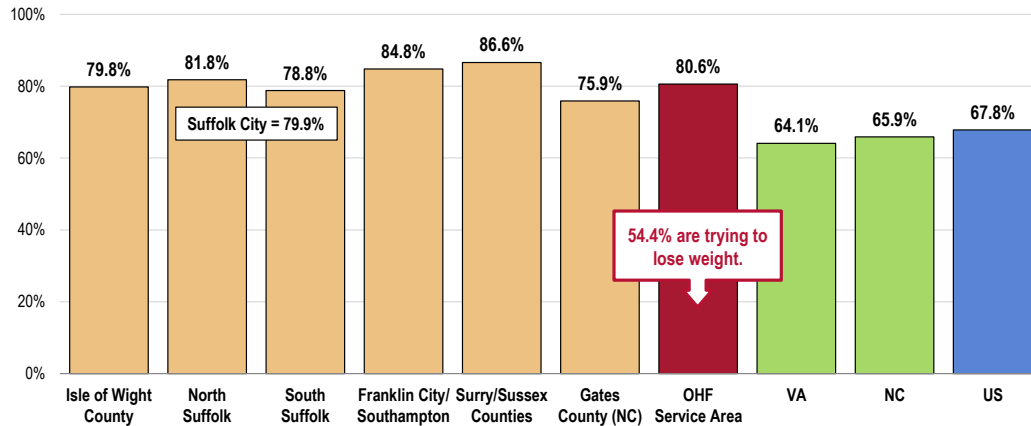
**A full 8 in 10 OHF Service Area adults (80.6%) are overweight.**

Here, "overweight" includes those respondents with a BMI value  $\geq 25$ .

- Far above the prevalence of overweight residents reported statewide and nationally.
- Findings are statistically comparable by area.

Note that 54.4% of overweight adults are currently trying to lose weight.

### Prevalence of Total Overweight (Overweight or Obese) (Percent of Adults With a Body Mass Index of 25.0 or Higher)



Sources:

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 158-159]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.

Notes:

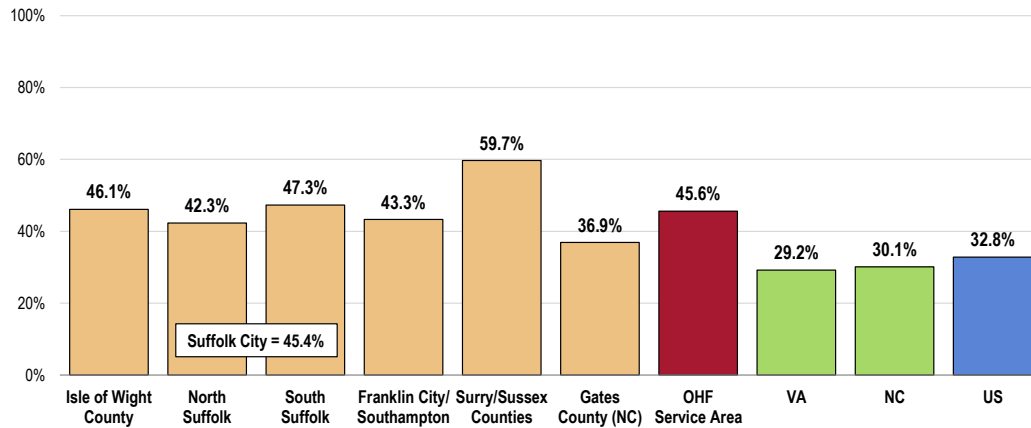
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

**Further, 45.6% of OHF Service Area adults are obese.**

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value  $\geq 30$ .

- Well above Virginia, North Carolina, and US findings.
- Far from satisfying the Healthy People 2020 target (30.5% or lower).
- Least favorable in Surry/Sussex counties.

### Prevalence of Obesity (Percent of Adults With a Body Mass Index of 30.0 or Higher) Healthy People 2020 Target = 30.5% or Lower



Sources:

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.

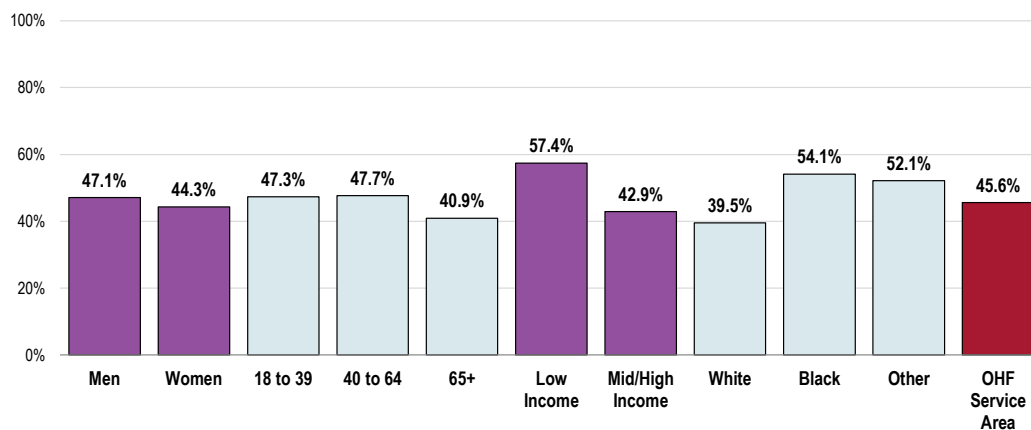
Notes:

- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Obesity is notably more prevalent among:

- Respondents under age 65.
- Low-income residents.
- Blacks and adults of Other race/ethnicity.

### Prevalence of Obesity (Percent of Adults With a BMI of 30.0 or Higher; OHF Service Area, 2017) Healthy People 2020 Target = 30.5% or Lower



Sources:

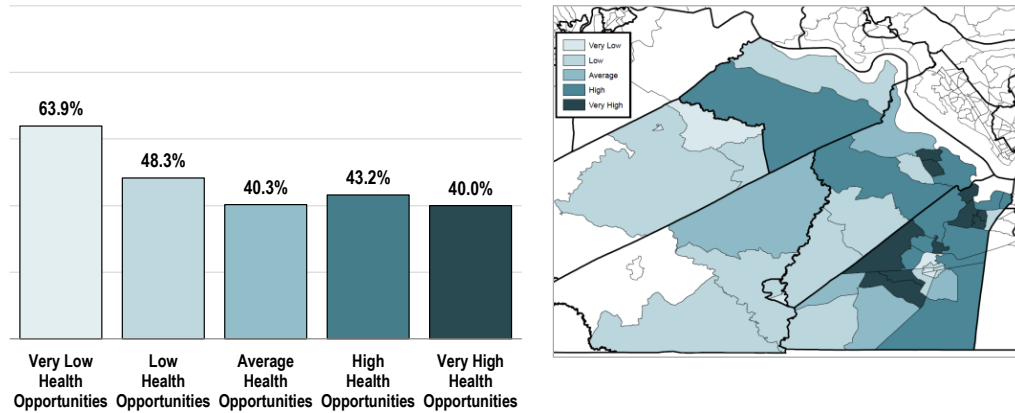
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]

Notes:

- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Viewed by HOI classification, the prevalence of obesity is highest among adults with the lowest health opportunities.

### Prevalence of Obesity (OHF Service Area by Health Opportunity Index Classification)



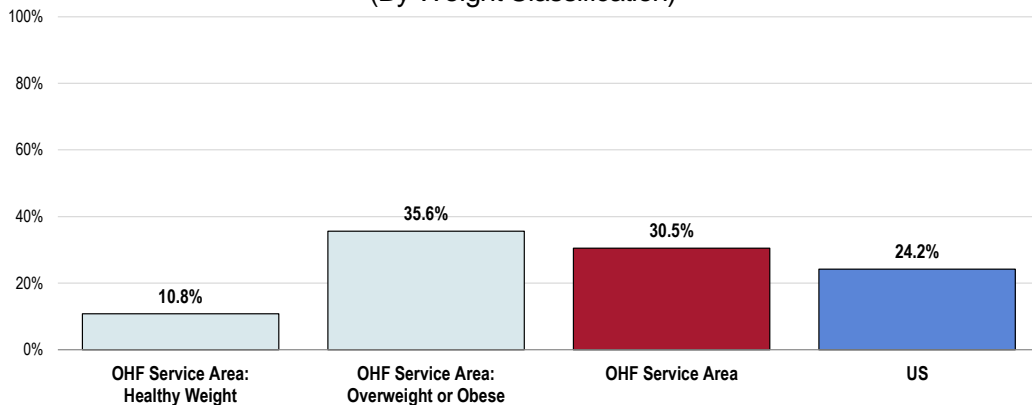
Sources: ● PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]  
 Notes: ● Based on reported heights and weights, asked of all respondents.  
 ● The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

### Health Advice

A total of 30.5% of adults have been given advice about their weight by a doctor, nurse, or other health professional in the past year.

- Statistically higher than national findings.
- Note that 35.6% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while over 6 in 10 have not).

### Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: ● 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 98, 160-161]  
 ● 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents.

The correlation between overweight and various health issues cannot be disputed.

### Relationship of Overweight With Other Health Issues

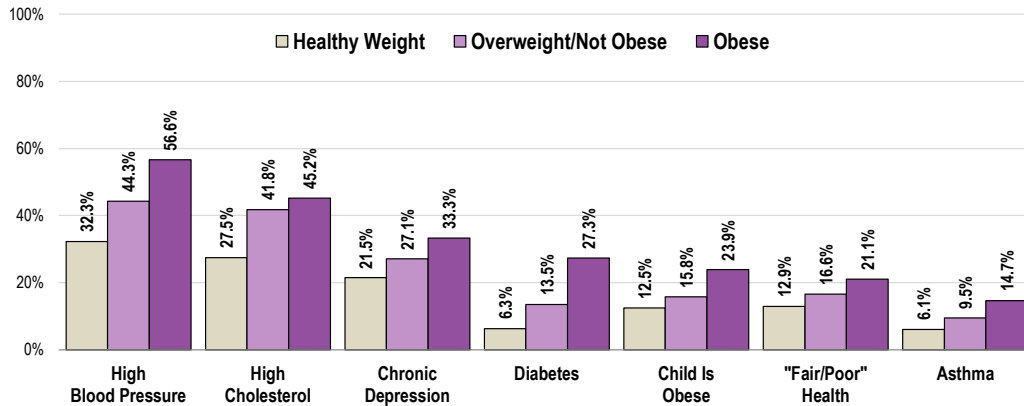
Overweight and obese adults are more likely to report a number of adverse health conditions.

Among these are:

- High blood pressure.
- High cholesterol.
- Chronic depression.
- Diabetes.
- “Fair” or “poor” overall health.
- Asthma.

Overweight/obese residents are also more likely to have obese children.

### Relationship of Overweight With Other Health Issues (By Weight Classification; OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 100, 129, 130, 138, 140, 162]  
 Notes: • Based on reported heights and weights, asked of all respondents.

### Children’s Weight Status

#### About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child’s BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5<sup>th</sup> percentile
- Healthy Weight ≥5<sup>th</sup> and <85<sup>th</sup> percentile
- Overweight ≥85<sup>th</sup> and <95<sup>th</sup> percentile
- Obese ≥95<sup>th</sup> percentile

• Centers for Disease Control and Prevention

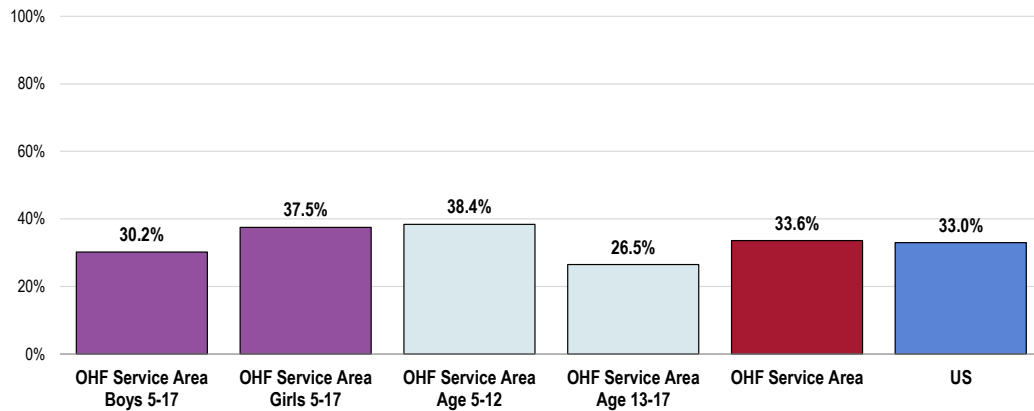


**Based on the heights/weights reported by surveyed parents, 33.6% of OHF Service Area children age 5 to 17 are overweight or obese (≥85th percentile).**

- Similar to that found nationally.
- Similar by child’s gender; higher among younger children (age 5 to 12) when compared with OHF Service Area teens.

### Child Total Overweight Prevalence

(Children Age 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)

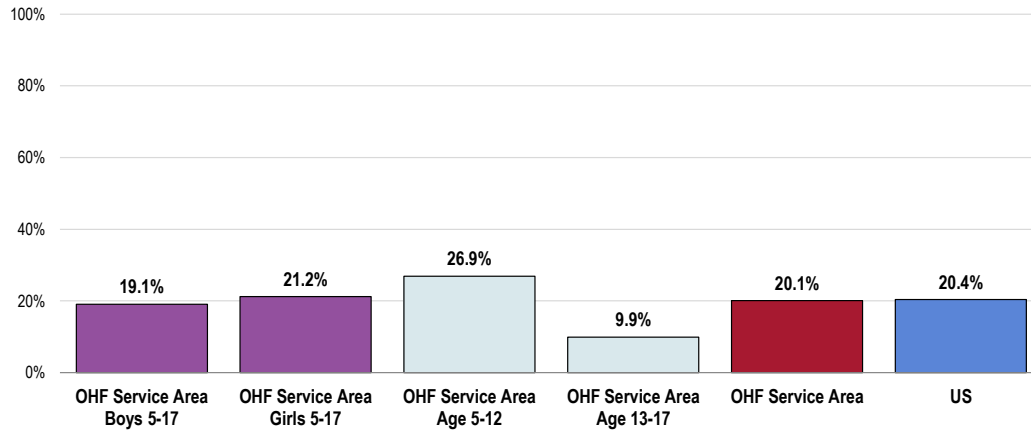


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 162]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children age 5-17 at home.  
 • Overweight among children is determined by children’s Body Mass Index status at or above the 85<sup>th</sup> percentile of US growth charts by gender and age.

**Further, 20.1% of area children age 5 to 17 are obese (≥95th percentile).**

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (14.5% or lower for children age 2-19).
- Statistically similar by child’s gender; much higher among younger children than among area teens.

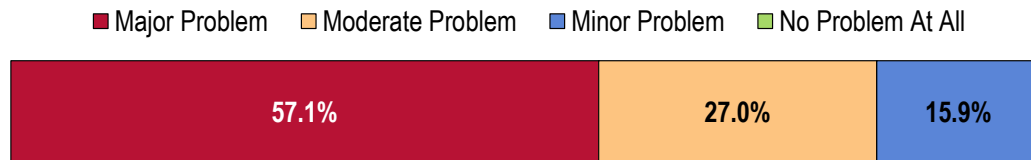
### Child Obesity Prevalence (Children Age 5-17 Who Are Obese; BMI in the 95<sup>th</sup> Percentile or Higher) Healthy People 2020 Target = 14.5% or Lower



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 162]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]  
 Notes: • Asked of all respondents with children age 5-17 at home.  
 • Obesity among children is determined by children’s Body Mass Index status equal to or above the 95<sup>th</sup> percentile of US growth charts by gender and age.

**Key Informant Input: Nutrition, Physical Activity & Weight**  
 Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a “major problem” in the community.

### Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### Health Education/Awareness

*General lack of education, poverty levels, and lack of insurance, all leading to poor understanding of sustaining a healthy lifestyle. Lack of motivation and behavior changes are needed, as the community doesn’t understand consequences of some lifestyles. – Public Health Representative*

*Lack of knowledge concerning nutrition and how to make healthy choices. Obesity is also a big problem in various age groups. – Community Leader*

*Nutrition: to encourage citizens to choose the healthy food choices for their family. Physical activity: lack of motivation for families to exercise five days a week. Weight: to continue to encourage citizens to choose healthy weight-loss strategies that they can manage for the long-term. – Other Health Provider*

*More areas are needed for nutrition and weight control, due to diabetes and other medical issues contributing to obesity. – Community Leader*

*Poor education about nutrition. Lack of resources to purchased quality food choices. Electronics. – Community Leader*

*Nutrition education. – Educator*

*Lack of education and resources. – Community Leader*

### **Insufficient Physical Activity**

*Our community does not encourage or provide gym facilities for adults to use. The track at the high school is available, but it's out of the way for most. – Educator*

*The community lacks a facility or it is limited for exercising such as the YMCA or other gyms. – Social Services Provider*

*Too much technology that keep us inactive; too much to do, stealing time for exercise; not enough facilities that are convenient to use; too much cost and cannot afford exercise classes or good foods; tons of bad food available on every corner; weight loss programs don't work, too expensive, or too hard. – Community Leader*

*Lack of physical activity and diet. – Educator*

*Children are not as active, physically, as they should be. – Educator*

### **Food Deserts and Fast Food**

*Several food deserts throughout Western Tidewater, both in more urban (Suffolk/Franklin) and rural areas (Isle of Wight and Southampton). Farmer's market in Suffolk does not accept EBT (WIC or SNAP). Rural nature does not lend itself to walkability and bike use (active forms of transportation). – Public Health Representative*

*People in the community eating a lot of fast food, lack of exercise, and a large population of childhood obesity along with adult obesity. – Other Health Provider*

*Fast food, not enough healthy choices in Suffolk, education, walking trails, safety. – Community Leader*

*Fast food, processed food, and people too lazy to cook wholesome meals. – Public Health Representative*

### **Lifestyle**

*This area is made up of a lot of hard-working people who eat poorly and keep working; individuals who eat but don't work or exercise; and those that eat to live but don't eat well because they can't afford to eat wholesome foods (or at least think they can't). It is easier in a city environment to get out and walk on the sidewalks or walk to the store than in a more rural setting, where this not a particular way of life. Education, support, and community activities may be motivators, since no one likes to exercise alone. – Other Health Provider*

*Diet, lifestyle, and access to healthy, fresh foods. Barriers to active lifestyles, built environment, family and cultural surroundings. Affordability of healthy foods, food and desserts. – Community Leader*

*Health eating, behavior change, exercise, access to fresh produce at an affordable price. – Other Health Provider*

*Poor eating habits due to lack of knowledge about nutrition and due to easy access to foods with huge calorie and fat counts. – Educator*

### **Vulnerable Populations**

*Progress is being made, more needs to take place at the school-aged children locations. – Other Health Provider*

*Underserved individuals. There needs to be more centralized resources for patients with respect to nutrition and activity. – Physician*

*Societal norms, health disparities and inequities. Lack of access to, payment based, exercise facilities. Lack of access to fresh fruits and vegetables and working knowledge of healthy preparation. – Other Health Provider*

### **Contributing Factors**

*Children don't have the proper foods in their homes. They also lack parental care to make sure that the healthy food is there for them; this would help with the weight issue. There is no encouragement for them to be physically active—walking, riding bikes, playing sports, etc. Lack of parents putting their child's need as a priority. – Educator*

*Obesity is a fast-growing problem, especially for the youth in our community. There is not enough focus on fitness and healthy eating. More and more kids are focused on a computer monitor or other such device and not spending enough time engaged in physical activities. – Public Health Representative*

*Gates County is a rural community. We do not have a chain of grocery store available to the citizens. The farmer's market may only be open on a Saturday morning and certain time of the year. Citizens have to travel outside of the county, and transportation may be a barrier. Our citizens shop at the Family Dollar and Dollar General stores for groceries. Most of the food is processed, canned, and frozen—not fresh. – Other Health Provider*

## Substance Abuse

### About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

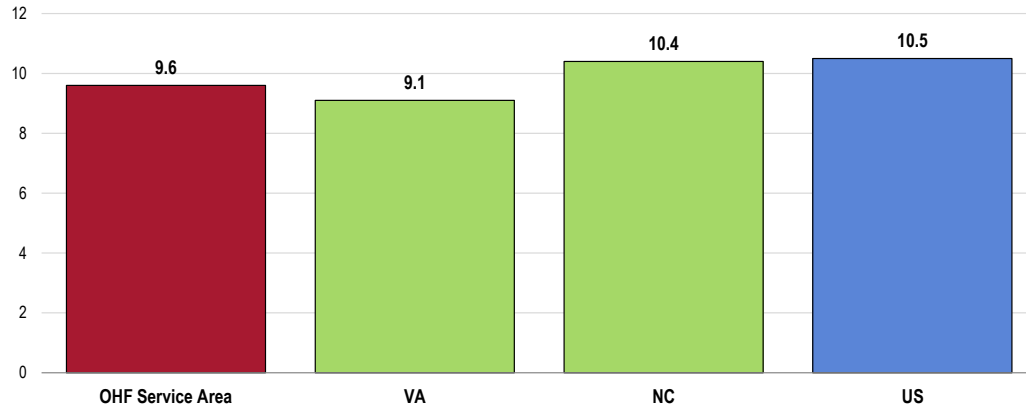
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Age-Adjusted Cirrhosis/Liver Disease Deaths

**Between 2013 and 2015, the OHF Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 9.6 deaths per 100,000 population.**

- Similar to the statewide and national rates.
- Similar to the Healthy People 2020 target (8.2 or lower).

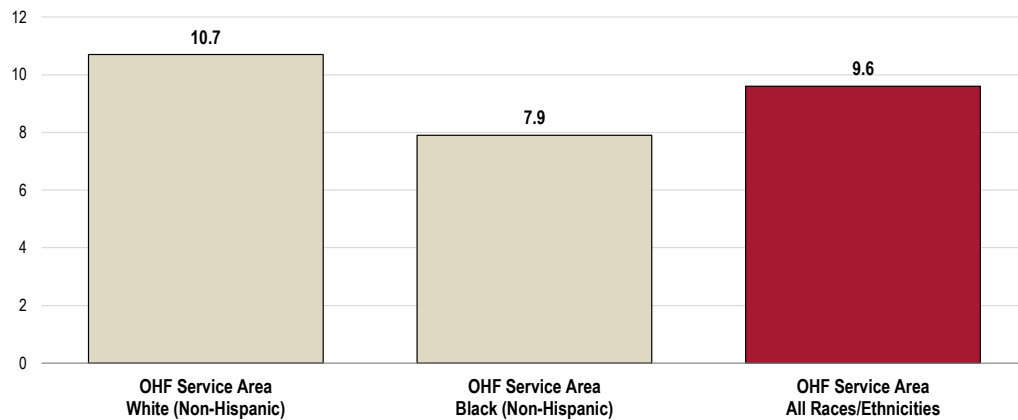
### Cirrhosis/Liver Disease: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The cirrhosis mortality rate appears to be higher among Whites when compared with Blacks in the OHF Service Area.

### Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Alcohol Use

### Excessive Drinking

"Excessive drinking" includes heavy and/or binge drinkers:

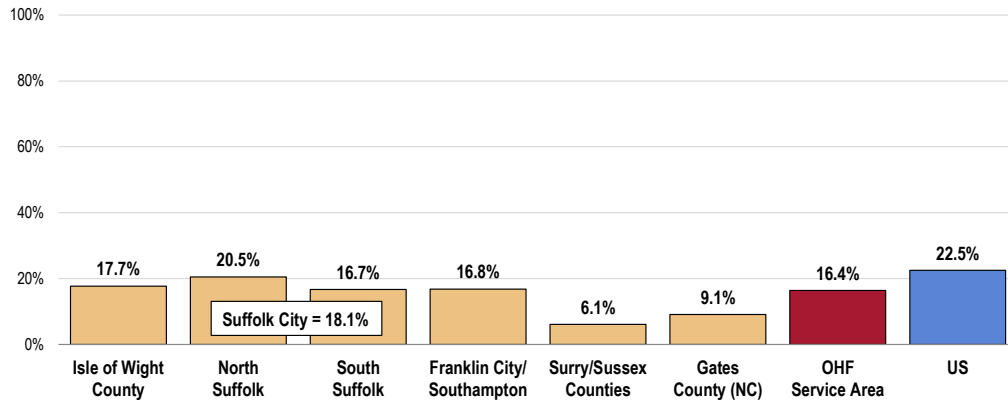
- **Heavy drinkers** include men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **Binge drinkers** include men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

**A total of 16.4% of area adults are excessive drinkers (heavy and/or binge drinkers).**

- More favorable than the national proportion.
- Easily satisfies the Healthy People 2020 target (25.4% or lower).
- The prevalence is highest in North Suffolk.

### Excessive Drinkers

Healthy People 2020 Target = 25.4% or Lower



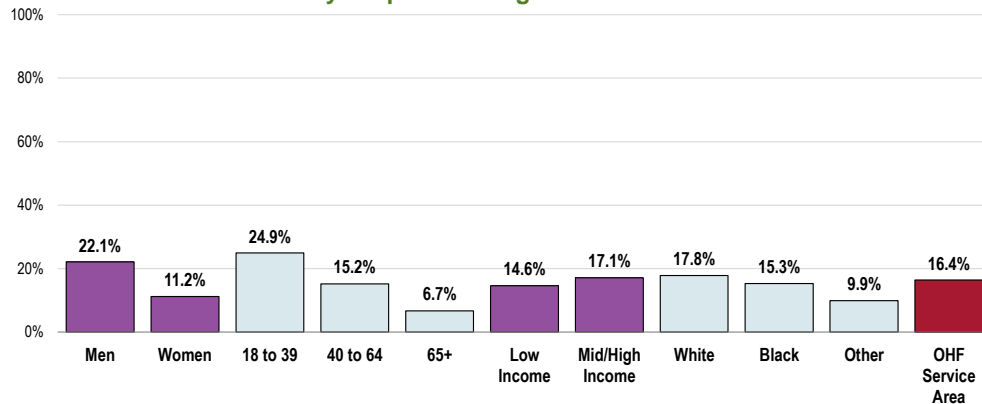
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 172]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]
- Notes:
- Asked of all respondents.
  - Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

- Excessive drinking is more prevalent among men, adults under 65, and Whites.

### Excessive Drinkers

(OHF Service Area, 2017)

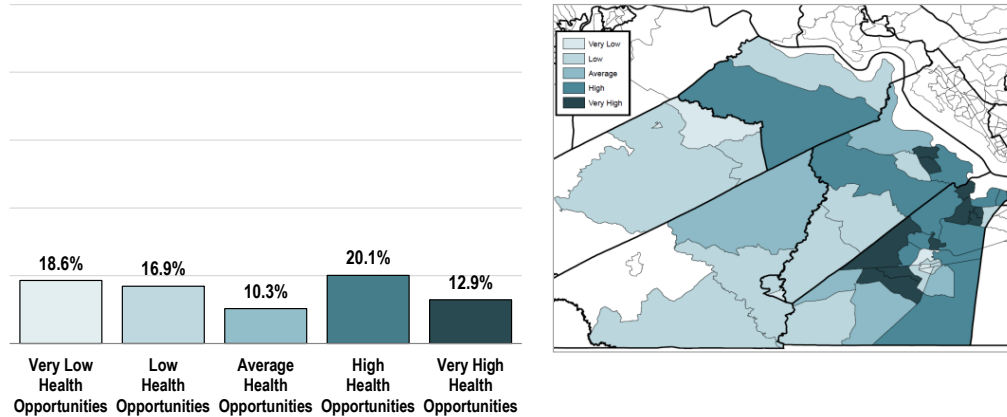
Healthy People 2020 Target = 25.4% or Lower



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 172]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Examining findings by HOI classification shows no clear correlation.

### Excessive Drinkers (OHF Service Area by Health Opportunity Index Classification) Healthy People 2020 Target = 25.4% or Lower



Sources: ● PRC Community Health Survey, Professional Research Consultants, Inc. [Item 172]  
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]  
 Notes: ● Asked of all respondents.  
 ● Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

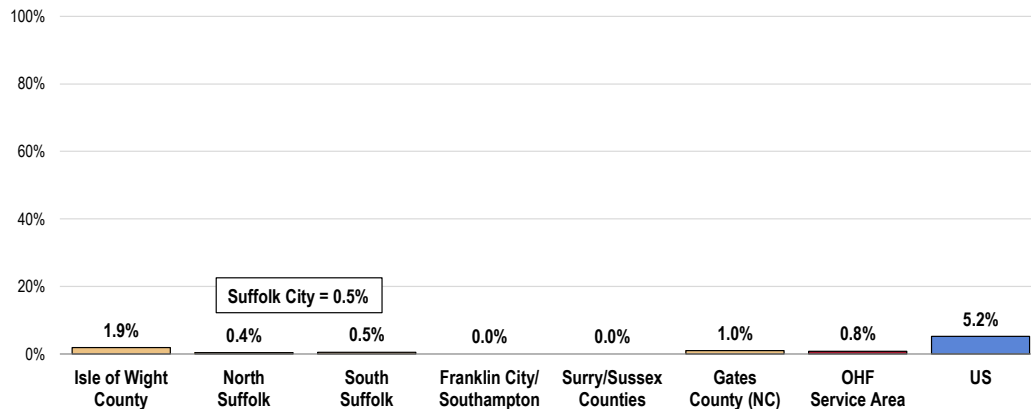
### Drinking & Driving

Just 0.8% of OHF Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

- Well below the national benchmark.
- Highest among Isle of Wight County residents.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

### Have Driven in the Past Month After Perhaps Having Too Much to Drink



Sources: ● 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]  
 ● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 VA and NC data.  
 ● 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: ● Asked of all respondents.

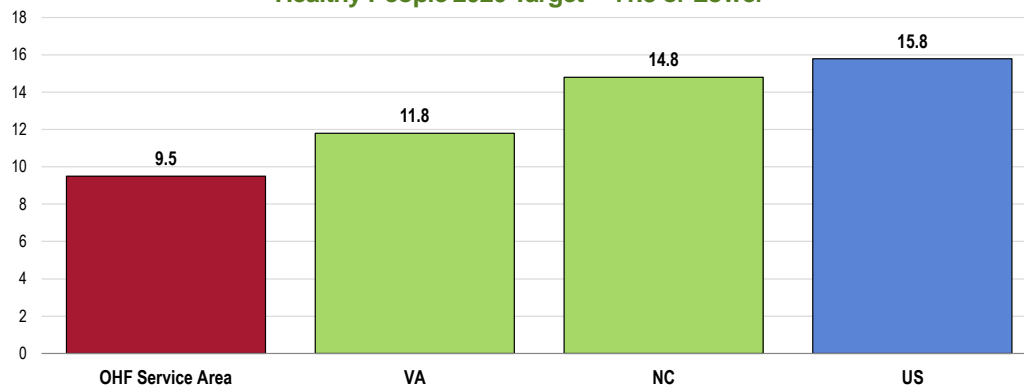


## Age-Adjusted Drug-Induced Deaths

Between 2013 and 2015, there was an annual average age-adjusted drug-induced mortality rate of 9.5 deaths per 100,000 population in the OHF Service Area.

- Well below the state and US mortality rates.
- Satisfies the Healthy People 2020 target (11.3 or lower).

### Drug-Induced Deaths: Age-Adjusted Mortality (2013–2015 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 11.3 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2017.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Illicit Drug Use

A total of 1.2% of OHF Service Area adults acknowledge using an illicit drug in the past month.

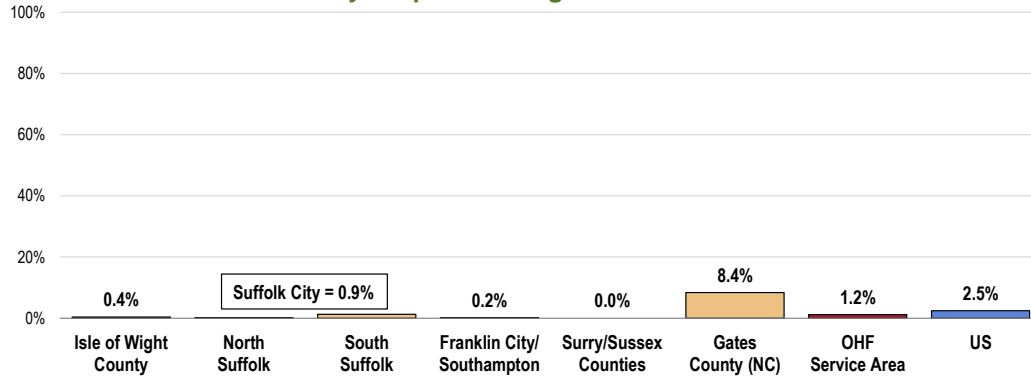
- More favorable than the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.
- Markedly higher among respondents in Gates County.

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

### Illicit Drug Use in the Past Month

Healthy People 2020 Target = 7.1% or Lower



Sources:
 

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]

 Notes:
 

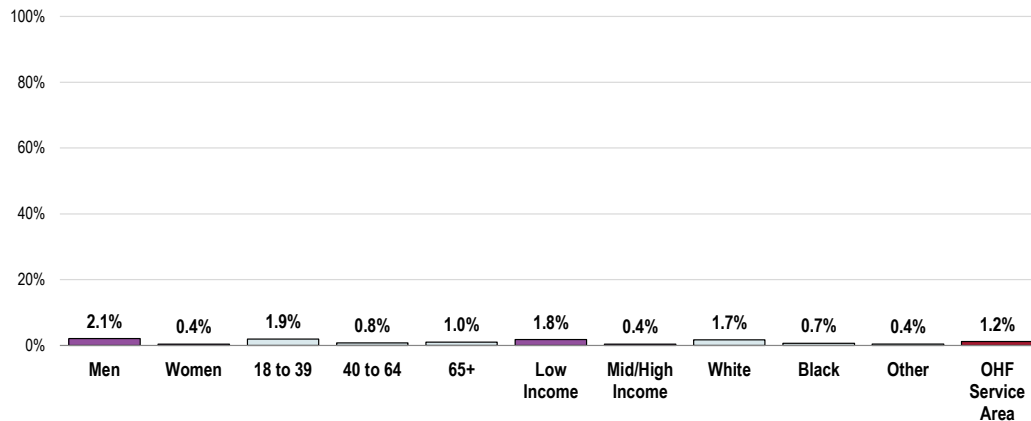
- Asked of all respondents.

- Illicit drug use is more prevalent among men and Whites in the OHF Service Area.

### Illicit Drug Use in the Past Month

(OHF Service Area, 2017)

Healthy People 2020 Target = 7.1% or Lower



Sources:
 

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]

 Notes:
 

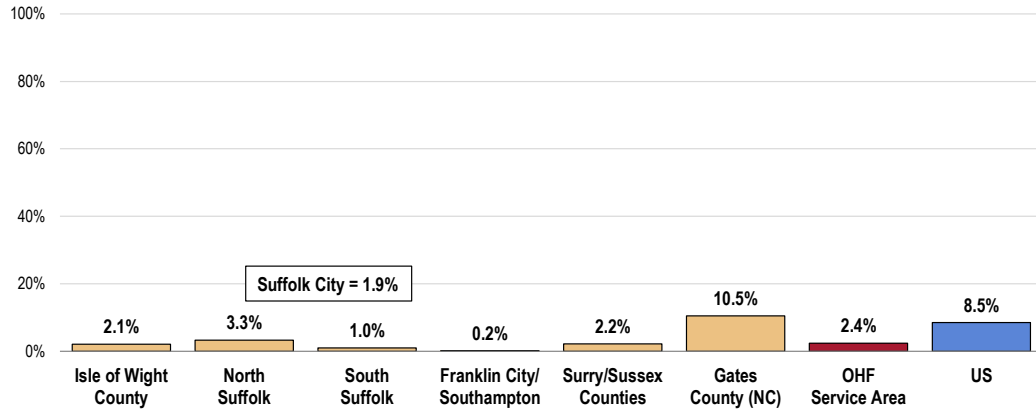
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Use of Marijuana

Despite the 1.2% prevalence of acknowledged illicit drug use in the area, a higher prevalence (2.4%) of survey respondents acknowledge using marijuana/hashish in the past 30 days.

- Well below the national figure.
- The prevalence of recent marijuana use is markedly higher in Gates County.

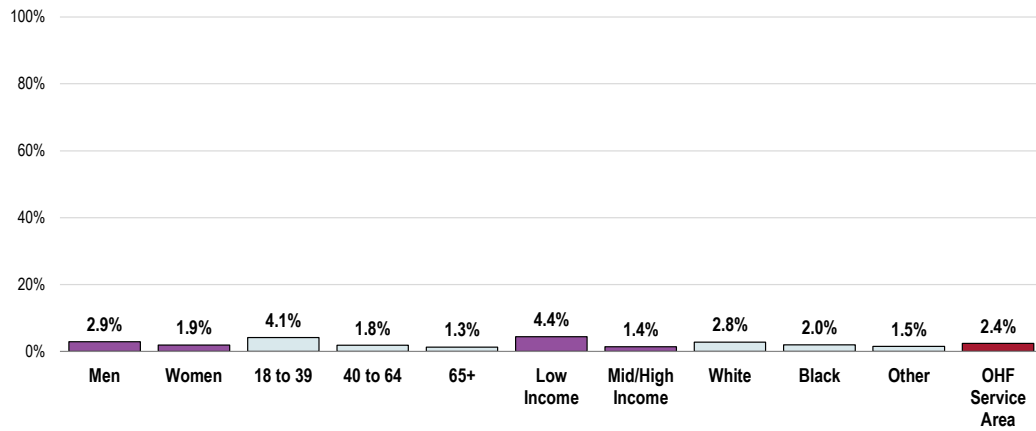
### Marijuana Use in the Past Month



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 306]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- OHF Service Area residents in low-income households are statistically more likely to report recent marijuana use.

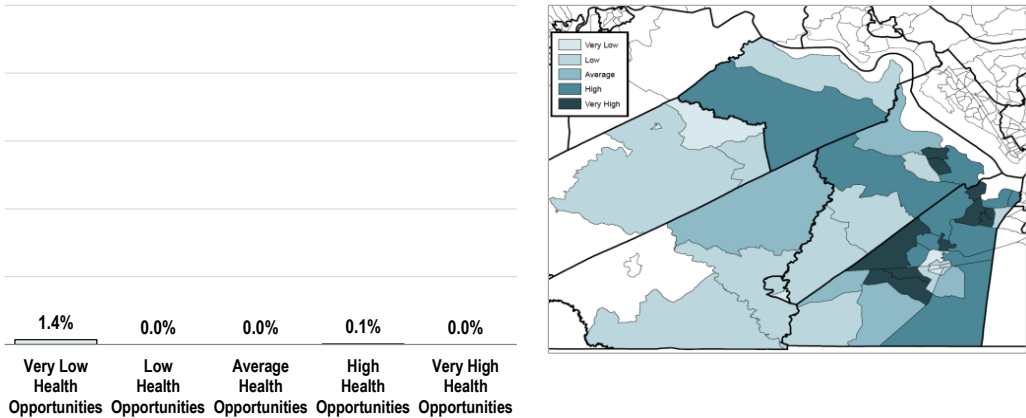
### Marijuana Use in the Past Month (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 306]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Viewed by HOI categorization, the prevalence of marijuana use is almost exclusively among OHF Service Area adults with the lowest health opportunities.

### Current Use of Marijuana (OHF Service Area by Health Opportunity Index Classification)



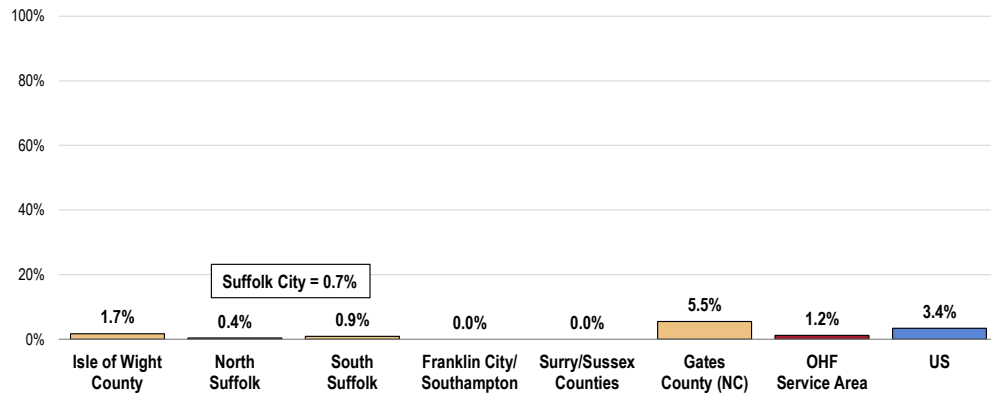
Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 306]  
 Notes: • Asked of all respondents.

## Alcohol & Drug Treatment

A total of 1.2% of OHF Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Below the national figure.
- Particularly high in Gates County.

### Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 60]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.

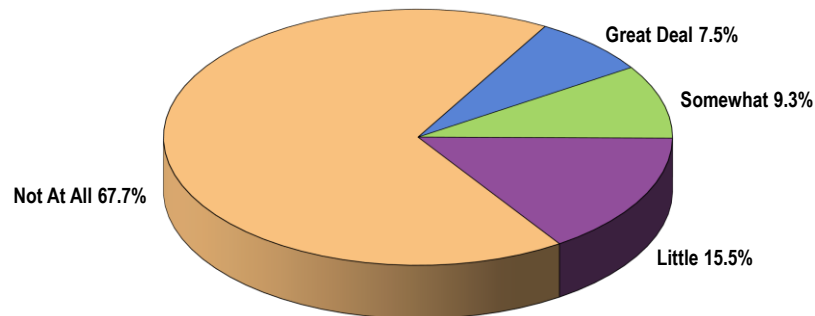
Notes: • Asked of all respondents.

## Negative Effects of Substance Abuse

Area adults were also asked to what degree their lives have been negatively affected by substance abuse (whether their own abuse or that of another).

In all, two in three have not been negatively affected (67.7% “not at all” responses).

### Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other’s) (OHF Service Area, 2017)

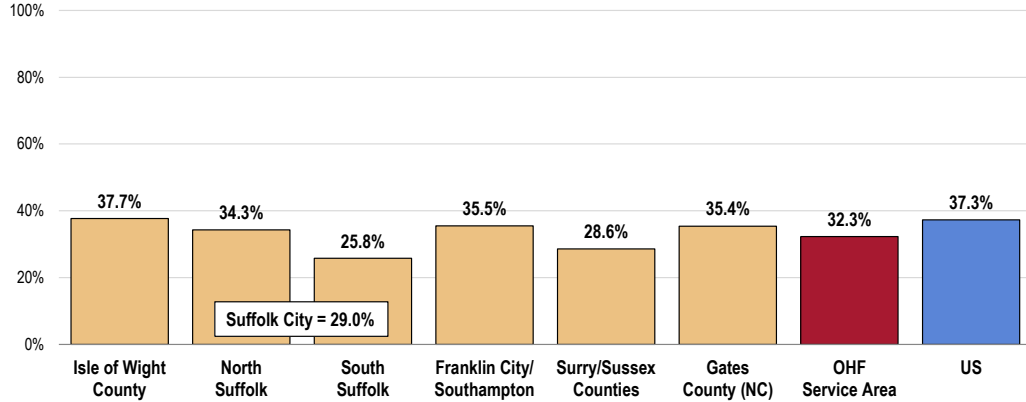


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]  
 Notes: • Asked of all respondents.

In contrast, 32.3% of respondents indicate that their lives have been negatively affected by substance abuse.

- Better than the US figure.
- Highest among respondents in Isle of Wight County.

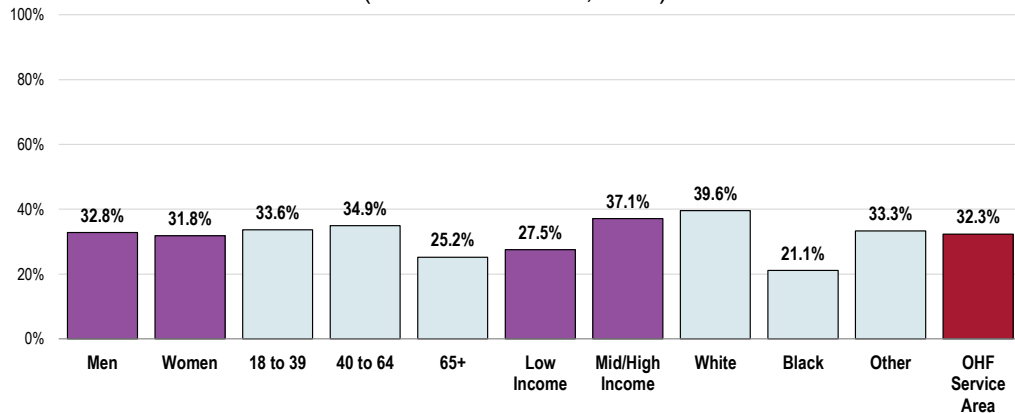
### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - Includes response of "a great deal," "somewhat," and "a little."

- The prevalence of survey respondents whose lives have been negatively impacted by substance abuse, whether their own abuse or that of another, is higher among adults under 65, upper-income residents, Whites, and Other race/ethnicities.

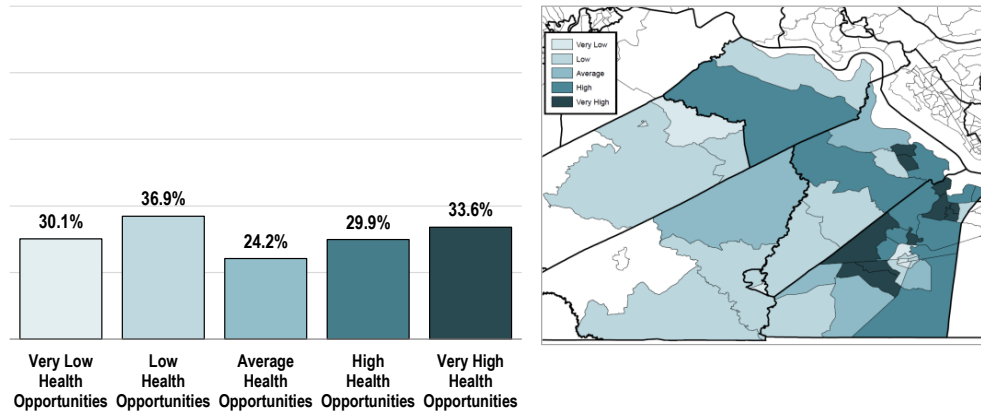
### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else) (OHF Service Area, 2017)



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
- Notes:
- Asked of all respondents.
  - Includes response of "a great deal," "somewhat," and "a little."
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Viewed by Virginia HOI, the prevalence is highest among OHF Service Area adults with low health opportunities.

### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else) (OHF Service Area by Health Opportunity Index Classification)

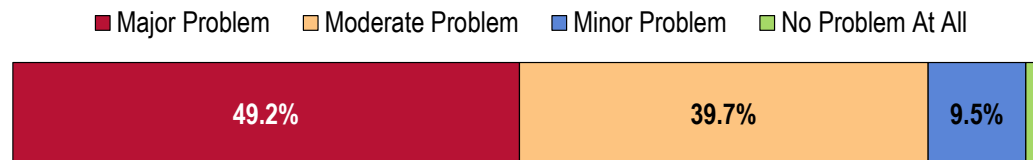


Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]  
Notes: • Asked of all respondents.

### Key Informant Input: Substance Abuse

Nearly half of key informants taking part in an online survey characterized *Substance Abuse* as a “major problem” in the community.

### Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” the greatest barriers to accessing substance abuse treatment are viewed as:

#### Access to Care/Services

- | Access, education. – Community Leader
- | There are no facilities in our area. – Community Leader

No resources other than Western Tidewater Community Services Board (WT CSB). The CSB is too slow, and few options for serious treatment are available. – Community Leader

Available space in treatment programs in other areas because there are none in the area. – Other Health Provider

No mental health services within the county. Residents must travel outside the county for treatment. – Social Services Provider

Treatment facilities are sometimes at their capacity when a patient is in need. Or the patient cannot afford the treatment themselves and doesn't have insurance. Or the insurance will not cover certain aspects of substance abuse. – Other Health Provider

There are very few treatment options, and many people fear that they will be prosecuted for drug offenses. – Public Health Representative

Access to treatment facilities is terrible: too many rules to get in to programs, treating the issue after someone is an addict instead of prevention; doctors prescribe too many drugs; parents ignore what their children are doing; programs that do exist are too short; healthcare dollars are extremely limited to treat this issue. – Community Leader

There are no treatment options available locally. – Other Health Provider

Rural community. – Educator

### **Denial/Stigma**

You can present someone with an opportunity, but you cannot force them to take advantage of it. There are resources available; however, it is limited in the Western Tidewater area. Resources available in surrounding communities. – Other Health Provider

User doesn't think there's a problem so doesn't seek help. – Educator

The perceived stigma associated with substance abuse is deterring individuals and families from seeking treatment in our community until it is too late. – Other Health Provider

### **Affordability of Care/Services**

Not many programs for uninsured and no ID, especially in the Western Tidewater area. No residential programs for the uninsured. – Other Health Provider

Poverty, depression. – Community Leader

### **Health Education/Awareness**

Be more aggressive in substance abuse education in facilities to help those who are struggling with substance abuse. Be more and more proactive in the education of opiate abuse. – Community Leader

Education. – Community Leader

### **Prevalence/Incidence**

So many things are being tried, but it is still growing. – Community Leader

Alcohol and legal/illegal substance abuse is on the rise. Affordable access to qualified professionals and facilities is limited. Most of the services are not locally available to those in western and far western Tidewater. – Other Health Provider

### **Prescription Medication Use**

Substance abuse is a major concern with prescription medication use: not taken properly, and left in the wrong hands. Treatment centers and agencies are available but outside of the county. Citizens can travel within 30 minutes to reach a facility. – Other Health Provider

### **Diagnosis/Treatment**

Too many people are not being treated for their accurate diagnosis and, instead, are only being stabilized and sent back out. Need stronger interventions in Suffolk to help. – Other Health Provider

### **Transportation**

Transportation for the addict/alcoholic to get to treatment or meetings once convicted. No driver's license and often no car. – Educator

### **Lack of Providers**

There are not enough providers in this area to assist with the need. – Public Health Representative



### Most Problematic Substances

Key informants (who rated this as a “major problem”) most often identified heroin/other opioids as the most problematic substances abused in the community, followed by alcohol and prescription medications.

Problematic Substances				
	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Heroin or Other Opioids	60.0%	20.0%	0.0%	<b>8</b>
Alcohol	10.0%	20.0%	40.0%	<b>7</b>
Prescription Medications	10.0%	20.0%	20.0%	<b>5</b>
Cocaine or Crack	10.0%	10.0%	10.0%	<b>3</b>
Methamphetamine or Other Amphetamines	10.0%	10.0%	0.0%	<b>2</b>
Marijuana	0.0%	10.0%	10.0%	<b>2</b>
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	10.0%	0.0%	<b>1</b>
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	0.0%	10.0%	<b>1</b>
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	0.0%	0.0%	10.0%	<b>1</b>

## Tobacco Use

### About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

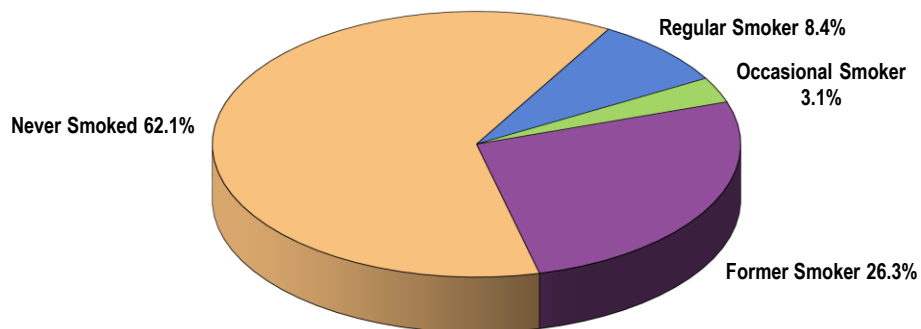
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Cigarette Smoking

### Cigarette Smoking Prevalence

A total of 11.5% of OHF Service Area adults currently smoke cigarettes, either regularly (8.4% every day) or occasionally (3.1% on some days).

### Cigarette Smoking Prevalence (OHF Service Area, 2017)



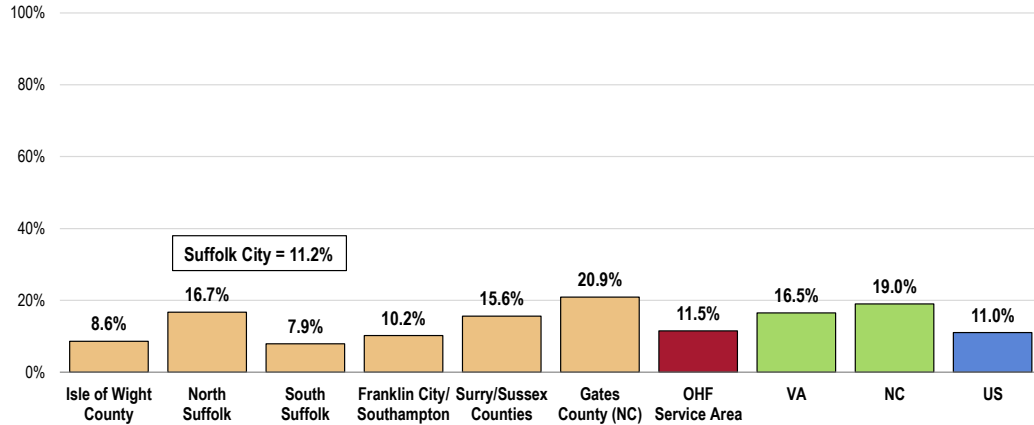
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]  
Notes: • Asked of all respondents.

- More favorable than statewide findings.
- Similar to the US figure.
- Similar to the Healthy People 2020 target (12% or lower).

- The smoking prevalence is highest among adults in North Suffolk and Gates County.

### Current Smokers

Healthy People 2020 Target = 12.0% or Lower



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
  - Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

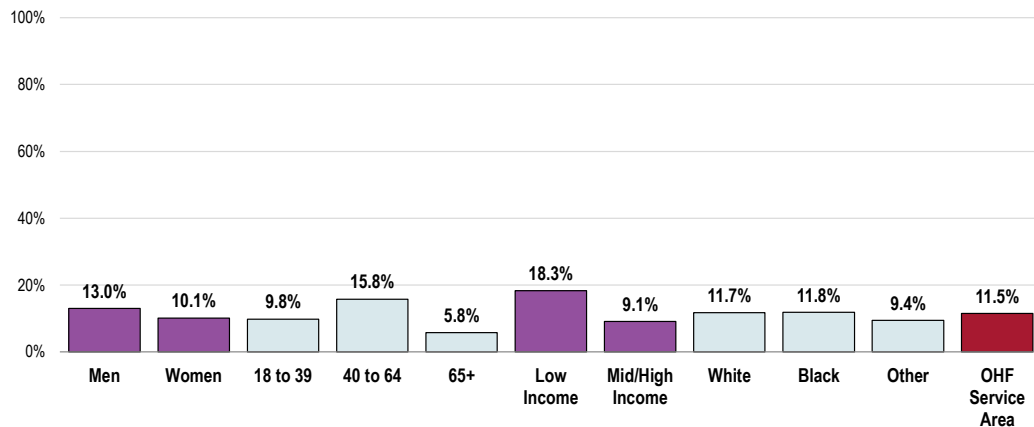
Cigarette smoking is more prevalent among:

- Adults age 40 to 64.
- Lower-income residents.

### Current Smokers

(OHF Service Area, 2017)

Healthy People 2020 Target = 12.0% or Lower



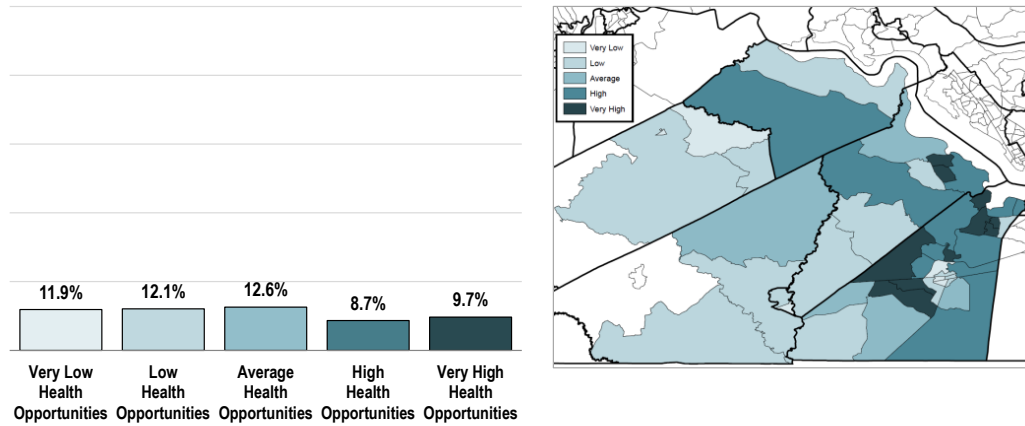
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Includes regular and occasion smokers (every day and some days).

The prevalence of cigarette smoking is higher among Total Sample populations with average or lower health opportunities.

### Current Smokers

(OHF Service Area by Health Opportunity Index Classification)

Healthy People 2020 Target = 12.0% or Lower



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]  
 Notes: • Asked of all respondents.  
 • Includes regular and occasion smokers (every day and some days).

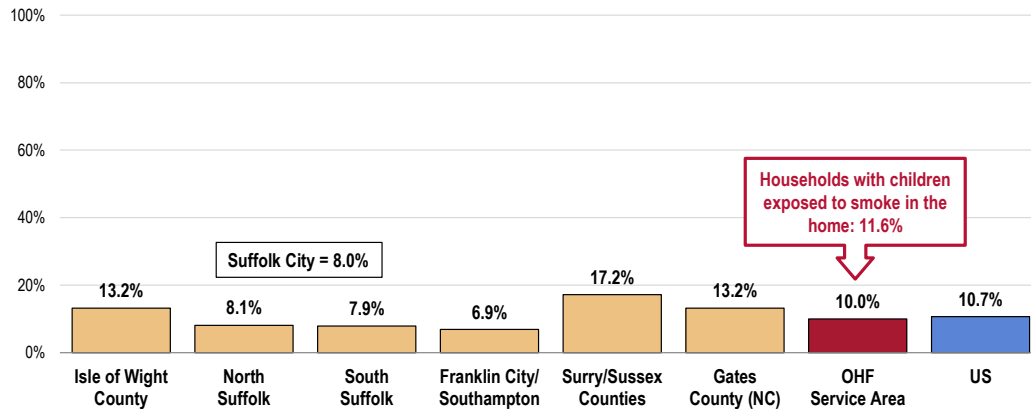
### Environmental Tobacco Smoke

A total of 10.0% of OHF Service Area adults (including smokers and nonsmokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Comparable to national findings.
- Least favorable in Isle of Wight and Surry/Sussex counties.

Note that 11.6% of OHF Service Area children are exposed to cigarette smoke at home, statistically similar to what is found nationally.

### Member of Household Smokes at Home

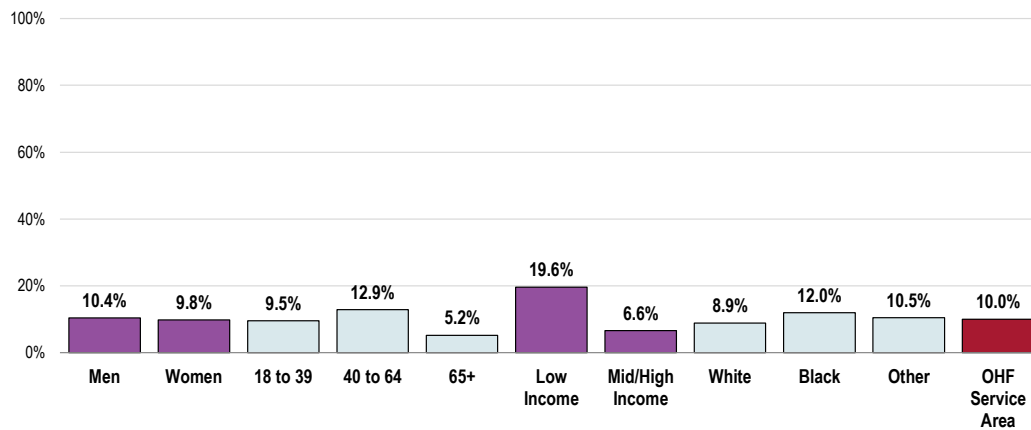


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 52, 166]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.  
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among residents with lower incomes; also higher among adults age 40 to 64.

### Member of Household Smokes At Home (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]

Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

## Smoking Cessation

### About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Smoking Cessation Attempts

**About 6 in 10 regular smokers (59.4%) went without smoking for one day or longer in the past year because they were trying to quit smoking.**

- Well above the national percentage.
- Fails to satisfy the Healthy People 2020 target (80.0% or higher).

Most current smokers (77.7%) have been advised by a healthcare professional in the past year to quit smoking.

### Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking (Among Everyday Smokers)

Healthy People 2020 Target = 80.0% or Higher



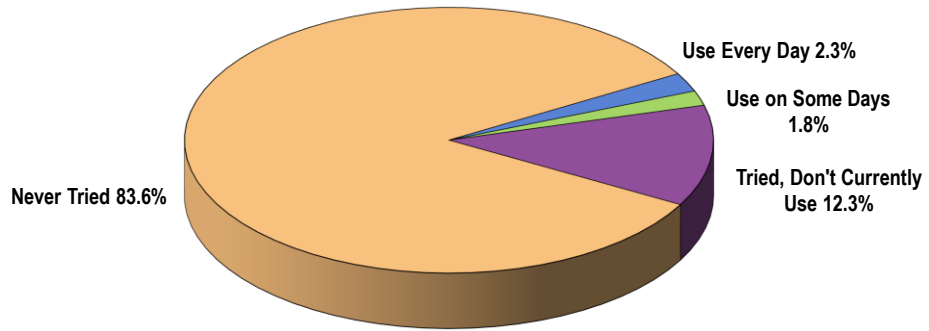
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 50-51]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-4.1]
- Notes:
- Asked of respondents who smoke cigarettes every day.

## Other Tobacco Use

### Electronic Cigarettes and Other Electronic “Vaping” Products

A total of 4.1% of OHF Service Area adults currently use electronic cigarettes (“e-cigarettes”) or other electronic “vaping” products either regularly (2.3% every day) or occasionally (1.8% on some days).

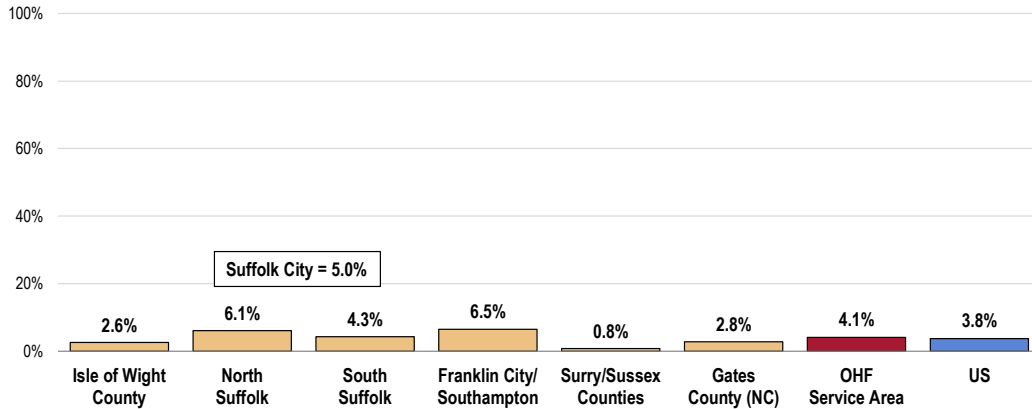
**Use of Vaping Products**  
(OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]  
Notes: • Asked of all respondents.

- Similar to national findings.
- Favorably low in Surry/Sussex counties.

### Currently Use Vaping Products (Every Day or on Some Days)

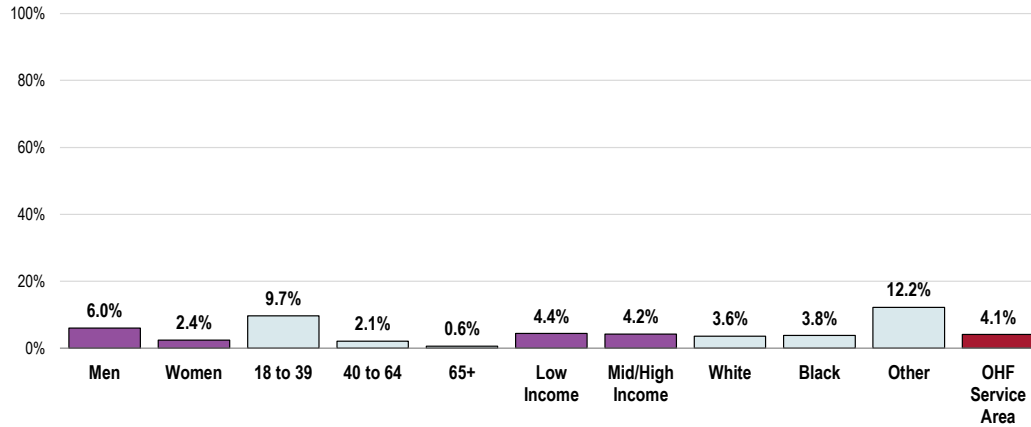


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]  
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.  
• Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Electronic cigarette/other “vaping” product use is more prevalent among:

- Men.
- Adults under age 65 (negative correlation with age).
- Those of Other race/ethnicity.

### Currently Use Vaping Products (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.  
 • Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

### Cigars & Smokeless Tobacco

**A total of 3.5% of OHF Service Area adults use cigars every day or on some days.**

- Well below the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).

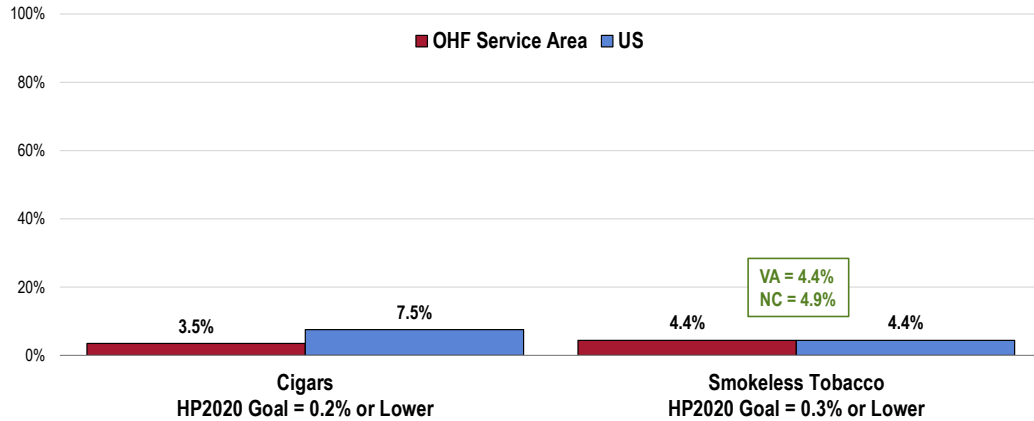
**A total of 4.4% of OHF Service Area adults use some type of smokeless tobacco every day or on some days.**

- Comparable to the state and national percentages.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).

Examples of smokeless tobacco include chewing tobacco, snuff, or snus.



### Other Tobacco Use



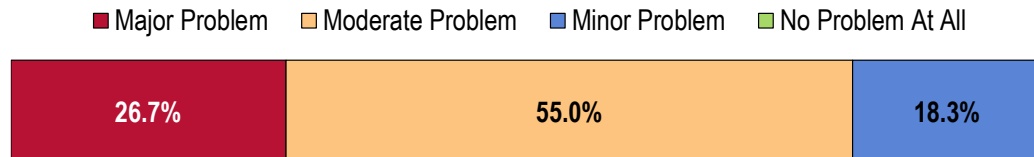
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 304, 305]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 Virginia and North Carolina data.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives TU-1.2, TU-1.3]

Notes: • Reflects the total sample of respondents.  
 • Smokeless tobacco includes chewing tobacco or snuff.

### Key Informant Input: Tobacco Use

Over half of key informants taking part in an online survey characterized *Tobacco Use* as a “moderate problem” in the community.

### Perceptions of Tobacco Use as a Problem in the Community (Key Informants, 2017)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

#### Prevalence/Incidence

- *Internal statistics from our practice, high incidence of tobacco use. Approximately 20%. – Public Health Representative*
- *It appears that a large percentage of students have elected to smoke or use other tobacco products. – Educator*
- *High volume of smokers, specifically low income. – Community Leader*

**Health Education/Awareness**

*More educational in the Windows programs to curb tobacco use in the minor age groups. – Community Leader*

*Education and cost. – Community Leader*

*Free cessation classes are needed. – Other Health Provider*

**Societal Norms/Community Attitude**

*This is tobacco country. – Community Leader*

*Ease of access, societal norms. – Other Health Provider*

*History of use, affordable. – Community Leader*

**Comorbidities**

*Tobacco use causes major health problems such as cancer, high blood pressure, and heart disease, which are chronic illnesses. – Other Health Provider*

*I believe smoking is the leading cause of many of the respiratory problems seen in the emergency department. – Other Health Provider*

**Preventable**

*Tobacco use still remains one of the largest preventable causes of illness, death, and disease. This is not due to poor education about the effects of tobacco use; however, upcoming generations are less likely to begin using tobacco because they have seen the side effects. Past generations are still smoking because they have become addicted and find the resources to quit costly or ineffective, with other side effects worse than tobacco use. – Other Health Provider*

# Access to Health Services



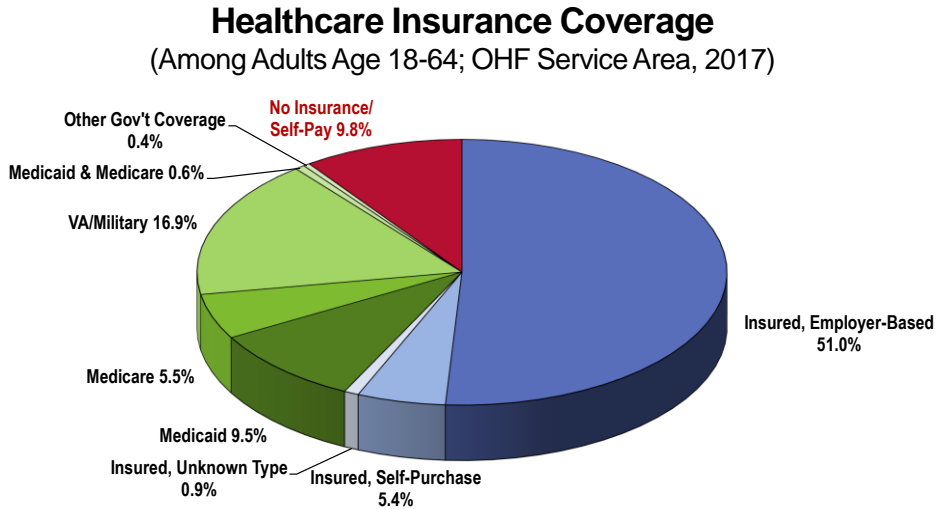
Professional Research Consultants, Inc.

## Health Insurance Coverage

### Type of Healthcare Coverage

A total of 57.3% of OHF Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 32.9% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

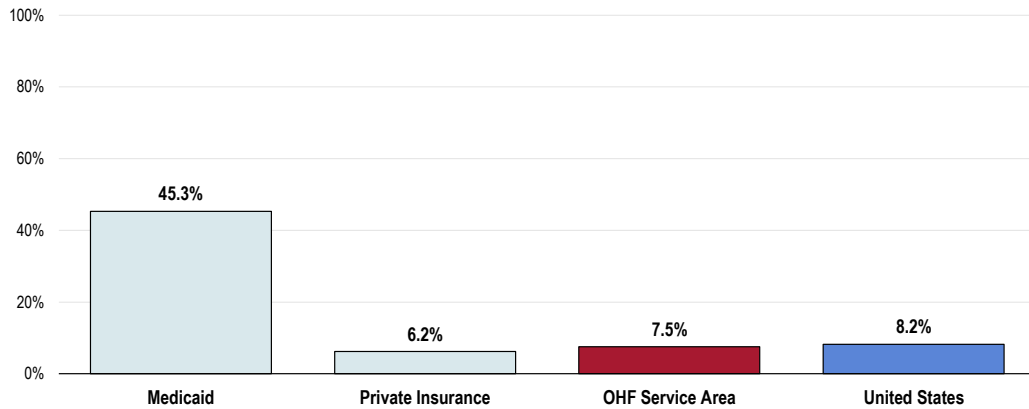


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 173]  
Notes: • Reflects respondents age 18 to 64.

A total of 7.5% of residents under age 65 with private coverage or Medicaid secured their coverage under the Affordable Care Act (ACA).

- Similar to the national finding.
- Note the 45.3% of affirmative responses among adults with Medicaid, compared with privately insured individuals (6.2%).

### Insurance Was Secured Under the Affordable Care Act (Among Those With Private Insurance or Medicaid, By Type of Coverage)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 307]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents under 65 with private insurance or Medicaid.

### Lack of Health Insurance Coverage

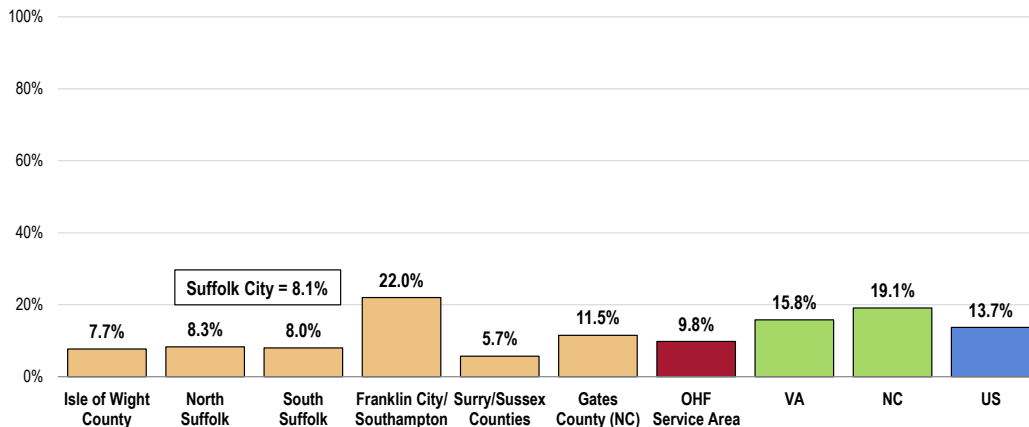
Among adults age 18 to 64, 9.8% report having no insurance coverage for healthcare expenses.

- More favorable than state and national findings.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Markedly higher in the Franklin City/Southampton community.

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

### Lack of Healthcare Insurance Coverage (Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)

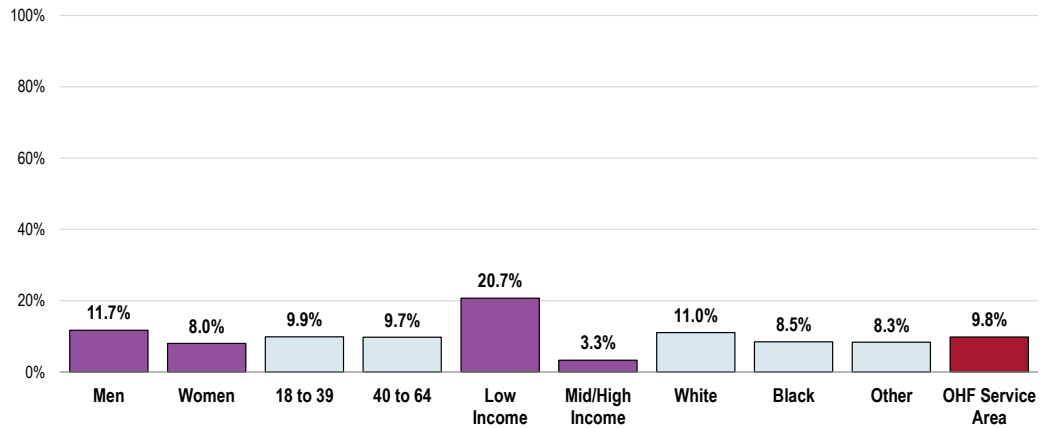


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 173]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1.1]  
 Notes: • Asked of all respondents under the age of 65.

The following population segments are more likely to be without healthcare insurance coverage:

- Men.
- Residents living at lower incomes (note the 20.7% uninsured prevalence among low-income adults).

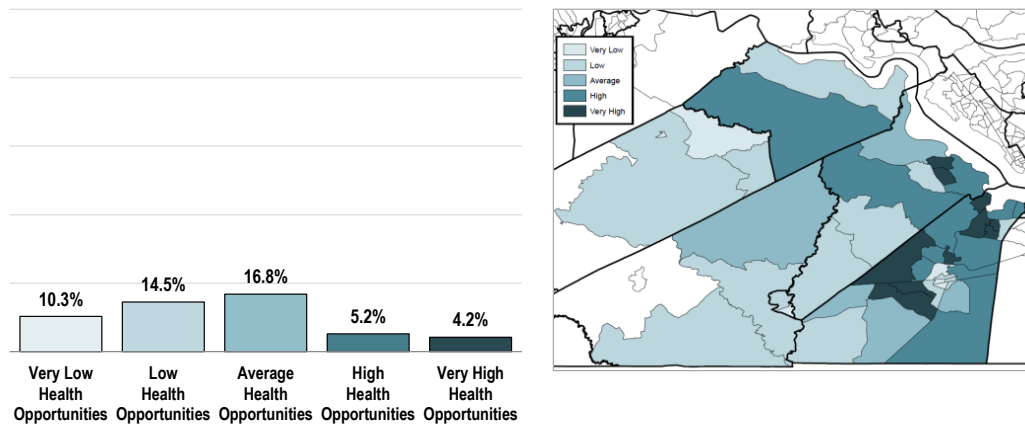
### Lack of Healthcare Insurance Coverage (Among Adults Age 18-64; OHF Service Area, 2017) Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 173]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1.1]  
 Notes: • Asked of all respondents under the age of 65.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Examined by Virginia HOI classification, lack of healthcare insurance coverage is higher among OHF Service Area adults with average or lower health opportunities.

### Lack of Healthcare Insurance Coverage (18-64) (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 173]  
 Notes: • Asked of all respondents.

## Difficulties Accessing Healthcare

### About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

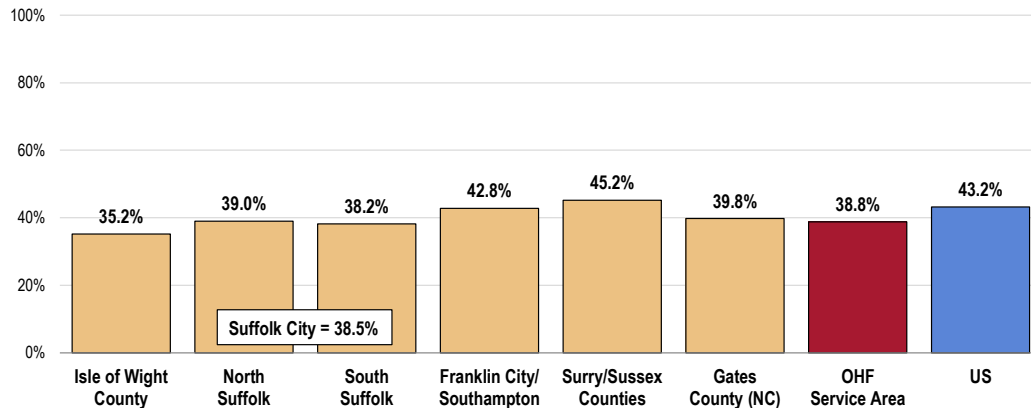
### Difficulties Accessing Services

A total of 38.8% of OHF Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- More favorable than national findings.
- Statistically similar by community.

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

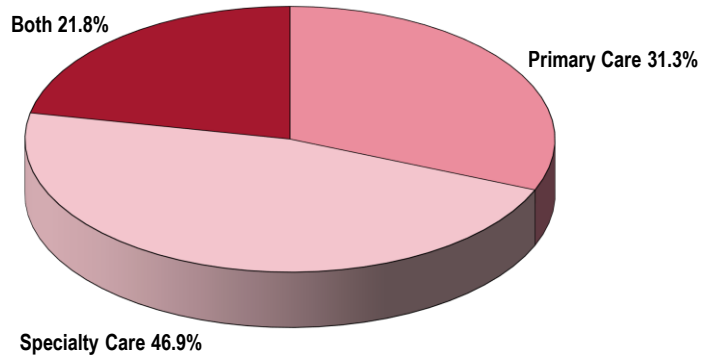
### Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 177]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

Note that, of those experiencing difficulty, 31.3% reported difficulty getting **primary care** in the past year, and 46.9% reported difficulty accessing a **specialist** (21.8% had issues with both types of care).

### Type of Access Difficulty (OHF Service Area Adults with Difficulty Accessing Healthcare Services in the Past Year, 2017)

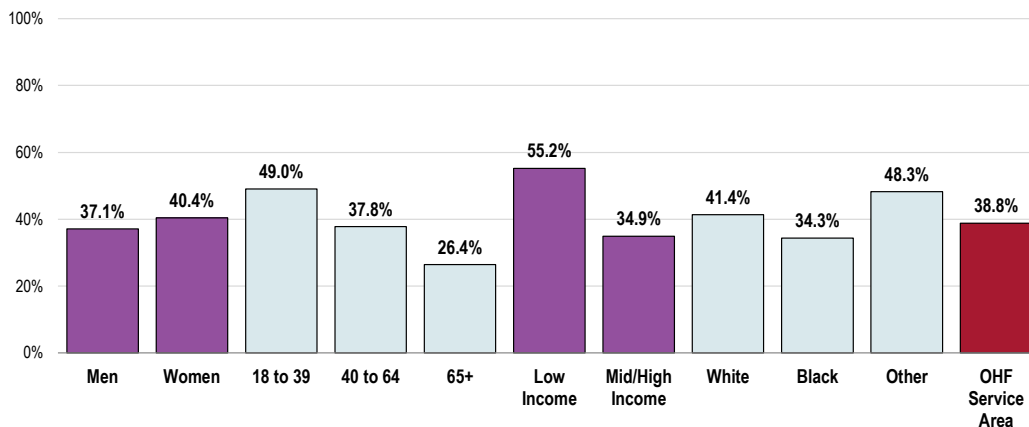


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 314]  
Notes: • Reflects those respondents with access difficulties.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Adults under age 65 (negative correlation with age).
- Lower-income residents.
- Whites and Other race/ethnicities.

### Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (OHF Service Area, 2017)

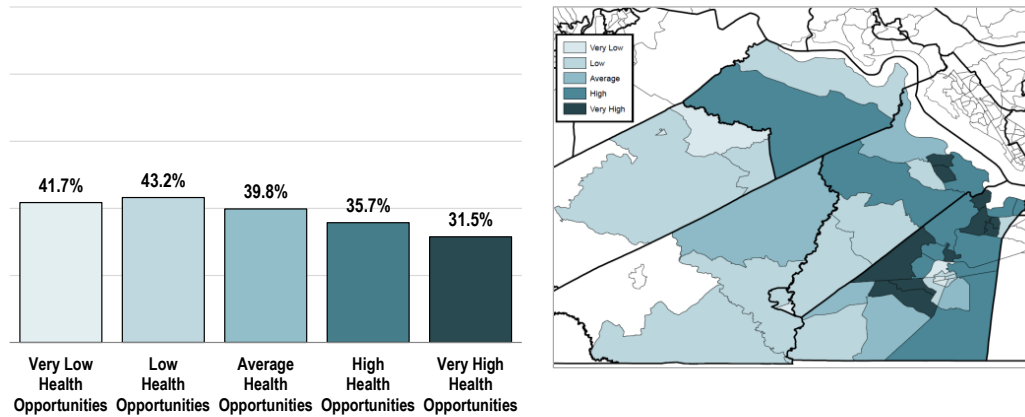


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 177]  
Notes: • Asked of all respondents.  
• Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



Viewed by HOI classification, OHF Service Area adults reporting the greatest prevalence of access difficulties are in the areas with lowest health opportunities.

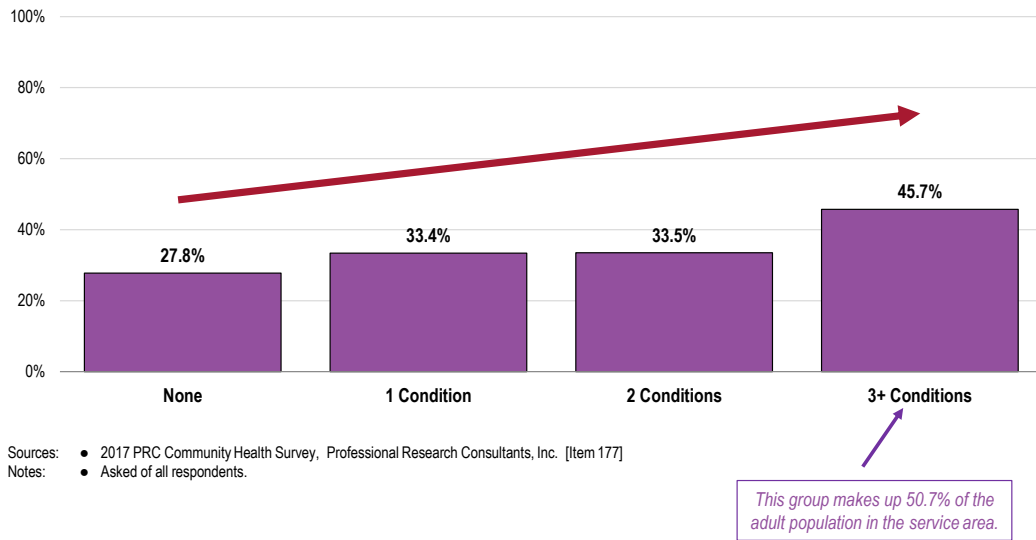
### Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 177]  
 Notes: • Asked of all respondents.

Note also the positive correlation between access difficulties and the prevalence of chronic conditions among OHF Service Area residents.

### Experienced Access Difficulties in the Past Year (OHF Service Area by Number of Reported Chronic Conditions)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 177]  
 Notes: • Asked of all respondents.

## Barriers to Healthcare Access

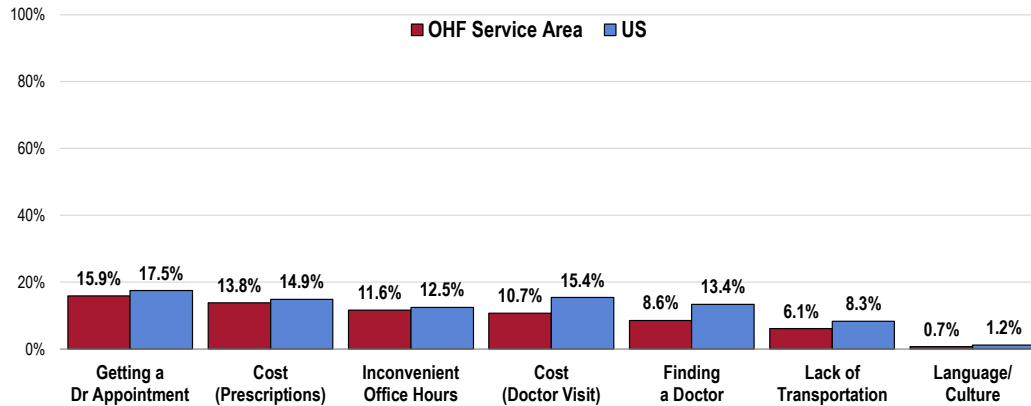
Of the tested barriers, difficulty getting an appointment with a physician impacted the greatest share of OHF Service Area adults (15.9% report difficulty obtaining a doctor’s appointment in the past year).

- The proportion of impacted OHF Service Area adults is statistically comparable to or better than that found nationwide for each of the tested barriers.

To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

### Barriers to Access Have Prevented Medical Care in the Past Year



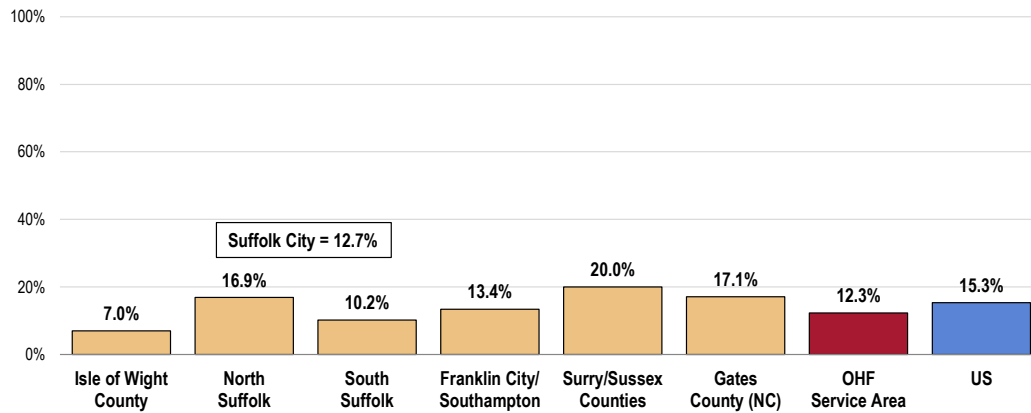
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Prescriptions

Among all OHF Service Area adults, 12.3% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- More favorable than national findings.
- Statistically higher in North Suffolk and Surry/Sussex counties.

### Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

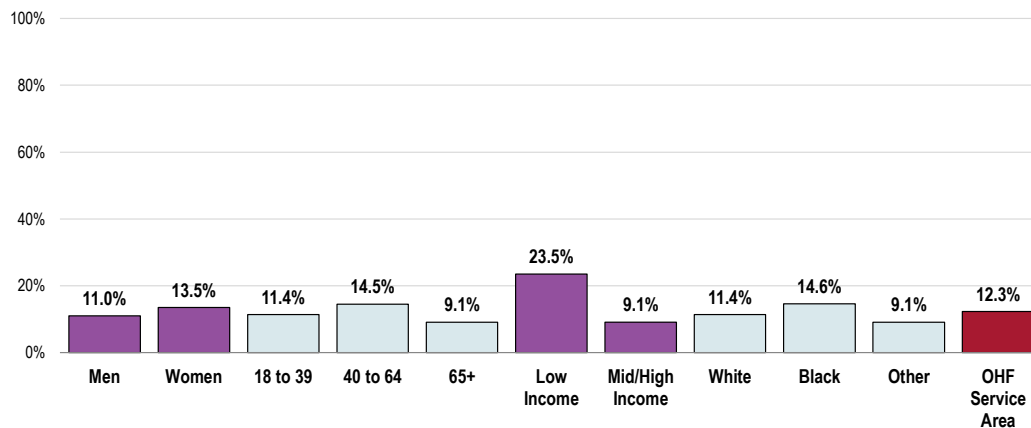


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

Adults more likely to have skipped or reduced their prescription doses include:

- Adults age 40 to 64.
- Respondents with lower incomes especially.

### Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

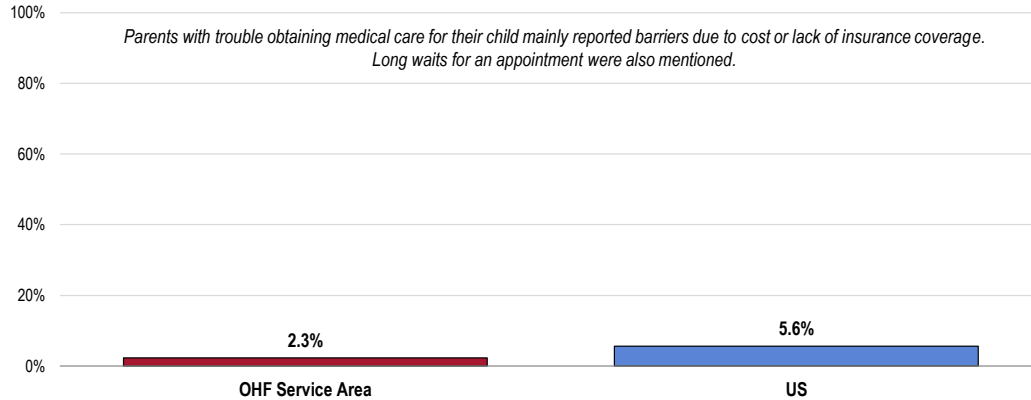
## Accessing Healthcare for Children

A total of 2.3% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

- More favorable than what is reported nationwide.

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

### Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)



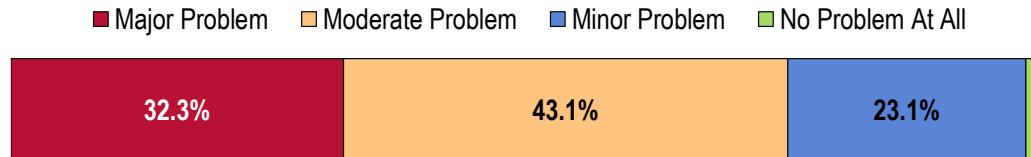
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 118-119]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents with children 0 to 17 in the household.

Among the parents experiencing difficulties, the majority cited **cost or a lack of insurance** as the primary reason; others cited long waits for appointments.

## Key Informant Input: Access to Healthcare Services

Key informants taking part in an online survey most often characterized **Access to Healthcare Services** as a “moderate problem” in the community.

### Perceptions of Access to Healthcare Services as a Problem in the Community (Key Informants, 2017)



- Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Transportation

*Transportation (specifically, a lack of good public transportation options) is a significant barrier to access in Western Tidewater. Health insurance coverage has improved under the Affordable Care Act, but long-term outlook is tenuous. Hospital in Franklin is for-profit, limiting access (at least to some degree) even to those with coverage. – Public Health Representative*

*Transportation for all. Getting the individual to the location of the provider. Second is the lack of funds to seek primary care. Third is the lack of access to education for those who need it. – Other Health Provider*

*This is in response to the population in the rural part of Gates County, North Carolina. A significant barrier is transportation and access to providers within 10 miles. – Other Health Provider*

*Public transportation is the biggest barrier for people to access healthcare. – Other Health Provider*

*Transportation, cost, amount of resources and the number of specialists, especially geriatricians. – Other Health Provider*

*Transportation for the elderly. – Community Leader*

*Transportation. – Social Services Provider*

### Affordability of Care/Services

*Cost, transportation, continued care. – Community Leader*

*A lot of residents simply can't afford access to affordable healthcare. This leads to misuse of emergency services. This also leads to a lack of preventive care, causing more funds to be spent at a later date. – Community Leader*

*Particularly for the low-income, uninsured. Options for care that are convenient and affordable. Access to medication to manage chronic conditions and maintain health are part of this access challenge.*

*Transportation is a piece of the access challenge. – Other Health Provider*

*Cost and availability. – Community Leader*

*High insurance cost for working families, especially those with children. Access for those with insurance is getting worse quickly. More and more practices refusing common insurance carriers. Out-of-pocket costs for services going up along with massive premium increases. Very damaging for middle class family finances. – Community Leader*

### Lack of Providers

*Low income individuals have minimal access to providers. If they have insurance through the exchange, they may have access to primary care. But beyond that, the deductibles and co-insurance are so high that they cannot afford the care. – Public Health Representative*

*Number and location of primary care and specialty care providers, insurance and financial costs, transportation. – Community Leader*

### Health Education/Awareness

*Information on what good things that are happening around health and living. We always hear the bad but never the good. Secondly hypertension. This is a great impact on heart disease. – Community Leader*

### Access to Care/Services

*We have no overnight service; it is gone after 6:00 p.m. – Community Leader*

### Socioeconomic Status

*Concentrations of poverty. – Community Leader*

### Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified mental health services, chronic disease care, and substance abuse treatment as the most difficult to access in the community.

<b>Medical Care Difficult to Access Locally</b>				
	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Services	29.4%	47.1%	5.9%	<b>14</b>
Chronic Disease Care	23.5%	17.6%	17.6%	<b>10</b>
Substance Abuse Treatment	11.8%	17.6%	17.6%	<b>8</b>
Dental Care	11.8%	5.9%	17.6%	<b>6</b>
Specialty Care	5.9%	5.9%	17.6%	<b>5</b>
Primary Care	5.9%	0.0%	11.8%	<b>3</b>
Elder Care	11.8%	0.0%	0.0%	<b>2</b>
Urgent Care	0.0%	5.9%	5.9%	<b>2</b>
Pain Management	0.0%	0.0%	5.9%	<b>1</b>

## Primary Care Services

### About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

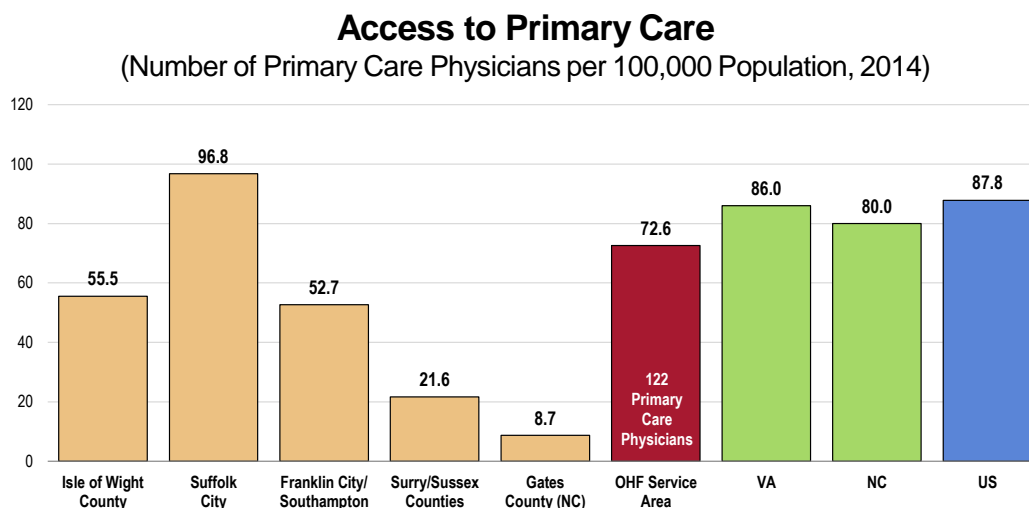
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Access to Primary Care

In the OHF Service Area in 2014, there were 122 primary care physicians, translating to a rate of 72.6 primary care physicians per 100,000 population.

- Below the Virginia and US rates.
- Comparable to the North Carolina rate.
- The rate is highest in Suffolk City and lowest in Gates County.



- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
  - Retrieved October 2017 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

## Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

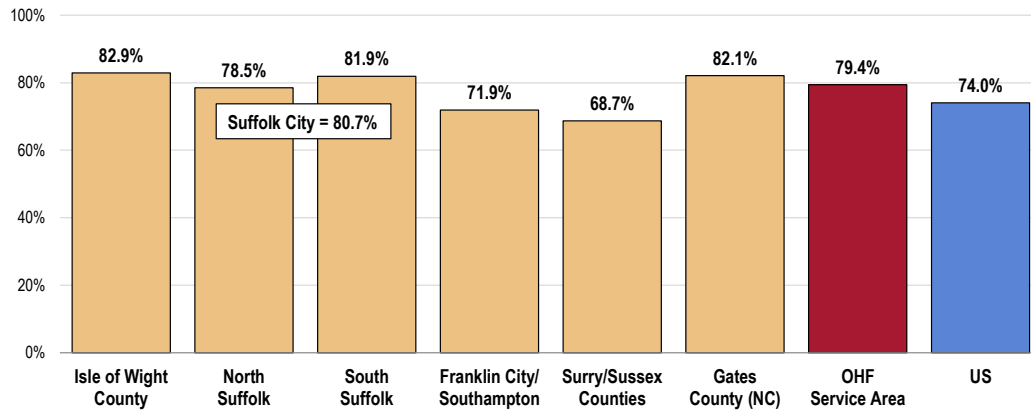
A hospital emergency room is not considered a specific source of ongoing care in this instance.

**A total of 79.4% of OHF Service Area adults were determined to have a specific source of ongoing medical care.**

- Similar to national findings.
- Fails to satisfy the Healthy People 2020 objective (95% or higher).
- Unfavorably low in Surry/Sussex counties.

### Have a Specific Source of Ongoing Medical Care

Healthy People 2020 Target = 95.0% or Higher



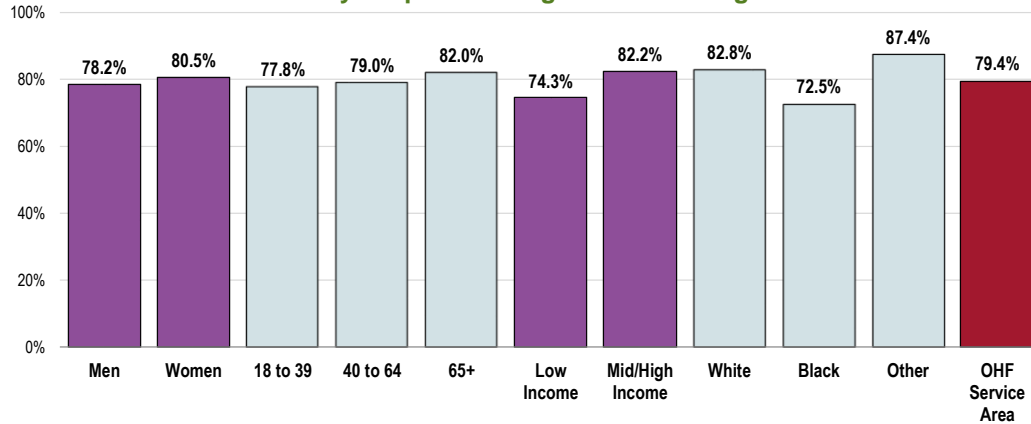
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.1]
- Notes:
- Asked of all respondents.

- When viewed by demographic characteristics, lower-income adults and Black residents are less likely to have a specific source of care.

### Have a Specific Source of Ongoing Medical Care

(OHF Service Area, 2017)

Healthy People 2020 Target = 95.0% or Higher



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 174-176]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.1]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



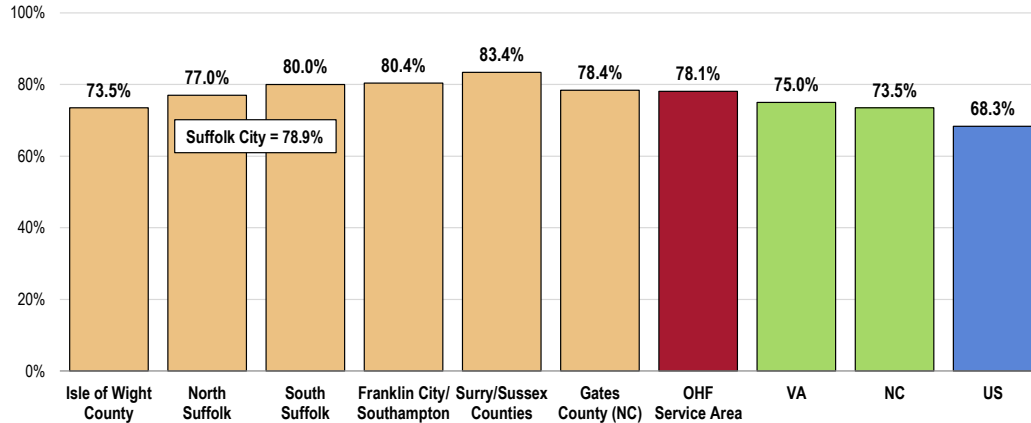
## Utilization of Primary Care Services

### Adults

Most adults (78.1%) visited a physician for a routine checkup in the past year.

- More favorable than state and US findings.
- Lowest in Isle of Wight County.

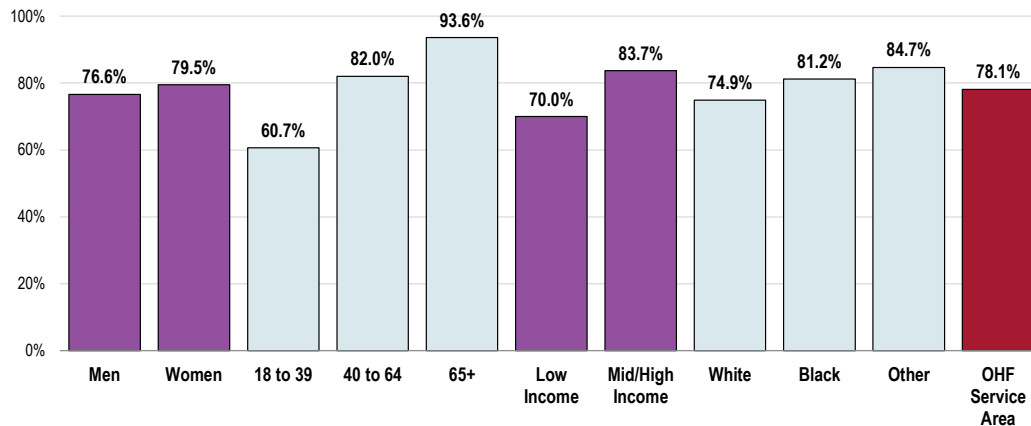
### Have Visited a Physician for a Checkup in the Past Year



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

- Adults under age 40 are less likely to have received routine care in the past year (note the positive correlation with age), as are low-income residents and Whites.

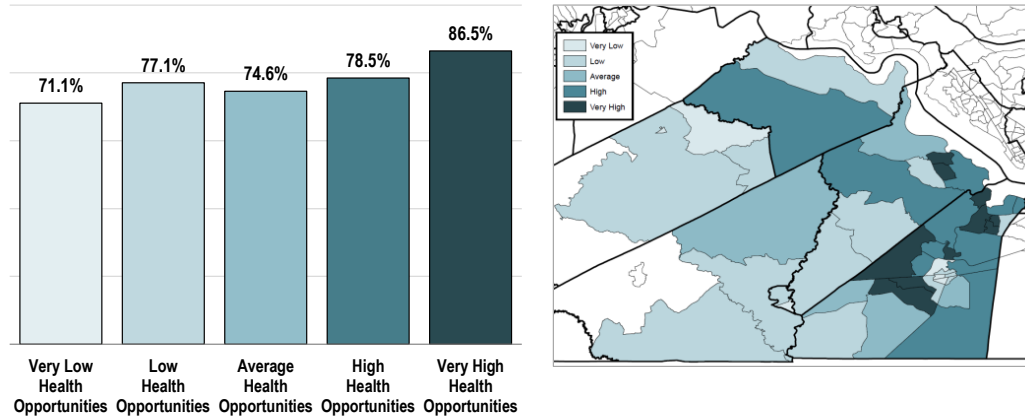
### Have Visited a Physician for a Checkup in the Past Year (OHF Service Area, 2017)



- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Viewed by Virginia HOI, adults with lower health opportunities are less likely to report recent routine checkups.

### Have Visited a Physician for a Checkup in the Past Year (OHF Service Area by Health Opportunity Index Classification)



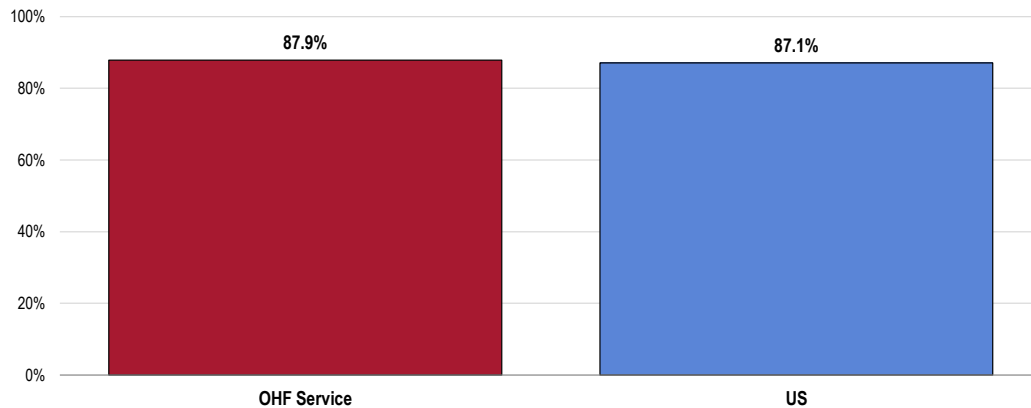
Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]  
Notes: • Asked of all respondents.

### Children

Among surveyed parents, 87.9% report that their child has had a routine checkup in the past year.

- Almost identical to national findings.

### Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)



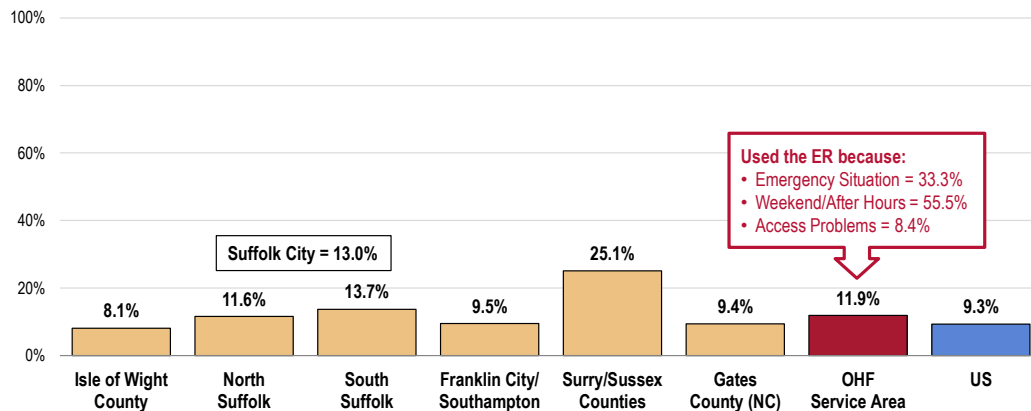
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]  
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents with children 0 to 17 in the household.

## Emergency Room Utilization

A total of 11.9% of OHF Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Higher than national findings.
- Markedly high in the Surry/Sussex County population.

### Have Used a Hospital Emergency Room More Than Once in the Past Year



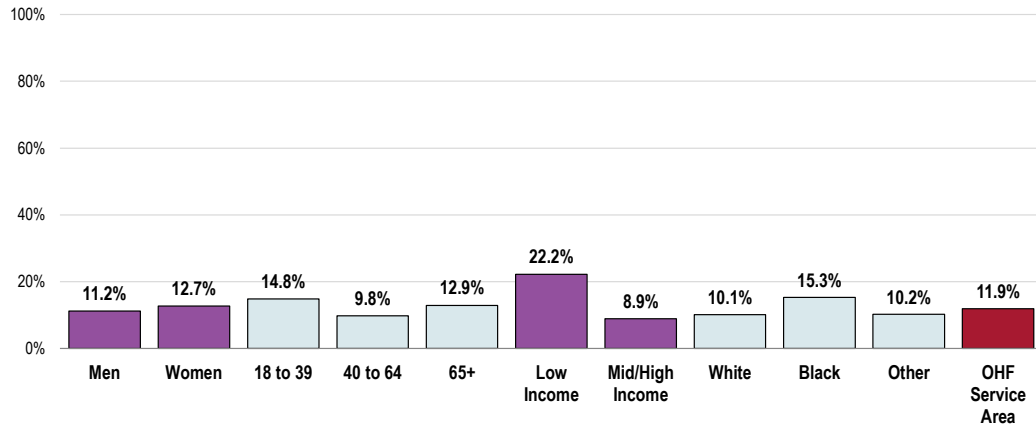
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

Of those using a hospital ER, 33.3% say this was due to an **emergency or life-threatening situation**, while 55.5% indicated that the visit was during **after-hours or on the weekend**. A total of 8.4% cited **difficulties accessing primary care** for various reasons.

These population segments are more likely to have used an ER for their medical care more than once in the past year:

- Residents in low-income households.
- Black adults.

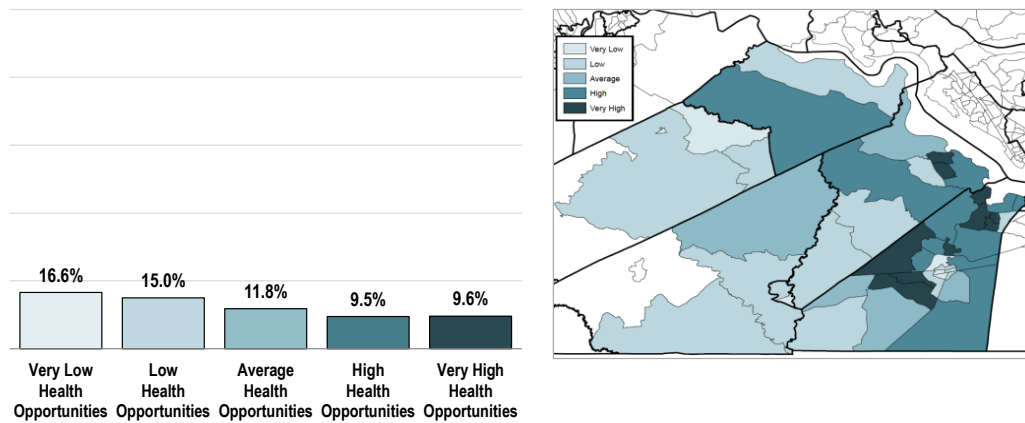
### Have Used a Hospital Emergency Room More Than Once in the Past Year (OHF Service Area, 2017)



Sources: ● 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]  
 Notes: ● Asked of all respondents.  
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Use of the ER is higher in the OHF Service Area among adults with low health opportunities.

### Used the ER More Than Once in the Past Year (OHF Service Area by Health Opportunity Index Classification)



Sources: ● PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]  
 Notes: ● Asked of all respondents.

## Preventive Quality Indicators (PQIs)

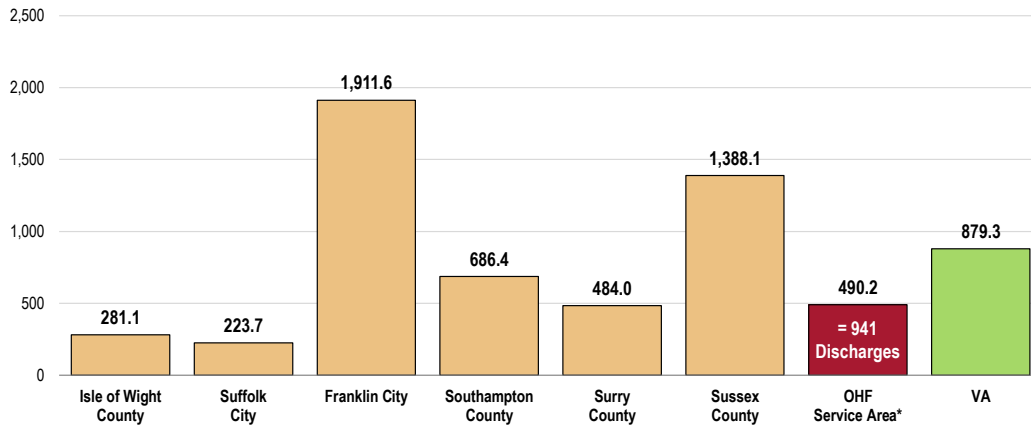
In 2013, the OHF Service Area (excluding Gates County) reported 941 PQI discharges, for a discharge rate of 490.2 per 100,000 population.

The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for “ambulatory care sensitive conditions.” These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population-based and adjusted for covariates.

PQIs can be used to provide a window into the community—to identify unmet community healthcare needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local healthcare systems across communities.

- The rate is lower than the Virginia PQI discharge rate.
- Note the substantial disparity by individual community, with particularly high PQI discharge rates among residents of Franklin City and Sussex County.

**PQI Total Age-Adjusted Discharges**  
(2013 Age-Adjusted Discharges per 100,000 Population)

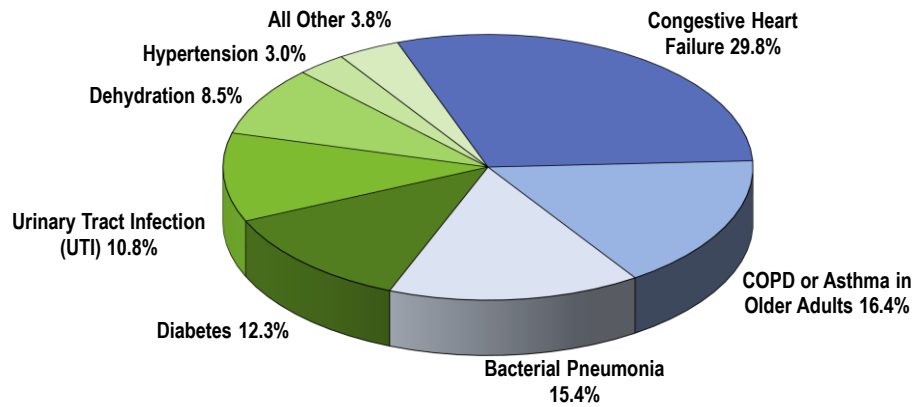


Sources: • Sentara Obici Hospital datafile 9/30/16  
 Notes: • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 • \*Results exclude Gates County data.  
 • The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for “ambulatory care sensitive conditions.” These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates.

Viewed by specific types of hospitalization, 29.8% of the 2013 PQI discharges were for care related to congestive heart failure, followed by COPD or asthma in older adults (16.4%) and bacterial pneumonia (15.4%).

- Other types of hospitalizations reported with less frequency included care for diabetes, UTIs, dehydration, and hypertension.

### Total Prevention Quality Indicator (PQI) Hospitalization (OHF Service Area, Excluding Gates County; 2013)



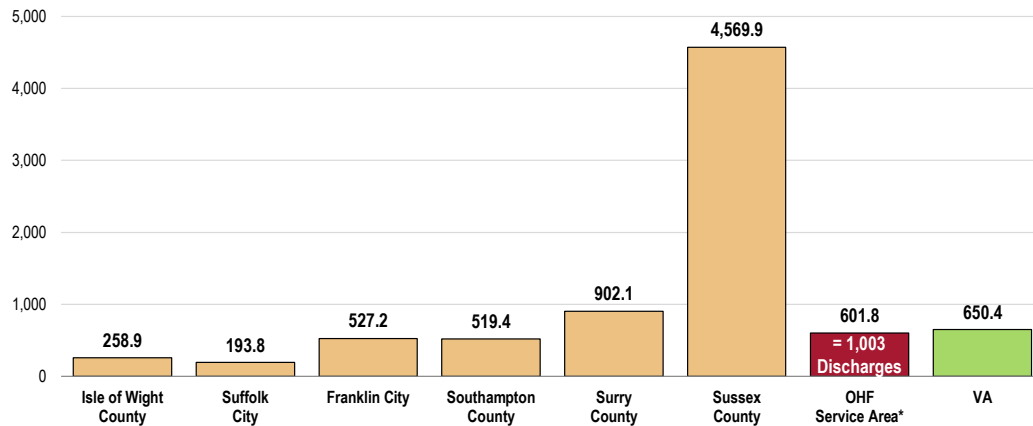
Sources: ● Sentra Obici Hospital datafile 9/30/16  
 Notes: ● Results exclude Gates County data.  
 ● The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The PQIs are population based and adjusted for covariates.

### Behavioral Health

In 2013, the OHF Service Area (excluding Gates County) reported 1,003 behavioral health-related discharges, for a discharge rate of 601.8 per 100,000 population.

- The rate is lower than the Virginia discharge rate.
- Note the significant disparity by individual community, with an exceptionally high behavioral health discharge rate among residents of Sussex County (544 discharges).

### Behavioral Health Hospitalization Age-Adjusted Discharges (2013 Age-Adjusted Discharges per 100,000 Population)

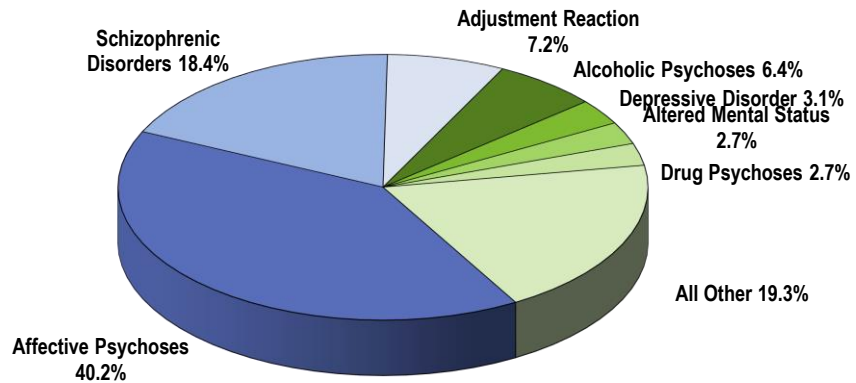


Sources: ● Sentara Obici Hospital datafile 9/30/16  
 Notes: ● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
 ● \*Results exclude Gates County data.

Viewed by specific types of behavioral health hospitalization, 40.2% of the 2013 behavioral health discharges were for care related to affective psychoses, followed by schizophrenic disorders (18.4%).

- Other types of behavioral hospitalizations reported with less frequency included care for adjustment reaction, alcoholic psychoses, depressive disorders, altered mental status, and drug psychoses.

**Total Behavioral Health Hospitalization**  
(OHF Service Area, Excluding Gates County; 2013)



Sources: • Sentra Obici Hospital datafile 9/30/16  
Notes: • Results exclude Gates County data.

## Oral Health

### About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use**; **excessive alcohol use**; and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

• Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

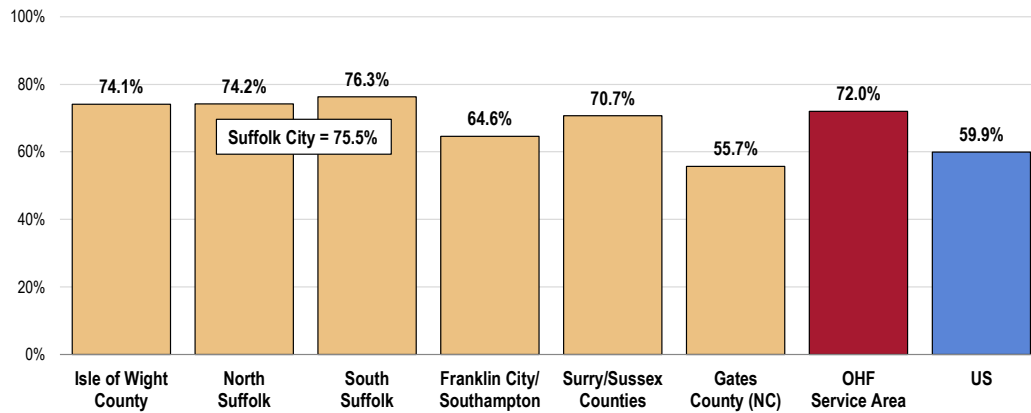
### Dental Insurance

**Over 7 in 10 OHF Service Area adults (72.0%) have dental insurance that covers all or part of their dental care costs.**

- More favorable than the national finding.
- Highest among South Suffolk residents, lowest in Gates County.



### Have Insurance Coverage That Pays All or Part of Dental Care Costs

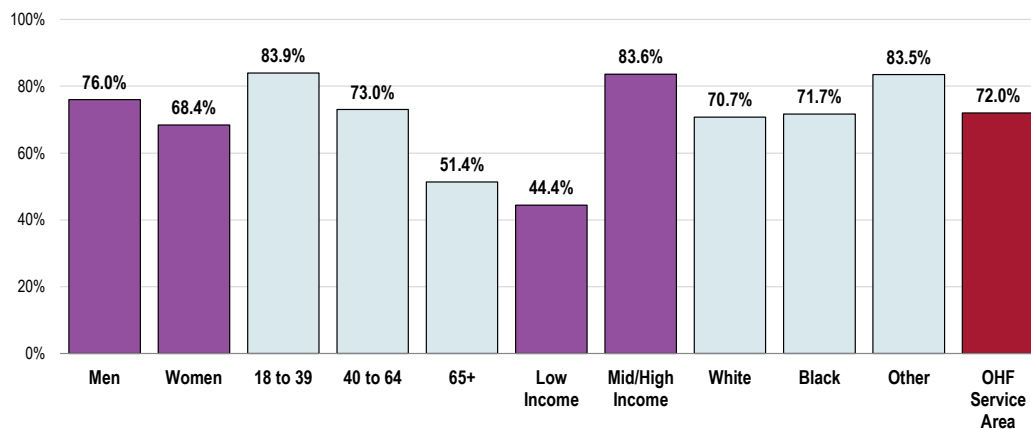


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

These adults are less likely to be covered by dental insurance:

- Women.
- Older residents (negative correlation with age).
- Those in low-income households especially.
- White adults and Black adults.

### Have Insurance Coverage That Pays All or Part of Dental Care Costs (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

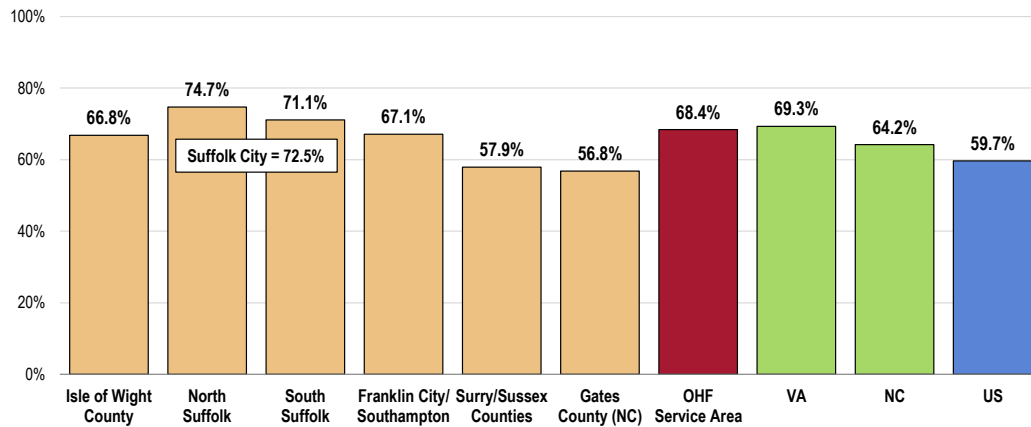
## Dental Care

### Adults

A total of 68.4% of OHF Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- Similar to Virginia findings.
- More favorable than North Carolina and US findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Unfavorably low in Surry/Sussex and Gates counties.

### Have Visited a Dentist or Dental Clinic Within the Past Year Healthy People 2020 Target = 49.0% or Higher



Sources:
 

- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2015 VA and NC data.

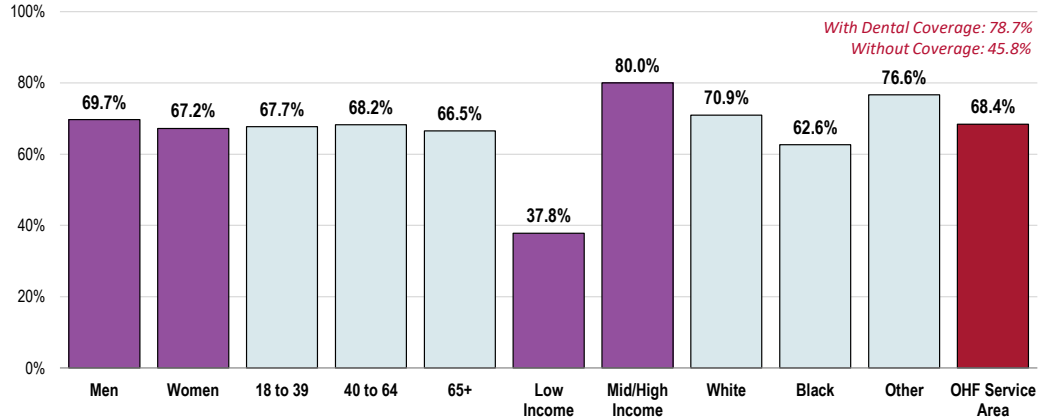
 Notes:
 

- Asked of all respondents.

Note the following:

- Persons living in the higher income categories report much higher utilization of oral health services (low-income adults fail to satisfy the Healthy People 2020 target).
- Blacks are less likely than Whites or Other races to report recent dental care.
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

## Have Visited a Dentist or Dental Clinic Within the Past Year (OHF Service Area, 2017) Healthy People 2020 Target = 49.0% or Higher

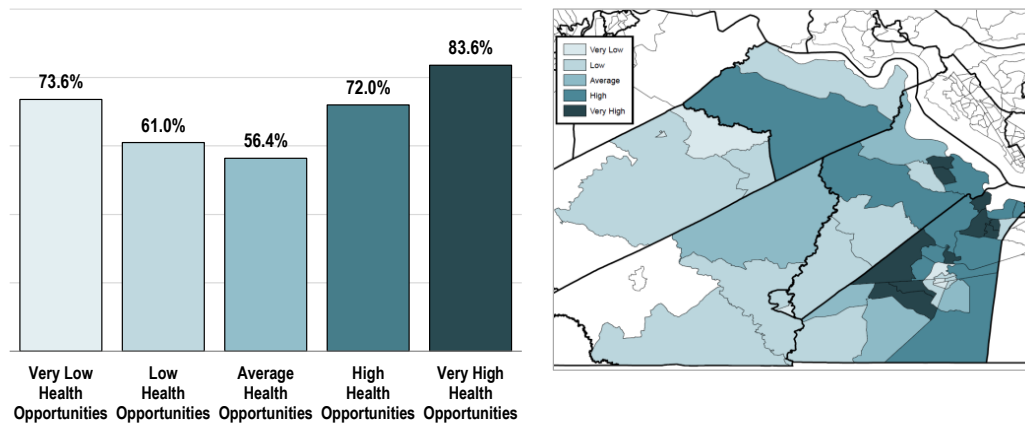


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental care appears to be worst for those with average health opportunities; those with lower or higher opportunities more often report regular care.

## Dental Care in the Past Year (OHF Service Area by Health Opportunity Index Classification)



Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]  
 Notes: • Asked of all respondents.

### Children

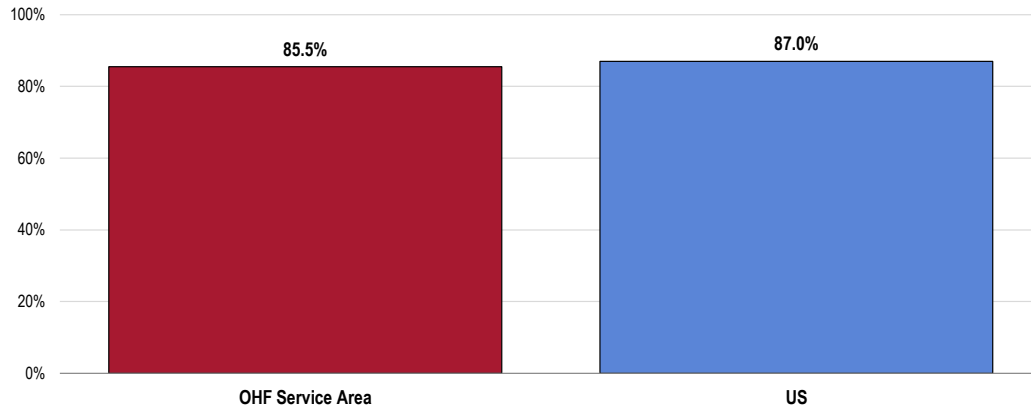
A total of 85.5% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Comparable to the US figure.
- Satisfies the Healthy People 2020 target (49.0% or higher).

### Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children Age 2-17)

Healthy People 2020 Target = 49.0% or Higher



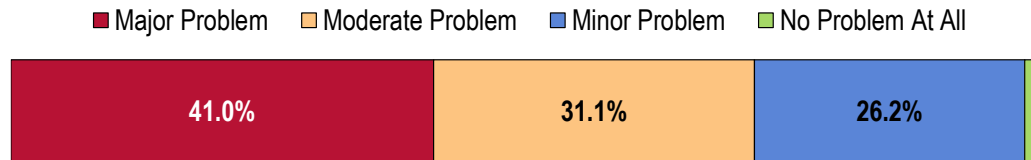
- Sources:
- 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
  - 2017 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
- Notes:
- Asked of all respondents with children age 2 through 17.

### Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a “major problem” in the community.

### Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2017)



- Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

### Lack of Providers

*Most dentists in this community do not accept uninsured or underinsured patients. Oral health is essential for children and adults. There are few providers to assist with routine dental exams at reduced costs. – Public Health Representative*

*Limited access to oral healthcare professionals, transportation, and education about oral health and preventative methods. When talking with individuals that are underinsured and/or uninsured, they find that payment for services based on the sliding scale fees are not always feasible, or that transportation for services is limited. – Other Health Provider*

*Lack of providers serving low- or no-income consumers. – Community Leader*

*It seems to be a major problem throughout the commonwealth. Not enough dental providers for low-income uninsured. – Other Health Provider*

### Access to Care/Services

*Rural community setting. Dental Health Professional Shortage area. Horizon Health Services provides the only dental services in a sixty-mile area. Many of the patients served there have not been to a dentist in over twenty years. Evidence of many extractions of teeth which cannot be salvaged/repaired due to gross neglect. Limited dental providers in area who accept nominal payments from the Medicaid system. – Public Health Representative*

*No dental services available in the community, and the uninsured and those who are over the age of 18 and are on Medicaid cannot afford dental services. – Social Services Provider*

*Lack of services in county. – Social Services Provider*

### Affordable Care/Services

*Patients are unable to afford dental care. – Other Health Provider*

*Cost. – Community Leader*

*Indigent and low income dental services are limited or non-existent. Poor oral health is a precursor to other major health issues. This is another major educational opportunity for the region. – Other Health Provider*

*There are many individuals in our area that have never had access to dental care—mainly the low-income population. There are not many dentists in our area willing to take patients who cannot afford to pay market prices. Consequently, these people tend to go without care until they end up in the emergency room. – Public Health Representative*

### Prevalence/Incidence

*I see this as a problem in my patient population, many of whom are underserved. – Physician*

*Statistics point to the evidence of the problems. Contributing to this are poor oral care, lack of insurance, and diet. – Community Leader*

*On any given day we have at least two to three people coming to the emergency room for dental pain. No dental insurance. – Other Health Provider*

### Socioeconomic Status

*Societal norms, health disparities, and inequities. Lack of access to appropriate levels of care and for preventative measures. – Other Health Provider*

### Screening in Schools

*Children should get basic dental exams at the school. Must be a way to offer interns in dental school the opportunity to provide exams. – Other Health Provider*

### Contributing Factors

*People don't think it's important; costly; no coverage. – Community Leader*

## Vision Care

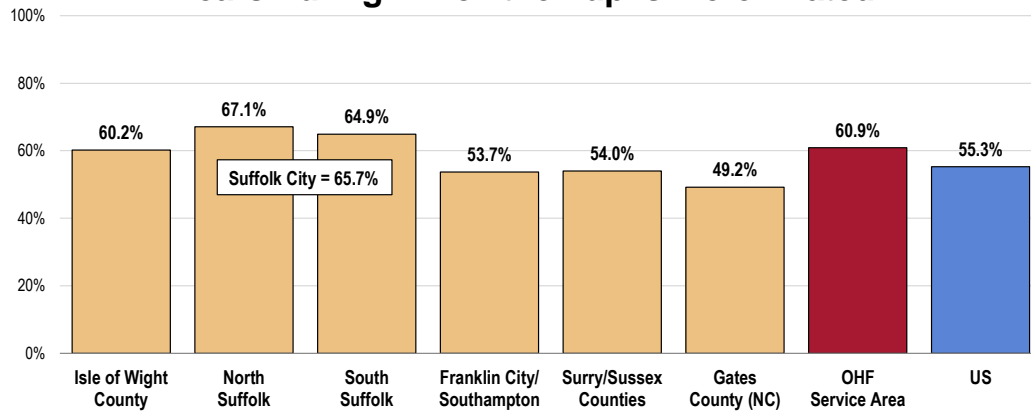
A total of 60.9% of OHF Service Area residents had an eye exam in the past two years during which their pupils were dilated.

RELATED ISSUE:

See also *Potentially Disabling Conditions: Vision & Hearing Impairment in the Death, Disease & Chronic Conditions* section of this report.

- More favorable than national findings.
- Lowest in Gates County.

### Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

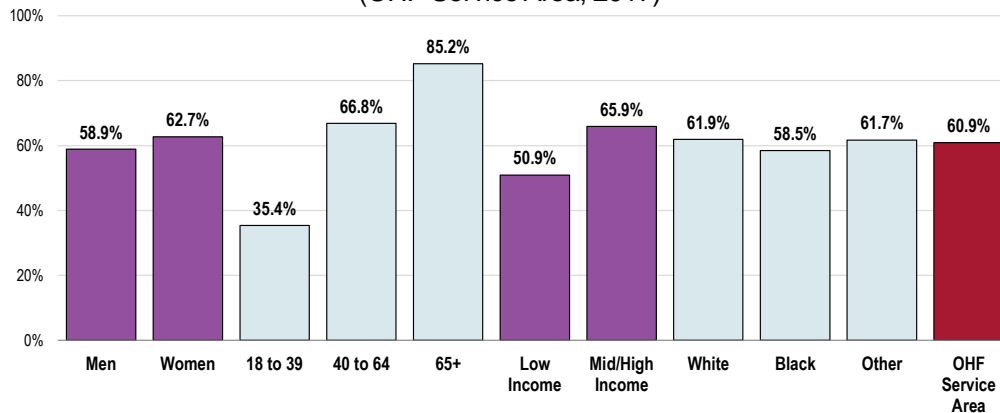


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]  
 • 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

Recent vision care in the OHF Service Area is more often reported among:

- Older residents (strong, positive correlation with age).
- Those with higher household incomes.

### Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

# Local Resources



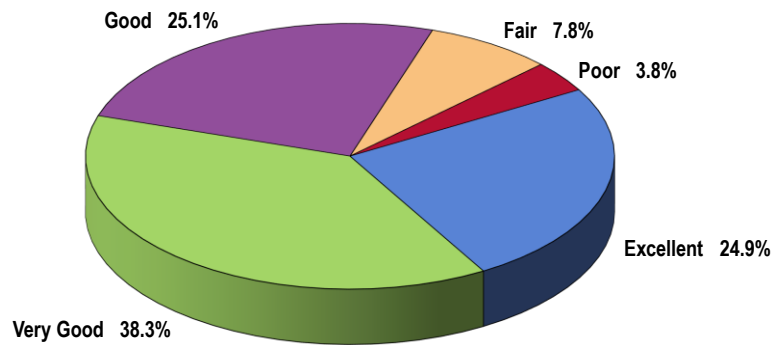
**Professional Research Consultants, Inc.**

## Perceptions of Local Healthcare Services

Over 6 in 10 OHF Service Area adults (63.2%) rate the overall healthcare services available in their community as “excellent” or “very good.”

- Another 25.1% gave “good” ratings.

**Rating of Overall Healthcare Services Available in the Community**  
(OHF Service Area, 2017)

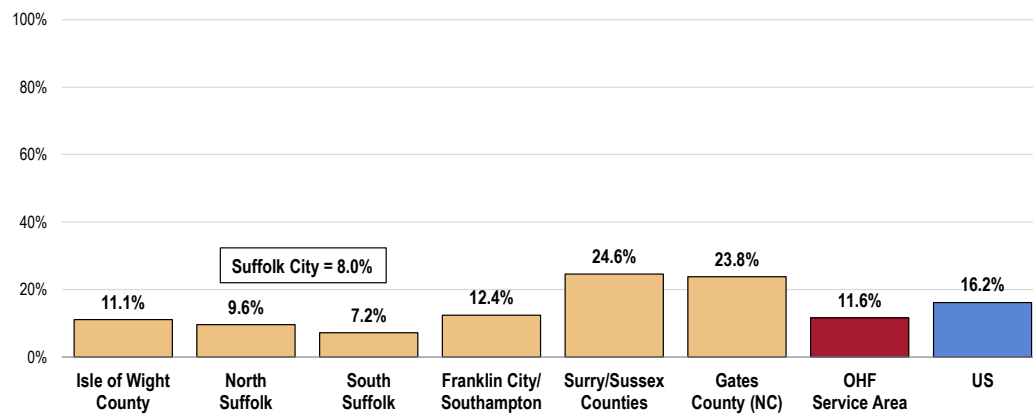


Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]  
Notes: • Asked of all respondents.

However, 11.6% of residents characterize local healthcare services as “fair” or “poor.”

- More favorable than reported nationally.
- Markedly higher in Surry/Sussex and Gates counties.

### Perceive Local Healthcare Services as “Fair/Poor”



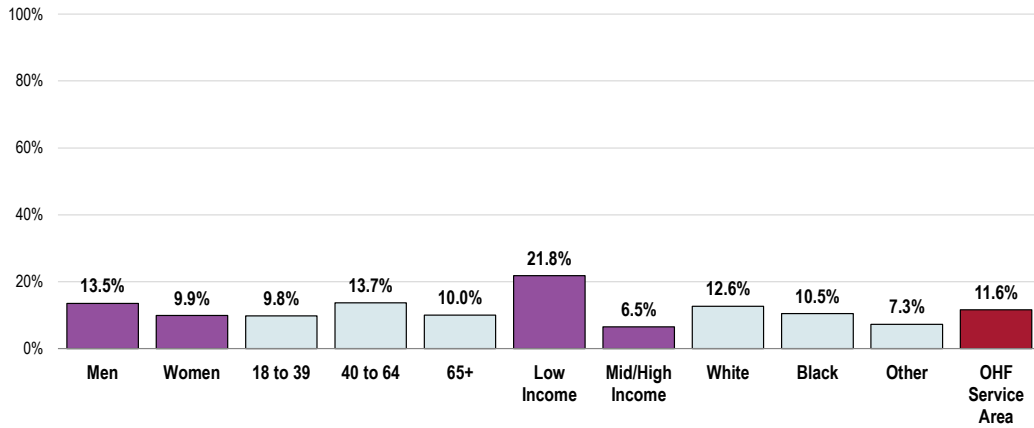
Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]  
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.



The following residents are more critical of local healthcare services:

- Adults age 40 to 64.
- Residents with lower incomes especially.

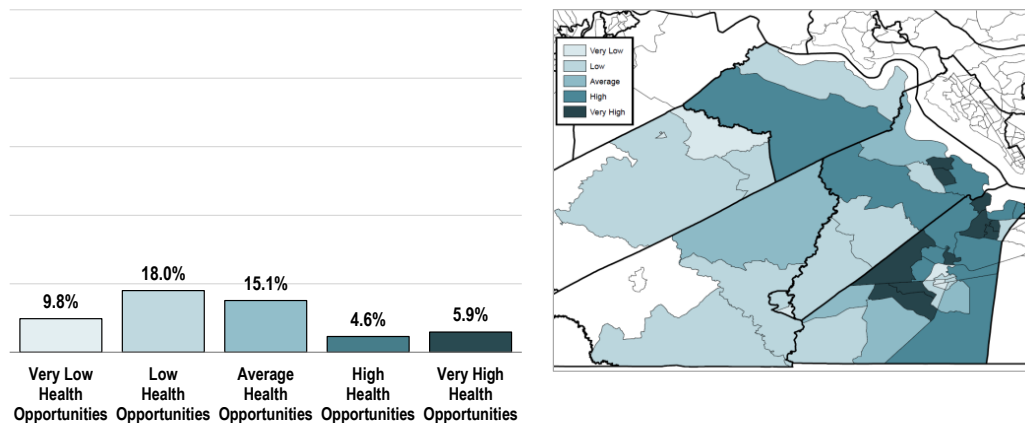
### Perceive Local Healthcare Services as “Fair/Poor” (OHF Service Area, 2017)



Sources: • 2017 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

OHF Service Area adults in average or low HOI census tracts are more likely to give low ratings of their local healthcare resources.

### Perceive Local Healthcare Services as “Fair/Poor” (OHF Service Area by Health Opportunity Index Classification)



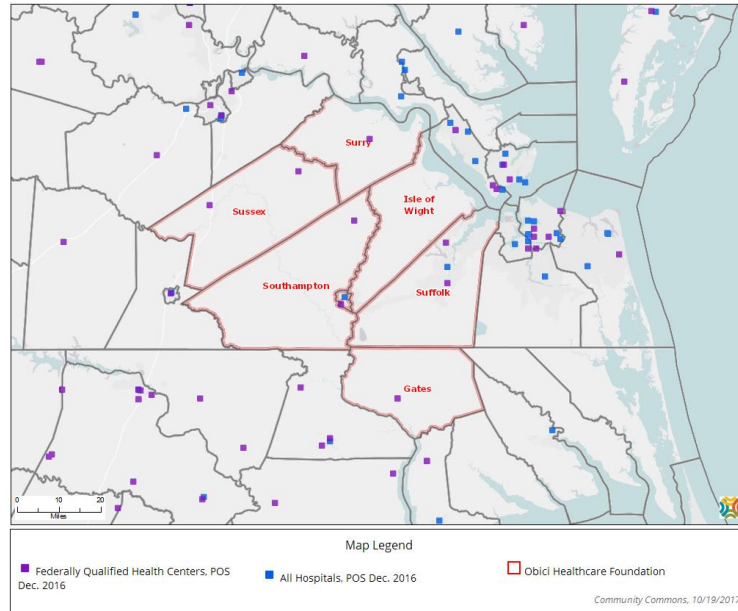
Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]  
 Notes: • Asked of all respondents.

## Healthcare Resources & Facilities

### Hospitals & Federally Qualified Health Centers (FQHCs)

The following map details the hospitals and Federally Qualified Health Centers within the OHF Service Area as of late 2016.

Federally Qualified Health Centers (FQHCs) as of December 2016



## Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

### Access to Healthcare Services

- Alzheimer's Association*
- ARHS- Inter-County Public Transportation Authority Transportation Services*
- Bon Secours Care-A-Van*
- Buses*
- County Transportation System*
- Dentist's Offices*
- Free Clinic*
- Gates Public Transportation*
- Hospitals*
- I-Ride*
- Main Street Clinic*
- Medicaid Cabs*
- Obici Healthcare Foundation*
- Rx Partnership*
- Senior Services of Southeastern Virginia*
- Sentara Obici Hospital*
- Social Services*
- Southeastern Virginia Health System*
- The Up Center*
- Western Tidewater Community Services Board*
- Western Tidewater Free Clinic*
- Western Tidewater Health District*

### Arthritis, Osteoporosis, & Chronic Back Conditions

- Doctor's Offices*
- Free Clinic*
- Healthcare*
- Hospitals*
- Obici Healthcare Foundation*
- Pharmacies*
- Pilates Studio*
- Virginia Orthopedic and Spine Specialists (VOSS)*
- YMCA*

### Cancer

- American Cancer Society*
- Belk*
- Bon Secours Health System*
- Cancer Support Groups*
- Community Health Fairs*
- County Transit*
- Doctor's Offices*
- Gates Partners for Health - Chronic Disease Prevention and Management Council*
- Health System*
- Horizon Health Services, Inc.*
- Hospitals*
- Lakeview Clinic*
- Obici Healthcare Foundation*
- Relay for Life*
- Sentara*
- Sentara Norfolk General Hospital*
- Sentara Obici Hospital*
- Surry Area Free Clinic*
- Surry Health Department*
- United Way*
- Vidant Health System*
- Virginia Cooperative Extension*
- Virginia Oncology Associates*
- Western Tidewater Free Clinic*
- Western Tidewater Health Department*

### Dementias, Including Alzheimer's Disease

- Autumn Care*
- Cortland Health Care*
- Doctor's Offices*
- East Pavilion Nursing Home*
- Free Clinic*
- Hospitals*
- Lake Prince Woods*

Nursing Homes  
 Sentara Obici Hospital  
 The Crossings at Harbour View  
 Village at Woods Edge

### Diabetes

Aging and Adult Services Task Force  
 American Diabetes Association  
 Bon Secours Health System  
 Children's Hospital of The King's  
 Daughters (CHKD)  
 Chronic Illness Self-Care Program  
 Crater Health District Clinic  
 Diabetes Prevention Program  
 Diabetic Education  
 Diabetic Support Group  
 Doctor's Offices  
 Eastern Virginia Medical School Strelitz  
 Diabetes Center of Western Tidewater  
 Farmer's Markets  
 Food Lion  
 Franklin City Health Department  
 Franklin City Health Department, Med  
 Assistance Prog  
 Free Clinic  
 Gates County Community Center for  
 Fitness  
 Girls on the Run  
 GP4H Chronic Disease Prevention and  
 Management Council  
 Healthcare  
 Healthy Suffolk  
 Horizon Health Services, Inc.  
 Hospitals  
 Individual Patient Assistance Programs  
 Obici Healthcare Foundation  
 Pre-Diabetes Program  
 Rx Partnership  
 Sentara Obici Hospital  
 Social Services  
 Southampton Memorial Hospital  
 Southeastern Virginia Health System  
 USDA Food Banks  
 Vidant Health System  
 Western Tidewater Free Clinic  
 Western Tidewater Health Department  
 YMCA

### Family Planning

Civic Organizations  
 Doctor's Offices  
 Faith Communities  
 Franklin City Health Department  
 Free Clinic  
 Health System  
 Isle of Wight Health Department  
 Planned Parenthood  
 School System  
 Southampton County Health Department  
 Western Tidewater Free Clinic

### Hearing & Vision

Free Clinic  
 Health Department  
 Obici Healthcare Foundation  
 Virginia Audiology  
 Western Tidewater Free Clinic

### Heart Disease & Stroke

Ambulance Services  
 American Heart Association  
 Bon Secours Care-A-Van  
 Churches  
 Communities of Faith  
 Community Health Fairs  
 Diabetes Prevention Program  
 Farmer's Markets  
 Fitness Centers/Gyms  
 Franklin City Health Department, Med  
 Assistance Prog  
 Free Clinic  
 Health System  
 Healthy Suffolk  
 Horizon Health Services, Inc.  
 Hospitals  
 Main Street Clinic  
 Obici Healthcare Foundation  
 Parks and Recreation  
 Rx Partnership  
 Sentara Obici Hospital  
 Southeastern Virginia Health System  
 Suffolk Parks and Recreation  
 Vidant Health System  
 Virginia Department of Health  
 Western Tidewater Free Clinic  
 Western Tidewater Health District

YMCA

**HIV/AIDS**

Free Clinic  
Health Department  
LGBT Life Center  
Obici Healthcare Foundation

**Immunization & Infectious Diseases**

Medicaid  
Western Tidewater Free Clinic

**Infant & Child Health**

Area Civic Groups  
Charitable Groups  
Children's Center  
Early Intervention Services  
Virginia Family Access to Medical Insurance Security (FAMIS)  
Health Department  
Medicaid  
Obici Healthcare Foundation  
Sentara Obici Hospital  
Smart Beginnings Western Tidewater  
SNAP  
Suffolk Early Childhood Development Commission  
United Way  
Western Tidewater Community Services Board  
Western Tidewater Free Clinic  
YMCA

**Injury & Violence**

Community Service Board  
ForKids, Inc.  
Genieve Shelter  
Law Enforcement  
Obici Healthcare Foundation  
Police  
Virginia Department of Health

**Kidney Disease**

ARHS- Inter-County Public Transportation Authority Transportation Services  
Bon Secours Health System  
GITS Transportation Service

National Kidney Foundation  
Sentara Obici Hospital  
Southeastern Virginia Health System  
Western Tidewater Free Clinic

**Mental Health**

Alzheimer's Association  
Community Service Board  
Doctor's Offices  
EAP at Work  
Eastern State  
ForKids, Inc.  
Franklin Methadone Clinic  
Free Clinic  
Health Care Collaborative  
Healthcare Plans  
Home Healthcare  
Lassiter and Associates  
Main Street Clinic  
Medical Services for the Poor and Children  
Medications  
Senior Services of Southeastern Virginia  
Sentara Obici Hospital  
Southampton Memorial Hospital  
The Up Center  
Therapeutic Interventions  
Trillium Health Resources  
Virginia Department of Health  
Western Tidewater Community Services Board  
Western Tidewater Free Clinic  
Western Tidewater Mental Health

**Nutrition, Physical Activity & Weight**

American Diabetes Association  
Community Sports Teams  
Cover 3 Foundation  
Doctor's Offices  
Family Dollar  
Farmer's Markets  
Fitness Centers/Gyms  
Food Banks  
Free Clinic  
Gates County School System  
Girls on the Run  
Health Department

Healthy Suffolk  
 Horizon Health Services, Inc.  
 Meals on Wheels  
 Nursing CAP, Inc.  
 Nutrition Services  
 Parks and Recreation  
 The Peninsula Institute for Community Health (PICH)  
 Planet Fitness  
 Public Health  
 SCCA  
 School System  
 Social Services  
 Southampton Health Services Diet Clinic  
 Suffolk Parks and Recreation  
 Suffolk Youth Athletic Association  
 Weight Watchers  
 Western Tidewater Free Clinic  
 YMCA

#### Oral Health

ACCESS Partnership  
 Aging and Adult Services Task Force  
 Catholic Charities  
 County Transit  
 Dentist's Offices  
 Free Clinic  
 Horizon Health Services, Inc.  
 Ivor Medical Center  
 Main Street Clinic  
 Mobile Dental Unit  
 Southeastern Virginia Health System  
 Virginia Oral Health Coalition  
 Western Tidewater Dental Voucher Program  
 Western Tidewater Free Clinic

#### Respiratory Diseases

Free Clinic  
 Health Department  
 Horizon Health Services, Inc.  
 Pharmacies  
 Rx Partnership  
 Smoking Cessation Programs  
 Western Tidewater Free Clinic

#### Sexually Transmitted Diseases

ADAP Program

Free Clinic  
 Gates County Health Department  
 Gateway Community Health Center  
 Health Department  
 STD/HIV Treatment  
 Suffolk Department of Health  
 Western Tidewater Free Clinic  
 Western Tidewater Health District

#### Substance Abuse

AA/NA  
 Albemarle Overdose Prevention Council  
 Alcohol and Drug Services Hotline  
 Community Child Protection Team  
 Community Service Board  
 Crater Health District Clinic  
 Doctor's Offices  
 Free Clinic  
 Health Department  
 Hospitals  
 Jails  
 Police  
 School System  
 Sentara Obici Hospital  
 System of Care Collaborative  
 The Up Center  
 Trillium Health Resources  
 Western Tidewater Community Services Board

#### Tobacco Use

Doctor's Offices  
 Free Clinic  
 Gates County School System  
 Health Department  
 Horizon Health Services, Inc.  
 Obici Healthcare Foundation  
 The Peninsula Institute for Community Health (PICH)  
 School System  
 Sentara Obici Hospital  
 Smoking Cessation Programs