



COMMUNITY HEALTH NEEDS ASSESSMENT

Sussex County is Our Specialty



JUNE 2022



TABLE OF CONTENTS

LETTER FROM CEO	4
MISSION	5
VISION	5
BEEBE HEALTHCARE: FY2022 KEY STATS AT-A-GLANCE	6
INTRODUCTION	7
IRS MANDATE	8
DATA GAPS	8
COMMUNITY AT-A-GLANCE	9
SUMMARY	13
THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS	14
BEEBE HEALTHCARE	15
EVALUATION OF 2019 CHNA IMPLEMENTATION STRATEGIES	18
ABOUT SOCIAL DETERMINANTS OF HEALTH (SDOH)	25
LESSONS FROM COVID-19	26
HEALTH NEEDS PRIORITIZATION PROCESS	33
BEEBE HEALTHCARE 2022 CHNA FOCUS	34
KEY COMMUNITY NEEDS	35
NEXT STEPS	57
CONSULTANTS	58
APPENDICES	59
A) GENERAL DESCRIPTION OF BEEBE HEALTHCARE	60
B) COMMUNITIES SERVED BY BEEBE HEALTHCARE	62
C) PROCESS OVERVIEW	63
D) EVALUATION OF PREVIOUS FY19 PLAN	64
E) COMMUNITY STAKEHOLDER INTERVIEW RESULTS	64
F) PUBLIC COMMENTARY RESULTS	66
G) COMMUNITY HEALTH DATA PROFILE (SECONDARY DATA)	68
H) COMMUNITY HEALTH SURVEY	72
I) FOCUS GROUPS	87
J) COMMUNITY RESOURCE INVENTORY	92
K) IMPLEMENTATION STRATEGY AND PLANNING	92
L) COMMITTEE MEMBERS	93

LETTER FROM CEO

Our Commitment to Your Good Health

With over a century of commitment to Sussex County, Beebe Healthcare is the healthcare provider of choice to the people and families of our community. Over the past 100 years, we have grown from a small community hospital to a progressive integrated healthcare system focused on bringing clinically sophisticated and innovative programs to our area to help people in our community lead and maintain healthy lifestyles.

We are pleased to present our 2022 Community Health Needs Assessment (CHNA). As a nonprofit health system, Beebe Healthcare conducts a community health needs assessment every three years to identify our county's evolving health priorities. This is accomplished by engaging our community members, leaders, and partners through surveys, interviews, and focus groups. These findings help Beebe Healthcare target solutions and specialize in what our communities need - by listening to those we serve and developing focused plans. We deeply believe in the importance of this work.

I would like to offer my gratitude to the residents, stakeholders, partners, and focus group participants throughout Sussex County for their valuable contributions and the time they offered to our CHNA process. We thank all our community partners for their dedicated collaboration to date and look forward to our next phase of implementation planning that will continue to include collective strategies for greatest impact.

We are committed to serving the needs of our growing community. We are proud that our Medical Staff continues to grow because of the excellent clinical programs and opportunities. A robust medical staff helps address a lack of access to care. Since our previous CHNA, Beebe has added well over 100 clinicians and this new assessment will facilitate adding more.

In June of 2022, Beebe announced its new 5-year strategic plan: One Beebe. This plan renews our commitment to providing the best care for our patients and our community. To ensure that we remain the best choice for area residents and visitors alike, we must strategically reaffirm our mission and vision; build on our momentum through focused action in pursuit of distinctive and essential goals; and strengthen our culture of empathy and excellence for all.



Beebe Healthcare is solely focused on the healthcare needs of the people who live, work, visit, and seek care in Sussex County. As the only health system headquartered in and focused solely on Sussex County, it is our unique position to truly understand the programs, technologies, and barrier breakers needed to provide excellent healthcare services to those we serve because Sussex County is Our Specialty.

Sincerely,

David A. Tam MD, MBA, CPHE, FACHE
President & CEO

MISSION

Beebe Healthcare's charitable mission is to encourage healthy living, prevent illness, and restore optimal health with the people residing, working, or visiting the communities we serve.

VISION

Our vision is that Beebe Healthcare will be the health system of choice for all people in Sussex County.



BEEBE HEALTHCARE: FY2022 KEY STATS AT-A-GLANCE



20,683
Emergency Room Visits



9,490
Total Discharges



350,908
Hospital Outpatient Encounters



38,473
COVID-19 Shots Administered



INTRODUCTION

Providing the best healthcare means understanding the needs of the community residents that Beebe Healthcare serves. It also means caring about their everyday lives and communicating and relying on the available services and programs to best meet their needs. Lastly, it means recognizing barriers to care and improving how residents can access, obtain, and use the healthcare resources that Beebe Healthcare offers.

The Patient Protection and Affordable Care Act (PPACA), which went into effect on March 23, 2010, requires tax-exempt hospitals to conduct a community health needs assessments and implementation strategy plan to improve the health and well-being of residents within the communities served by the hospitals. These strategies created by hospitals and institutions consist of programs, activities, and plans that are specifically targeted toward populations within the community. The execution of the implementation strategy plan is designed to increase and track the impact of each hospital's efforts.

Health care providers in Sussex County are committed to understanding, assessing, and addressing the health care needs of their communities. In order to maintain the alignment of Beebe Healthcare with the health needs of the community, a CHNA was once again initiated. In January 2022, Beebe Healthcare formed an internal working group and a larger Steering Committee to help identify the needs of those living in Sussex County. With a mutual interest in the health and well-being of residents in the region served by Beebe Healthcare, a comprehensive CHNA was conducted to evaluate and understand the region's health needs. This study, conducted by Tripp Umbach, identifies specific community health needs and evaluates how those needs are being met to better connect health and human services with the needs of residents within the region.

The community health needs assessment represented a comprehensive community-wide process where Beebe Healthcare connected with a wide range of public and private organizations, such as health-related professionals, local government officials, and human service organizations, to evaluate the community's health and social needs. Tripp Umbach's independent review of existing data, in-depth interviews with local stakeholders, and detailed findings from a community health survey resulted in the identification and confirmation of key community health needs served by Beebe Healthcare. The following community health needs will be further addressed in an implementation strategy phase that will further explore ways Beebe Healthcare can assist in meeting the needs of the communities they serve. The identified needs below are in no particular order.

This report documents how Beebe Healthcare's CHNA was conducted and describes the related findings.



Beebe Hospital welcomes questions and comments on its CHNA.

Please contact Beebe Healthcare's Population Health Department at **302-645-3337**.

The CHNA report can be accessed online by clicking [here](#).

IRS MANDATE

The CHNA report is a complete review of primary and secondary data analyzing demographic, health, and socioeconomic data at the local, state, and national levels. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA), requiring that nonprofit hospitals conduct CHNAs every three years. Beebe Healthcare's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements.

DATA GAPS

The most current and up-to-date data was used to determine the community needs of Beebe Healthcare's community. Beebe Healthcare acknowledges that not all aspects of health can be measured, nor can it adequately represent all populations. For example, certain population groups (such as residents who are institutionalized, etc.) are not represented in the survey data. Beebe Healthcare attempted to collect data from residents whose primary language is not English; however, the analysis of specific populations in the community survey might not be represented due to insufficient numbers for analyses. While data was extensive, data gaps may exist.

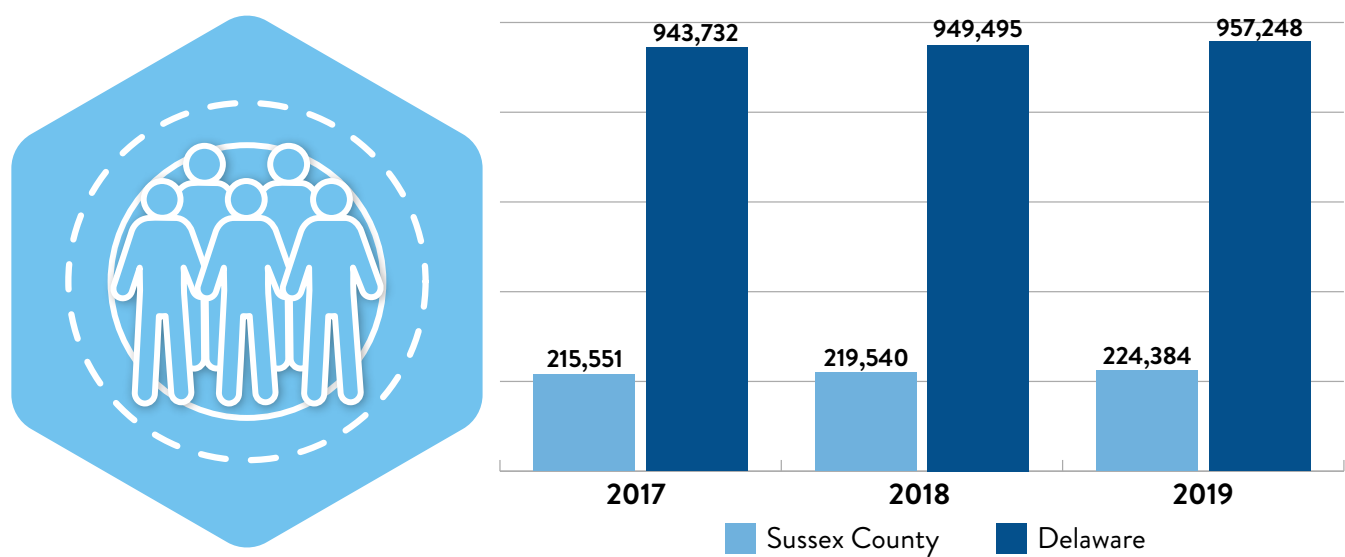
Overall, the assessment was designed to provide a comprehensive and broad picture of the health of the overall community. It must be recognized that information gaps can limit the ability to assess all of the community's health needs.



COMMUNITY AT-A-GLANCE

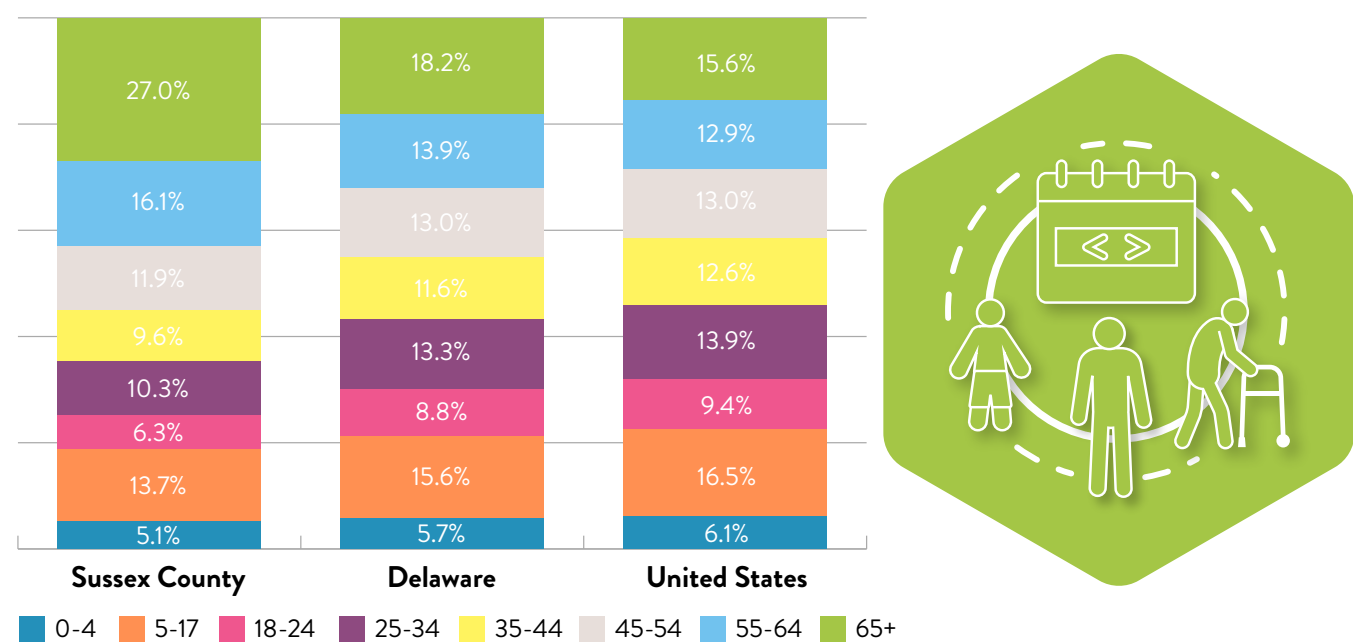
Beebe Healthcare’s community is defined as southern Delaware. Besides its primary location in Lewes, Beebe Healthcare operates outpatient facilities in Rehoboth Beach, Milton, Georgetown, Long Neck, Millsboro, and Millville. The health care institution’s primary service area are ZIP codes in Sussex County. With a 106-year presence in the same neighborhood, Beebe Healthcare has long served its mission and vision and will continue to provide high-quality patient services to its community.

Figure 1: Total Population (Estimate 2017-2019)



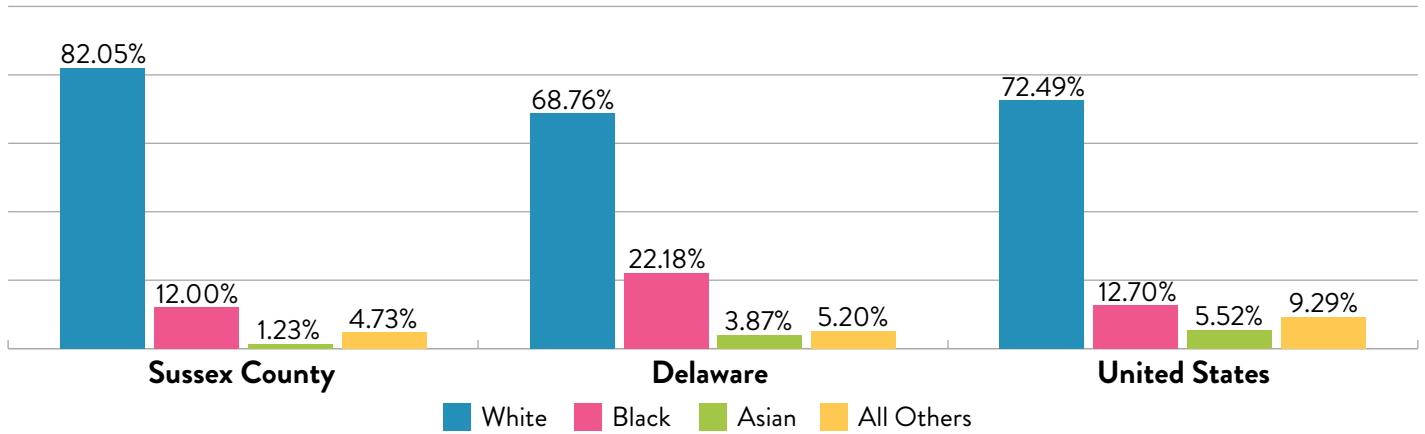
Source: U.S. Census Bureau

Figure 2: Age Distribution (five-year estimate 2015-2019)



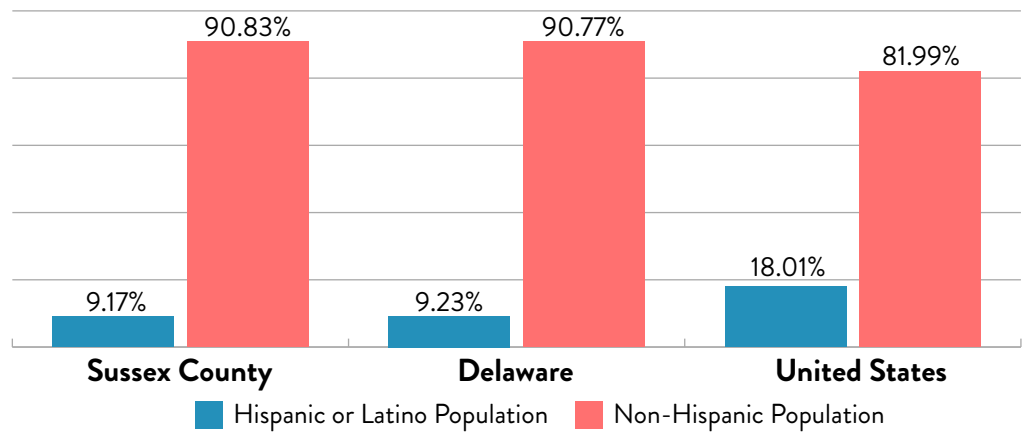
Source: U.S. Census Bureau

Figure 3: Total Population by Race Alone (Estimate)



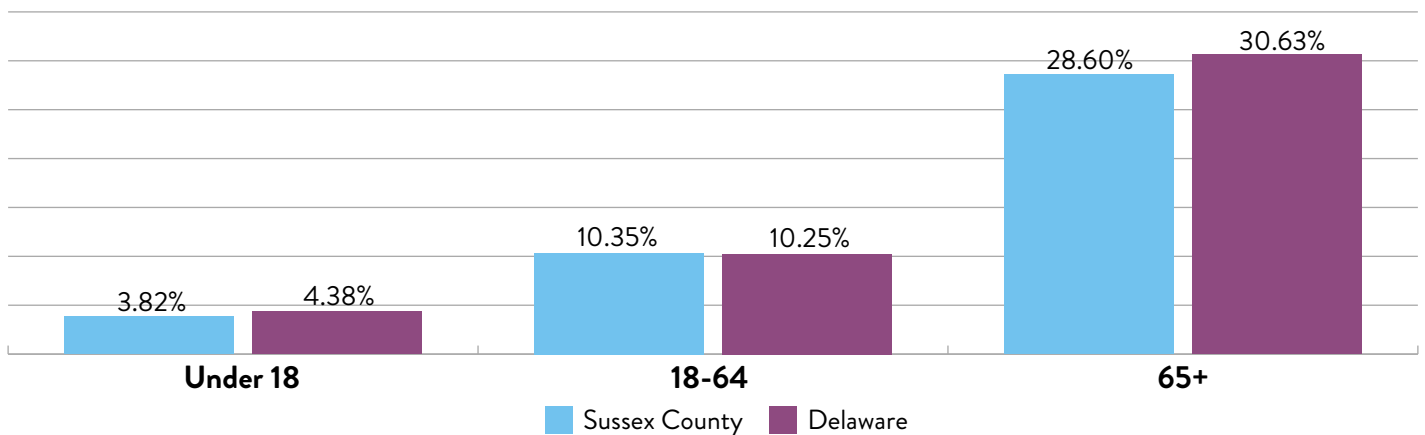
Source: U.S. Census Bureau 2015-2019

Figure 4: Total Population by Ethnicity Alone (Estimate)



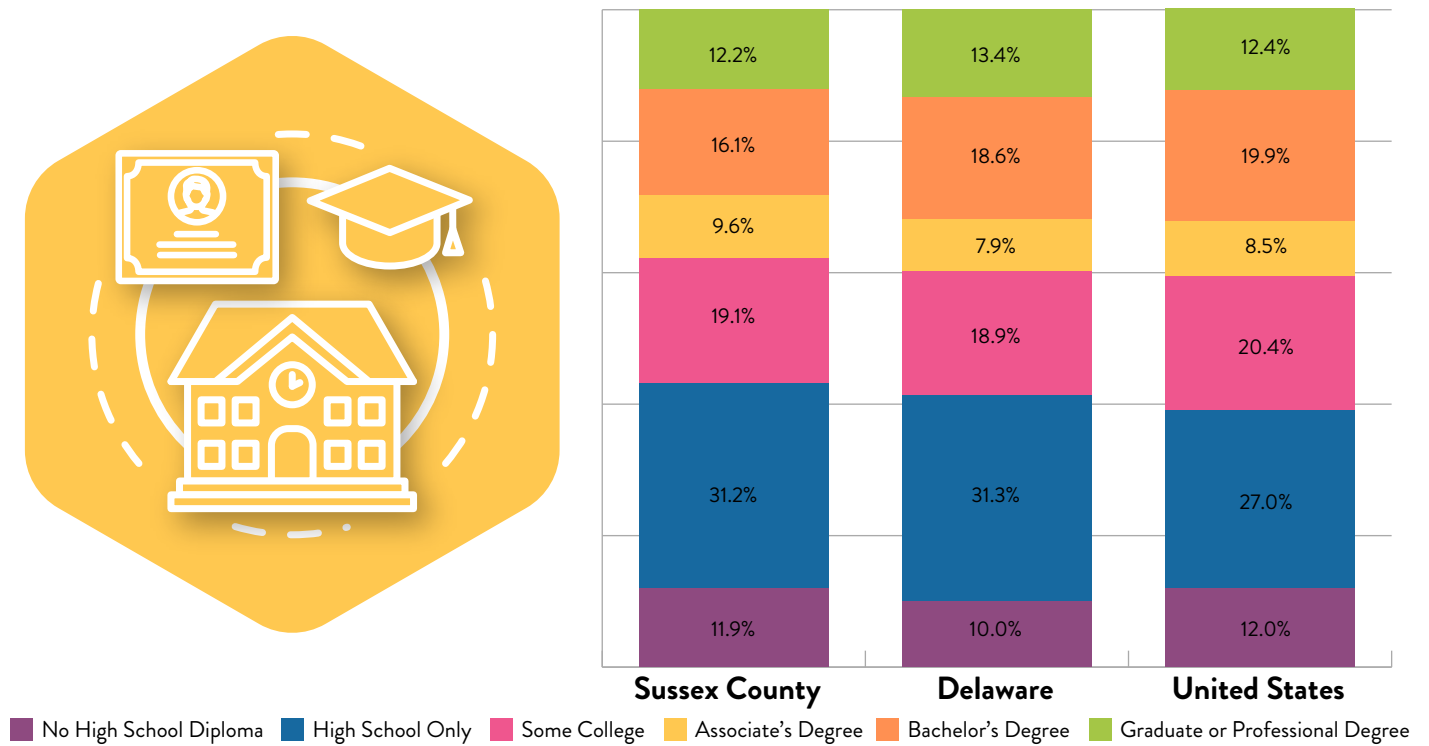
Source: U.S. Census Bureau 2015-2019

Figure 5: Population with Any Disability by Age



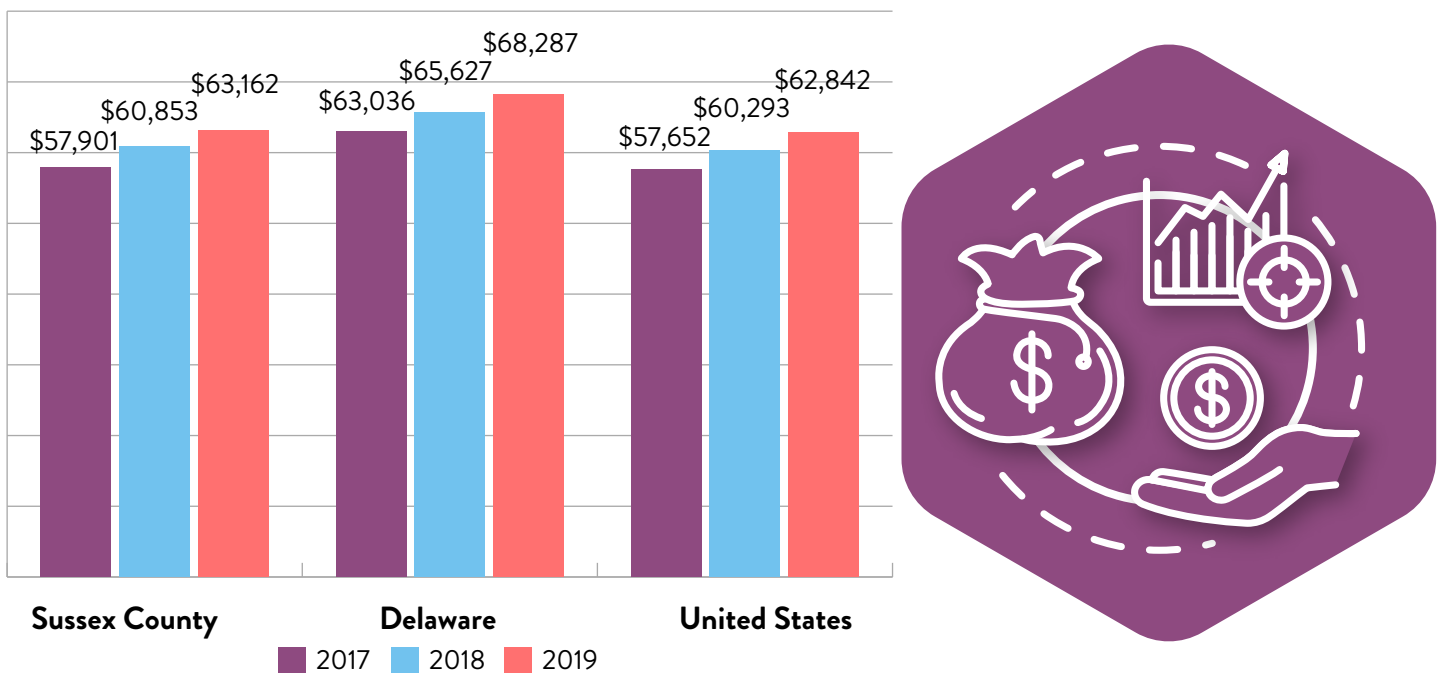
Source: U.S. Census Bureau 2015-2019

Figure 6: Education Level



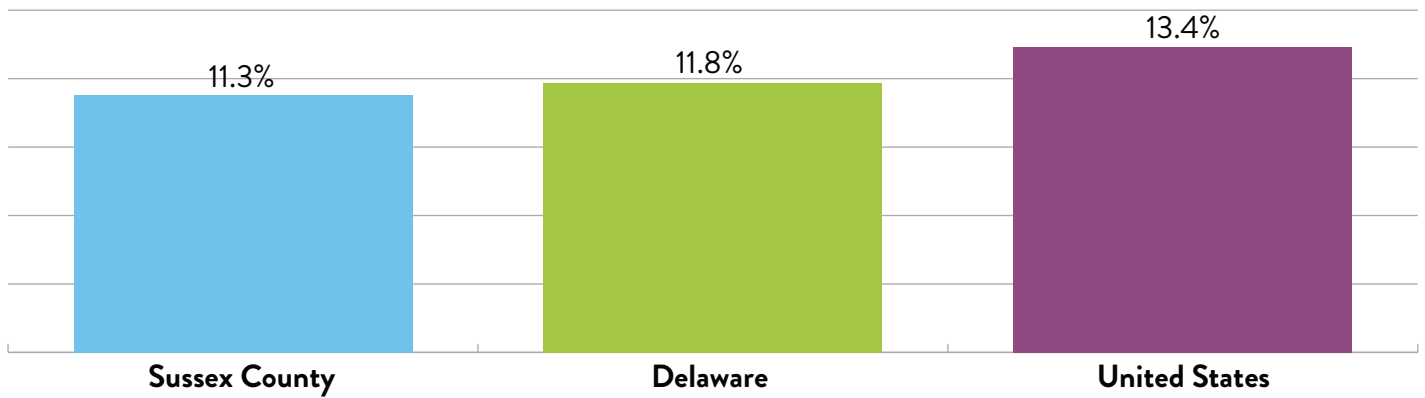
Source: U.S. Census Bureau 2015-2019

Figure 7: Median Household Income



Source: U.S. Census Bureau 2015-2019

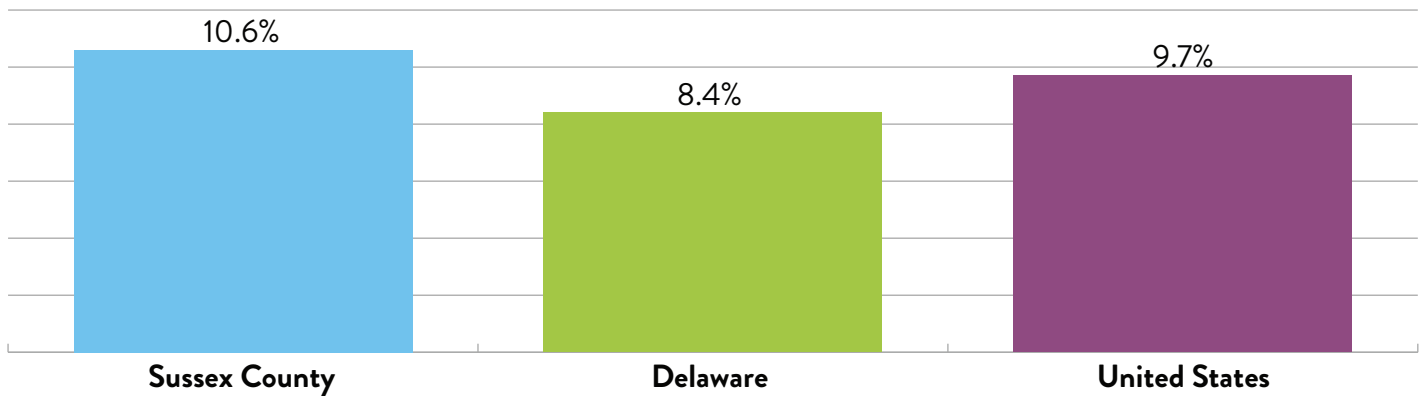
Figure 8: Population Below 100% Federal Poverty Level



Note: The 2021 [Annual Poverty Guidelines](#) states that a family of four has a household income of \$26,500.

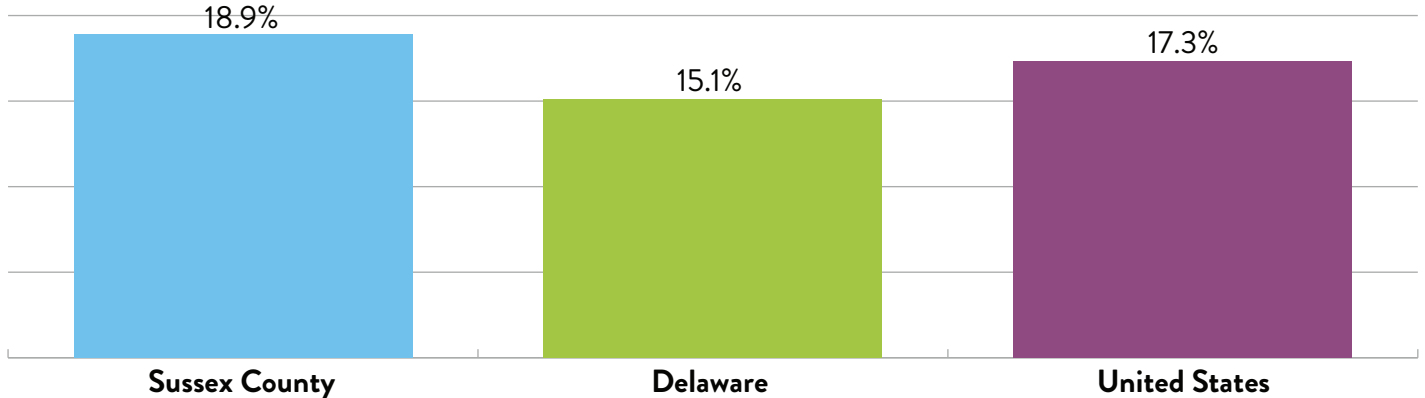
Source: U.S. Census Bureau 2015-2019

Figure 9: Household with No Computer



Source: U.S. Census Bureau 2014-2019

Figure 10: Households with No or Slow Internet



Source: U.S. Census Bureau 2014-2019



SUMMARY

Sussex County is growing. The population estimates indicate steady county growth between the years 2017 – 2019. Based on five-year estimates, Sussex County has a large elderly population. The differences include a greater percentage of persons 65 years and older living in Sussex County when compared to the state and the nation. In addition, overall, there is a greater percentage of individuals aged 55 -64 living in Sussex County when compared to the state and the nation.

There are no significant racial/ethnic differences in population when comparing Sussex County to the state as a whole. Specifically, the proportions of Black and Asian residents are lower in the county when compared to the state. Non-Hispanic persons and Hispanic persons living in Sussex County are relatively the same in the state. The education level of residents who have a bachelor's degree or Graduate/Professional Degree is lower when compared to the state. Additionally, the median household income level of Sussex County residents in 2019 is lower than state; however, higher when compared to the U.S.

Residents in Sussex County are more likely not to have a computer when compared to the state and the nation. There are also higher rates of residents in Sussex County who use dial-up as their only way of internet connection or have internet access but don't pay for the service or have no internet access in their home.

THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

Overview

The CHNA process began in January 2022 with the collection of quantitative and qualitative data. A significant number of community leaders representing government, educators, health care professionals, and health and human services leaders in Beebe Healthcare’s service area participated in the study. Data collected from a variety of sources were included as part of the assessment. County demographics, health outcomes, and chronic disease prevalence were gathered from local, state, and federal databases and were part of a robust secondary data compilation.

Information related to high-risk behaviors, societal issues, and barriers were key themes that resonated within the collection process. Information from focus groups with vulnerable populations was also included in the collection phase.

Tripp Umbach directed and managed a comprehensive community health needs assessment for Beebe Healthcare, resulting in the identification and prioritization of community health needs at the regional level.

CHNA Roadmap

The CHNA roadmap below was designed to engage the community, from community residents to health, social, and business leaders, community-based organizations, policymakers, and educators to identify health care needs and recommend solutions to address the identified health and social issues.

Secondary and quantitative data sources were gathered to create a snapshot of the current health status of the region.

Primary data in the form of an online community survey was made available in English, Spanish, and Haitian Creole to gain participation from community residents. Beebe Healthcare collected community surveys at health affairs and promoted the community survey through social media efforts and internal email communications. Community stakeholder interviews were implored to collect information from leaders who have a deep understanding of the region’s health and social factors impacting residents’ health and well-being. The data also provided a deeper understanding of community matters and community needs.

Figure 11: CHNA Roadmap for Beebe Healthcare



BEEBE HEALTHCARE

Who Are We?

Beebe Healthcare, founded in 1916, is a not-for-profit community health system with services offered throughout Sussex County, Delaware. Beebe has become the premier healthcare facility in the County, serving thriving coastal towns, vacation resort areas, the desired retirement destination as well as farming and rural communities. Beebe provides comprehensive inpatient, outpatient, and emergency services. The current structure includes the Margaret H. Rollins Lewes Campus and its 210-bed medical center, the Rehoboth Health Campus, South Coastal Health Campus, as well as primary and specialty care practices throughout southern Delaware.

Outpatient services include Home Care, an Outpatient Surgical Center, Diagnostic Imaging, Physical Rehabilitation, four Walk-In Care Centers, and three High School-Based – Wellness Centers. In addition, the Margaret H. Rollins School of Nursing at Beebe Healthcare is the only hospital-based nursing school in Delaware.

Over the last five years, Beebe Healthcare has continued to expand and improve access to health care in Sussex County with its South Coastal Health Campus near Millville which includes a free-standing Emergency Department and Cancer Center. In addition, the expansion includes a brand-new Specialty Surgical Hospital on the Rehoboth Campus as well as an extension of its Center for Heart and Vascular Services at the Lewes Campus. Beebe was also the first hospital in the state to launch a Hospital at Home Program which allows qualifying patients to be treated for their medical condition in the comfort of their own home as a substitute for traditional inpatient, in-the-hospital care.

The mission of Beebe Healthcare is rooted in three actions: encouraging healthy living, preventing illness, and restoring optimal health within our community. To optimize the health of people in our community, Beebe Healthcare supports the provision of the community health needs assessment so that Beebe Healthcare may identify the community needs and adapt services to create a healthier community and bring services to where people live and work. The health care, education, and services provided today are key to the healthy communities of tomorrow.





How Do We Rate?

Beebe Healthcare’s mission is to encourage healthy living, prevent illnesses, and restore health. Community stakeholders considerably agree that the care, services, and outreach efforts aimed at improving the overall health of community residents are reflected in their undertaking.

Table 12: Community Stakeholder Responses

Community Stakeholders	
Beebe Hospital Offers High Quality Care	94.7% Strongly Agree/Agree
Beebe Healthcare Addresses the Needs of Diverse & Disparate Populations	84.2% Strongly Agree/Agree
Beebe Healthcare Ensures Access to Care Regardless of Race, Gender, Education, and Economics.	88.9% Strongly Agree/Agree
Beebe Healthcare is Actively Working to Identify and Address Health Inequities that Impact its Patients.	94.8% Strongly Agree/Agree

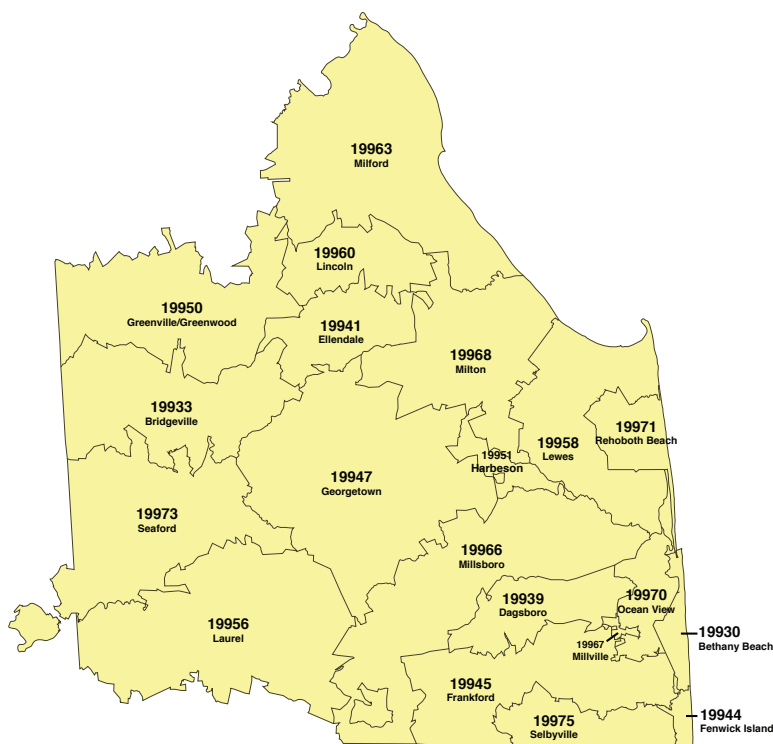
Communities Served by Beebe Healthcare

The primary service area for Beebe Healthcare was defined by ZIP codes that contain a majority of inpatient discharges. Beebe Hospital is the single largest provider of acute care services, the use of hospital services provides the clearest definition of the community. Beebe Healthcare's primary service area (PSA) includes 20 ZIP codes located within Sussex County.

Table 13: Primary Service Area ZIP Codes

ZIP Code	Population	City
19930	3,584	Bethany Beach
19933	10,332	Bridgeville
19939	7,500	Dagsboro
19941	3,032	Ellendale
19944	779	Fenwick Island
19945	8,465	Frankford
19947	21,436	Georgetown
19950	7,815	Greenville/Greenwood
19951	1,682	Harbeson
19956	16,801	Laurel
19958	24,834	Lewes
19960	7,674	Lincoln
19963	21,090	Milford
19966	32,035	Millsboro
19967	1,988	Millville
19968	13,683	Milton
19970	7,930	Ocean View
19971	16,508	Rehoboth Beach
19973	26,509	Seaford
19975	10,281	Selbyville

Map 14: Study Area





EVALUATION OF 2019 CHNA IMPLEMENTATION STRATEGIES

Representatives from Beebe Healthcare have worked over the last three years to develop and implement strategies to address the health needs and issues in the study area and evaluate the effectiveness of the strategies created in terms of meeting goals and combating health problems in the community.

The purpose of the evaluation process is to determine the effectiveness of the 2019 strategies, including each of the identified priorities: Behavioral Health and Mental Health; Cancer/Prevention & Screening; and Obesity/Nutrition/Chronic Disease. The working group tackled the goals from each past priority and strategy and developed ways to address its effectiveness. The self-assessments on each of the strategies are internal markers to denote how to improve and track each of the strategies and action steps for the next three years.

The following tables reflect highlights and accomplishments from Beebe Healthcare.

HEALTH PRIORITY:













BEHAVIORAL HEALTH AND MENTAL HEALTH



GOAL(S):

1. Identify patients more quickly by implementing expanded screening methods in the inpatient, outpatient, and emergency department environments.
2. Intervene in the patient stage and refer them to quality, targeted services available in the community that are equipped and focused on supporting their specific substance use disorder treatment needs and mental health needs.
3. Ensure alignment of clinical providers prescribing behaviors as well as state and federal regulations surrounding pain medication management.
4. Evaluate compliance, current interventions, and alignment with the Behavioral Health Consortium's three-year action plan and the Delaware State Health Improvement Plan.
5. Assess and address educational deficits.

Table 15: Behavioral Health and Mental Health

OBJECTIVES	STRATEGIES	2019	2020	2021
Improve behavioral and mental health by ensuring access to appropriate, quality behavioral and mental health services.	Screened for behavioral, mental, and emotional health indicators in both inpatient and outpatient settings.			
	Connected clients/patients to effective community resources aimed at providing mental health care and substance abuse treatment programs and/or facilities.			
Increase education and awareness in the community at large about mental and behavioral health needs, as well as substance abuse prevention, addiction and recovery, addressing existing stigma.	Supported education of area providers regarding current evidence-based opioid prescribing standards.			
Establish more partnerships with local community organizations to augment connections to resources.				

HEALTH PRIORITY:

CANCER, PREVENTION, AND SCREENING



GOAL(S):

1. Improve early detection through early detection cancer screening, risk reduction education, and navigation services
2. Expand reach on awareness, screenings, and education
3. Expand whole person care through the cancer journey
4. Expand Survivorship Programs

Table 16: Cancer, Prevention, and Screening

OBJECTIVES	STRATEGIES	2019	2020	2021
Improve early detection through early detection cancer screening, risk reduction education, and navigation services	<p>Provided outreach education and presentations to various community venues including churches, civic associations, schools, community health fairs, and events.</p> <p>Timeliness of care for patients with LDCT positive findings.</p>			
Expand reach on awareness, screenings, and education	Nurse Navigator continued to provide resources for screenings and connect clients to specialists and education when necessary.			
Expand whole person care through the cancer journey				
Expand Survivorship Programs				

Note: * Due to the impact and priorities of COVID-19, there is a paucity of state data and benchmarks available.

HEALTH PRIORITY:










OBESITY, NUTRITION, AND CHRONIC DISEASE



GOAL(S):

1. Increase the percentage of Sussex County residents reporting targeted health behaviors including healthy eating and an active lifestyle.
2. Increase the percentage of Sussex County residents with a healthy weight range.
3. Increase education and awareness around targeted health behaviors that positively impact the resident's lifestyle choices, improving their overall health and weight.

Table 17: Obesity, Nutrition, and Chronic Disease

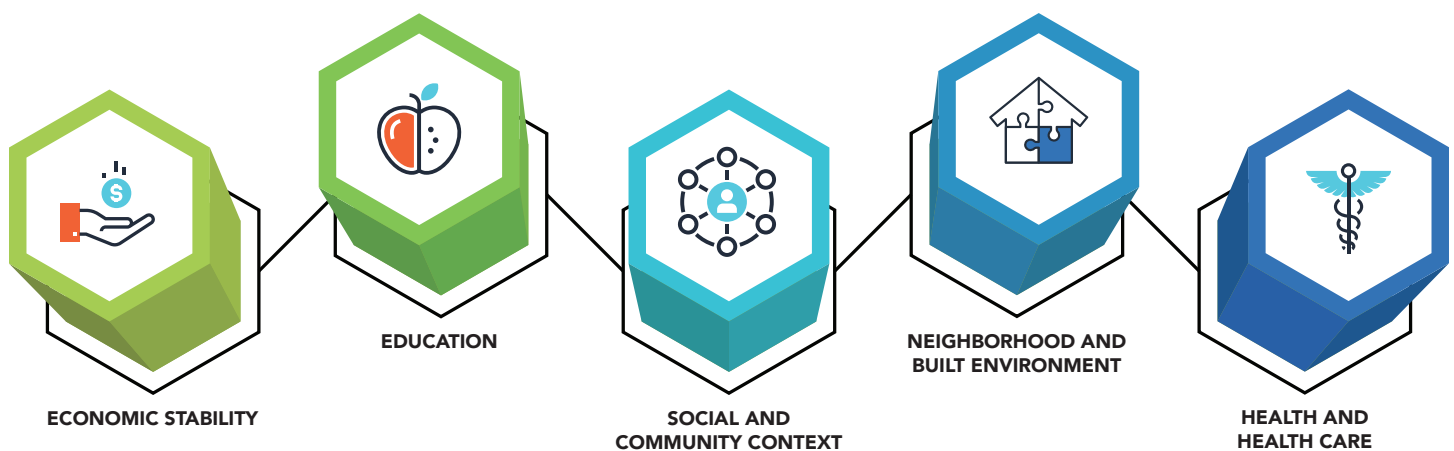
OBJECTIVES	STRATEGIES	2019	2020	2021
Increase the percentage of Sussex County residents reporting targeted health behaviors including healthy eating, and an active lifestyle.	<p>Refined, build, and expanded Beebe programs that target individuals who are living with chronic health conditions or are overweight/obese.</p> <p>Leveraged community partnerships for more efficient and effective implementation of programs, improving reach and outcomes.</p>			
Increase the percentage of Sussex County residents with a healthy weight range.				
Increase education and awareness around targeted health behaviors that positively impact the resident's lifestyle choices, improving their overall health and weight.	Integrated education and skills approach to address specific screening results and connect them to resources that implement and support patient-centered lifestyle changes.			

Note: * Due to the impact and priorities of COVID-19, there is a paucity of state data and benchmarks available.

ABOUT SOCIAL DETERMINANTS OF HEALTH (SDOH)

Social Determinants of Health are defined by the [World Health Organization](#) as “the conditions in which people are born, grow, live, work and age” and that “these circumstances are shaped by the distribution of money, power and resources at global, national and local levels.” These economic and social conditions under which people and groups live may increase or decrease the risk for a health condition or disease among individuals and populations. Addressing SDOH is paramount to creating a healthy community.

There are various domains that categorize SDOH; however, Figure 15 displays five domains as categorized by [Healthy People](#). SDOH domains are also contributors to health disparities and inequities across the nation. There is a wealth of data that links these determinants and domains to health status, such as the correlation of one’s ZIP code resulting in drastically different health statuses for patients with similar health conditions. For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing. They also are less likely to have access to sidewalks, parks or playgrounds, recreation centers, or a library, according to [Kaiser Family Foundation](#). The literature stresses the need for multi-sector organizations to collaborate in efforts to address these determinants and make positive impacts to overall patient health. Furthermore, targeting specific populations with specialized interventions is imperative to providing equitable healthcare.



Source: [Healthy People 2030](#)

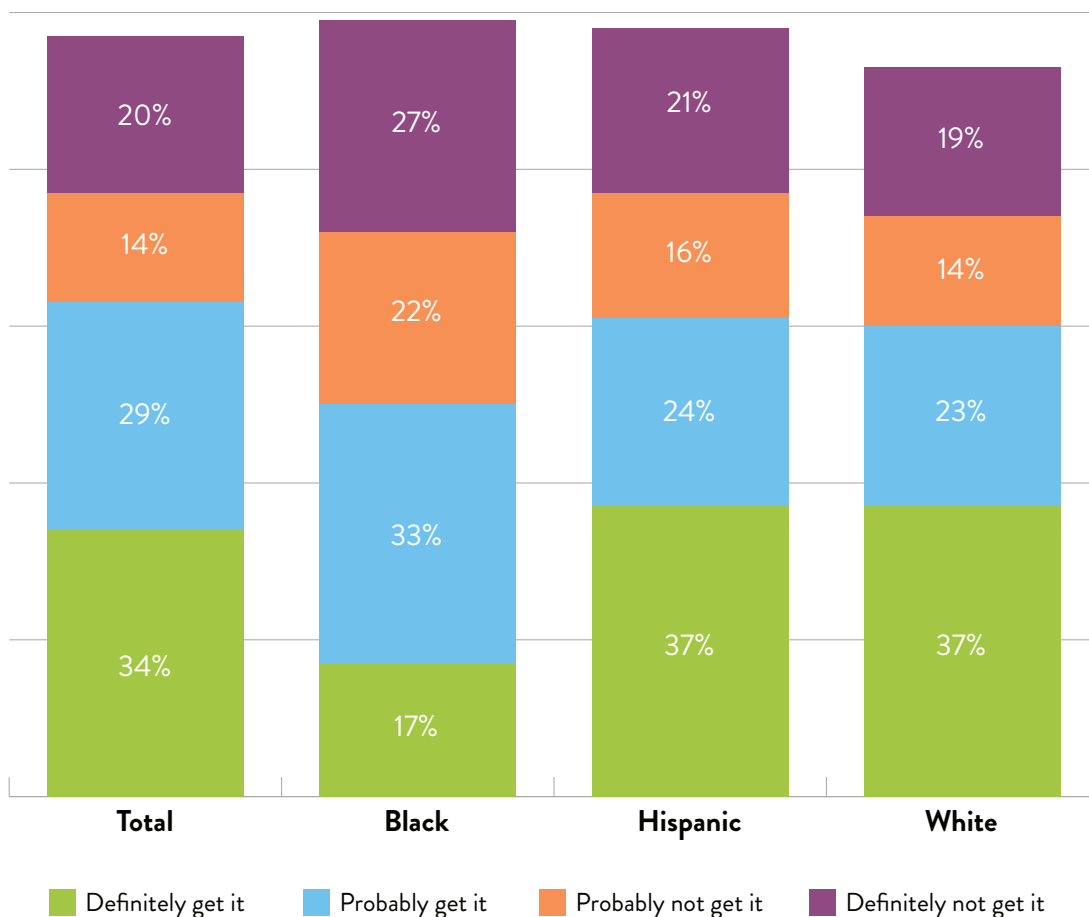
LESSONS FROM COVID-19

COVID-19 is a health, social, and economic crisis. The effects of the pandemic are far-reaching, from the death of millions of people worldwide to challenges in public health, education, and work. Additional areas that COVID-19 highlighted were the social and racial injustices and inequities in the health care arena. The pandemic highlighted health inequities as the illness affected many racial and ethnic minority groups unequally, putting them more at risk of getting sick and dying from COVID-19. According to the Centers for Diseases Control and Prevention ([CDC](#)), negative encounters are common to racial and ethnic minority groups and some social determinants of health have historically prevented them from having fair opportunities for economic, physical, and emotional health.

Figure 18 illustrates Black adults are less likely to get a COVID-19 vaccine if it was free and determined safe by scientists. Half of Black adults say if a COVID-19 vaccine was determined to be safe by scientists and available for free to everyone who wanted it, they would “definitely” or “probably” get vaccinated, compared to six in 10 Hispanic adults and 65% of White adults. Just 17% of Black adults say they would “definitely” get the vaccine, 20 percentage points lower than the share of both Hispanic and White adults (37% each).

Figure 18: Getting COVID-19 Vaccine Even If It Was Free and Determined Safe

If a COVID-19 vaccine was determined to be safe by scientists and available for free to everyone who wanted it, would you...?

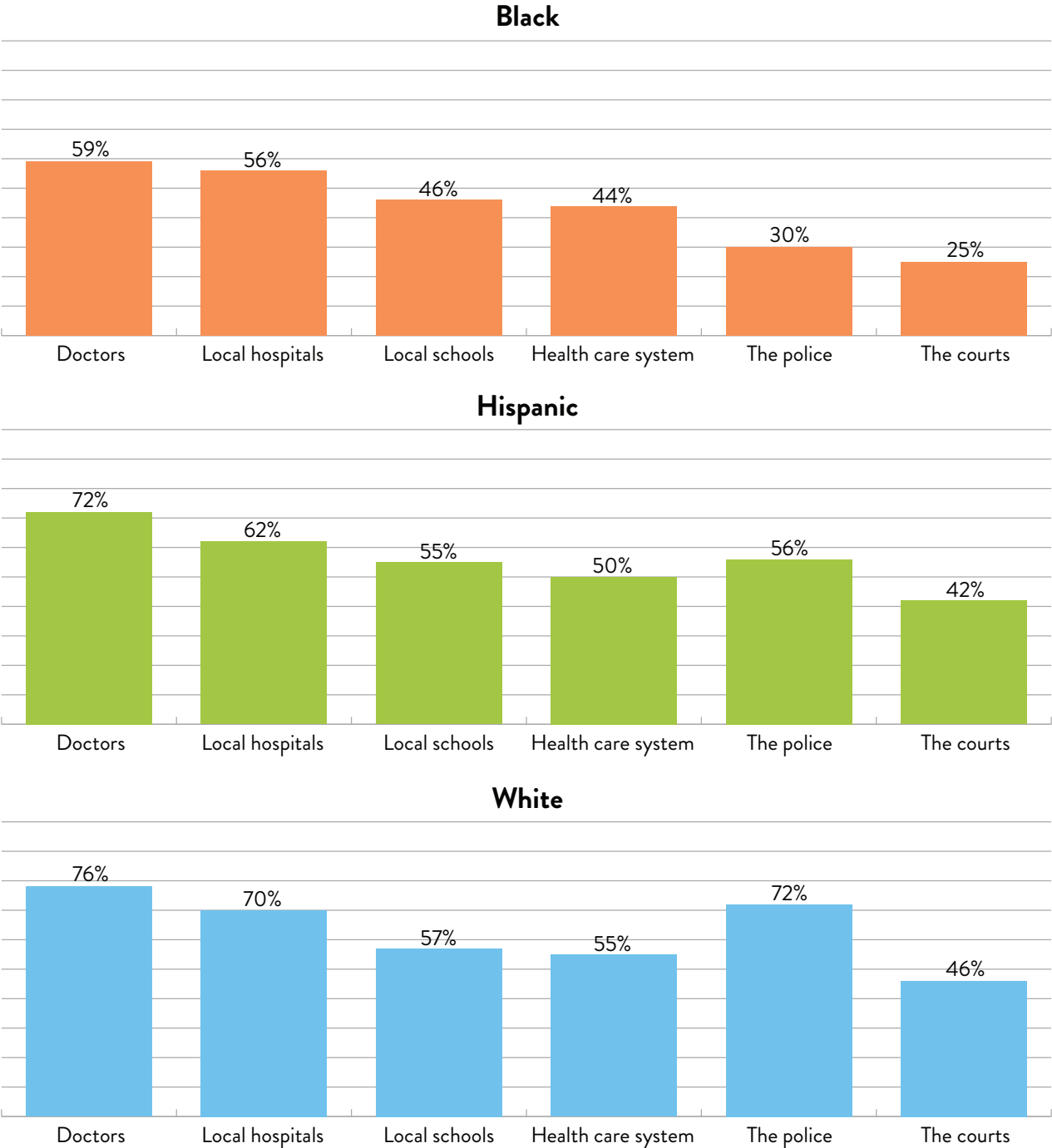


Source: [Kaiser Family Foundation; The Undeclared Survey on Race and Health 2020](#)

Black people express lower levels of trust in a variety of organizations and institutions compared to those who are White. The gulf is widest when asked how often they can trust the police to do what is right for them and their community – just 30% of Black adults say they can trust the police “almost all of the time” or “most of the time,” compared with 72% of White adults. A little over half of Hispanic adults (56%) say they can trust the police.

Compared to White adults, Black adults are 19 percentage points less likely to trust doctors (59% vs. 78%), 14 percentage points less likely to trust local hospitals (56% vs. 70%), and 11 percentage points less likely to trust “the health care system” (44% vs. 55%) to do what is right for them and their communities.

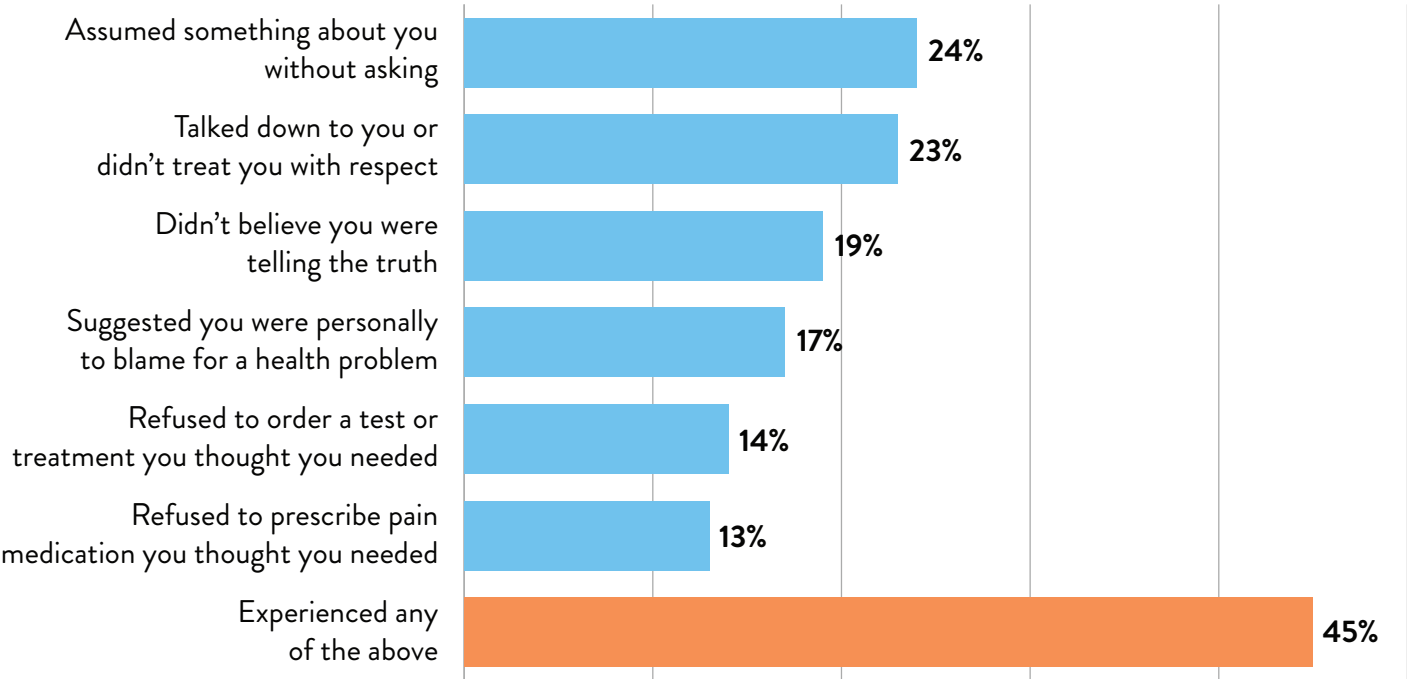
Figure 19: Percent who say they can trust each of the following to do what is right for them or their community almost all of the time or most of the time:



Source: [Kaiser Family Foundation; The Undeclared Survey on Race and Health 2020](#)

Across racial and ethnic groups, many adults report having some specific negative experiences with health care providers. Overall, about a quarter of adults say that in the past 3 years, a doctor or other health care provider has assumed something about them without asking (24%) or talked down to them, or treated them without respect (23%). Just under one in five say there was a time in the past 3 years when a provider didn't believe they were telling the truth (19%) or suggested they were personally to blame for a health problem (17%). About one in seven say a doctor refused to order a test or treatment (14%) or pain medication (13%) they thought they needed.

Figure 20: In the last 3 years, have you ever felt that a doctor or health care provider...? (Percent saying “yes”)

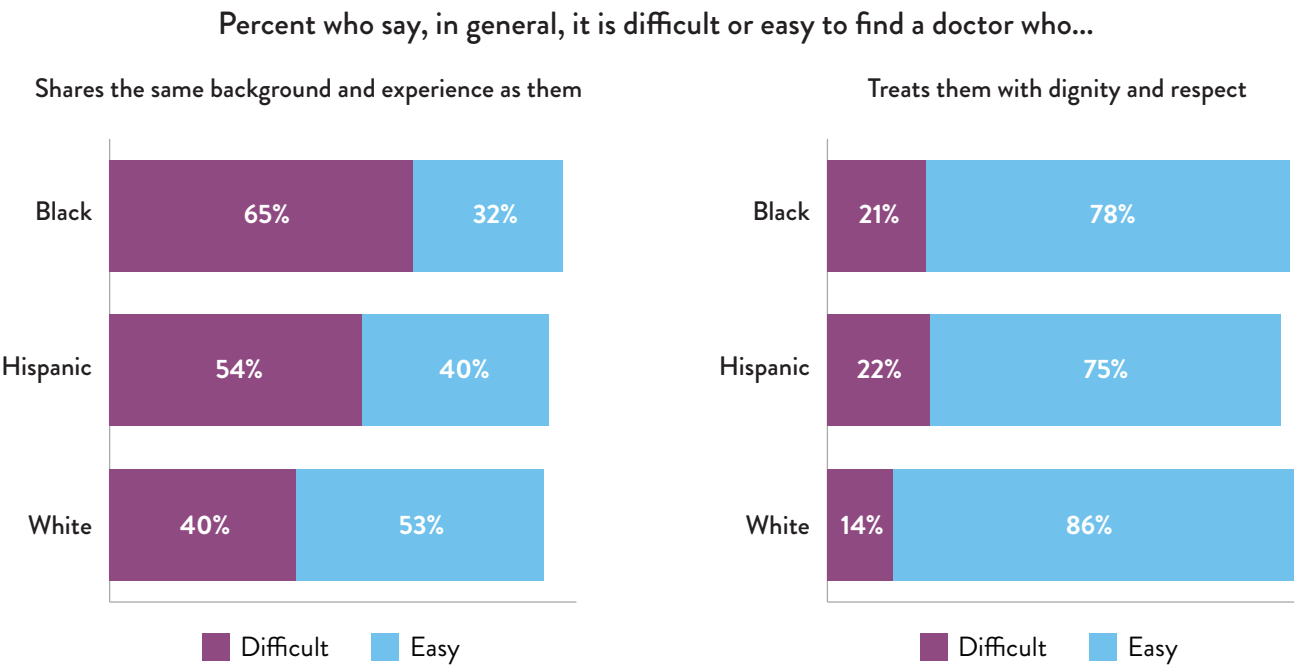


Source: [Kaiser Family Foundation; The Undeclared Survey on Race and Health 2020](#)



Black and Hispanic adults are more likely than their white counterparts to say it is difficult to find a doctor who shares their background and experiences and one who treats them with dignity and respect. About two-thirds (65%) of Black adults and over half (54%) of Hispanic adults say it is very or somewhat difficult for them to find a doctor who shares their background and experiences, while most White adults (53%) say this is easy. Similarly, about one in five adults who are Black (21%) or Hispanic (22%) say it is difficult to find a doctor who treats them with dignity and respect, compared to a smaller share of those who are White (14%).

Figure 21: Difficulty Finding Doctors Who Share Their Background and Treat Them with Respect



Source: [Kaiser Family Foundation; The Undeclared Survey on Race and Health 2020](#)

Data presented from the CDC related to the impact of the disease quantifies the severity of the pandemic on the health care system and society. The estimates can direct and allocate health care resources; assist in planning for prevention and control measures, including vaccination; predict the future burden of COVID-19; and evaluate the potential impact of interventions.

Figure 22: Estimated COVID-19 Infections, Symptomatic Illnesses, Hospitalizations, and Deaths in the U.S.

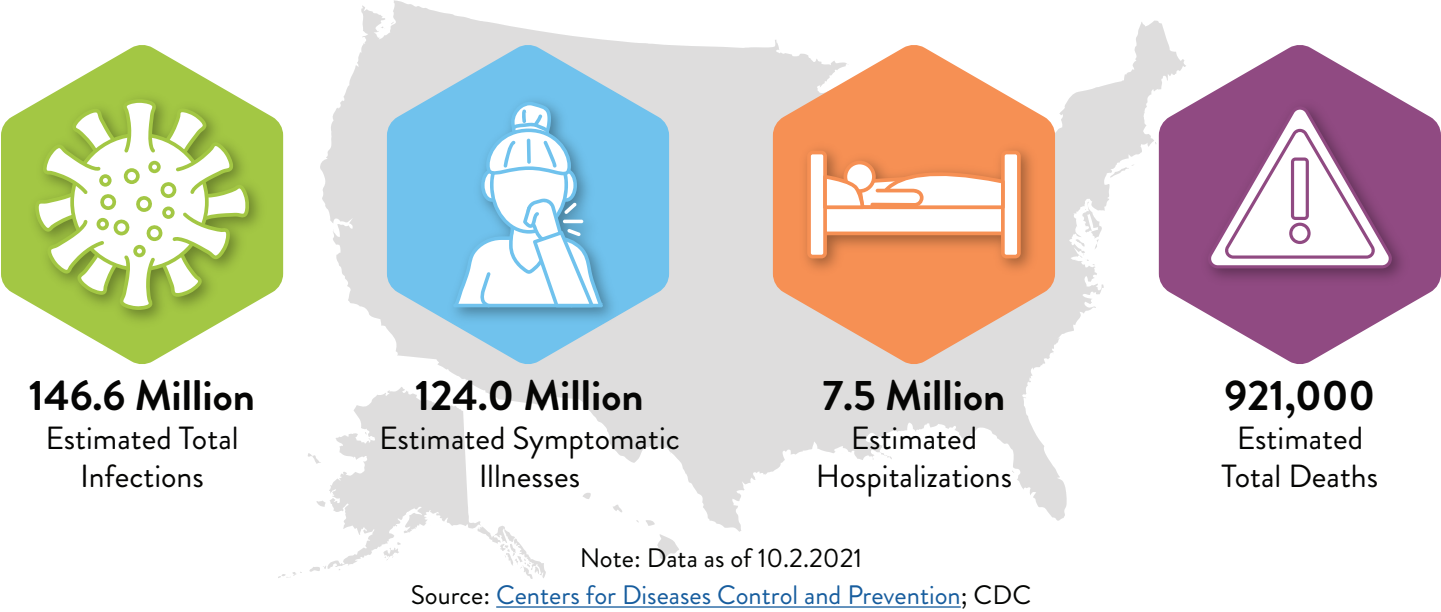
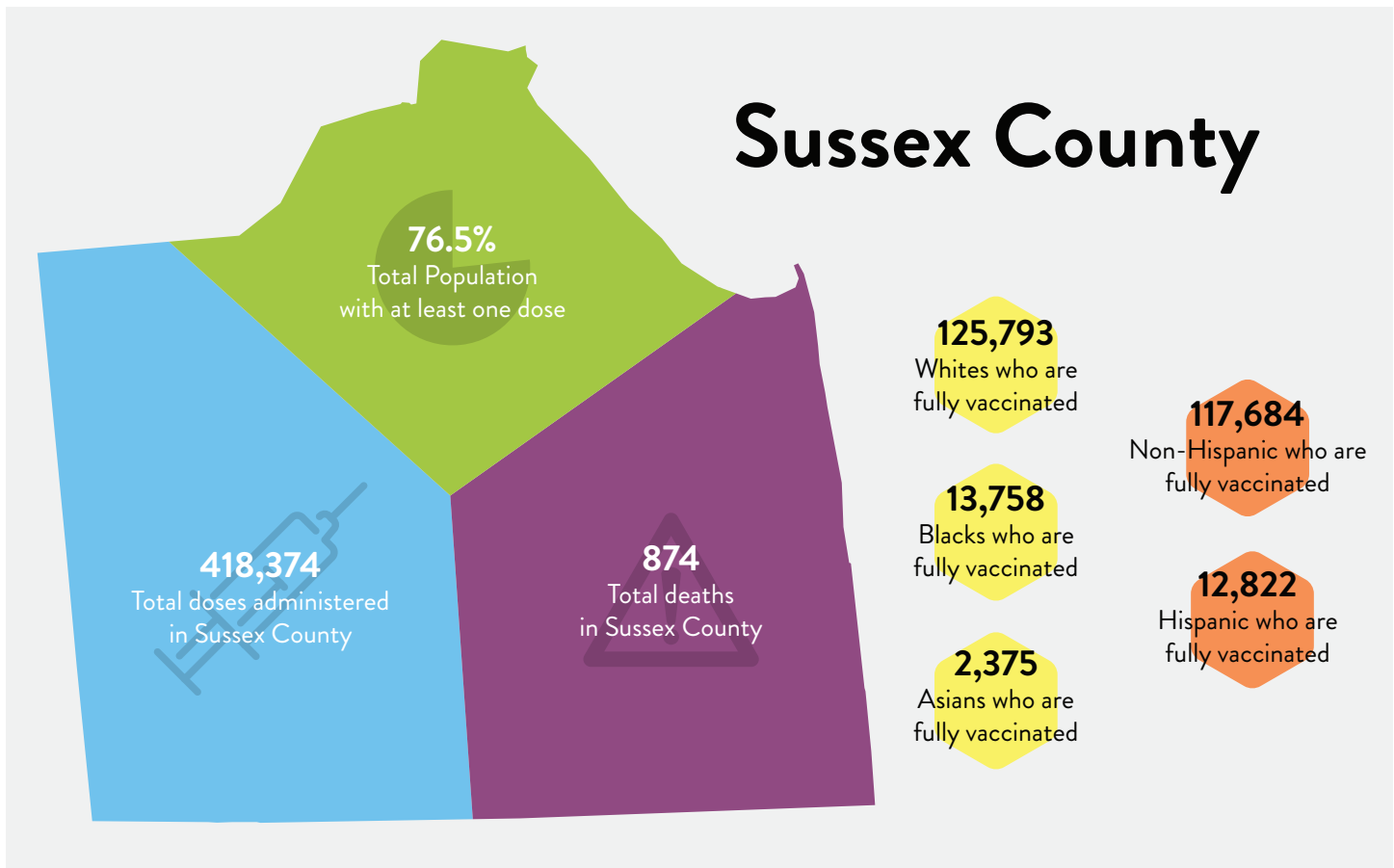


Table 23: COVID-19 Overview



Note: Data reflective as of 6.29.2022

Source: [Delaware Health and Social Services](#)

The table below represents COVID-19 deaths by ZIP Codes. Issues of equity such as access to testing and vaccinations; differing vulnerability of workers, the elderly, etc. have been central to the COVID-19 pandemic response.

Table 24: COVID-19 Deaths by ZIP Code

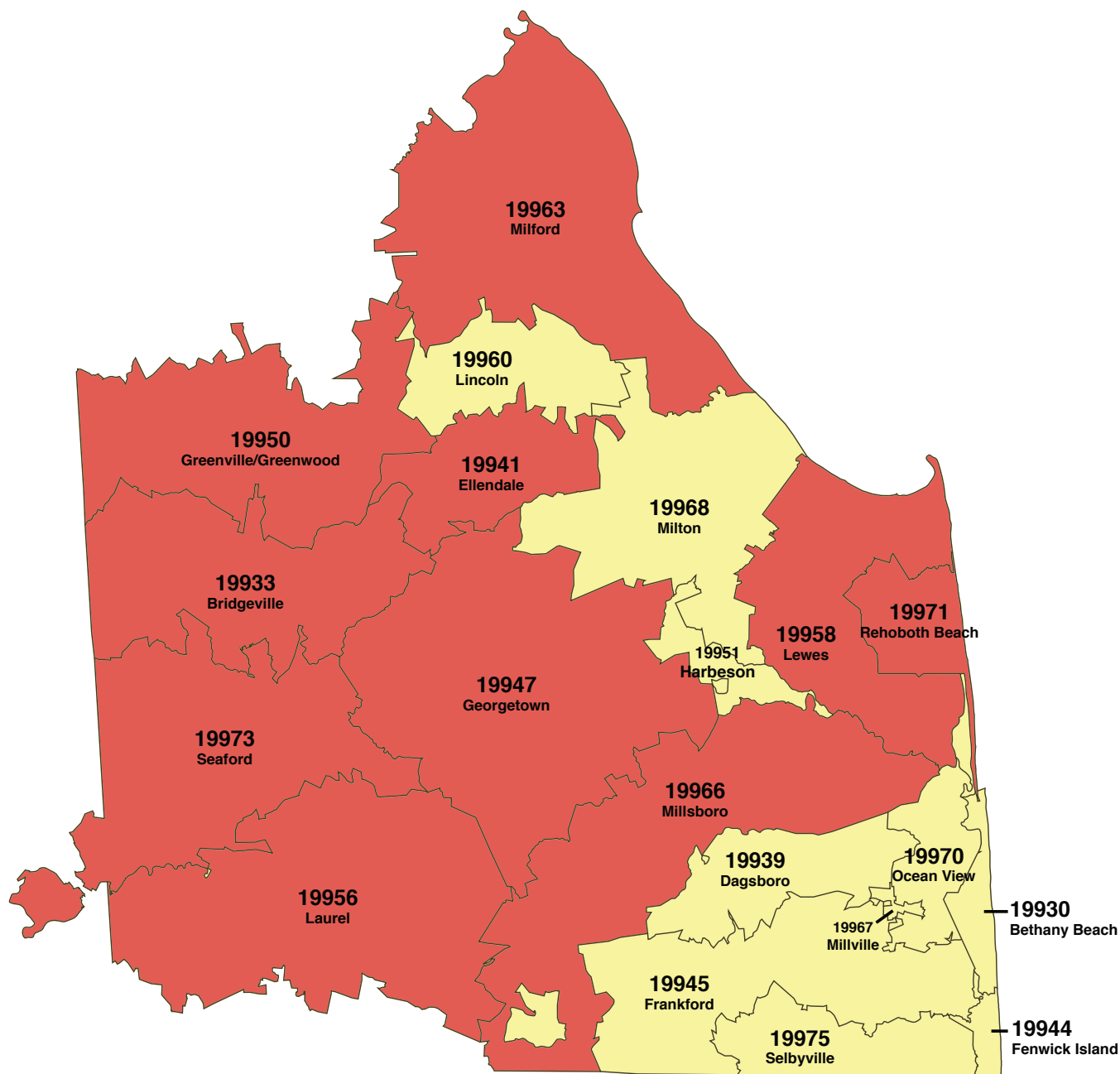
ZIP Code	COVID Deaths (per 10,000 Population)	ZIP Code	COVID Deaths (per 10,000 Population)
19930	0.0	19958	40.4
19933	35.8	19960	27.7
19939	25.7	19963	57.9
19941	42.8	19966	41.6
19944	0.0	19967	0.0
19945	17.7	19968	24.0
19947	38.5	19970	21.2
19950	49.6	19971	33.5
19951	0.0	19973	43.2
19956	38.4	19975	19.7
		Delaware	31.2

Note: Data pulled and obtained as of 7.2022. ZIP codes in red indicate higher rates when compared to the state rate.

Source: [Delaware Government: My Healthy Community](#)

The map below illustrates the rate of COVID-19 deaths (per 10,000 population) broken out by ZIP Codes. ZIP codes in red indicate higher rates when compared to the state rate. Please refer to Table 24 for COVID-19 death rates.

Map 25: Map of COVID-19 Deaths by ZIP Codes





Over the last few years, vaccinating community residents has been a driver for Beebe Healthcare and as such, strategies to increase vaccine distribution will include a focus on underserved communities. The below are recommended [CDC](#) strategies when addressing communities with mistrust.

1. Focus on effective messaging delivered by trusted messengers (offering recommendations provided by trusted healthcare professionals).
2. Use tactics to address misinformation and hesitancy within the population of focus.
3. Tailor strategies for the specific community.
4. Build vaccine confidence to help eliminate stigmas associated with receiving COVID-19 vaccination while also fostering relationships between community members and public health entities.
5. Address community concerns by using clear, easy-to-read, transparent, and consistent information that addresses specific misinformation or perceived concerns.
6. Partner with trusted messengers in the delivery of critical information for communities to continue advocating for positive change regarding COVID-19 vaccine efforts.
7. Develop culturally relevant materials.

HEALTH NEEDS PRIORITIZATION PROCESS

On May 26, 2022, Tripp Umbach facilitated an internal prioritization session with members of the working group as well as members of the steering committee representing hospital leaders, administration, and clinicians.

The purpose of the internal prioritization session was to present the CHNA findings, which included existing data, in-depth community stakeholder interview results, focus group results, and community survey findings, and to obtain input regarding the needs and concerns of the community overall. The group discussed the data, shared their visions and plans for community health improvement in their communities, and identified and prioritized the top community health needs in their region.

Once the needs were identified, the prioritization session streamlined the needs from the previous assessment into more defined categories, continuing the great work of Beebe Healthcare. With input received from the session, Beebe Healthcare finalized the prioritized and identified top priority areas.



BEEBE HEALTHCARE 2022 CHNA FOCUS

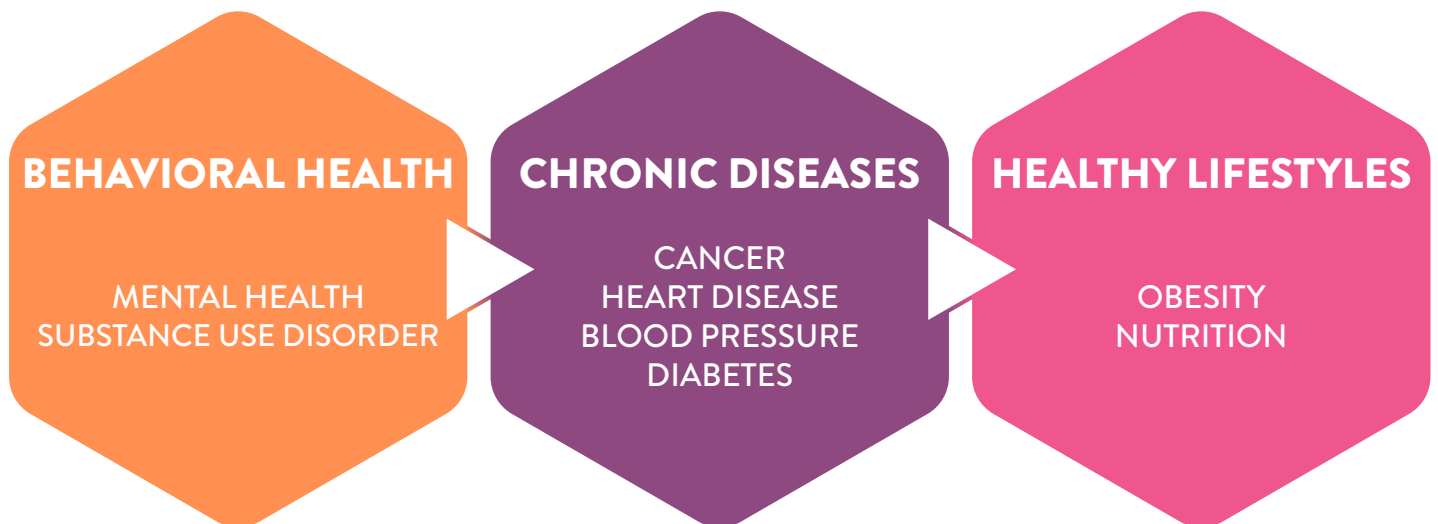
Beebe Healthcare will continue to address the needs of its community with outreach efforts and effective programs, working closely with partners and local organizations to reach underserved residents and those affected by health and social disparities across the region.

A comprehensive CHNA process that engaged a variety of community organizations, agencies, and community stakeholders showed Beebe Healthcare's commitment to the community. With support obtained from health officials, policymakers, community stakeholders, and hospital leadership, the CHNA helped identify and prioritize the community's needs.

An objective of the Patient Protection and Affordable Care Act (PPACA) is to provide overall health care access and identify better care coordination allowing for greater accessibility, with the intent to reduce health care costs for patients and caregivers. As such, community agencies, organizations, and health care organizations are streamlining services and partnering to capitalize on the ability to share resources. By providing affordable health care insurance, previously uninsured populations have a pathway to access preventive services.

Through the assessment process, the CHNA identified three key need areas the identified community needs are depicted in the graph below (See Figure 26).

Figure 26: Beebe Healthcare's FY2022 CHNA Needs



KEY COMMUNITY NEEDS

Throughout the community health needs assessment process, Tripp Umbach reviewed primary and secondary data from local, state, and national resources, community stakeholder interviews, community surveys, focus groups, a prioritization session, and a resource provider inventory (highlighting organizations and agencies that serve the community) to identify the regional health needs of residents in Sussex County. The data provided a cross-section of information essential to the identification of the key community health needs in Beebe Healthcare's community.





A) Behavioral Health

Nationwide, behavioral health has become a prominent health issue affecting residents across all income levels, ethnic groups, and education levels. Sussex County residents are no exception to the growing health problem. Behavioral health includes the emotions and behaviors that affect one's overall well-being. Behavioral health is sometimes called mental health and often includes substance use, according to the [Centers for Medicare & Medicaid Services \(CMS\)](#). As a major issue and a main health concern in the study area, findings from community stakeholder interviews, community surveys, and secondary data demonstrate the growing effects of behavioral health in the community.

It is important to note, that behavioral health issues affect both the mental health and well-being of an individual as well as a person's spiritual, emotional, and physical health. Individuals with a mental illness can face short and long-term issues associated with the disease. Issues related to occurrences of chronic diseases such as diabetes, heart disease, and cancer, in addition to an overall decrease in accessing health services, can, unfortunately, increase the likelihood of adverse health outcomes. The coexistence of both a mental illness and a substance use disorder is also common among people in medication-assisted treatment (MAT). People with mental illnesses are more likely to experience a substance use disorder than those not affected by a mental illness ([SAMHSA](#)).

A nationwide and regional physician shortage plays a significant role in the delivery of health care services to those individuals who struggle with behavioral health issues and other associated problems. As identified by community stakeholders, shortages of physicians and specialists, appropriate funding for mental and behavioral health services, access issues, and high rates of behavioral health issues create a growing concern related to the current and future state of behavioral health services in the region and the growing need for additional focus on providing adequate behavioral health services.

Obtainable behavioral health services are essential to one's physical and mental health. Effective treatment plans and prevention allow people to recover. Those suffering from behavioral health require access to providers and services in order to receive proper care allow them to lead healthy and productive lives.

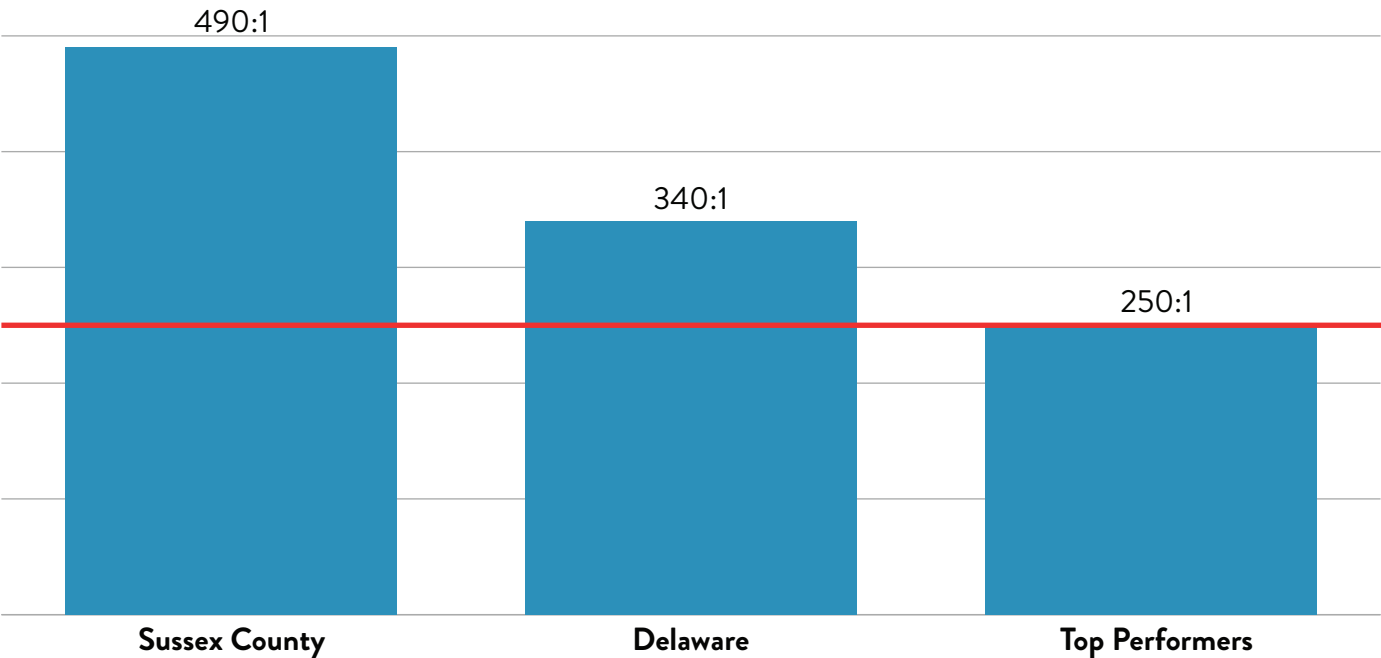
The table below presents information collected from community stakeholder interviews, community surveys, key informants and low-income focus groups.

Table 27: Listening to the Community

 Community Stakeholder Interviews	 Community Surveys
<p>What are the biggest health/social concerns?</p> <ul style="list-style-type: none"> Behavioral Health <p>Largest Barriers for People not Receiving Care or Services</p> <ul style="list-style-type: none"> Lack of services Mental illness <p>What are the persistent high-risk behaviors?</p> <ul style="list-style-type: none"> Substance Abuse Tobacco Use <p>What would improve the quality of life for residents?</p> <ul style="list-style-type: none"> Access to behavioral health services Mental health services Substance abuse support Health care access <p>Vulnerable Populations</p> <ul style="list-style-type: none"> Homeless Mentally ill 	<p>Health Problems with Greatest Impact on Overall Community Health</p> <ul style="list-style-type: none"> Lack of health care providers Mental health Drug Use/Abuse <p>What does your community need to do/have to improve the quality of life and health?</p> <ul style="list-style-type: none"> More health care providers/specialty physicians Affordable health care services Access to drug/alcohol and mental health services <p>Type of Information Needed in Community</p> <ul style="list-style-type: none"> Substance abuse prevention <p>Health Challenges Currently Faced</p> <ul style="list-style-type: none"> Mental Health Issues Alcohol overuse <p>Statements that Apply</p> <ul style="list-style-type: none"> I smoke cigarettes I have more than four alcoholic drinks a day
 Focus Groups	
<p>Health issues and concerns according to key informants and low-income participants.</p> <ul style="list-style-type: none"> Lack of physicians (e.g., specialists, etc.) Lack of access to mental health/behavioral health services <p>Health Related Problems in the Community/Barriers</p> <ul style="list-style-type: none"> Access to mental health services is lacking especially for low-income residents. People who are low-income do not have the same levels of access to mental health services as those who can afford it. Residents are aware their income status prohibits them from seeking specialty care and access. Residents encounter a lot of drug use in this area. Support services for this type of behavioral health issue such as counseling or rehabilitation services are not adequate for those who face addiction. There is a lack of supply and demand is significantly high. 	<p>How do we improve health and quality of life?</p> <ul style="list-style-type: none"> Creating recreational space such as parks and green space for better health promotion and improved mental health. <p>What is being Done to Address Issues in the Community?</p> <ul style="list-style-type: none"> Need to execute mental health and behavioral health screenings in collaboration with the school districts to get children screened and diagnosed who are in need of assistance. <p>Emerging Issues or Barriers in the Community</p> <ul style="list-style-type: none"> Culturally competent care is good as it positively impacts one's physical and mental health. Mental health issues are already high due in part to COVID-19 and the stigma has persisted. Not enough providers to treat this growing population.

The below figures depict the shortage in the number of mental health providers (per 100,000 population) in Sussex County when compared to the state and the top performers in the country. Top performers are counties setting and meeting benchmark levels. They are counties that are 10th/90th percentile (i.e., 10%) better.

Figure 28: Mental Health Providers (Ratio of Population to Mental Health Providers)

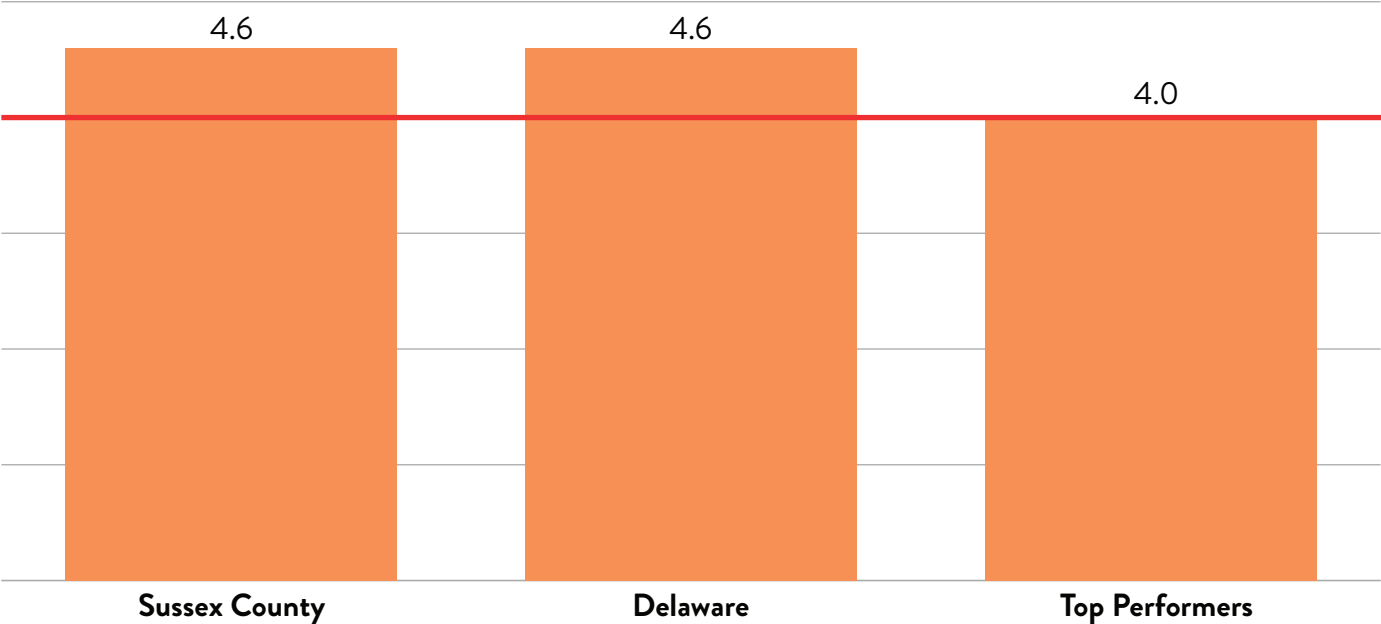


Note: The red line indicates top performers and provides a visual where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2021](#)

The figure below illustrates the average number of mentally unhealthy days reported in past 30 days (age-adjusted).

Figure 29: Poor Mental Health Days



Note: The red line indicates top performers and provides a visual where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2019](#)

Table 30 reported the number of adults who have been told they have a depressive disorder (including depression, major depression, dysthymia, or minor depression).

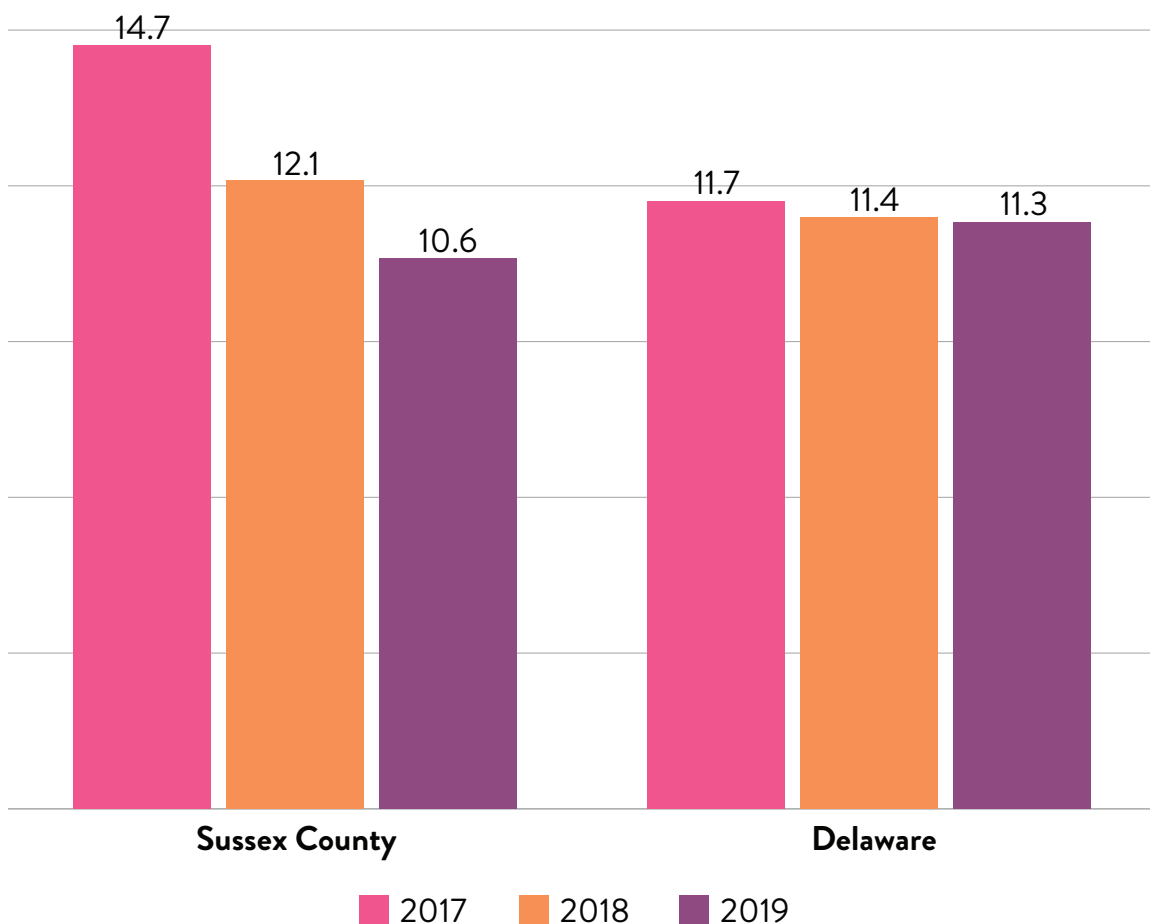
Table 30: Sussex County Depression

Depression	
Number of adults who have been told they have a depressive disorder	18.4%
Percent change between 2012-2019	24% (increase)

Source: [Delaware Government](#); [My Healthy Community](#)

Nearly 600 Delawareans died by suicide between 2014 and 2018. The figure reported the rate of death due to intentional self-harm (suicide) per 100,000 population. This indicator is relevant because suicide is an indicator of poor mental health.

Figure 31: Suicide Mortality (per 100,000 Population)

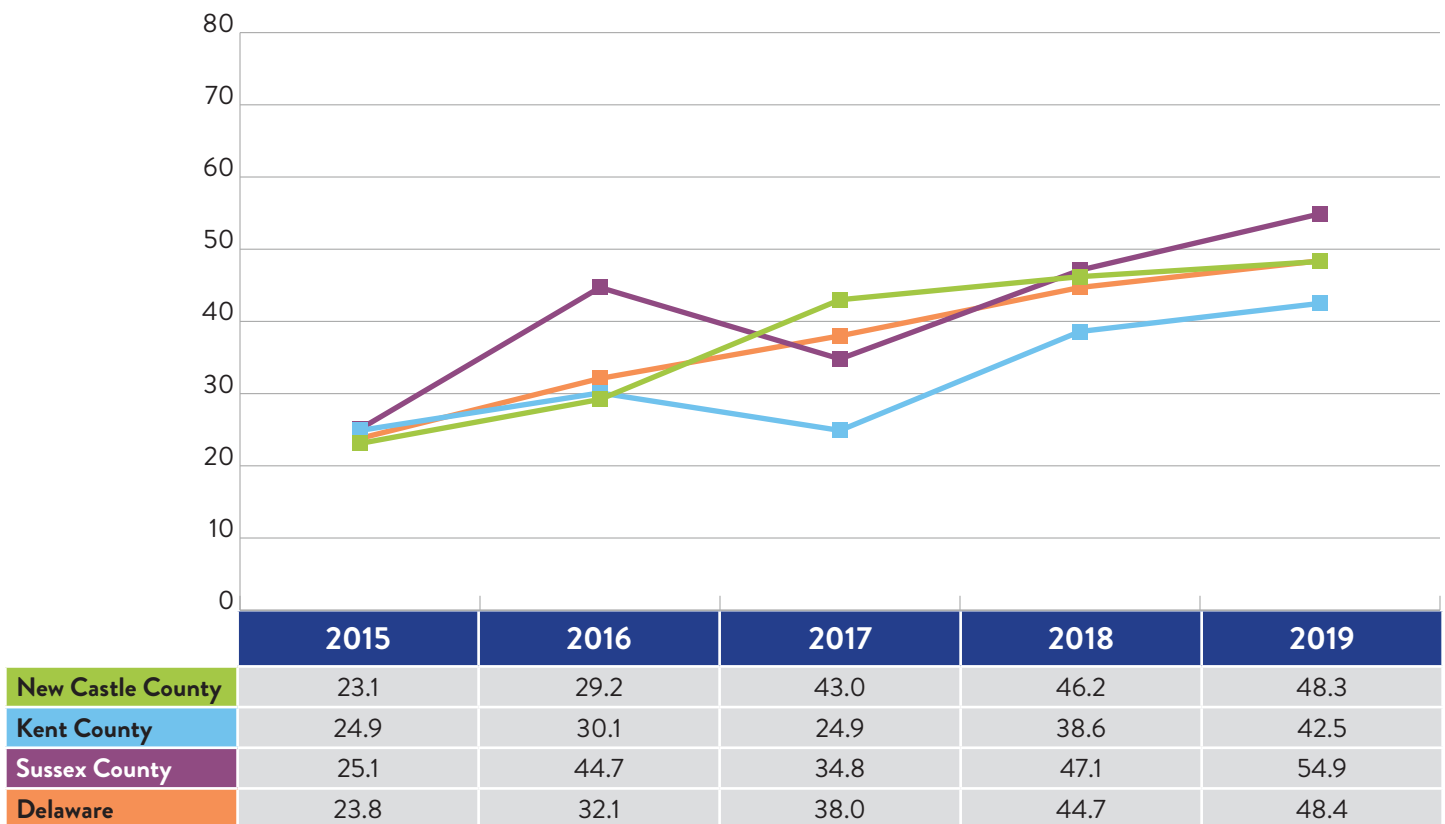


Source: [My Health Community: Delaware Environmental Health Tracking Network](#)

According to the [Delaware Opioid Crisis Report](#), almost every day, a Delawarean dies from a drug overdose. 3 out of 4 were aged 25 to 54 years old at death. 4 out of 5 interacted with a health system* in the year prior to death.

Drug overdose death rates in Delaware have increased from 2015 to 2019. Sussex County saw an increase in overdose death rates from 2017 – 2019. Sussex County also had higher death rates in 2019 when compared to Kent and New Castle counties and the state.

Figure 32: Drug Overdose Deaths in Delaware



Source: [My Health Community: Delaware Environmental Health Tracking Network](#)

In 2021, 515 overdose deaths occurred in the state; with New Castle County (334) accounting for the most deaths when compared to Kent (87) and Sussex (94) counties.

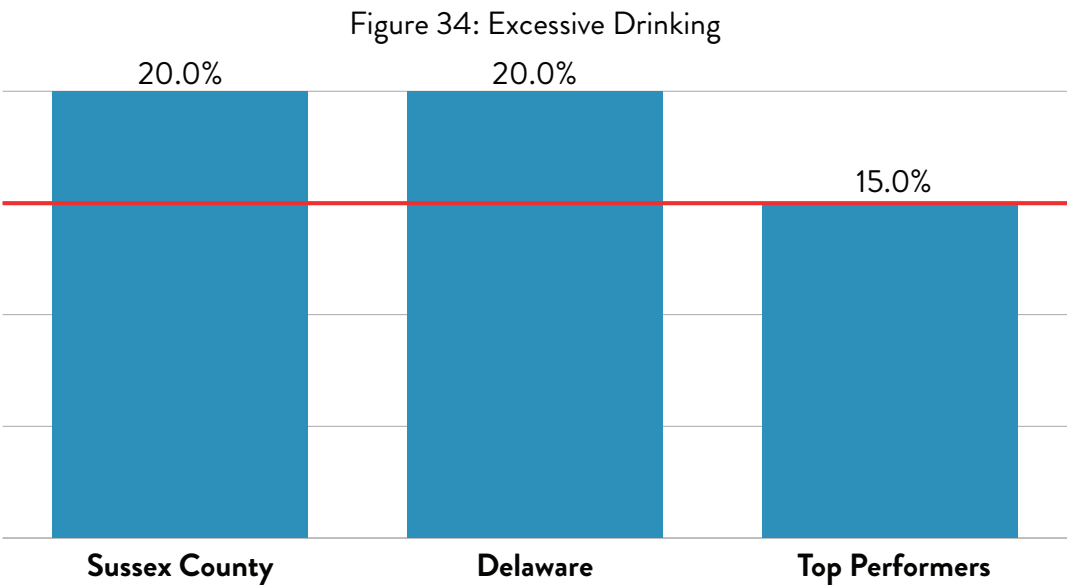
Table 33: Drug Overdose Fatalities by County 2021 Overdose

County	Overdose Death Fatalities
Kent County	87
New Castle	334
Sussex County	94
Delaware	515

Source: Delaware Drug Monitoring Initiative 2021

Figure 34 depicts the percentage of adults reporting binge or heavy drinking (age-adjusted).

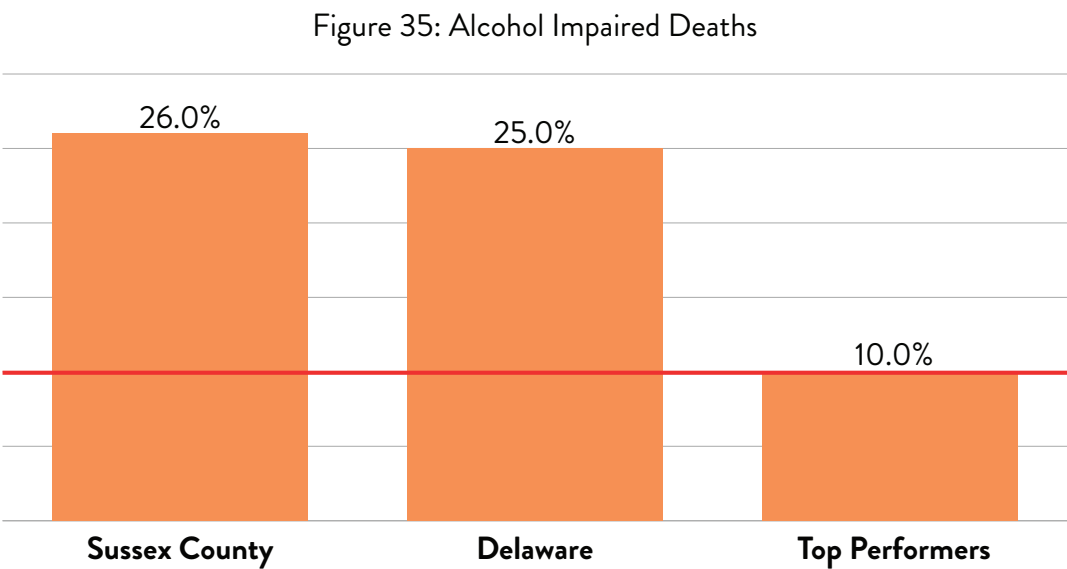
According to the [CDC](#), a heavy drinker is 8 drinks or more per week for women. For men, heavy drinking is 15 drinks or more per week. A binge drinker is defined as consuming 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women.



Note: The red line indicates top performers and provides a visual where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2019](#)

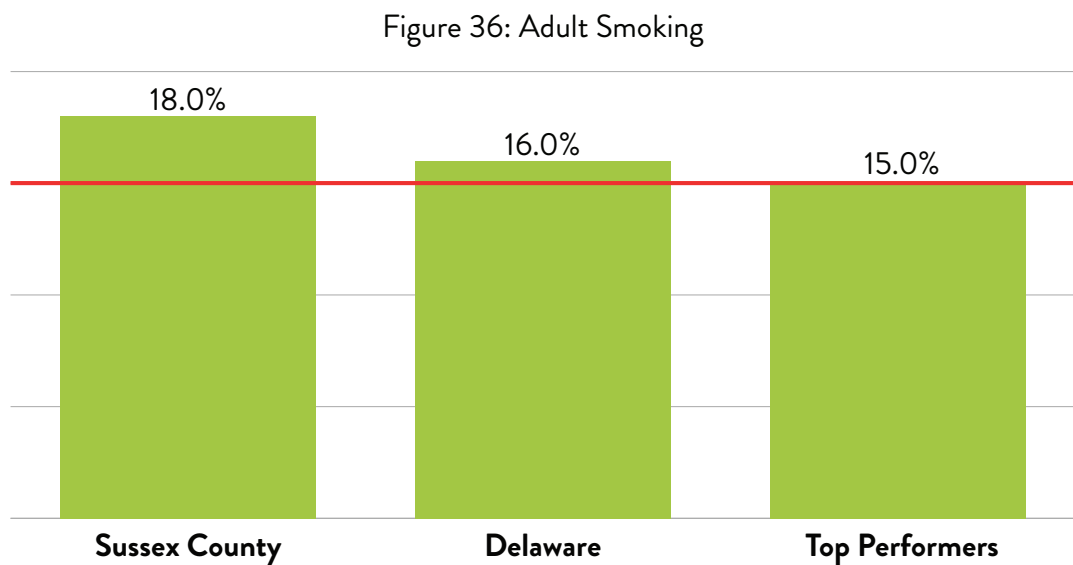
The figure below depicts the percentage of driving deaths with alcohol involvement.



Note: The red line indicates top performers and provides a visual where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2016-2020](#)

Figure 36 shows the percentage of adults who are current smokers (age-adjusted).



Note: The red line indicates top performers and provides a visual where Sussex County and Delaware compare.
Source: [County Health Rankings & Roadmaps 2019](#)

Figure 37 the data reports the number of mental health care facilities designated as “Health Professional Shortage Areas” (HPSAs) in Sussex County. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. An HPSA is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals.

Table 37: Facilities Designated as Health Professional Shortage Area (HPSA)

Mental Health Care Facilities	
Sussex County	3
Delaware	11
U.S.	3,617

Source: U.S. Department of Health Resources and Services Administration



B) Chronic Diseases

Genetics, an individual's personal lifestyle in addition to their environment and other factors, plays a significant role in developing a chronic disease. Chronic diseases have a big impact on community residents. The overall health care of residents with a chronic disease versus one without is staggering. Annually, direct health care costs for a patient with chronic disease average \$6,032, approximately 5 times that of a person without a chronic disease. These costs are primarily derived from more frequent hospitalizations and emergency room visits and greater prescription drug use ([American Action Forum](#)). The toll and the overall health care costs associated with chronic diseases are staggering.

Heart disease, cancer, diabetes, and stroke are leading causes of death and disability among individuals. In fact, 90% of the nation's \$4.1 trillion in annual health care expenditures are for people with chronic and mental health conditions ([CDC](#)). Chronic diseases are broadly defined as conditions that last one or more years and require ongoing medical attention and or limit activities of daily living. Six in ten adults in the U.S. have a chronic disease and four in ten adults have two or more. Chronic diseases occur when residents engage in poor lifestyle risks such as tobacco use, poor nutrition, lack of physical activity, and excessive alcohol use.




Heart disease and stroke cause the most deaths in Americans. More than one-third or roughly 877,500 Americans die of heart disease or stroke every year. In addition, roughly 34.2 million Americans have diabetes and another 88 million adults in the U.S. have prediabetes, and more than 1.7 million people are diagnosed with cancer, with 600,000 individuals dying from it, making it the second leading cause of death.

Although common, many chronic diseases are preventable. Living a healthy lifestyle by incorporating exercise, eating healthy, and avoiding tobacco and alcohol can assist community residents from developing certain diseases. Health education and interventions can halt and assist with better health management of existing chronic diseases; thus, reducing direct and long-term costs and improving the health and well-being of community residents.

Preventative health measures such as obtaining vaccinations, screenings, and physicals are critical to preventing disease and disability. Disparities in preventative health care can be indicative of inequities in health care access, differing environmental exposures, service gaps, and other systemic factors potentially linked to race, gender, and other identities.

The table below presents information collected from community stakeholder interviews, community surveys, key informant and low-income focus groups.

Figure 38: Listening to the Community

 Community Stakeholder Interviews	 Community Surveys
<p>What are the biggest health/social concerns?</p> <ul style="list-style-type: none"> • Diabetes • Poor Diet <p>Largest Barriers for People not Receiving Care or Services</p> <ul style="list-style-type: none"> • Availability of services • Cultural barriers • Economic disparities • Health Literacy • Language barriers • Perceptions of difficulties in navigating the healthcare system • Lack of health care coordination services • Lack of trust • Affordability • No insurance coverage <p>What would improve the quality of life for residents?</p> <ul style="list-style-type: none"> • Availability of bilingual providers • Health care access • Employment opportunities <p>Vulnerable Populations</p> <ul style="list-style-type: none"> • Chronically Ill 	<p>Health Problems with Greatest Impact on Overall Community Health</p> <ul style="list-style-type: none"> • Lack of health care providers • Cancers • Heart disease • High blood pressure • Diabetes • Lack of exercise <p>What does your community need to do/have to improve the quality of life and health?</p> <ul style="list-style-type: none"> • More health care providers/specialty physicians • Elder care options • Affordable health care services <p>Type of Information Needed in Community</p> <ul style="list-style-type: none"> • Chronic disease prevention/management • Eldercare • Managing weight • Eating well/nutrition • Stress management • Exercising/fitness • Going to the doctor for yearly check-ups and screenings <p>Health Challenges Currently Faced</p> <ul style="list-style-type: none"> • High Blood Pressure • Diabetes <p>Statements that Apply</p> <ul style="list-style-type: none"> • I exercise at least three times a week • I eat at least five serving of fruits and vegetables each day
 Focus Groups	
<p>Health issues and concerns according to key informant participants. They included:</p> <ul style="list-style-type: none"> • Lack of physicians (e.g., primary, specialists, etc.) <p>Health Related Problems in the Community/Barriers</p> <ul style="list-style-type: none"> • The inability to secure appointments. Appointment wait times are long especially when trying to secure care with a specialist. • Many physicians are not located locally, and residents must travel further for care. Seniors are traveling great lengths to see a physician as seeking care is only obtained when there is a crisis. Low-income residents cannot access care without transportation. • Care is only available if residents can afford it. The cost of health care services make it more difficult to obtain care. Unavailable doctors and affordability are factors why residents do not prioritize maintaining good health. • Undocumented residents or those who do not have a legal status will face greater roadblocks to health care services. This will exasperate the need for care as those in this population will seek care when their health is deteriorating. 	

The table below represents percentages of residents who have a chronic condition broken out by ZIP codes.

Table 39: Chronic Disease Percentages by ZIP Code

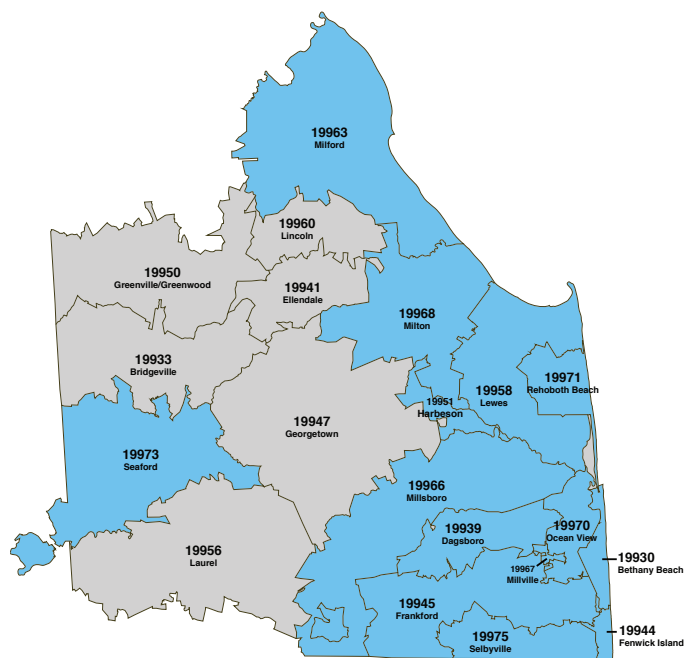
ZIP Code	Cancer	Heart Disease	Diabetes	Stroke
19930	14.0%	9.7%	13.4%	4.2%
19933	7.8%	8.0%	13.8%	4.4%
19939	9.9%	8.2%	13.2%	4.0%
19941	6.8%	7.1%	13.2%	4.2%
19944	13.3%	9.3%	12.8%	4.1%
19945	8.6%	7.1%	11.8%	3.7%
19947	6.9%	6.9%	11.6%	3.7%
19950	8.1%	8.0%	12.9%	4.2%
19951	8.7%	7.3%	11.8%	3.7%
19956	7.9%	8.0%	12.9%	4.3%
19958	11.2%	8.4%	12.3%	4.0%
19960	7.1%	6.0%	11.2%	3.4%
19963	8.5%	7.5%	12.6%	4.0%
19966	9.9%	9.2%	14.0%	4.6%
19967	9.6%	7.3%	10.7%	3.5%
19968	8.9%	7.0%	11.4%	3.6%
19970	12.0%	9.3%	13.2%	4.3%
19971	10.9%	7.7%	11.2%	3.5%
19973	8.3%	7.9%	13.2%	4.3%
19975	10.6%	9.0%	13.5%	4.4%
Delaware (18+)	8.20%	4.40%	12.8%	4.0%

Note: ZIP codes in red indicate higher rates when compared to the state rate. Cancer excludes skin cancer percentages.

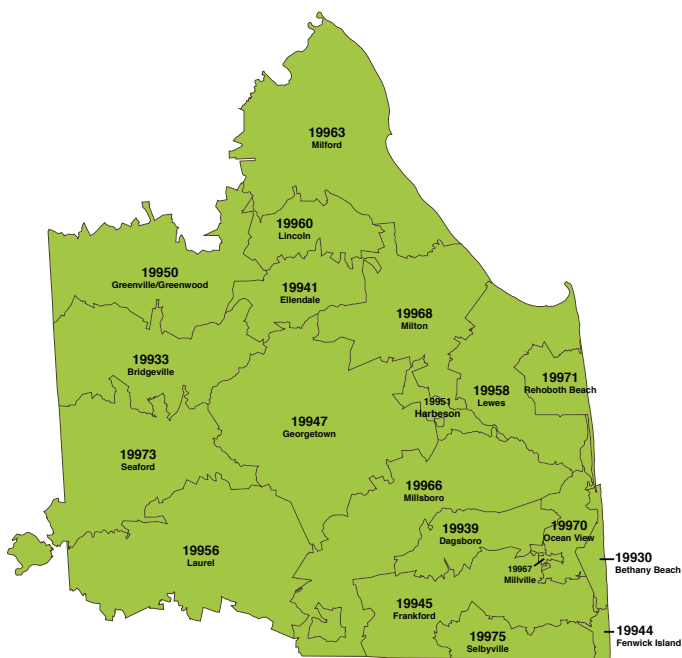
Source: [Delaware Government: My Healthy Community 2019](#)

The maps below illustrate the percentages of residents who have cancer, heart disease, diabetes, and strokes broken out by ZIP Codes. ZIP codes highlighted are higher than the state percentages.

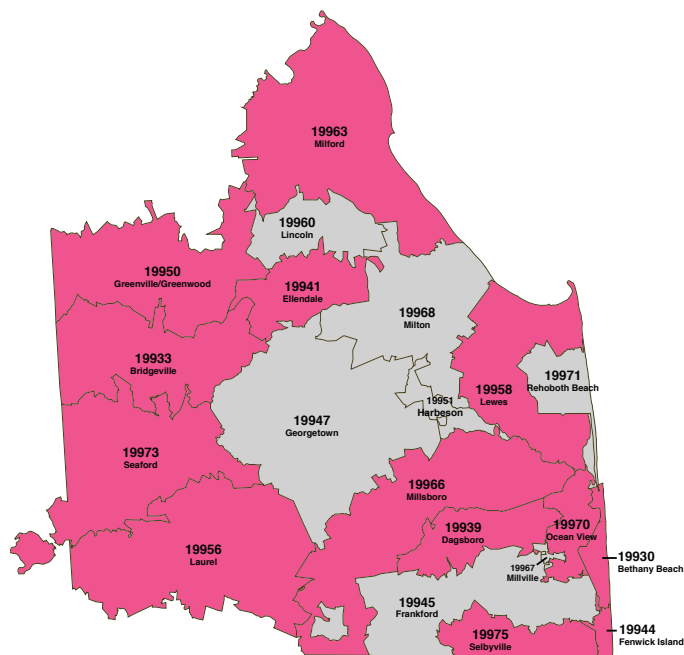
Map 40: Cancer Percentages by ZIP Codes



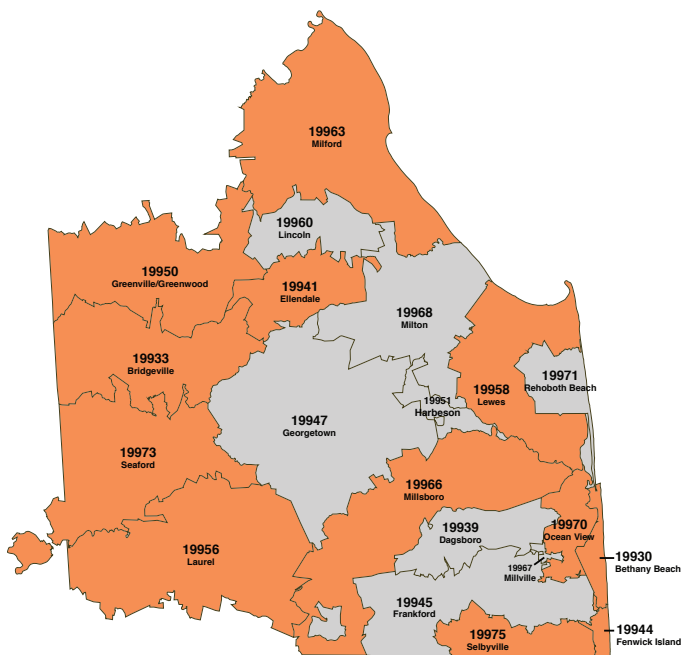
Map 41: Heart Disease Percentages by ZIP Codes

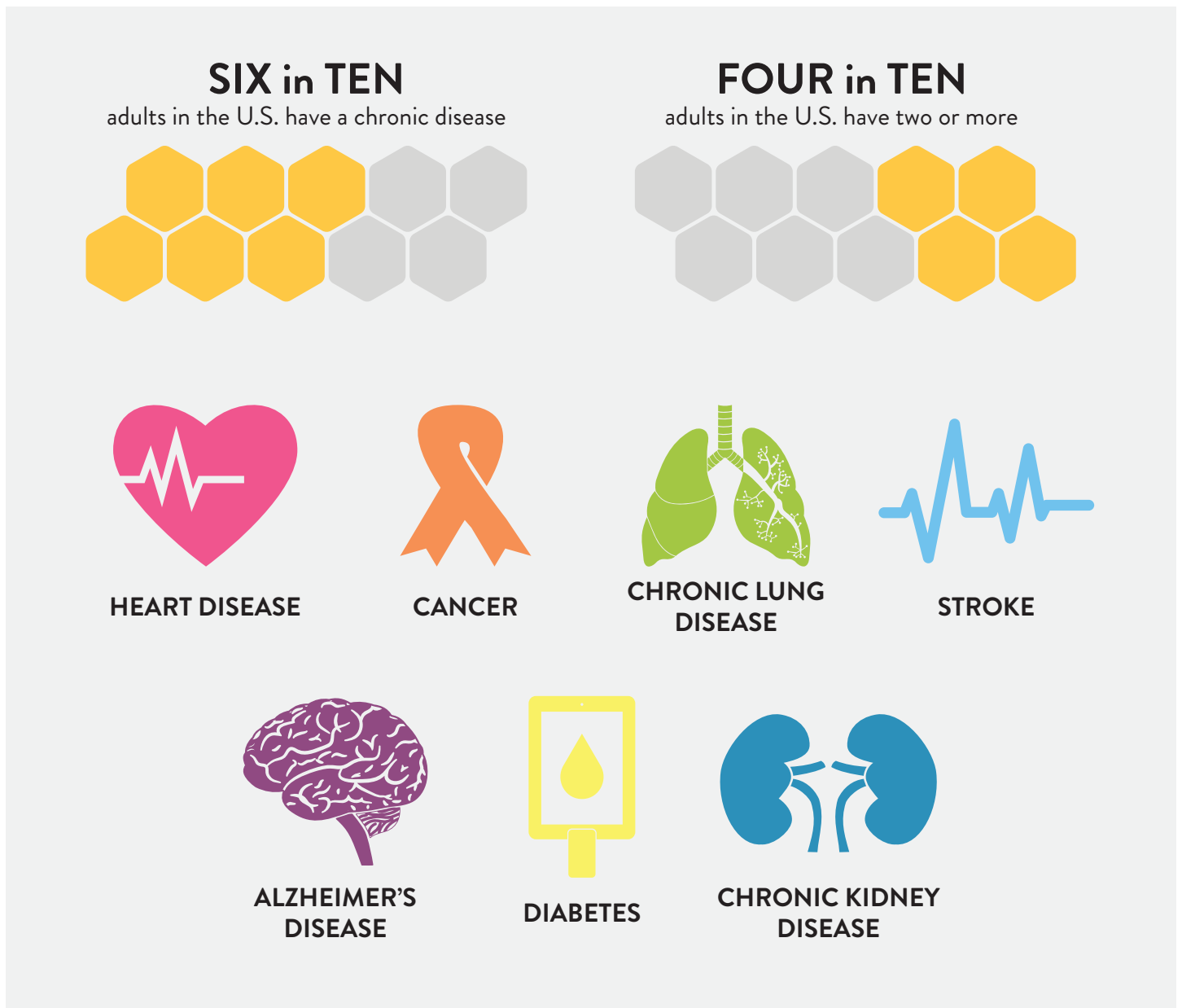


Map 42: Diabetes Percentages by ZIP Codes



Map 43: Stroke Percentages by ZIP Codes





Source: [Centers for Disease Control and Prevention](#)

Table 44 reported the number of adults who reported ever being ever told they have high blood pressure. Hypertension is a broad classification referring to heart disease, vascular disease, and cerebrovascular disease. The two main heart disease conditions are coronary artery disease and heart attack.

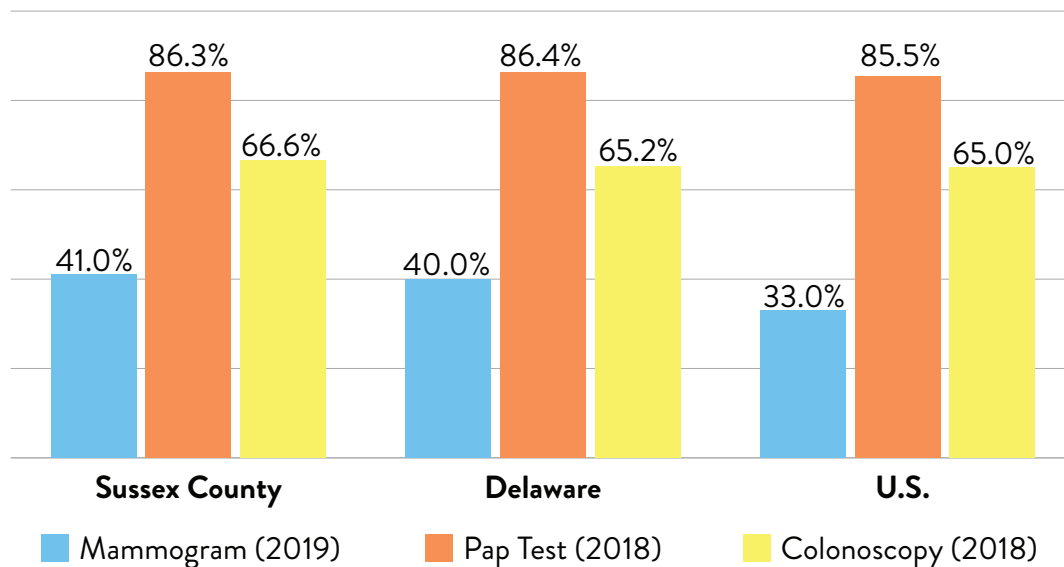
Table 44: Sussex County Hypertension

Hypertension	
Delaware adults who report ever being told they have high blood pressure	41.4%
Percent change between 2013-2019	1% (increase)

Source: [Delaware Government](#); [My Healthy Community](#)

Figure 45 illustrates screenings obtained for mammograms, pap tests, and colonoscopies in Sussex County, the state, and the nation.

Figure 45: Health Screenings



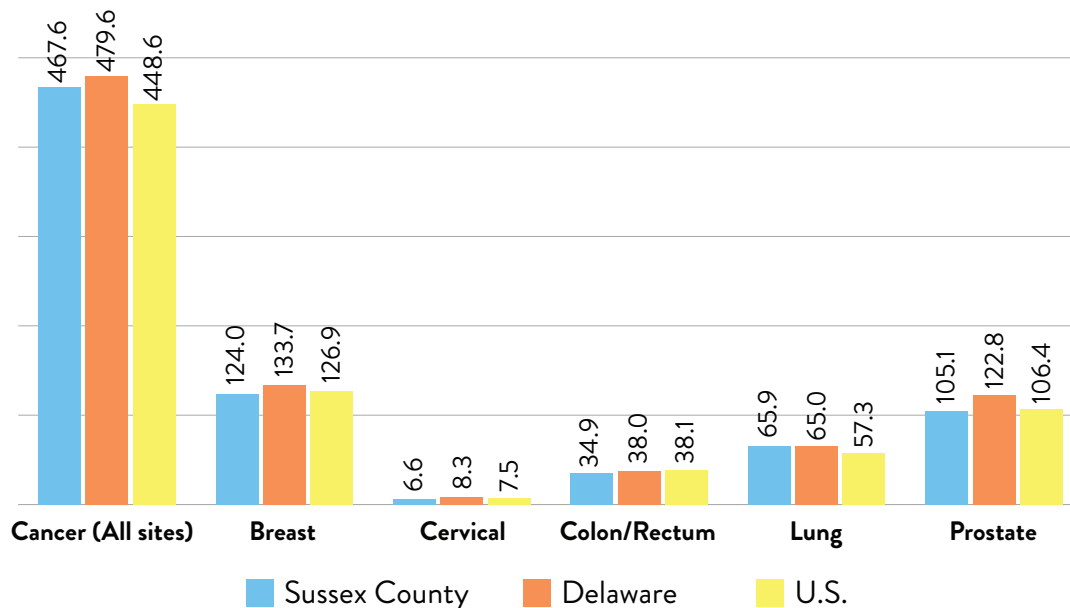
Note: Mammogram: Female Medicare beneficiaries aged 35 and older that had a mammogram. Pap Test: Women aged 21 to 65.

Colonoscopy: Adults 50 and older.

Source: Centers for Diseases Control and Prevention

Figure 46 illustrates the cancer incidence rates (per 100,000 population) in Sussex County when compared to the state and the nation.

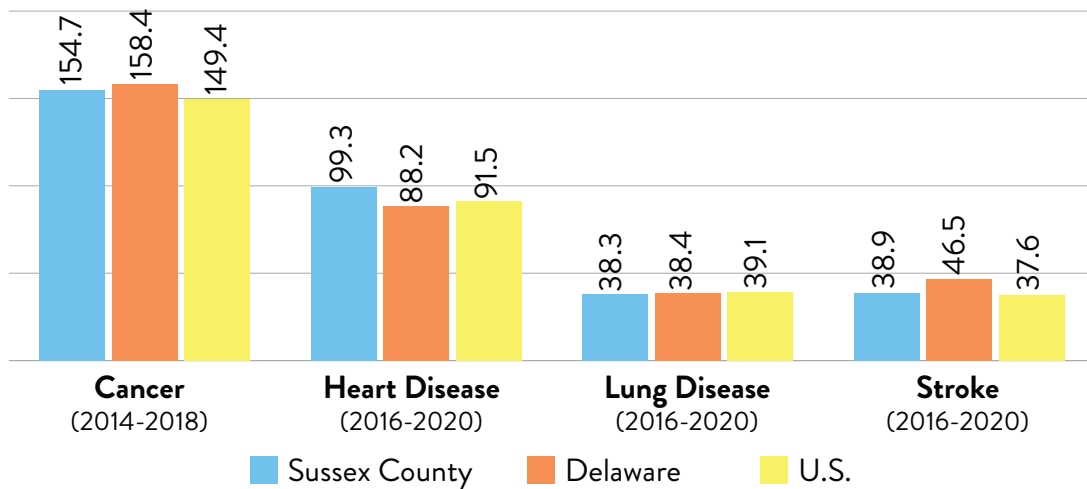
Figure 46: Cancer Incidence Rates (Per 100,000 Population)



Source: Centers for Diseases Control and Prevention 2014-2018

The data below illustrates mortality rates (per 100,000 population) by disease types in Sussex County when compared to the state and the nation.

Figure 47: Mortality by Disease (Per 100,000 Population)

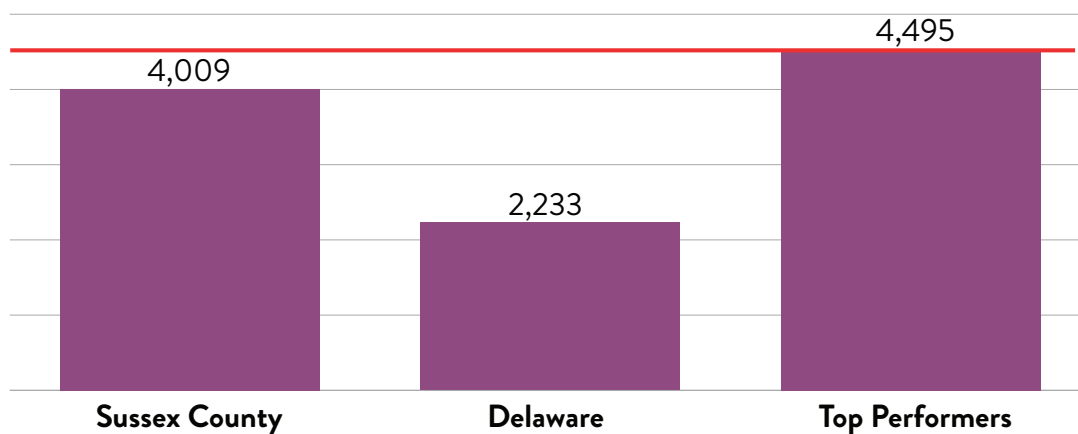


Source: Centers for Diseases Control and Prevention 2014-2018

Hospitalizations for ambulatory-care sensitive conditions are typically treatable in outpatient settings. The data below may represent a tendency to overuse emergency rooms and urgent care as a main source of care as well as inaccessible quality outpatient care accessible. Preventable hospital stays could be classified as a quality and access measure. Figure 48 illustrates the rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.

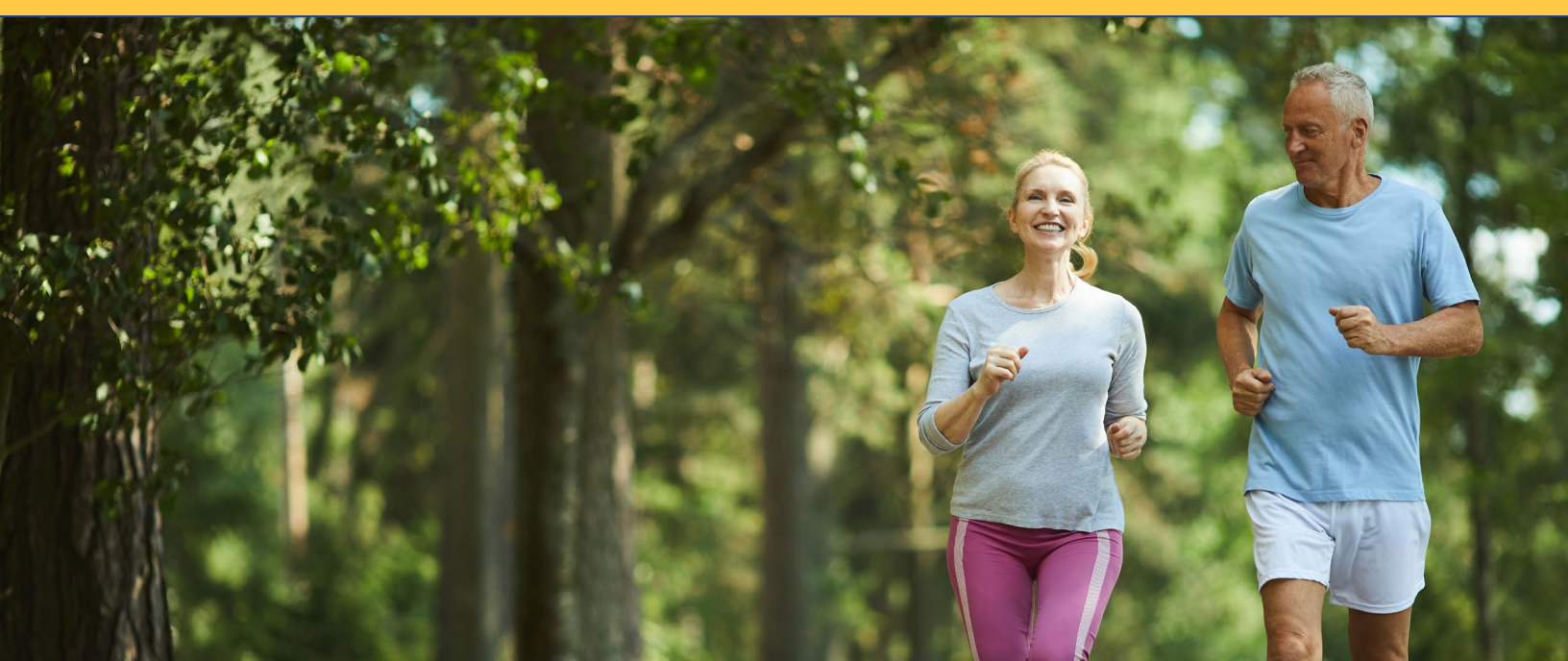
Implementing solutions to adversely address issues and improve health measures to reduce preventable hospital stays can include the implementation of multi-component efforts that include coordination of health services by multidisciplinary teams of health care professionals, patient self-management, and patient education ([County Health Rankings & Roadmaps](#)).

Figure 48: Preventable Hospital Stays (Per 100,000 Medicare Enrollees)



Note: The red line indicates top performers and provides a visual where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2019](#)



C) Healthy Lifestyles

Personal lifestyle choices can affect one's health and, in many cases, people can control their lifestyles. Poor health behaviors, such as smoking or lack of physical activity, and an unhealthy diet are health behaviors that can lead to chronic diseases. Socioeconomic factors and conditions, and the lack of education are reasons why people do not lead healthy lifestyles. It is essential for health providers and community organizations to continue to provide health education and information promoting the long-term benefits associated with living a healthy lifestyle.

Physical activity plays a significant role in a person's overall health. Just like other health behaviors one's level of physical activity is a determinant of health. Failing to be physically active can increase a person's chance of chronic diseases and can have a negative effect on one's overall health. The Office of Disease Prevention and Health Promotion created the [Physical Activity Guidelines for Americans](#) to provide recommendations on how to improve health through physical activity with the goal of increasing levels of physical activity in the U.S. According to the guide, regular physical activity includes participation in moderate and vigorous physical activities and muscle-strengthening activities. A total amount of at least 150 minutes a week of moderate-intensity aerobic activity consistently reduces the risk of many chronic diseases and other health outcomes. Unfortunately, only 53.3% of adult Americans aged 18 and over met the Physical Activity Guidelines for aerobic physical activity, while a dismal 23.3% meet the aerobic and muscle-strengthening activity, according to the [CDC](#). Obesity-related conditions include heart disease, stroke, type 2 diabetes, and certain types of cancer. These are among the leading causes of preventable, premature death.

Poor nutrition/diet is a top reason for high obesity rates. Beebe Healthcare, along with community leaders, and organizations recognize the determinantal effects of this poor health behavior. Much like physical inactivity, the lack of education, socioeconomics, and the inability to implement the long-term benefits associated with a healthy diet are top reasons for why community residents do not engage in following or eating a healthy diet.

For many, engaging in a healthy diet is cost prohibited as healthier fresh foods are more expensive. This makes it difficult for some residents to obtain these types of foods and makes it more likely for low-income residents to purchase processed foods. Education also plays a role in the obesity problem. Arming residents on how to eat properly and healthily, especially for those on a budget can be instilled in future generations. Obesity prevalence decreased with levels of education. Adults without a high school degree or equivalent had the highest self-reported obesity (38.8%), followed by adults with some college (34.1%) or high school graduates (34.0%), and then by college graduates (25.0%) ([CDC](#)).

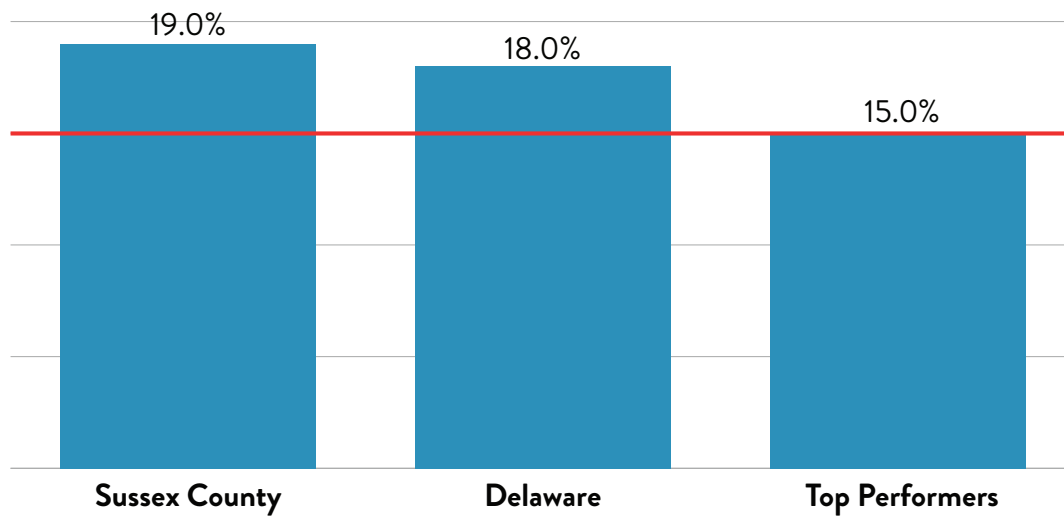
The table below presents information collected from community stakeholder interviews, community surveys, key informant and low-income focus groups.

Table 49: Listening to the Community

 Community Stakeholder Interviews	 Community Surveys
<p>What are the biggest health/social concerns?</p> <ul style="list-style-type: none"> • Obesity • Access to healthy foods • Poor diet <p>Largest Barriers for People not Receiving Care or Services</p> <ul style="list-style-type: none"> • Cultural barriers • Economic disparities • Health literacy • Language barriers <p>What are the persistent high-risk behaviors?</p> <ul style="list-style-type: none"> • Poor eating habits/Unhealthy eating habits • Lack of education • Lack of exercise/inadequate physical activity <p>What would improve the quality of life for residents?</p> <ul style="list-style-type: none"> • Availability of bilingual providers • Educational opportunities • Community health education 	<p>Health Problems with Greatest Impact on Overall Community Health</p> <ul style="list-style-type: none"> • Lack of exercise <p>What does your community need to do/have to improve the quality of life and health?</p> <ul style="list-style-type: none"> • Affordable health care services • Wellness services <p>Type of Information Needed in Community</p> <ul style="list-style-type: none"> • Managing weight • Eating well/nutrition • Exercising/Fitness <p>Health Challenges Currently Faced</p> <ul style="list-style-type: none"> • Overweight/obesity <p>Statements that Apply</p> <ul style="list-style-type: none"> • Exercise at least three times per week • Eat five servings of fruits/vegetables per week • Access to wellness program through employer
 Focus Groups	
<p>Health issues and concerns according to key informants and low-income participants. They included:</p> <ul style="list-style-type: none"> • Distribute health education and information. Specifically, information on blood pressure, cholesterol, obesity, diabetes, etc. • Lack of education and awareness of available resources. <p>Health Related Problems in the Community/Barriers</p> <ul style="list-style-type: none"> • There is a rural disconnect in communities as health care is not seen as a priority. Rural residents have other concerns such as daily living expenses; therefore, health care is not seen as a high need or priority. • Low-income and homeless populations do not have access to healthy foods. Healthy foods are unaffordable and hard to find for a zero to minimum wage individual. Unhealthy eating is a common among this population. <p>Addressing Persistent Health Issues</p> <ul style="list-style-type: none"> • Collaborate with employers to distribute health education and materials. Materials can include information on blood pressure, cholesterol, obesity, diabetes, etc. Information that is distributed at health fairs can be provided to employers for employees. <p>Emerging Issues or Barriers in the Community</p> <ul style="list-style-type: none"> • Lack of education and awareness of available resources, especially to the low-income and homeless population. Residents are not aware of health care resources that are available. With an increased awareness of resources (spiritual, emotional, mental, financial) that are available, it would improve the health status of residents in the community. <p>What is being Done to Address Issues in the Community?</p> <ul style="list-style-type: none"> • Providing educational resources and teaching the community how and where they can access care. The services to help people get coverage are complex and the hospital needs to promote their assistance to the population. 	

The data below depicts the percentage of adults reporting fair or poor health (age-adjusted).

Figure 50: Poor or Fair Health

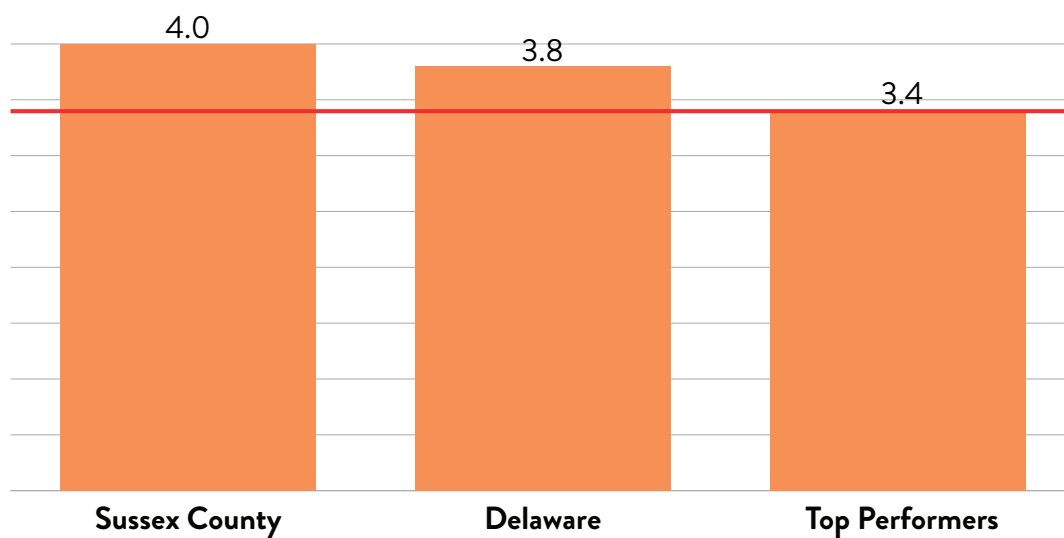


Note: The red line indicates top performers and where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2019](#)

Figure 51 illustrates the average number of physically unhealthy days reported in past 30 days (age-adjusted).

Figure 51: Poor Physical Health Days

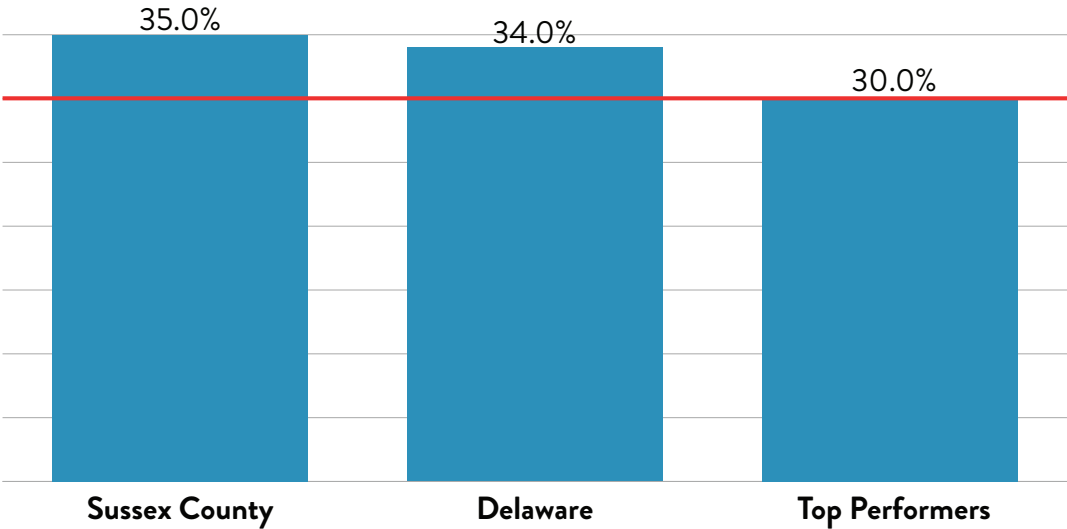


Note: The red line indicates top performers and where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2019](#)

Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted).

Figure 52: Adult Obesity

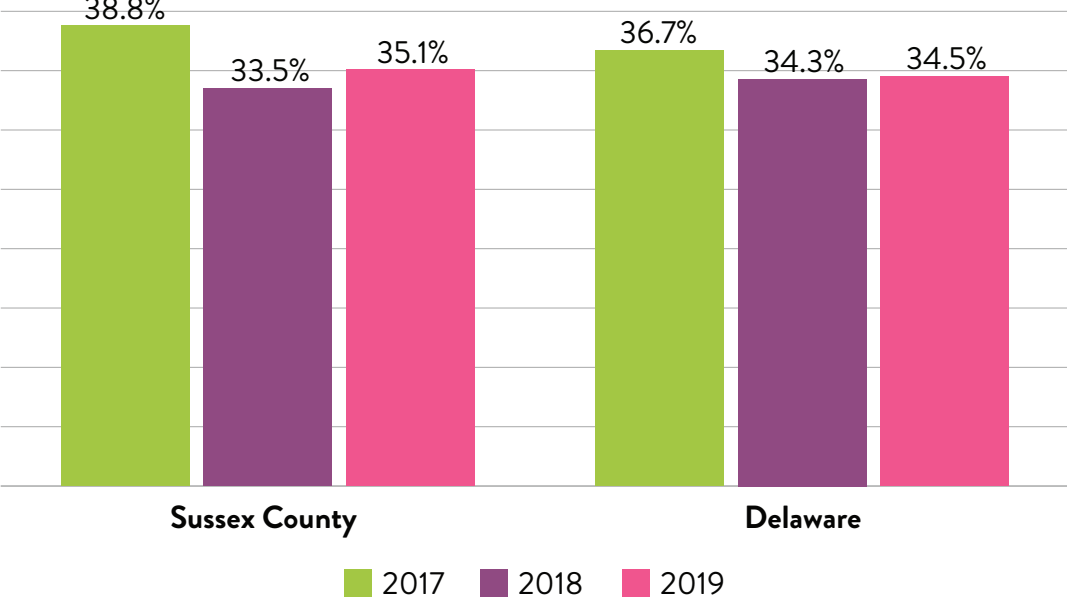


Note: The red line indicates top performers and where Sussex County and Delaware compare.

Source: [County Health Rankings & Roadmaps 2022](#)

The below figure reports the percentage of the population who are overweight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

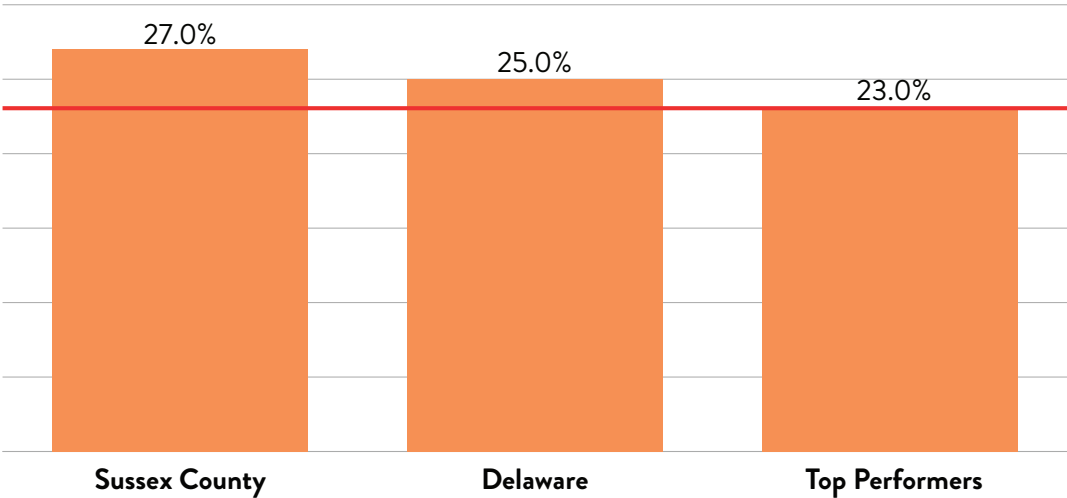
Figure 53: Overweight



Source: My Health Community: Delaware Environmental Health Tracking Network

Percentage of adults aged 18 and over reporting no leisure-time physical activity (age-adjusted).

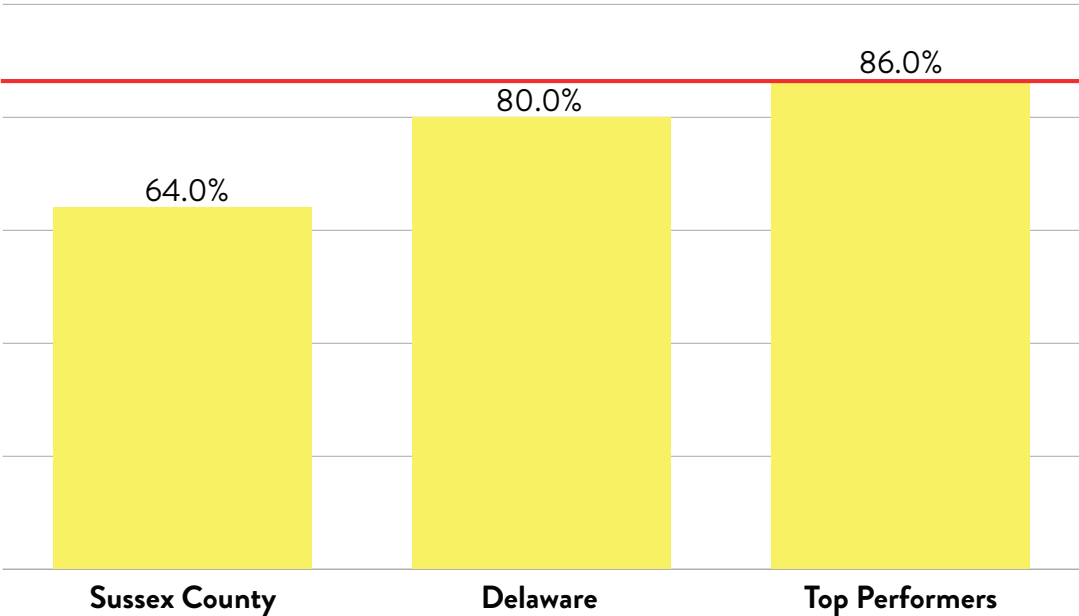
Figure 54: Physical Inactivity



Note: The red line indicates top performers and where Sussex County and Delaware compare.
Source: [County Health Rankings & Roadmaps 2019](#)

Percentage of population with adequate access to locations for physical activity.

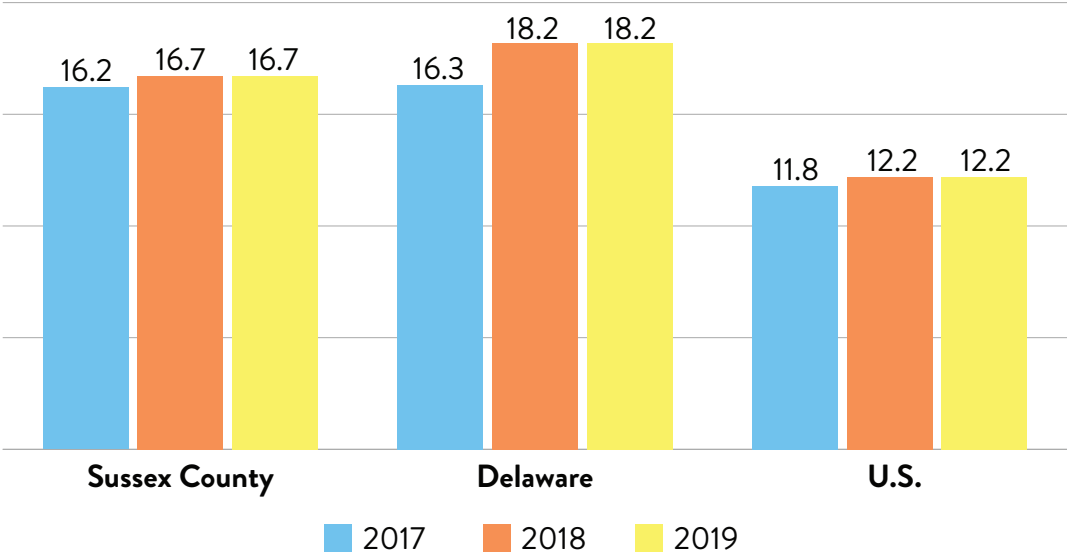
Figure 55: Access to Exercise Opportunities



Note: The red line indicates top performers and where Sussex County and Delaware compare.
Source: [County Health Rankings & Roadmaps 2019](#)

The below data reports access to recreation and fitness facilities. Access to recreation and fitness facilities encourages physical activity and other healthy behaviors. The data represents fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports.

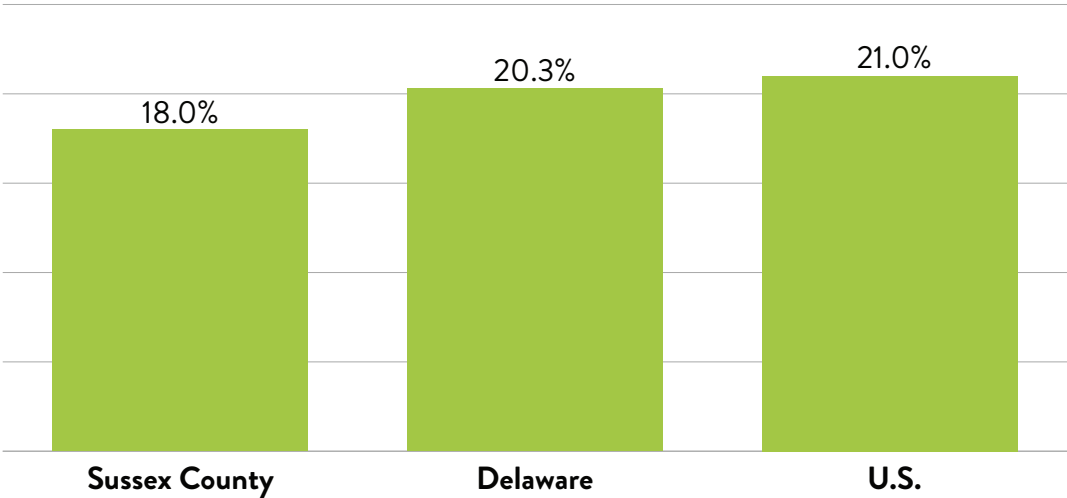
Figure 56: Recreation and Fitness Facility Access (rate per 10,000 Population)



Source: Centers for Disease Control and Prevention

Figure 57 illustrates the percentage of population with inadequate fruit/vegetable consumption. This measure is essential as current behaviors are determinants of future health and unhealthy eating habits may cause of significant health issues, such as obesity and diabetes.

Figure 57: Inadequate Fruit/Vegetable Consumption



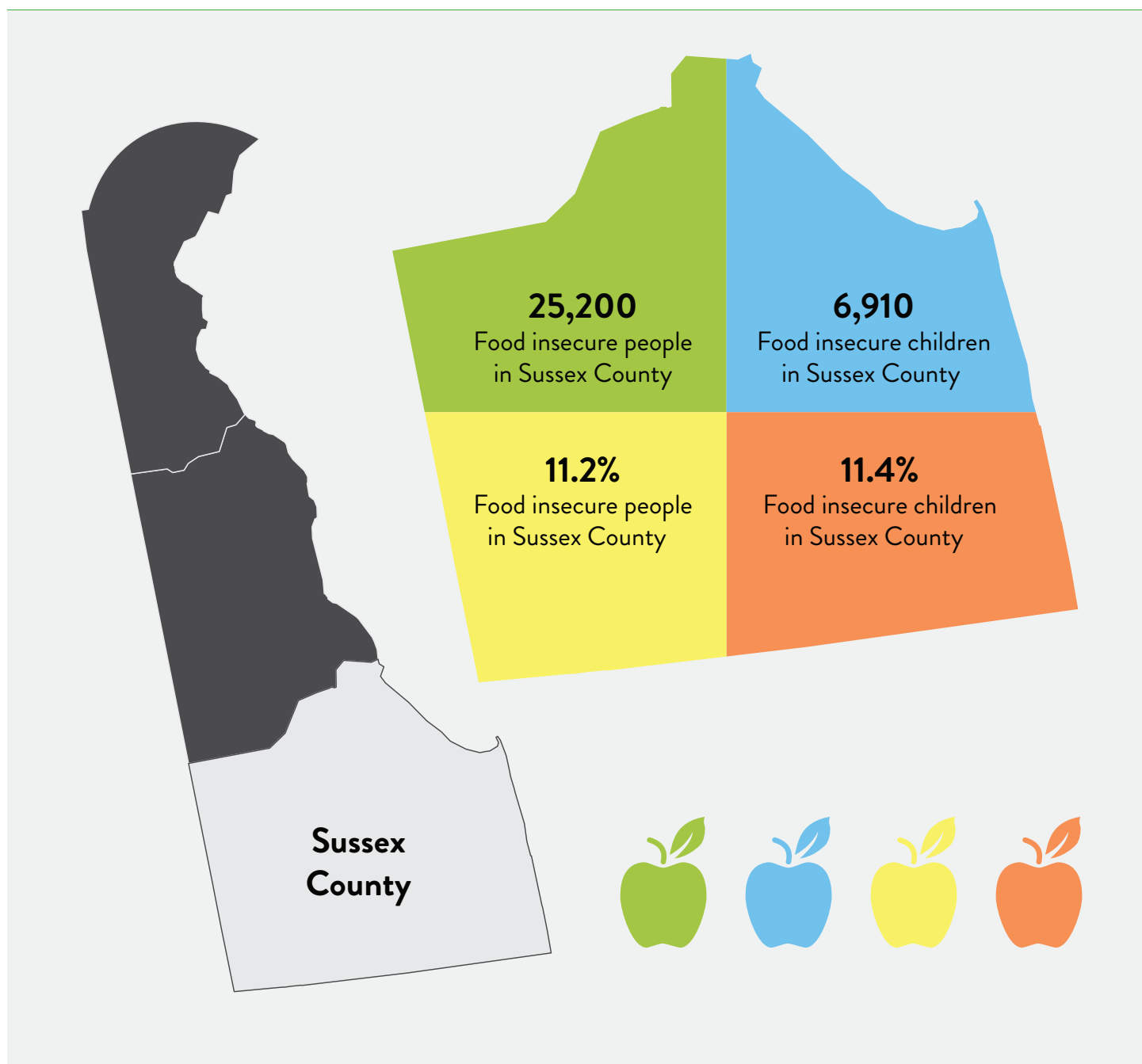
Source: Centers for Disease Control and Prevention

Food insecurity is the lack of consistent access to enough food for every person in a household to live an active, healthy life. This can be a temporary situation for a household or can last a long time. Food insecurity is one way to measure how many people cannot afford food. According to the USDA, more than 38 million people, including 12 million children experience food insecurity in the United States.

The causes of food insecurity are complex. Some of the causes of food insecurity include:

- Poverty, unemployment, or low income
- Lack of affordable housing
- Chronic health conditions or lack of access to healthcare
- Systemic racism and racial discrimination

Map 58: Map of Food Insecure People in Sussex County



Source: [Feeding America 2019](#)

NEXT STEPS

Partnering with community organizations and regional partners, Beebe Healthcare understands that the CHNA document is not the last step in the assessment phase, but rather part of an ongoing evaluation process. Information from the CHNA findings will be important to disseminate to residents, community-based organizations, regional stakeholders, and other organizations that seek to better understand the health needs of the communities surrounding Beebe Healthcare and how to best serve their community's needs.

The CHNA will be used to develop an effective implementation plan to address the needs identified. Beebe Healthcare will develop goals and strategies for the CHNA implementation phase. In this phase, Beebe Healthcare will leverage its strengths, resources, and outreach to help identify ways to address their communities' health needs, thus improving overall health and addressing the critical health needs and well-being of residents in their communities. CHNA partners will be instrumental in assisting Beebe Healthcare to execute the best ways to address these priorities. Working closely with CHNA partners, Beebe Healthcare will create effective strategies and most importantly gather support from community residents. The developed strategies will include performance metrics through which progress can be measured. The prioritization of the identified needs will guide the community health improvement efforts for residents served by Beebe Healthcare.

Our Plans for the Future

- Develop a plan in the implementation strategy planning phase to continue to provide high-quality health care services.
- Improve level of awareness related to available services and programs.
- Strengthen communication and community engagement. Solidify existing partnerships and collaborations.
- Continue to improve health literacy and promote prevention by addressing the community health issues related to behavioral health, chronic diseases, and healthy lifestyles.



FAST FACTS:

A comprehensive community health needs assessment was conducted in Sussex County for Beebe Healthcare.

The 2022 CHNA needs are Behavioral Health, Chronic Diseases, and Healthy Lifestyle.

The 2022 full CHNA report will be available for review on Beebe Healthcare's website.

For more information on the assessment, please contact the Population Health Department at Beebe Healthcare.



CONSULTANTS

Beebe Healthcare contracted with Tripp Umbach, a private healthcare consulting firm with offices throughout the United States, to complete a community health needs assessment (CHNA). Tripp Umbach has worked with more than 300 communities in all 50 states. In fact, more than one in five Americans live in a community where our firm has worked.

From community needs assessment protocols to fulfilling the new Patient Protection and Affordable Care Act (PPACA) IRS 990 requirements, Tripp Umbach has turned needs assessments into practical action plans with sound implementation strategies, evaluation processes, and funding recommendations for hundreds of communities. Tripp Umbach has conducted more than 400 community health needs assessments and has worked with more than 800 hospitals.

Changes introduced as a result of the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts among providers, public health agencies, and community organizations to improve the overall health of communities.



APPENDICES



A) GENERAL DESCRIPTION OF BEEBE HEALTHCARE

Beebe Healthcare, founded in 1916, is a not-for-profit community health system with services offered throughout Sussex County, Delaware. Beebe has become the premier healthcare facility in the County, serving thriving coastal towns, vacation resort areas, the desired retirement destination as well as farming and rural communities. Beebe provides comprehensive inpatient, outpatient, and emergency services. The current structure includes the Margaret H. Rollins Lewes Campus and its 210-bed medical center, the Rehoboth Health Campus, South Coastal Health Campus, as well as primary and specialty care practices throughout southern Delaware.

Outpatient services include Home Care, an Outpatient Surgical Center, Diagnostic Imaging, Physical Rehabilitation, four Walk-In Care Centers, and three High School-Based – Wellness Centers. In addition, the Margaret H. Rollins School of Nursing at Beebe Healthcare is the only hospital-based nursing school in Delaware.

Over the last five years, Beebe Healthcare has continued to expand and improve access to health care in Sussex County with its South Coastal Health Campus near Millville which includes a free-standing Emergency Department and Cancer Center. In addition, the expansion includes a brand-new Specialty Surgical Hospital on the Rehoboth Campus as well as an extension of its Center for Heart and Vascular Services at the Lewes Campus. Beebe was also the first hospital in the state to launch a Hospital at Home Program which allows qualifying patients to be treated for their medical condition in the comfort of their own homes as a substitute for traditional inpatient care.



Beebe Healthcare Campuses

Margaret H. Rollins Lewes Campus provides semiprivate patient rooms, private rooms, and additional onsite parking. An improved main entrance and the creation of a new West Lobby make navigation easier for patients and visitors. A new Hybrid Operation Room and a third Cardiac Catheterization/Electrophysiology Lab were completed in 2019. With the latest in advanced technology such as state-of-the-art da Vinci Robotic Surgical System and the Center for Heart and Vascular Services, patients will have access to less invasive procedures resulting in shortened recovery times and decreased risk of post-operative complications.

South Coastal Cancer Center offers all of the services currently available at the Tunnell Cancer Center in Rehoboth: medical oncology, chemotherapy, and radiation oncology. Beebe Healthcare's cancer care teams are committed to providing every patient and their family extraordinary care with great compassion.

Beebe's South Coastal Health Campus near Millville provides care at a new freestanding Emergency Department (ED) as well as a Level III trauma center. It will be open year-round, 24 hours a day, 7 days a week. There will be 14 emergency bays, onsite imaging and laboratory, and a helipad. We expect to provide emergency care for approximately 15,000 people annually. The South Coastal Emergency Department opened in May 2020 and will be in addition to the existing Millville Walk-In clinic.

Specialty Surgical Hospital Rehoboth Campus will enhance and expand access to advanced medical technologies and outpatient services. Outpatient and short stay surgeries offer many advantages over traditional inpatient surgery, without compromising quality of care. Some benefits of outpatient and short stay surgery include recovering in the privacy of your own home, generally lower costs, and less stress than an extended patient stay.

The mission of Beebe Healthcare is rooted in three actions: encouraging healthy living, preventing illness, and restoring optimal health within our community. To optimize the health of people in our community, Beebe Healthcare supports the provision of the community health needs assessment so that Beebe Healthcare may identify the community needs and adapt services to create a healthier community and bring services to where people live and work. The health care, education, and services provided today are key to the healthy communities of tomorrow.

www.BeebeHealthcare.org

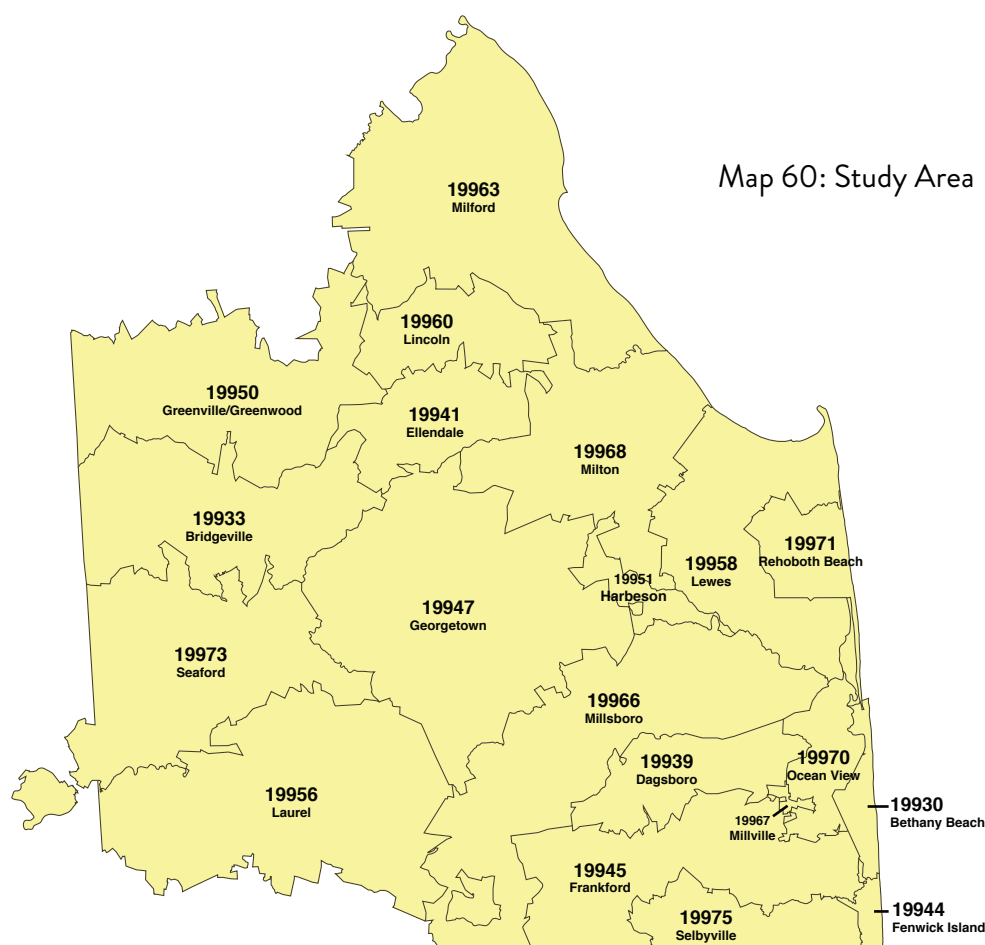


B) COMMUNITIES SERVED BY BEEBE HEALTHCARE

The primary service area for Beebe Healthcare was defined by ZIP codes that contain a majority of inpatient discharges. Beebe Hospital is the single largest provider of acute care services, the use of hospital services provides the clearest definition of the community. Beebe Healthcare's primary service area (PSA) includes 20 ZIP codes located within Sussex County.

Table 59: Primary Service Area ZIP Codes

ZIP Code	Population	City	ZIP Code	Population	City
19930	3,584	Bethany Beach	19958	24,834	Lewes
19933	10,332	Bridgeville	19960	7,674	Lincoln
19939	7,500	Dagsboro	19963	21,090	Milford
19941	3,032	Ellendale	19966	32,035	Millsboro
19944	779	Fenwick Island	19967	1,988	Millville
19945	8,465	Frankford	19968	13,683	Milton
19947	21,436	Georgetown	19970	7,930	Ocean View
19950	7,815	Greenville/Greenwood	19971	16,508	Rehoboth Beach
19951	1,682	Harbeson	19973	26,509	Seaford
19956	16,801	Laurel	19975	10,281	Selbyville



C) PROCESS OVERVIEW

A comprehensive community wide CHNA process was completed for Beebe Healthcare, connecting public and private organizations such as health and human service entities, government officials, and educational institutions to evaluate the needs of the community. The 2022 assessment included primary and secondary data collection that incorporated public commentary feedback, community stakeholder interviews, a community survey, focus groups, and an internal hospital prioritization session.

Primary and secondary data brought about the identification of key community health needs in the region. Beebe Healthcare will develop an implementation strategy that will highlight, discuss, and identify ways Beebe Healthcare will meet the needs of the communities it serves.

Tripp Umbach worked closely with Beebe Healthcare to collect, analyze, review, and discuss the results of the CHNA, culminating in the identification and prioritization of the community's needs at the local level. The flow chart below outlines the process of each project component in the CHNA.

Figure 61: Process Chart of Community Health Needs Assessment (CHNA) 2022



D) EVALUATION OF PREVIOUS FY2019 PLAN

Representatives from Beebe Healthcare have worked over the last three years to develop and implement strategies to address the health needs and issues in the study area and evaluate the effectiveness of the strategies created in terms of meeting goals and combating health problems in the community.

Tripp Umbach received the 2019 CHNA implementation plan status and outcome summary assessments provided by the working group charged with assisting in completing the CHNA. Tripp Umbach provided the Beebe Healthcare working group with an implementation strategy planning evaluation matrix to use for the 2022 implementation strategy planning. The purpose of the evaluation process is to determine the effectiveness of the 2019 CHNA and implementation plan strategies, including each of the identified priorities: Behavioral Health and Mental Health, Cancer/Prevention & Screening, and Obesity/Nutrition/Chronic Disease. The summary matrix is located in the evaluation section of the report. The full evaluation matrix can be obtained from the Population Health Department.

E) COMMUNITY STAKEHOLDER INTERVIEW RESULTS

As part of the CHNA phase, telephone interviews were completed with community stakeholders in the service area to better understand the changing environment. Twenty interviews were completed to gain a deeper understanding of community health needs from organizations, agencies, and government officials that have a deep understanding from their day-to-day interactions with populations in greatest need. Interviews provide information about the community's health status, risk factors, service utilizations and community resource needs, as well as gaps and service suggestions.

The interviews also offered community leaders an opportunity to provide feedback on the needs of the community, suggestions on secondary data resources to review and examine, and other information relevant to the study. Community stakeholders targeted for interviews encompassed a wide variety of professional backgrounds including:

1. Public health expert
2. Professionals with access to community health-related data
3. Social service representatives
4. Representatives of underserved populations; and
5. Government leaders

The qualitative data collected are the opinions, perceptions, and insights of those who were interviewed as part of the CHNA process. Within the interview and discussion process, overall health needs, themes, and concerns were presented. Within each of the overarching themes, additional topics fell under each category.

Overall Community Feedback

- **70.0%** rated health/human services in the community as very good/good.
- **94.7%** — Strongly agree/agrees Beebe Healthcare offers high-quality health care for the community.
- **84.2%** — Strongly agree/agrees Beebe Healthcare addresses the needs of diverse and disparate populations.
- **88.9%** — Strongly agree/agrees Beebe Healthcare ensures access to care for everyone regardless of race, gender, education, and economic status.
- **94.8%** Strongly agree/agrees Beebe Healthcare is actively working to identify and address health inequities that impact its patients.

Health/Social Concerns in the Community (Top Five)

1. Behavioral Health
2. Homelessness
3. Unemployment/Underemployment
4. Aging Problems
5. Care for moms/babies

Largest Barriers for People not Receiving Care/ Services (Top Five)

1. Availability/Lack of Transportation
2. Availability of services (i.e., lack of providers such as PCP, dentist, and therapists/services)
3. Cultural barriers
4. Economic disparities
5. Health literacy

Contributors to Transportation Issues (Top Three)

1. Limited services
2. Location of bus stops
3. Cost of services is too high

Persistent High-Risk Behaviors (Top Five)

1. Substance abuse
2. Poor eating habits/unhealthy eating habits
3. Lack of Education
4. Lack of exercise/inadequate physical activity
5. Social injustice

Would Improve Quality of Life for Residents (Top Five)

1. Housing
2. Access to behavioral health services
3. Mental health services
4. Strategic focus on specific SDOH issues
5. Substance abuse support

Vulnerable Populations (Top Five)

1. Low-income
2. Homeless
3. Minorities
4. Mentally ill
5. Children/Adolescents

F) PUBLIC COMMENTARY RESULTS

Tripp Umbach solicited comments related to the 2019 CHNA and Implementation Strategy Plan (ISP) on behalf of Beebe Healthcare. The solicitation of feedback was obtained from community stakeholders. Observations offered community representatives the opportunity to react to the methods, findings, and subsequent actions taken because of the previous 2019 CHNA and implementation planning process. The public comments are a summary of stakeholders' feedback regarding the former documents. The collection period for the survey began in March 2022.

When asked whether the assessment “included input from community members or organizations,” 61.1% reported that it did, 11.1% reported that it did not, and 27.8% were unsure.

According to respondents, the CHNA and the ISP benefited them and their community in the following manner (in no specific order):

- It had members advocate community events, cultural community events, and touching the community.
- Affirmed what we know as a community leader.
- Beebe Healthcare is a partner and they reached out as educational partners.
- Beebe Healthcare is a community hospital, they want to expand and be involved in the region.
- The hospital is a huge asset, it helps gives them insight into the community. It also helped develop more strategies to help the community.
- Partnership with Beebe Healthcare has grown significantly, working with low income, and nutrition/food programs.
- More preventive services, education or resources were provided.
- Benefitted by driving programming into communities to improve access to care - immunization clinics.

When asked whether the implementation strategies were directly related to the needs identified in the CHNA, 62.5% reported that it did, 6.3% reported that it did not, and 31.3% did not know.

Additional feedback related to the CHNA and ISP included (in no particular order):

- Take a strategic assessment of the response to lessons learned from COVID-19 and move it forward.
- Implementation for community health workers in alignment with the challenges identified in the CHNA could strengthen the healthcare system's response.
- The need for more experienced specialists (neurology).
- Need to break down silos pertaining to access to care and transportation services.
- Excited to partner with Beebe Healthcare moving forward.
- Implementation plans for Sussex County healthcare systems should be developed collaboratively because that causes a greater impact. Work in conjunction with the state plan to align efforts and data and outcomes specifically tied to plans like in a dashboard on regular basis. Community efforts should be better supported. Systems need to partner with organizations that are representative. Identify and address.
- Finding ways to go to people, proving primary care, and preventative care services. This helps remove the burdens of the ED.
- More integrated efforts for seniors.

Listed below are the organizations represented by the community stakeholders who participated in the community health needs assessment for Beebe Healthcare.

Table 62: Organizations of Community Stakeholders

Organizations	
A.C.E. Community Resource Center	First State Community Action Agency
CAMP Rehoboth	Highmark Community Reinvestment Council
Cape Community Coordination for COVID-19 (CCC4COVID) Grassroots Coalition	Highmark Health, Blue Cross/Blue Shield of Delaware
Community Resource Ctr/The Lewes-Rehoboth Association of Churches	Highmark Health, Blue Cross/Blue Shield of Delaware
Delaware Department of Health	Joshua M. & Carl M. Freeman Foundations
Delaware Healthcare Association	La Red Health Center
Delaware Racial Justice Collaborative	PMG Consulting/The Sussex County Health Coalition
Delaware State Representative (District 37)	The Delaware Coalition Against Domestic Violence
Delaware State University	United Way of Delaware
Delaware Technical Community College	Village Volunteers



G) COMMUNITY HEALTH DATA PROFILE (SECONDARY DATA)

Tripp Umbach completed a comprehensive analysis of health status and socioeconomic environmental factors related to the health and well-being of residents in the community from existing data sources, such as state and county public health agencies. These agencies include America's Health Rankings®, Centers for Disease Control and Prevention, Community Commons Data, Community Needs Index (CNI), County Health Rankings, FBI Crime Report, Feeding America, Kaiser Family Foundation, National Center for Education Statistics, U.S. Census Bureau, and other additional data sources. Tripp Umbach benchmarked data against state and national trends where applicable.

The secondary data profile includes information from multiple health, social, and demographic resources. Tripp Umbach used secondary data sources to compile information related to disease prevalence, socioeconomic factors, and behavioral habits. The information supplied is an overview of the secondary figures collected as part of the CHNA. The robust secondary data report was provided to the working group of Beebe Healthcare to review and evaluate the needs of the region.

The data provided does not replace existing local, regional, and national sites but rather provides a comprehensive (not all-inclusive) overview that complements and highlights existing and changing health and social behaviors of community residents for the health system and social and community health organizations involved in the community health needs assessment. A full comprehensive secondary data document was generated for Beebe Healthcare. Below are some highlights from the report.

- Information on Children
- Clinical Care
- Community Needs Index (CNI)
- County Health Rankings
- Crime and Safety
- Demographic Information
- General Health
- Health Behaviors
- Health Outcomes

Community Needs Index (CNI)

Tripp Umbach obtained data from Dignity Health and Truven Health Analytics to quantify the severity of health disparities. Truven Health Analytics provides data and analytics to hospitals, health systems, and health-supported agencies.

The Community Need Index (CNI) data source was used in the health assessment. CNI considers multiple factors that are known to limit healthcare access; the tool is useful in identifying and addressing the disproportionate and unmet health-related needs of neighborhoods. The five prominent socioeconomic barriers to community health quantified in the CNI are income barriers, cultural/language barriers, educational barriers, insurance barriers, and housing barriers.

A score of 5.0 represents a ZIP code area with the most socioeconomic barriers (high need), while a score of 1.0 indicates a ZIP code area with the lowest socioeconomic barriers (low need). A low score is the ultimate goal; however, ZIP codes with a low score should not be overlooked. Rather, communities should identify what specific entities are succeeding, which ensures a low score.

The ZIP codes reflected in the below slides reflect the primary service area of Beebe Healthcare. The CNI scores within each ZIP code will be able to assist the hospital as the implementation planning strategies will require efforts in specific geographic locations.

Map 63: ZIP Code Map of CNI Scores

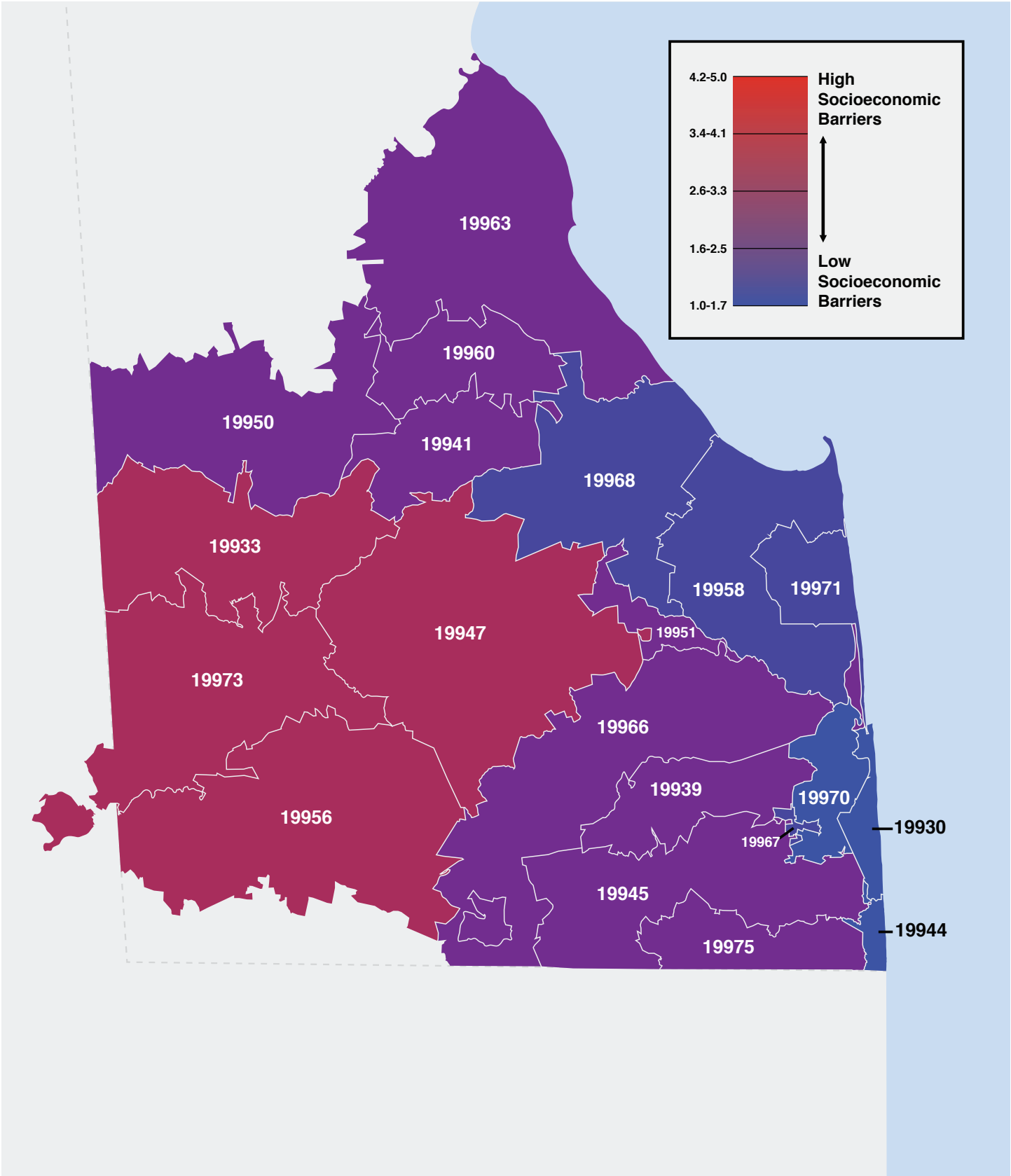
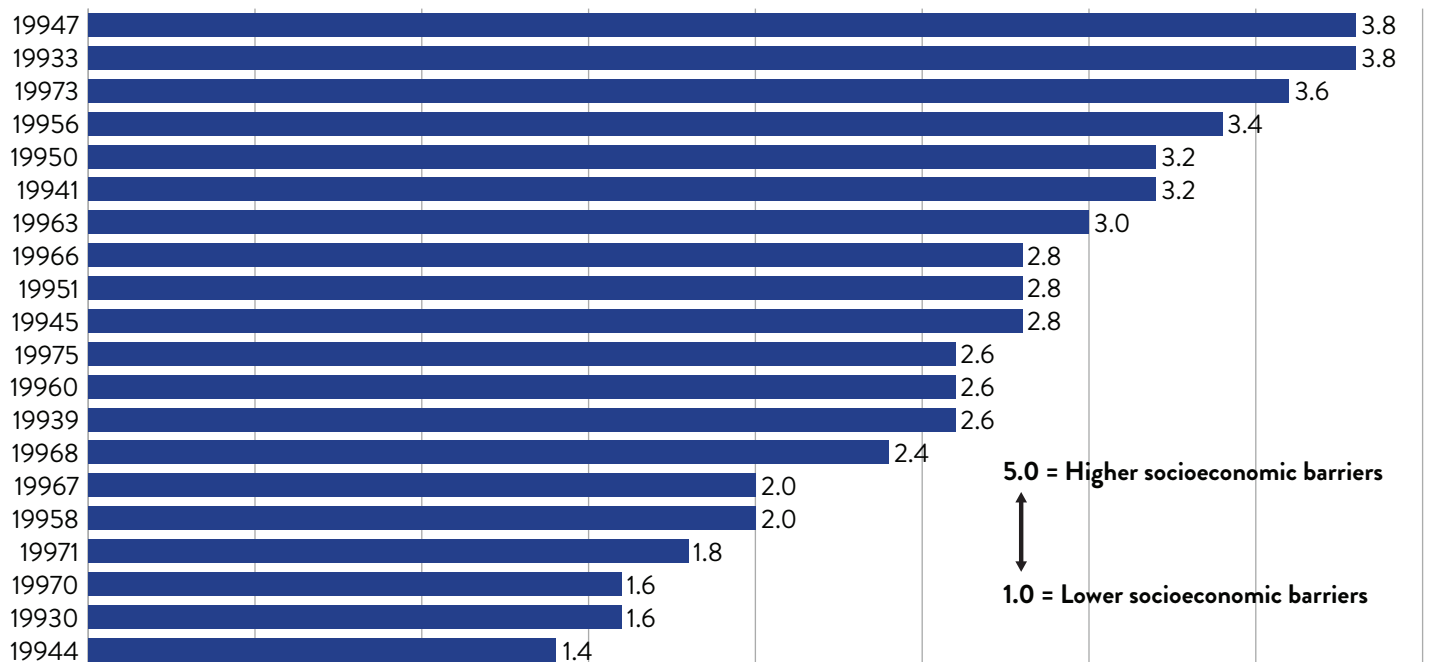


Table 64: Sussex County CNI Scores

ZIP Code	CNI Score	Population	City
19930	1.6	3,584	Bethany Beach
19933	3.8	10,332	Bridgeville
19939	2.6	7,500	Dagsboro
19941	3.2	3,032	Ellendale
19944	1.4	779	Fenwick Island
19945	2.8	8,465	Frankford
19947	3.8	21,436	Georgetown
19950	3.2	7,815	Greenville/Greenwood
19951	2.8	1,682	Harbeson
19956	3.4	16,801	Laurel
19958	2.0	24,834	Lewes
19960	2.6	7,674	Lincoln
19963	3.0	21,090	Milford
19966	2.8	32,035	Millsboro
19967	2.0	1,988	Millville
19968	2.4	13,683	Milton
19970	1.6	7,930	Ocean View
19971	1.8	16,508	Rehoboth Beach
19973	3.6	26,509	Seaford
19975	2.6	10,281	Selbyville

Figure 65: CNI Summary of ZIP Codes



Source: Dignity Health; Truven Health Analytics

- ZIP codes 19947 (Georgetown) and 19933 (Bridgeville) have the highest score within the PSA of Beebe Healthcare (3.8).
- ZIP code 19944 (Fenwick Island) has the lowest score within the PSA (1.4).

America's Health Rankings®

America's Health Rankings® is the longest-running annual assessment of the nation's health on a state-by-state basis. For the past 25 years, America's Health Rankings® has provided a holistic view of the health of the nation. America's Health Rankings® is the result of a partnership between United Health Foundation, American Public Health Association, and Partnership for Prevention™.

Delaware's Top Strengths, based on America's Health Rankings® 2021:

- Low prevalence of frequent mental distress
- High childhood immunization rate
- High prevalence of colorectal cancer screening

Delaware's Top Challenges, based on America's Health Rankings® 2021:

- High prevalence of obesity
- High prevalence of high-risk HIV behaviors
- High preventable hospitalization rate

Delaware's Top Highlights, based on America's Health Rankings® 2021:

- Drug deaths increased 29% from 35.9 to 46.2 deaths per 100,000 population between 2017 and 2019
- Mental health providers increased 27% from 235.7 to 299.0 per 100,000 population between 2017 and 2021
- High health status increased 12% from 49.2% to 55.2% of adults between 2019 and 2020

County Health Rankings

The County Health Rankings were completed as a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Each county receives a summary rank for its health outcomes, health factors, and also for the four different types of health factors: health behaviors, clinical care, social and economic factors, and the physical environment. Analyses can also drill down to see specific county-level data (as well as state benchmarks) for the measures upon which the rankings are based. Counties in each of the 50 states are ranked according to summaries of more than 30 health measures. Those having high ranks, e.g., 1 or 2, are considered to be the “healthiest.”

- Delaware has three counties. A score of 1 indicates the “healthiest” counties for the state in a specific measure. A score of 3 indicates the “unhealthiest” county for the state in a specific measure. The counties that hold the lowest rankings, symbolize the unhealthiest of the study area.

Table 66: Sussex County Health Rankings

Years	2012	2015	2018	2021
Health Outcomes	2	1	1	2
Health Factors	2	2	2	2
Length of Life (Mortality)	3	1	2	2
Quality of Life (Morbidity)	1	2	1	1
Health Behaviors	2	2	2	2
Clinical Care	1	2	2	2
Social & Economic Factors	1	2	2	2
Physical Environment	1	1	3	3

Source: County Health Rankings & Roadmaps

H) COMMUNITY HEALTH SURVEY

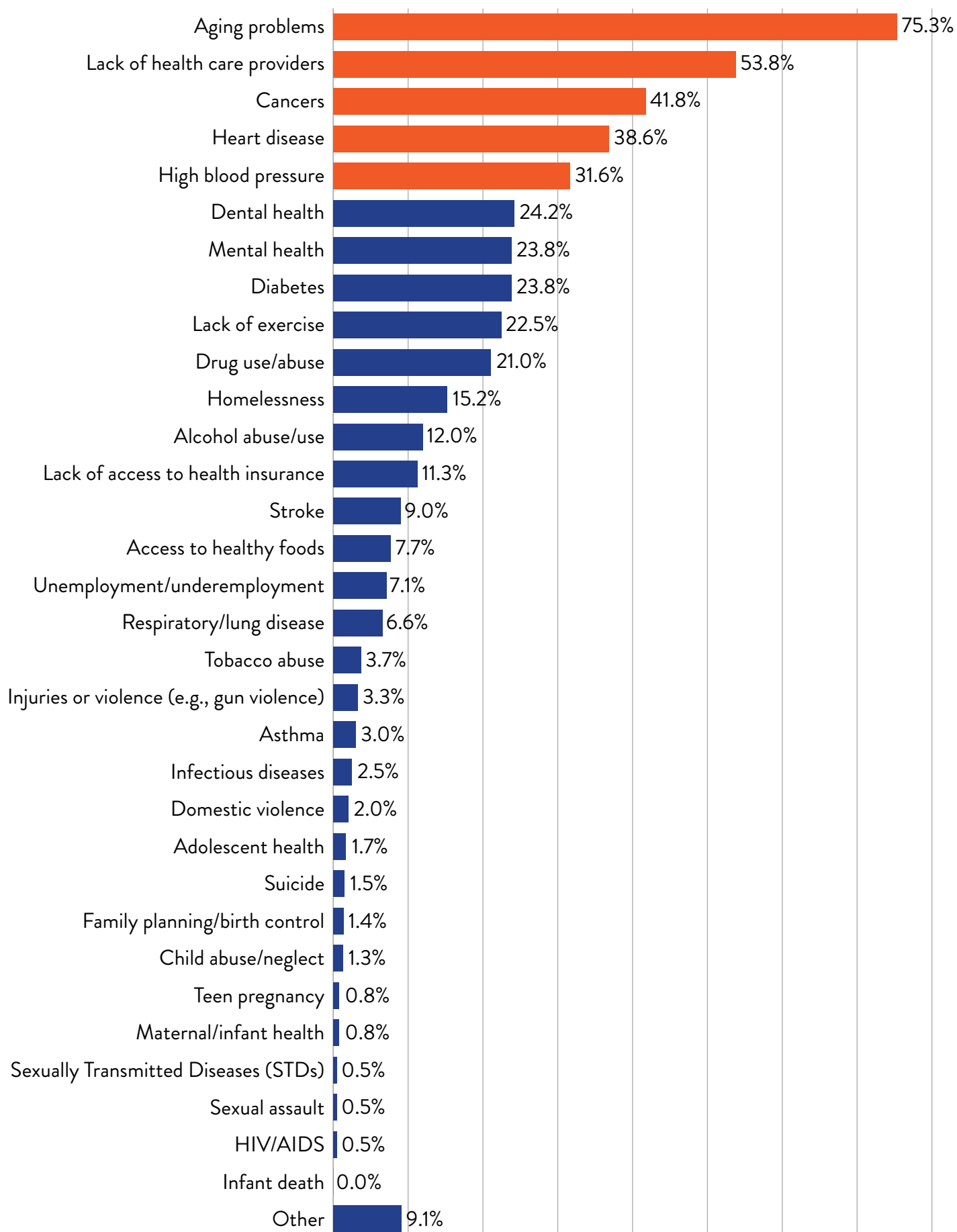
A community survey was employed to collect input from populations within Beebe Healthcare's service area in order to identify health risk factors and health needs in the community. Working with the working group from Beebe Healthcare the community survey was promoted internally, on social media platforms, and with existing relationships with a community-based organization. Thousands of surveys were collected from community residents as a result.

The survey was accessible electronically on Survey Monkey and was available in English, Spanish, and Haitian Creole. In total, 1,991 surveys were used for analysis. Hand copies of the survey were also distributed to participants at several health fairs sponsored by Beebe Healthcare. The data collection period ran from March 2022 to April 2022.

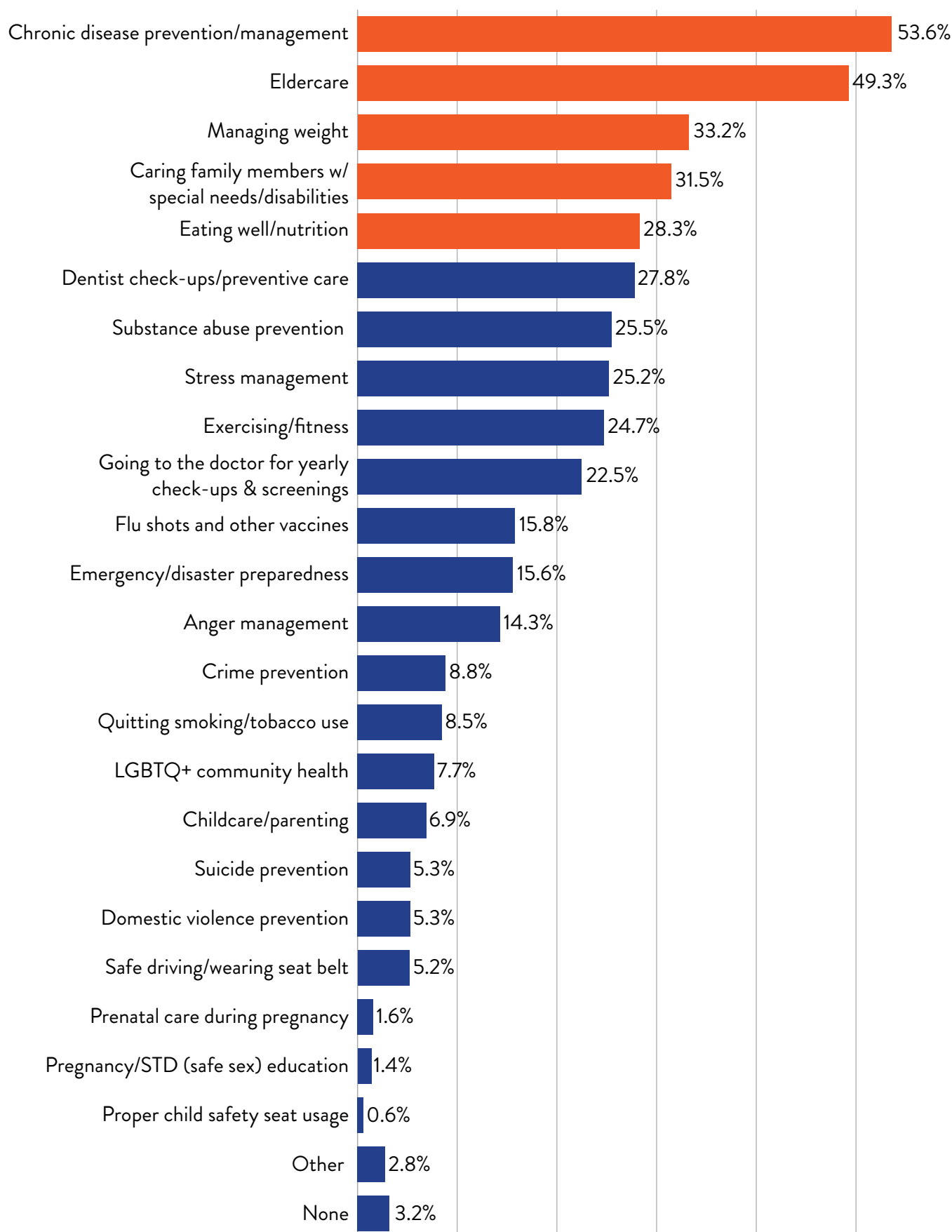
- 1,986 surveys were collected in English
- 4 were collected in Spanish
- 1 was collected in Haitian Creole
- 83 hand-surveys were collected



Q: Health Problems with Greatest Impact on Overall Community Health

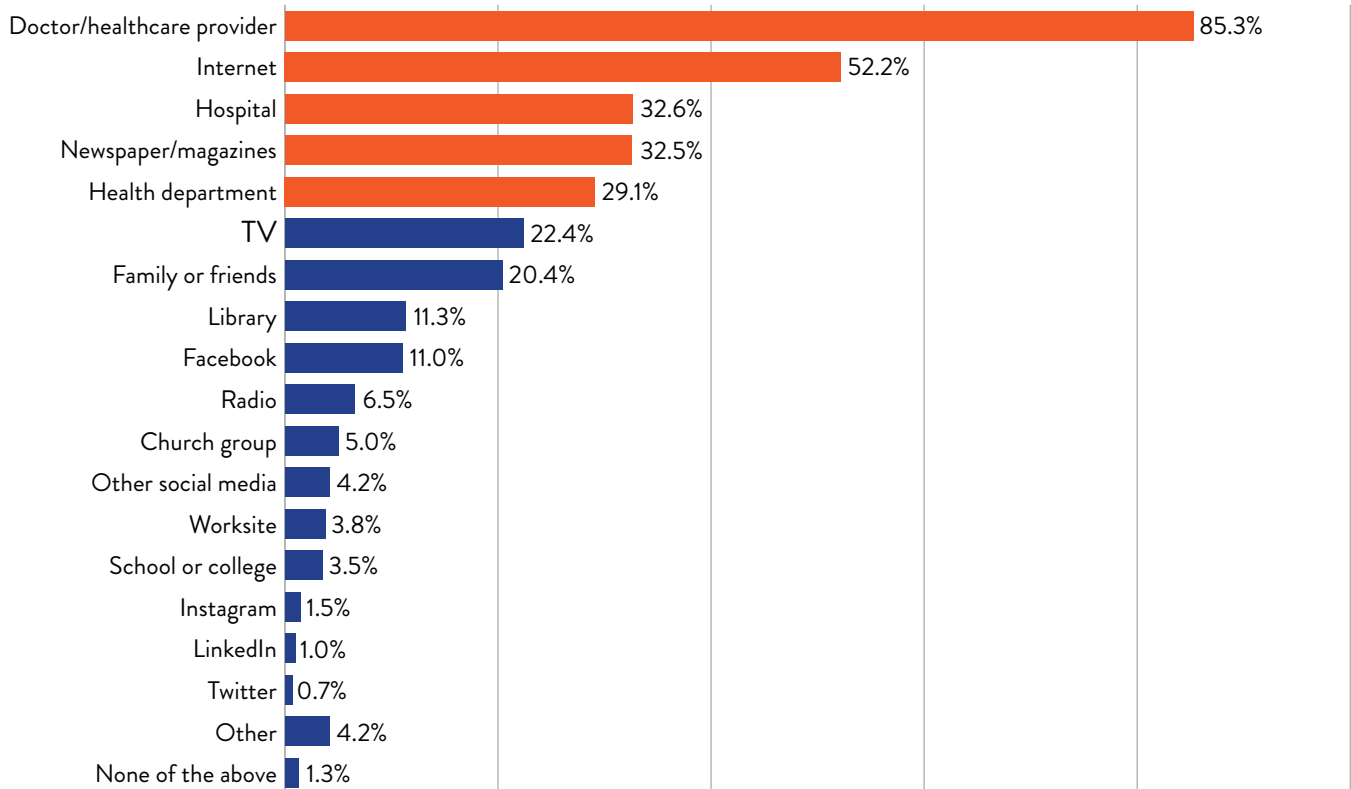


Q: Type of Information Needed in Community



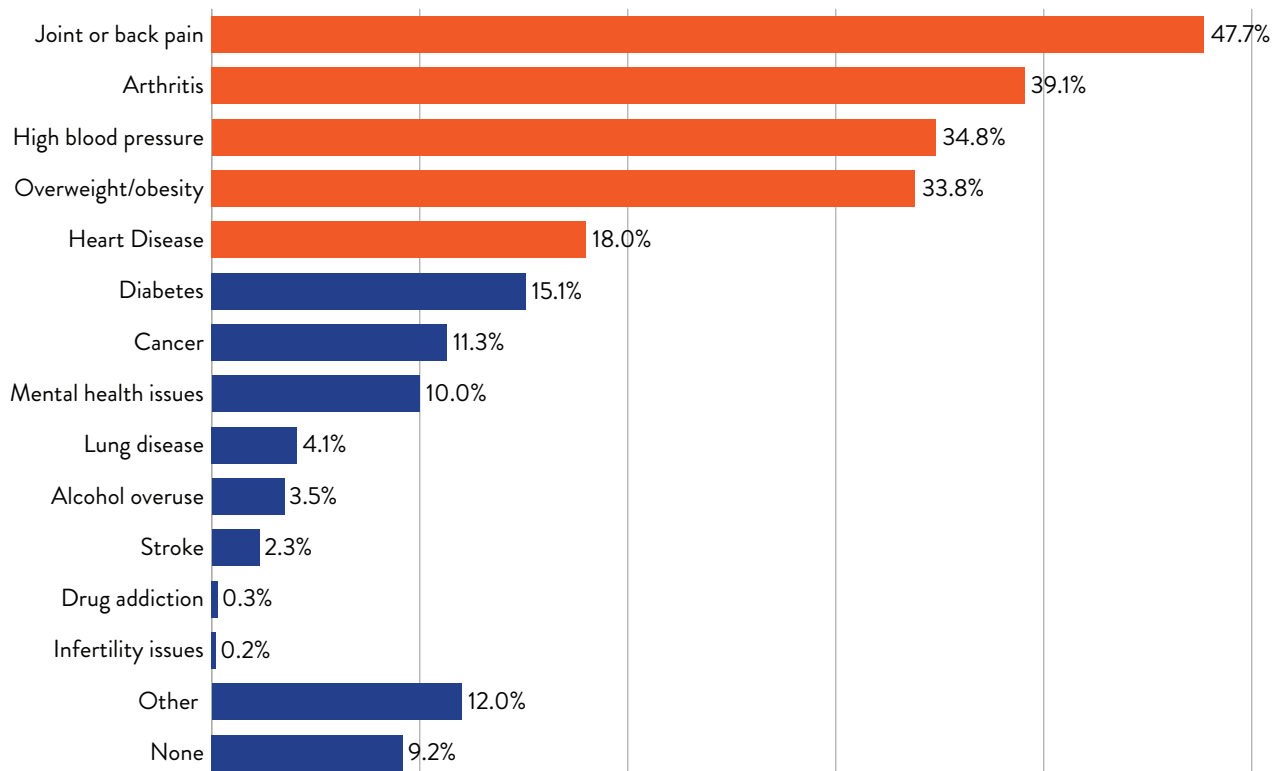
Note: This is a check all that apply question. Responses for the “other” category included: None/Not applicable (74.5%), Covid-19 (9.3%), Lack of available doctor/healthcare provider (9.3%), Time (3.1%) Transportation (1.2%)

Q: How to Receive General Health Information

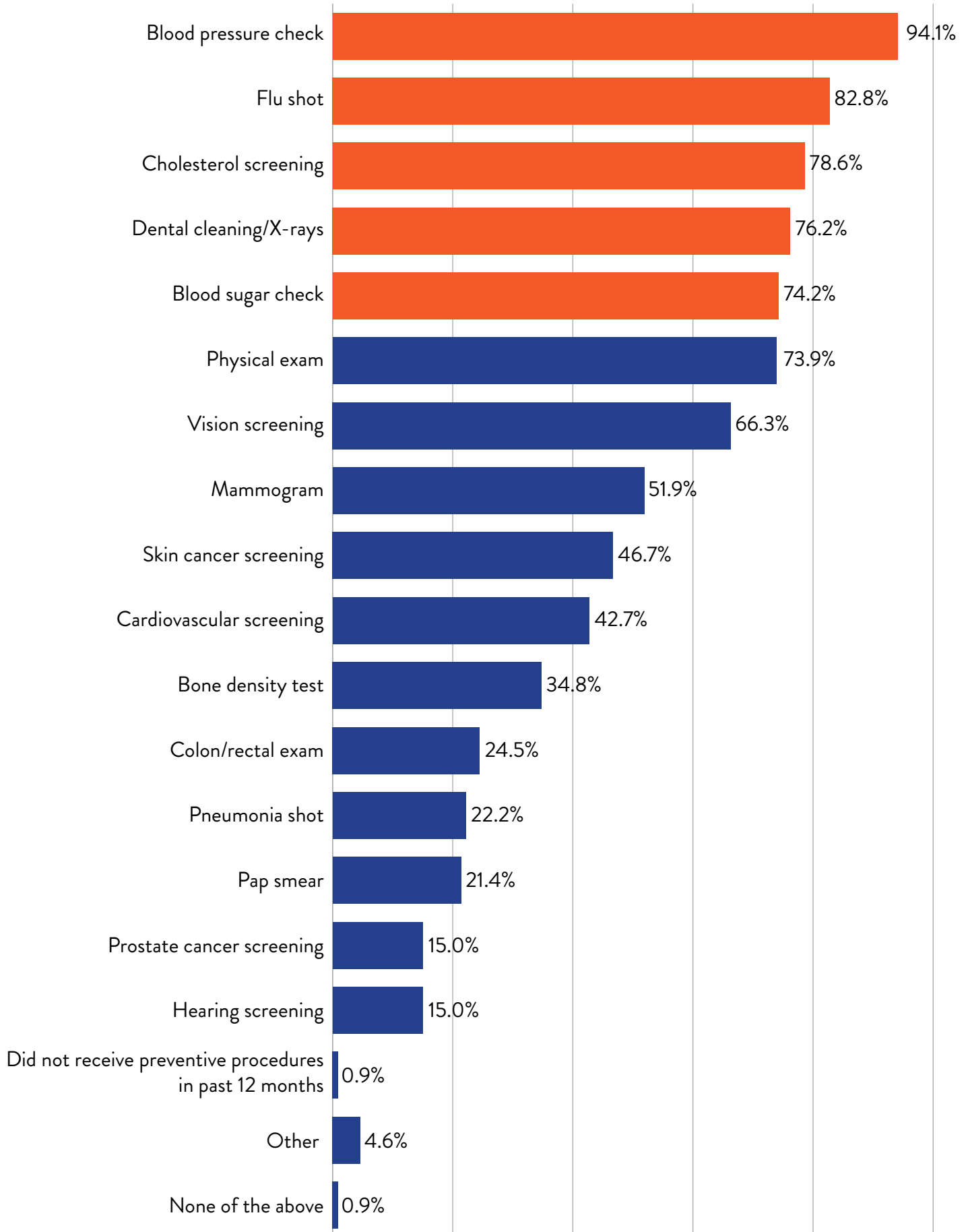


Note: This is a check all that apply question. Responses for the “other” category included: None/Not applicable (80.7%), Lack of availability of doctors (7.5%), Unavailable appointment times (5.0%), Unable to Pay (3.4%), Lack of coordination (1.0%).

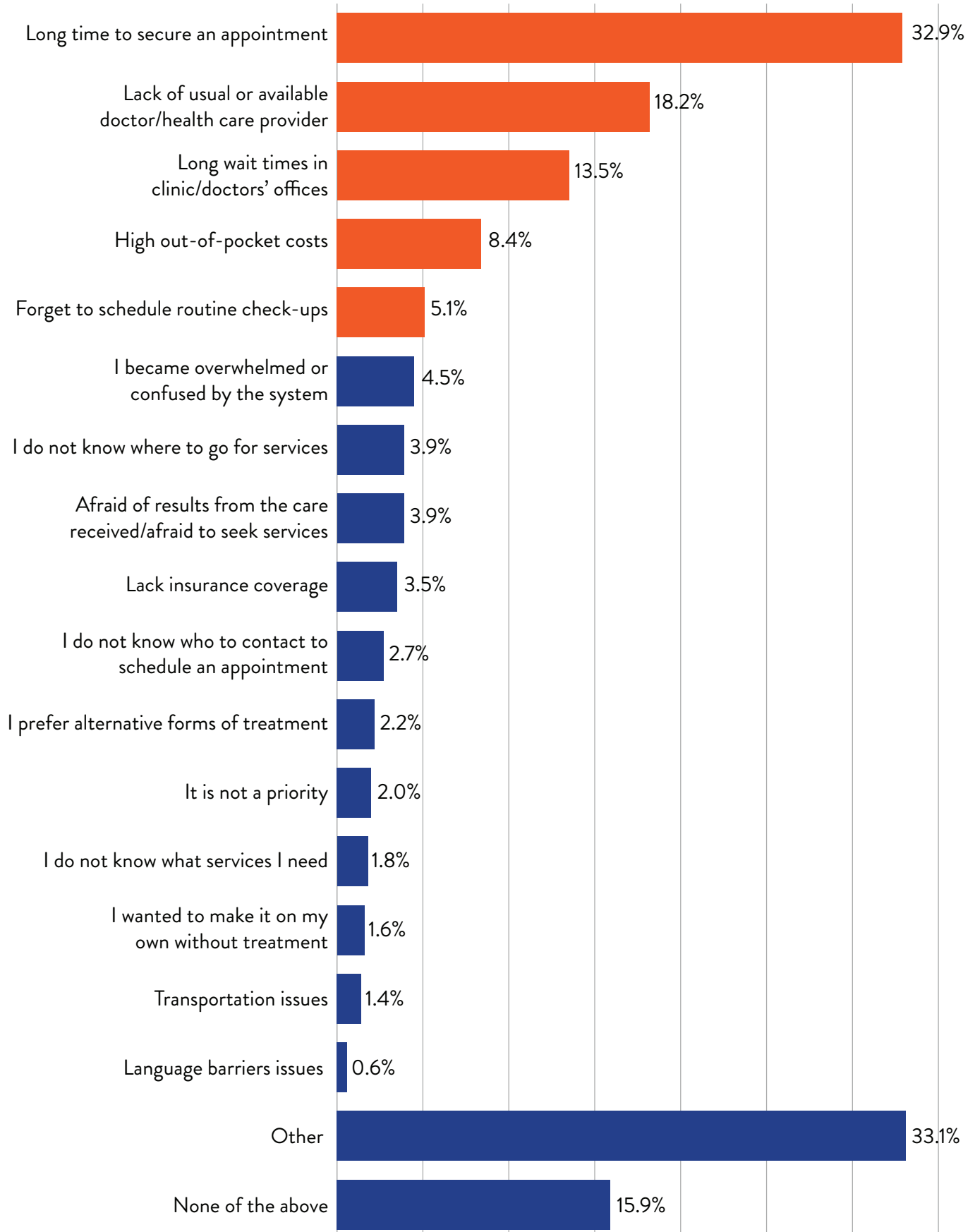
Q: Health Challenges Currently Faced



Q: Preventive Procedures Had in the Past Twelve Months

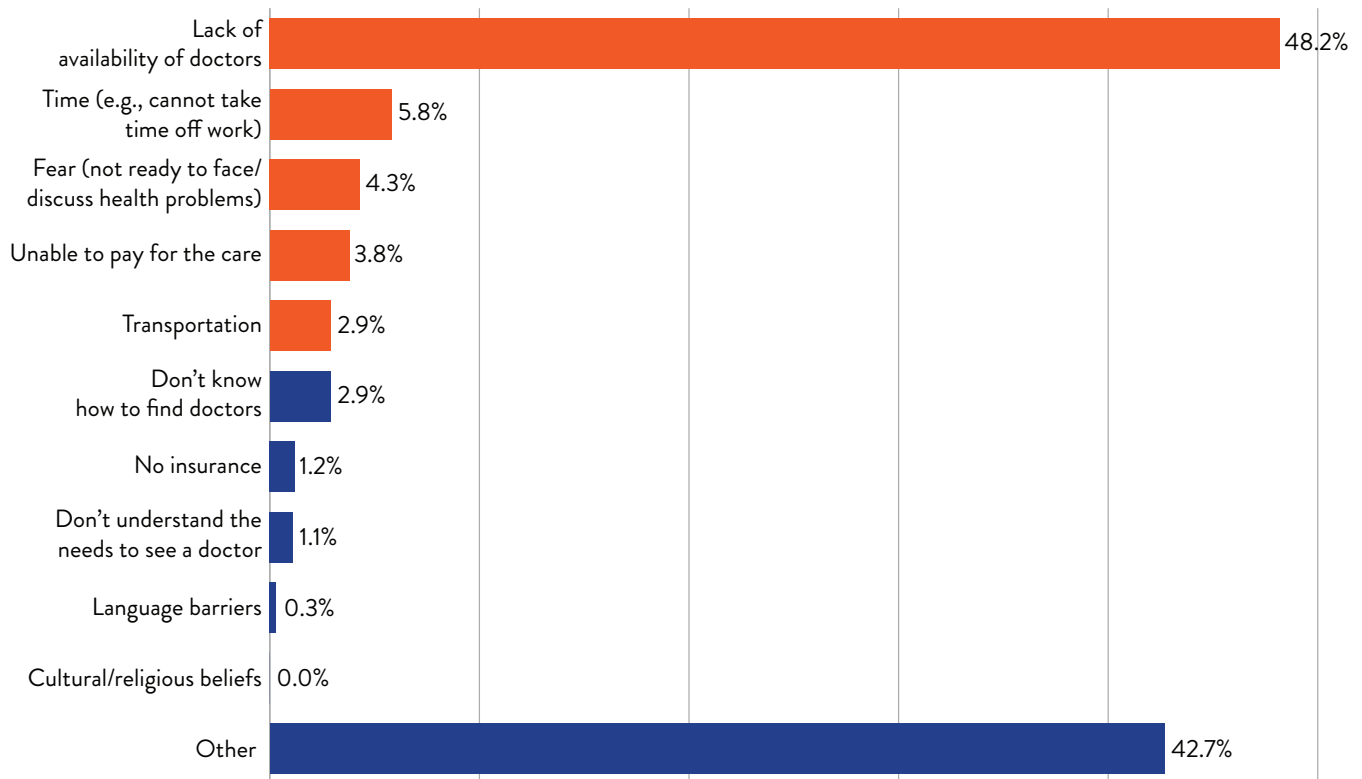


Q: If you have not received preventive care services, why not?



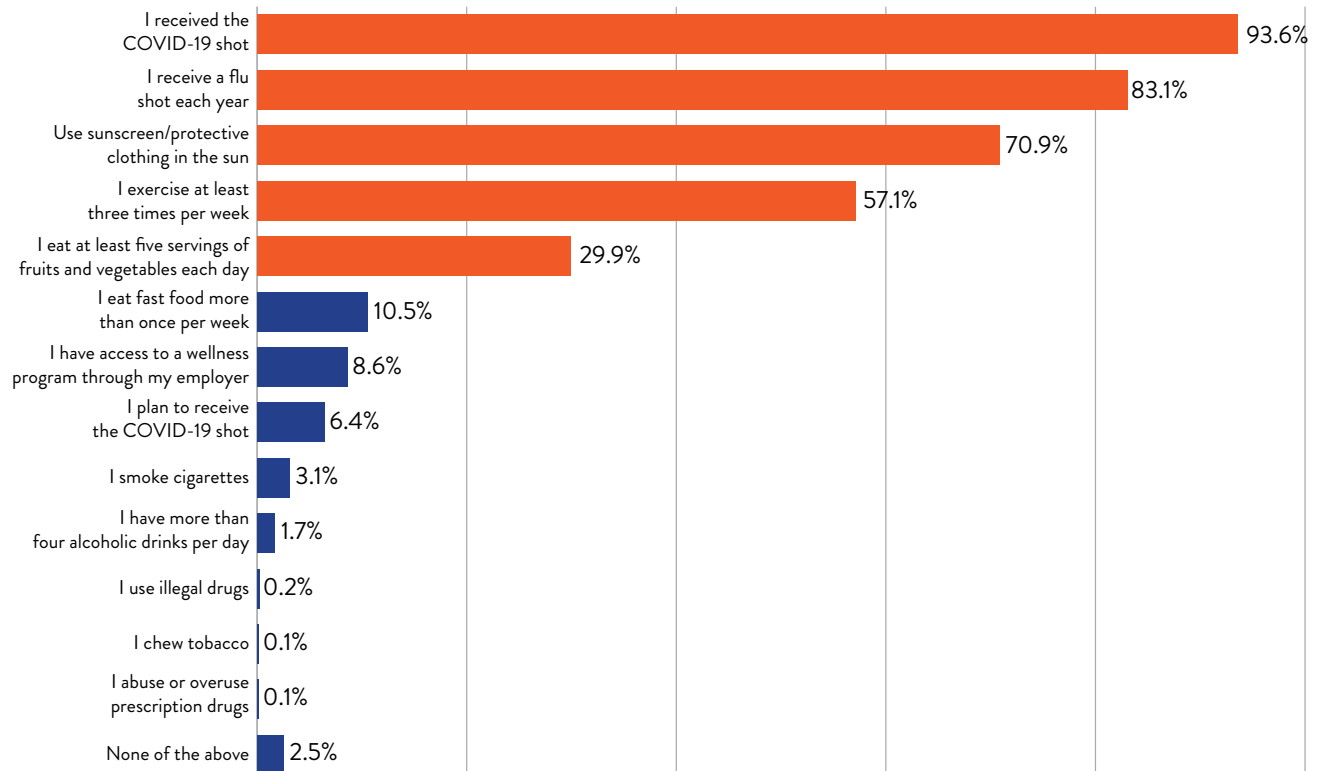
Note: This is a check all that apply question. Responses for the “other” category included: None/Not applicable (74.5%), Covid-19 (9.3%), Lack of available doctor/healthcare provider (9.3%), Time (3.1%) Transportation (1.2%)

Q: Issues That Prevent You from Accessing Care



Note: This is a check all that apply question. Responses for the “other” category included: None/Not applicable (80.7%), Lack of availability of doctors (7.5%), Unavailable appointment times (5.0%), Unable to Pay (3.4%), Lack of coordination (1.0%).

Q: Statements That Apply...



Q: Rating the Following Statements

	Very Satisfied	Satisfied	Unsatisfied	Very Unsatisfied
I am satisfied with the quality of life in my community. (Weighted average 1.8)	33.7%	58.5%	6.6%	1.2%
I am satisfied with the health care system in my community. (Weighted average 2.3)	13.9%	48.6%	30.3%	7.2%
All individuals and groups in my community have the same and equal access to contributing and participating in the community's quality of life. (Weighted average 2.3)	12.7%	48.7%	30.5%	8.1%
I am satisfied with the amount of health and social services in my community. (Weighted average 2.6)	6.9%	40.7%	42.6%	9.8%
I am satisfied with the diversity of my health care providers. (Weighted average 2.1)	18.4%	59.9%	16.5%	5.3%



Q: How can your hospital better meet your health care needs?

Highlights/Overarching Themes (Continue to next page)

- Access to healthcare providers/specialists in growing areas in Sussex County
- Address the needs of an aging population
- Advance cancer treatment
- Advocate for better health services and prevention services for marginalized communities and low-income persons
- Affordable housing
- Affordable dental care services
- Align the EMRs so ambulatory and acute setting records are more easily available
- Allow for longer doctor visits
- Allow providers more autonomy to care for patients with less administrative intervention
- Attract more doctors and specialists
- Beebe Healthcare should be available to all
- Better access to specialty services such as geriatric care, dental care, cardiology, urology, dermatology, arthritis care, etc.
- Better scheduling, availability, and coordination of services
- Better signs/room numbering system at the hospital
- Better women's health facilities and more comprehensive women's services
- Better care coordination
- Better/more specialized care
- Bilingual providers and mobile clinics
- Care for the uninsured and those with high deductibles
- Need for closer facilities
- Communicate, collaborate, and cooperate with other health care systems
- Continue development of South Coastal center in Millville
- Continue to offer cultural diversity and acceptance of our population and communities
- Create a more understandable billing system for patients
- Create one central Health Portal by which patients and users can access their medical information and billing needs
- Develop a paramedic training program
- Improve the waiting period to schedule and see a physician

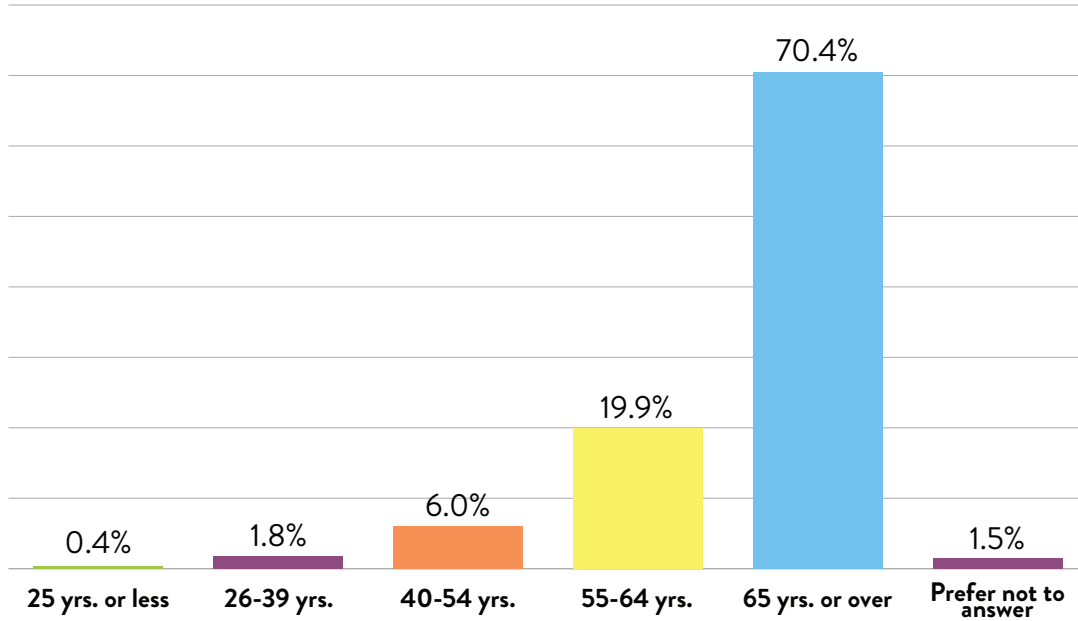
Q: How can your hospital better meet your health care needs?

Highlights/Overarching Themes

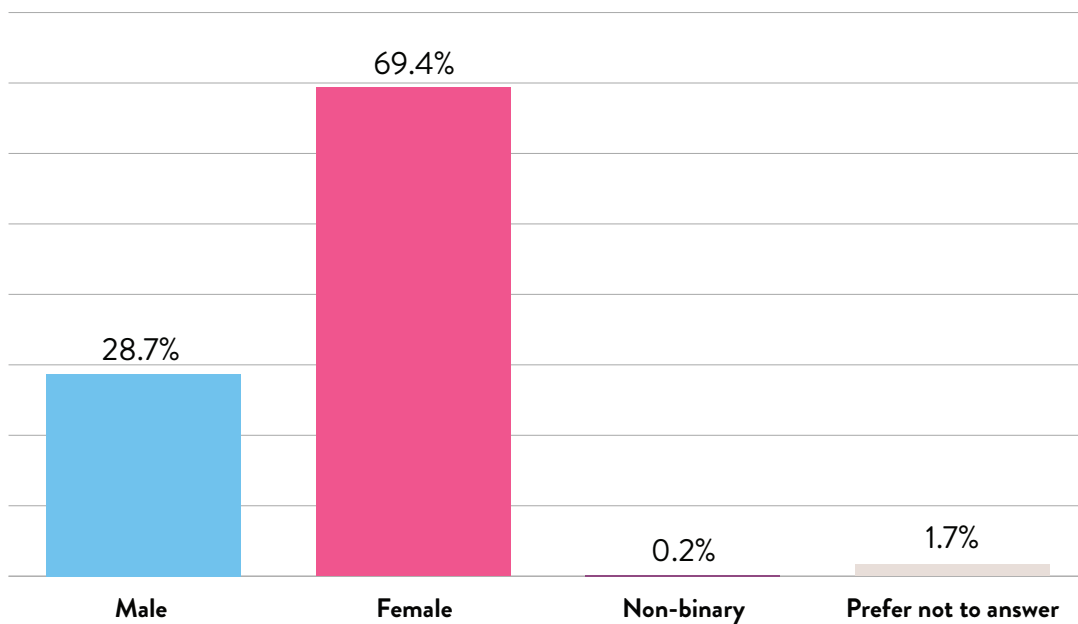
- Better weekend and evening access
- Difficulty in establishing relationships with some specialists who were in short supply
- Education, preventive care, and continued outreach
- Electronic medical records for physicians to access
- Expand services to other communities
- Focus more on prevention and health promotion and home-based care
- Grow services & access to match population growth
- Improve access to and availability of health care professionals. Improve the quality of care. Establish and track standards for health care access and outcomes
- Improve long appointment/wait times
- Improve medical infrastructure (i.e., physicians, specialists, dental, and locations)
- LGBTQ+ focused care
- Listen more to the concerns about patients' health issues
- Make all service buildings handicapped accessible
- Meet the needs of an aging population
- More community outreach programs
- More diversity in healthcare providers
- More programs offered regarding weight loss and weight management
- Need for walk-in care/clinic care
- Offering wellness and preventive programs. I have been looking for nutritional classes for diabetes and plant-based sources of proteins and recipes.
- Online waiting room
- Wellness seminars and community outreach

Demographics

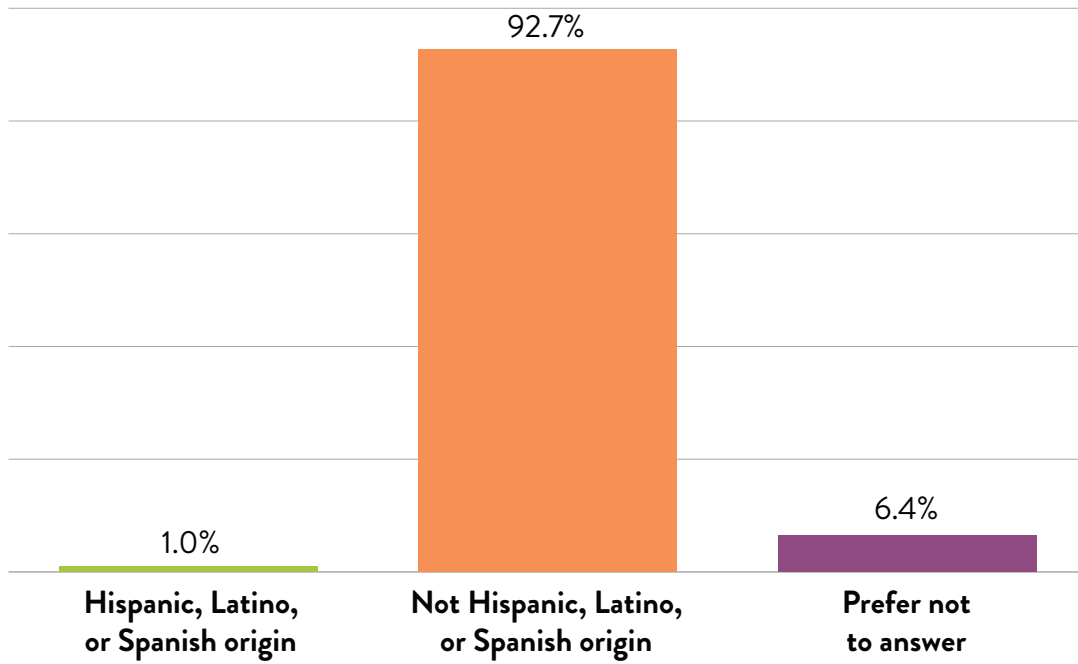
What is your age?



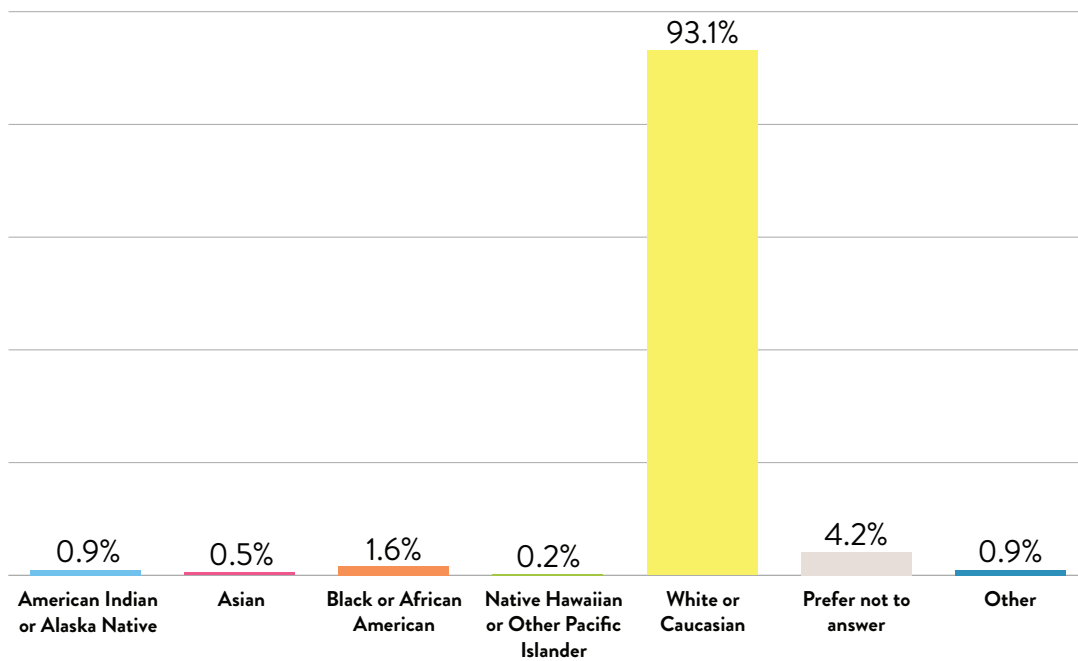
What is your gender?



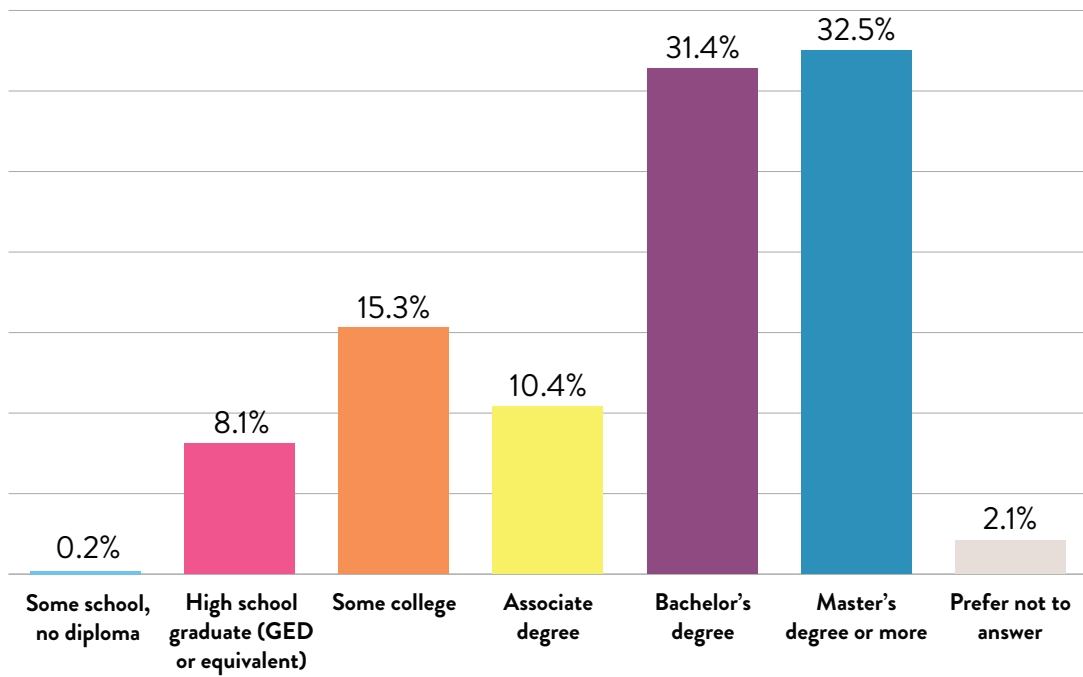
What is your ethnicity?



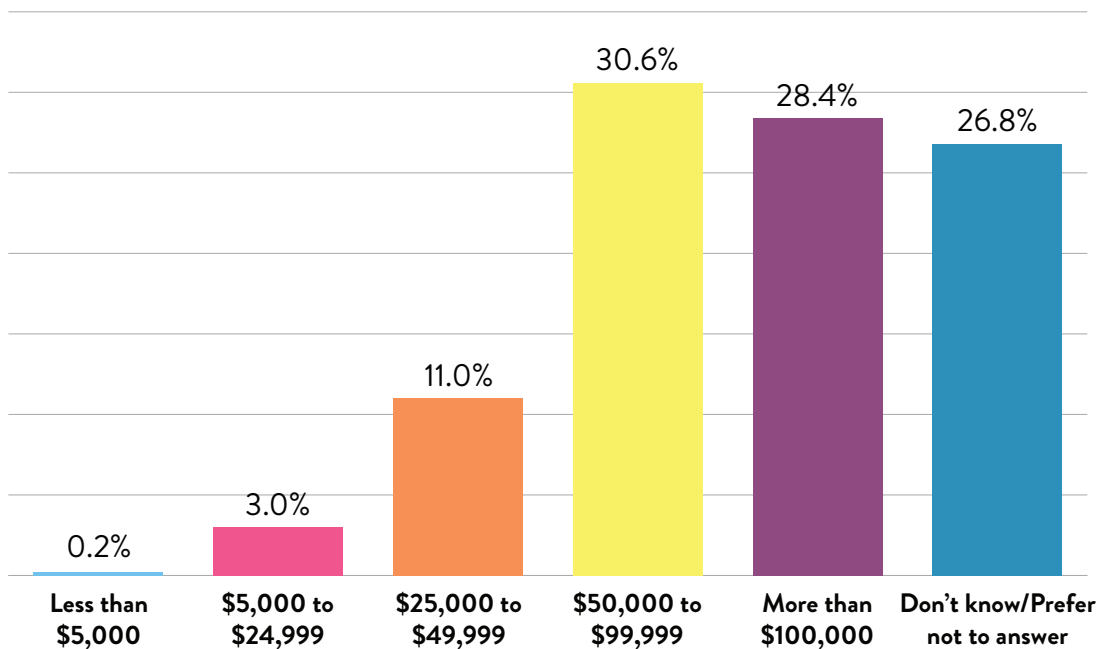
What is your race or origin?



What is your highest level of education?



What is your annual household income?



The information represented below are the summary of key survey findings collected from the community survey.

Most Significant Health Problems (Top Five)

1. Aging problems
2. Lack of health care providers
3. Cancers
4. Heart disease
5. High blood pressure

Needs to Improve Quality of Life/Health (Top Five)

1. More health care providers/specialty physicians
2. Elder care options
3. Affordable health care services
4. Dental care access
5. Affordable, quality housing

Health Behaviors Communities Need More Information About (Top Five)

1. Chronic disease prevention/management
2. Eldercare
3. Managing weight
4. Caring for family members with special needs/disabilities
5. Eating well/nutrition

Ways to Receive General Health Information (Top Five)

1. Doctor/health care provider
2. Internet
3. Hospital
4. Newspaper/magazines
5. Health department

Health Challenges Individuals Currently Face (Top Three)

1. Joint or back pain
2. Arthritis
3. High blood pressure

Preventive Procedures Undergone in the Last 12 Months (Top Five)

1. Blood pressure check
2. Flu shot
3. Cholesterol screening
4. Dental cleaning/X-rays
5. Blood sugar check

Reasons why Residents did not Receive Preventive Care

1. Long time to secure an appointment
2. Lack of usual/available physician/provider
3. Long wait times in clinic/doctor's offices
4. High out-of-pocket-costs
5. Forget to schedule routine check-ups

Issues Preventing Access to Care (Top Five)

1. Lack of availability of doctors
2. Time (e.g., cannot take time off work for an appointment)
3. Fear (not ready to face/discuss health problems)
4. Unable to pay for the care
5. Transportation

Statements that apply to Residents (Top Five)

1. Received COVID-19 shot
2. Received flu shot annually
3. Use sunscreen/protective clothing when in the sun
4. Exercise three times a week
5. Eat five servings of fruits/vegetables daily

Overall

- **92.2%** — Satisfied with their quality of life in their community.
- **62.5%** — Satisfied with the health care system in their community.
- **61.4%** — Agree Individuals and Groups have Equal Access to contributing and participating in Community's Quality of Life.
- **47.6%** — Satisfied with Amount of Health and Social Services in their community.
- **78.3%** — Satisfied with the diversity of the health care providers.



I) FOCUS GROUPS

GROUP: Key Informants

COMMUNITY: Sussex County

INTRODUCTION

The following qualitative data was gathered during a discussion/focus group conducted with key informants from the Lewes community. The target population was defined by the working group of Beebe Healthcare. The discussion group was conducted by Tripp Umbach and facilitated through a virtual platform. The discussion group was conducted using a guide provided to the working group of Beebe Healthcare. The purpose of this focus group was to identify health issues, needs, and concerns affecting residents in the community, as well as ways to address those concerns through the lens of key informants who have interactions with residents who seek care and services.

The below information includes key highlights from the discussion group.

During the discussion group, key informants discussed health issues and concerns in their community. Overall, they included:

1. Lack of physicians (e.g., primary, specialists, etc.)
2. Lack of transportation
3. Growing elderly and minority population
4. Housing challenges

Health Related Problems in the Community/Barriers

- There is a rural disconnect in communities as health care is not seen as a priority. Rural residents have other concerns such as daily living expenses (e.g., rent, food, etc.) therefore, health care is not seen as a high need or priority.
- Transportation is a problem for many community residents. The hospital has done a good job in providing supplemental services to care but as a whole, transportation is a significant issue. Residents struggle with living on a minimal wage to be able to afford a car as the expenses relate to maintaining and operating a car.
- Residents face the inability to secure appointments in a short time period. Appointment wait times are long especially when trying to secure care with a specialist. Many physicians are not located locally, and residents must travel further for care. Logistics play a big part in obtaining care. Seniors are traveling great lengths to see a physician as seeking care is only obtained when there is a crisis. Low-income residents cannot access care without transportation. Overall, there are many challenges regarding access.
- Care is only available if residents can afford it. The cost of health care services (i.e., coverage and out-of-pocket costs) make it more difficult to obtain care. Unavailable doctors and affordability are factors why residents do not prioritize maintaining good health.
- There is a need for culturally appropriate doctors to treat the patient population. Residents are more likely to respond better to those who look like the patients they serve.
- The lack of available physician specialists force residents to obtain care outside of the region. Physicians are also referring patients for specialty services outside of the area due to availability. Residents have difficulty securing appointments in a reasonable timeframe.
- A lot of residents fall in the “gap” of coverage; therefore, they do not have adequate coverage. These residents do not have the income to pay for high co-pays as they have a higher income and do not qualify for services.

- There are high poverty rates in our community and seniors are greatly affected. Looking to the future, seniors will face large issues related to economics.
- Inflation will be detrimental to many residents in particular for those seeking housing. Residents will prioritize their needs and health care services will not be seen as a priority.
- Undocumented residents or those who do not have a legal status will face greater roadblocks to health care services. This will exasperate the need for care as those in this population will seek care when their health is deteriorating and has declined dramatically. Those in this population do not have access to employer sponsored care.

Emerging Issues or Barriers in the Community

- Overall, culturally competent care is good as it positively impacts one's physical and mental health. Mental health issues are already high due in part to COVID-19 and the stigma has persisted. Currently, there are not enough providers to treat this growing population.
- Cultural awareness as it is important for patient care and services. It provides a lens to residents who seek health care that is entuned and aligned with their background.
 - Being trauma informed is part of the healthcare service line. This is also cultural competency as it falls with safety and security. There should be more education as many do not know where to go for services. A system should be devised where residents are trauma informed.
- Low-cost affordable dental care does not exist. Poor dental health affects everyone as dental care is very costly, and many employers do not offer dental health coverage.
- The navigation of resources is difficult for those unfamiliar with the system. There is a need to help steer those who require assistance.
- There is a lack of available senior health services due in part to the rapidly growing senior population.
- The language and cultural barriers residents face.
- Lack of public transportation. As more people relocate to the area, there needs to be improvements related to infrastructure (e.g., affordable homes, transportation, etc.)
- Available housing is an issue; therefore, recruiting physicians/providers is problematic. The cost for physicians to relocate is costly. The housing compensation from the hospital could help recruit physicians to the area, however, available homes is lacking. Hospitals may need to secure/help provide homes for recruited doctors. Currently, specialists are hard to recruit and retain.
- The availability of affordable, safe, clean, quality homes for low-income residents and families.

What is being Done to Address Issues in the Community?

- There are unique collaborations occurring locally with universities and health care systems. Beebe Healthcare and DelTech are working together to fund community health worker programs – this will help address some barriers that residents face.
- Having a multicultural resource directory present for African Americans, Hispanics, and minorities to secure services with diverse health care providers.
- A cross referral system called Unite Us is available. The system coordinates care across clinical, social, and behavioral health.
- Implore the implementation of health care individuals who provide lectures on available resources and screenings at the local library.
- Execute mental health and behavioral health screenings in collaboration with the school districts to get children screened and diagnosed who are in need of assistance.
- Strategically place accessible services as many seniors will have difficulties driving long distances for care.
- As a health care facility, there needs to be home grown programs. The hospital can provide medical training for students who are local residents who could ultimately practice in the area, partner with local schools and provide programs to attract students interested in STEM programs.

Addressing Persistent Health Issues

- The need for oral health services for many who do not have coverage cannot afford the out-of-pocket costs. The need for affordable dental care is crucial.
- Improve the waiting period for scheduling appointments.
- Due to the growing senior population, there has been an uptick in senior health care services.
- Screenings and events in the public area; use the libraries to get the screenings to the people – preventative health.
- Work with book mobiles to distribute health education and information. Increase partnerships with churches as they are trusted community partners.
- Reach residents where they gather, barber shops, and hair salons programs and services.
- Provide wrap around services upon discharge for patients to stay on track. Improve navigation services.
- Collaborate with employers to distribute health education and materials. Materials can include information on blood pressure, cholesterol, obesity, diabetes, etc. Information that is distributed at health fairs can be provided to employers for employees.

How do we improve health and quality of life?

- Better transportation services for residents. It was recommended that the community develop ways to transport residents throughout town.
- Creating recreational spaces such as parks and green space.
- Affordable quality housing for low-income residents.
- Low-cost affordable assisted living homes/senior housing as seniors are being priced out of the market for homes. There are not a lot of assisted living areas. More seniors living in area and having housing options would be important.
- Additional health care providers for the growing population seeking services.
- Doctors are coming to Millsboro area – but there are challenges when new doctors come to the area – there are trust factors – in particular from seniors. New physicians must gain the trust of those they work with, and this takes time.

Effects on Community Residents due to COVID-19

- Residents cannot access reliable and affordable internet services; therefore, telemedicine was not an option for those who needed health care treatment.
- COVID-19 highlighted the deficit and need for physicians in our area. We currently struggle to retain and recruit health care providers.
- Residents are not computer savvy nor technology literate, as such, the health of residents declined further as they did not seek services during the pandemic.

Listed below are the organizations represented by key informants who attended the focus group. In total, 13 key informants attended the event and represented a cross section of organizations who have direct interaction with community residents.

Table 67: Organizations Represented by Key Informants

Organizations	
Alternative Solutions Consulting Group, LLC	First State Community Action Agency
Beebe Healthcare - Home Care	Milestones Consultants
Brain Injury Association of Delaware	Project The Way Home
Chief of Police of Millsboro	Property Development/Management
Wilmington University College of Behavioral Sciences	United Way of Delaware
CTU Consulting	Wilmington VA Hospital
Sussex County Libraries	

GROUP: Low-Income Focus Group

COMMUNITY: Sussex County

INTRODUCTION

The following qualitative data was gathered during a discussion/focus group conducted with low-income community members. The target population was defined by the working group of Beebe Healthcare. The discussion group was conducted by Tripp Umbach and facilitated through a virtual platform. The discussion group was conducted using a guide provided to the working group of Beebe Healthcare. The purpose of this focus group was to identify health issues, needs, and concerns affecting residents in the community, as well as ways to address those concerns through the lens of low-income community members who seek care and services.

The below information includes key highlights from the discussion group.

During the discussion group, low-income community members discussed health issues and concerns in their community. Overall, they included:

1. Lack of transportation
2. Lack of access to mental health/behavioral health services
3. Housing challenges
4. Negative perceptions and stigma against low-income/homeless population

Health Related Problems in the Community/Barriers

- Residents encounter a lot of drug use in this area. Support services for this type of behavioral health issue such as counseling or rehabilitation services are not adequate for those who face addiction. There is a lack of supply, and demand is significantly high.
- Access to mental health services is lacking especially for low-income residents. People who are low-income do not have the same levels of access to mental health services as those who can afford them. Residents are aware their income status prohibits them from seeking specialty care and access.
- Transportation is a significant problem for many community residents. Residents struggle with living on a minimal to no wage to be able to afford a car or bus pass as the expenses are too high.
- Residents face the inability to secure appointments in a short time period. Appointment wait times are long especially when trying to secure care with a specialist. The group noted a lack of available providers in the region.
- Appointment wait times are long especially when trying to secure care with a specialist. Many residents must travel for care as treatment/services are not available in the region. Many people cannot fill out the paperwork because it is too long and difficult to understand. Overall, there are many challenges regarding access to health care for the low-income population.
- The lack of affordable housing is inaccessible. There are many developments being forged; however, the low-income population understands their population are not the intended buyers. The low-income population cannot afford new or current housing options, and many are being pushed out of the area. Unfortunately, many face the strong possibility of being homeless/remaining homeless.
- Low-income and homeless populations do not have access to healthy foods. Healthy foods are unaffordable and hard to find for a zero to minimum wage individual. Unhealthy eating is a common trend among this population.
- The focus group participants overall did not feel their concerns were often heard. An overall sense of frustration as their input is often dismissed when relayed to health care professionals.

Emerging Issues or Barriers in the Community

- The navigation of resources is difficult for those unfamiliar with the system. Many in the group are unfamiliar with what is available and the structure of an organization. Oftentimes residents are not as aware of how to appropriately access healthcare; therefore, there is a need to help steer those who require assistance.
- Lack of public transportation. As more people relocate to the area, there need to be improvements related to infrastructure (e.g., location of bus stops, frequency of pickups, etc.)
- Affordable housing is an issue; therefore, the population is unhealthy because they have no place to live. Housing is being built, but it is unaffordable for many. The need for affordable housing for the average person is not being addressed.
- There are a lot of negative perceptions and stigmas against the homeless population. Those in these populations have great issues accessing care and services. A sense of belonging and strong support from the community would be helpful.
- The availability of affordable, safe, clean, quality homes for low-income residents and families.
- Lack of education and awareness of available resources, especially for the low-income and homeless population. Residents are not aware of health care resources that are available. With an increased awareness of resources (spiritual, emotional, mental, and financial) that are available, it would improve the health status of residents in the community.

What is being Done to Address Issues in the Community?

- The decision makers (e.g., politicians, health care providers, business leaders, etc.) should be more representative of the population they are serving. The people in charge have a limited scope of the needs of people in the community. The focus group participants indicated that better policies are needed to help those of lower socioeconomic status to get the care they need.
 - The policies that are implemented are restrictive for care and services. Medicaid is problematic and prescription medications are not covered. The out-of-pocket expenses are too high for those on a limited to no income level.
- A better hospital discharge system. People are being discharged without coverage, a place to go, or a treatment/follow-up plan. If the hospital knows that the discharge patient needs continuous care, they should not be discharged, especially if the patient is low-income and does not have a home support system. More hospital beds are needed, or the patient should not be discharged.
- Address high-cost prescription medications for seniors. Seniors are on a fixed income; therefore, many cannot afford the medicine that they need.
- Providing educational resources and teaching the community how and where they can access care. Helping people understand how to get insurance coverage for medications and access to health care services they need. The services to help people get coverage are complex and the hospital needs to promote their assistance to the population.

How do we improve health and quality of life?

- Better transportation services for residents. It was recommended that the community develop ways to transport residents throughout town such as a van service.
- Creating recreational spaces such as parks and green space for better health promotion and improved mental health.
- Affordable quality housing for low-income residents.
- Additional healthy food choices to implement healthy eating within the community.

Effects on Community Residents due to COVID-19

- There is misinformation being spread throughout the community on the disease. A lot of people lost family due to the misinformation presented (e.g., residents did not get vaccinated, the diseases were not taken seriously, etc.). Residents in the focus group were unsure what their course of action was due to the misinformation.
- Availability of doctors and appointments.
- Living in fear. Community members were afraid to go out in public, there was a lot of miscommunications, residents did not know who to trust, and what information was false. The community needed better accurate sources of information. Information distributed from trusted entities in the community.

J) COMMUNITY RESOURCE INVENTORY

An inventory of programs and services specifically related to the key prioritized needs was compiled by Tripp Umbach. The inventory highlights programs and services within the service area. The inventory identifies the range of organizations and agencies in the community that is serving the various target populations within each of the prioritized needs. It provides program descriptions, contact information, and the potential for coordinating community activities by creating linkages among agencies. The resource inventory was provided as a separate document due to its interactive nature and is available on [Beebe Healthcare's](#) website.

K) IMPLEMENTATION STRATEGY AND PLANNING

With the completion of the community health needs assessment, an implementation phase will begin with the onset of work sessions facilitated by Tripp Umbach. The work sessions will maximize system cohesion and synergies, during which leaders from Beebe Healthcare will be guided through a series of identified processes. The strategy planning process will ultimately result in the development of an implementation plan that will meet system and IRS standards.



L) COMMITTEE MEMBERS

The CHNA was overseen by a committee of representatives who worked diligently during the process. Members of the Working Group are listed in alphabetical order by last name.

Table 68: Steering Group Members (Listed alphabetically by last name)

Steering Group	Organization
Ngozi Azuogu	Beebe Healthcare
Kim Blanch	Beebe Healthcare
William Chasanov, D.O.	Beebe Healthcare
Christina Deidesheimer	Beebe Healthcare
Corrin Harris	Beebe Healthcare
Matt Lukasiak	Beebe Healthcare
Holly Marvel	Beebe Healthcare
Loretta Ostroski	Beebe Healthcare
Laurene Roth	Beebe Healthcare
Angela Scott	Beebe Healthcare
Danielle Socrates	Beebe Healthcare
David Tam, M.D.	Beebe Healthcare
Charlotte Werner	Beebe Healthcare
Haley Winward	Beebe Healthcare
Kay Young	Beebe Healthcare
Julia Muchow	Tripp Umbach
Ha T. Pham	Tripp Umbach
Barbara Terry	Tripp Umbach

Table 69: Working Group Members (Listed alphabetically by last name)

Working Group	Organization
Ngozi Azuogu	Beebe Healthcare
Kim Blanch	Beebe Healthcare
Corrin Harris	Beebe Healthcare
Angie Scott	Beebe Healthcare
Julia Muchow	Tripp Umbach
Ha T. Pham	Tripp Umbach
Barbara Terry	Tripp Umbach



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[beebe-healthcare](https://www.linkedin.com/company/beebe-healthcare)

www.beebehealthcare.org