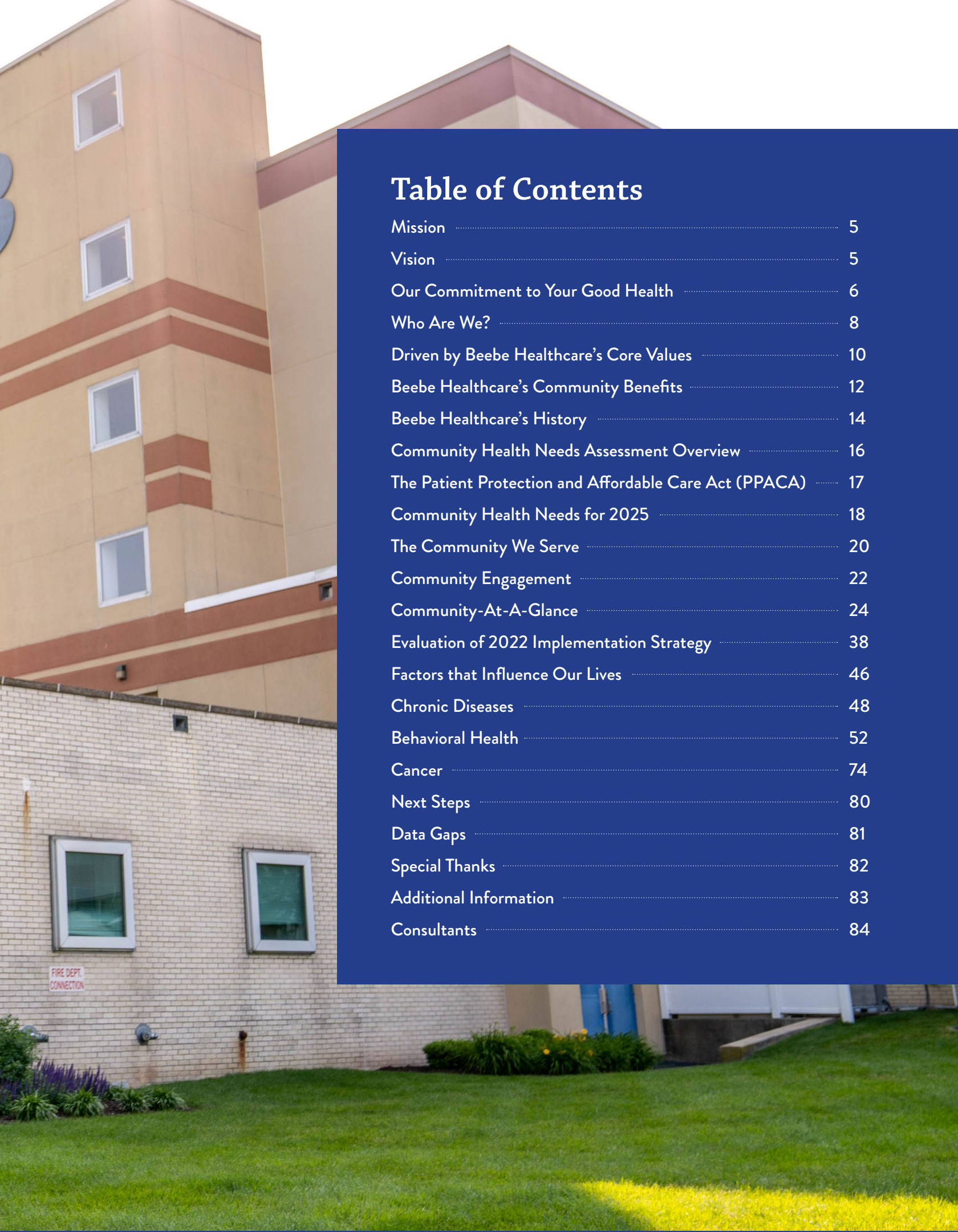
HEALTHY FUTURES:
A COMMUNITY-DRIVEN ASSESSMENT FOR BETTER LIVING

COMMUNITY HEALTH NEEDS ASSESSMENT
2025

Beebe Healthcare

Sussex County is Our Specialty


Beebe
Healthcare



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Beebe Healthcare welcomes questions and comments regarding its Community Health Needs Assessment (CHNA). The current and previous CHNAs can be accessed at beebehealthcare.org.

Questions or comments regarding the Community Health Needs Assessment can be emailed to Kim Blanch.

kblanch@beebehealthcare.org

Beebe Healthcare

Mission

Beebe Healthcare's charitable mission is to encourage healthy living, prevent illness, and restore optimal health in the people who reside, work, or visit the communities we serve.

Vision

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

Our Commitment to Your Good Health

A Letter from Beebe Healthcare's President & CEO

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 2025 Community Health Needs Assessment (CHNA). As a nonprofit health system, Beebe conducts a community health needs assessment every three years to identify the evolving health priorities in our county. This is accomplished by engaging our community members, leaders, and partners through surveys, interviews, and focus groups. These findings help Beebe Healthcare craft 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.

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

In June 2022, Beebe announced its new five-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.

We face—together—challenging headwinds in our efforts to improve healthcare in our community. State and federal reimbursement changes, expansive growth in both population and healthcare complexities, supply chain stresses, and national shortages in the healthcare workforce all continue to add layers of difficulties. Tough decisions will have to be made. That's why I believe we must all be strongly aligned in doing what is right for those we care for in Sussex County.

I'm proud to say 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 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.

Sussex County is Our Specialty

Who Are We?

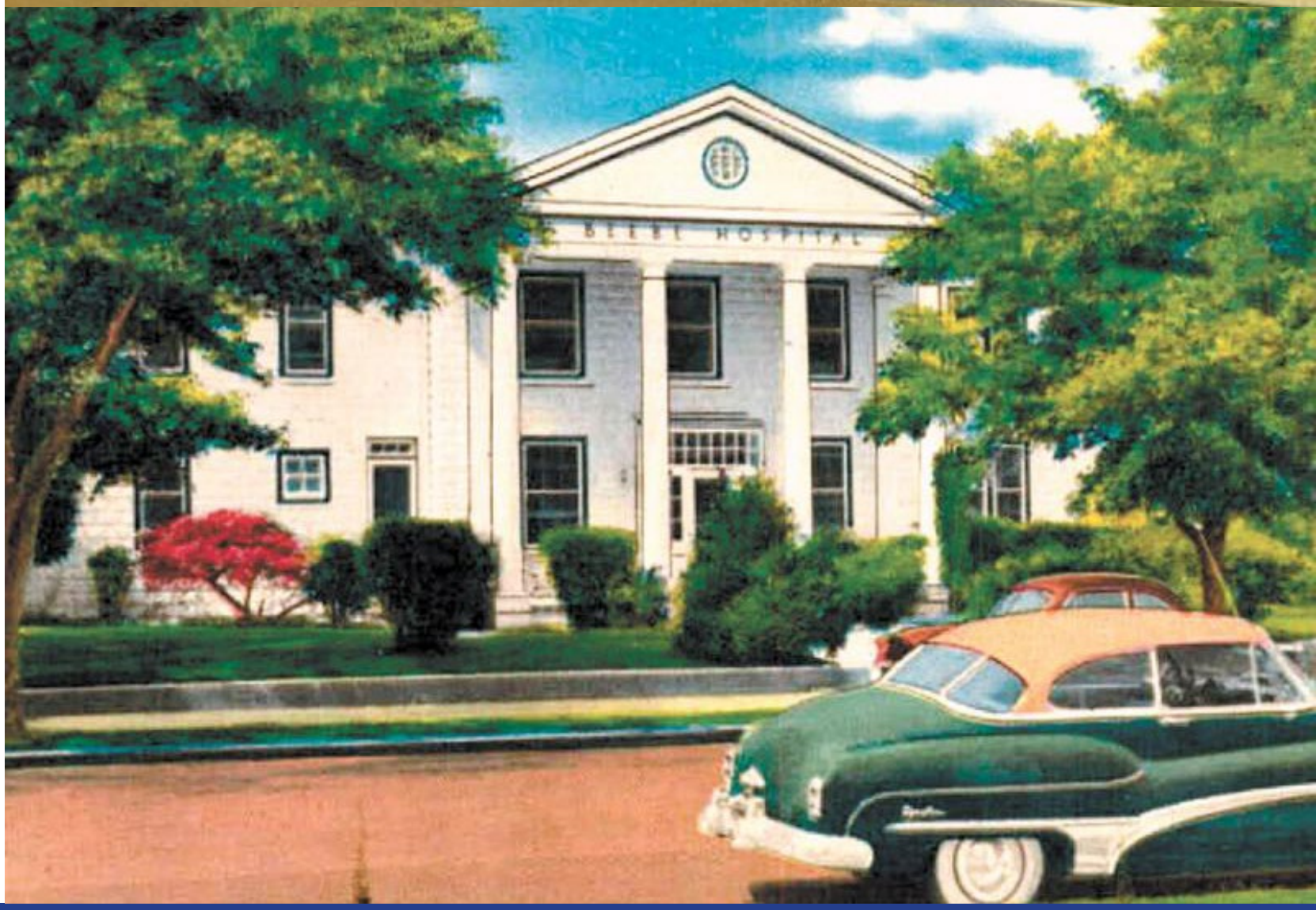
Beebe Healthcare started as a small three-bed facility and has grown into a comprehensive community health system serving Sussex County.

Beebe Healthcare (Beebe), a cornerstone of medical care in Sussex County, Delaware, has a long-standing legacy dating to its founding in 1916. Initially established by Drs. James and Richard Beebe, founders of Beebe Healthcare, a small, community-focused hospital in Lewes, Delaware, has grown into a comprehensive healthcare system serving the rapidly expanding population of southern Delaware. Over the past century, Beebe has evolved from a modest 15-bed healthcare facility into a 210-bed licensed regional health system with more than 200 medical staff members in 40 specialties, employing approximately 3,000 team members and making it one of the largest employers in Sussex County. The system now encompasses acute care services and an integrated network of outpatient facilities, specialty care practices, and urgent care centers strategically located throughout the county.

Beebe Healthcare's footprint has expanded over the years to meet the health demands of a growing population. The original Margaret H. Rollins Lewes Campus remains a vital hub, offering a full range of acute care services. More recently, Beebe Healthcare has broadened its reach by opening the Specialty Surgical Hospital at the Beebe Health Campus in Rehoboth Beach in 2022, now the Abessinio Health Campus, enhancing its surgical care capabilities in a patient-centered environment. Additional campuses include outpatient and walk-in centers such as Georgetown, Millsboro, Long Neck, Millville, and South Coastal. These expansions reflect Beebe's proactive approach to bringing care closer to where people live and work, addressing access and continuity of care across the region.

Beebe Healthcare has also been recognized for excellence in clinical quality and community engagement. It has received accolades from organizations such as the American Heart Association for stroke care and Healthgrades for patient safety and clinical excellence. In addition, The Leapfrog Group has designated Beebe Healthcare as a Top Rural Hospital and Beebe Healthcare it consistently earns high patient satisfaction ratings. These honors underscore Beebe Healthcare's commitment to delivering high-quality, compassionate care while continuously innovating to meet the evolving needs of its community. As a not-for-profit, community-based health system, Beebe Healthcare remains deeply committed to the well-being of Sussex County residents and strives to continue being a trusted health partner for generations to come.

Beebe Healthcare


BIBBY HOSPITAL

Driven by Beebe Healthcare's Core Values

A Testament to Beebe Healthcare's Mission-Driven Service

Beebe Healthcare offers a comprehensive range of inpatient, outpatient, emergency, and diagnostic services. Beebe offers specialized care in various areas, including cardiology, oncology, orthopedics, women's health, and surgical services, which include robotic-assisted procedures. The health system also operates outpatient facilities throughout the county, offering services such as imaging, laboratory testing, physical rehabilitation, walk-in care, and home health programs. With a network of primary and specialty care providers, Beebe Healthcare is committed to delivering accessible, high-quality care to the communities it serves.

Beebe Healthcare has long been recognized for its commitment to delivering high-quality, patient-centered care to the residents of Sussex County and beyond. With more than a century of service, Beebe has earned the trust of its community through consistent excellence in clinical outcomes, safety standards, innovation, and compassionate care. This dedication has not gone unnoticed, as Beebe has received numerous national, regional, and specialty-specific awards and accreditations that reflect its pursuit of excellence across all service lines. The following is a summary of Beebe Healthcare's most notable awards and recognitions.

Awards and Honors

Beebe Healthcare has garnered numerous awards and recognitions, reflecting its commitment to delivering high-quality, patient-centered care. Below is an overview of some of the notable honors.

U.S. News & World Report – Best Hospitals in Delaware

Beebe Healthcare is recognized as a "Best Regional Hospital" and the only one in southern Delaware, with high performance in seven specialty areas, including heart attack, cancer surgery, and joint replacement.

American Heart Association – Get With The Guidelines® Awards

Beebe earned five national awards in 2024 for excellence in cardiovascular and stroke care, reflecting adherence to evidence-based guidelines and improved patient outcomes.

- Heart Failure Gold Plus with Target: Heart Failure & Type 2 Diabetes Honor Roll:
  - Recognizes top care for heart failure patients, focusing on reducing readmissions and improving outcomes.
- Stroke Gold Plus with Target: Type 2 Diabetes Honor Roll:
  - Honors Beebe's commitment to rapid, guideline-based stroke care and continuous program development.
- Coronary Artery Disease STEMI Receiving Center Gold Plus with Target: Type 2 Diabetes Honor Roll:
  - Acknowledges rapid, research-based care for severe heart attacks (STEMI), with efficient protocols for diagnosis and treatment.
- Rural Coronary Artery Disease STEMI Silver:
  - Recognizes high-quality heart attack care in rural settings, with a focus on diabetic patients.
- Rural Coronary Artery Disease NSTE-ACS Bronze:
  - Awards efficient care for Non-ST-Elevation Acute Coronary Syndrome, emphasizing timely diagnosis and follow-up.

The Joint Commission – Gold Seal of Approval®

Beebe holds this prestigious accreditation for hip and knee joint replacement, stroke, and heart failure, reflecting a commitment to providing safe and effective patient care.

Level III Trauma Center Verification

Verified by the American College of Surgeons, Beebe's Trauma Center demonstrates excellence in emergency care for serious injuries.

Human Rights Campaign Foundation – Healthcare Equality High Performer

Beebe is recognized for providing inclusive and equitable care for LGBTQ+ patients, visitors, and staff.

Healthgrades Five-Star Recipient for Coronary Interventional Procedures

Beebe's cardiovascular team earned a five-star rating for excellence in complex coronary procedures, ensuring optimal outcomes and patient experience.

Age-Friendly Health System

Beebe is part of a national initiative to provide evidence-based, harm-free care that aligns with the needs and preferences of older adults.

Blue Distinction Center for Cardiac and Maternity Care

Beebe is designated by Highmark Blue Cross Blue Shield Delaware for expertise and quality in both cardiac and maternity care, based on rigorous national standards.

American College of Cardiology – Quality Awards

Beebe is recognized for excellence in cardiovascular care, demonstrating adherence to clinical guidelines and quality improvement.

Cardiac & Pulmonary Rehabilitation Accreditations

- Cardiac Rehab: Accredited for Intensive Cardiac Rehabilitation.
- • Pulmonary Rehab: Certified by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) for high standards in pulmonary care.

Beebe Oncology Services – Commission on Cancer Accreditation

The center has received a Three-Year Accreditation with Commendation from the American College of Surgeons, recognizing quality cancer care.

Breast Health Program – NAPBC Accreditation

Beebe's Breast Health Program is fully accredited by the National Accreditation Program for Breast Centers, reflecting excellence in breast care since 2013.

Baby-Friendly Hospital

Beebe is re-certified as a Baby-Friendly Hospital, the first in Delaware, for promoting optimal infant feeding and mother-infant bonding.

Safe Sleep Champion

Recognized by the National Safe Sleep Hospital Certification Program for leadership in infant safe sleep education and practices.

NICHE Designated Site

Since 2011, Beebe has been a NICHE (Nurses Improving Care for Health System Elders) site, committed to exemplary care for patients aged 65 and older.

Laboratory Accreditations

Beebe's laboratory is accredited by the College of American Pathologists and the American Association of Blood Banks (AABB) and is CLIA-certified across multiple specialties, ensuring high standards in laboratory services.

Centers for Medicare & Medicaid Services – Care Compare

Beebe voluntarily participates in CMS' Care Compare, demonstrating transparency and commitment to quality through public reporting of clinical outcomes.

Leapfrog Hospital Safety Grade

Beebe participates in the Leapfrog Hospital Safety Grade, reflecting dedication to patient safety and quality improvement.

Leapfrog Top Rural Hospital

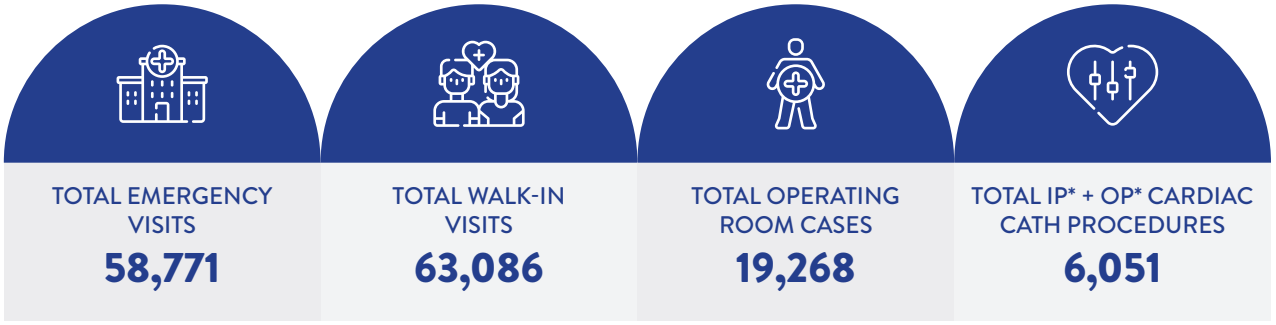
Beebe's Specialty Surgical Hospital is recognized as one of the top 15 rural hospitals in the United States for 2024, based on excellence in safety, quality, and patient outcomes.

These awards underscore Beebe Healthcare's unwavering dedication to excellence in patient care, safety, and community health. Additional information regarding Beebe Healthcare's awards and achievements can be found at beebehealthcare.org.

Beebe Healthcare's Community Benefits

Turning Purpose into Progress

Beebe Healthcare remains deeply committed to improving the health and well-being of individuals and families across Sussex County. As a nonprofit organization, Beebe reinvests resources in the community through a broad range of programs and services that extend beyond clinical care. The community benefit data below reflect Beebe's ongoing dedication to providing uncompensated care, supporting public health initiatives, and addressing the underlying social determinants that impact health outcomes. In Fiscal Year 2024 (FY24), Beebe Healthcare contributed more than $188 million in total community benefit, including essential services such as charity care, subsidized health programs, medical education partnerships, and investments in behavioral health and wellness. These efforts demonstrate Beebe's holistic approach to healthcare, ensuring access and long-term community resilience through strategic partnerships and targeted outreach.



OUTPATIENT PROCEDURES

EKG Procedures	21,106
Cardiac Lab Procedures	17,507
Lab Procedures	1.04M
Radiation Oncology (procedures)	16,374
Medical Oncology (patients)	8,200
Medical Oncology (visits)	18,981
Home Health (visits)	52,550

COMMUNITY BENEFIT COST

Charity Care
(at cost)
$2,558,378

Bad Debt
(at cost)
$6,314,004

Government-Sponsored Healthcare

$17,393,394

Medicare - **$118,411,118**
Medicaid - **$4,954,794**

Community Benefit Program
(net loss)

Health Promotion and Wellness Programs	$972,604
Behavioral Health Services	$287,176
Sexual Assault Nurse Examiner Programs	$172,953
Oncology Research Program	$228,328
Interpreter Services	$644,689
Physician Services Recruitment	$629,531
Physician Practice Guarantees	$11,477,965
Workforce Development with Educational Institutions	$2,605,652
Sponsorships	$3,374,497

$17,393,394

Beebe Medical Group

$39,033,464

TOTAL COMMUNITY BENEFIT **$188,666,151**

Beebe Healthcare's History

A Century of Vision, Service, and Community Impact

Founded in 1916 by Drs. James and Richard Beebe in Lewes, Delaware, Beebe Healthcare has grown from a four-room hospital into a comprehensive healthcare system serving the entire county of Sussex. These visionary brothers, sons of a merchant and housekeeper, sought to bring modern medicine to a rural region in dire need of healthcare services. Their first procedures were conducted in farmhouse kitchens, and by 1921, with the support of philanthropists Benjamin and Helen Shaw, the hospital had expanded to include surgical suites, X-ray services, and a burgeoning Nursing Training School. This school, founded in response to local demand, has grown steadily and is now known as the Margaret H. Rollins School of Nursing, consistently producing highly skilled graduates each year.

Throughout the decades, Beebe has relied on community generosity—financial and personal—to meet the rising demand. Key expansions included the Thompson Wing (1930s), Mary Thompson Wing (1938), and the Lynch Wing (1950s), which modernized maternity and pediatric services. Volunteers, such as Ernest Gooch, played critical roles in Beebe's formative years, and their dedication set a precedent for the strong community ties the hospital maintains today.

Beebe's commitment to innovation and regional access continued through the 1980s and 1990s, marked by the creation of satellite emergency services and the Tunnell Cancer Center, Sussex County's first radiation oncology facility. Strategic additions such as the Rollins Wing (1985), the Rehoboth Beach Health Campus (2003), and the Hudson Wing (2008) have expanded emergency, critical care, and outpatient services. Beebe also introduced advanced cardiovascular capabilities, including a cardiac catheterization lab (1998), a cardiac surgery program (2007), and a state-of-the-art hybrid operating room, all of which are part of its Heart and Vascular Center of Excellence.

By 2018, Beebe Healthcare launched its most ambitious expansion to date, including a Specialty Surgical Hospital and South Coastal Health Campus in Millville. From humble beginnings to a health system rooted in innovation and compassion, Beebe's legacy continues, honoring the founding vision of delivering exceptional care close to home.

Community Health Needs Assessment Overview

Engaging Voices, Identifying Needs, Driving Solutions

In fall 2024, Beebe Healthcare launched a CHNA to evaluate the health status, needs, and gaps affecting residents across Sussex County, Delaware, Beebe Healthcare's primary service area. Guided by IRS requirements under the Affordable Care Act, the CHNA aimed to identify key health challenges, highlight service gaps, and inform future community health planning efforts. Beebe Healthcare collaborated with stakeholders, including health officials and providers (i.e., individuals or organizations that deliver healthcare services), nonprofit leaders, and community members, to ensure a well-rounded and inclusive approach to understanding community needs. Through the integration of primary data, such as focus groups and stakeholder interviews, and secondary data on demographics, health outcomes, and social drivers of health, the CHNA provided a comprehensive picture of health in the region.

Following the data collection and analysis phase, Beebe Healthcare convened a prioritization session with internal leaders and community members to review findings and determine which health issues warranted the most immediate and focused attention. This collaborative session was guided by criteria such as the severity of the issue, disproportionate impacts on at-risk populations, and Beebe Healthcare's capacity to address the needs through existing or potential resources. The process identified and reinforced three top priorities for the region: chronic conditions (such as diabetes, heart disease, hypertension, and obesity), behavioral health (encompassing mental health and substance use), and cancer, with a specific focus on education, screening, and navigation. These issues emerged as highly prevalent and critical to the well-being of individuals and families across Sussex County.

Beebe Healthcare is committed to developing and implementing strategic initiatives that directly address these priority areas. The organization will leverage its clinical expertise, community partnerships, and outreach capabilities to drive measurable improvements in these domains. For chronic conditions, efforts will focus on prevention, disease management, and health education, particularly among high-risk populations. In behavioral health, Beebe Healthcare plans to expand access to mental health services, integrate behavioral health into primary care settings, and work alongside local partners to address stigma and social support gaps. Cancer prevention and treatment initiatives will include access to behavioral health services, community screening events, navigation services, and enhanced care coordination across oncology and support services.

Beebe Healthcare's approach is grounded in data and its long-standing commitment to the health of the communities it serves. The 2025 CHNA reflects current challenges and serves as a roadmap for continued action. As Beebe Healthcare enters the CHNA implementation phase, it will regularly monitor progress, engage with stakeholders, and adjust strategies to ensure a lasting impact. By prioritizing chronic conditions, behavioral health, and cancer, Beebe takes deliberate, informed steps to improve population health outcomes and foster a healthier, more resilient region.

The CHNA serves as a foundational tool for strategic planning and community benefit activities. It enables Beebe Healthcare to align its services and initiatives with the most urgent and relevant community needs. By fostering collaboration with local agencies and stakeholders, the CHNA promotes a unified approach to addressing healthcare gaps, effectively leveraging resources and driving the implementation of impactful, data-informed solutions. Through this process, Beebe Healthcare is positioned to deliver measurable health improvements and sustain long-term progress for the residents of Sussex County.

The CHNA followed a multi-step approach, as illustrated in the flowchart below.

Figure 1: Methodology Flow Chart

The Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA), enacted on March 23, 2010, requires all tax-exempt hospitals to conduct a Community Health Needs Assessment every three years and to develop an implementation strategy to improve the health of their communities. These strategies consist of evidence-based programs, targeted initiatives, and collaborative activities designed to address the specific needs identified in the CHNA. The Internal Revenue Service (IRS) requires hospitals to not only implement these strategies but also report on the progress made, including an explanation of any identified needs that remain unaddressed.

Beebe Healthcare's CHNA fulfills the requirements of Section 501(r)(3) of the Internal Revenue Code by thoroughly analyzing primary and secondary data related to demographics, health outcomes, and socioeconomic conditions at the local, state, and national levels. The CHNA and its resulting implementation strategy demonstrate Beebe Healthcare's full compliance with federal regulations and its ongoing commitment to enhancing the well-being of the community it serves.

The full IRS requirement for the CHNA and Implementation Strategy Plan can be found here.

Community Health Needs for 2025

Framing the Path Forward

Beebe Healthcare identified chronic diseases, behavioral health, and cancer as its top priorities for the 2025[1] CHNA, based on community input, data trends, and the health impact in Sussex County. To address these pressing needs, Beebe will implement targeted interventions and collaborative strategies to improve health outcomes and ensure access to care across the region.

This assessment prioritizes chronic conditions, including diabetes, heart disease, hypertension, and obesity, recognizing their profound impact on overall health and well-being. Chronic diseases have been prioritized as the leading healthcare concern because of their prevalence across multiple age cohorts, particularly among individuals aged 50 and older. This demographic experiences a greater incidence of chronic conditions, often dealing with comorbidities that exacerbate health risks and increase healthcare utilization. As people age, physiological changes, lifestyle factors, and genetic predispositions contribute to the persistence and progression of these diseases, making them a central focus for prevention and intervention efforts.

The impact of chronic conditions extends beyond individual health, influencing healthcare costs, workforce stability, and the overall well-being of the community. Studies indicate that managing chronic diseases in older populations requires comprehensive care strategies, including early detection, lifestyle modifications, and access to specialized treatment. Prioritizing chronic disease management ensures that healthcare resources are allocated efficiently, addressing the most pressing needs within the population and promoting healthier aging across the community.

[1] Beebe Healthcare's 2022 CHNA identified behavioral health (including mental health and substance use disorders), chronic diseases (such as cancer, heart disease, high blood pressure, and diabetes), and healthy lifestyles (including obesity and nutrition) as key community health priorities. In preparation for the 2025 CHNA cycle, Beebe's Population Health Advisory Council convened a prioritization session to assess and reorganize the needs based on updated data and emerging trends. As a result, Beebe Healthcare will continue its strong focus on chronic diseases and behavioral health, while recognizing that healthy behaviors remain a foundational element that will be integrated across all priority areas. Notably, cancer has emerged as a growing health concern in Sussex County. In response, Beebe Healthcare has elevated cancer as a distinct priority area requiring intensified focus and dedicated resources to address its increasing impact on the community.

Additionally, behavioral health remains a crucial focus, addressing the ever-present needs related to mental health and substance use disorders. Rural communities often face significant barriers to accessing behavioral health services, including clinician shortages, stigma, and financial limitations, which can exacerbate untreated conditions. Mental health challenges and substance use disorders impact individuals across socioeconomic backgrounds, meaning that residents throughout the county may struggle to find adequate care. By prioritizing behavioral health, Beebe Healthcare aims to bridge gaps, ensure equitable access to care, and promote the overall well-being of the community. Addressing these needs holistically strengthens Beebe's mission, reduces emergency department visits, and stimulates long-term health improvements for residents of all backgrounds.

Cancer prevention, education, and patient navigation are also highlighted to enhance early detection, improve treatment outcomes, and cultivate collaborative solutions that empower individuals while promoting lasting community wellness. Given its widespread impact, a proactive approach through a broader framework of access to care is essential to improve early detection, expand access to screenings, and enhance patient support throughout the treatment journey. Rural communities often face challenges in accessing cancer care due to limited healthcare resources, financial barriers, and geographic isolation. Meanwhile, even in more developed coastal areas, individuals may struggle to navigate complex treatment options or access timely preventive services. By prioritizing cancer-focused initiatives, a community-based hospital can reduce the burden of late-stage diagnoses, empower residents with knowledge, and create pathways to comprehensive care that improve outcomes for all. Strengthening these efforts aligns with Beebe's mission to provide equitable healthcare and address a leading cause of mortality in the region.

Figure 2: 2025 Identified Community Health Needs

The 2025 identified health needs highlight the necessity for targeted interventions and resources to address the complex health landscape of Sussex County. Beebe Healthcare's prioritized needs reflect a strategic response to these pressing community health issues.

The Community We Serve

Meeting Needs, Bridging Gaps

Beebe Healthcare's primary service area for the CHNA consists of the central and eastern portions of Sussex County, where the majority of its patients reside and receive care. The area includes communities such as Bethany Beach, Dagsboro, Ellendale, Fenwick Island, Frankford, Georgetown, Harbeson, Lewes, Lincoln, Milford, Millville, Millsboro, Milton, Ocean View, Rehoboth, and Selbyville—regions that represent Beebe Healthcare's highest volume of inpatient and outpatient encounters. These towns and their surrounding ZIP codes are considered the core geographic areas where Beebe Healthcare's services have the greatest reach, impact, and ensure that the identified health needs and priorities are directly aligned with the community most dependent on Beebe Healthcare's services.

Additionally, primary service area ZIP codes tend to reflect the resources, partnerships, and programs developed in response to the CHNA, which have the most significant impact when tailored to the population that engages with the health system. This targeted approach enhances efficiency, relevance, and accountability, ensuring that strategic planning and implementation efforts are focused where they are most needed.

While the CHNA centers on ZIP codes within Beebe Healthcare's primary service area, it is essential to emphasize that Beebe Healthcare proudly serves all residents of Sussex County and extends its reach across the broader Delmarva Peninsula. Many individuals from surrounding communities in the secondary and tertiary service areas rely on Beebe Healthcare for high-quality, compassionate care. Beebe Healthcare's role as a regional health leader, mission, and resources are not confined to a single geography. Instead, the organization remains committed to improving health outcomes for all individuals who seek care within its network, including those in rural and at-risk parts of the region. This broader commitment is reflected in Beebe Healthcare's partnerships, outreach efforts, and strategic planning that consider the evolving needs of its entire service region.

The 2025 CHNA emphasizes that data collection, analysis, and strategic planning are centered on the populations most directly dependent on Beebe Healthcare's services.

This focused approach allows a more accurate understanding of the region's health status, needs, and health and social gaps, ultimately guiding resource allocation and community health improvement efforts.

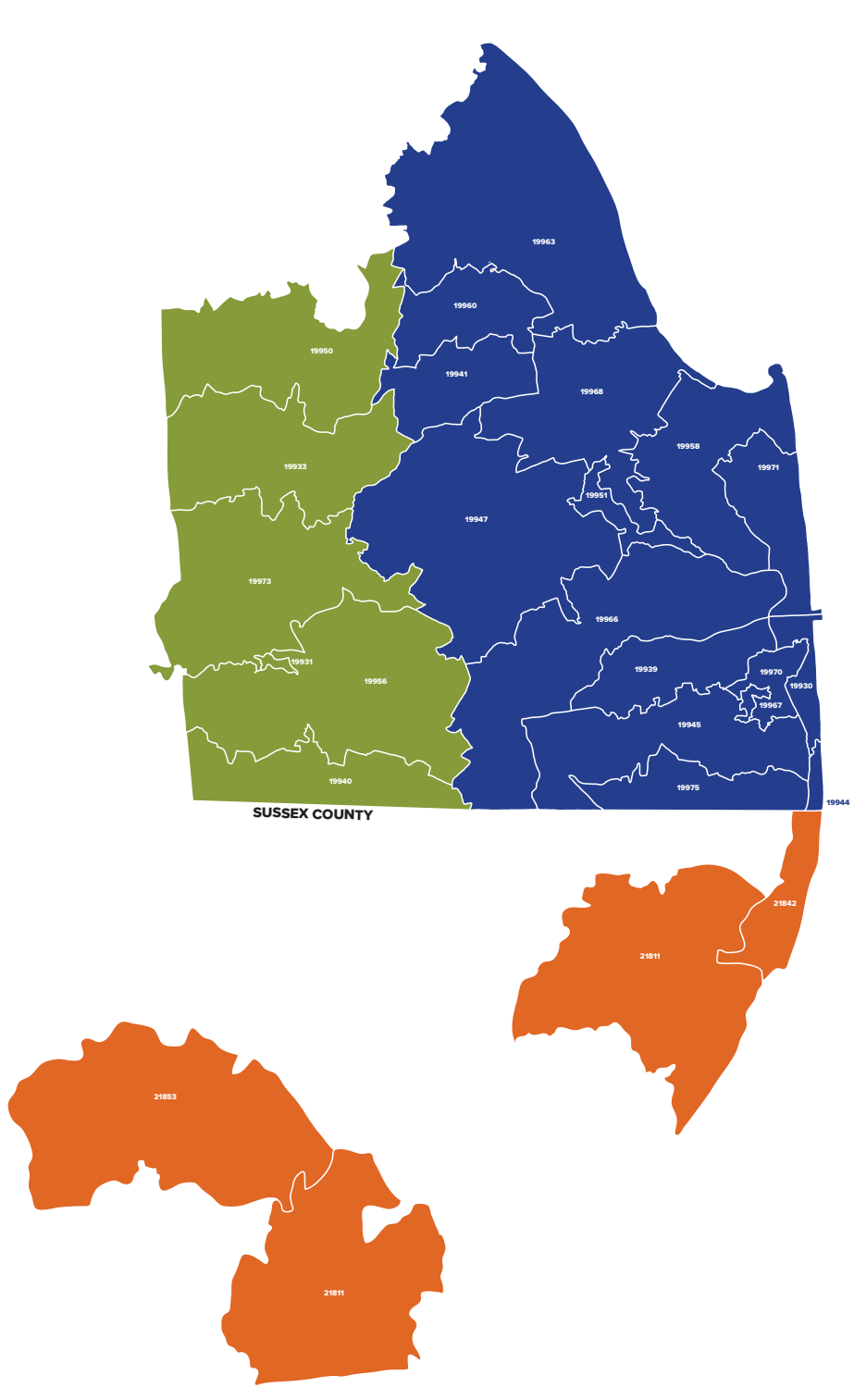
Table 1: Beebe Healthcare's Service Areas

PRIMARY SERVICE AREA	
ZIP CODE	**CITY/TOWN**
19930	Bethany Beach
19939	Dagsboro
19941	Ellendale
19944	Fenwick Island
19945	Frankford
19947	Georgetown
19951	Harbeson
19958	Lewes
19960	Lincoln
19963	Milford
19966	Millsboro
19967	Millville
19968	Milton
19970	Ocean View
19971	Rehoboth
19975	Selbyville

SECONDARY SERVICE AREA	
ZIP CODE	**CITY/TOWN**
19931	Bethel
19933	Bridgeville
19940	Delmar
19950	Greenwood
19956	Laurel
19973	Seaford

TERTIARY SERVICE AREA	
ZIP CODE	**CITY/TOWN**
21811	Berlin
21842	Ocean City
21851	Pocomoke City
21853	Princess Anne

Map 1: Beebe Healthcare's Service Area Map



Community Engagement

Listening to Voices, Building Solutions

Beebe Healthcare's comprehensive CHNA was deeply rooted in community engagement, ensuring that a broad range of voices guided the process. Input was gathered from a wide array of community stakeholders, including educators, government officials, healthcare professionals, nonprofit leaders, and representatives from health and human service organizations across Beebe Healthcare's service area in Sussex County. These individuals brought unique perspectives and frontline experiences that highlighted the region's most pressing health concerns, particularly affecting people who face greater barriers to care.

To strengthen the assessment, the data collection included one-on-one stakeholder interviews and a series of targeted focus groups with residents from varied backgrounds, including seniors and low-income families. These discussions provided candid, firsthand accounts of barriers to care, gaps in local services, and the lived experiences that shape health outcomes in Sussex County. The engagement process was not only informative but essential for building trust and ensuring that community voices guided the CHNA's direction.

In parallel, secondary data analysis from local, state, and federal databases provided context on demographic trends, disease prevalence, and inclusive engagement across the region. The integration of qualitative insights and quantitative data enabled a deep understanding of health and social gaps, facilitating the identification of key themes, including high-risk behaviors, chronic disease burdens, and access challenges. Beebe Healthcare's commitment to inclusive engagement laid the groundwork for actionable strategies that reflect the needs, priorities, and aspirations of the communities it serves.

Figure 3: Community Engagement


MIRACLE MILE
20th Anniversary


PREVENTING THE FLU

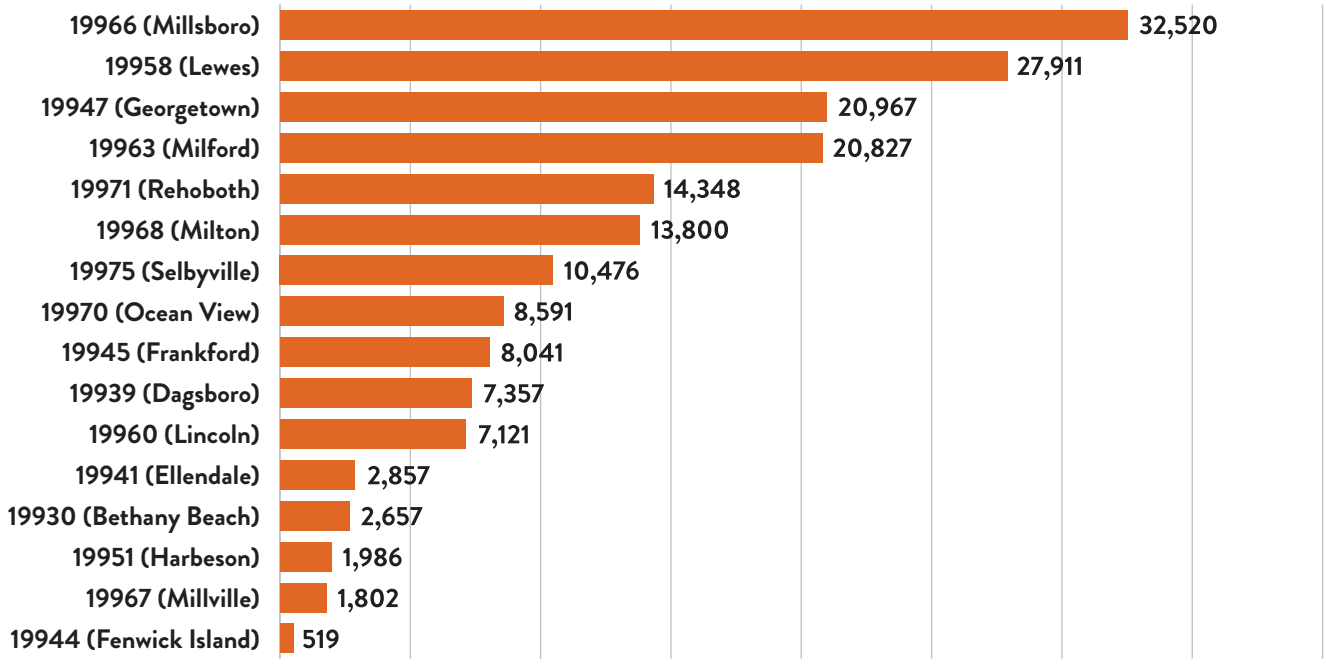
Community-At-A-Glance

Understanding Who We Serve

The data presented in Beebe Healthcare's community-at-a-glance section focuses on its primary service areas, encompassing the core communities that utilize Beebe Healthcare's services most actively. These regions represent the greatest patient volume and have the strongest ties to Beebe Healthcare's clinical and community outreach efforts. While Beebe Healthcare also serves individuals beyond these primary areas, data from secondary regions are not included because of comparatively lower service utilization and limited direct impact on Beebe Healthcare's operations. Beebe Healthcare's primary service area ZIP codes are defined below.[2]

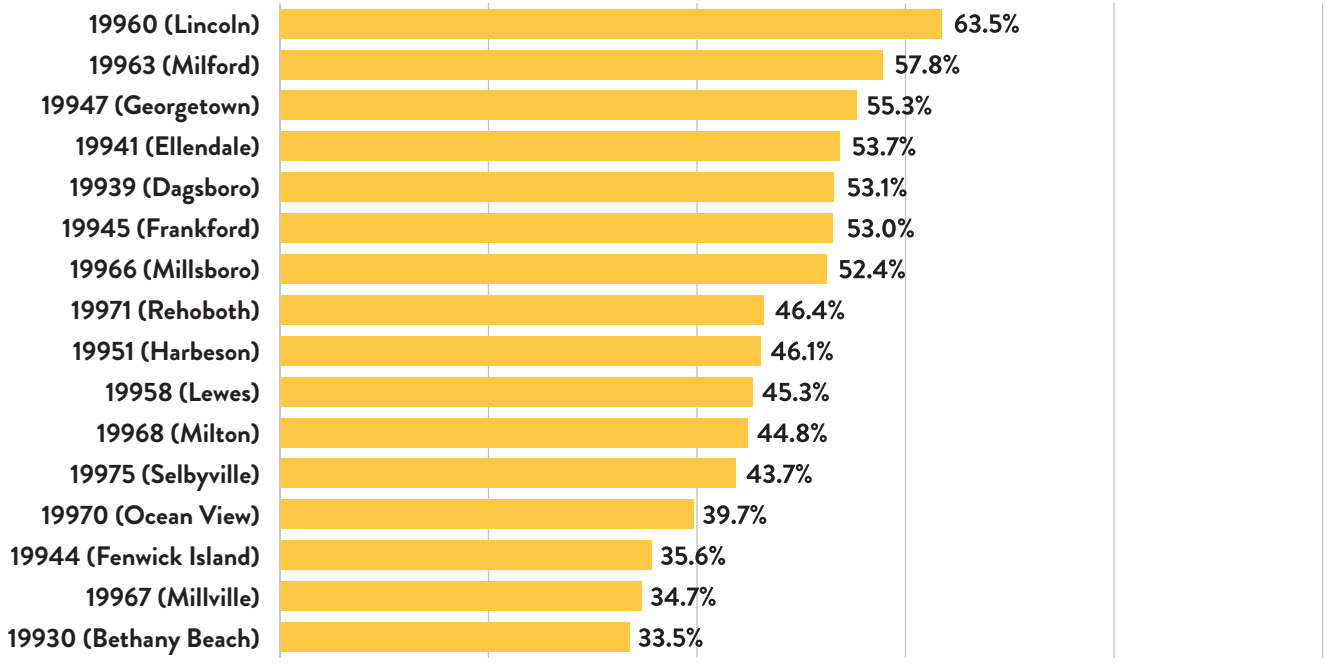
[2] Beebe Healthcare's commitment to community health extends to every resident of Sussex County and the broader Delmarva Peninsula, not just those living in its primary service area. By embracing the needs of all communities in the region, Beebe Healthcare ensures equitable access to care for every individual, regardless of where they live.

Figure 4: Number of Residents



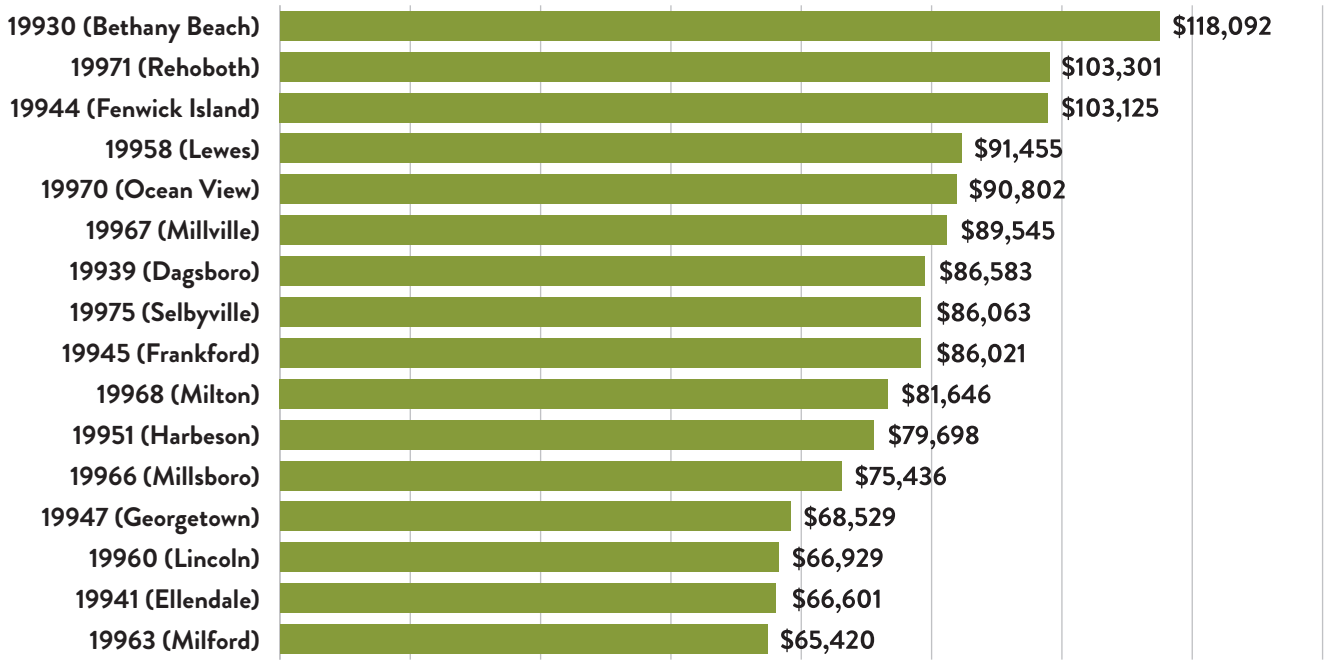
Source: U.S. Census Bureau, 2020

Figure 5: Percent Employed



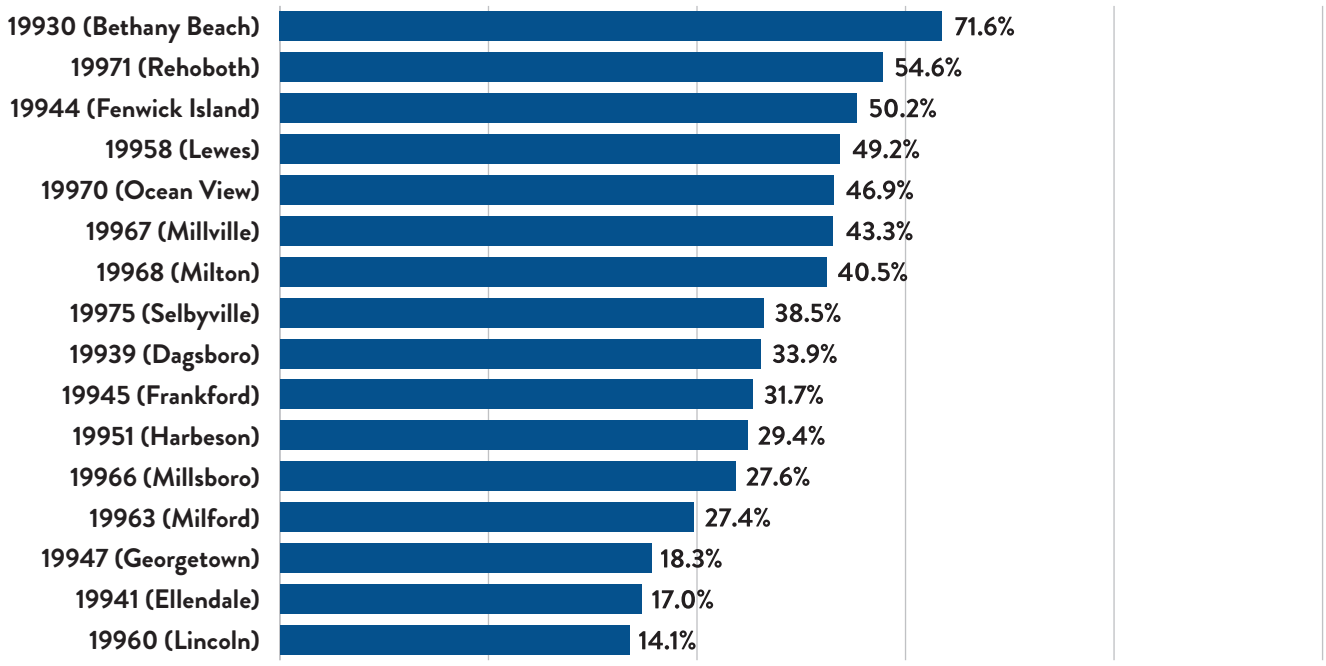
Source: U.S. Census Bureau, 2023

Figure 6: Median Household Income



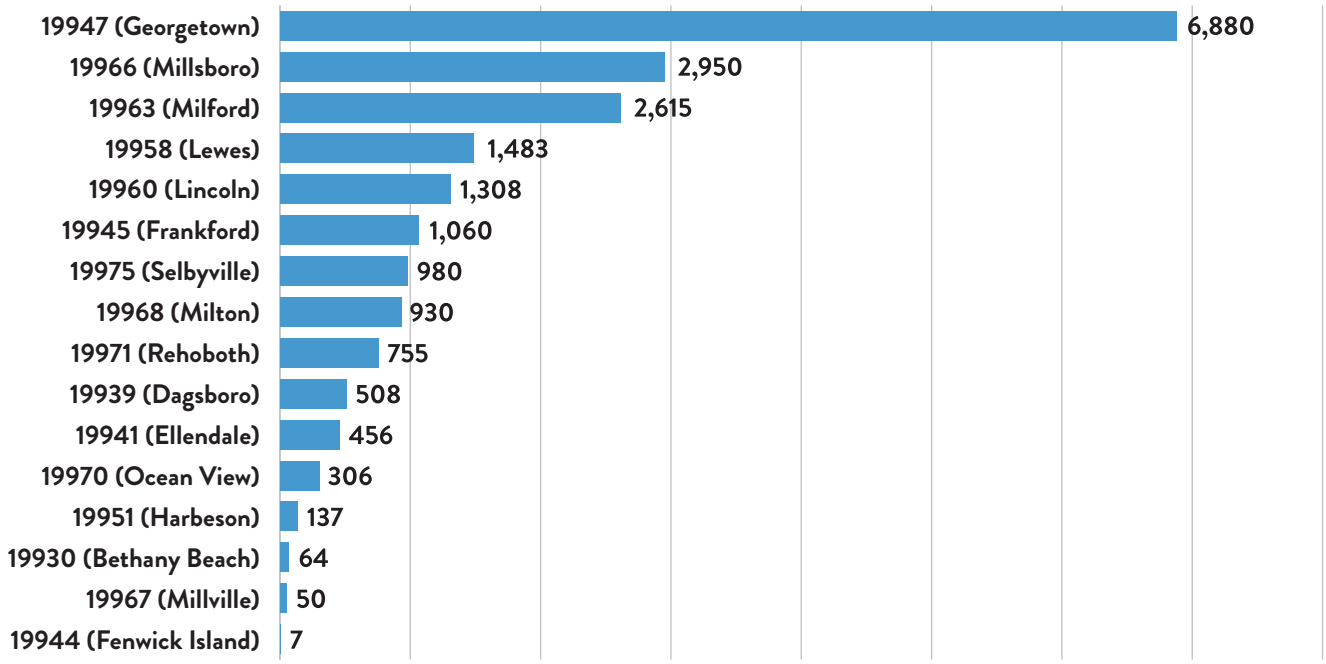
Source: U.S. Census Bureau, 2023

Figure 7: Bachelor's Degree or Higher



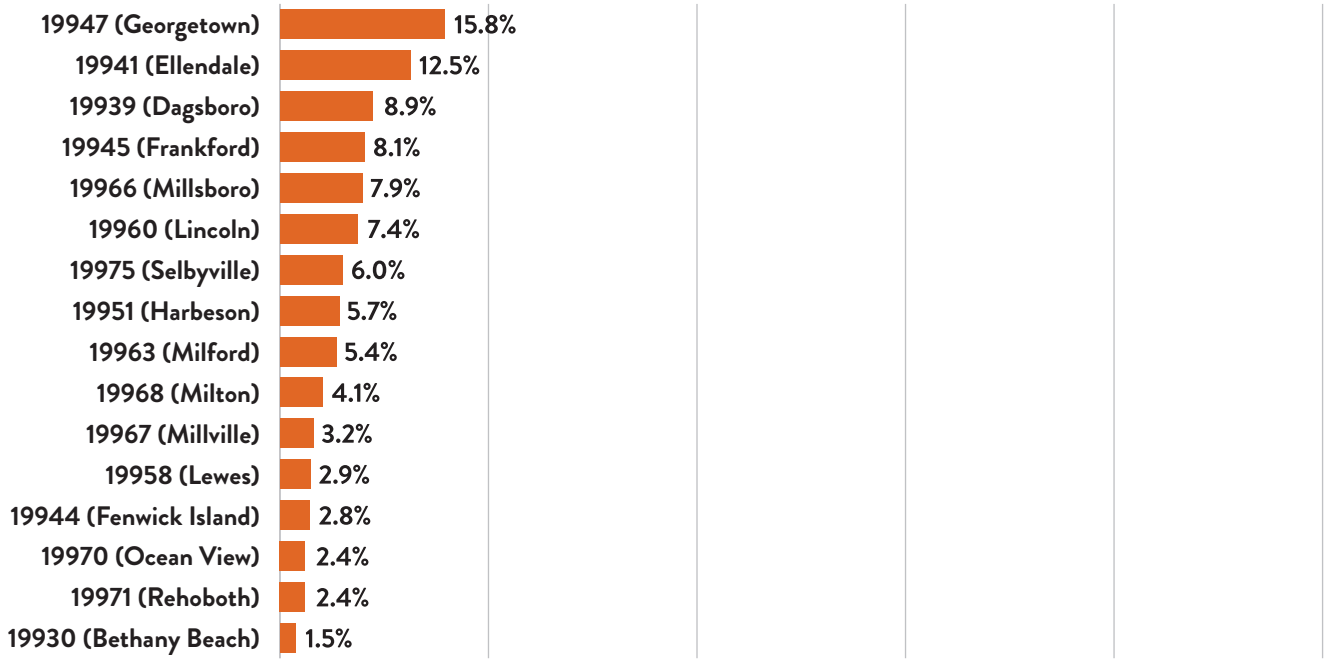
Source: U.S. Census Bureau, 2023

Figure 8: Residents who are of Hispanic/Latino Ethnicity (of any race)



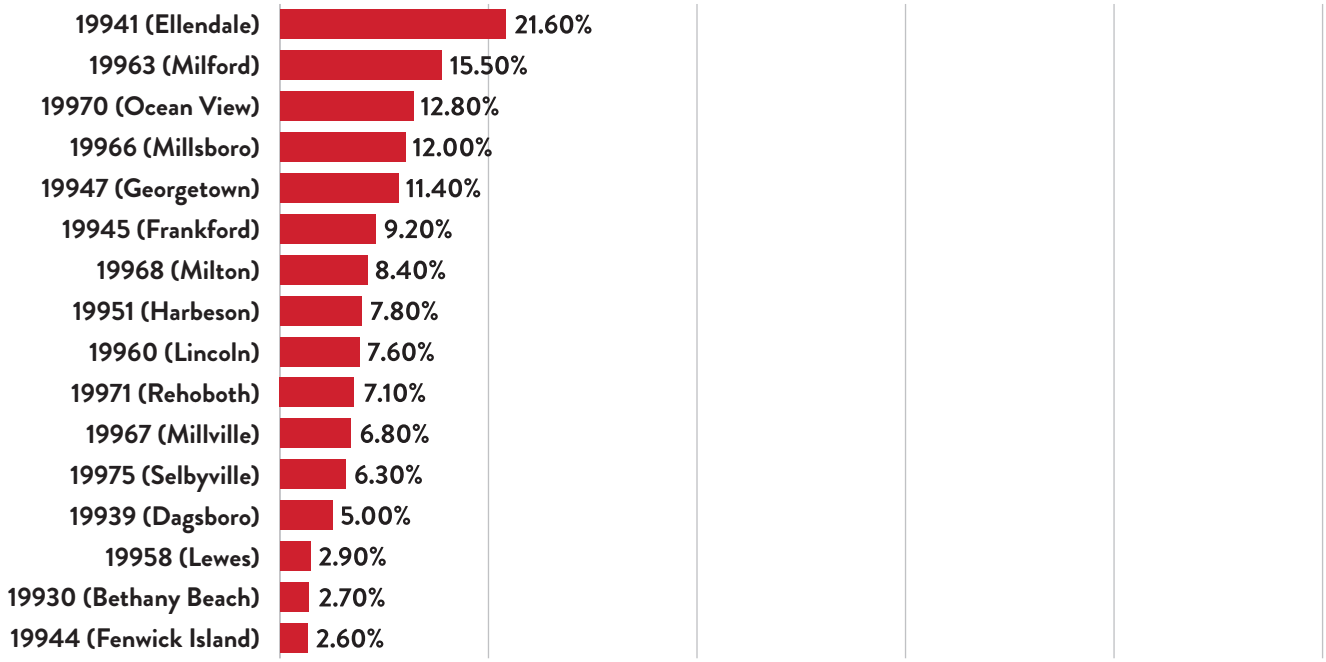
Source: U.S. Census Bureau, 2020

Figure 9: Residents with No Healthcare Coverage



Source: U.S. Census Bureau, 2023

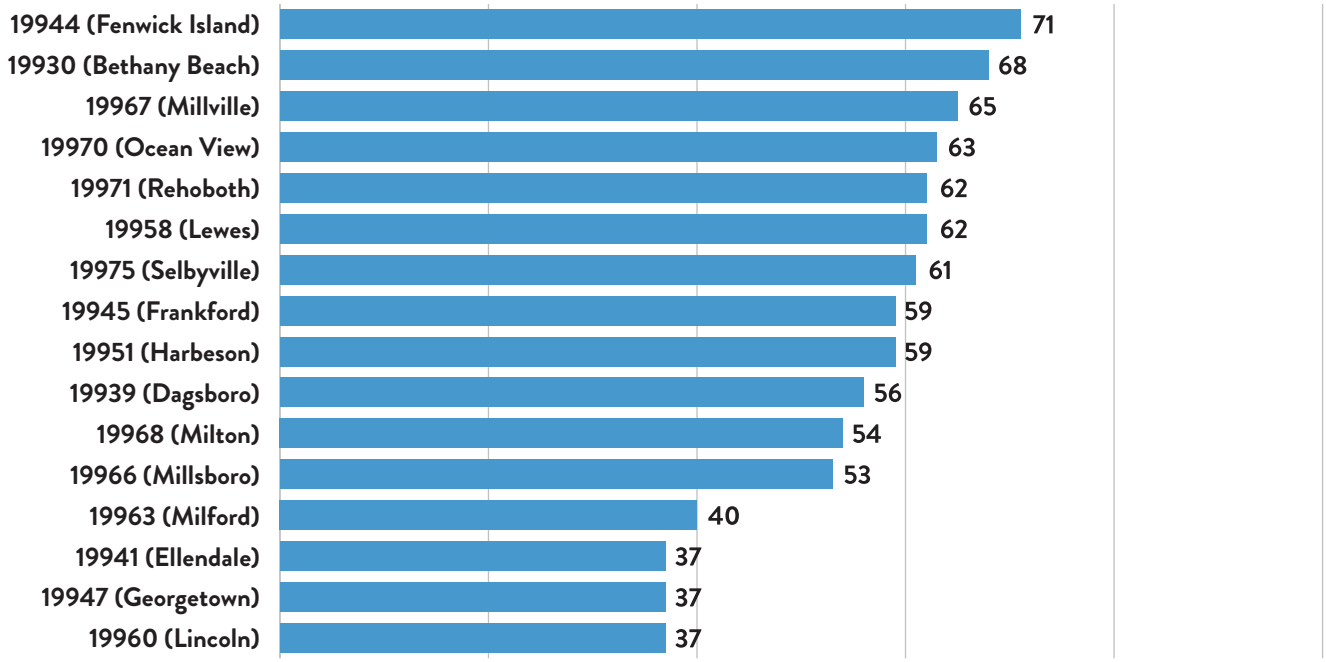
Figure 10: Poverty[3]



Source: U.S. Census Bureau, 2023

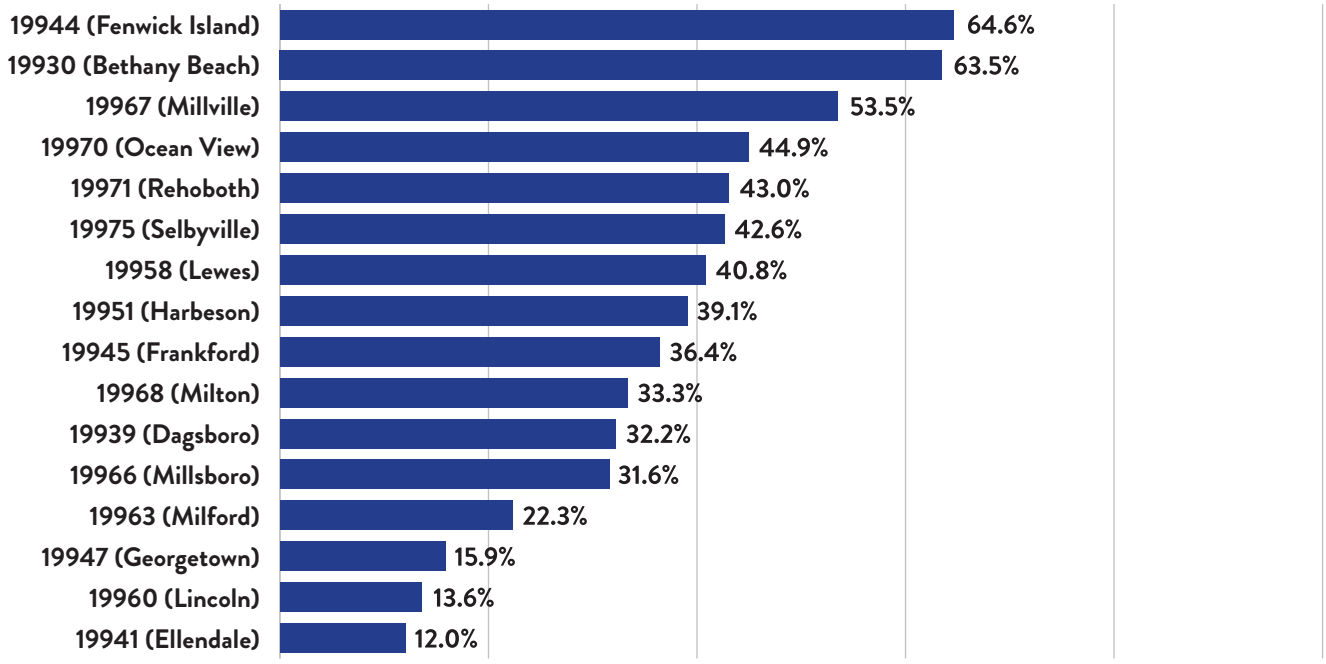
[3] According to the Office of Management and Budget's (OMB) Statistical Policy Directive 14, the U.S. Census Bureau uses a set of income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it are considered in poverty. In 2025, according to the U.S. Department of Energy, the federal poverty guideline for a family of four in the 48 contiguous states and the District of Columbia is $32,150. It's important to note that the poverty guidelines differ for Alaska and Hawaii due to their higher living costs.

Figure 11: Median Age



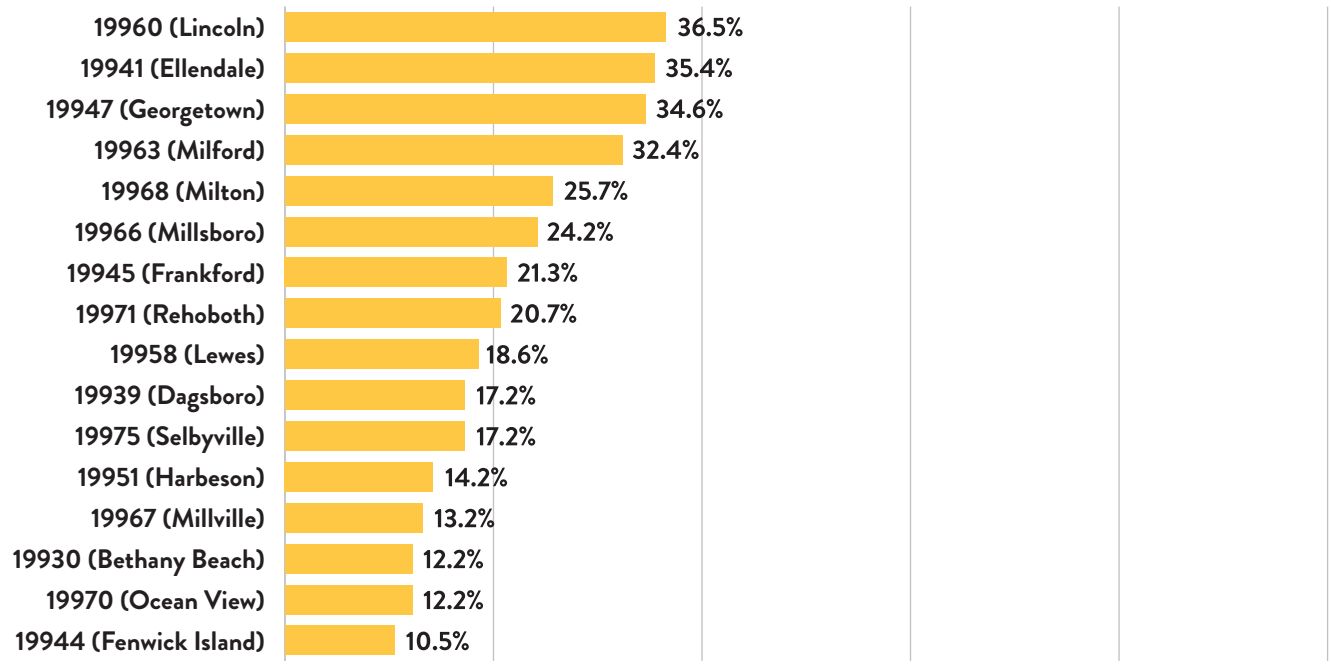
Source: U.S. Census Bureau, 2023

Figure 12: Age 65 and Older



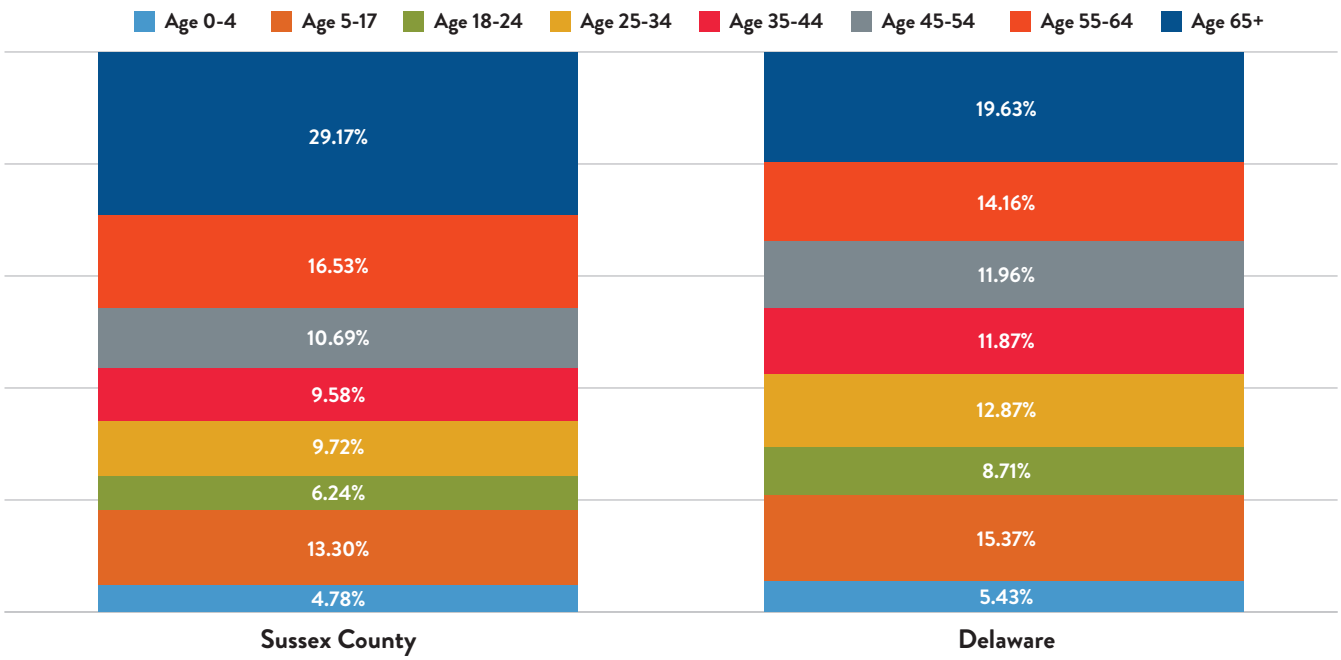
Source: U.S. Census Bureau, 2023

Figure 13: Residents who Have Never Been Married



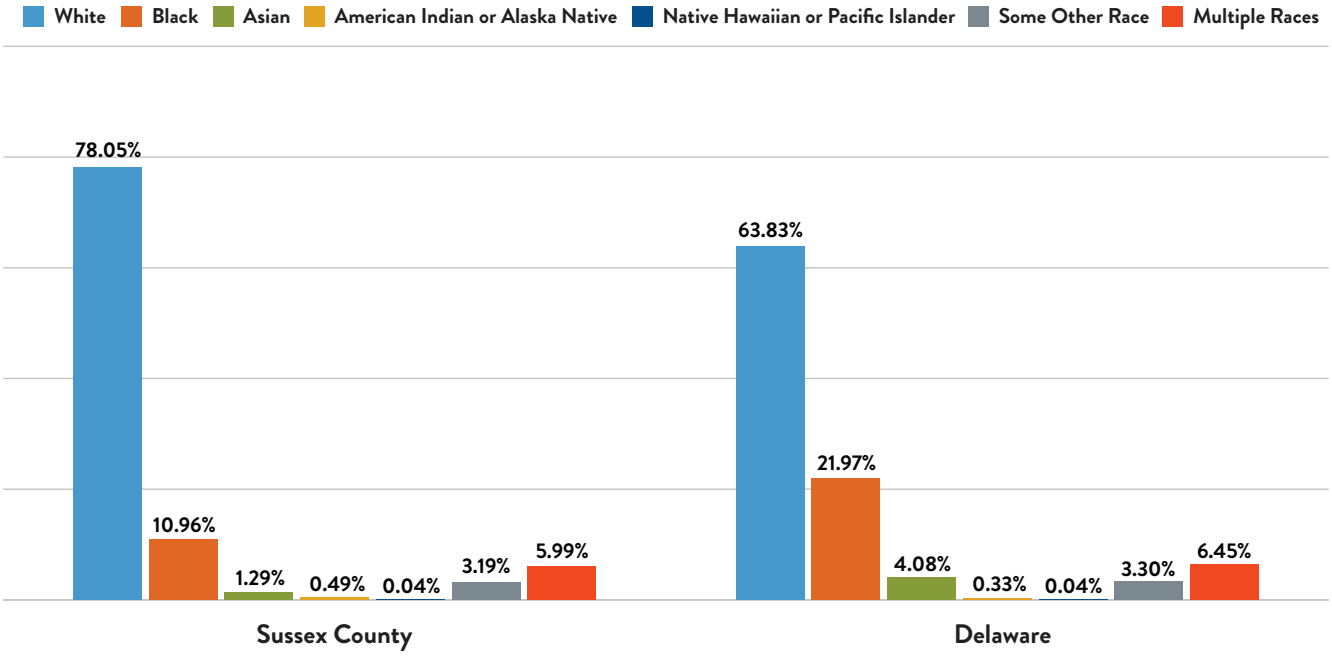
Source: U.S. Census Bureau, 2023

Figure 14: Percentage of Residents Broken into Age Groups



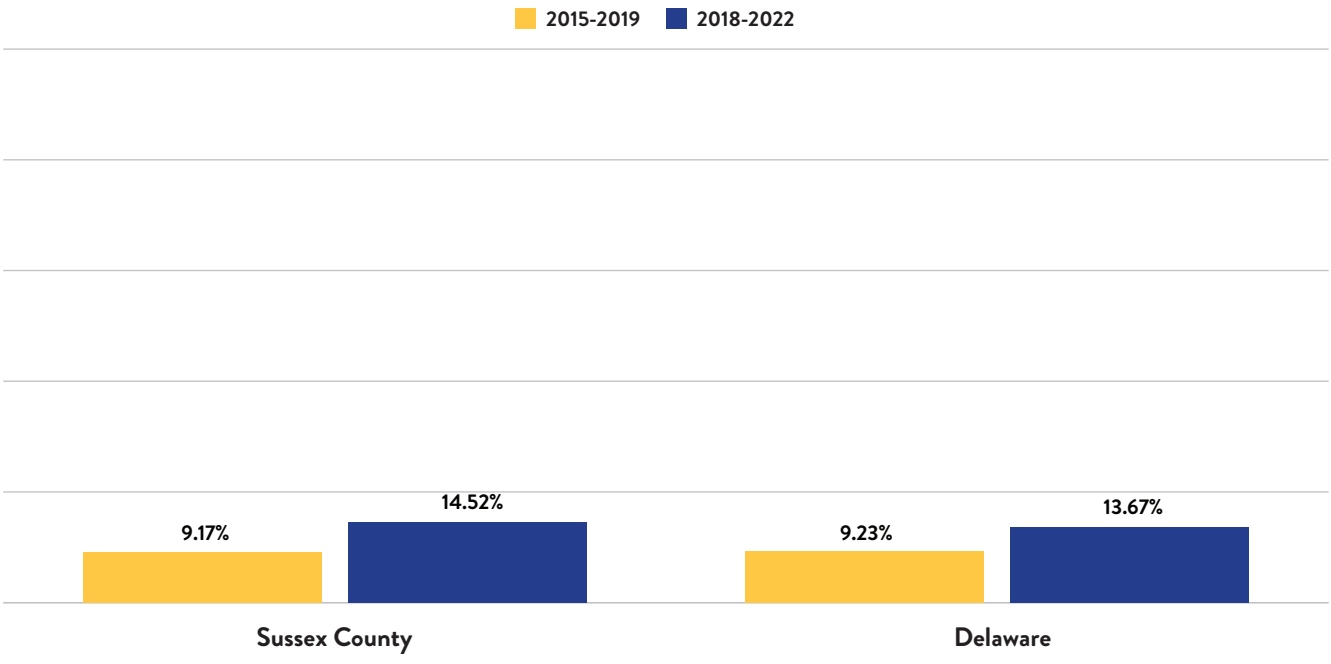
Source: U.S. Census Bureau, American Community Survey, 2018-2022

Figure 15: Population by Race



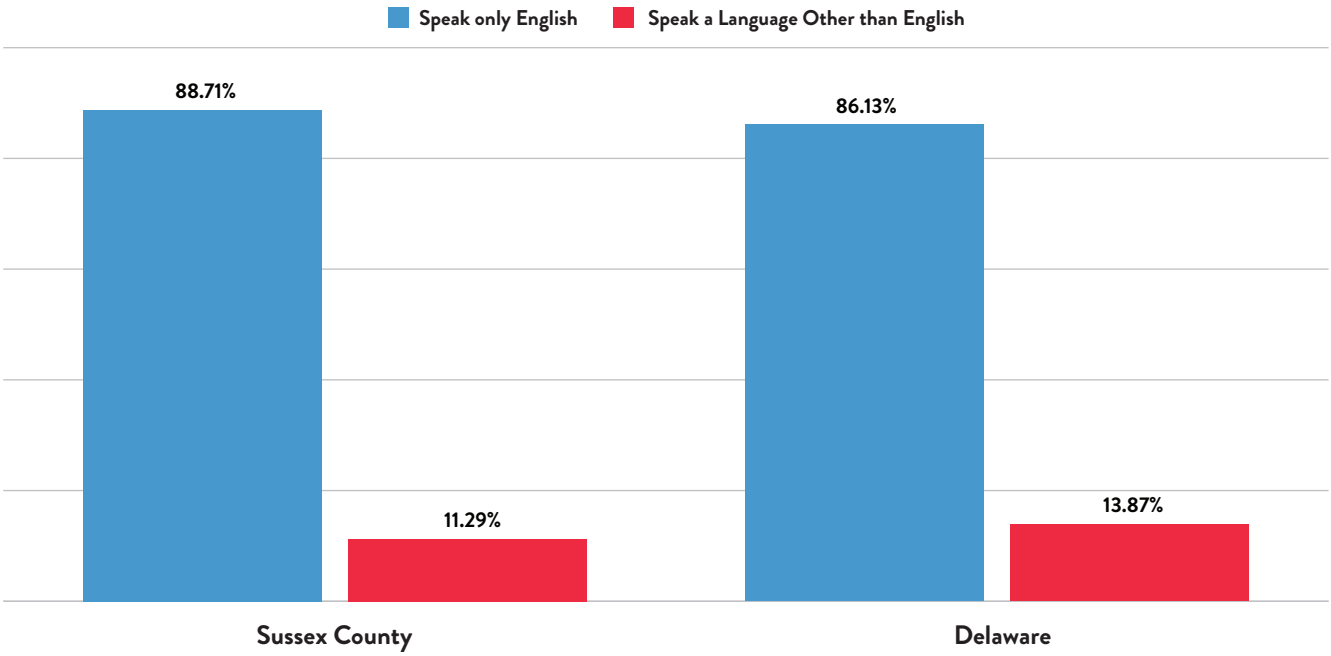
Source: U.S. Census Bureau, ACS. 2018-2022

Figure 16: Population with Any Disability



Source: U.S. Census Bureau, American Community Survey, 2015-2019; 2018-2022

Figure 17: Disabled Population of English-Speakers vs. Non-English Speakers



Source: U.S. Census Bureau, American Community Survey, 2018-2022

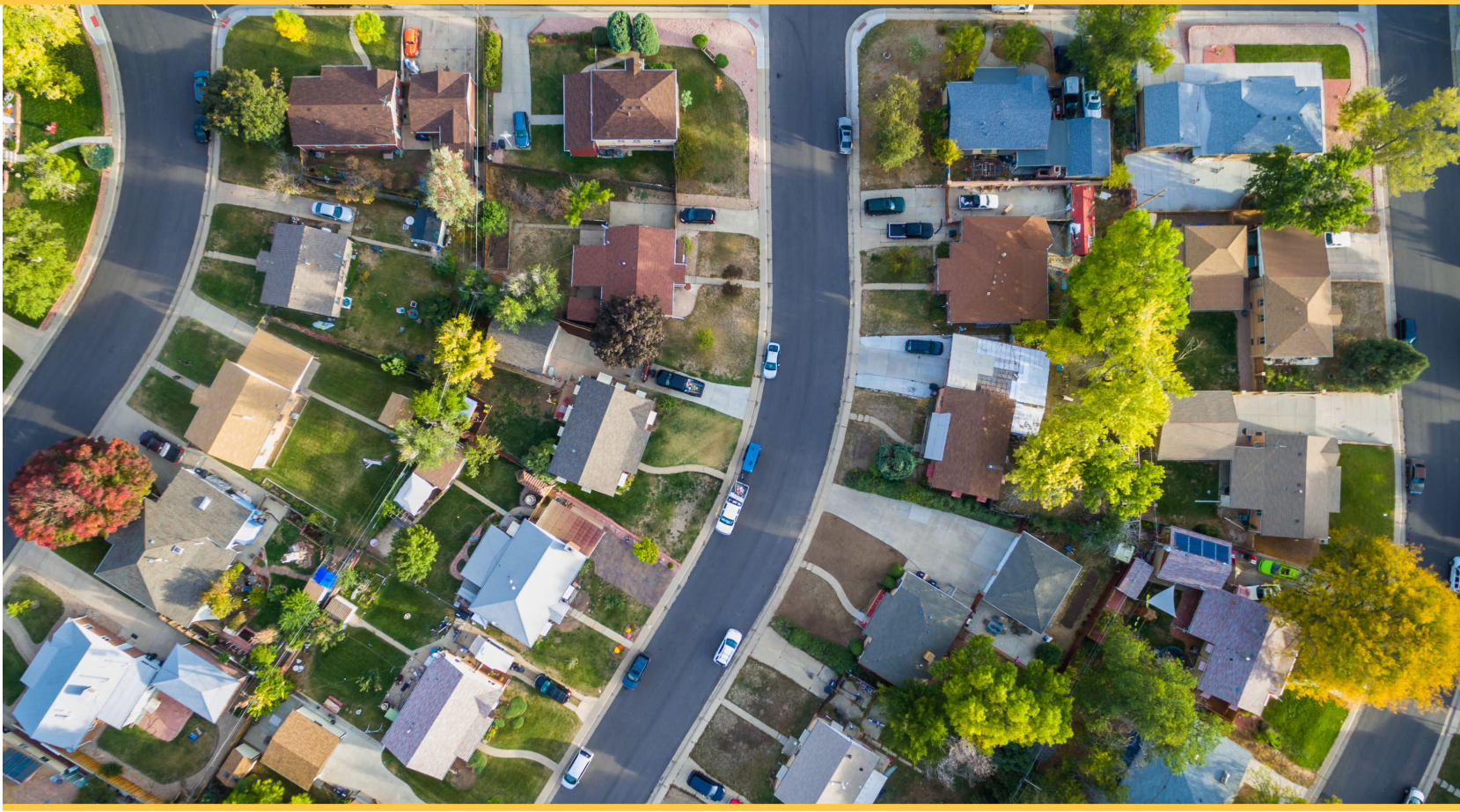
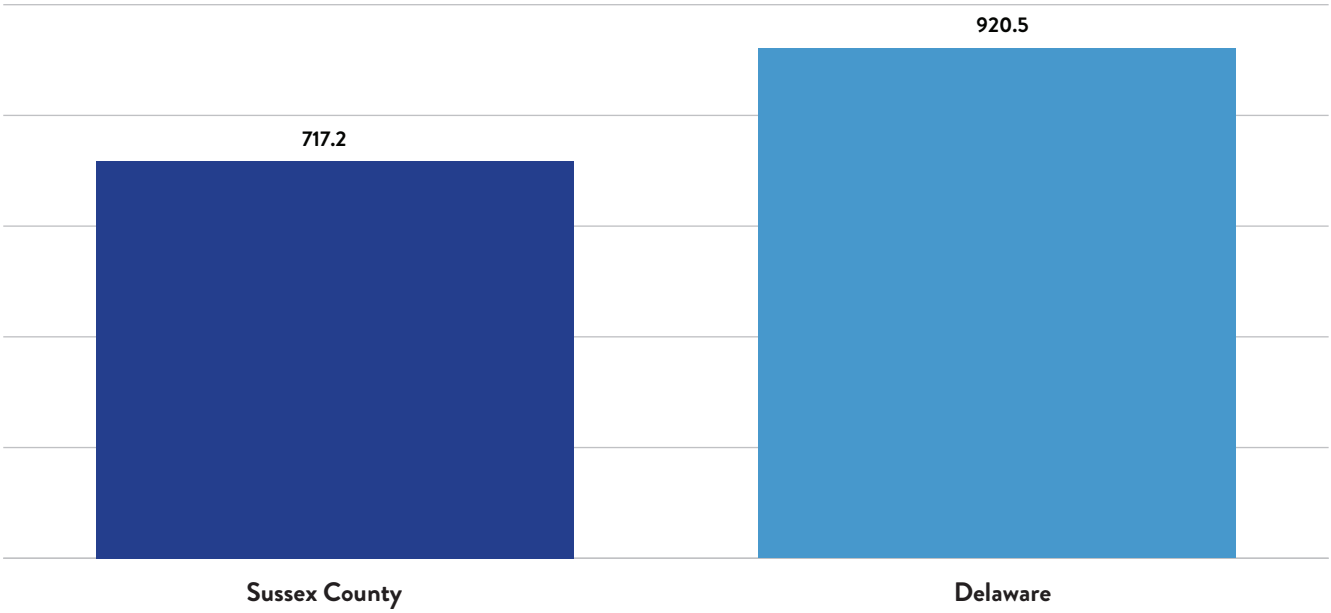
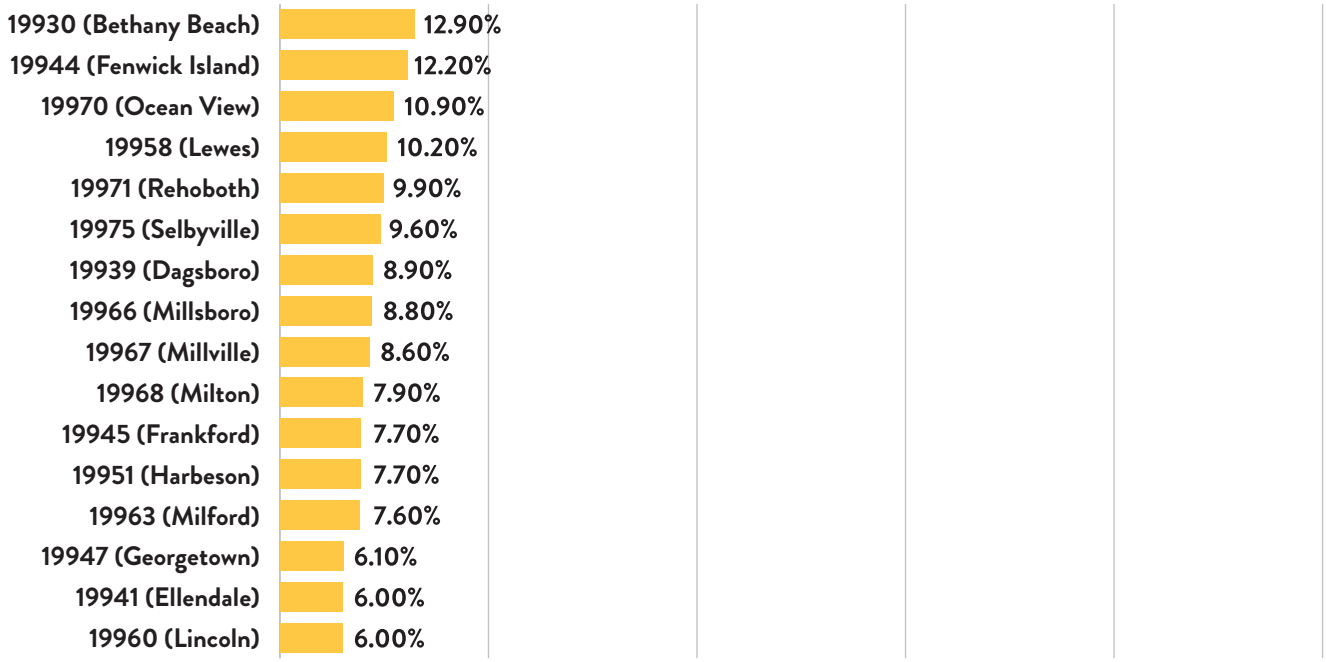


Figure 18: Violent Crime (Per 100,000 Population)



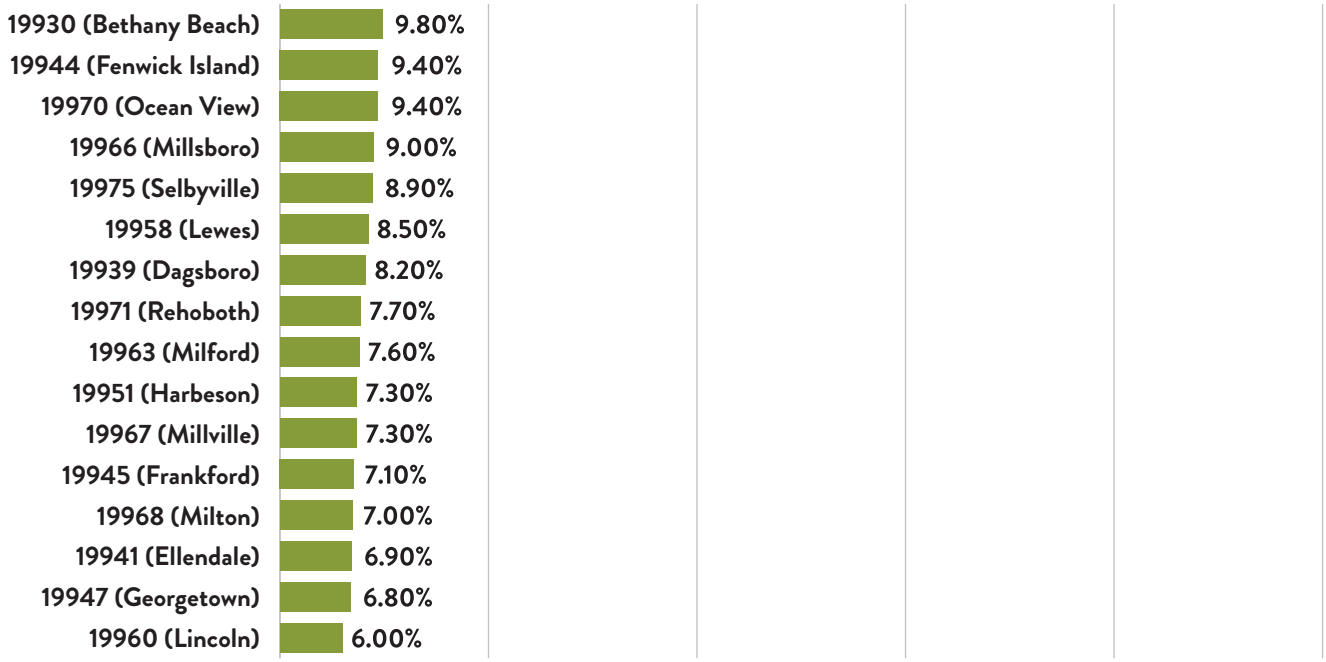
Source: IP3 Assess; Urban Data Catalog, 2022

Figure 19: Cancer by Zip Codes



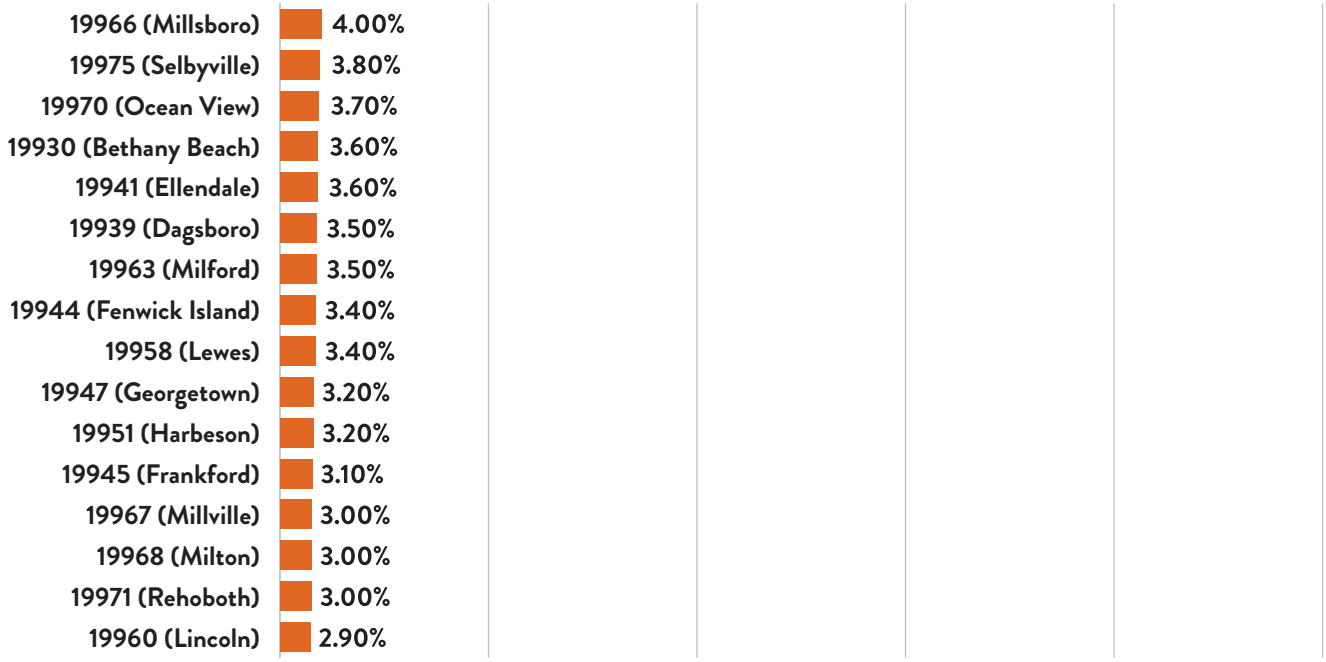
Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Figure 20: Heart Disease by Zip Codes



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Figure 21: Stroke by Zip Codes



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Evaluation of 2022 Implementation Strategy

Assessing Impact and Advancing Improvement

Over the past three years, representatives from Beebe Healthcare have implemented and monitored strategies to address key health needs within the service area. This evaluation process focused on assessing the impact and effectiveness of the 2022 implementation strategies aligned with the following priority areas: Behavioral Health, Chronic Diseases, and Healthy Lifestyles. The working group reviewed the goals and actions taken under each priority, identifying successes and areas for improvement. These internal evaluations served as valuable tools to inform adjustments and guide future planning.

The tables below highlight significant achievements and outcomes of Beebe Healthcare's efforts over this period.

Figure 22: Beebe Healthcare's FY2022 CHNA Needs

Each strategy was evaluated through a self-assessment process, serving as an internal benchmark to highlight opportunities for improvement and monitor progress over time. These assessments offer valuable insights to refine strategies and guide action steps for the next three years.


Beebe
Primary Care
Lab Express

Behavioral Health

Goal: To improve behavioral and mental health by providing access to appropriate, quality behavioral, mental health, and substance use disorder services.

Objectives	Strategies/Actions	Metrics	FY23	FY24	FY25
Identify patients more quickly by implementing expanded screening methods in the inpatient, outpatient, and emergency department environments.	Screen for behavioral, mental, and emotional health indicators in inpatient and outpatient settings.	• Number of behavioral health (BH) patients identified • Number of mental health patients identified • Number of co-occurring patients identified • Number of SUD patients identified • Number of referrals generated by high positive Columbia Screening Tool	✓	✓	✓
	Open BH practice in October 2022.	• Number of new patients served • Number of referrals received Note: The practice opened in FY23.	✓	–	–
	Conduct Columbia Suicide Screening Tool with every patient 12 and older. (Refers to inpatient and outpatient)	• Number of patients screened • Number of patients referred based on screening results Note: In FY23-FY25 the inpatient metrics were completed; however, the outpatient metrics were unable to be completed across all practices due to staffing constraints. The PHQ-2 was embedded in outpatient check-in workflows, with the PHQ-9 completed if responses to PHQ-2 triggered the full assessment.	✓	✓	✓
	Integrate BH provider into Primary Care Office 2-3 days a week.	• Number of behavioral health providers serving in primary care physician (PCP) offices • Number of patients served Note: Unable to complete due to provider recruitment challenges and associated financial considerations.	–	–	–
Connect clients/ patients to effective community resources that provide behavioral healthcare, mental healthcare, and substance use disorder treatment programs and/ or facilities.	Assess patient status and readiness and refer to appropriate services.	• Number of patients connected to quality services yearly • Number of peer referrals • Date of implementation of BH RN template and Peer Recovery Specialists template	✓	✓	✓
	Continue to foster relationships with Sussex County and State providers/ agencies.	• Number of additional partnerships established each year	✓	✓	✓
	Provide MAT induction and increase warm handoffs to MAT programs for SUD/COD patients. (Refers to inpatient, outpatient, and mobile outreach)	• Number of patients inducted • Percent of SUD/COD patients with warm handoffs to MAT programs yearly • Data collection reporting process established by year 1 In FY23, mobile outreach metrics were not completed due to clinician beginning 2nd half of FY24. Inpatient data for FY23 were still in process due to staffing transitions and challenges with internal and external data sources.	✓	✓	✓

Objectives	Strategies/Actions	Metrics	FY23	FY24	FY25
Ensure alignment of clinical providers' prescribing behaviors and state and federal regulations surrounding pain medication management.	Support education of area providers regarding current evidence-based opioid and pain management prescribing standards. (Refers to inpatient, outpatient, and mobile outreach)	• Number of primary care offices that are involved Note: In FY23 and FY24 the inpatient services measures were unable to be completed due to staffing and capacity. Note: In FY23 and FY24 mobile outreach provider education was unable to be completed, due to the provider on mobile outreach onboarding date in 2nd half of FY24. Grand rounds on SUD and Pain Management, in FY25; these topics continue to be a focus for FY26/FY16 education in the inpatient setting.	✓	✓	✓
	Identify Primary Care Hubs for future expansion.	• Number of primary care hubs established Note: in FY23 through FY25 this measure was unable to be completed due to organizational resources being redirected to address other presenting priorities.	–	–	–
	Recruit and retain psychiatrists, advance practice providers, psychologists and therapists (LCSW, LPC, CADC).	• Number recruited each year	✓	✓	✓
	By CY2023, integrate BHC Behavioral Health Team and BMG Behavioral Health into one organization team.	• Date of integration Note: In FY23 through FY25 this measure was not fully integrated; however, successful collaboration is occurring, and a continuum of care process is progressing forward.	–	–	–
	Develop behavioral health training for family medicine residents, psychiatric APRN students and social work interns by CY2025.	• Number of residents and interns trained • Date of training initiation Note: APRNs and MSWs come with clinical objectives.	–	✓	✓
Evaluate compliance, current interventions and alignment with the Behavioral Health Consortium's three-year action plan and the Delaware State Health Improvement Plan.	Develop Behavioral Health Governing Body representing Beebe Medical Group (BMG), Beebe Medical Center (BMC), and major stakeholders.	• Number of Behavioral Health Governing Body (BHGB) meetings scheduled • Number of Beebe Healthcare representatives attending at Behavioral Health Consortium (BHC) • Quarterly meeting with SHIP lead	✓	✓	✓
Assess and address educational deficits within the community.	Increase education and awareness about behavioral health needs, recovery, and addressing stigma.	• Number of PODs held each monthly and yearly • Number of partnered events each year	✓	✓	✓
	Engage organizing partner in annual prevention and awareness event.	• Participating as partner in annual event	✓	✓	✓

Chronic Diseases

Goal: To reduce, prevent, and manage chronic diseases.

Cancer					
Objectives	**Strategies/Actions**	**Metrics**	**FY23**	**FY24**	**FY25**
Improve early detection and prevention.	Provide cancer screenings, risk reduction education and follow-up care services through Care Coordination Population Health Services.	• Number of screening events held • Number of cancer screenings • Number of positive findings and follow-ups in FY2024 and 2025 • Number of attendees • Number of outreach events where materials were distributed Note: In FY23 the metric was not completed as processes were not established in calendar year (CY) 23 due to team leadership transitions. Due to the electronic medical records (EMR) transition and reallocation/reduction of resources in CY25, regular data reporting has been affected, thus affecting collection and reporting of metrics. Data collection will resume after November 1, 2025.	–	✓	✓
Expand whole person care through the cancer journey.	Assess, address needs, and barriers through Psychosocial/ Navigation Staff.	• Number of staff in each Psychosocial Services (PSS) area (Social Work, Navigation, Chaplain, and Nutrition) • Number of referrals for each service area • Number of Palliative Care referrals • Number of providers recruited	✓	✓	✓
	Further integrate and expand Palliative Care services into Oncology Service Line.	• Date of integration	✓	✓	✓
Expand survivorship continuum of care programs.	Offer survivorship programs throughout the year on various key topics.	• Number of attendees	✓	✓	✓
	Increase opportunities for survivorship programs and community engagement.	• Number of programs offered yearly • Number of attendees Note: In FY25 the metric was not completed as there was not an increase in the opportunities for survivorship programs; however, the planning team consolidated the programs into three events. Programs were consolidated with the goal of increasing engagement.	✓	✓	–
	Partner with community-based organizations to expand survivorship programs.	• Number of community organizations participating	✓	✓	✓
Increase access to cancer care throughout Sussex County.	Establish and expand at South Coastal Cancer Center providing care closer to home.	• Number of existing and new patients served at South Coastal Cancer Center.	✓	✓	✓

Diabetes					
Objectives	**Strategies/Actions**	**Metrics**	**FY23**	**FY24**	**FY25**
Reduce and prevent the occurrence of diabetes and pre-diabetes diagnosis through health screenings and health education.	Expand community-based education and awareness on the health risks and lifestyle behaviors associated with diabetes.	• Number of education programs, awareness sessions, health fairs held. • Number of attendees • Improved lifestyle changes and A1C levels reported	✓	✓	✓
	Reduce A1C rates across hospital service areas.	• Number of outpatients with A1C < 9% in measurement period • Number of outpatients with A1C > 9% that received referral for follow-up • Percent of reduction from initial A1C value (continue measurement) • Percent of participants reaching personal goal by completion of group series • Number of admission referrals (insulin pumps, continuous glucose monitors, U 500 and insulin other than Lantus)	✓	✓	✓
	Continue partnerships with organizations to support outreach.	• Number of persons reached with letter campaigns distributed through Quality Insights • Number of collaborations with Beebe Healthcare's Population Health to increase referral services • Number served in each ZIP code to monitor outreach success	✓	✓	✓
	Expand access to Diabetic Courses offered through Beebe Healthcare's Diabetes Self-Management Education (DSME).	• Number of telemedicine visits • Number of total enrollments in program • Number of support group meetings (minimum of six per year) • Number of no-shows and cancellation rates • Complete optimization of Cerner (EMR) to streamline documentation and allow for more patient visits/access Note: In FY25 the metric was not completed as data was not retrievable. Optimization of Cerner was not completed.	✓	✓	–
	Continue to support early intervention for children enrolled in school-based health centers.	• Number of students with calculated BMI • Number of referrals to dietician within SBHC for dx of obesity or overweight • Number of diabetic (Type 1 or Type 2) serviced in the School Based Health Center (SBHC) Note: Data not retrievable because of disparate systems. Staffing and leadership changes occurred in this timeframe.	✓	✓	✓

Chronic Diseases (continued)

Goal: To reduce, prevent, and manage chronic diseases.

Heart Disease					
Objectives	**Strategies/Actions**	**Metrics**	**FY23**	**FY24**	**FY25**
Reduce and prevent the occurrence of heart disease through health screenings and health education.	Expand community-based awareness on heart disease prevention and the health risks associated with heart disease.	• Number of heart disease prevention education sessions conducted • Number of attendees • Number of health fairs, events held • Number of heart health prevention materials distributed	✓	✓	✓
	Continue to conduct health screenings for early detection of heart disease and appropriate treatment.	• Number of heart screenings conducted • Number of referrals	✓	✓	✓
Expand community outreach education on improvement and management of heart disease.	Provide heart health education to churches, civic associations, schools, community health fairs and events.	• Number of heart health education/ awareness programs conducted • Number of events and health fairs held • Number of attendees	✓	✓	✓

High Blood Pressure/Hypertension					
Objectives	**Strategies/Actions**	**Metrics**	**FY23**	**FY24**	**FY25**
Reduce and prevent the occurrence of hypertension and stroke through health screenings and health education.	Expand education and awareness on health risks and lifestyle behaviors (diet, weight, activity) associated with hypertension and stroke.	• Number of education and awareness sessions, health fairs held • Number of attendees • Increase in number of people achieving normal blood pressure range Note: Metrics were for community outreach only.	✓	✓	✓

Health Priority/Healthy Lifestyles

Goal: To improve health and quality of life.

Objectives	Strategies/Actions	Metrics	FY23	FY24	FY25
Increase the percentage of Sussex County residents reporting targeted health behaviors including healthy eating and an active lifestyle.	Refine, build, and expand Beebe Healthcare's programs that target individuals who are living with chronic health conditions or are overweight/ obese.	• Number of education/awareness programs conducted that promote disease management, prevention, healthy eating, and active lifestyle • Number of community outreach events including Social Vulnerability Index (SVI)	✓	✓	✓
	Provide awareness and education on healthy eating and making good food choices to outpatients, schools, and community.	• Number of nutrition programs offered • Number of partnerships with community-based organizations and schools • Number of participants • Number of outpatient nutrition referrals including school-based wellness centers	✓	✓	✓
	Leverage community partnerships for more efficient and effective implementation of programs, improving reach and outcomes.	• Number of nutrition programs offered • Number of partnerships with community-based organizations and schools	✓	✓	✓
Increase the percentage of Sussex County residents with a healthy weight range.	Expand programs that promote weight management and healthy living.	• Number of weight management and healthy living programs offered • Number of attendees	✓	✓	✓
	Connect patients to resources that implement and support patient-centered lifestyle changes.	• Number of patients screened and connected to appropriate resources Note: In FY23, the metrics was not completed as the provider transitioned to address patient volumes; therefore, subsequent staffing model impacted this measure.	–	✓	✓
	Provide awareness and education on benefits and risks of bariatric surgery.	• Track number of bariatric surgeries performed	✓	✓	✓
	Expand education and awareness regarding weight management alternatives and implications of obesity.	• Document results of bariatric surgery through follow-up at six-month, nine-month, and one-year intervals (check on timing and intervals)	✓	✓	✓

Factors that Influence Our Lives

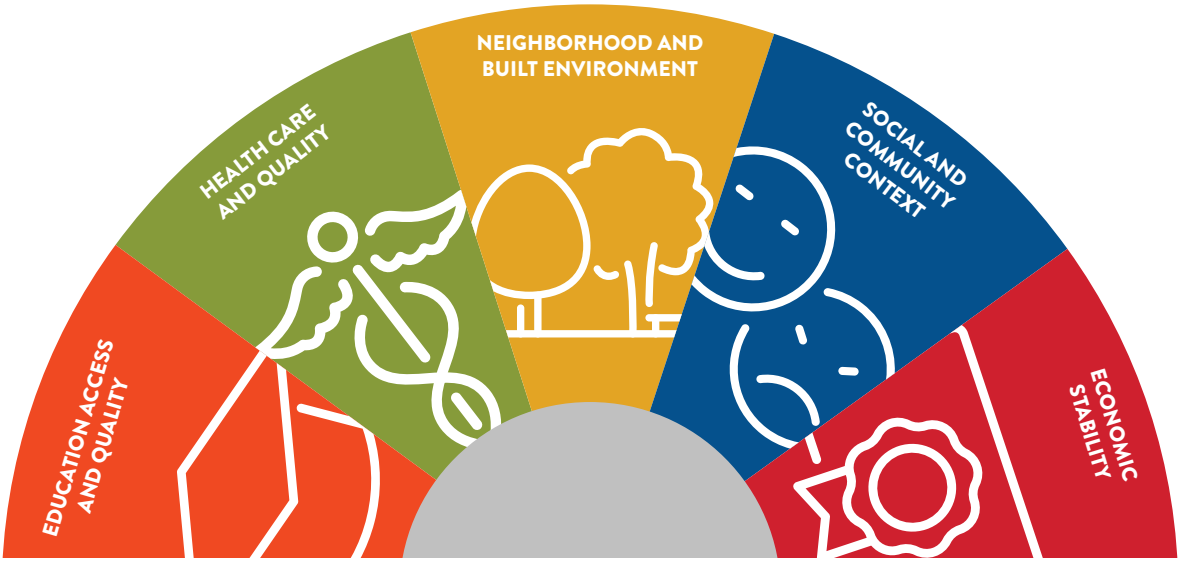
Social Determinants of Health (SDOH)

Social determinants of health—the conditions in which people are born, grow, live, work, and age—play a critical role in shaping individual and community health outcomes. Factors such as income, education, housing stability, food security, transportation access, employment, and neighborhood safety influence nearly every aspect of health and well-being. In Sussex County, these social and economic conditions contribute to gaps in access to care, chronic disease prevalence, mental health challenges, and life expectancy. Individuals facing poverty may struggle to afford nutritious food or stable housing, while those without reliable transportation may delay or forgo medical care entirely.

All community stakeholders interviewed for the CHNA unanimously agree that there is a significant lack of affordable housing options available to residents, as well as a dire need to focus on transportation, which is a significant barrier for residents not receiving care or services. These barriers compound over time, creating cycles of poor health and limited opportunity. Beebe Healthcare recognizes that clinical care alone cannot address the full spectrum of factors that affect community health; understanding and addressing these broader determinants are essential.

Within Beebe Healthcare's service area, residents continually adapt their lives in response to these social and economic realities. Many families must make difficult trade-offs between healthcare and other essential needs, such as housing or utility costs. Those in rural areas often rely on community-based programs and support services to bridge gaps in access, such as food pantries, transportation assistance, and mobile health units. Others seek care at Beebe Healthcare's network of outpatient centers and partner organizations that help bring services closer to where people live. In response to these challenges, Beebe Healthcare has increased its focus on community partnerships and outreach initiatives aimed at mitigating the impacts of SDOH. By collaborating with schools, local governments, housing organizations, and food security programs, Beebe Healthcare is working to reduce barriers and create environments that promote healthier, more stable lives. These efforts not only reflect Beebe Healthcare's commitment to health justice but also empower residents to lead healthier lives despite the systemic challenges they face.

Figure 23: Social Determinants of Health



Source: Centers for Disease Control and Prevention

Beebe Healthcare's CHNA highlights the significant impact of SDOH on the well-being of residents across Sussex County. Economic instability, educational attainment, barriers to healthcare access, food insecurity, and unreliable transportation continue to drive social gaps, particularly among at-risk and rural populations. By identifying these systemic challenges, Beebe Healthcare and its community partners are positioned to implement targeted interventions such as expanding mobile health outreach, enhancing food access initiatives, and strengthening transportation networks. These strategies aim to reduce health inequities and support healthier, more resilient communities within Beebe Healthcare's service area.

Table 4 reveals data from the Delaware Environmental Public Health Tracking Network. Highlighted in red, the data represents the highest values across key indicators that impact social determinants in each ZIP code:

- ZIP code 19951: Highest unemployment rate, 8.1%.
- ZIP code 19970: Highest child poverty rate, 59.4%, and highest family poverty rate, 27.3%.
- ZIP code 19971: Most significant rent burden, 63.9%.
- ZIP code 19963: Highest proportion of renters, 35.7%.
- ZIP code 19941: Highest rate of households receiving SNAP benefits, 20.7%.

These elevated figures highlight critical areas of economic hardship, housing instability, and food insecurity, all of which contribute to poor health outcomes and inequities in access to healthcare. Addressing these indicators is essential to improving the overall health and quality of life for at-risk populations within Beebe Healthcare's service area.

Table 4: Environmental Public Health Tracking Network ZIP Code

Zip Code	Un-Employment	Child Poverty	Family Poverty	Rent Burden	Renters	Households Receiving SNAP
19930 (Bethany Beach)	5.4%	5.50%	9.4%	50.8%	15.6%	3.9%
19939 (Dagsboro)	4.2%	9.9%	15.3%	18.2%	7.6%	10.3%
19941 (Ellendale)	6.1%	31.6%	24.2%	53.7%	30.9%	**20.7%**
19944 (Fenwick Island)	3.1%	0.0%	0.0%	0.0%	8.0%	0.9%
19945 (Frankford)	4.9%	17.9%	14.7%	45.1%	11.7%	5.4%
19947 (Georgetown)	3.2%	20.7%	15.0%	63.4%	33.8%	18.2%
19951 (Harbeson)	**8.1%**	3.3%	5.0%	27.8%	1.6%	2.2%
19958 (Lewes)	3.9%	17.0%	14.1%	49.5%	15.3%	9.3%
19960 (Lincoln)	2.4%	5.6%	4.7%	30.4%	9.5%	6.0%
19963 (Milford)	4.4%	19.3%	15.6%	47.0%	**35.7%**	12.8%
19966(Millsboro)	7.0%	20.8%	12.1%	54.0%	15.3%	10.0%
19967 (Millville)	3.7%	7.0%	1.4%	19.1%	11.9%	0.0%
19968 (Milton)	5.9%	18.6%	16.3%	53.1%	15.2%	8.2%
19970 (Ocean View)	2.4%	**59.4%**	**27.3%**	62.5%	10.5%	4.5%
19971 (Rehoboth)	4.9%	9.3%	20.0%	**63.9%**	12.4%	7.0%
19975 (Selbyville)	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%

Note: Rent burden is the proportion of households that spend 30% of their total income on rent.

Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020 Data

Chronic Diseases

(Diabetes, Heart Disease, Hypertension, and Obesity)

Chronic diseases are significant public health concerns because of their high prevalence and substantial impact on the community. Chronic diseases, including diabetes, heart disease, hypertension, and obesity, account for seven of the 10 leading causes of death in Delaware and impose billions of dollars in health-related costs annually. Approximately 10% of Delaware residents live with multiple chronic conditions, reflecting a considerable burden on the healthcare system.[4]

Over the past decade, rates of chronic diseases have steadily climbed, reflecting both national trends and unique regional challenges. According to the Delaware Department of Health and Social Services, Sussex County has the highest adult obesity rate in the state at 32.3%, compared to the statewide average of 30.4%.[5] This increase in obesity correlates strongly with a rise in type 2 diabetes and cardiovascular disease. Diabetes affects nearly 12.5% of Sussex County adults, exceeding the state average of 11.5%, while high blood pressure impacts more than 34% of adults in the region.[6] Several factors contribute to these rising rates, including limited access to healthy foods, a growing aging population, socioeconomic gaps, and insufficient physical activity. The county's rural geography and transportation barriers further complicate access to preventive care and effective management of chronic diseases. If these conditions are not addressed through comprehensive, community-based interventions, the long-term consequences could be devastating, leading to increased disability, premature mortality, and unsustainable healthcare costs.

The prevalence of diabetes among Delaware adults increased from 2011 to 2022. Notably, non-Hispanic Black Delaware adults had higher prevalence and mortality rates from diabetes compared to non-Hispanic White or Hispanic adults. This trend highlights the importance of targeted interventions, such as the Diabetes Prevention Program offered by Beebe Healthcare and the YMCA. This program has shown effectiveness in reducing the risk of developing type 2 diabetes through lifestyle modifications. [7,8]

Heart disease remains a leading cause of death in Delaware. While the prevalence of specific heart diseases has been stable since 2011, the five-year age-adjusted mortality rate from heart disease decreased in Delaware and nationally from 2006-2010 to 2016-2020. However, continued efforts are necessary to sustain and further this decline.[9]

Hypertension is a prevalent condition in Delaware, with no significant changes in prevalence from 2011 to 2021. The five-year age-adjusted hypertension mortality rate remained stable from 2006-2010 to 2016-2020 in Delaware and the United States. However, in 2016-2020, Delaware had a lower hypertension mortality rate compared to nationally. Addressing hypertension through lifestyle modifications and medication adherence is crucial to prevent complications such as heart disease and stroke.[10]

Proactive measures, including preventive care, health education, and access to healthcare services, are crucial in combating the rise of chronic diseases in Sussex County.[11] By focusing on prevention and management strategies, Sussex County can improve health outcomes, reduce healthcare costs, and enhance the overall well-being of its residents.

[4] State of Delaware News, 2024

[5] Delaware Health and Social Services/Division of Public Heath: The Burden of Chronic Disease in Delaware, 2024

[6] The Impacts of Diabetes in Delaware, 2023

[7] Delaware Health and Social Services/Division of Public Heath: The Burden of Chronic Disease in Delaware, 2024

[8] Delaware Journal of Public Health, 2017

[9] Delaware Health and Social Services/Division of Public Heath: The Burden of Chronic Disease in Delaware, 2024

[10] Delaware Health and Social Services/Division of Public Heath: The Burden of Chronic Disease in Delaware, 2024

[11] Delaware Health and Social Services/Division of Public Heath: The Burden of Chronic Disease in Delaware, 2024

Table 5 summarizes key findings from stakeholder interviews and focus groups as part of a community health assessment. Listening to the community helps identify community needs and is crucial in ensuring that health strategies align with the lived experiences of those affected. The findings from stakeholder interviews and focus groups highlight the prevalence of chronic diseases.

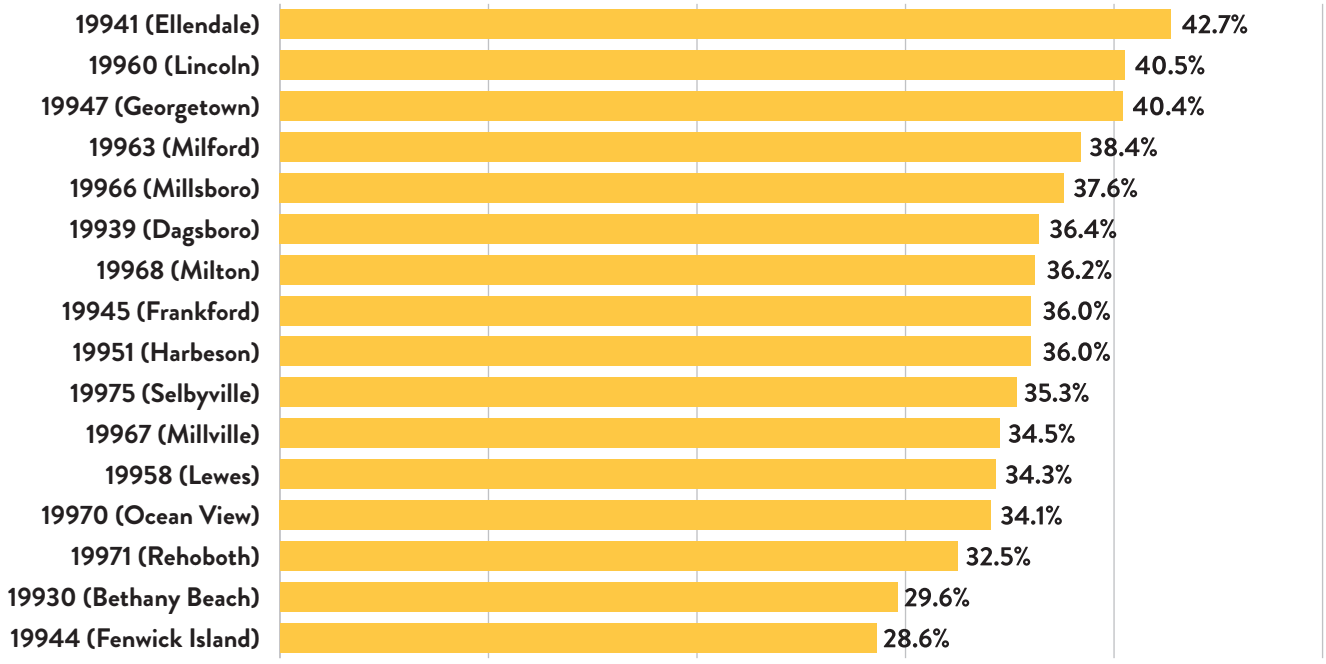
Table 5: Listening to the Community

Stakeholder Interviews Findings Shared Feedback	Focus Groups Findings Shared Feedback
Persistent Health Problems • 60.0% — Obesity • 46.6% — Diabetes • 46.6% — Heart disease and stroke • 33.3% — High blood pressure ***What can be offered to suppress the prevalence of chronic diseases and maintain optimal health?*** • 80.0% — Access to healthy foods • 73.3% — Preventative healthcare services • 66.7% — Health promotion and education ***Significant Barriers to Improving Health and Quality of Life*** • 66.6% — Access to affordable healthy food options ***Persistent High-Risk Behaviors*** • 66.6% — Being overweight/obese • 60.0% — Lack of exercise/physical activity • 46.6% — Poor eating habits ***Innovations/Strategies to Improve Health Outcomes*** Preventative Care and Education • Emphasize preventative work, such as screenings and education on chronic diseases. ***Impactful Community-Based Educational Programs*** Health and Wellness Programs • Address diabetes, obesity, and high blood pressure through education on nutrition, exercise, and substance abuse prevention. • Develop community education programs promoting healthy lifestyles with supportive resources. ***Area of Health Focus over the Next Years*** Preventive and Chronic Care • Address chronic diseases, behavioral/mental health, dental care, and cancer through early detection and prevention. • Promote weight management, healthy eating, and affordable diet and exercise programs to enhance overall health. Preventative and Educational Efforts • Educate communities about better eating habits, weight management, and preventive care to improve health literacy.	***African Americans*** • Low-income neighborhoods are 'food deserts' with limited access to healthy food or nutritious groceries, and participants noted differences in food quality and pricing between stores in affluent and less affluent areas. • Despite the surrounding agricultural land, residents reported limited access to local farmers' markets or produce stands that accept SNAP/EBT, raising concerns about whether food banks will continue to meet growing community demand with looming budget cuts. ***Low-Income Participants*** • Chronic diseases such as diabetes, hypertension, and kidney disease are commonplace. They are often poorly managed because of limited access to education, healthy foods, and preventive care. • Group participants requested more free mobile screenings, health fairs, and chronic disease education to increase early detection and promote healthier living habits. • Interest was shown in mobile units offering routine health screenings, vaccinations, chronic disease management, dental care, and behavioral health support. • Beebe Healthcare and its partners must invest in prevention. This includes regular community screenings for key health indicators and education campaigns focused on nutrition, exercise, and stress management. Partnering with churches, community groups, and local businesses to host wellness activities such as walking clubs, cooking demos, and health fairs will increase community engagement and support healthier lifestyles. Preventive care must be made easy, accessible, and culturally relevant. • Chronic illnesses were frequently mentioned as prevalent across families and age groups. Participants described multiple barriers to managing these conditions, including difficulty affording medications, poor diet due to food insecurity, and limited access to primary care. • Families struggle to afford nutritious food despite living in a largely agricultural area. Partnering with local growers to develop affordable farm-to-family pipelines can create solutions—supporting local agriculture while addressing food insecurity. • Mobile health units provide an opportunity to meet residents where they are. By deploying these clinics to high-need neighborhoods. Beebe Healthcare and its partners can deliver preventive screenings, immunizations, primary care visits, and health education directly to the community.

Monitoring chronic diseases is crucial for enhancing health outcomes, preventing complications, and lowering healthcare costs. Regular monitoring enables the early detection of changes in a patient's condition, allowing for timely adjustments to treatment plans. It also empowers individuals to manage their health more effectively through lifestyle changes, medication adherence, and regular check-ups. For healthcare providers and systems, understanding and monitoring the disease enables the tracking of trends, identification of at-risk populations, and the efficient allocation of resources to support prevention and intervention efforts.

The figure below illustrates the prevalence of obesity by ZIP code. ZIP code 19941 (Ellendale) reports the highest obesity rate at 42.7%, followed closely by 19960 (Lincoln) and 19947 (Georgetown) at 40.5% and 40.4%, respectively. In contrast, coastal areas like 19944 (Fenwick Island) and 19930 (Bethany Beach) exhibit lower obesity rates, at 28.6% and 29.6%, respectively. These ZIP codes highlight the widespread prevalence of obesity across the region.

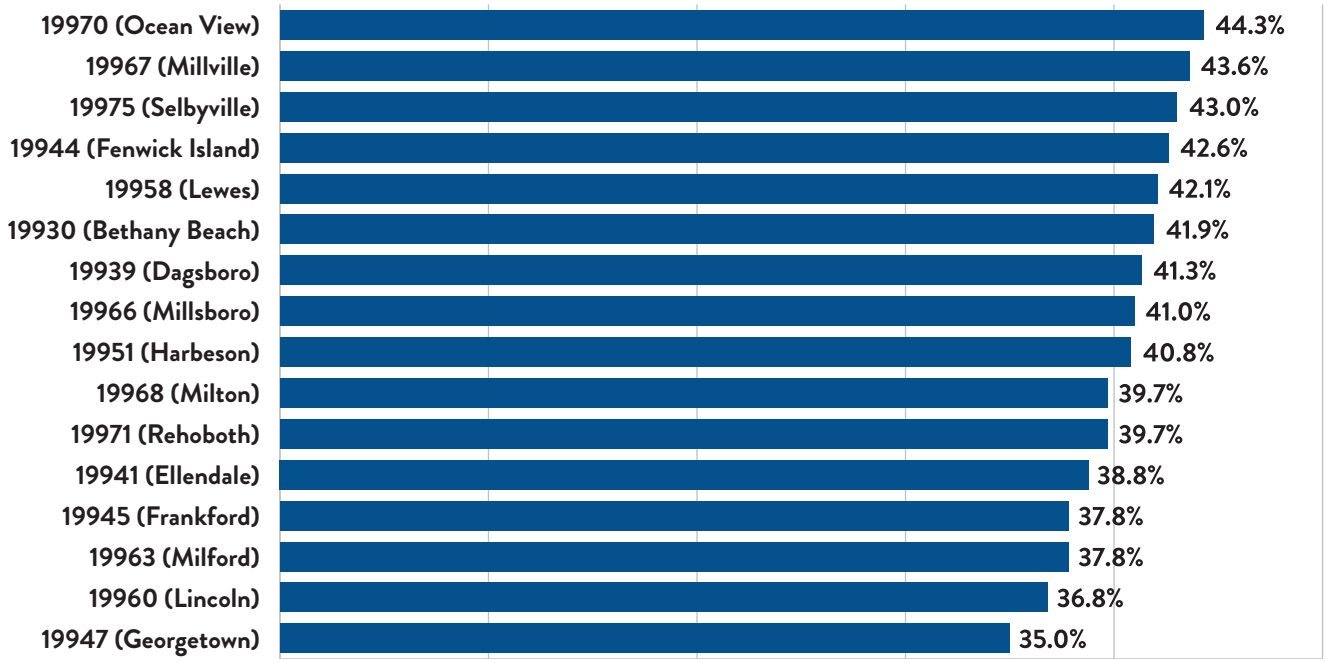
Figure 24: Obesity among Adults, Crude Prevalence



Source: Centers for Disease Control and Prevention; Places, 2022

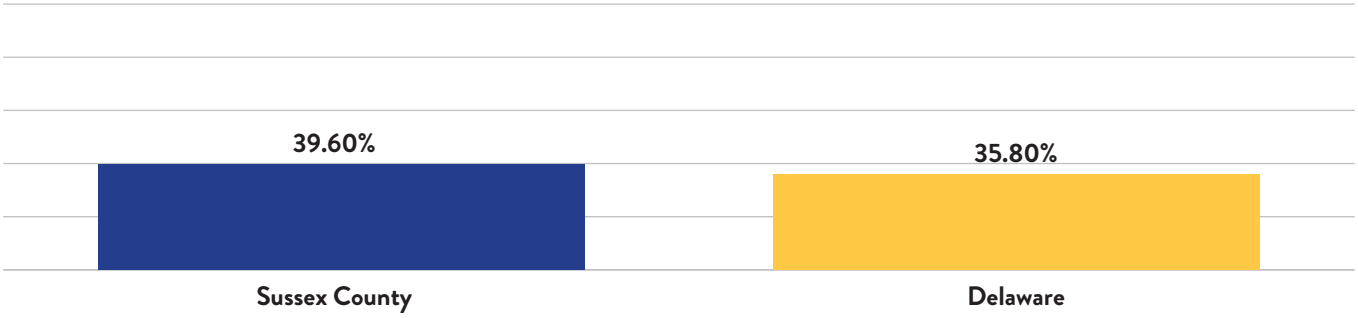
Figure 25 below illustrates the crude prevalence of high blood pressure among adults across ZIP codes in Beebe Healthcare's PSA. The highest prevalence is observed in 19970 (Ocean View) at 44.3%, followed closely by 19967 (Millville) at 43.6% and 19975 (Selbyville) at 43.0%. Several other areas, including Fenwick Island, Lewes, and Bethany Beach, also report rates exceeding 40%, signaling a widespread hypertension issue across the region. The lowest prevalence is in 19947 (Georgetown) at 35.0%, though still notably high. Given hypertension's strong link to heart disease, stroke, and kidney failure, these figures highlight the urgent need for preventive measures and expanded chronic disease management programs within these high-risk communities.

Figure 25: High Blood Pressure among Adults, Crude Prevalence



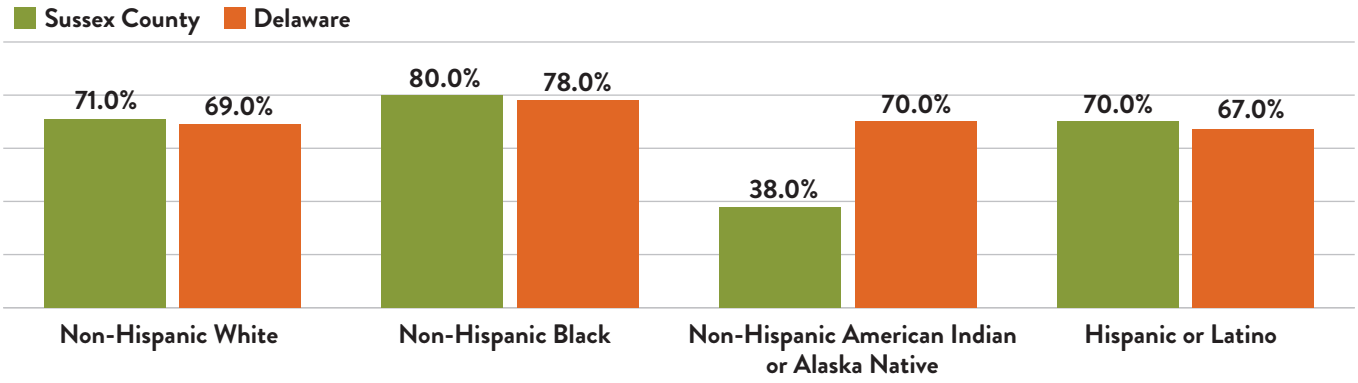
Source: Centers for Disease Control and Prevention; Places, 2021

Figure 26: Adults with High Blood Pressure



Source: My Health Community: Delaware Environmental Health Tracking Network, 2021

Figure 27: High Blood Pressure Prevalence by Race/Ethnicity

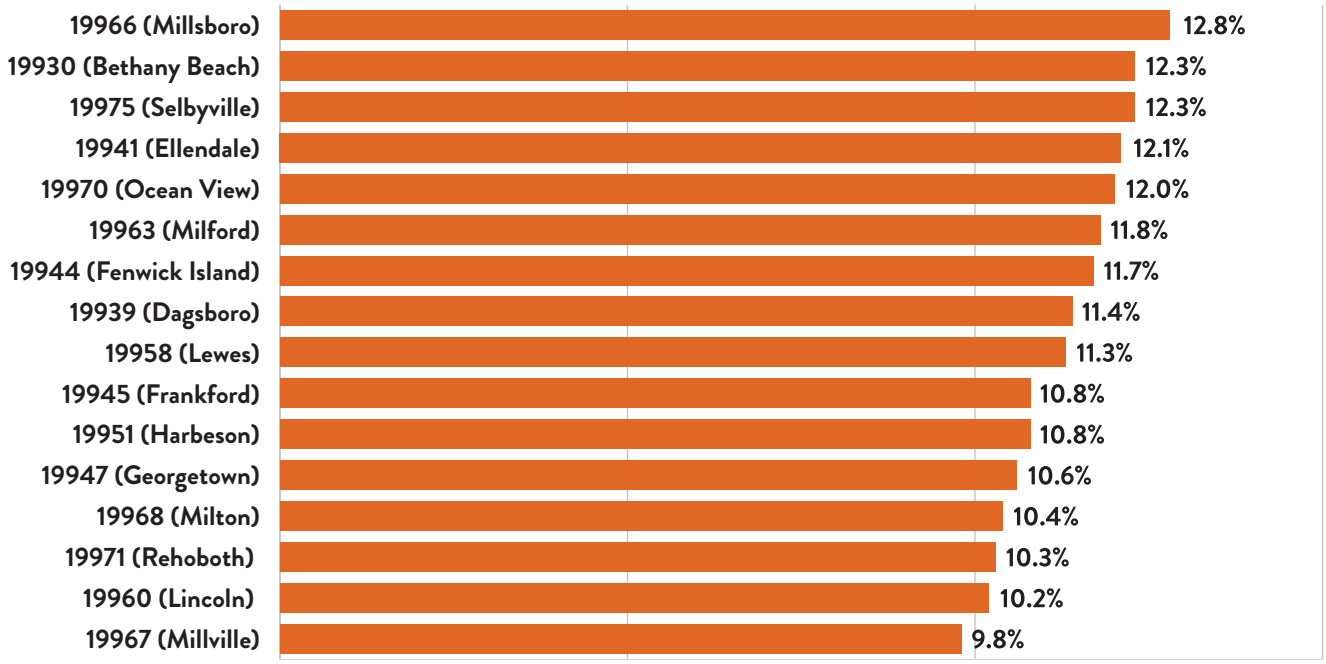


Source: Centers for Medicare and Medicaid Services, 2022

Figure 28 displays the percentage of residents with diabetes distribution across ZIP codes, highlighting health gaps within the region. ZIP code 19966 (Millsboro) stands out with the highest percentage at 12.8%, followed by residents in 19930 (Bethany Beach) and 19975 (Selbyville) at 12.3%.

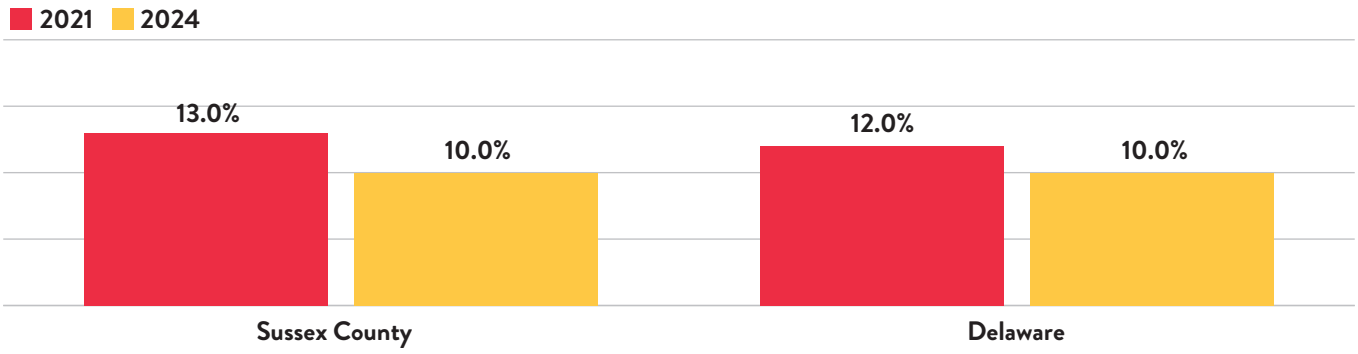
The lowest percentage is observed in ZIP code 19967 (Millville), at 9.8%, indicating relatively lower representation or occurrence compared to others. This distribution helps identify areas with higher concentration or need, making it a valuable reference for targeted resource allocation or community health planning.

Figure 28: Diabetes by ZIP Codes



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

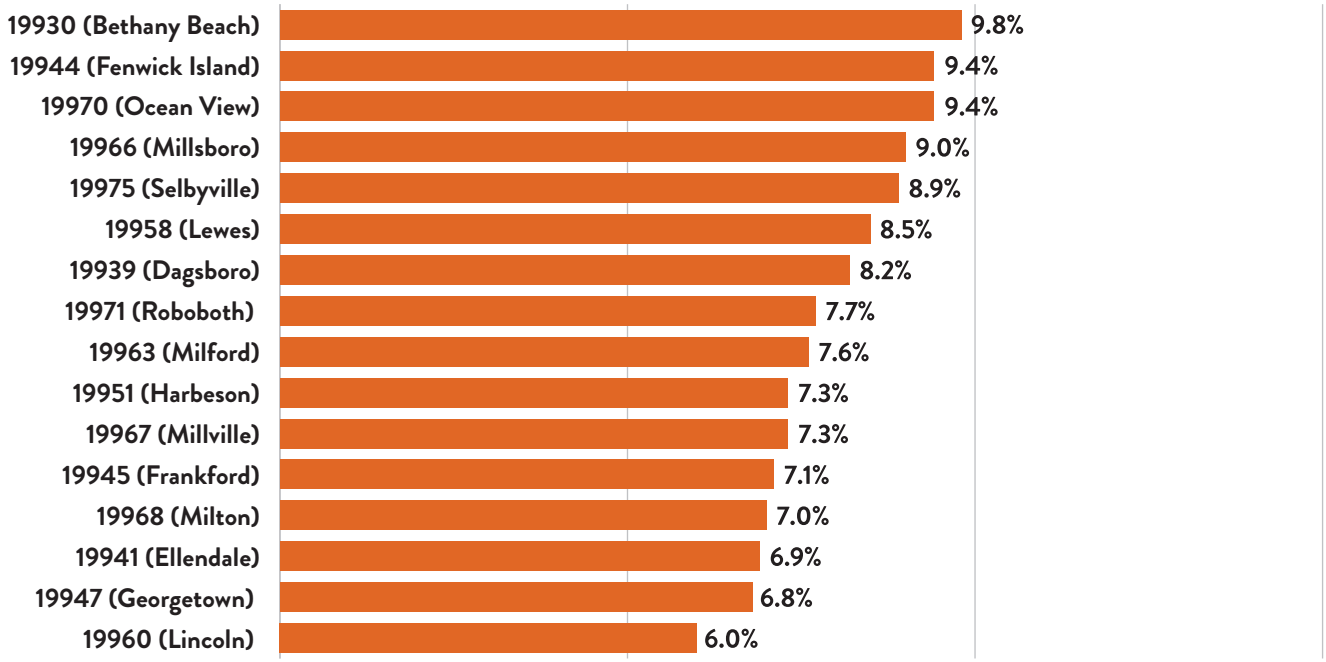
Figure 29: Diabetes Prevalence



Source: County Health Rankings

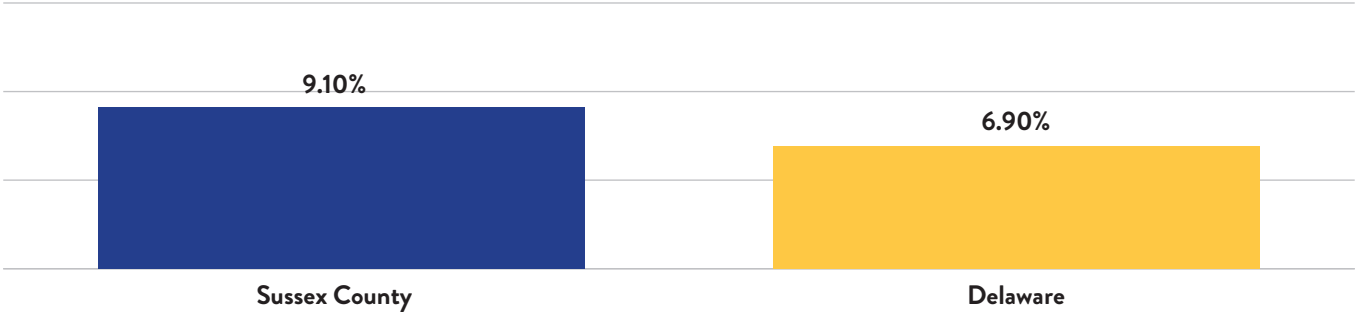
Figure 30 illustrates the prevalence of heart disease by ZIP code. ZIP code 19930 (Bethany Beach) has the highest rate at 9.8%, closely followed by 19944 (Fenwick Island) and 19970 (Ocean View), both at 9.4%. In contrast, ZIP code 19960 (Lincoln) reports the lowest heart disease prevalence at 6.0%. These figures, sourced from the Delaware Environmental Public Health Tracking Network, underscore the need for targeted health interventions in ZIP codes with higher heart disease burdens to reduce risk factors and improve cardiovascular outcomes.

Figure 30: Heart Disease by ZIP codes



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

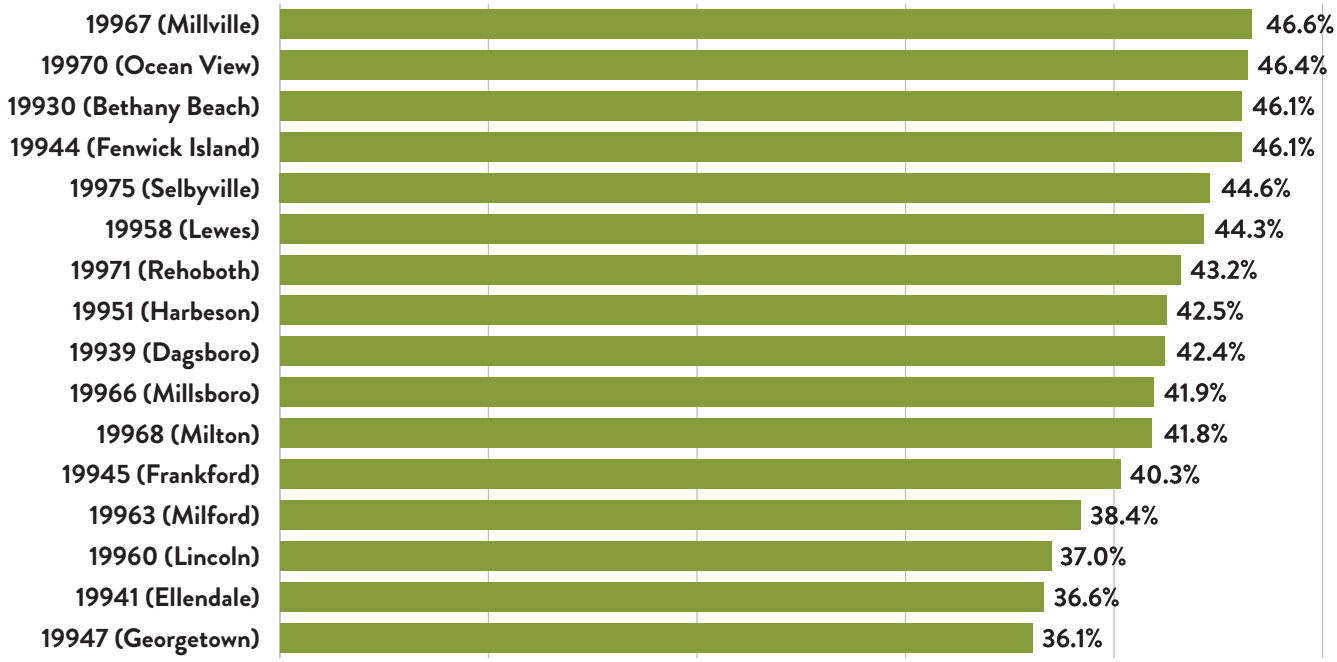
Figure 31: Adults with Heart Disease



Source: CMS, Geographic Variation Public Use File, 2022

Figure 32 shows that ZIP code 19967 (Millville) has the highest crude prevalence of high cholesterol among adults who have ever been screened at 46.6%, closely followed by Ocean View (19970) at 46.4% and Fenwick Island (19944) at 46.1%, indicating a widespread burden of cholesterol-related health risks at the neighborhood levels.

Figure 32: High Cholesterol among Adults Who Have Ever Been Screened, Crude Prevalence



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2021

Table 6 shows that heart disease is the leading cause of death for individuals under 75 years old in Sussex County, with 662 deaths or a mortality rate of 102.7 per 100,000 people. This highlights the importance of preventing and managing cardiovascular risk factors, including obesity, high blood pressure, and high cholesterol.

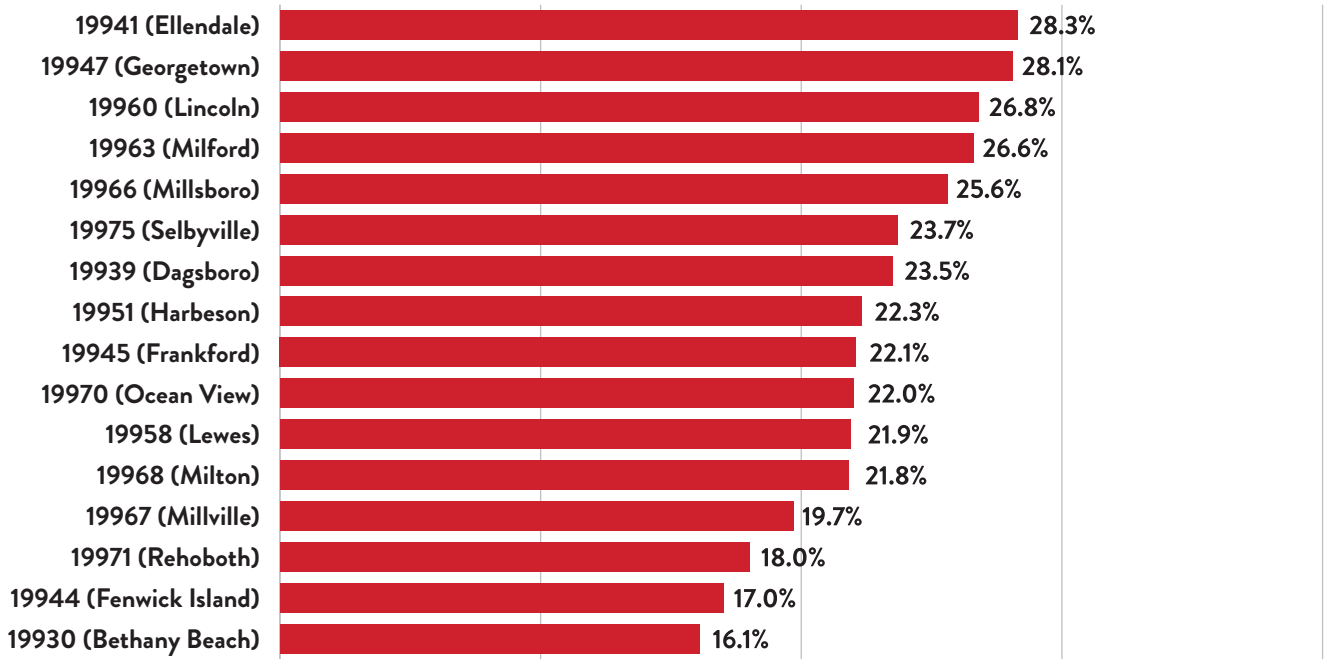
Table 6: Leading Cause of Death in Sussex County

Leading Causes of Death Under 75 years Old	Deaths	Rate per 100,000
Diseases of heart	662	102.7

Source: County Health Rankings, 2024

A lack of regular physical activity is a significant contributor to the development and progression of chronic diseases. Sedentary lifestyles increase the risk of conditions such as heart disease, type 2 diabetes, obesity, high blood pressure, and certain cancers.[12] Additionally, inactivity leads to weight gain, decreased muscle strength, and poor mental health, further compounding health risks. Promoting regular physical activity through accessible community programs, safe recreational spaces, and public awareness is essential for improving overall health outcomes and reducing chronic disease rates.

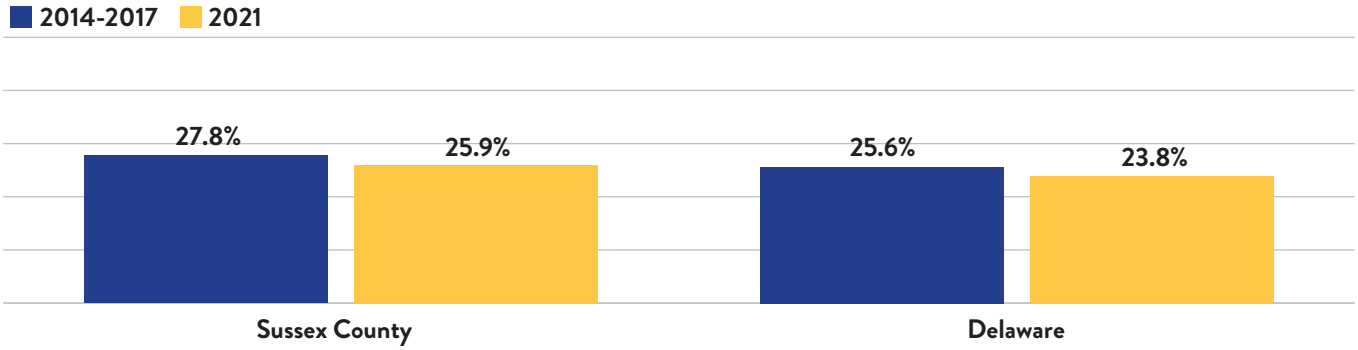
Figure 33: No Leisure-Time Physical Activity among Adults, Crude Prevalence



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2022

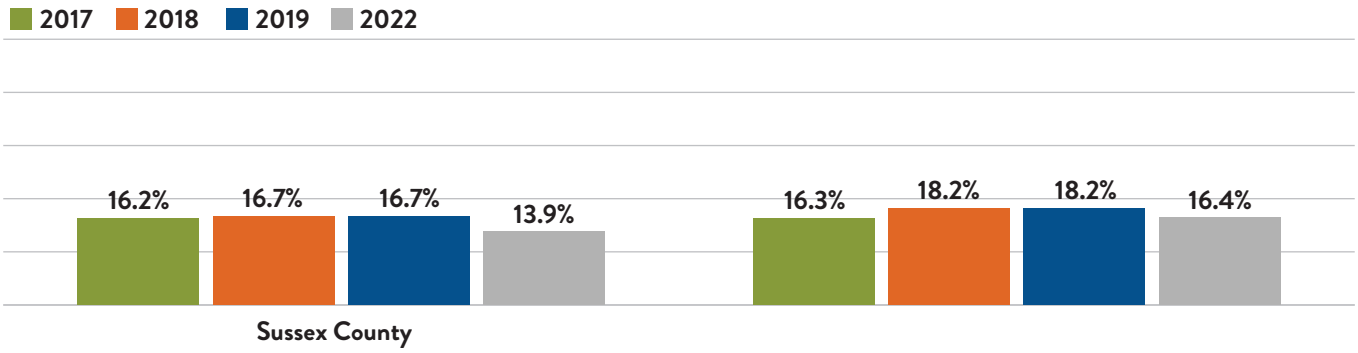
[12] Centers for Diseases Control and Prevention

Figure 34: Physical Inactivity (No Leisure Time Physical Activity)



Source: CDC, National Center for Chronic Disease Prevention and Health Promotion

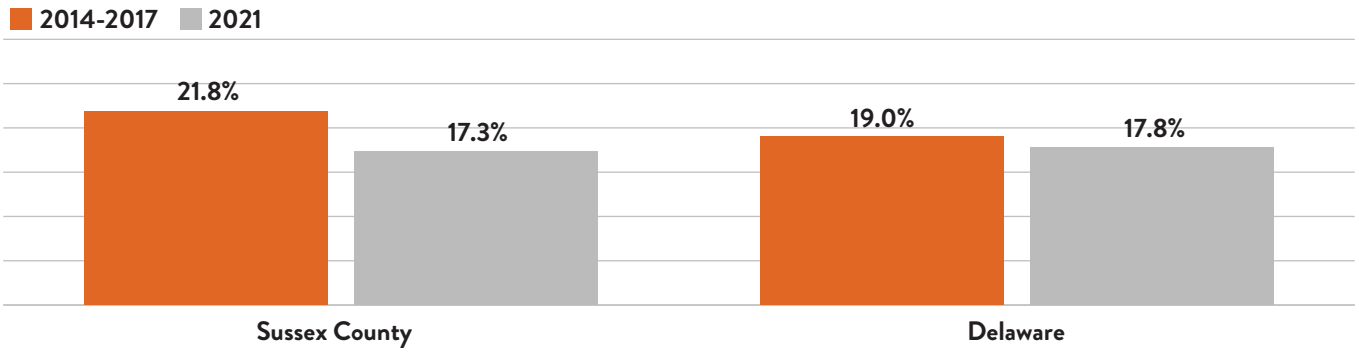
Figure 35: Recreation and Fitness Facility Access (Rate per 100,000 Population)



Source: U.S. Census Bureau

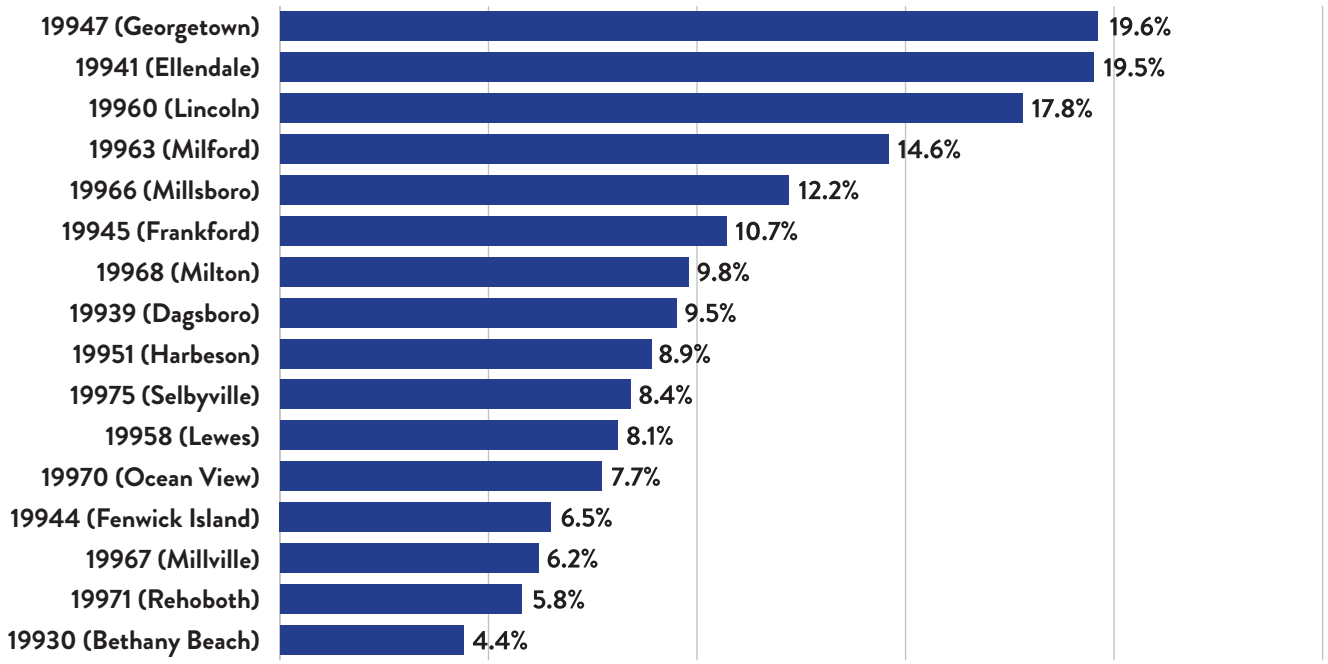
The relationship between food and chronic diseases is well-established, with poor dietary habits contributing to long-term health conditions. Diets high in saturated fats, added sugars, and sodium contribute to obesity, hypertension, type 2 diabetes, and cardiovascular disease. Conversely, consuming nutrient-rich foods such as fruits, vegetables, whole grains, and lean proteins can help prevent or manage these chronic conditions. In many communities, limited access to affordable, healthy food options—often referred to as food deserts—exacerbates these issues, particularly among low-income populations. Addressing nutritional gaps through education, policy changes, and enhanced food access is crucial to reducing the burden of chronic diseases and promoting long-term health.

Figure 36: Grocery Store Availability (Rate per 100,000 Population)



Source: U.S. Census Bureau

Figure 37: Food Insecurity in the Past 12 Months among Adults, Crude Prevalence



Source: Centers for Disease Control and Prevention; Places, 2022

Feeding America is a hunger-relief organization, operating a nationwide network of food banks, pantries, and meal programs. Feeding America works to combat food insecurity by distributing billions of meals annually and advocating for policies that address the root causes of hunger. In 2022, Sussex County has:

Table 7: Food Insecurity in Sussex County and Delaware

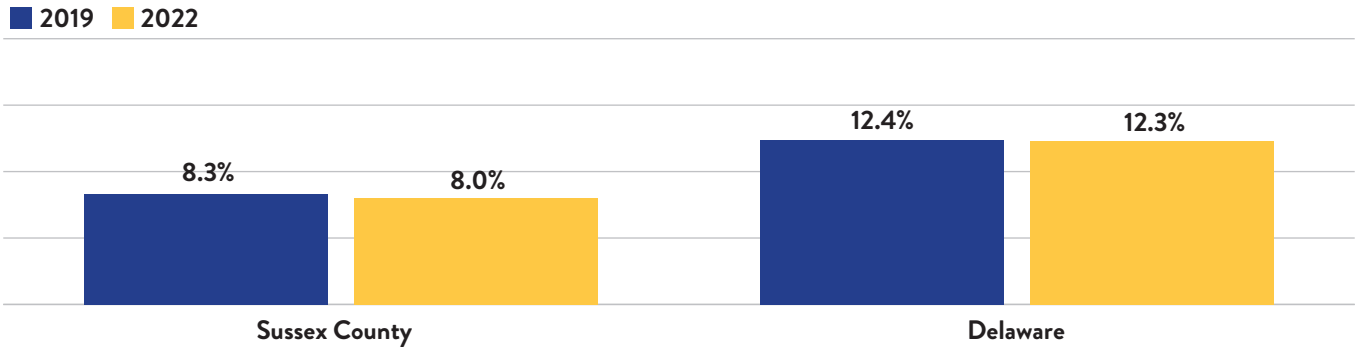
2024	Sussex County	Delaware
Food-insecure population in Sussex County	32,380	134,320
Food insecure rate in Sussex County	13.9%	13.0%
Average meal cost in Sussex County	$3.85	$3.54

Source: Feeding America, 2024

The Supplemental Nutrition Assistance Program (SNAP) is a federal assistance program that provides low-income individuals and families with financial support to purchase nutritious food. Administered by the U.S. Department of Agriculture, SNAP helps reduce food insecurity by allowing participants to buy eligible groceries at authorized retailers using an Electronic Benefit Transfer (EBT) card.

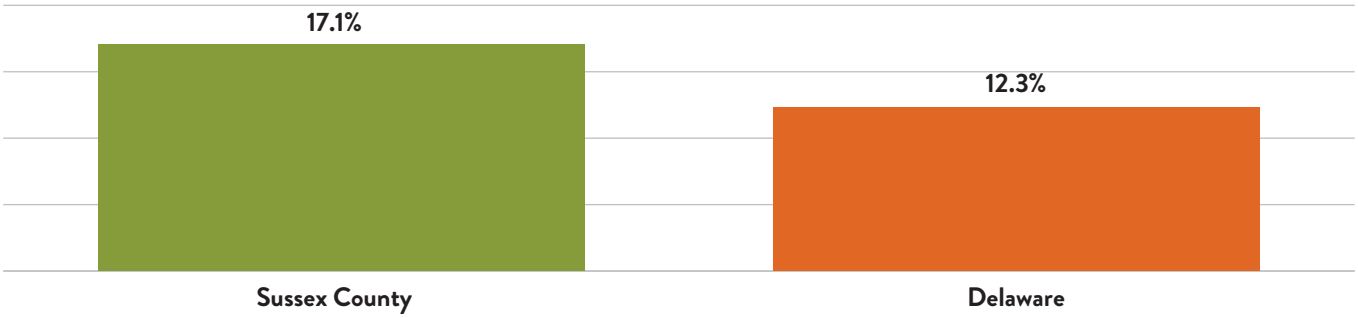
Figure 35 illustrates the percentage of the population receiving SNAP benefits in 2019 and 2022 for Sussex County and the state of Delaware. In Sussex County, SNAP participation decreased slightly from 8.3% in 2019 to 8.0% in 2022, while statewide participation declined marginally from 12.4% to 12.3%.

Figure 38: Population Receiving SNAP Benefits



Source: U.S. Census Bureau, ACS

Figure 39: SNAP Authorized Food Stores



Source: U.S. Department of Agriculture, Food and Nutrition Service, 2024

Addressing chronic diseases is a critical priority for Beebe Healthcare as it strives to improve health outcomes and enhance the quality of life for its residents. The high prevalence of conditions such as diabetes, hypertension, heart disease, and obesity not only threaten individual well-being but also places a growing strain on the healthcare system and local economy. Beebe Healthcare remains committed to leading proactive efforts through community partnerships, evidence-based wellness programs, and expanded access to care. By targeting the root causes of chronic diseases—including lifestyle factors, social determinants of health, and healthcare access barriers— Beebe Healthcare aims to curb these rising trends and prevent long-term complications. The path forward demands coordinated, data-driven strategies that empower individuals to take charge of their health while ensuring that the most at-risk populations are not left behind. Through sustained commitment and innovation, Beebe Healthcare is laying the foundation for a healthier, more resilient community.

Behavioral Health

(Mental Health and Substance Use Disorder)

Behavioral health refers to the connection between behaviors and the health and well-being of the body, mind, and spirit. It includes mental health conditions such as depression, anxiety, and schizophrenia, but also substance use disorders, stress-related disorders, and life challenges that affect overall wellness. Behavioral health plays a crucial role in how residents function in daily life, how they cope with stress, and how they make choices related to their overall well-being, including their physical health. Left unaddressed, behavioral health issues can impair personal well-being, strain family relationships, reduce workplace productivity, and increase the burden on healthcare and social support systems.

Sussex County has the highest concentration of older adults in Delaware, with 29.48% of its population aged 65 and older.[13] This demographic is particularly at risk for behavioral health issues, and the projected increase in the elderly population is expected to exacerbate these challenges.[14] The impacts of untreated behavioral health conditions are evident and concerning. Data from Delaware's My Healthy Community shows that 18.4% of adults in Sussex County report having been depressed, which underscores the widespread prevalence of mental health challenges in the area.[15] In 2024, residents also experienced an average of 4.6 poor mental health days per month, suggesting a chronic level of emotional and psychological distress, suicide, emergency department visits, and involvement with the criminal justice system.[16] Access to behavioral health services in Sussex County remains a persistent challenge. The ratio of mental health providers to residents is approximately 1 to 450, compared to 1 to 310 in the state, which contributes to delays in care and inadequate treatment.[17] A lack of timely intervention often results in higher rates of hospitalization, poor health outcomes, and a cyclical pattern of untreated symptoms. Furthermore, Sussex County's aging population—median age 51.3 years—and a poverty rate of 11.6% add layers of vulnerability, particularly among older adults and economically disadvantaged residents who may face stigma, transportation barriers, and limited insurance coverage.[18]

The broader effects of untreated behavioral health conditions ripple through the community. Children exposed to untreated parental mental health issues often experience developmental delays and academic challenges. Communities with high levels of untreated mental illness and substance use tend to report elevated rates of homelessness, unemployment, and incarceration. For healthcare systems such as Beebe Healthcare and its partners in Sussex County, this underscores the urgent need for access to care, comprehensive behavioral health strategies that include early screening, culturally competent care, integration with primary health services, and expansion of the behavioral health workforce.

Addressing behavioral health needs improves an individual's well-being but also enhances overall public health, economic productivity, and community resilience. As Sussex County continues to face demographic shifts, health, and social gaps, it is essential to invest in sustainable behavioral health infrastructure and partnerships that prioritize prevention, access, and recovery. Without such interventions, the burden of untreated behavioral health conditions will continue to weigh heavily on individuals, families, and the broader healthcare system.

[13] Neilsberg Sussex County, DE Population by Age, 2025 Update

[14] A 4-D view of Delaware's Geriatric Behavioral Health Issues: Dementia, Depression, Drugs, and Diversity

[15] Delaware Environmental Public Health Tracking Network, My Healthy Community

[16] County Health Rankings

[17] County Health Rankings

[18] U.S. Census Bureau, American Community Survey

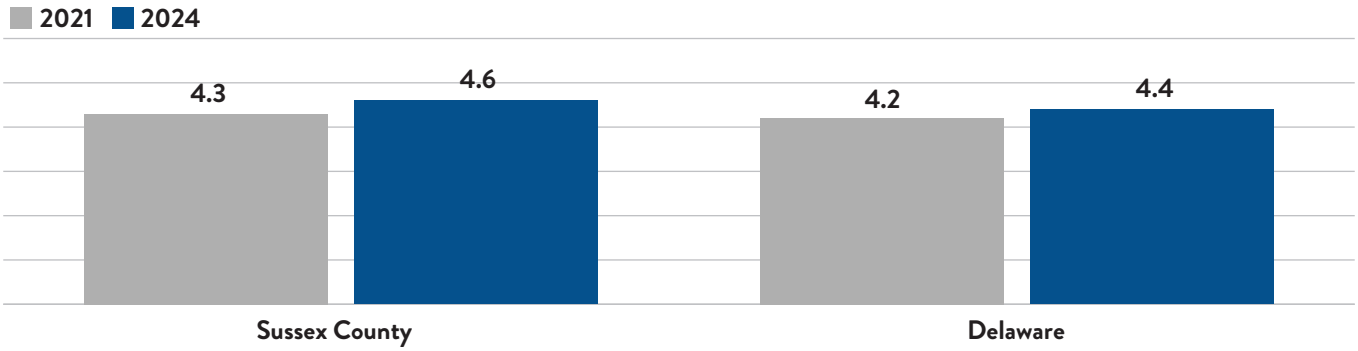
Table 8 below summarizes key findings from stakeholder interviews and focus groups related to behavioral health as part of a community health assessment. Engaging with the community is essential for identifying behavioral health needs and ensuring that strategies reflect the genuine challenges residents face. The insights gathered reveal significant concerns around mental health, substance use, and barriers to accessing behavioral health services.

Table 8: Listening to the Community

Stakeholder Interviews Findings Shared Feedback	Focus Groups Findings Shared Feedback
Persistent health problems • 80.0% – Behavioral health • 53.3% – Substance use disorder/addiction ***What Can Be Offered to Suppress the Prevalence of Chronic Diseases in the Community?*** • 60.0% – Behavioral health/stress management • 40.0% – Recovery/addiction services ***Changing Healthcare Needs of Sussex County Over the Past 3 Years*** Mental Health Needs • Higher rates of depression and loneliness in isolated individuals. • Increased awareness of mental health issues post-pandemic. • Strain on mental health services rising demand. ***Significant Barriers to Improving Health and Quality of Life*** • 66.7% – Access to behavioral resources • 60.0% – Access to substance use/drug/alcohol resources ***Persistent High-Risk Behaviors*** • 60.0% – Unmanaged stress or anxiety • 53.3% – Drug abuse • 46.6% – Alcohol Abuse • 40.0% – Loneliness and isolation • 20.0% – Smoking/Tobacco Use ***At-risk Groups in Community*** • 64.2% – People living with mental illness ***Actions Hospital Can Take to Address Health Gaps*** • 46.6% – Mental health & Substance abuse services ***Community needs that are currently siloed and need further collaboration*** • 100.0% - Behavioral Health ***Implementing a New Behavioral Health Initiative/Program*** Substance Abuse and Mental Health Initiatives • Provide addiction services and mental health programs in Haitian Creole and Spanish to build trust and encourage service utilization among diverse communities. • Launch additional programs that tackle drug/substance abuse and associated mental health challenges. ***Improvements to Make Behavioral Health More Accessible and Effective*** Increase Healthcare Access • Need more doctors, bilingual providers, and mental health services to improve trust and communication with patients. Expand behavioral health services which includes additional beds and specialty services for specific groups (e.g., for marriage/divorce and bereavement). ***Area of Focus Over Next Years*** Community Health and Wellness • Tackle drug addiction as a driver of homelessness and crime while improving access to mental health services.	***African American Participants*** • Services are needed to address trauma, grief, stress, and behavioral health challenges, especially for youth and seniors. • Community members shared stories of youth and adults living with unresolved trauma, often stemming from family instability, poverty, and exposure to violence. • Drug addiction is rampant in some areas. The lack of accessible treatment options, detox services, and long-term recovery programs was noted as a significant gap. • Participants working with young people stressed the urgent need for early intervention programs and anger management resources. • Existing stigma surrounding behavioral health prevents individuals, particularly men and those in communities of color, from seeking help. • Academic and behavioral support is needed starting in early childhood to set children on a healthy path, along with engaging and educating parents, especially those lacking the tools or time to support their children's academic and emotional development. ***Low-Income Participants*** • Behavioral health issues are prevalent but under-resourced. Widespread presence of anxiety, depression, trauma, and substance use disorders throughout the community. Need for more behavioral health professionals/services to meet demand that are affordable, culturally competent, or tailored to youth and family needs. • Lengthy waiting months to secure a behavioral health appointment, even for urgent needs such as substance use recovery or childhood behavioral concerns. The delays were especially detrimental for youth. • Beebe Healthcare and its partners should prioritize expanding the availability and accessibility of behavioral health services, particularly for youth and families. Integrating licensed counselors and behavioral health professionals into school settings, young people can receive early intervention and support. Community-based mental health services such as peer support, group therapy, and substance use programs should be more widely-used. In addition, deploying mobile mental health units in rural and at-risk areas who face transportation or stigma-related barriers to care. • Community organizations, faith groups, and schools could play a more significant role in rebuilding trust and shared responsibility. Such facilities have advocated for programs that unite parents, provide mental and emotional support, and reinforce consistent values across households.

Reporting poor mental health days is important because it provides a snapshot of how frequently individuals experience emotional or psychological distress, which can be an early indicator of broader behavioral health challenges in a community. This measure captures more than just clinical diagnoses—it reflects the everyday mental well-being of residents, including stress, anxiety, depression, and other mood-related concerns.

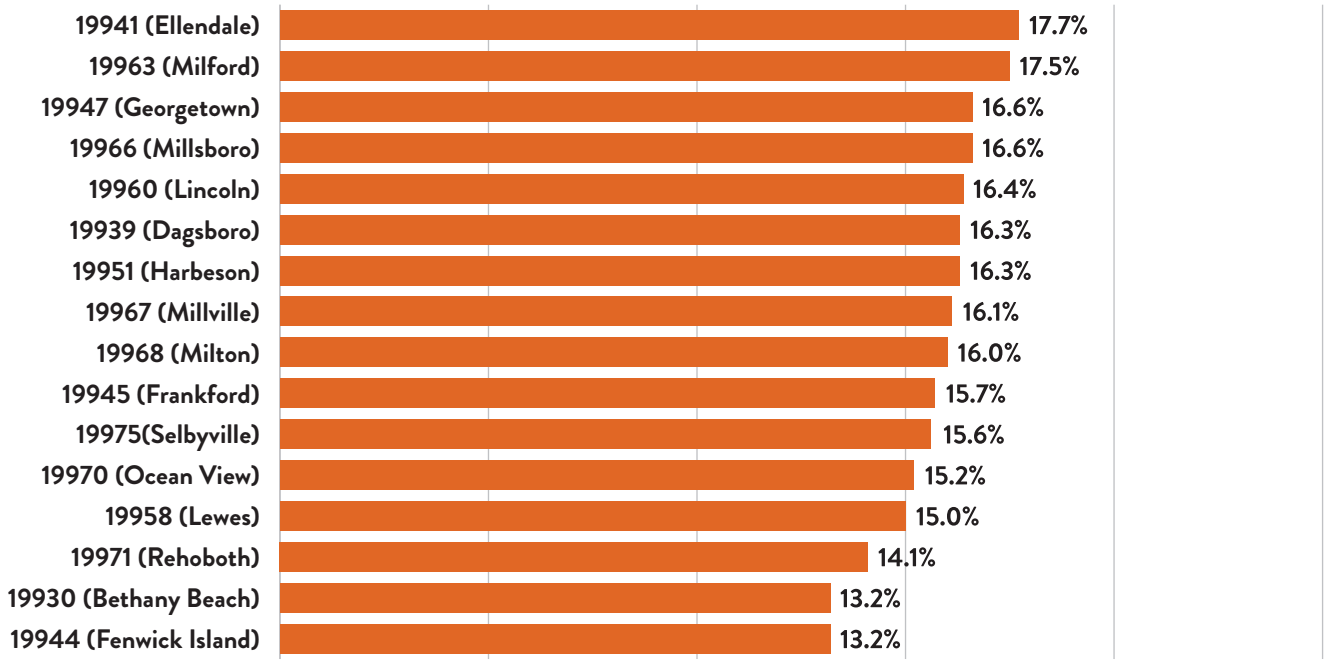
Figure 40: Poor Mental Health Days



Source: County Health Rankings

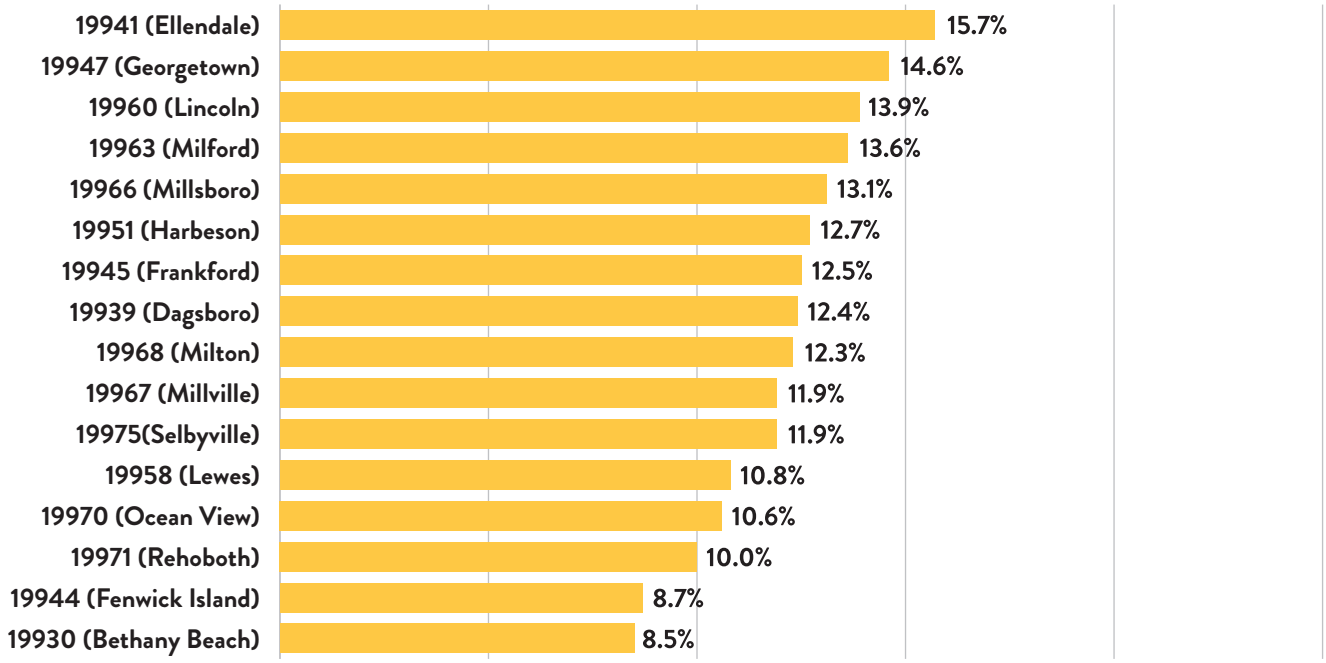
The following figures present key behavioral health indicators across ZIP codes, including rates of depression, poor mental health days, binge drinking, smoking, and opioid prescriptions. ZIP code 19941 (Elldendale) shows the highest rates for depression (17.7%), poor mental health (15.7%), and smoking (21.9%). ZIP code 19947 has the highest rate of binge drinking at 14.8%, while ZIP code 19970 leads in opioid prescription rates at 17.3%. These elevated values indicate geographic areas with the most significant behavioral health concerns, emphasizing the need for targeted mental health and substance use interventions in these specific communities.

Figure 41: Depression by ZIP Codes



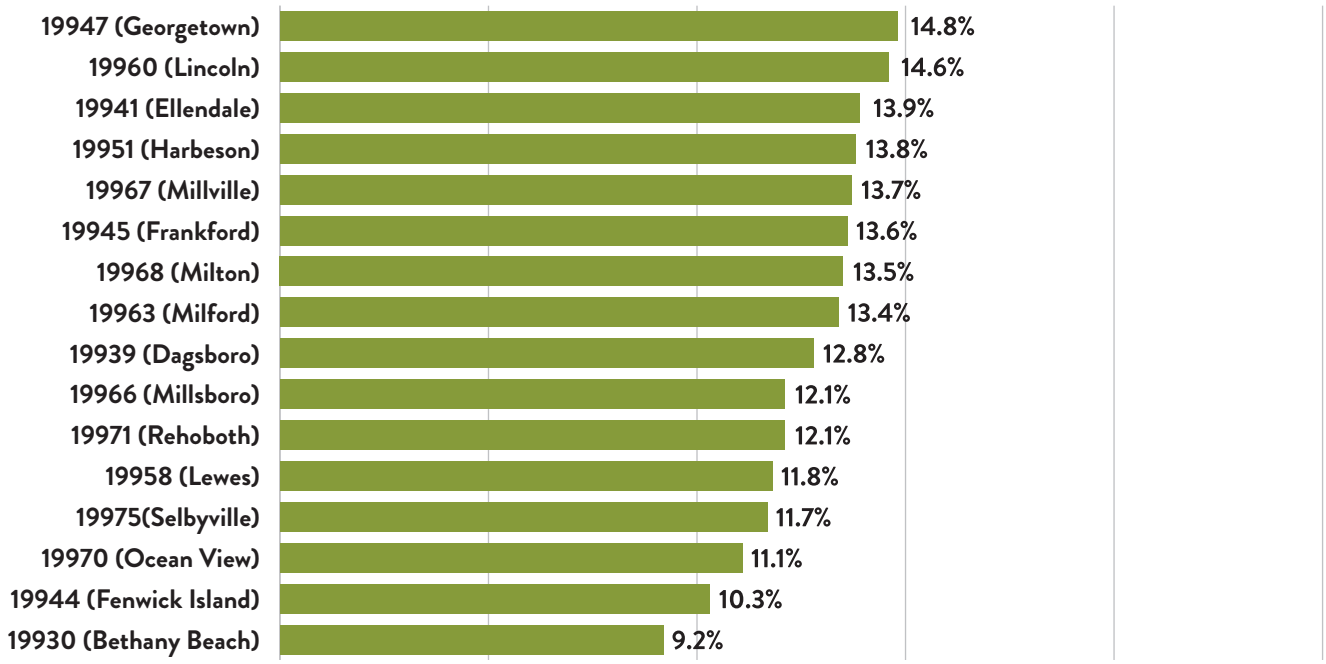
Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Figure 42: Poor Mental Health by ZIP Codes



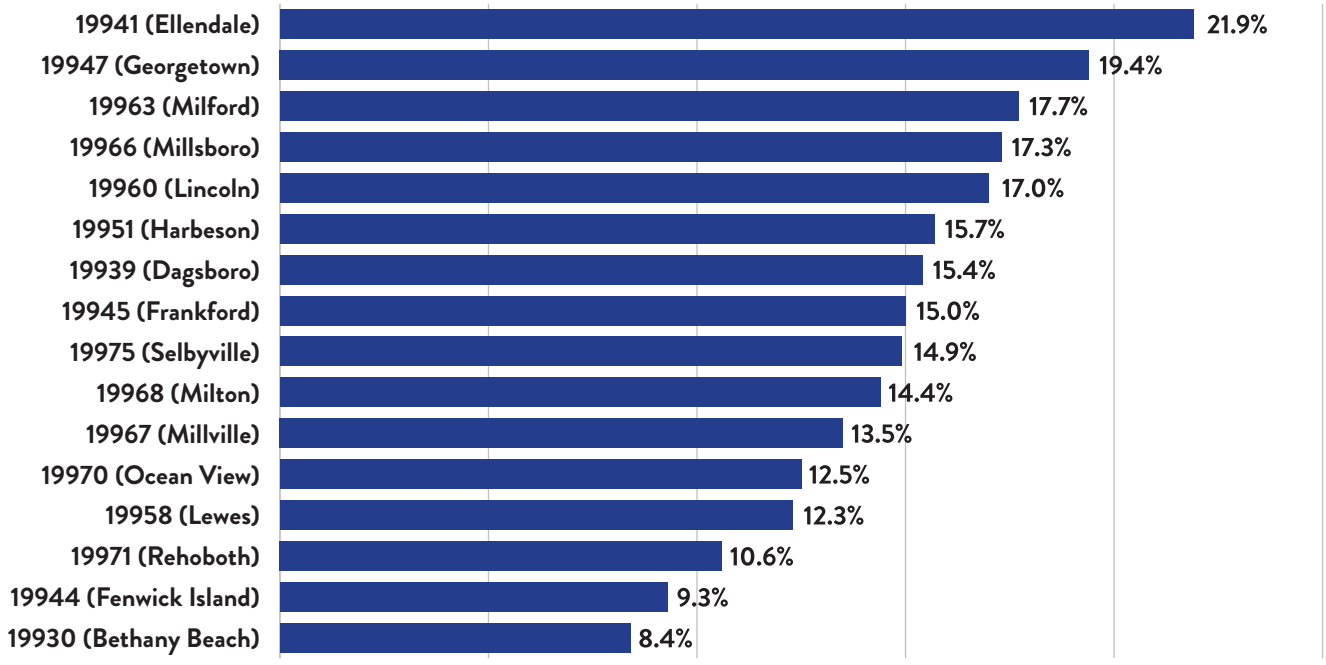
Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Figure 43: Binge Drinking by ZIP Codes



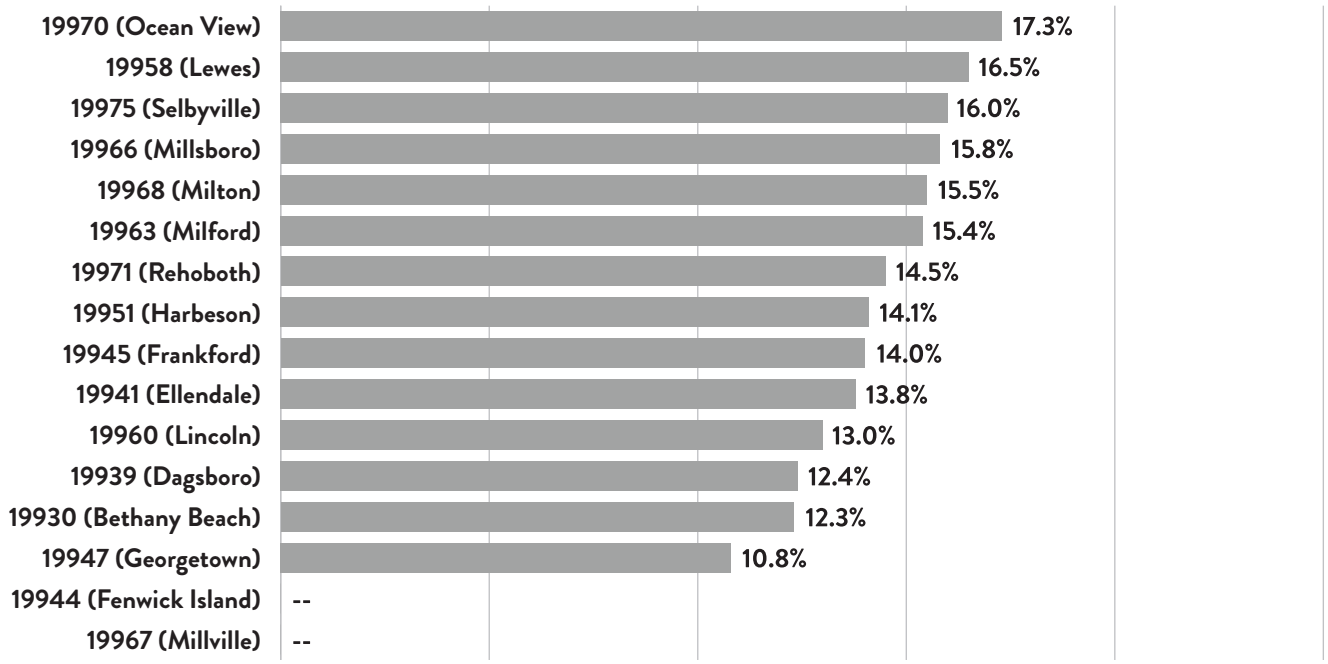
Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Figure 44: Smoker by ZIP code



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Figure 45: Opioid Prescription Use (per 100,000 Population)

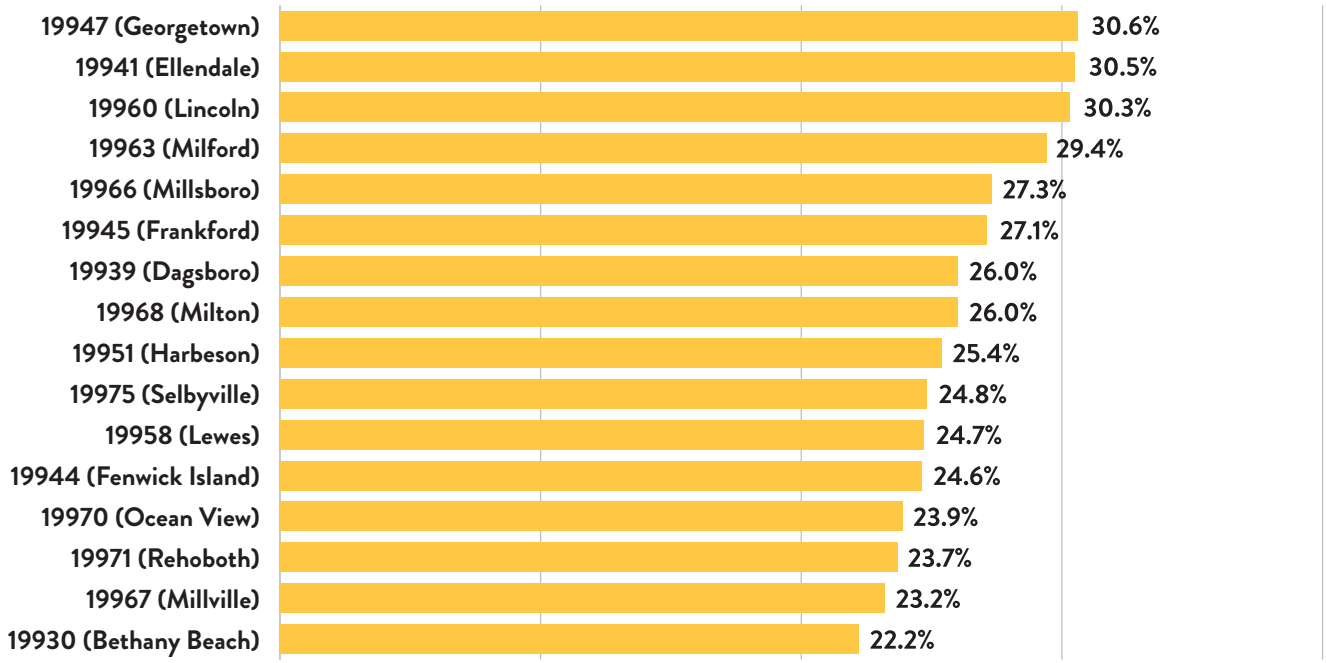


Note: Data was not available for 19944 (Fenwick Island) and 19967 (Millville).

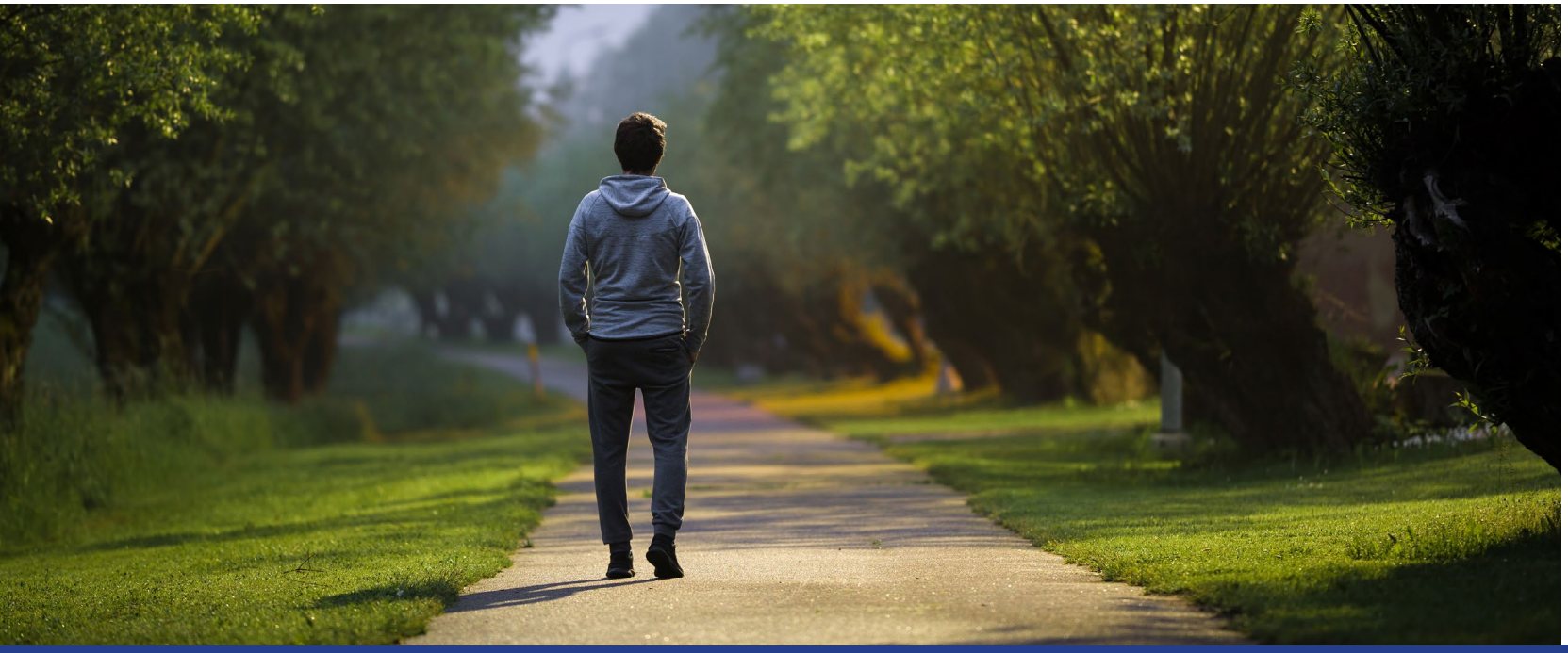
Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

Figure 46 illustrates the crude prevalence of adults experiencing social isolation across ZIP codes in Sussex County. The highest rates are observed in Georgetown (ZIP 19947) at 30.6%, Ellendale (19941) at 30.5%, and Lincoln (19960) at 30.3%, indicating that nearly one in three adults in these areas report feeling socially isolated. In contrast, Bethany Beach (19930) has the lowest reported prevalence at 22.2%. These data suggest that social isolation is a significant concern in several communities, potentially reflecting gaps in access to social support, community programming, and behavioral health services. Addressing social isolation is critical, as it is closely linked to poor mental and physical health outcomes, including depression, anxiety, and chronic disease.

Figure 46: Feeling Socially Isolated among Adults, Crude Prevalence



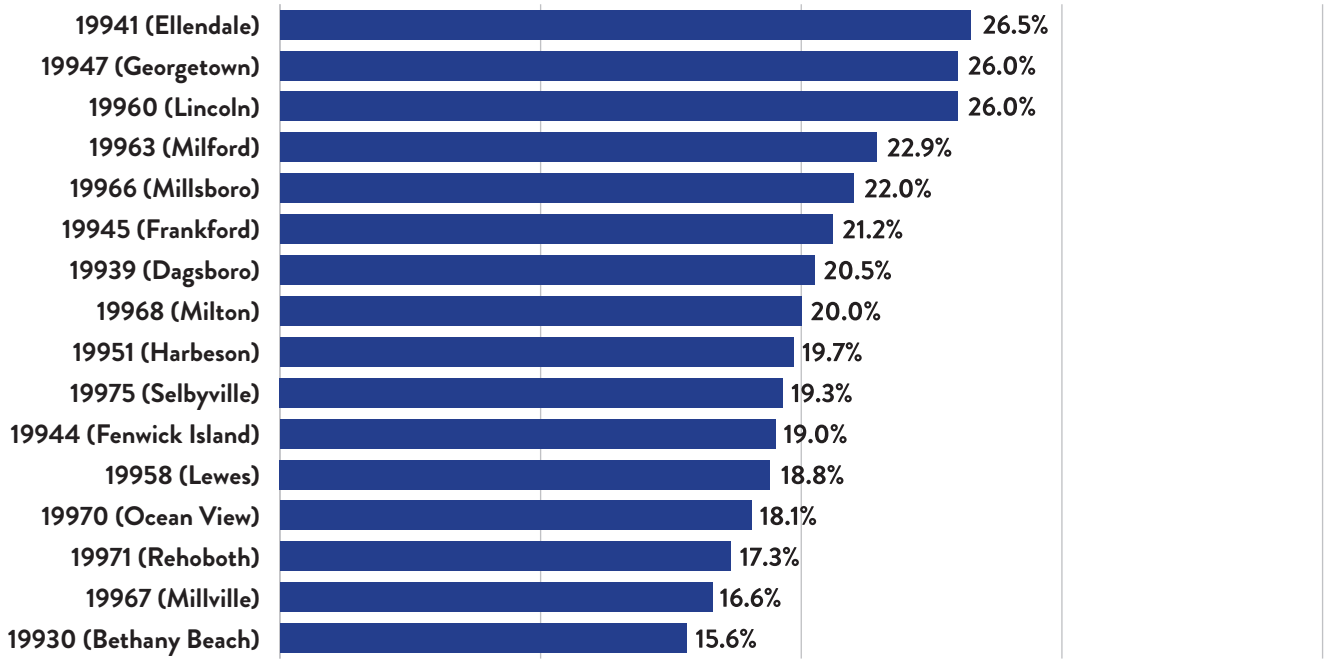
Source: Centers for Disease Control and Prevention; Places, 2022



Individuals who lack social and emotional support are more likely to experience elevated stress levels, frequent mental distress, and conditions such as depression, anxiety, heart disease, stroke, dementia, and type 2 diabetes. This lack of support has also been linked to premature mortality and poorer self-rated physical health, particularly among older adults. Approximately one in four U.S. adults reports not having adequate social and emotional support, underscoring the widespread nature of this issue and its significant impact on both mental and physical health.[19]

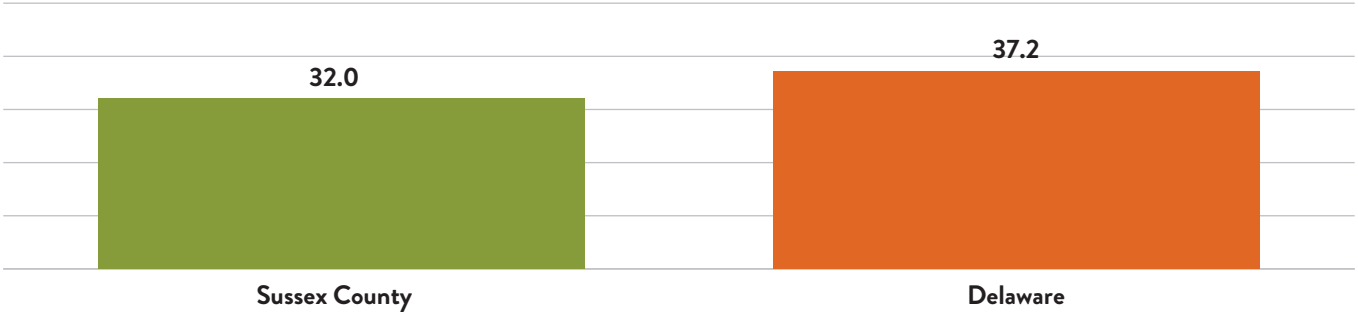
Social and emotional support play a vital role in reducing stress, improving mental health, and fostering a sense of belonging and resilience. The data show that Ellendale (ZIP code 19941) has the highest percentage of adults lacking social and emotional support at 26.5%, closely followed by Lincoln and Georgetown, both at 26%.

Figure 47: Lack of Social and Emotional Support among Adults, Crude Prevalence



Source: Centers for Disease Control and Prevention; Places, 2022

Figure 48: Severe Depression (per 100,000 population)

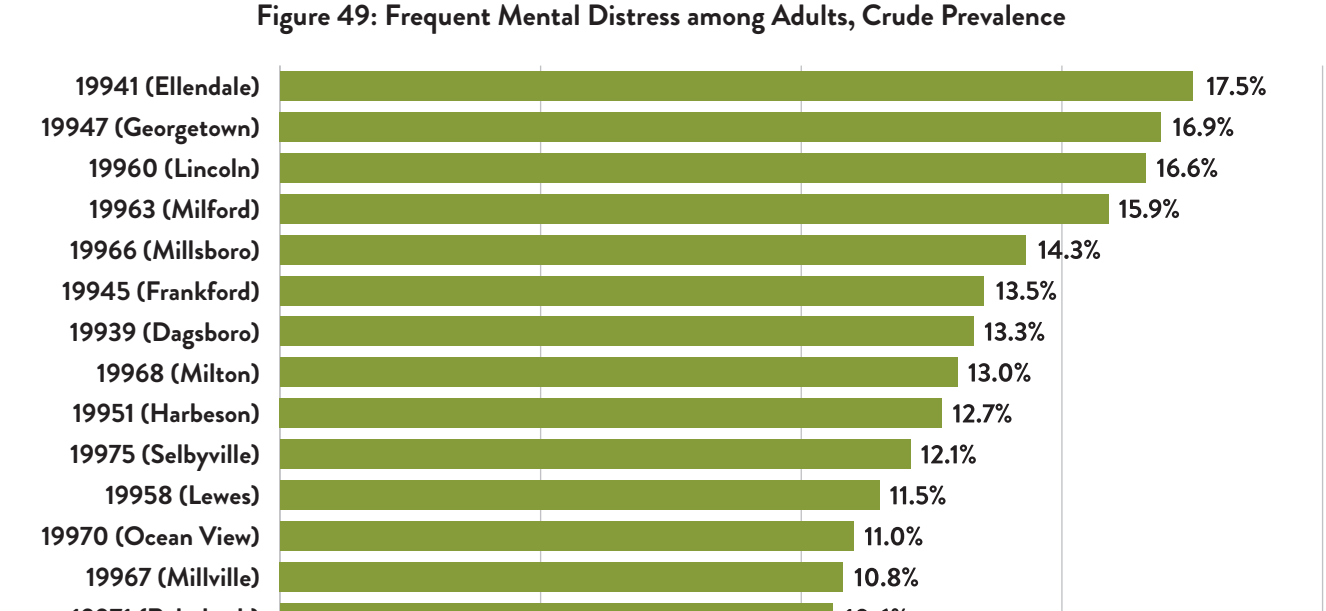


Source: IP3 Healthy Communities Delaware, 2024

[19] County Health Rankings

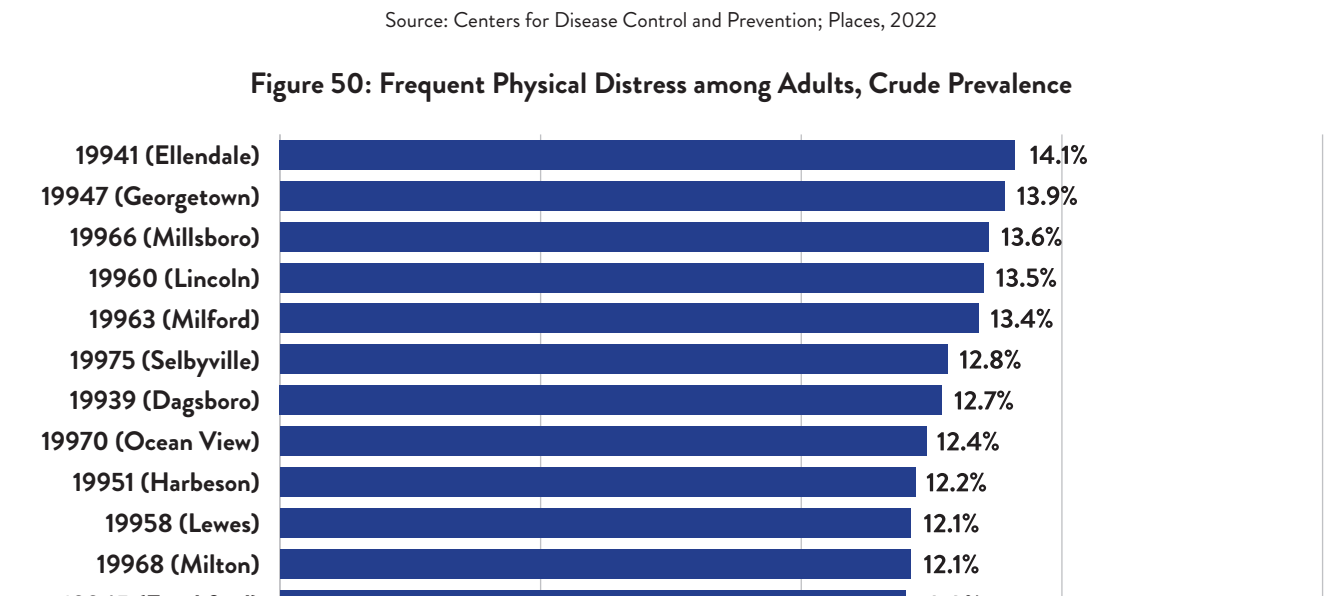
Mental distress and physical distress are both forms of suffering that can impact a person's well-being, and while they differ in origin, they often overlap. Mental distress involves emotional and psychological symptoms such as anxiety, depression, and mood changes, whereas physical distress manifests in the body through symptoms like pain, fatigue, or gastrointestinal issues. Despite these differences, both types of distress can influence each other—mental distress can lead to physical symptoms (e.g., headaches or muscle tension), and chronic physical conditions can contribute to mental health struggles. Addressing both simultaneously is essential for comprehensive care and improved health outcomes.

Figure 49: Frequent Mental Distress among Adults, Crude Prevalence



Source: Centers for Disease Control and Prevention; Places, 2022

Figure 50: Frequent Physical Distress among Adults, Crude Prevalence



Source: Centers for Disease Control and Prevention; Places, 2022

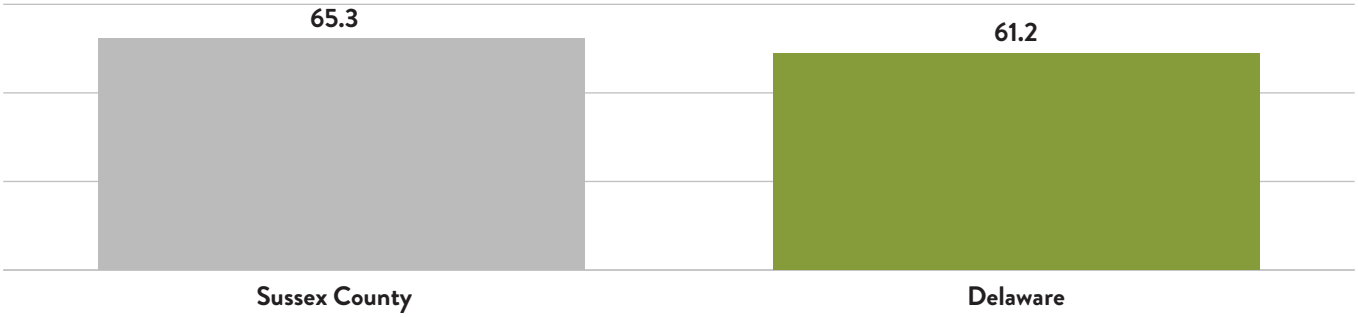
Table 9 shows that from 2019 to 2021, Sussex County reported a drug overdose death rate of 45.0 per 100,000 population. This figure highlights the severity of the substance use crisis in the region and underscores the urgent need for expanded behavioral health and addiction recovery services in the region.

Table 9: Key Indicators for Basic Needs for Health and Safety 2015-2022

2019-2021	Sussex County
Drug overdose deaths per 100,000 population	45.0

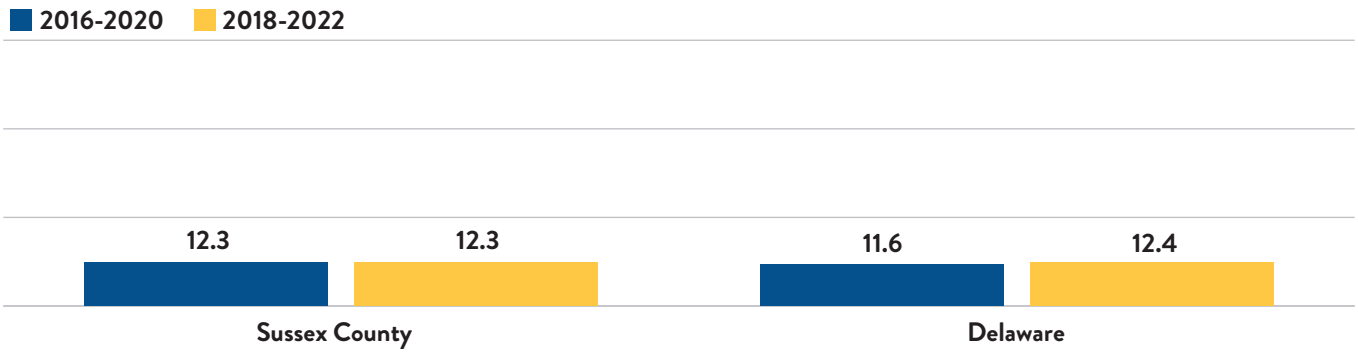
Source: Delaware State Assessment

Figure 51: Drug, Alcohol, Suicide Deaths (per 100,000 Population)



Source: IP3 Healthy Communities Delaware, 2024

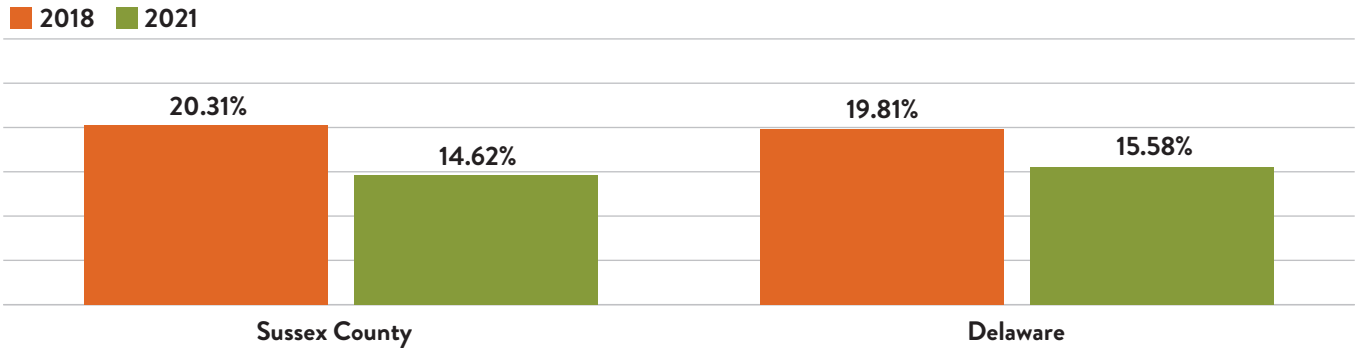
Figure 52: Suicide Mortality (Age-Adjusted Rate per 100,000 Population)



Source: Centers for Disease Control and Prevention, National Vital Statistics System

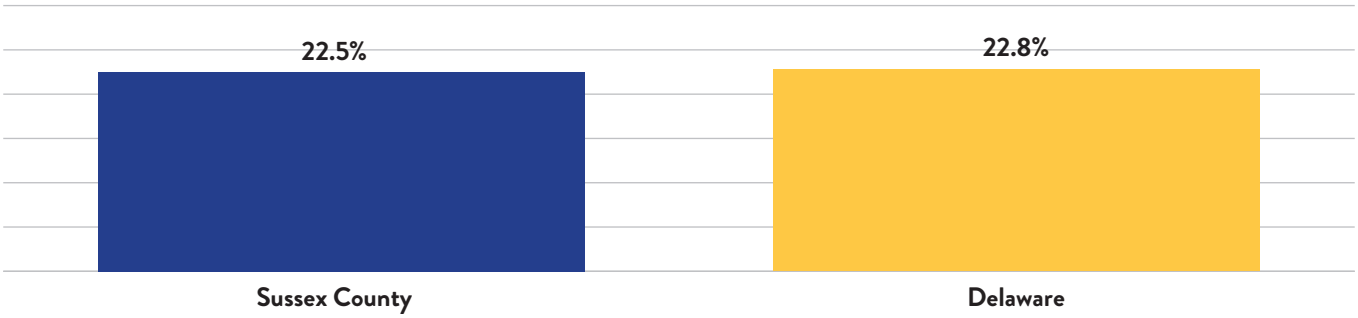
Tracking alcohol consumption helps identify patterns of risky or excessive drinking that can lead to serious health consequences, including liver disease, cancer, heart problems, and mental health disorders. It also enables public health officials and communities to monitor trends, target prevention efforts, and implement policies that reduce alcohol-related harm, such as accidents, injuries, and substance use disorders.

Figure 53: Heavy Alcohol Consumption



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System

Figure 54: Alcohol-Impaired Driving Deaths



Source: IP3 Healthy Communities Delaware, 2024

Beebe Healthcare is committed to actively monitoring and will continue to address behavioral health issues identified in the CHNA across its service areas. Through ongoing data collection, collaboration with local partners, and integration of behavioral health indicators into routine community health tracking, Beebe Healthcare will evaluate trends in mental health, substance use, and social support. Beebe Healthcare will work closely with stakeholders and community organizations to implement targeted strategies, expand access to services, and support prevention and early intervention efforts tailored to the unique needs of each service area. By prioritizing behavioral health alongside physical health, Beebe Healthcare aims to reduce health and social gaps, enhance the community's well-being, and ensure that residents throughout Sussex County and the broader Delmarva Peninsula have access to the care and resources needed.

Cancer

(Education, Screenings, and Navigation)

Cancer remains the second-leading cause of death in both Delaware and Sussex County. From 2016 to 2020, Delaware's all-site cancer incidence rate was 457.6 per 100,000 population, higher than the national rate of 442.2 per 100,000. During the same period, Sussex County reported 8,880 new cancer cases and 3,191 cancer-related deaths, underscoring the disease's substantial impact on the local population.[20]

Cancer screenings, education, and patient navigation play a crucial role in reducing cancer incidence and mortality, particularly in rural regions like Sussex County. Access to timely and appropriate cancer screenings remains a pressing concern. According to the Delaware Cancer Consortium, colorectal cancer is the third-leading cause of cancer deaths in the state and kills about 170 Delawareans annually. Rates of death caused by colon cancer in Delaware are 36% higher among African Americans than among other Delawareans.[21]

Similarly, the top four cancers for mortality in Delaware are: lung and bronchus (36.4 per 100,000 population), female breast (21.1 per 100,000 population), prostate (19.0 per 100,000 population), and colorectal (12.3 per 100,000 population). These trends are also observed in the United States, with slight variations in rates.[22] Screening for lung cancer with annual low-dose CT scans among those at-risk can reduce the lung cancer death rate by up to 20% by detecting the disease at early stages when it is more likely to be curable. These trends underscore the need for enhanced cancer education and services to facilitate early diagnosis, particularly in at-risk neighborhoods.

To address these health and social gaps, Beebe Healthcare is implementing a multifaceted approach that includes enhanced cancer screenings, targeted education campaigns, and improved patient navigation support.[23] Mobile screening units and local partnerships with community organizations aim to bring community-based services such as risk assessments, manual clinical exams, lab draws, referrals, and other critical screenings to rural and hard-to-reach areas, where residents may face transportation or cost barriers.

Health educators play an essential role in increasing cancer awareness by promoting risk reduction strategies, emphasizing the importance of early detection, and dispelling myths about screenings. In parallel, care navigators provide one-on-one assistance to help individuals understand their results, schedule follow-up care, and manage complex treatment pathways—especially important for older adults and low-income residents who may struggle to access or understand cancer-related services.

The absence of early cancer detection can lead to advanced-stage diagnoses, more intensive treatments, poorer survival rates, and higher healthcare costs. Communities that lack access to regular screenings often face preventable cancer-related deaths and significant emotional and financial strain. By focusing on data-driven outreach, investing in health literacy, and strengthening support systems - Beebe Healthcare is taking essential steps to close screening gaps and reduce cancer care gaps. These efforts align with broader public health goals to increase the utilization of preventive care and promote fair health outcomes across Sussex County.

[20] First State Health

[21] Delaware Health and Social Services

[22] Delaware Health and Social Services

[23] Beebe Healthcare

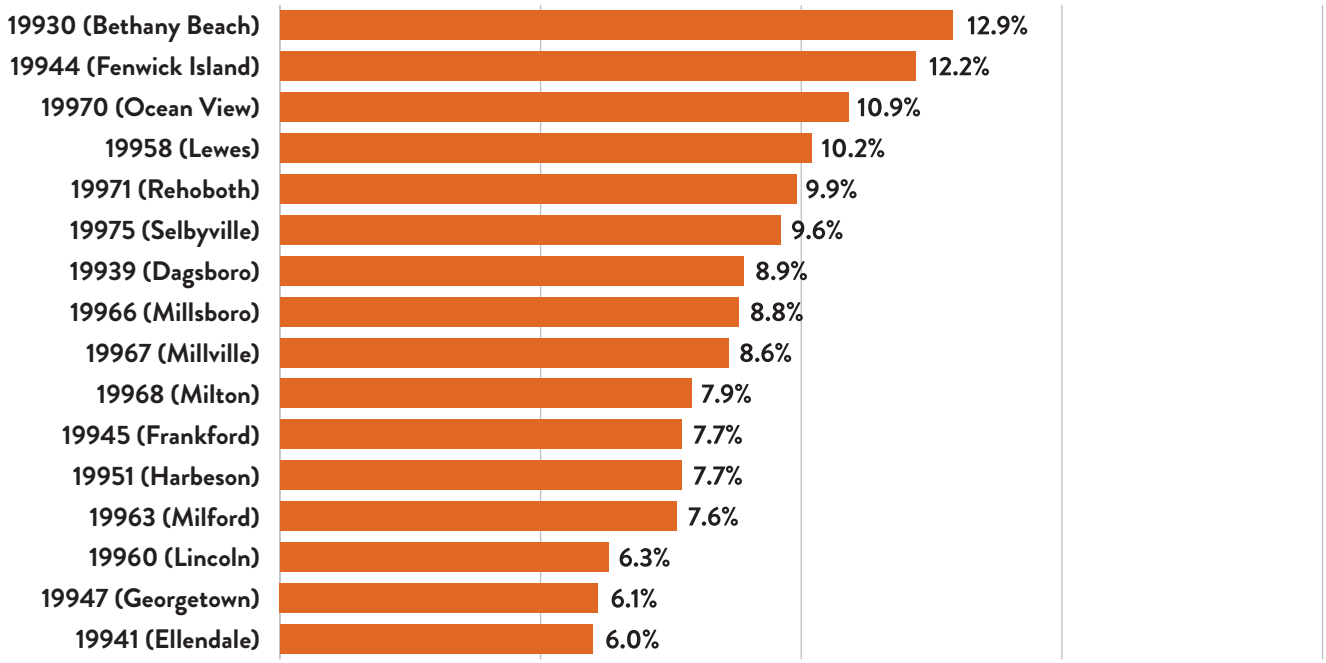
Table 10 summarizes key findings from stakeholder interviews and focus groups related to cancer as part of a community health assessment. Engaging with the community is crucial for identifying cancer-related concerns and ensuring that strategies address the genuine challenges residents face. The insights gathered reveal significant concerns around cancer, prevention, detection, access to screenings, and the availability of treatment and support services.

Table 10: Listening to the Community

Stakeholder Interviews Findings Shared Feedback	Focus Groups Findings Shared Feedback
What Can Be Offered to Suppress the Prevalence of Chronic Diseases in the Community? • 73.3% – Preventative healthcare services • 66.7% – Health promotion and education ***Persistent Health Problems*** • 33.3% – Cancer ***What Can Be Offered to Suppress the Prevalence of Chronic Diseases and Maintain Optimal Health?*** • 66.7% – Health promotion and education ***Actions Hospital Can Take to Address Health Gaps*** • 40.0% – Enhance Preventive Care ***Type of Resources to Assist Residents*** • 66.6% – Giving health information in their own language • 66.6% – Making information easier to understand ***Strategies/Initiatives to Ensure Equitable Healthcare*** Expanding Access and Outreach • Ensure critical information reaches the people who need it most through targeted, intentional outreach efforts. • Continue and expand mobile units for screenings in local communities with better financial support, centralized coordination, and regular scheduling to build awareness. ***Impactful Community-Based Educational Programs*** Community Partnerships and Education Initiatives • Provide educational resources to support younger populations and local education programs. Health and Wellness Programs • Develop community education programs promoting healthy lifestyles with supportive resources. ***Health Challenges Facing the Community and Steps Taken to Improve Health for All Residents*** • Focus on providing culturally appropriate and sensitive care. ***Innovations/Strategies to Improve Health Outcomes*** Preventative Care and Education • Emphasize preventative work, such as screenings and education on chronic diseases. • Improve health literacy through educational programs for all ages, including after-school programs for children and workshops for seniors.	***African American Participants*** • Existing outreach efforts, such as mobile health units, vaccination clinics, and community events, are not always widely known, consistent, or accessible. Residents often find out about services only after they are urgently needed, indicating a lack of proactive outreach or clear communication. • Difficult relying on mobile units caused by shifting locations. Outreach efforts sometimes fail to reach rural areas or neighborhoods most in need. • Establish a predictable monthly or quarterly schedule for mobile units and pop-up clinics. • Promote services through trusted community channels such as church bulletins, local radio, neighborhood flyers, and word-of-mouth. • Consider including wrap-around services (e.g., mental health counseling, nutrition education, benefit enrollment) when conducting health outreach. • Outreach efforts often fail to reach those who need them most, particularly individuals without internet access, seniors unfamiliar with technology, or families with limited English proficiency. • Trusted community figures such as faith leaders, teachers, and advocates are not always engaged in sharing information, resulting in lost opportunities for word-of-mouth communication. • Even when resources are shared, there can be too much scattered information and not enough clarity on where to go or how to access services. • Pollution from poultry farms and industrial facilities contribute to high rates of cancer, respiratory problems, and other chronic illnesses. While some of these concerns are based on personal or anecdotal experience, they reflect a broader perception that the environment directly harms residents' health. • Chicken farms, processing plants, and manufacturing facilities are major contributors to air and water pollution. Several shared personal stories of family members or neighbors who developed cancer or respiratory issues, which they believed were tied to long-term exposure to local pollutants. • Participants acknowledged that existing outreach efforts, such as mobile health units, vaccination clinics, and community events, are not always widely known, consistent, or accessible.

Figure 55 displays cancer prevalence percentages by ZIP code. The data indicates that ZIP code 19930 (Bethany Beach) has the highest cancer rate, at 12.9%, followed closely by ZIP code 19944 (Fenwick Island), at 12.2%. Several other areas also report elevated rates, including 19970 (Ocean View) at 10.9% and 19958 (Lewes) at 10.2%. In contrast, lower rates are observed in ZIP codes such as 19941 (Ellendale) at 6.0% and 19947 (Georgetown) at 6.1%. These geographic gaps may reflect differences in population demographics, healthcare access, environmental exposures, and socioeconomic factors. The data underscores the need for targeted cancer prevention, screening, and outreach efforts tailored to high-risk communities.

Figure 55: Cancer by ZIP codes



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2020

The table 11 presents age-adjusted cancer incidence rates for Sussex County from 2017 to 2021 compared to national averages in the United States. Sussex County exceeds the national rate in several key cancer categories, indicating areas of concern. Notably, the overall cancer incidence rate in Sussex County is 461.1 per 100,000—higher than the U.S. rate of 444.4. Specific cancers with elevated rates include leukemia (13.4 vs. 11.0), lung and bronchus (57.4 vs. 53.1), melanoma of the skin (32.2 vs. 22.7), and prostate cancer (119.7 vs. 113.2). These higher-than-average figures underscore the importance of sustained investment in cancer prevention, early detection, and treatment strategies across the county, especially in Beebe Healthcare's primary service areas.

Table 11: Incidence Rate Report for Sussex County

Age-Adjusted 2017-2021 (per 100,000)	Sussex County	United States
All Cancer Sites	461.1	444.4
Breasts (female)	129.6	129.8
Leukemia	13.4	11.0
Lung & Bronchus	57.4	53.1
Non-Hodgkin Lymphoma	22.7	22.3
Melanoma of the skin	32.2	22.7
Ovary (female)	9.7	10.1
Pancreas	12.9	13.5
Prostate (male)	119.7	113.2

Note: The red text highlights cancer incidence rates in Sussex County that are higher than the national (U.S.) rates for the same cancer type.

Source: State Cancer Profiles

The table presents age-adjusted cancer mortality rates per 100,000 population for Sussex County compared to national averages from 2018 to 2022. Sussex County's overall cancer mortality rate is 154.4, which exceeds the U.S. average of 146.0, highlighting a significant public health concern. Specific cancer types with higher local mortality rates include breast cancer in females (21.8 vs. 19.3), lung and bronchus cancer (37.5 vs. 32.4), melanoma of the skin (3.3 vs. 2.0), ovarian cancer (7.3 vs. 6.0), and pancreatic cancer (12.0 vs. 11.2). While prostate cancer mortality in Sussex County (18.5) is slightly below the national average (21.2), the data suggests that residents face disproportionately high risks of dying from several major cancers. These findings underscore the importance of intensifying cancer prevention, early detection, and treatment efforts, particularly in areas with high incidence rates.

Table 12: Mortality Rate Report for Sussex County

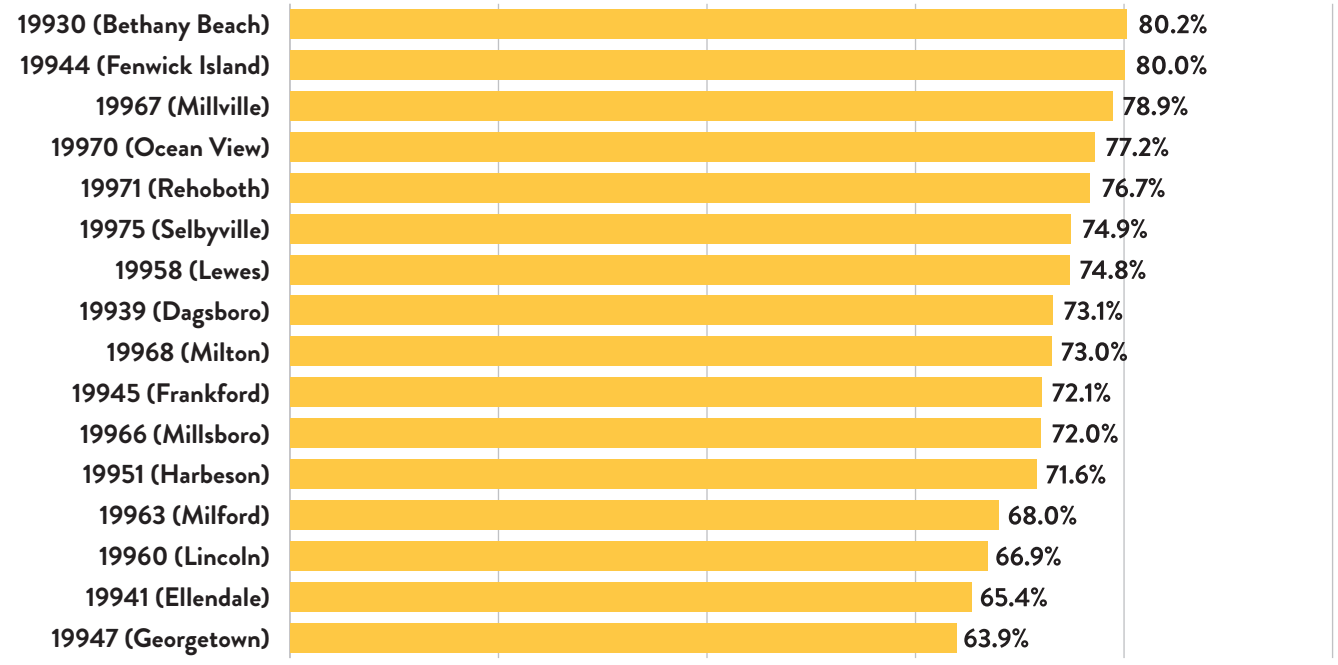
Age-Adjusted 2018-2022 (per 100,000 population)	Sussex County	United States
All Cancer Sites	154.4	146.0
Breasts (female)	21.8	19.3
Leukemia	6.5	5.9
Lung & Bronchus	37.5	32.4
Non-Hodgkin Lymphoma	6.3	5.0
Melanoma of the skin	3.3	2.0
Ovary (female)	7.3	6.0
Pancreas	12.0	11.2
Prostate (male)	18.5	21.2

The red text in the table highlights cancer mortality rates in Sussex County that are higher than the national (U.S.) rates for the same cancer type.

Source: State Cancer Profiles

Figure 56 depicts notable gaps in colorectal cancer screening rates among adults aged 45 to 75 across specific neighborhoods. Coastal communities such as Bethany Beach (19930) and Fenwick Island (19944) report the highest screening rates at 80.2% and 80.0%, respectively, indicating strong engagement with preventive healthcare services in these areas. Nearby communities Millville (78.9%), Ocean View (77.2%), and Rehoboth (76.7%) also show high levels of participation, suggesting relatively good access to care and awareness of cancer prevention. In contrast, several inland and rural ZIP codes exhibit lower screening prevalence. Georgetown (19947) ranks the lowest at 63.9%, followed by Ellendale (65.4%) and Lincoln (66.9%), pointing to potential barriers such as limited access to screening facilities, transportation issues, or lower health literacy. The difference of more than 16 percentage points between the highest and lowest rates highlights a pressing need for targeted outreach and education in underperforming areas. Improving colorectal cancer screening across all regions of Sussex County is essential for early detection, better health outcomes, and reduced cancer-related mortality.

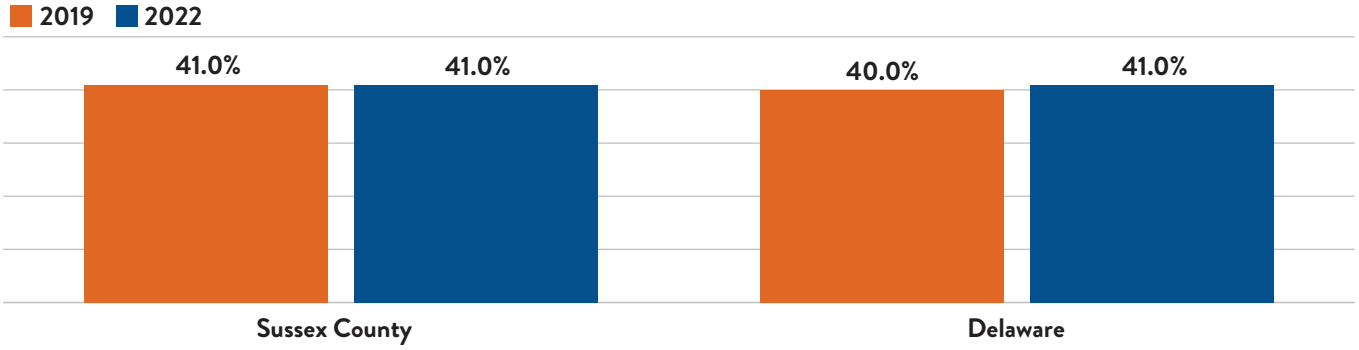
Figure 56: Colorectal Cancer Screening among Adults Aged 45–75 Years, Crude Prevalence



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2022

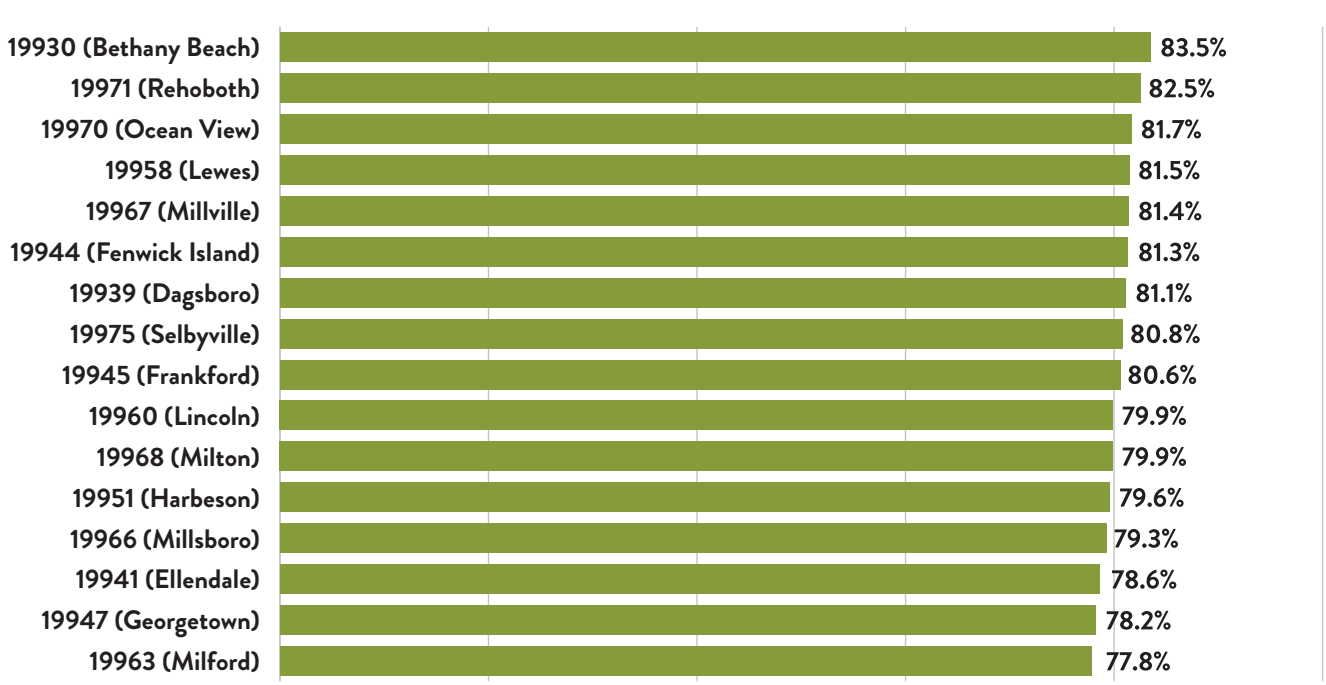
Mammogram screening rates among Medicare recipients in Sussex County remained steady at 41.0% from 2019 to 2022. This rate also matches the 2022 statewide average for Delaware, indicating consistent performance in breast cancer screening across the county and state.

Figure 58: Cancer Screening – Mammogram (Medicare)



Source: Centers for Medicare and Medicaid Services

Figure 57: Mammography Use among Women Aged 50-74 years, Crude Prevalence



Source: Delaware Environmental Public Health Tracking Network; My Healthy Community, 2022

Beebe Healthcare remains committed to reducing the burden of cancer across Sussex County by continuing to invest in comprehensive education, early screening, and patient navigation services. Through community outreach initiatives, accessible screening programs, and support systems that guide individuals through diagnosis and treatment, Beebe Healthcare aims to detect cancer earlier, improve patient outcomes, and close care gaps. By partnering with local organizations and leveraging data to target high-need areas, Beebe Healthcare will ensure that all residents have the knowledge, tools, and support needed to take proactive steps toward cancer prevention and care. This ongoing commitment is essential to ensuring fair access to healthcare and enhancing quality of life across the region.

Next Steps

After completion of the CHNA, Beebe Healthcare will transition into the implementation planning phase, during which strategic goals and action-oriented initiatives will be developed to address the most pressing health priorities identified. Beebe Healthcare will collaborate closely with community partners, leveraging its clinical expertise, outreach capacity, and regional relationships to co-create impactful solutions that reflect local needs. Through this collaborative process, Beebe Healthcare will align its internal resources with external efforts to maximize reach and effectiveness. The prioritization of health issues—chronic conditions, behavioral health, and cancer— will serve as a roadmap for targeted community health improvement initiatives aimed at advancing wellness and overall quality of life for all residents in the communities it serves. Additionally, Beebe Healthcare will focus on enhancing health literacy across the community, ensuring that residents have the knowledge and tools to make informed decisions about their health and well-being.

Data Gaps

Beebe Healthcare's community health needs assessment was based on the most current and comprehensive data available. Beebe Healthcare recognized several data gaps during its CHNA, particularly in reaching specific, disparate, and at-risk populations. While significant efforts were made to engage a broad cross-section of the community, including outreach through focus groups and stakeholder interviews, some groups remained underrepresented. For example, it was challenging to collect data from incarcerated individuals or residents who did not speak English. Challenges remained because of restrictions and limited communication channels. Despite these limitations, the assessment was designed to offer a broad and insightful overview of the community's health, recognizing that data constraints may impact the ability to capture every aspect of community health needs.

Special Thanks

Motivated by a shared commitment to community well-being, the creation of this report reflects Beebe Healthcare's ongoing dedication to driving meaningful change. Spearheaded by the Population Health Advisory Council, this initiative brought together a diverse network of voices—including local leaders, healthcare professionals, and social service partners—to listen, learn, and prioritize our region's most pressing needs. Through thoughtful engagement and collaboration, we have built a clearer understanding of the barriers to health and the opportunities for progress. While challenges remain, our path forward is strengthened by the passion, insight, and resolve of those who stand with us. Together, we are building a healthier, more equitable future for all.

Table 12: Community Health Needs Assessment Steering Committee (in alphabetical order by last name)

NAME	POSITION
Kimberly Blanch	Director of Community & Mobile Outreach - Beebe Healthcare
Dr. Bill Chasanov	Senior Vice President /Chief Health Systems Design Officer - Beebe Healthcare
Stacie Gosting	Manager of Community Services - Beebe Healthcare
Sandra Meagher	Population Health Advisory Council Member - Beebe Healthcare
Loretta Ostroski	Vice President of Continuum of Care & Integrated Care - Beebe Healthcare
Cristen Owen	Community Relations & Events Coordinator - Beebe Healthcare
Angie Scott	Community & Mobile Outreach Coordinator - Beebe Healthcare
Danielle Socrates	Vice President of Value Based-Care & Transformation - Beebe Healthcare
Kristen Rios	Population Health Data Coordinator - Beebe Healthcare
Dr. David Tam	President & Chief Executive Officer - Beebe Healthcare

Additional Information

Beebe Healthcare will develop implementation plans that leverage its strengths and resources to effectively address community health needs and improve the overall well-being of residents in Sussex County. For more information about the CHNA and its findings, please contact:

Kim Blanch

Director of Community & Mobile Outreach at Beebe Healthcare

Beebe Healthcare 424 Savannah Road, Lewes, DE 19958

kblanch@beebehealthcare.org

Beebehealthcare.org

Consultants

Beebe Healthcare contracted with Tripp Umbach, a private healthcare consulting firm, to complete a Community Health Needs Assessment and Implementation Strategy Plan. 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 Tripp Umbach has worked.

From community needs assessment protocols to fulfilling Patient Protection and Affordable Care Act 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 because 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.

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