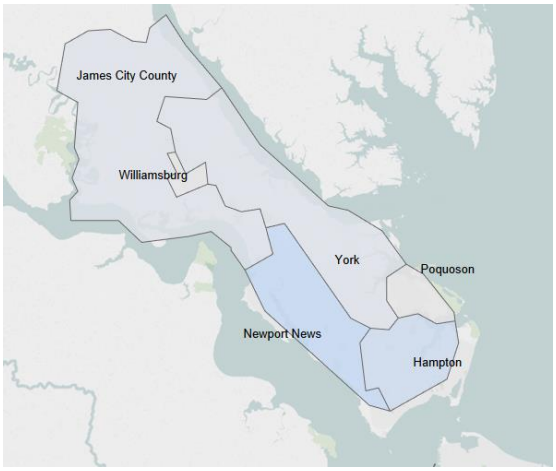
Healthy People in Healthy Communities

A Community Health Assessment and Improvement Plan

Hampton/Peninsula Health District

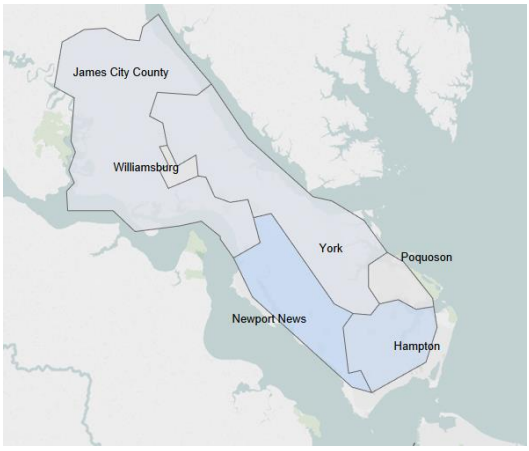
Summary Report



Introduction

This report presents a summary community health assessment and improvement plan for Health Planning District (HPD) 21. The purpose of this report is to help inform and advance community health improvement efforts within the District. HPD 21 is a large and diverse area that is home to more than 476,000 people in six local jurisdictions including the City of Hampton, the City of Newport News, the City of Poquoson, the City of Williamsburg, James City County, and York County. As outlined in the following sections, HPD 21 has both complex health challenges and substantial health assets. Our hope is that this report will help inform community action for health improvement.

Exhibit 1. Map of HPD 21



This report also reflects the commitment of Hampton/Peninsula Health District to fulfill its role as the local health agency for the region. The guiding vision for our agency is "Healthy People in Healthy Communities." Our mission is to protect, promote and preserve the health of the people who live, work and play on the Peninsula, including the residents of Hampton, Newport News, Poquoson, Williamsburg, James City County and York County. We pursue this mission in collaboration with our community partners throughout the region, where our work is guided by the values of excellence, inclusion, and partnership.

Exhibit 2
Core Functions and Essential Services of Public Health

As illustrated in *Exhibit 2,* our core functions include assessment, policy development, and assurance for public health. We fulfill these core functions by delivering ten essential health services as outlined in the exhibit. We have made it a priority to deliver these core functions and essential services in support of efforts to improve the health of our region and our local communities.

This report is the result of an ongoing process of community health assessment and planning involving Hampton/Peninsula Health District and the communities we serve. The process began in 2015 with establishment of a strategy development team within the agency. The process continued into 2016 with development of local community health indicators, structured listening meetings with multiple civic groups, and collection of community insights from hundreds of community professionals and community residents. During this period Hampton/Peninsula Health District coordinated its efforts with local health systems who were also conducting community needs assessments in service of their missions and in response to federal requirements. We plan to continue this work through ongoing data collection, community education, and focused planning meetings with community stakeholders interested in developing community health initiatives.

This report is organized into two main sections. In the *Community Health Assessment* section, we present summary findings from an ongoing effort to assess community health needs. In the *Community Health Improvement* section, we present a plan for working together to improve the health of our shared community. Please note that this summary report presents a high-level overview of the assessment results and the plan for improvement. Hampton/Peninsula Health District has much more detailed information available through our offices and our website. For more information, please contact Irene Ferrainolo at 757-315-3766 or visit our website www.vdh.virginia.gov/hampton or www.vdh.virginia.gov/peninsula.

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Part I. Community Health Assessment

This section presents summary findings from our recent efforts to assess community health needs. The findings are based on analysis of County Health Rankings, indicators of health opportunity, indicators of community health risks and health status, and insights from community members. The findings show that HPD 21 is a large and diverse region with complex health needs. Our region also has substantial health assets and many community members who are committed to working together for health improvement.

County Health Rankings

One way to examine community health is to consider local health rankings. *County Health Rankings* is a national project of the University of Wisconsin Public Health Institute with support from the Robert Wood Johnson Foundation. The rankings are widely used by communities interested in developing health improvement strategies. As shown in *Exhibit 3*, James City County, Poquoson, and York County rank in the top quartile (25 percent) among 134 Virginia cities and counties. Hampton, Newport News, and Williamsburg rank in the second, third, or fourth quartile on the ranked indicators. The *County Health Rankings* provide a good starting point for understanding community health, but the rankings have some technical limitations, and they do not fully capture the diversity of health needs within each city and county.

Exhibit 3. County Health Rankings Profile (2016)

Indicator	City of Hampton	City of Newport News	City of Poquoson	City of Williamsburg	James City County	York County
Health Outcomes	84	80	6	88	16	5
• Length of Life	79	74	9	77	16	11
• Quality of Life	90	86	6	97	15	4
Health Factors	86	92	7	48	9	8
• Health Behaviors	110	118	14	45	9	19
• Clinical Care	56	51	10	47	2	9
• Social & Economic Factors	84	88	4	76	23	8

Rank: 1-34 | 35-67 | 68-100 | 101-134

Source: County Health Rankings for Virginia, http://www.countyhealthrankings.org/

Indicators of Health Opportunity

A second way to examine community health is to consider social indicators of health opportunity, or what are often called *social determinants of health*. As described in Healthy People 2020,[1] a range of personal, social, economic, and environmental factors contribute to individual and population health. For example, people with a quality education, stable employment, safe homes and neighborhoods, and access to preventive services tend to be healthier throughout their lives. Conversely, poor health outcomes are often made worse by the interaction between individuals and their social and physical environment. Consequently, social determinants are in part responsible for the unequal and avoidable differences in health status within and between communities.

As shown in *Exhibit 4*, substantial numbers of local residents may face challenges in achieving or sustaining optimal health due to personal, social and economic factors. This is evident in the number of local residents who may face health-related challenges based on advanced age, low income, low education, lack of insurance, or other social and economic factors that influence. In citing these factors we recognize that they are not definitive predictors of health status, and we do not propose that all community members with these characteristics are at risk for adverse health or access problems. But these factors do place many individuals at elevated risk for health challenges, as has been shown by decades of published research. The important point is that even in cities and counties that rank high on indicators such as the *County Health Rankings*, there are substantial populations who may be struggling with health issues as a result of socioeconomic factors.

[1] https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Social-Determinants

Exhibit 4. Selected Indicators of Social Determinants of Health (2014)							
Indicators (all estimates)	**City of Hampton**	**City of Newport News**	**City of Poquoson**	**City of Williamsburg**	**James City County**	**York County**	**HPD 21**
Total Population	136,904	69,832	181,362	12,103	14,401	65,808	136,904
Estimated Child Population (age 0-17)							
Estimated Older Adult Population (65+)	17,614	15,222	20,216	2,022	2,101	8,747	17,614
Children in Poverty							
Population at or below 100% of Poverty							
Population at or below 200% of Poverty							
Pop. Age 25+, less than High School	9,490	3,207	12,800	610.499	577.368	2,601	29,286
Uninsured Children							
Uninsured Adults							
Population by Race / Ethnicity:							
Asian	3,145	2,047	5,061	342	778	3,346	14,719
Black or African American	68,794	9,581	72,732	83	2,132	8,852	162,174
Multiple or Other Race	6,169	1,951	11,591	232	704	2,738	23,385
White	58,796	56,253	91,978	11,446	10,787	50,872	280,132
Hispanic Ethnicity	6,848	3,562	14,546	257	1,002	3,367	29,582
Source: US Census Bureau Small Area Estimates							

A related view of health opportunity can be found in the **Health Opportunity Index (HOI)** produced by the Virginia Department of Health. The HOI provides a composite measure of multiple social determinants at the census tract level. While not an exhaustive or definitive examination of social determinants, Virginia's HOI has been calibrated with the health outcome measures of life expectancy, disability-adjusted life expectancy and low birth weight, and is strongly predictive of key health outcomes in Virginia. Across the six jurisdictions within HPD 21, an estimated 110,000 people, or about 23 percent of the population, live in census tracts that have a "very low" health opportunity score compared to the rest of Virginia. While noting that living within these census tracts is not a definitive predictor of poor health, there are likely to be substantial numbers of people within these census tracts who have socioeconomic obstacles to optimal health and health care.

Community Health Status Indicators

In addition to examination of *County Health Rankings* and *Indicators of Health Opportunity*, a third way to examine community health is to analyze specific indicators of community health status. By learning more about the incidence and prevalence of specific health risks and conditions, we can gain a better understanding about the scope and magnitude of local health challenges. *Exhibit 5* provides a summary of selected community health indicators for the region.

We note that *Exhibit 5* does not show every possible indicator, but it does provide an overview of key health challenges facing our communities. The exhibit also shows counts rather than rates in order to emphasize the number of people affected by specific health risks and conditions. Additional data on counts and rates for the risks and conditions shown, as well as many other indicators, are available from Hampton/Peninsula Health District.

Maternal and Infant Health. In 2013 HPD 21 had 6,171 total live births. Among these, 660 (11%) occurred without early prenatal care; 548 (9%) had a low birth weight; and 391 were born to teens. There were also 52 infant deaths in the region.

Youth Health Risk. In 2014 HPD 21 was home to more than 60,000 youth age 10 to 19. As shown in the Exhibit, substantial numbers of youth are at risk for overweight, sedentary lifestyle, and not meeting nutrition guidelines. There are also substantial numbers who have used alcohol and tobacco. These risk indicators are not unique to HPD 21, and they represent a challenge in communities across Virginia and the nation. If sustained, these risks can contribute to significant health problems across the lifespan, and substantial costs for associated health care services.

Exhibit 5. Community Health Indicator Profile							
Indicator	**City of Hampton**	**City of Newport News**	**City of Poquoson**	**City of Williamsburg**	**James City County**	**York County**	**HPD 21**
Maternal and Infant Health Indicators[2]							
Total Live Births	1,817	2,856	88	79	718	613	6,171
Late Prenatal Care Births	160	321	2	16	120	41	660
Low Weight Births	175	256	6	4	67	40	548
Births to Teens	122	208	5	6	33	17	391
Infant Deaths	18	22	22	0	6	4	52
Youth Health Risk Behaviors (age 10-19 except as noted)[3]							
Overweight or Obese (14-19 only)	3,530	4,483	284	639	1,385	1,626	11,947
Not Meeting Physical Activity Guidelines	7,611	9,942	751	684	3,653	4,206	26,764
Not Meeting Nutrition Guidelines	9,164	12,328	1,078	1,041	4,898	5,660	34,029
Used Tobacco	2,378	3,183	251	457	1,126	1,319	8,715
Used Alcohol	2,946	4,005	347	696	1,464	1,739	11,197
Adult Health Risk Behaviors[4]							
Overweight or Obese	68,418	86,660	5,740	8,567	34,654	29,866	235,213
Smoke	24,588	23,384	1,600	2,349	9,502	8,462	69,884
Recent Binge Drinking	19,243	24,760	1,976	2,211	10,061	10,951	67,204
High Blood Pressure	32,071	39,891	2,635	4,145	16,209	14,435	108,273
High Cholesterol	38,485	49,520	3,388	4,698	20,121	17,919	134,407
Diabetes	11,759	13,756	1,223	829	5,589	4,978	37,335
Potentially Preventable Hospitalizations[5]							
Total	554	1,696	65	4	219	287	2,825
Congestive Heart Failure	154	524	13	1	60	97	849
COPD or Asthma in Older Adults	93	304	6	2	29	39	473
Diabetes	96	238	8	1	29	29	401
Bacterial Pneumonia	63	64	65	66	67	68	374
Dehydration	63	153	9	0	20	34	279
Behavioral Health Hospitalizations[6]							
Total	896	1,312	53	8	270	163	2,702
Affective Psychoses	373	498	30	2	85	73	1,061
Schizophrenic Disorders	212	321	2	0	36	5	576
Depressive Disorders	80	117	9	0	26	20	252
Alcoholic Psychoses	42	78	3	2	24	13	162
Leading Causes of Death[7]							
Total Deaths (All Causes)	1,198	1,404	88	139	638	396	3,863
Malignant Neoplasms (Cancer)	287	315	21	27	165	113	928
Heart Disease	220	275	15	38	132	87	767
Cerebrovascular Disease	59	59	3	10	29	22	182
Chronic Lower Respiratory Diseases	65	58	5	7	29	13	177
Unintentional Injury	52	55	2	4	23	16	152
Diabetes	43	53	3	5	12	9	125
Alzheimer's Disease	37	40	3	2	28	8	118
Septicemia	38	30	2	0	8	5	83
Nephritis and Nephrosis	25	39	0	2	7	10	83
Influenza and Pneumonia	31	24	3	3	15	6	82
Sources: See footnotes							

[2] Virginia Department of Health birth record data, 2013
[3] Community Health Solutions analysis of statewide Virginia Middle School and High School Youth Risk Surveillance Survey from the Centers for Disease Control (2013), and demographic data from Alteryx, Inc. (2014).
[4] Community Health Solutions analysis of a multi-year data set (2006-2010) from the Virginia Behavioral Risk Factor Surveillance System, and demographic data from Alteryx, Inc. (2014).
[5] Community Health Solutions analysis of Virginia inpatient hospital discharge data from Virginia Health Information (2013), and demographic data from Alteryx, Inc. 2013.
[6] See note 5
[7] Virginia Department of Health death record data, 2013

Adult Health Risk. An estimated 373,000 adults age 18 or older resided in HPD 21 as of 2014. As with the youth population, substantial numbers of adults are at risk for overweight, smoking, and binge drinking. It is also estimated that more than 108,000 may have high blood pressure, more than 134,00 may have high cholesterol, and more than 37,000 may have diabetes. One or more of these risk factors contributes to development of cancer, heart disease, cerebrovascular disease, chronic respiratory disease, and diabetes.

Potentially Preventable Hospitalizations. The U.S. Agency for Healthcare Research and Quality has identified specific types of hospitalizations that are potentially preventable with quality outpatient care. In 2013, residents of HPD 21 had 2,825 of these hospitalizations in Virginia facilities. The leading causes of these hospitalizations were congestive heart failure (849), chronic obstructive pulmonary disease or asthma in older adults (473), diabetes (401), bacterial pneumonia (374), and dehydration (279). The majority of these hospitalizations were for seniors age 65+. While it is not feasible to eliminate all of these hospitalizations, it is possible to reduce them with quality outpatient care and lifestyle change for behavior-related conditions.

Behavioral Health Hospitalizations. Although it is not a comprehensive indicator of behavioral health needs, analysis of behavioral health hospitalizations can provide helpful insight into the needs of the community. For this report the analysis is focused on residents of HPD 21 who were hospitalized at Virginia hospitals not including state facilities. In 2013, residents of HPD 21 had 2,702 hospitalizations for conditions related to mental health and substance use. The leading causes of hospitalization (based on primary diagnosis) were affective psychoses (1,061), schizophrenic disorders (576), depressive disorders (252), and alcoholic psychoses (162).

Leading Causes of Death. In 2013 there were 3,863 total deaths for residents of HPD 21. The leading causes of death were malignant neoplasms (928), heart disease (767), cerebrovascular disease (182), chronic lower respiratory disease (177), and unintentional injury (152). These conditions are also among the leading causes of premature death (deaths occurring before age 75).

Community Insights

A fourth and very important way to examine community health is through the eyes of those who live and work in the community. In an effort to understand these perspectives, Hampton/Peninsula Health District has conducted surveys with hundreds of community professionals and community residents. We have also conducted listening meetings with a wide range of community stakeholders in various group settings. We are conducting this work on an ongoing basis with the goal of continuously refreshing our understanding of community needs, and sharing this information with our many partners in community health.

Please note that the community insights presented in this section represent a summary snapshot of community survey results captured through mid-April 2016. This summary is based on analysis of surveys from 243 community professionals, and 283 community residents. The survey respondents come from across the region, and they have provided valuable insights from their professional and personal perspectives. More detail on the survey results is available from the Hampton/Peninsula Health District.

Community Health Concerns. Survey respondents were asked to review a list of common community health issues, as drawn from the *Healthy People 2020* framework with some refinements. Respondents were asked to identify from the list what they view as important health concerns in the community where they live or work. They were also invited to identify additional concerns not already on the list. As shown in *Exhibit 6,* a wide range of concerns were identified on both surveys. Among the most commonly identified concerns in both surveys were cancer, diabetes, drug use, high blood pressure, nutrition and weight status, and physical activity.

Community Health Environment. Survey respondents were asked to review a list of factors that create a supportive environment for health, and identify those that could use improvement. As shown in *Exhibit 7,* all of the factors presented were identified as needing improvement by a substantial number of respondents. Crime protection was the number one factor identified in both surveys. Additional factors in the top five in both surveys include housing safety, spaces for walking, and spaces for biking.

Exhibit 6. Community Insights on Health Concerns

Topic / Number Identifying as a Concern	Community Professional Survey (Top Ten Shaded)	Community Resident Survey (Top Ten Shaded)
Alcohol Use	107	210
Arthritis, Osteoporosis, and Chronic Back Conditions	82	156
Autism	65	70
Cancer	121	189
Chronic Kidney Disease	43	33
Dementias, including Alzheimer's	91	90
Dental/Oral Health Conditions	58	128
Diabetes	172	224
Drug Use	116	189
Eye Health	43	131
Food Safety	69	112
Health for People with Disabilities	108	123
Hearing and Communication Disorders	41	81
Heart Disease and Stroke	129	131
High Blood Pressure	157	279
High Cholesterol	98	158
HIV / AIDS	69	63
Immunization	68	57
Infectious Disease	63	61
Injury and Violence	96	144
Maternal, Infant and Child Health	85	46
Mental Health and Mental Disorders	136	147
Nutrition and Weight Status	149	216
Occupational Safety and Health	45	50
Physical Activity	124	184
Respiratory Diseases	60	83
Sexually Transmitted Diseases	112	133
Teen Pregnancy	98	96
Tobacco Use	98	191

Exhibit 7. Community Insights on Environmental Factors

	Community Professional Survey (Top Five Shaded)	Community Resident Survey (To Five Shaded)
Access to Healthy Foods	97	175
Access to Public Transportation	67	135
Access to Public Parks or Playgrounds	77	153
Air Quality	63	166
Crime Protection	160	235
Healthy Messaging in Media and Public Spaces	70	101
Housing Safety	105	176
Opportunities to Participate in Community Activities	84	154
School Safety	102	125
Spaces for Walking	107	188
Spaces for Biking	116	228
Traffic Safety	92	193
Water Quality	57	146

Access to Community Services. Survey respondents were asked to review a list of health care services that may be needed in the community, and to identify those that need improvement. As shown in *Exhibit 8,* all of the services presented were identified as needing improvement by a substantial number of respondents. Affordable health insurance was the most commonly identified service on both surveys. Additional factors in the top five in both surveys were dental services, mental health services, and services for weight control.

Exhibit 8. Community Insight on Access to Health Care Services

Access to….	Community Professional Survey (Top Five Shaded)	Community Resident Survey (To Five Shaded)
Affordable Health Insurance	170	234
Dental Services	123	213
Hearing Services	45	94
Home Health Services	67	96
Hospital Services	45	120
Mental Health Services	148	191
Pharmacy Services	73	116
Primary Care Services	107	112
Services for Quitting Smoking	76	153
Services for Weight Control	128	229
Substance Use Services	91	115
Vision Services	66	135

Survey respondents were also asked to review a list of community support services that may be needed in the community, and to identify those that need improvement. As shown in *Exhibit 9,* all of the services presented were identified as needing improvement by a substantial number of respondents. Among the top five services on both lists were child care services, financial services, and services for older adults.

Exhibit 9. Community Insight on Access to Community Support Services

Access to…	Community Professional Survey (Top Five Shaded)	Community Resident Survey (To Five Shaded)
After School Programs	85	152
Assisted Living Services	76	127
Child Care Services	99	145
Financial Services	108	191
Legal Counseling Services	84	107
Long Term Care Services	75	83
Public Transportation	94	245
Services for Adults with Disabilities	113	144
Services for Children with Special Needs	118	111
Services for Older Adults	121	184

Additional Insights on Community Health Improvement. Survey respondents were invited to provide additional insight in response to five open-ended questions about emerging health issues, vulnerable populations, community health assets, opportunities for collaboration, and vision of a healthy community. *Exhibit 10* presents paraphrased examples of responses to the first four questions from the hundreds that were received. Additional details on these survey responses are available from Hampton/Peninsula Health District.

Exhibit 10. Additional Insights on Community Health Improvement

Topic	Example Insights from Surveys
Emerging Health Issues	• Crime and violence • Drug abuse • Environmental safety • Services for seniors and persons with disabilities • Tobacco and e-cigarettes
Vulnerable Populations	• Adults with Disabilities • At-risk youth • Older Adults / Elderly • Homeless • Minority populations with particular health concerns • Low income
Community Assets	• Community institutions • Community service programs • Natural environment • People of the region • Parks, recreation centers, trails, wellness centers
Opportunities for Community Collaboration	• Collaboration between clinical care and community agencies • Collaboration between business and health • Collaboration across public agencies • Community health drives, food drives, promoting awareness • Healthy community action teams • Neighborhood gardens

In Your Own Words, How Would Define the Idea of a "Healthy Community"

- *A community were everyone has the same opportunities to their health, housing, feeling secure where they live.*
- *A healthy community has access to affordable health care, is able to safely exercise, has good wages, clean environment with accessible natural areas and safe areas for work, play and living.*
- *A healthy community is one that focuses on improving individuals' health for the benefit of the entire population regardless of financial or socio-economic status.*
- *A healthy community is one where services are there for everyone and all the organizations such as, churches, schools. doctor's offices etc. work together to make sure services are there for the community.*
- *A healthy community is one where the children have an awareness of potential harm such as drug solicitation, squandering money, and value health. The youngsters can then lead the future to make sound decisions when they get older.*
- *A community striving for health in all policy, resilient to adversity.*
- *A healthy community has access to affordable health care, is able to safely exercise, has good wages, clean environment with accessible natural areas and safe areas for work, play and living.*
- *A community with universal access to opportunities for physical activity in a safe environment and access to healthy foods. Acknowledgement by city governance that the best asset a community can have is a healthy population.*
- *A healthy community has access to affordable health care, is able to safely exercise, has good wages, clean environment with accessible natural areas and safe areas for work, play and living.*
- *A "healthy community" is one in which in my dreams that everyone is taken care of and contributing to the community. We would watch out for each other and not use violence.*
- *A community that has the health and safety of those who live there as their top priority*
- *A community that strives to be better and comes together to help each other in always expecting health*
- *A community where everyone has access and can get whatever their particular need is met*
- *A healthy community is one where exercise is incorporated and the risk or illness or disease is low*
- *Access to health care, education, job services, opportunity for everyone*
- *Access to information regarding health, safety, nutrition and care. Awareness as well. Measures available to people might not know (ex. posters and figures)*
- *Both mentally and physically healthy with access to tools that will keep the community thriving*
- *Diversity, open community (everyone knows each other), entrepreneurship opportunity*
- *People working together to create a mental, physical, social, and spiritual environment that benefits everyone*
- *Safe, clean, and ideal for children to learn and grow*

Part II. Community Health Improvement

Part I of the report presents summary findings from an ongoing effort to assess community health needs. In this section, we present a strategy for engaging in collaborative efforts to identify and address particular health problems.

As context for this work, we note that community health improvement is a shared responsibility that presents both challenges and opportunities. The challenges lie in addressing community health issues that are too numerous and complex for any one sector to address all by itself. The opportunities can be found in collaborating to achieve more through collective impact than we could achieve by working in silos. Ideally, each community sector will bring its own energy and capabilities to the job of health improvement. Everyone has a role to play, including business, civic organizations, community service organizations, faith communities, education, government agencies, neighborhood groups, and philanthropy in addition to health care and public health.

As we proceed together, it will be important to recognize that the six jurisdictions in HPD 21 may have shared or different priorities for community health improvement. Our local jurisdictions are diverse in terms of their size, demography, geography, economy, government structures, civic organizations, and culture. It should not be surprising if our diverse cities and counties also have varying interests and priorities for community health improvement. As the local public health agency, Hampton/Peninsula Health District is committed to helping our local jurisdictions act collectively for health improvement when interests align. We are also committed to assisting local initiatives that do not cross jurisdictional lines.

For its part, Hampton/Peninsula Health District is committed to working with willing partners from all sectors to identify and address community health issues identified in this assessment and others. Our work is guided by our core functions and essential services as a local public health agency. Our work is also guided by the presence of community stakeholders who are willing to engage as partners in community health improvement. Together we can make a tremendous difference in the health and well-being of our shared community.

It is in this spirit of collaboration that Hampton/Peninsula Health District presents the following framework for planning community health improvement initiatives. We begin by introducing suggested focus areas for community health improvement. Next we define the types of supports that Hampton/Peninsula Health District can bring to community partnerships for health improvement. We conclude with an invitation to work in partnership for community health improvement.

Suggested Focus Areas for Community Health Improvement

As is evident in the summary of community health assessment findings, there is an extensive list of health issues that could be addressed within our local communities. This is not unusual for a region of our size and diversity. No community can address all identified health needs at once, but it is possible to make significant progress over time. Among the keys to success are community commitment, and a willingness to identify and address issues over time.

To help facilitate local planning efforts, we offer a suggested set of focus areas for community health improvement. As shown in *Exhibit 11*, the suggested focus areas include *Promote Wellness and Healthy Living for All*; *Support a Strong Start for Children*; *Strengthen Community Supports for Older Adults and Persons with Disabilities*; *Improve Access to Coordinated Community Services*; and *Expand Health Opportunity*. Each of the five focus areas includes a set of specific action goals that can be used to further define local initiatives.

In defining the focus areas, our first and most important step was to assure that the aims and action goals are grounded in the findings from the local community health assessment. Next we compared the focus areas and action goals to established state and national initiatives including the *Virginia Plan for Well Being*, the *National Prevention Strategy*, and *Healthy People 2020*. This comparison was helpful for refining the overall organization of the framework.

The purpose of the suggested focus areas is to create a common language that community members can use to discuss and focus their health improvement plans. This type of tool can be especially helpful in large and diverse regions like ours, where there may be variations in local interest and capacity to address particular health issues. Where interests align, the focus areas can be used to inform initiatives that cross geographic or sectoral boundaries. The focus areas can also be used to plan more localized projects.

We invite community members to use the suggested focus areas as a menu for developing local plans for community health improvement. A good way to start is by convening a group of people to review the community health assessment summary, and use the suggested focus areas to discuss possible initiatives. We emphasize that the suggested focus areas are not intended to displace other planning frameworks already in use within the region. Our intention and hope is that the suggested focus areas will be viewed as a flexible tool that can complement both new and existing initiatives in community health improvement. Hampton/Peninsula Health District is available to assist with regional and local planning efforts, as outlined in the following section.

Exhibit 11. Suggested Focus Areas for Community Health Improvement
Focus 1 - Promote Wellness and Healthy Living for All
1.1 Promote Healthy Eating
1.2 Promote Active Living
1.3 Promote Tobacco Free Living
1.4 Promote Mental and Emotional Well Being
1.5 Prevent Drug abuse and Excessive Alcohol Use
1.6 Prevent Injury and Violence
1.7 Promote Timely Cancer Screening
1.8 Prevent the Spread of Communicable Disease
1.9 Promote Reproductive and Sexual Health
1.10 Protect against Foodborne, Waterborne, and Animal Diseases
1.11 Promote Emergency Preparedness
Focus 2 – Support a Strong Start for Children
2.1 Promote Healthy Pregnancy
2.2 Reduce Infant Mortality
2.3 Prevent Childhood Injury
2.4 Prevent Child Abuse
2.5 Promote Healthy Weight for Children
2.6 Promote Childhood Immunization
2.7 Promote Childhood Oral Health
2.8 Promote Prevention and Management of Childhood Asthma
2.9 Promote Child Care Quality
Focus 3 – Strengthen Community Supports for Older Adults & Persons with Disabilities
1.1 Reduce Social Isolation
1.2 Promote Healthy Nutrition
1.3 Promote Safety in the Home and Community Setting
1.4 Promote Access to Essential Community Services
1.5 Support Family Caregivers
Focus 4 – Improve Access to Coordinated Community Services
4.1 Promote Access to Health Services for Medically Underserved Populations
4.2 Promote Care Coordination for Individuals with Chronic Conditions
4.3 Promote Connections between People, Services, and Information to Support Optimal Health Outcomes
Focus 5- Expand Health Opportunity
5.1 Engage Community Residents in Community Health Improvement
5.2 Support Health in All Policies
5.3 Assure Equitable Access to Community Services
5.4 Create Healthy Environments in all Community Settings

Public Health Assistance for Community Health Improvement

As the region's local public health agency, Hampton/Peninsula Health District is committed to assisting community health improvement efforts. Our menu of available supports is defined by the core functions and essential services of public health, as outlined in *Exhibit 12*. As shown, we can provide assistance with various aspects of assessment, policy development, and assurance as they relate to community health assessment, planning, and implementation. We are poised to deliver these services (as applicable) in support of community health improvement planning.

Exhibit 12. Public Health Role in Assisting Community Health Improvement

Supports Available from Hampton/Peninsula Health District	Community Health Assessment	Community Health Planning	Community Implementation
Assessment			
1. Conduct and disseminate assessments focused on population health status and public health issues facing the community	•		
2. Investigate health problems and environmental public health hazards to protect the community	•		
Policy Development			
3. Inform and educate about public health issues and functions		•	
4. Engage with the community to identify and address health problems		•	
5. Develop public health policies and plans		•	
Assurance			
6. Enforce public health laws			•
7. Promote strategies to improve access to health care			•
8. Maintain a competent public health workforce			•
9. Evaluate and continuously improve public health processes, programs and interventions			•
10. Contribute to and apply the evidence base of public health	•	•	•

An Invitation

In this report we have presented a summary of a recent community health assessment, suggested focus areas for community health improvement, and a menu of supports that can be provided by Hampton/Peninsula Health District. Within our defined role as your local public health agency, we are committed to working collaboratively with our community to identify and address specific health challenges. We invite you to take action for health improvement in your sphere of influence, whether it be your home, neighborhood, school, workplace, or other community setting. We also invite you view Hampton/Peninsula Health District as your partners in health improvement. As a starting point, we will be pleased to talk with your local organization or group to discuss community health needs and ideas for community health improvement. For more information, please contact us at (contact information here) or visit our website at (web address here).

Thank you for creating a healthier community!