COMMUNITY HEALTH NEEDS ASSESSMENT

KENT COUNTY, DELAWARE

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Overview

The 2025 Community Health Needs Assessment (CHNA) for Kent County was conducted through a collaborative effort led by Bayhealth, in partnership with local health organizations and community stakeholders. The purpose of this assessment is to identify the county's health strengths, challenges and priorities to inform future health initiatives and guide resource allocation. Input was gathered from residents, healthcare clinicians and community-based organizations. This inclusive, community-driven approach ensures that the assessment accurately reflects the lived experiences, needs and priorities of those it serves.

Executive Summary

Introduction

Bayhealth is the largest healthcare system serving central and southern Delaware. The system includes:

- **Bayhealth Hospital, Kent Campus**
- **Bayhealth Hospital, Sussex Campus**
- **Freestanding Emergency Center, Smyrna**
- **Bayhealth Walk-in Medical Care, Blue Hen** in Dover
- **Bayhealth Total Care**, a comprehensive facility in Milton
- Numerous **satellite facilities** and **employed physician practices** offering a wide array of specialty services

Bayhealth is a technologically advanced, not-for-profit healthcare system supported by nearly 5,000 team members and over 500 clinicians.

Bayhealth is affiliated with **Penn Medicine** for Cardiothoracic Surgery and is a member of the **Penn Cancer Network**.

Fiscal Year 2024 Highlights

- **Emergency Department Visits**: 126,199
- **Inpatient Admissions**: 18,601
- **Births**: 2,249

Bayhealth Facilities Overview

Bayhealth Hospital, Kent Campus

- Location: Dover, Delaware

- Bed Count: 279
- Services: 24-hour emergency department, level III trauma center, cardiac care, cancer services and women's health

Bayhealth Hospital, Sussex Campus

- Location: Milford, Delaware
- Bed Count: 157 staffed beds
- Services: 24-hour emergency department, cardiac care, cancer services and women's health

Bayhealth Total Care, Milton

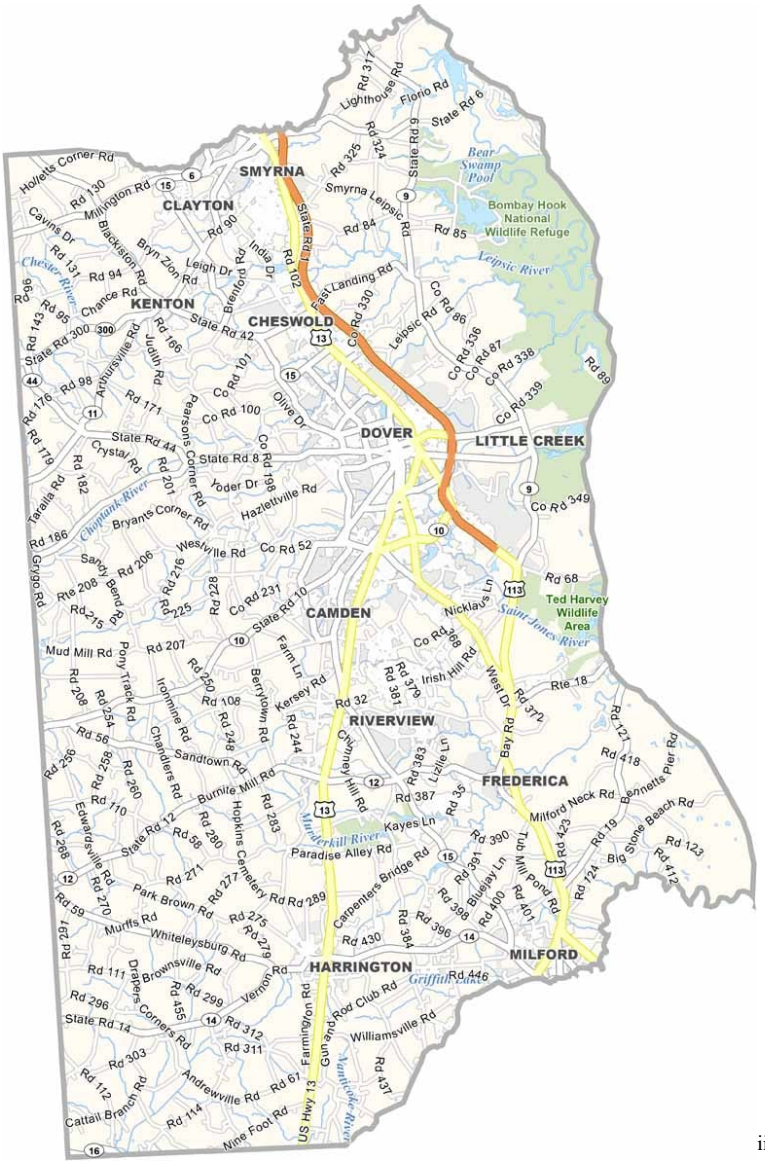
- Location: Milton, Delaware
- Features: Hybrid emergency and urgent care center, diagnostic and imaging services and a variety of specialty care including:
    - Primary care
    - Cardiology
    - Orthopedics
    - Neurosciences
    - Urology
    - Palliative care
    - Women's Services

For a complete list of Bayhealth locations, visit Bayhealth.org/Locations.

Kent County Demographics

Kent County is in central Delaware. According to the 2020 U.S. Census, the population was 181,851, making it the least populous county in the state. The county seat is **Dover**, which is also the capital of Delaware.[i]

- **2024 Estimated Population**: 192,690[ii]



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Racial and Ethnic Composition[iv]

- **White (non-Hispanic)**: 62.3%
- **Black or African American (Non-Hispanic)**: 30.1%
- **Two or More Races (Non-Hispanic)**: 4.3%

- **Asian (non-Hispanic)**: 2.4%
- **Hispanic or Latino (of any race)**: 8.3%

Citizenship Status[v]

- **U.S. Citizens**: 97.2%
- **Foreign-Born Residents**: 7.1% (Approximately 13,200 individuals)

Additional Demographic Indicators[vi]

- **Median Age**: 39 years
- **Total Households**: 66,720
- **Average Household Size**: 2.63 persons
- **2023 Median Household Income**: $72,872

Key Health Priorities Identified

Based on community input and a comprehensive data analysis, the following health priorities have been identified for Kent County:

1. **Access to Healthcare Services**
   Residents face challenges such as a shortage of healthcare clinicians limited access to specialized care and transportation barriers that impede timely and effective care.
2. **Mental Health and Substance Use Disorder**
   There is a rising demand for mental health and substance use services, particularly in underserved and rural communities. Enhanced access to behavioral healthcare and integrated treatment programs is essential.
3. **Chronic Disease Prevention and Management**
   The high prevalence of chronic conditions—such as diabetes, hypertension and obesity—underscores the need for targeted prevention efforts and improved disease management strategies.
4. **Maternal and Child Health**
   Kent County has a higher infant mortality rate compared to other parts of Delaware; Black and Hispanic infant mortality rates have increased in recent years. [vii]
   According to the CDC, Delaware has the third highest infant mortality rate in the United States and Kent County the highest within the State.[viii]
5. **Health Equity and Social Determinants of Health**
   Addressing disparities related to income, education, housing and other social factors is critical for achieving equitable health outcomes across all population groups.

6. **Children's Mental Health: A Growing Priority**
   Mental health emerged as a top concern for children and adolescents across the community. Stakeholders consistently cited rising levels of anxiety, depression, behavioral health challenges and lack of access to timely care as critical issues affecting youth.

Health Disparities in Delaware

Chronic Diseases are the leading causes of death nationally and in Delaware. Cardiovascular disease — including heart disease and stroke — is still the leading cause of death; cancer is second, followed by lung diseases and diabetes.[ix] According to Delaware Division of Public Health, tens of thousands of Delawareans live with a chronic disease and 10% of residents have multiple chronic conditions. Chronic diseases account for seven of the top 10 leading causes of death in Delaware and cost Delaware billions of dollars each year in health-related expenses.[x]

Social Determinants of Health

Bayhealth recognizes that social determinants of health (SDoH) have a profound impact on overall health, well-being and quality of life. These non-medical factors often contribute to health disparities and inequities across communities.

According to *Healthy People 2030*, SDoH fall into five key domains:

1. **Healthcare Access and Quality**
2. **Economic Stability**
3. **Education Access and Quality**
4. **Neighborhood and Built Environment**
5. **Social and Community Context**

Examples of social determinants include:

- Access to nutritious food and opportunities for physical activity
- Safe housing, reliable transportation and secure neighborhoods
- Exposure to racism, discrimination and violence
- Access to education, job opportunities and stable income
- Environmental factors such as clean air and water
- Language proficiency and literacy levels

Since 2021, Bayhealth has incorporated SDoH screening questions into the electronic medical record (EMR) system. These screenings assess patients' needs related to housing, transportation, finances, family and community support and personal safety.

In 2022, Bayhealth partnered with **Unite Delaware**, a coordinated care network connecting healthcare and social service providers. Through this shared technology platform, partners can send and receive secure electronic referrals to address patients' social needs and promote community health. This system is particularly valuable for care managers coordinating services across sectors.

Community Outreach

In recognition of increasing needs among vulnerable populations, Bayhealth established a **Community Outreach** Department in 2023.

The department is led by:

- **Vice President:** Amanda Bowie, MSM
- **Manager:** Carrie Hart, MA
- **Community Outreach and Events Specialist:** Kylie Frazer
- **Nursing Professional Development Specialist and Community Outreach RN:** Teresa (Terry) Towne, MSN, RN, NPD-BC, NE-BC

This strategic addition supports Bayhealth's mission to promote health equity and reflects the organization's long-term commitment to serving our community and meeting our neighbors where they are.

Key goals of the Community Outreach team include:

- Expanding engagement with vulnerable populations
- Strengthening systems that ensure equitable care
- Connecting individuals to both medical and social resources
- Increasing access to health education and screenings

The team collaborates with local churches and nonprofit organizations to raise awareness, improve access to services and address social determinants of health.

In Kent County, Bayhealth's community outreach includes strong partnerships with organizations such as Habitat for Humanity, HOPE Street Summer Events and major cultural events including HOLA Dover, the African American Festival, Dover PRIDE and the Caribbean Festival. Many individuals served through these collaborations face barriers to accessing primary care. To help close this gap, Bayhealth partnered with its **Graduate Medical Education (GME)** program to launch a **Street Medicine curriculum**, bringing on-site medical services directly to people experiencing homelessness.

Population Health

In November 2020, Bayhealth established a dedicated Population Health Department. Over the past five years, it has grown into a robust, multidisciplinary team that now serves thousands of patients across the community through the Bayhealth Medical Group.

The department is led by:

- **Vice President:** Dr. Lawrence Ward, MD, MPH, MACP
- **Medical Director:** Dr. Preeti Gupta, MD
- **Senior Director:** Lara Hudson, MSM, BSN, RN
- **Senior Managers:** Ashley Istenes, MSN, RN and Tasheema Heyliger, MSN, BSN, RN

Rooted in Bayhealth's mission of helping one life at a time and placing patients first, the Population Health team brings together licensed practical nurses, registered nurses, clinical educators, social workers, behavioral health clinicians and specialists in practice optimization and quality.

This team delivers high-quality, patient-centered care through a wide range of services, including:

- **Preventive care and annual wellness visits**
- **Mental health support**
- **Social needs assistance** (e.g., food insecurity, housing, transportation)
- **Chronic disease management** (e.g., heart failure, diabetes, hypertension)
- **Health disparities reduction**

Additionally, the department ensures alignment with insurance payor requirements and industry quality standards—such as cancer screening rates—across primary care services for over 28,000 patients.

Population Health also plays a vital role in supporting clinical staff and providers by offering clinical education, practice optimization and compliance resources.

Strategic partnerships across Delaware further extend the department's impact. Collaborators include the Health Literacy Council of Delaware, the Delaware Breast Cancer Coalition, the Food Bank of Delaware and many others.

By integrating clinical care with social, economic, environmental and behavioral health factors, the Population Health team is helping to transform the delivery of healthcare and improve outcomes across the region.

The 2025 Needs Assessment

The 2025 CHNA for Kent County, Delaware, was led by Bayhealth's Community Outreach team. Planning began in August 2024, when team members defined the scope of work and established a project timeline. The assessment focused on two key populations: (1) residents of Kent County and (2) community stakeholders, including organizations and professionals serving the region.

As part of the planning process, the team reviewed the 2022 Community Health Needs Assessment (CHNA) survey tools and collaborated with other Delaware hospital partners to incorporate standardized health literacy questions. This unified approach allows for a more comprehensive understanding of health literacy challenges across the state. By including the same questions in their surveys, all hospital systems in Delaware are now equipped to assess and compare health literacy needs at both local and statewide levels. Two distinct surveys were developed:

- **Community-at-Large Survey**
- **Community Stakeholder Survey**

While both surveys shared similar content, the differing perspectives of community members and stakeholders provided valuable insight and alternative interpretations of the data. A copy of the community-at-large survey and the stakeholder survey can be found in **Appendix A**.

How the Assessment was Conducted

Bayhealth's Marketing & Communications and Community Outreach teams worked collaboratively to develop a comprehensive communications strategy. The **community-at-large survey** was launched in **February 2025**, promoted primarily through digital channels and made available in **English, Spanish and Haitian Creole**.

Survey distribution methods included:

- Digital ads and social media (Bayhealth Facebook, LinkedIn, etc.)
- Bayhealth's internal and external websites
- Internal communications and newsletters
- Community email newsletters

To increase participation, respondents were offered the chance to enter a **gift card raffle**.

Multilingual postcards featuring QR codes linked to the survey were distributed at:

- Bayhealth medical offices

- Wellness and Occupational Health sites
- Bayhealth facility waiting rooms
- Community partner locations including the **Food Bank of Delaware**, **Westside Healthcare** and **La Red Health Center**

The **community stakeholder survey** was also launched in **February 2025** and distributed via email to:

- Healthcare providers
- Businesses and community organizations
- Churches
- City, county and state government entities
- Non-profit organizations

Email addresses were collected from a broad network of employees, members and organizational leaders. The email invitation included both the stakeholder survey link and a request to forward the community survey to additional contacts. All communications were available in English, Spanish and Haitian Creole to ensure inclusive participation. Two follow-up reminders were sent to encourage response.

Appendix A- Community Health Needs Assessment Results

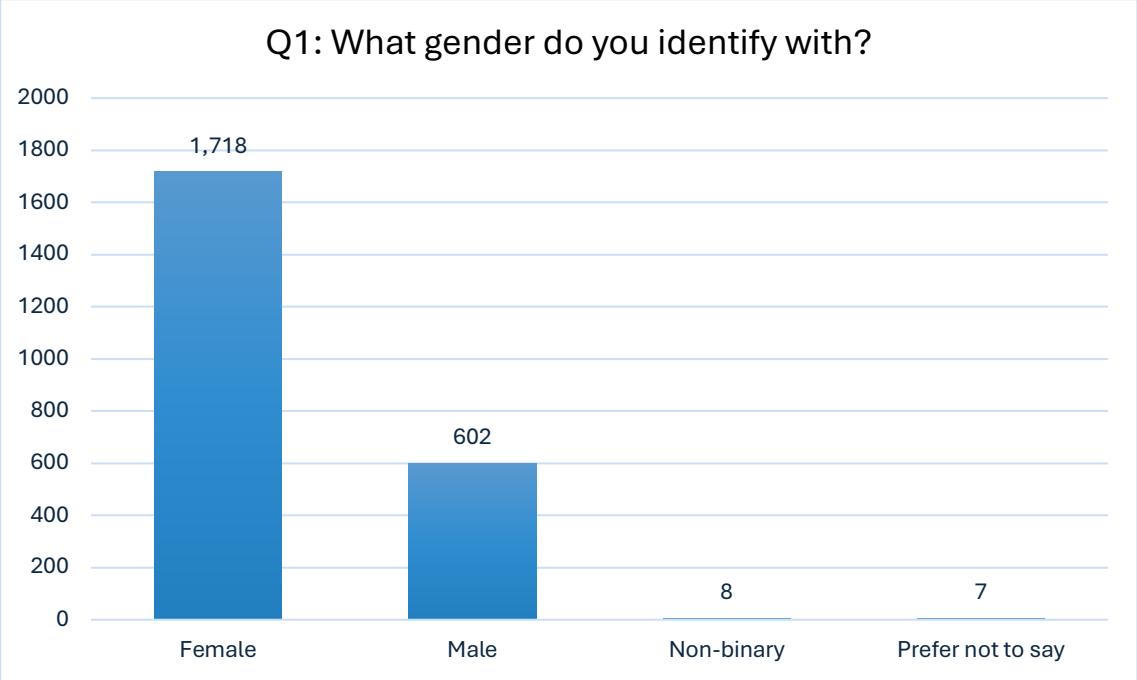
Community at Large Survey Results

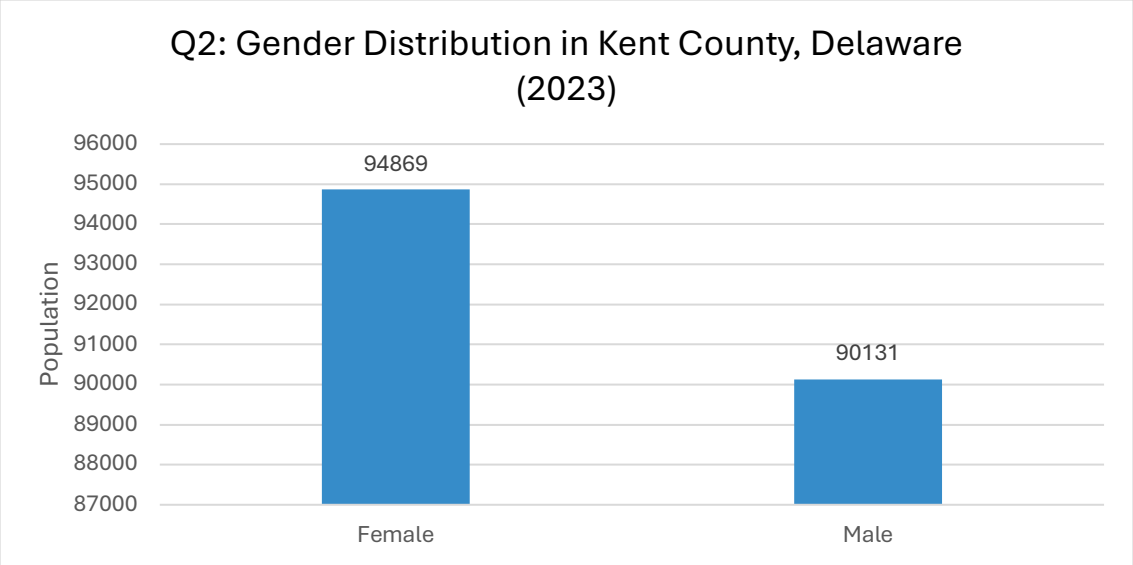
Federal law requires[xi] that tax-exempt hospital facilities conduct a CHNA every three years and adopt an Implementation Strategy that addresses significant community health needs. In Delaware, additional state-level expectations—such as alignment with the Delaware State Health Improvement Plan and collaboration with local stakeholders—reinforce the importance of using CHNAs to promote health equity, guide strategic investments and foster data-driven decision-making across sectors. For more detail on requirements and methodology, see Appendix B.

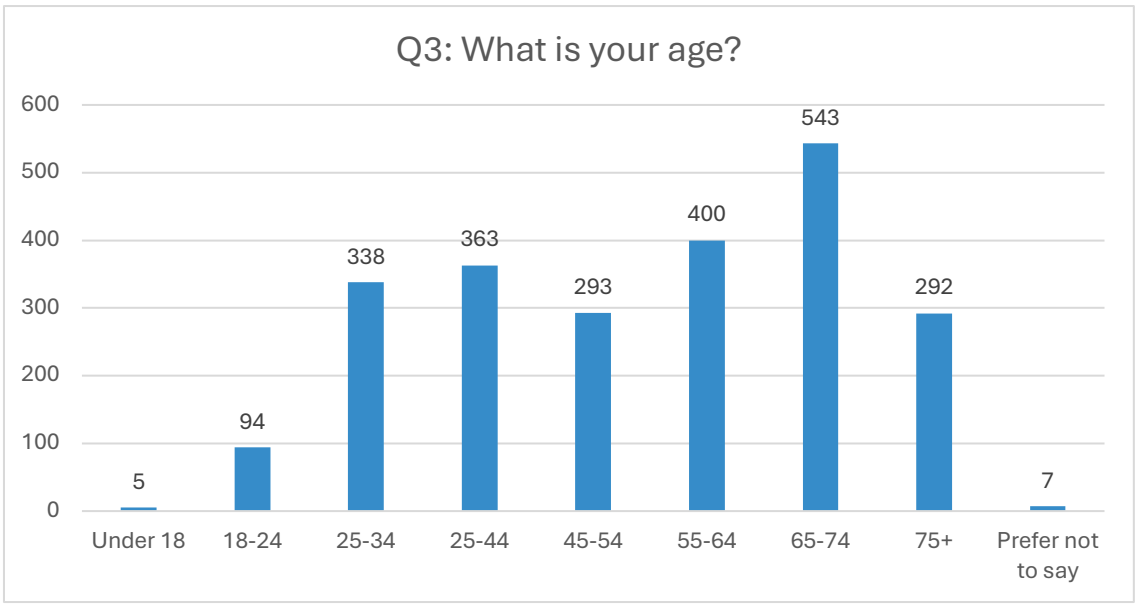
Survey Demographics and Representativeness

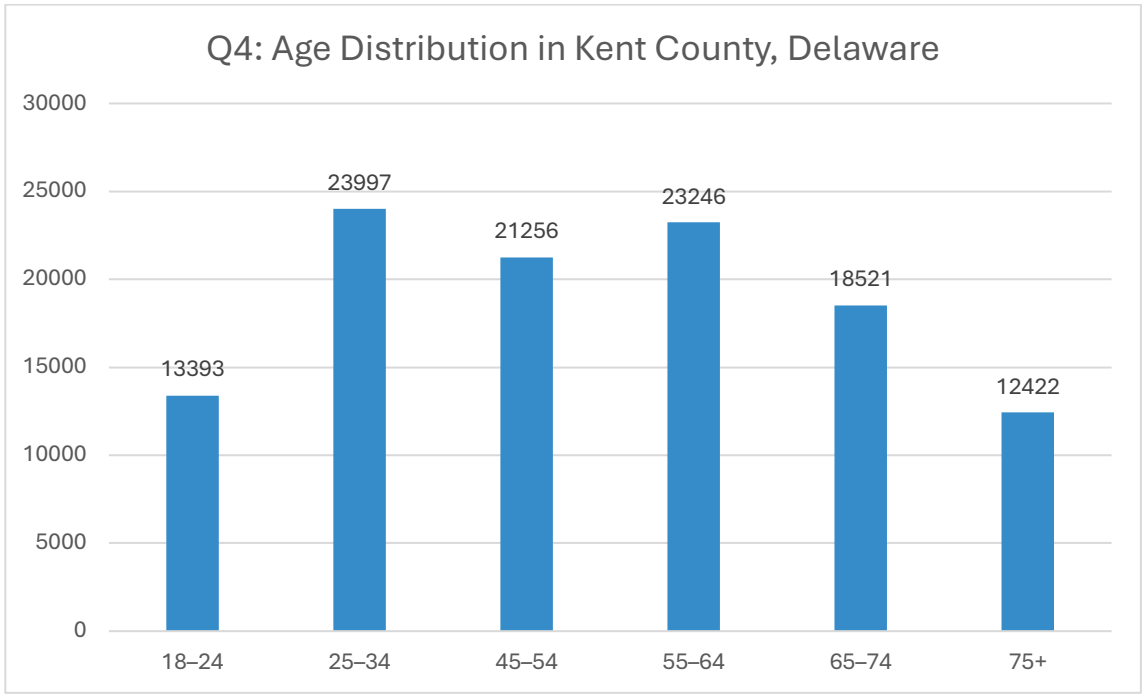
The community-at-large survey was structured using multiple-choice questions and garnered responses from **2,335 residents** of Kent County. To assess the representativeness of the survey sample, the first four demographic questions—**age, gender, ethnicity and education level**—are presented alongside corresponding data from the overall Kent County population. This comparison allows for a clearer understanding of how well the survey reflects the community's demographics and ensures the validity of insights drawn from the responses.

Detailed results from the community-at-large and stakeholder surveys are presented in the following section.


Q1: What gender do you identify with?
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1,718
602
8
7
Female
Male
Non-binary
Prefer not to say


Q2: Gender Distribution in Kent County, Delaware (2023)
Population
96000
95000
94000
93000
92000
91000
90000
89000
88000
87000
94869
90131
Female
Male


Q3: What is your age?
600
500
400
300
200
100
0
5
94
338
363
293
400
543
292
7
Under 18
18-24
25-34
25-44
45-54
55-64
65-74
75+
Prefer not to say


Q4: Age Distribution in Kent County, Delaware
30000
25000
20000
15000
10000
5000
0
13393
23997
21256
23246
18521
12422
18–24
25–34
45–54
55–64
65–74
75+

The age demographics of **Kent County, Delaware**—like much of the U.S.—are shifting in ways that will have significant implications for health care, the economy and community planning over the next 5, 10 and 20 years. [xii]

1. Aging Population: A Growing Senior Demographic

Trend:

Kent County's **65+ population is growing rapidly**, driven by longer life expectancies, aging Baby Boomers and the county's appeal as a retirement destination.

Implications by Timeline:

- **5 Years (2030):**
  Adults aged 65+ will make up a noticeably larger share of the population. Demand will increase for:
  - Geriatric care and chronic disease management
  - Home health services and long-term care facilities
  - Transportation and housing adapted for mobility and independence
- **10 Years (2035):**
  The county may begin to see a **retirement-to-working-age imbalance**, with more people leaving the workforce than entering it. This will place strain on:
  - The local healthcare workforce
  - Family caregivers
  - Public health and social service programs
- **20 Years (2045):**
  Seniors could comprise **1 in 4 residents** in Kent County. This will affect:
  - Medicaid and Medicare planning
  - End-of-life care and palliative services
  - Housing market shifts (e.g., downsizing, assisted living)

2. Shrinking Youth and Young Adult Population

Trend:

Birth rates are declining and young adults may increasingly move to larger metro areas for education or work, leading to a **smaller youth and young adult population**.

Implications by Timeline:

- **5–10 Years (2030-2035):**
  School districts may face declining enrollment, requiring potential **consolidation or redistricting**.

- **10–20 Years (2035-2045):**
  A shrinking base of working-age adults may limit local economic growth and make it harder to staff:
  - Schools
  - Healthcare facilities
  - Public safety roles

3. Multigenerational and Caregiver Strain

As the aging population grows and younger populations shrink or migrate, Kent County will likely see:

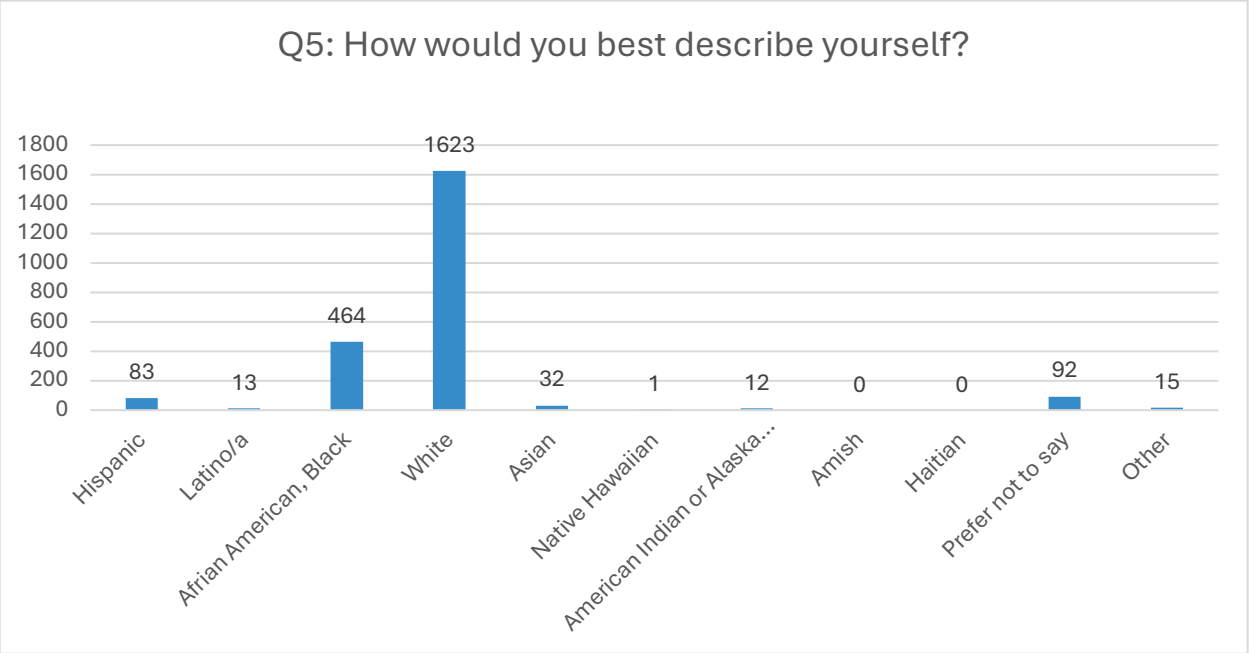
- More **multi-generational households**, as adult children care for aging parents
- Higher demand for **caregiver support services**, respite care and mental health resources
- Increased pressure on women (who often take on caregiver roles) to balance work and family

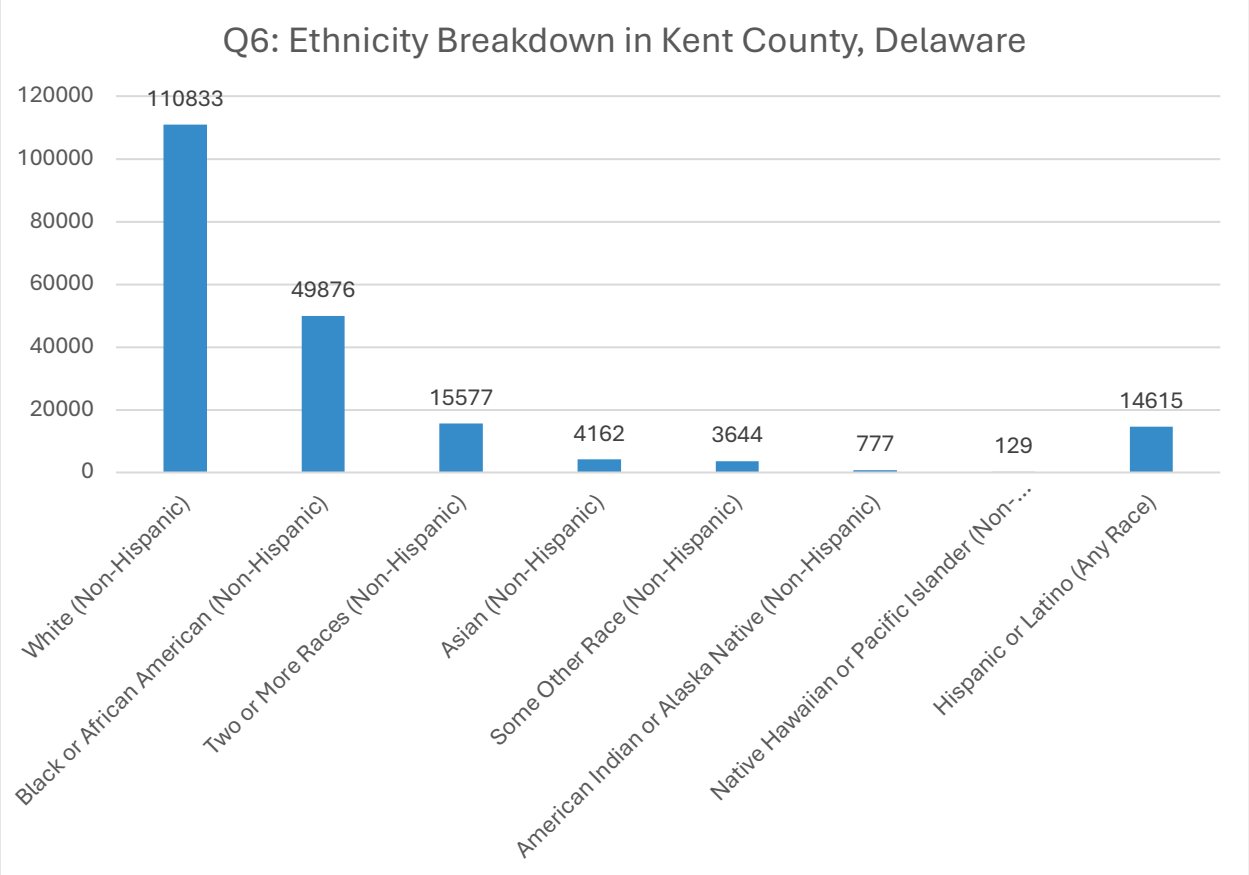
4. Health System Implications

- **Chronic Disease Burden Will Rise:**
  As the population ages, so will the prevalence of diabetes, heart disease, arthritis and dementia.
- **Preventive Care and Aging-in-Place Supports Will Be Crucial:**
  Expanding wellness programs, fall prevention and remote monitoring technology will be essential.
- **Behavioral Health Needs Will Grow:**
  Social isolation, depression and dementia-related conditions will become more prominent among seniors.

5. Equity and Access Concerns

- **Rural seniors** may face access barriers to care, transportation and nutritious food.
- Diverse communities, including **Black and Hispanic seniors**, may face higher chronic disease rates and lower access to culturally competent care.


Q5: How would you best describe yourself?
1800
1600
1400
1200
1000
800
600
400
200
0
83
13
464
1623
32
1
12
0
0
92
15
Hispanic
Latino/a
Afrian American, Black
White
Asian
Native Hawaiian
American Indian or Alaska...
Amish
Haitian
Prefer not to say
Other


Q6: Ethnicity Breakdown in Kent County, Delaware
120000
100000
80000
60000
40000
20000
0
110833
49876
15577
4162
3644
777
129
14615
White (Non-Hispanic)
Black or African American (Non-Hispanic)
Two or More Races (Non-Hispanic)
Asian (Non-Hispanic)
Some Other Race (Non-Hispanic)
American Indian or Alaska Native (Non-Hispanic)
Native Hawaiian or Pacific Islander (Non-...
Hispanic or Latino (Any Race)

Demographic Diversity in Kent County, Delaware

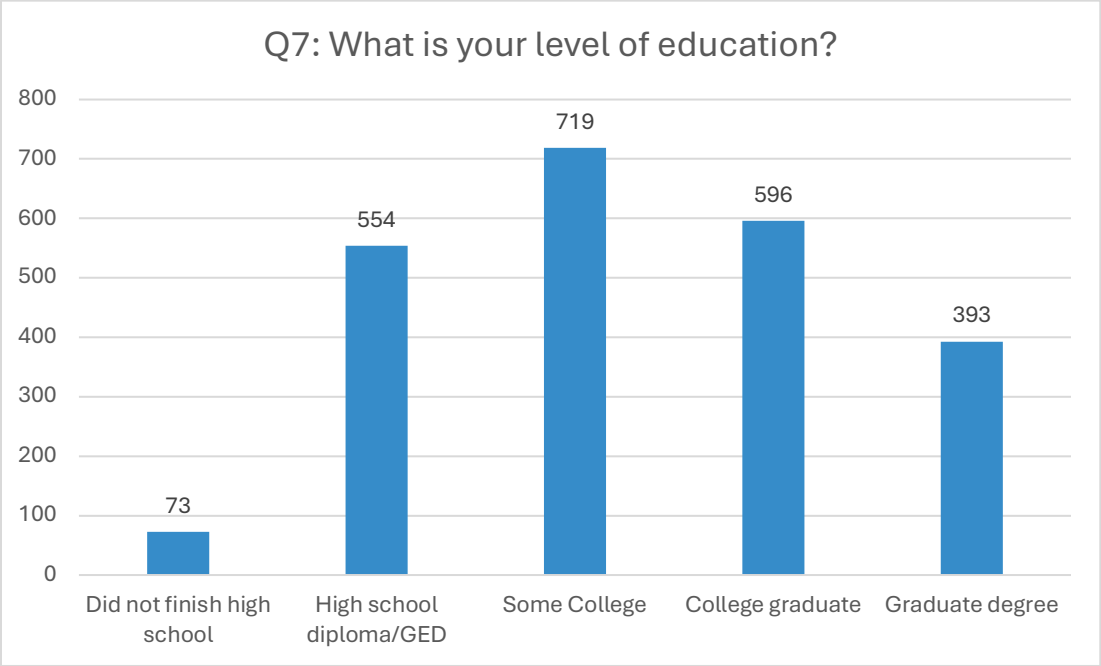
Kent County's demographic profile reflects a **moderately diverse and evolving community**, characterized by substantial representation from **White** and **Black or African American** populations, along with a **steadily growing Hispanic or Latino/a population**. This shifting demographic landscape carries important implications for how health services, community outreach and public policy are designed and delivered.

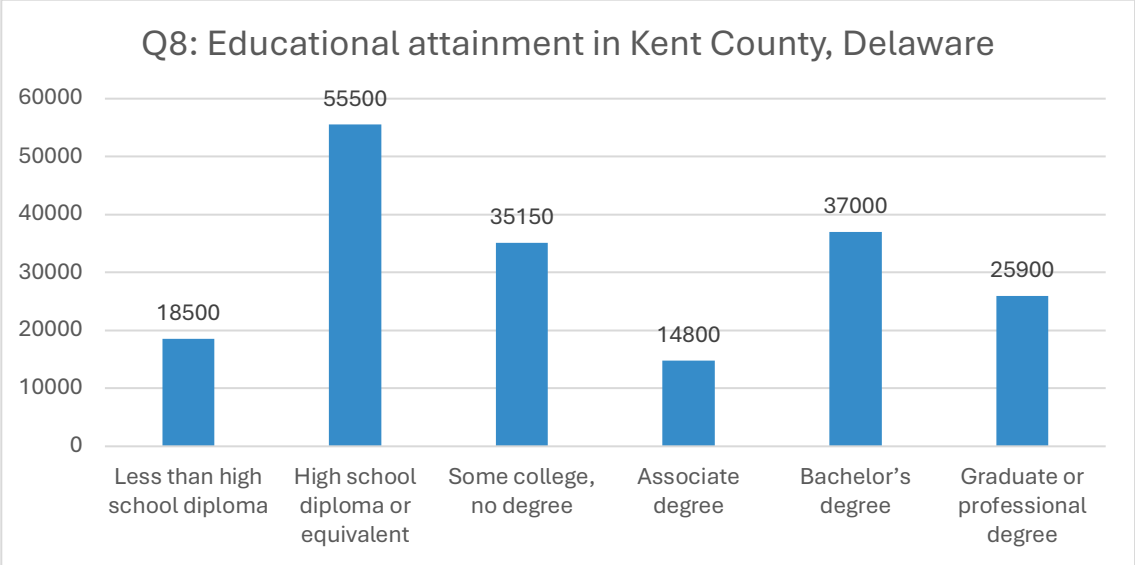
- According to the most recent data, **87.8%** of residents in Kent County identify as **Non-Hispanic or Latino/a**, while **8.3% identify as Hispanic or Latino/a**—a proportion that has been increasing over the past decade due to both migration and natural growth.[xiii]
- The largest subgroup within the Hispanic population in Kent County is of **Puerto Rican origin**, though there are also growing numbers of residents with Mexican, Dominican and Central American backgrounds.[xiv]

This data emphasizes the importance of developing and maintaining **linguistically and culturally appropriate services**, particularly in healthcare, education and social support programs. Language barriers, immigration status and cultural perceptions of care can all affect **health literacy**, **access to preventive care** and **willingness to engage with formal institutions**.

To address these disparities, Kent County stakeholders should prioritize:

- **Translation and interpretation services** in Spanish and other commonly spoken languages.
- **Bilingual and bicultural staff** in clinics, schools and community organizations.
- **Targeted outreach and education** that reflects cultural values, practices and communication preferences.
- **Partnerships with trusted community leaders and organizations** within the Hispanic/Latino/a community to co-design programs and build trust. Ensuring equity in service delivery for Hispanic or Latino/a populations is not only a matter of compliance with federal standards (e.g., Title VI of the Civil Rights Act)—it is a critical step toward **eliminating health disparities**, building stronger communities and improving outcomes across the county.





[1]

These figures suggest that while a significant portion of Kent County's adult population has attained at least a high school education, there is room for growth in higher education attainment levels.[xv]

[1] This bar chart presents the estimated number of people in Kent County, Delaware, based on their highest level of educational attainment. The total county population used for this estimate is approximately **185,000**.

Key Insights:

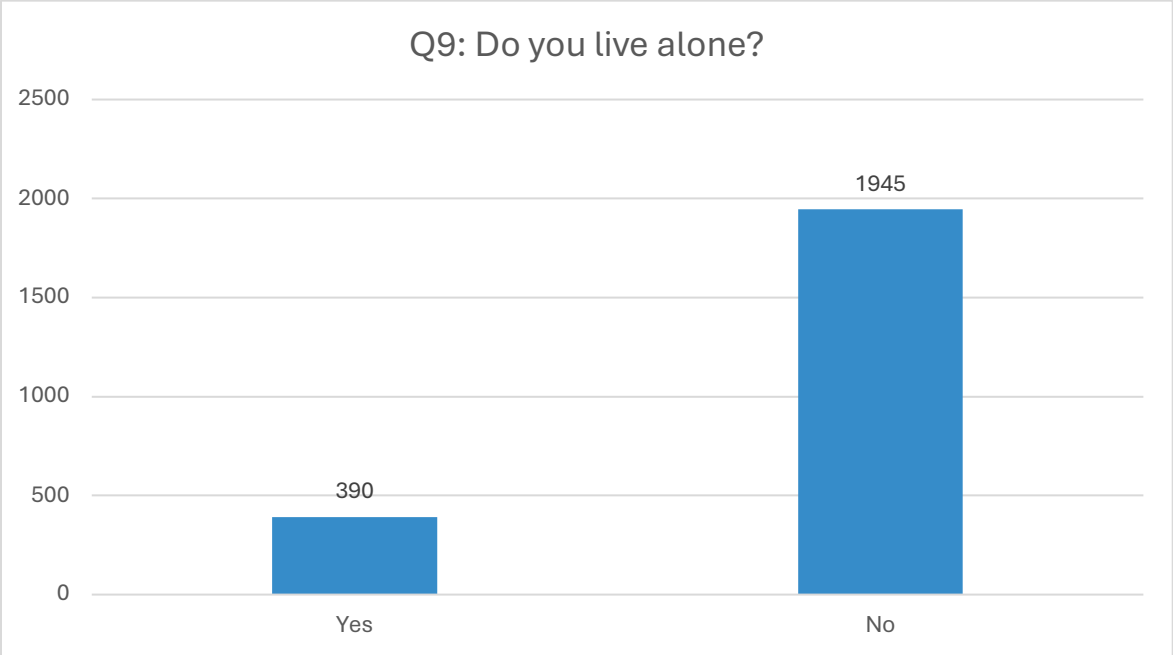
- About **18,500** people have **less than a high school diploma**, highlighting the need for continued adult education and literacy efforts.
- **High school diploma or equivalent** is the most common level of education, with **55,500** individuals—representing the largest single group.
- **Associate degrees** are held by **14,800** individuals.
- **Some college, no degree** includes **35,150** people, indicating a significant portion of the population has pursued higher education but not completed a degree.
- **Bachelor's degree** holders make up **37,000** of the population, while **graduate or professional degree** holders account for **25,900**.

Implications:

This educational profile helps inform public health communication, workforce development and community outreach strategies.

For example:

- **Health literacy materials** should accommodate varying education levels.
- Programs targeting chronic disease management and preventive care may need tailored approaches for populations with lower educational attainment.
- Economic and training initiatives could benefit from expanding access to postsecondary credentials and adult education.



Living alone can pose several health risks—both physical and mental—particularly for older adults and individuals with limited social support. These include:

1. Mental Health Risks

- **Loneliness and Social Isolation:**
  People living alone are at increased risk of chronic loneliness and isolation, which are linked to depression, anxiety and cognitive decline.
- **Depression:**
  Lack of daily social interaction can lead to or worsen depressive symptoms, particularly among the elderly or those with preexisting mental health conditions.
- **Cognitive Decline:**
  Studies suggest that individuals who live alone—especially those who are socially isolated—may have a higher risk of developing dementia or Alzheimer's disease.

2. Physical Health Risks

- **Delayed Medical Attention:**
  In emergencies such as falls, strokes or heart attacks, individuals living alone may experience delays in receiving help, leading to worse outcomes.
- **Chronic Disease Management:**
  People living alone may struggle with managing conditions like diabetes or hypertension without daily support or reminders, which can lead to complications.

- **Nutrition and Physical Activity:**
  Individuals who live alone may have poorer diets and are less likely to prepare nutritious meals or engage in regular physical activity, contributing to malnutrition, weight gain or other health issues.

3. Higher Mortality Risk

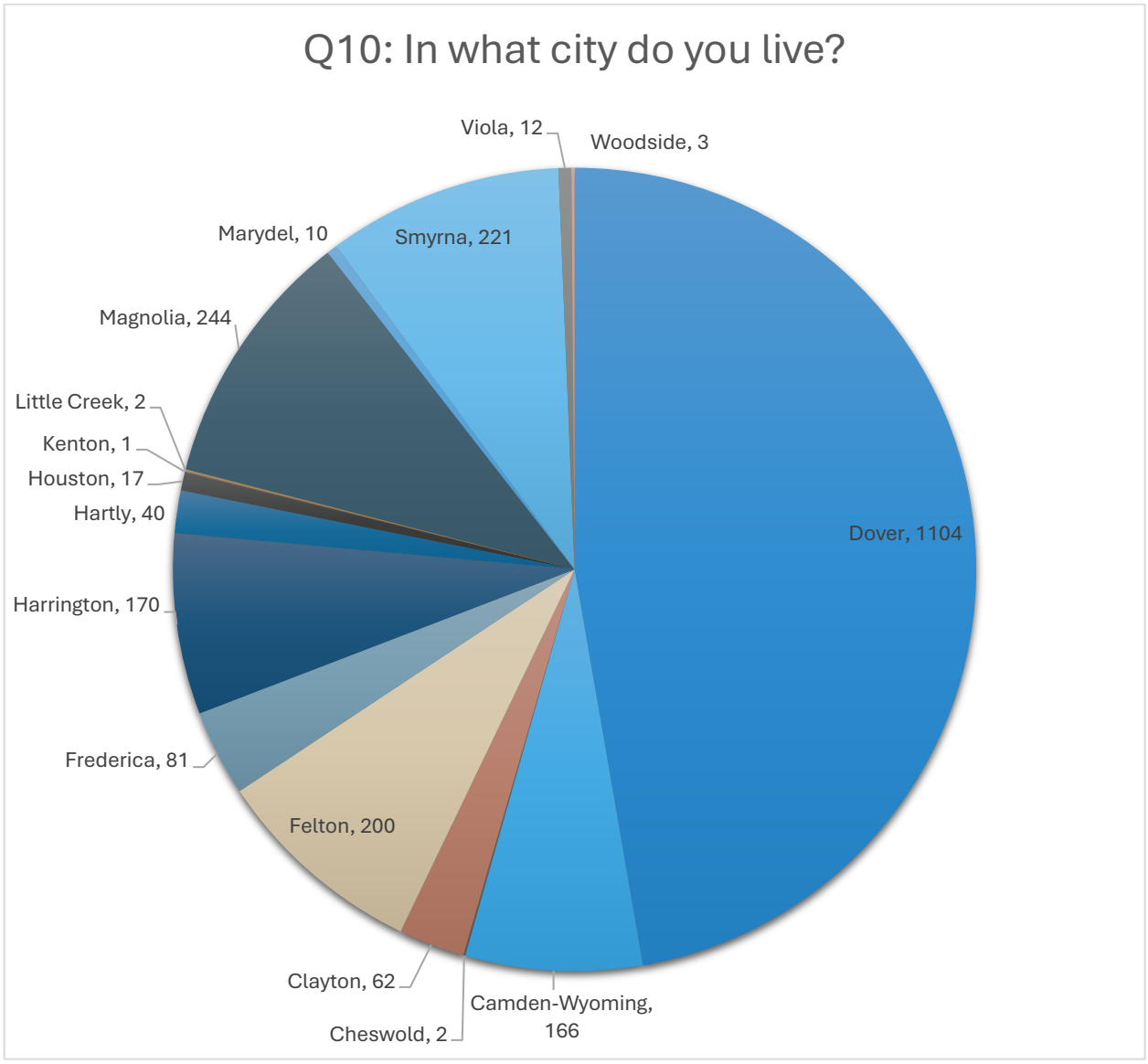
- Several studies have found that living alone is associated with a higher risk of premature death. This is partly due to the compounded effects of isolation, unmanaged chronic conditions and mental health issues.

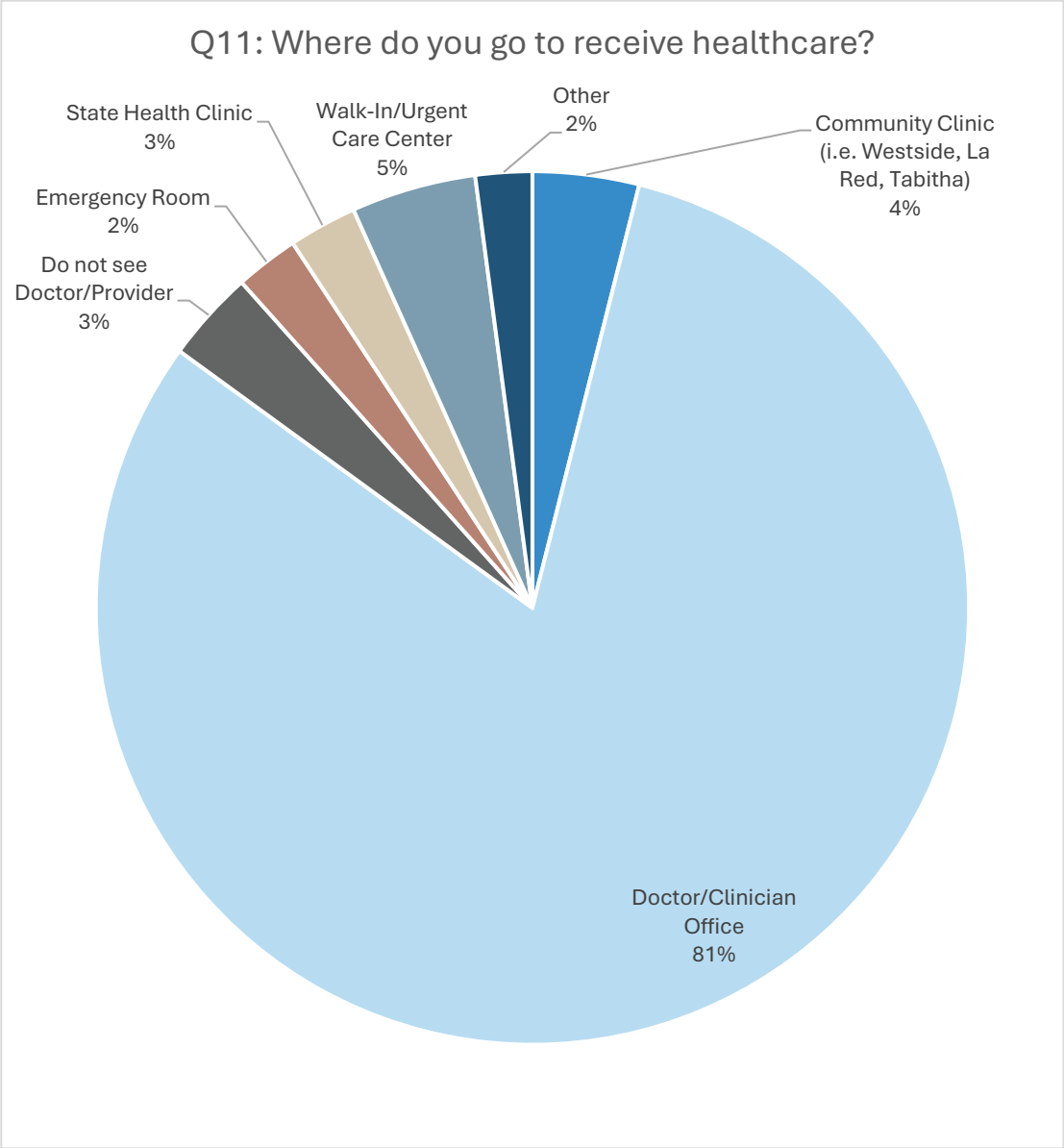
4. Increased Use of Emergency Services

- People living alone tend to use emergency services more frequently due to lack of regular care or preventive support. They may also lack transportation or access to primary care, relying more heavily on emergency departments.

Protective Factors and Interventions

- **Technology Aids:** Medical alert systems, telehealth and remote monitoring can help mitigate some risks.
- **Community Programs:** Social groups, senior centers and community health worker (CHW) programs can provide connection and support.
- **Regular Check-ins:** Family, neighbors or volunteers can check in regularly, improving both safety and well-being.
- **Home Modifications:** Fall prevention modifications and accessibility improvements can reduce physical risk.


Q10: In what city do you live?
Viola, 12
Woodside, 3
Marydel, 10
Smyrna, 221
Magnolia, 244
Little Creek, 2
Kenton, 1
Houston, 17
Hartly, 40
Dover, 1104
Harrington, 170
Frederica, 81
Felton, 200
Clayton, 62
Cheswold, 2
Camden-Wyoming, 166



Where you go for healthcare absolutely impacts your health outcomes over time. The type of setting you use (e.g., primary care doctor, urgent care, emergency room or community clinic) influences everything from the **continuity and quality of care** to **cost, trust and health outcomes**.[xvi]

1. Primary Care vs. Emergency or Urgent Care

Primary Care (Best for Long-Term Health)[xvii]

- **Continuity:** Ongoing relationship with a clinician who knows your history
- **Preventive care:** Screenings, immunizations and early detection of disease
- **Chronic disease management:** Regular monitoring and coordinated care

- **Lower costs:** Routine visits are less expensive than emergency care
- **Better outcomes:** Strong links to reduced hospitalizations and longer life expectancy

Long-term use of primary care is linked to better health outcomes, fewer complications and higher patient satisfaction.

Emergency Room (ER)

- **Appropriate for true emergencies** (e.g., chest pain, trauma, difficulty breathing)
- **Not designed for continuity or chronic disease management**
- **Higher cost** and **limited follow-up**

Repeated ER use for non-emergencies often reflects gaps in access to primary care and leads to fragmented, reactive care.[xviii]

Urgent Care/ Walk-in

- Useful for after-hours or non-life-threatening issues (e.g., minor infections, sprains)
- Typically, **does not provide follow-up or comprehensive care**
- Better than the ER for convenience, but not a substitute for a medical home

Frequent reliance on urgent care can delay diagnosis of complex or chronic issues.

2. Community Health Centers or Clinics[xix]

- Offer **accessible, sliding-scale care** for underserved populations
- Provide **integrated services**, including dental, behavioral health and case management
- Can serve as a **medical home** for people without private providers

When well-resourced, clinics support strong outcomes and reduce ER dependence.

3. Specialty Care Without Coordination

- Seeing specialists without coordination from a primary care provider can lead to:
  - **Duplicated tests**
  - **Conflicting treatments**
  - **Poor communication** between clinicians

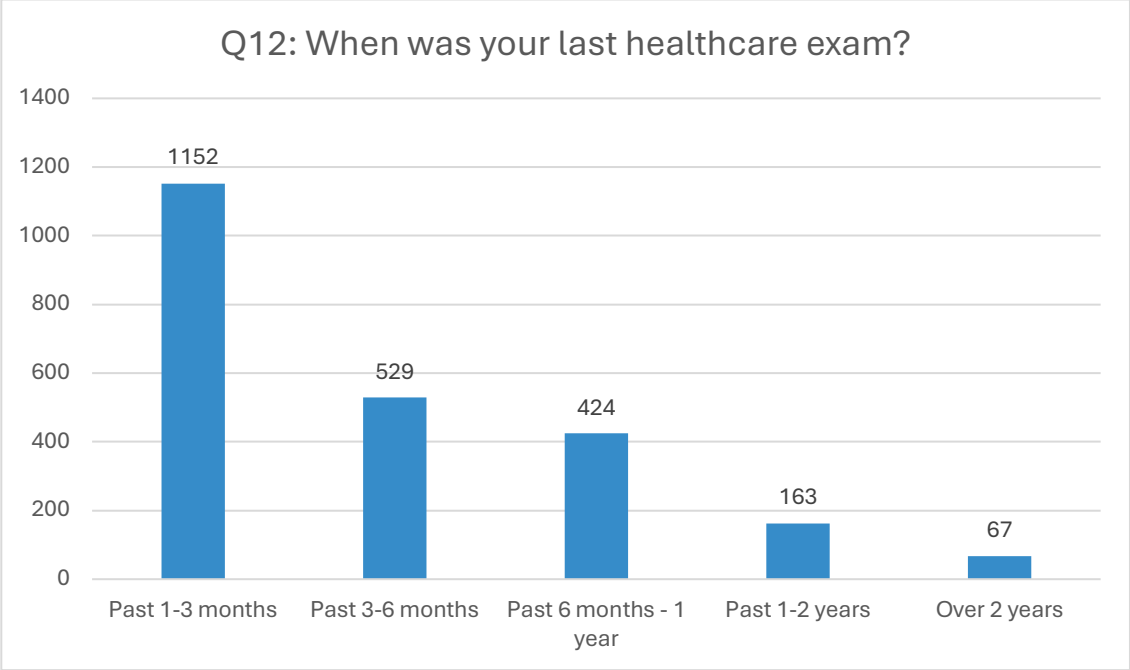
Coordinated referrals through primary care are safer and more effective.

Public Health Implications

- Overuse of ERs for non-emergencies strains the system and drives up costs.
- Underuse of preventive care leads to late diagnoses and worse outcomes.
- Disparities in access (transportation, insurance, language) impact where people go—and how their health is managed.

Conclusion

Where you go for care shapes the kind of care you receive and over time, this affects your health, finances and quality of life. Establishing a relationship with a primary care provider or a consistent medical home is one of the most important steps people can take toward better long-term health.



Timely healthcare—receiving medical attention at the right time—is essential for maintaining health, improving outcomes and reducing healthcare costs. Delays in care can lead to worsening health conditions, higher risk of complications and increased use of emergency services.

1. Prevents Disease Progression

- **Early diagnosis** allows for prompt treatment, which can stop or slow the progression of many conditions such as cancer, diabetes or heart disease.
- Chronic diseases are more manageable when identified early, reducing the risk of severe complications and hospitalizations.

2. Improves Health Outcomes

- **Faster treatment** for acute conditions (e.g., infections, injuries or strokes) can dramatically improve recovery and reduce long-term damage.
- **Timely prenatal care** improves outcomes for both mothers and babies by detecting and addressing risks early in pregnancy.

3. Reduces Emergency Room and Hospital Use

- When patients delay care, conditions can worsen, leading to more expensive and intensive treatments.
- Timely access to **primary care and preventive services** helps avoid unnecessary ER visits and hospital admissions.

4. Enhances Quality of Life

- Proactive management of conditions means less time spent in pain, fewer missed days of work or school and a higher overall quality of life.
- People are more likely to maintain their independence, particularly older adults, when their health issues are addressed promptly.

5. Saves Lives

- In emergencies such as heart attacks, strokes or severe infections, **every minute counts**. Timely intervention can mean the difference between full recovery and long-term disability—or between life and death.

6. Supports Health Equity

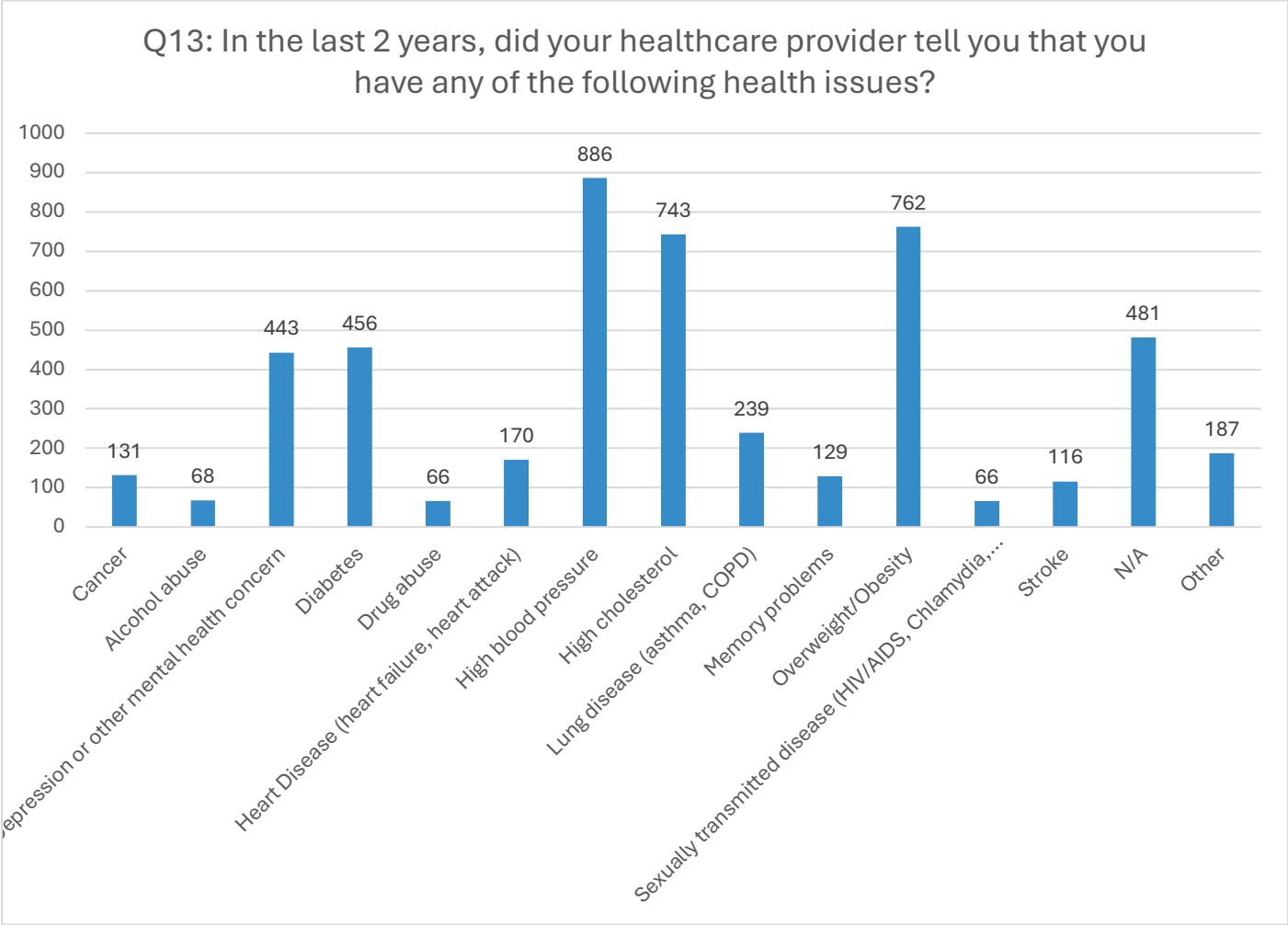
- Ensuring all individuals—regardless of income, race, geography or insurance status—have timely access to care helps close health disparity gaps and promotes community well-being.

Key Enablers of Timely Care:

- Accessible primary care
- Efficient care coordination

- Transportation services
- Insurance coverage
- Health literacy and navigation support
- Technology (e.g., telehealth, patient portals)

Timely healthcare isn't just about speed—it's about ensuring the **right care at the right time** to improve lives and create a healthier, more equitable community.



When your physician raises a medical concern, it's not just routine—it's a critical opportunity to protect your health. Ignoring or dismissing these concerns can delay diagnosis, worsen conditions and limit treatment options. Here's why paying close attention matters:

1. Physicians Spot Problems Early

Doctors are trained to detect warning signs that may not feel serious to you yet. Something as simple as a blood pressure reading, lab result or symptom pattern can point to early stages of a serious condition like:

- Heart disease
- Diabetes
- Cancer
- Depression or anxiety

Early detection = more treatment options + better outcomes.

2. Ignored Issues can Worsen Quickly

A concern your physician brings up today might be manageable now—but if ignored, could escalate into a more complex or life-threatening problem. For example:

- Ignoring mild chest discomfort could lead to a heart attack.
- Dismissing a high blood sugar level could lead to nerve or kidney damage.

3. Your Doctor has a Broader Perspective

Your physician considers your full medical history, lab results, medications and risk factors. They may recognize patterns or red flags that aren't obvious to you—and that's exactly why you go to them.

4. It Builds Trust and Shared Responsibility

Listening to your doctor's concerns shows you're invested in your health. It creates a partnership, where you both work toward the same goal: helping you live a longer, healthier life.

5. Missed Follow-Up can have Consequences

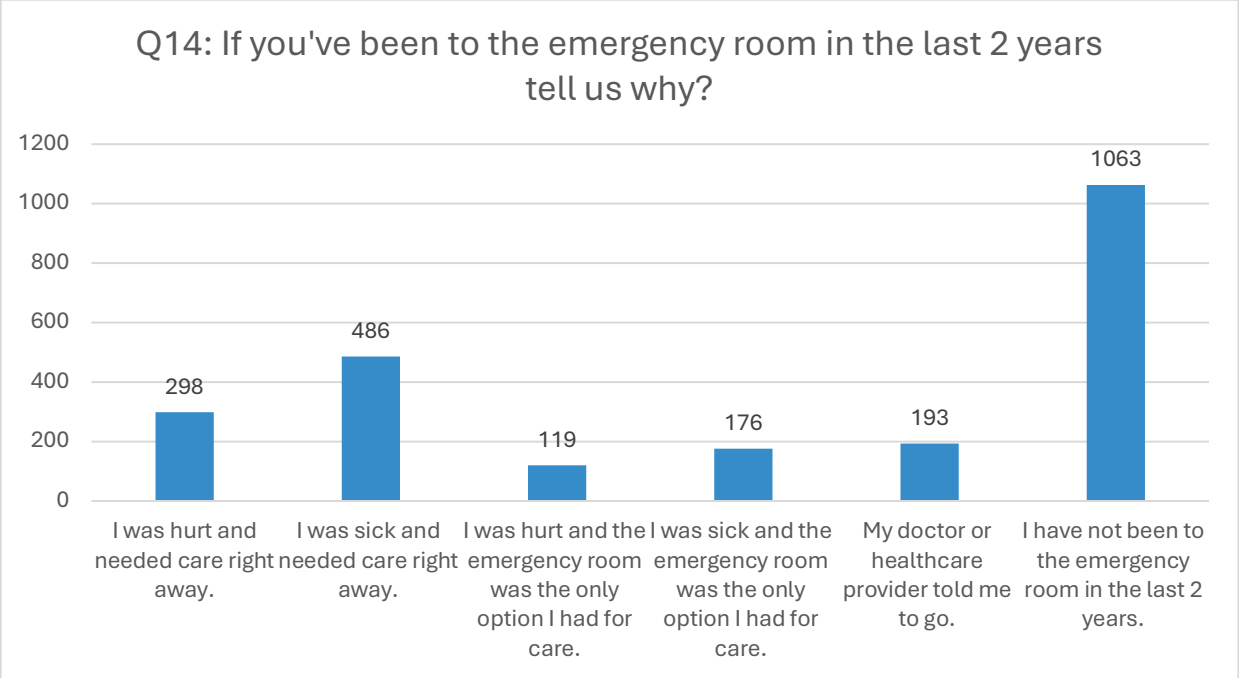
If your doctor recommends additional tests, referrals or lifestyle changes, it's because there's a valid reason. Not following through may:

- Miss a diagnosis
- Lead to a medical emergency
- Delay care that could improve or save your life

What You Can Do:

- Ask questions if you don't understand something.
- Take notes or bring someone with you to appointments.
- Follow through on labs, imaging or referrals.
- Be honest about your symptoms, habits and concerns.

Bottom line:
Your doctor's concern is not just medical—it's personal. Listening carefully and taking action can make a big difference in your health, both now and in the future.



Understanding emergency room (ER) usage trends is crucial for improving healthcare systems, reducing unnecessary costs and ensuring patients receive the right level of care at the right time. Below is a summary of current and emerging trends in ER usage:

1. Rising Overall Use of Emergency Services

- **ER visits have been increasing** steadily in many regions, driven by a combination of population growth, aging demographics and limited access to timely primary care.
- Older adults and individuals with chronic conditions make up a significant share of repeat ER visits.

2. Increase in Preventable and Non-Emergent Visits

- A significant proportion of ER visits are for **non-emergent or preventable conditions**, such as minor infections, medication refills or chronic disease flare-ups.
- Common reasons include:
  - Lack of insurance or access to primary care
  - Inability to get same-day appointments
  - Transportation barriers

3. Behavioral Health-Related Visits Are Climbing

- **Mental health and substance use crises** are a growing reason for ER visits, particularly since the COVID-19 pandemic.
- Many communities lack enough behavioral health providers, leading individuals in crisis to seek help at emergency departments.

4. Disparities in ER Utilization

- Low-income individuals, racial/ethnic minorities and rural residents tend to rely more heavily on the ER.
- These trends reflect broader inequities in healthcare access, affordability and SDoH.

5. Impact of COVID-19 on ER Trends

- During early phases of the pandemic, ER usage dropped dramatically as people avoided hospitals.
- Post-pandemic, usage rebounded, especially for **mental health**, **long COVID** and **delayed care complications**.

6. Shift Toward Alternative Models of Care

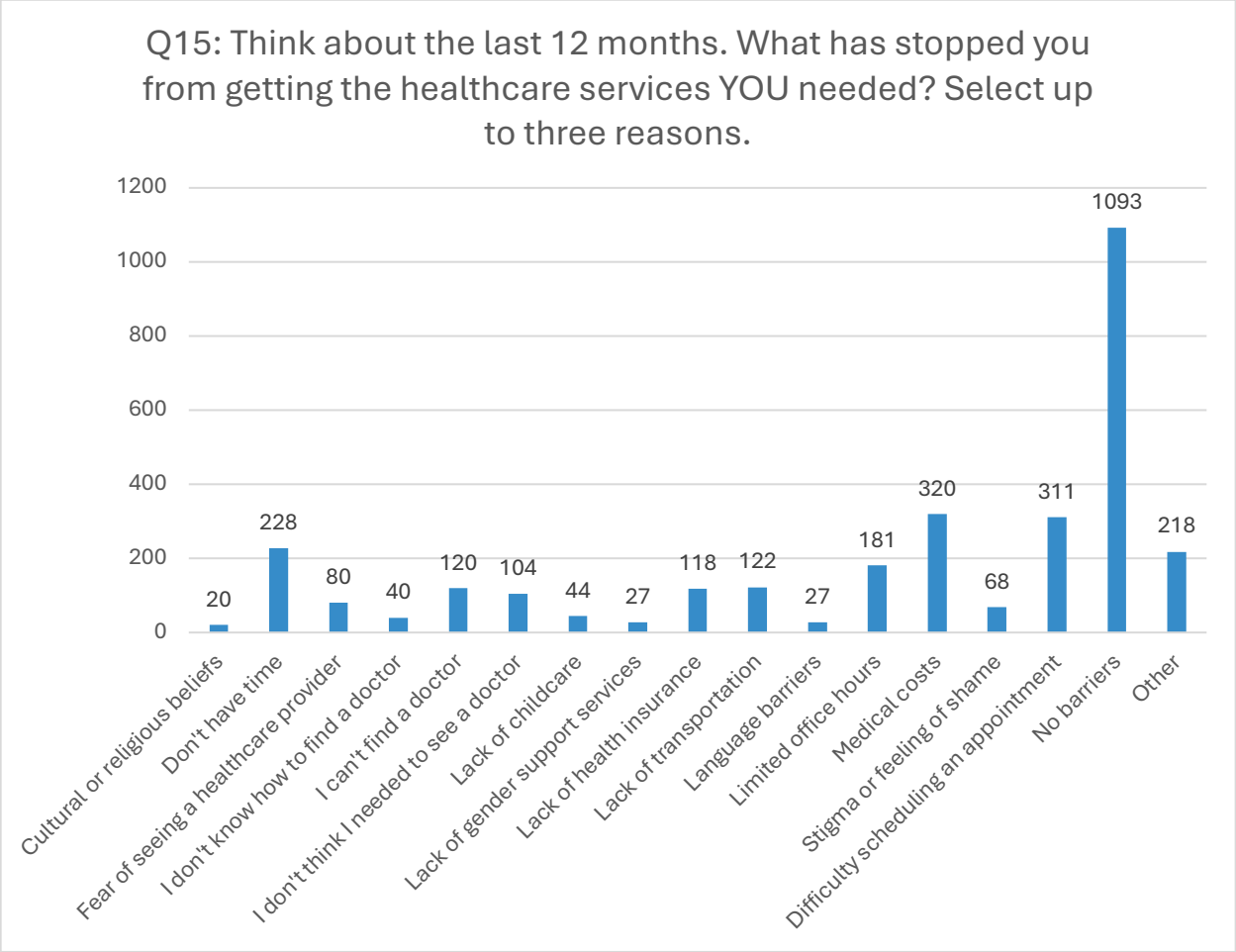
- To reduce unnecessary ER use, healthcare systems, such as Bayhealth, are investing in:
  - **Urgent care centers**
  - **Telehealth visits**
  - **Care navigation and chronic care management**
- **Community Health Workers (CHWs)** and case managers play a growing role in diverting patients to appropriate levels of care.

7. Frequent Users ("Super-Utilizers")

- A small percentage of patients—often with complex medical and social needs—account for a large portion of ER visits.
- Programs targeting these individuals with wraparound support services have shown success in reducing overuse.

Conclusion

Trends in ER usage highlight both challenges and opportunities for the healthcare system. By improving access to primary and behavioral care, investing in social supports and using data to identify at-risk populations, health systems can reduce unnecessary ER use and improve overall community health outcomes.



Despite advances in medical technology and healthcare delivery, many people still face significant barriers to accessing timely and appropriate care. Among the most common and impactful barriers are the **cost of care**, **difficulty scheduling appointments** and **lack of time**.

1. Cost of Medical Care

Why It's a Barrier:

- Even with insurance, many patients face **high deductibles, copays or uncovered services**.
- **Uninsured individuals** are significantly more likely to delay or forgo care entirely.
- The cost of prescriptions, imaging and specialist visits can make routine healthcare **financially inaccessible** for low- and middle-income families.

Impact:

- Delays in care due to cost often lead to **worsening conditions** and increased emergency room use.
- People may skip necessary treatments, tests or follow-up visits due to affordability concerns.

2. Difficulty Scheduling Appointments

Why It's a Barrier:

- Long wait times to see primary care or specialty clinicians are common, especially in underserved areas.
- Many clinicians have **limited office hours**, with few options for evenings or weekends.
- Complex phone systems, lack of online scheduling and overbooked practices can discourage patients from seeking care.

Impact:

- Patients may go without necessary follow-up, preventive screenings or chronic disease management.
- Delayed access can result in **avoidable hospitalizations** or deterioration of health.

3. Lack of Time

Why It's a Barrier:

- Work schedules, caregiving responsibilities and transportation logistics make it difficult for many people to fit in medical appointments.

- People working hourly or multiple jobs may not have **paid time off**, making time away for a doctor's visit financially risky.

Impact:

- Health becomes **a lower priority** when daily survival or income is at stake.
- Conditions go unmanaged and preventive care is often neglected, increasing long-term health risks.

Combined Effects

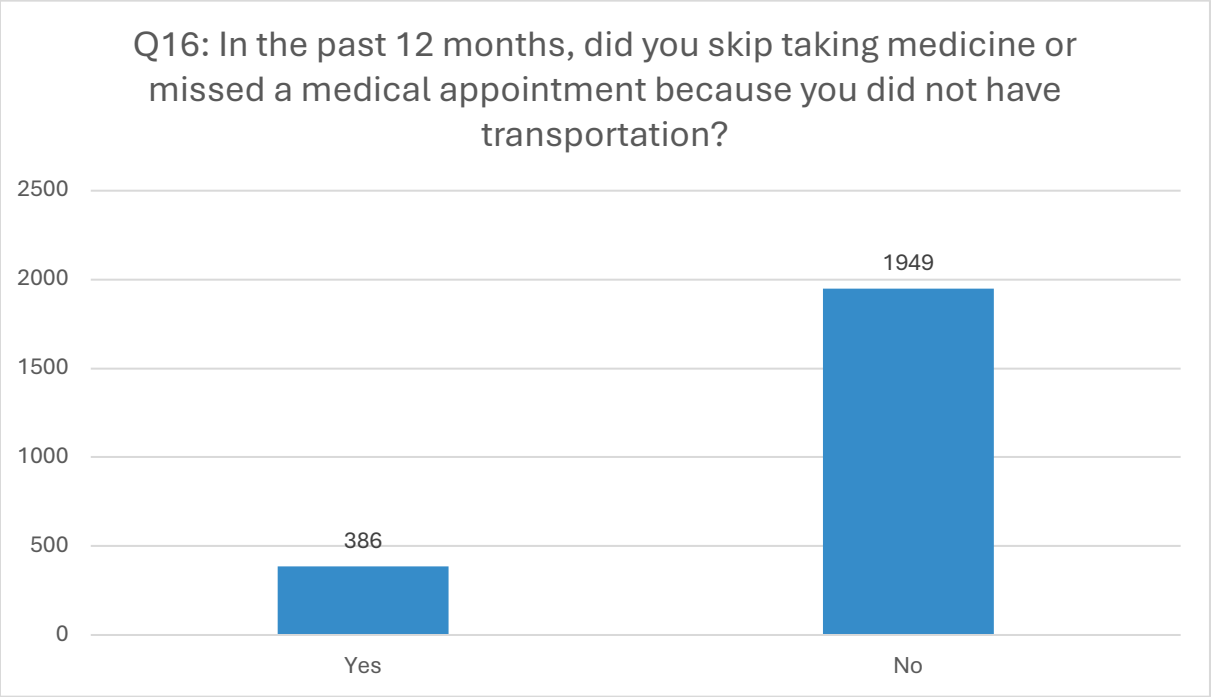
These barriers often intersect. For example:

- A person may avoid scheduling a visit due to cost concerns, only to find that the earliest available appointment is weeks away and they can't take time off work when it finally arrives.
- The result is a system where **reactive care** (emergency room visits, hospital admissions) is overused while **proactive care** (check-ups, screenings, chronic care) is underutilized.

Solutions and Interventions

- **Sliding scale clinics** and community health centers, such as Westside and La Red, reduce cost burdens.
- **Telehealth and mobile health services** increase flexibility and convenience.
- **Extended hours and walk-in clinics** help people who can't attend during the workday.
- **Care navigators, CHWs and patient portals** make it easier to book and keep appointments.

Conclusion:
Addressing these barriers—especially affordability, appointment accessibility and time constraints—is essential to creating a healthcare system that works for everyone, not just those with resources and flexibility. Reducing these obstacles improves health equity, outcomes and patient satisfaction.



Access to reliable transportation is a critical SDoH. In Kent County, Delaware—where rural geography, limited public transit options and economic disparities intersect—lack of transportation remains a significant barrier to medical care. This issue disproportionately affects low-income residents, seniors, individuals with disabilities and those living in remote or underserved areas.

Why Transportation Matters

1. Medication Adherence

Missing doses or not filling prescriptions due to transportation issues can lead to:

- Poor management of chronic conditions like diabetes, hypertension or heart disease
- Increased hospitalizations and ER visits
- Higher risk of complications and preventable deaths

Even short-term lapses in medication—especially for mental health, cardiovascular or infectious diseases—can have serious health consequences.

2. Missed Medical Appointments

Without reliable transportation, patients may:

- Miss routine check-ups, follow-up visits or lab work
- Delay diagnosis and treatment of worsening conditions

- Be unable to access specialty care, particularly in rural parts of Kent County

In Kent County, where many residents live outside of the city of Dover and lack access to frequent bus service, this can lead to health disparities—especially among residents who are elderly, low-income or managing multiple chronic illnesses.

Local Context: Kent County, Delaware

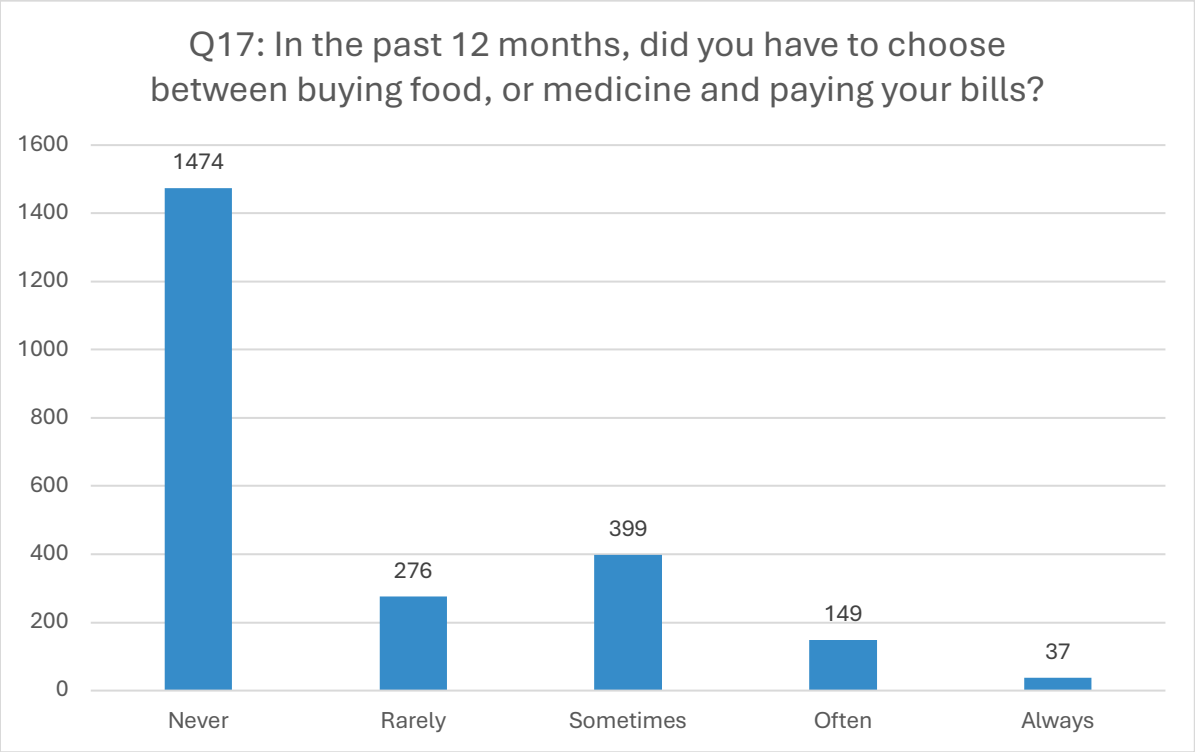
- **DART First State** offers public transit, but coverage and frequency are limited outside of Dover.
- Many health services are concentrated in a few areas, requiring long travel distances for rural residents.
- Seniors and people without access to a personal vehicle often rely on friends, family or community agencies—if those are even available.
- Missed care due to transportation barriers contributes to **avoidable ER usage**, which increases costs and reduces continuity of care.

Potential Solutions and Resources

- **Bayhealth Community Outreach** and **Population Health teams** connect patients to transportation resources when available.
- **Unite Delaware** allows providers to refer patients to social services, including transportation assistance.
- **Non-emergency medical transportation (NEMT)** services are available for Medicaid recipients, but these require advance scheduling and are not always reliable.
- Expanding **mobile health units** and **telehealth** can help mitigate some access issues.

Conclusion

Skipping medication or missing doctor appointments due to lack of transportation is not just a personal inconvenience—it's a public health issue that affects the entire community. In Kent County, addressing transportation barriers is vital to improving health equity and reducing preventable illness. Expanding partnerships, leveraging technology and funding transportation support programs are key steps toward a healthier and more accessible healthcare system for all residents.



For many individuals and families—especially those living on fixed or limited incomes—the monthly budget becomes a painful balancing act. Choosing between paying for **food**, **housing and utilities** or **medications** is a reality that directly threatens health, dignity and long-term stability.

1. Skipping Medication to Pay for Food or Bills

Why It Happens:

- Prescription drugs can be very expensive, especially for those without insurance or with high deductibles.
- People often prioritize visible, immediate needs like food or rent over preventive care or medication.

Impact:

- **Worsening of chronic conditions** like diabetes, asthma, heart disease and mental health disorders.
- **Increased ER visits and hospitalizations**, which are more costly than proper medication adherence.
- **Poor disease control**, leading to permanent complications and disability.
- Loss of income due to illness or missed work, perpetuating the financial hardship.

2. Skipping Food to Afford Medications or Utilities

Why It Happens:

- Food budgets are often the most flexible line item in a household's expenses.
- People may ration meals or buy inexpensive, low-nutrient foods to afford other essentials.

Impact:

- **Malnutrition**, particularly in children, seniors and people with chronic illnesses.
- **Medication side effects** may worsen without proper nutrition (e.g., taking meds on an empty stomach).
- Weakened immune systems, fatigue and decreased cognitive function.

3. Skipping Utility Payments or Rent to Afford Medication or Food

Why It Happens:

- Housing and utility costs often outpace wage growth or fixed income levels, leaving people in a financial bind.
- Threat of eviction or loss of heating/air conditioning can become a lesser priority than survival needs.

Impact:

- **Housing instability**, which is linked to higher rates of stress, anxiety and depression.
- **Unsafe living conditions**, especially for individuals with medical equipment or mobility issues.
- Long-term cycles of poverty due to damage to credit, eviction histories and homelessness.

Who Is Most Affected

- Older adults on fixed incomes
- Low-wage workers
- Single-parent households
- People with chronic illnesses or disabilities
- Undocumented and uninsured individuals

Local Relevance: Kent County, Delaware

In Kent County, rising housing and food costs combined with transportation and healthcare access issues make these trade-offs especially common. Community health

workers, local nonprofits and hospitals report frequent encounters with residents making impossible choices just to get through the month.

Potential Interventions

- **Food pharmacies** or medically tailored food boxes
- **Sliding scale clinics and prescription assistance programs**
- **CHW navigation services** to connect residents with rental assistance, utility grants or food benefits (e.g., SNAP)
- **Policy efforts** to expand affordable housing and cap prescription costs

Conclusion

No one should have to choose between their health and their basic needs. When people are forced into these decisions, it harms not only individual well-being but community health outcomes. Addressing these trade-offs requires coordinated efforts from healthcare providers, policymakers and community organizations to ensure that basic needs and medical care are not mutually exclusive.

Homelessness and health are deeply intertwined—each one can cause and worsen the other. People experiencing homelessness face significantly greater health risks than the general population, while untreated or poorly managed medical issues can be both a **cause** and **consequence** of losing stable housing.

1. Health Issues as a Cause of Homelessness

Chronic Illness and Disability

- Serious medical conditions such as cancer, diabetes or a disabling injury can lead to job loss, depleted savings and eviction.
- Long-term health problems can make it difficult to maintain employment or qualify for housing, especially without a strong support system.

Mental Illness and Substance Use Disorders

- Conditions like depression, PTSD, schizophrenia and opioid use disorder are disproportionately represented among people experiencing homelessness.[xx]
- Lack of early diagnosis, poor access to behavioral health services and stigma can lead to crisis situations and housing instability.

2. Health Issues Caused or Worsened by Homelessness

Lack of Basic Hygiene and Shelter

- Exposure to the elements increases risk of **hypothermia, heatstroke, frostbite** and chronic respiratory infections.
- Inadequate hygiene contributes to **skin infections, wound complications and infestations**.

Difficulty Managing Chronic Conditions

- People without stable housing struggle to store medications properly, access follow-up care or manage diets necessary for conditions like diabetes or hypertension.
- Emergency departments are often used as a last resort for care, leading to **fragmented and reactive treatment**.

Higher Risk of Infectious Diseases

- Homeless individuals are more likely to contract **tuberculosis, hepatitis, HIV/AIDS and COVID-19**, particularly in shelters or encampments where physical distancing and hygiene are difficult.

3. Systemic Barriers to Care

- **Lack of insurance**, transportation, identification or permanent address can make accessing care nearly impossible.
- **Discrimination and stigma** from providers often lead to avoidance of healthcare settings until conditions become emergencies.

4. Financial and Societal Impact

- Individuals experiencing homelessness have **much higher healthcare costs**, largely due to reliance on emergency care and hospitalizations.
- This cycle leads to **avoidable strain on healthcare systems**, shelters and public services.

5. Solutions and Promising Practices

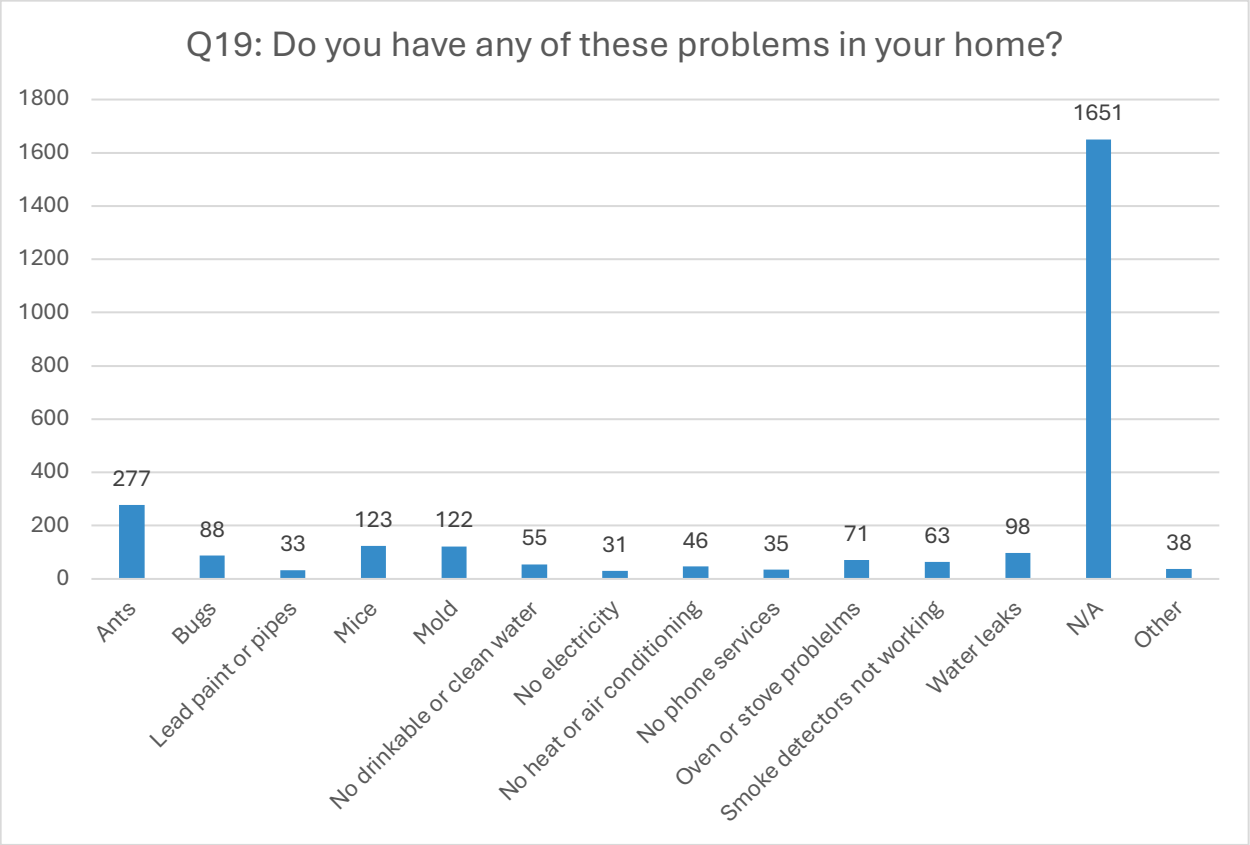
- **Bayhealth's street medicine teams** bring care directly to people in encampments or shelters, building trust and continuity.
- **Housing-first models** have proven effective at improving both housing stability and health outcomes.
- **Community Health Workers (CHWs)**, such as Bayhealth's first one in the Kent Emergency Department and social workers can coordinate care, connect people to resources and address social determinants like food and transportation.
- **Mobile health units** and partnerships with behavioral health providers increase reach and access.

Local Context: Kent County, Delaware

In Kent County, the intersection of homelessness and healthcare is a growing concern. Providers report seeing individuals with unmanaged chronic conditions, untreated mental illness and preventable hospitalizations. Community outreach programs, like those at Bayhealth, have partnered with organizations such as Springboard Pallet Village and Milford Advocacy for the Homeless to deliver care and connect individuals to services.

Conclusion

Homelessness is both a medical emergency and a public health issue. Addressing it requires more than a shelter bed—it demands coordinated efforts to provide stable housing, accessible healthcare, behavioral health support and community trust. Without housing, health suffers; without health, housing is harder to maintain. The solution lies at the intersection of both.



How Poor Housing Quality Exacerbates Health Issues

A person's home is foundational to their health. When housing conditions are unsafe, unstable or unsanitary, they can directly worsen physical and mental health, particularly for children, seniors and people with chronic conditions. Inadequate housing is a social determinant of health—and one of the most visible reflections of health inequity.

1. Pests (Mice, Ants, Cockroaches)

- **Health Impact:**
  - Rodents and insects can trigger or worsen **asthma and allergies**, especially in children.
  - They carry bacteria and viruses that can lead to **gastrointestinal illness** and **skin infections**.
  - Rodents chew wires, increasing fire risk and housing instability.
- **Vulnerable Populations:**
  - Children in pest-infested homes experience higher rates of school absenteeism and ER visits for asthma.

2. Mold and Dampness

- **Health Impact:**
  - Exposure to mold spores is strongly linked to **respiratory problems**, including chronic coughing, wheezing and sinus infections.
  - Mold can weaken the immune system over time, especially in **older adults and immunocompromised individuals**.
- **Compounding Effect:**
  - If mold is left untreated due to cost or lack of landlord response, health issues become more chronic and costly to manage.

3. Lack of Drinkable Water

- **Health Impact:**
  - Without clean water, residents risk **dehydration, gastrointestinal illness and skin conditions**.
  - Families may be unable to cook safely, wash hands, bathe regularly or clean the home, increasing **infection risk**.
- **Public Health Concern:**
  - Unsafe water disproportionately affects rural, low-income or historically marginalized communities.

4. Inadequate Heating or Cooling

- **Health Impact:**
  - Lack of heat in winter increases risk of **hypothermia, respiratory infections and cardiovascular stress**.
  - Lack of cooling in summer leads to **heat exhaustion or stroke**, especially among the elderly and people with heart conditions.
- **Indirect Effects:**
  - People may use unsafe methods to heat their homes (e.g., ovens or space heaters), increasing the risk of **fire and carbon monoxide poisoning**.

5. No Electricity

- **Health Impact:**
  - Without electricity, individuals may lose access to:
    - **Refrigeration** for food or medication (e.g., insulin)
    - **Medical equipment** (e.g., oxygen machines, CPAP devices)
    - **Lighting**, which increases risk of injury
  - Children may fall behind in school if unable to study or attend virtual learning.

- **Mental Health Impact:**
    - Living without electricity is associated with **high stress, anxiety and depressive symptoms**—especially when families must hide their living conditions due to fear of losing housing or custody of children.

6. Long-Term Consequences

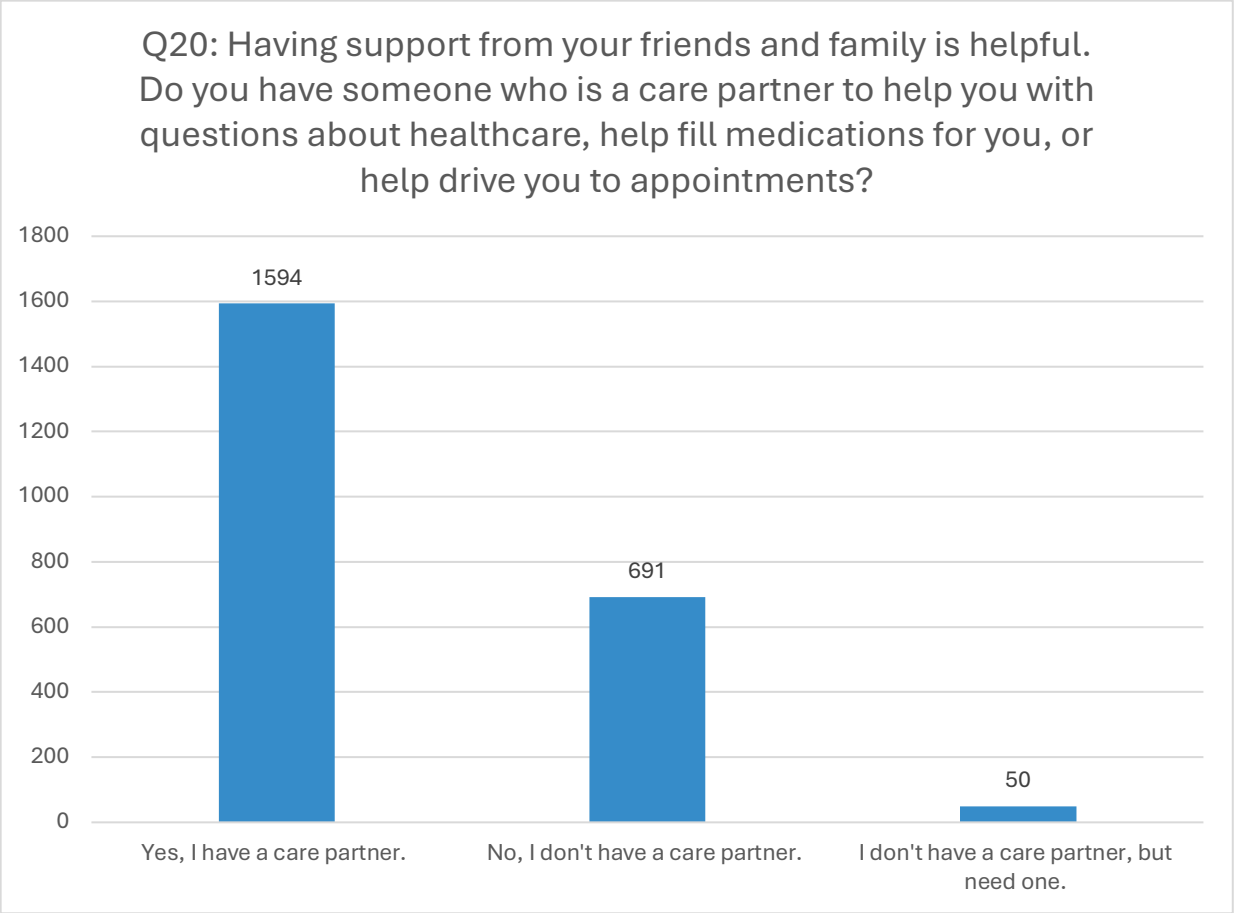
- Increased use of emergency services and hospitalizations
- Worsening of chronic conditions and preventable illnesses
- Lower school attendance and performance among children
- Job instability when homes are not safe or functional
- Cycle of poverty and poor health due to ongoing instability

Local Relevance: Kent County, Delaware

Many low-income and rural households in Kent County face housing conditions that impact health, including homes with **poor insulation, water contamination, mold and vermin**. Community health workers and care managers in the region often report seeing patients with preventable health issues made worse by their living environment.

Conclusion

Safe, healthy housing is a form of healthcare. When homes have pests, mold, unsafe temperatures or lack of basic utilities, the home itself becomes a hazard. Addressing housing quality through public health programs, legal protections and community partnerships is essential to improving health outcomes—especially for our most vulnerable neighbors.



Health is not managed alone. A strong **social support network**—including family, friends, neighbors or trusted community members—can make a profound difference in a person's ability to stay well, recover from illness and manage long-term conditions. For people facing chronic illness, disability, aging or limited transportation and income, this network becomes not just helpful but essential.

1. Practical Support: Getting to Appointments and Filling Prescriptions

- **Transportation:**
  Many people—especially in rural areas like parts of Kent County, Delaware—don't have easy access to transportation. A friend or family member who can drive them to doctor appointments or pharmacies can prevent missed care, delayed diagnoses and worsening conditions.
- **Prescription Pickup:**
  Individuals who are sick, disabled or without transportation often rely on someone else to pick up prescriptions. Without this help, medications can be missed or delayed, which can lead to hospitalization or serious complications.

2. Help Navigating the Healthcare System

- **Understanding Instructions:**
  Medical terminology can be confusing and people may be overwhelmed, especially after a new diagnosis or hospital visit. A support person can help clarify information, take notes, ask questions and ensure that instructions are followed properly.
- **Coordinating Care:**
  Managing multiple specialists, medications, insurance forms or follow-up visits can be daunting. A social support network can help organize care and reduce stress.

3. Emotional and Mental Health Support

- **Reduces Isolation:**
  Loneliness and isolation are linked to worse health outcomes, including depression, anxiety and even increased risk of mortality. A social network provides emotional encouragement, companionship and a reason to stay engaged in life.
- **Improves Recovery:**
  People with strong support systems often recover more quickly from surgery or illness. They are more likely to complete rehab, follow medication plans and eat healthier.

4. Emergency Support

- When someone becomes seriously ill, falls or has a mental health crisis, a support network can **act fast** calling for help, taking them to urgent care or staying with them until professionals arrive.
- For people living alone, having someone check in regularly can **literally save lives.**

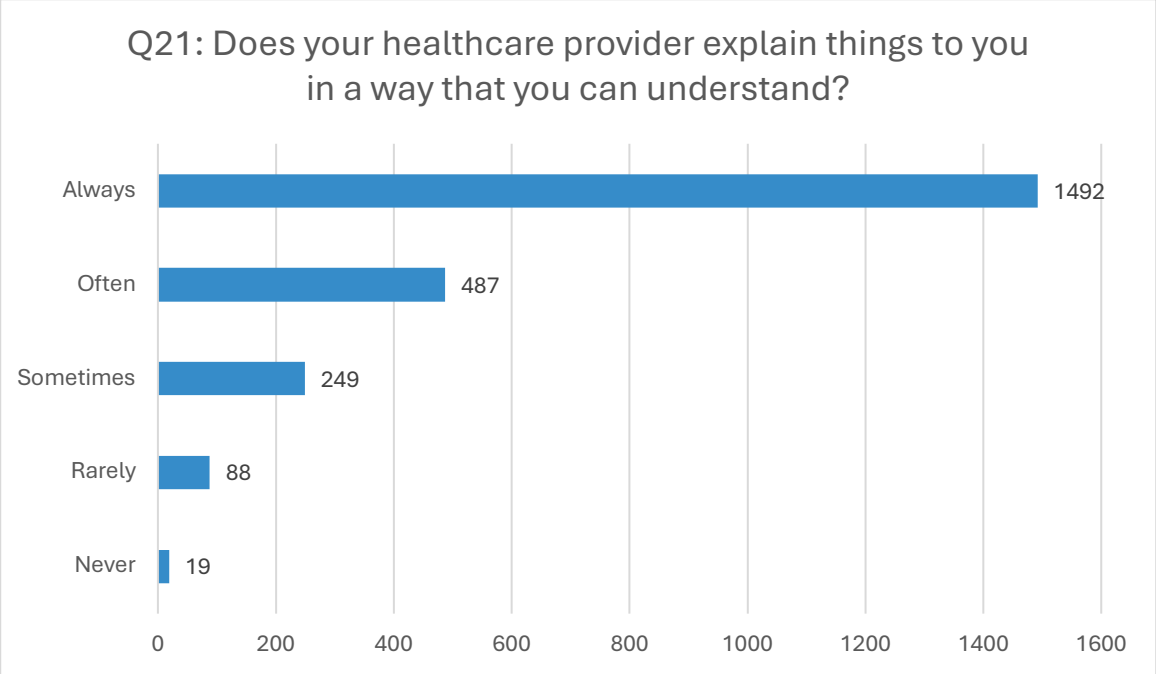
5. Accountability and Encouragement

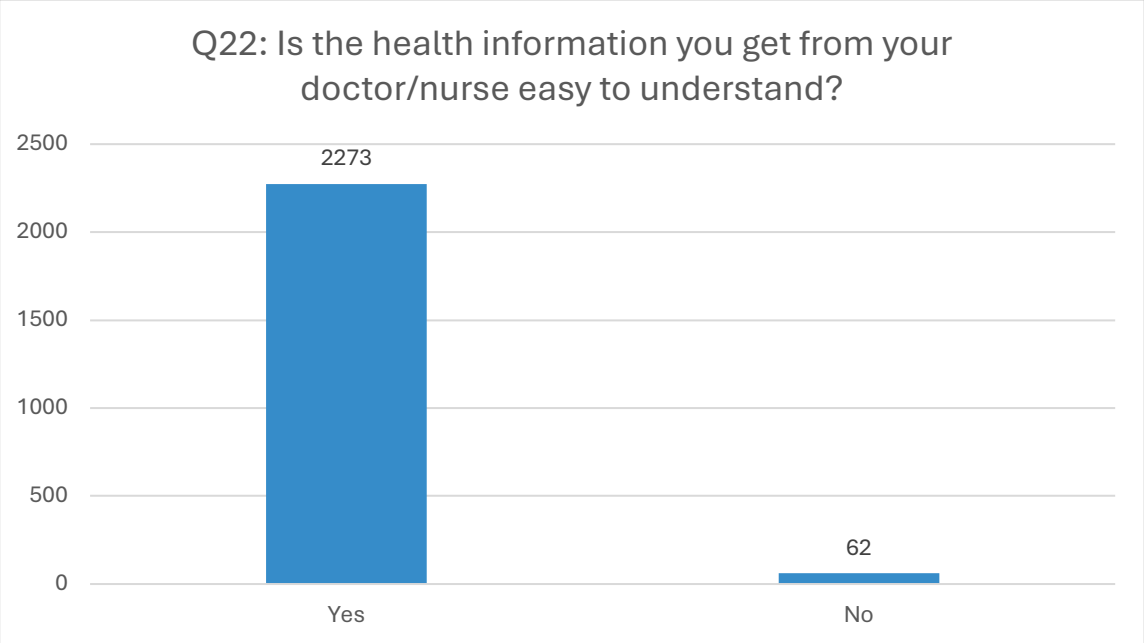
- A friend or loved one can remind someone to take their medication, follow dietary restrictions or attend appointments.
- Support networks increase **motivation and confidence**, especially for people managing difficult health journeys like cancer, substance recovery or new diagnoses.

Conclusion

Having a social network is not just about feeling connected—it's a lifeline. It helps with the **logistics of care**, **emotional resilience** and **health literacy**. For those without one, it's critical that community organizations, health systems and care teams step in with support structures like **community health workers**, **transportation programs** or **patient advocates**.

The following questions were asked by all hospitals in Delaware during their community surveys. This standardized approach allows hospitals and the Delaware Healthcare Association (DHA) to gain a clearer understanding of health literacy challenges across the state.





Health literacy is the ability to find, understand and use information and services to make informed health decisions for yourself and others. It goes beyond reading pamphlets or

following doctor's orders—it's about empowering people to manage their health confidently and effectively.

Why Health Literacy Matters

1. Helps People Understand Their Health Conditions

- Individuals with strong health literacy can better grasp **what their diagnosis means**, how it affects them and what steps to take next.
- They are more likely to understand how to **monitor symptoms**, **manage medications** and follow treatment plans.

2. Reduces Preventable Medical Errors

- Misunderstanding medication instructions, hospital discharge papers or appointment schedules can lead to serious errors—like taking the wrong dose or missing a follow-up.
- Health-literate patients are more likely to **ask questions**, verify information and **catch mistakes**.

3. Improves Chronic Disease Management

- Conditions like **diabetes, heart disease and asthma** require regular monitoring and self-care.
- Health literacy helps people:
    - Know when to seek help
    - Follow dietary or activity recommendations
    - Adjust medications correctly

4. Reduces Emergency Room Visits

- People with low health literacy are more likely to use the ER for routine issues because they don't know where else to go or when a problem is urgent.
- Those who understand how to navigate the healthcare system can make better use of **primary care**, **telehealth** and **preventive services**.

5. Promotes Equity

- Health literacy is closely tied to education, language and socioeconomic status. When health information isn't accessible or understandable, it **worsens disparities** in care and outcomes—especially among:
    - People with limited education
    - Non-English speakers
    - Older adults
    - Rural or underserved populations

6. Encourages Preventive Care and Healthy Choices

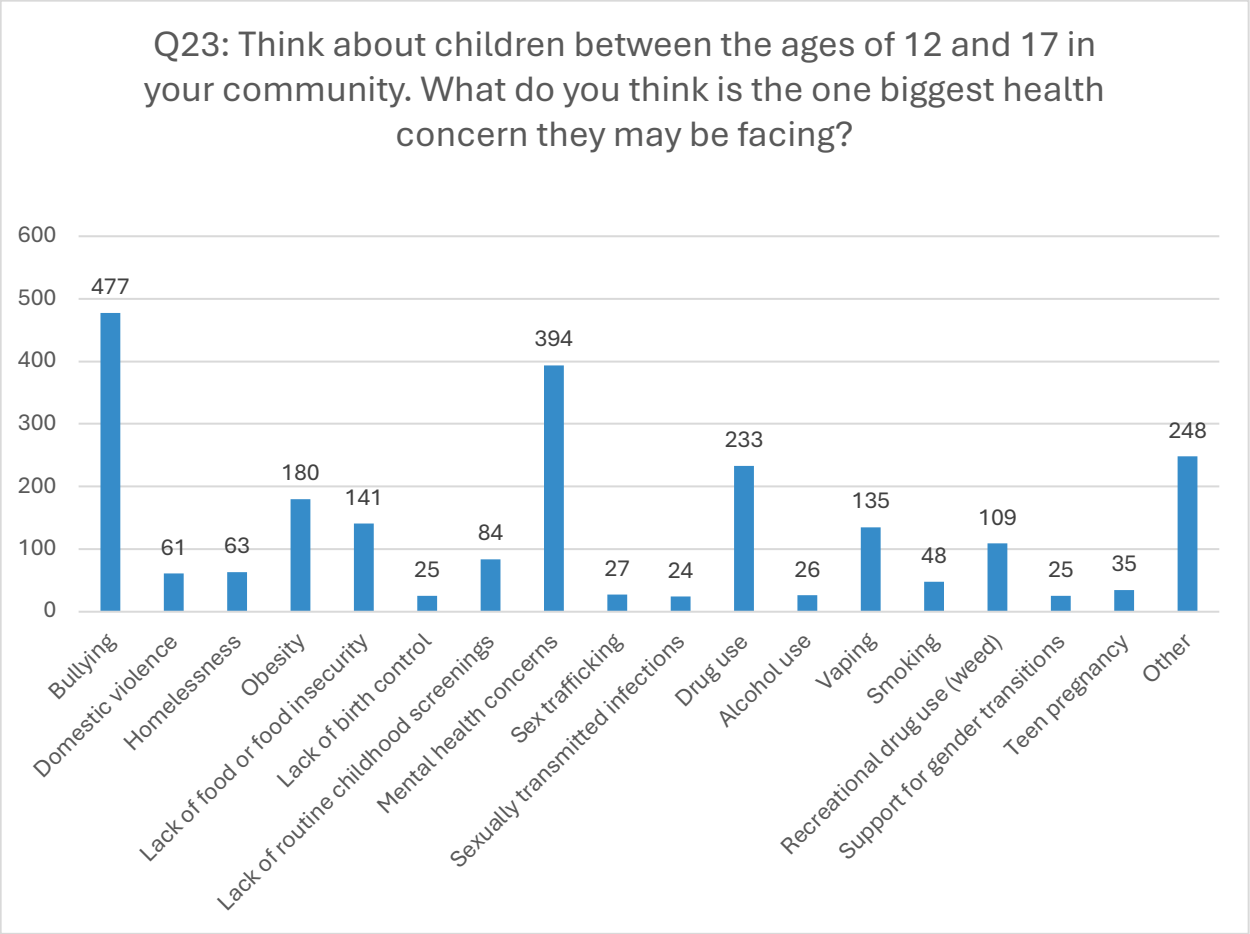
- Understanding **how and when to get vaccines, screenings and checkups** helps people stay healthier, longer.
- Health-literate individuals are also more likely to:
    - Eat healthy
    - Exercise regularly
    - Avoid risky behaviors (e.g., smoking, unsafe sex)

Local Relevance: Kent County, Delaware

In Kent County, challenges such as low general literacy rates, language barriers and limited access to digital tools make health literacy a critical issue. Efforts like including **health literacy questions in community health needs assessments**, partnering with the **Health Literacy Council of Delaware** and using **plain language communication** are essential to improving community health.

Conclusion

Health literacy is not just a personal skill—it's a shared responsibility among individuals, providers and systems. By making health information **clear, accessible and actionable**, we help people live healthier lives, reduce system costs and promote a more equitable healthcare environment.



Poor mental health impacts many areas of a student's life, including school and grades, decision making and their physical health. Negative behaviors and habits that result from poor mental health carry over into adult years.[2]

Children today face a complex set of challenges that impact not only their physical health but also their emotional and social development. Four of the most pressing and interconnected concerns are **bullying, mental health struggles, substance use and obesity**. These issues can have lasting effects on a child's ability to learn, grow and thrive into adulthood.

1. Bullying

Why It's a Concern:

- Bullying—whether physical, verbal or online—can lead to **serious emotional and psychological harm**.
- Victims of bullying often experience **low self-esteem, anxiety, depression** and in some cases, suicidal thoughts.

[2] Poor mental health impacts many areas of a student's life, including school and grades, decision making and their physical health. Negative behaviors and habits that result from poor mental health carry over into adult years.

- **Cyberbullying** has made it harder for children to escape bullying, with harassment continuing beyond school hours.

Consequences:

- School avoidance or declining academic performance
- Long-term trauma and trust issues
- Increased risk of self-harm or aggressive behavior

2. Mental Health[xxi]

Why It's a Concern:

- Rates of **anxiety, depression and behavioral disorders** are rising among children and adolescents.
- The pandemic, social isolation, academic pressures and social media have intensified emotional stress for many children.

Barriers to Care:

- **Stigma**, lack of pediatric mental health providers and limited access to affordable counseling prevent many families from getting help.
- Some children **don't have the language or support** to express what they're feeling.

Consequences:

- Increased rates of suicide (the second leading cause of death among youth ages 10–24)
- Difficulty forming healthy relationships and coping with stress
- Interference with academic and social development

3. Drug Use and Substance Exposure

Why It's a Concern:

- Early exposure to substances like **vaping, alcohol, marijuana and opioids** is increasing.
- Children may be influenced by peer pressure, social media or family members using substances at home.

Health Risks:

- Impaired brain development
- Academic failure or school discipline
- Higher likelihood of developing **substance use disorders** later in life

Kent County Note:

- The opioid crisis has touched many families in Delaware, with children either directly experimenting or being indirectly affected by a parent or caregiver's addiction.

4. Obesity

Why It's a Concern:

- **Childhood obesity rates** have increased dramatically, with poor nutrition, lack of physical activity and screen time contributing factors.
- Many children live in **food deserts** or lack access to healthy, affordable food and safe places to play.

Health Risks:

- Type 2 diabetes
- High blood pressure and cholesterol
- Joint and sleep problems
- Emotional health issues, including **low self-esteem and body image concerns**

Delaware ranks 36 in overall prevalence with 33.2% of children considered either overweight or obese.[xxii] Among the three counties in Delaware, Kent County has the highest rate of obesity. This highlights the need for targeted interventions to address nutrition, physical activity and access to preventive care.

These four concerns often overlap:

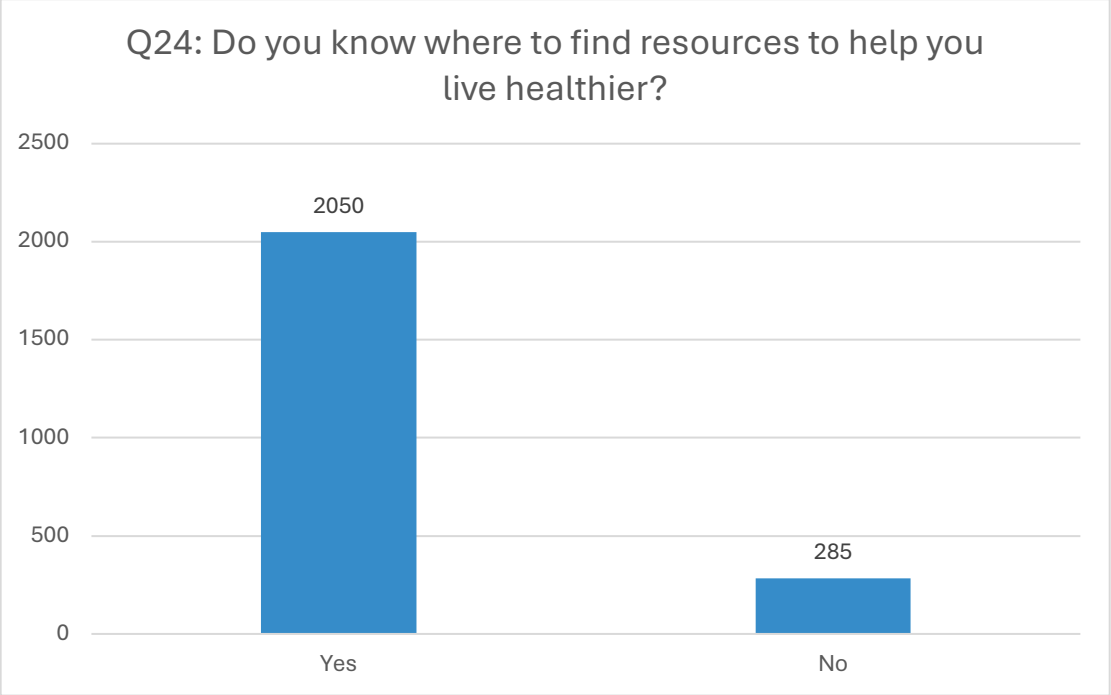
- **Bullying and mental health** are tightly linked, especially when body image or identity are involved.
- **Obesity can lead to bullying**, which then affects mental health.
- **Drug use may be a coping mechanism** for stress, depression or trauma.
- **Children without strong support systems** are more vulnerable to all of these risks.

What Can Help:

- **Access to school counselors and mental health services**
- **Anti-bullying policies** and inclusive school environments
- **Parent education and engagement**
- **Nutrition programs** and opportunities for physical activity
- **Early education about substance risks** and emotional regulation, such as the Bayhealth Wellness Centers embedded in seven local high schools.

Conclusion

Children need more than healthcare—they need understanding, protection and opportunity. Addressing bullying, mental health, drug use and obesity requires schools, healthcare providers, families and community organizations to work together in creating safe, supportive environments where all children can grow up healthy in body and mind.



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- Offers low-cost exercise classes, swim programs and chronic disease prevention programs
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- Hosts mobile food pantries, healthy cooking classes and SNAP education
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- Offers free classes on **healthy eating, gardening and physical activity**
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6. Mental Health Resources

- **Delaware 211** – Call 2-1-1 or visit delaware211.org for referrals to mental health, housing or addiction services
- **NAMI Delaware** – namidelaware.org for mental health education and support groups
- **SUN Behavioral Health – Dover** offers inpatient and outpatient mental health and substance use care

7. Unite Delaware

Website: unitedelaware.org

- A closed-loop referral system used by hospitals and nonprofits to connect residents to **free and low-cost services**, including:

- Medical care
- Food
- Transportation
- Financial assistance
- Housing support

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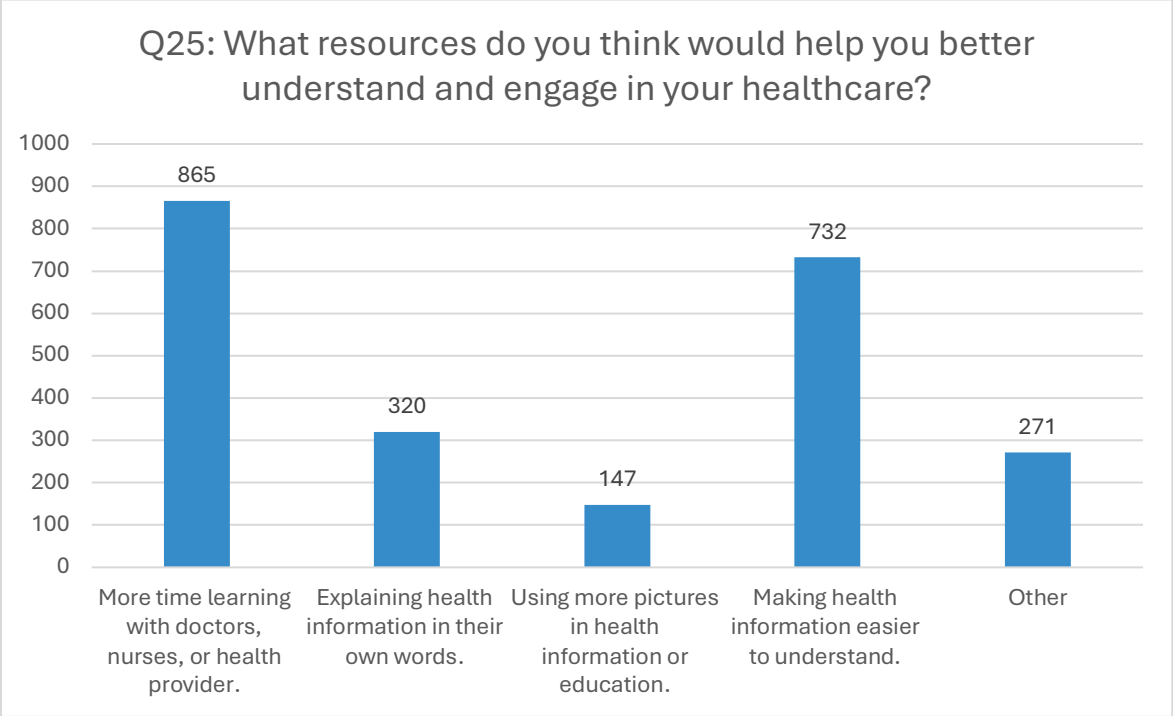
- Offers health education workshops
- Develops **plain-language materials** to help residents better understand their care.



Effective healthcare isn't just about the treatment—it's about how well patients understand what's happening to their bodies and what they need to do next. For many people, especially those with low health literacy, language barriers or chronic stress, the healthcare system can feel overwhelming and confusing.

Making health information **clear, visual and accessible**—and giving patients the **time and space to understand it**—can dramatically improve outcomes.

1. The Importance of More Time with Clinicians

Why It Matters:

- Short appointments can lead to **missed information, rushed explanations** and patients leaving with more questions than answers.
- When clinicians take time to **listen, explain and confirm understanding**, patients are more likely to follow care plans, take medications correctly and return for follow-ups.

Impact of More Time:

- Builds **trust and rapport**
- Allows for **questions and clarification**
- Helps address **fear or misinformation**
- Encourages shared decision-making

2. Explaining Health Issues in Plain Language

Why It Matters:

- Many people don't understand medical jargon (e.g., "hypertension" instead of "high blood pressure").
- Using everyday terms helps people feel **included, not intimidated**.

Best Practices:

- Say **"heart doctor" instead of "cardiologist"**
- Explain **what a test is for**, not just what it's called
- Avoid acronyms or define them clearly (e.g., say "emergency department" not just "ED")

3. Using Visuals in Health Education

Why It Matters:

- Visuals like pictures, diagrams and infographics can **cross language barriers**, reinforce verbal information and make abstract concepts concrete.
- For people who struggle with reading, visuals **make health education more accessible and memorable**.

Examples:

- A diagram showing what happens during a heart attack
- Icons showing medication times (morning, noon, night)
- Illustrations of portion sizes, symptoms or step-by-step care instructions

4. Making Health Information Easier to Understand and Access

Why It Matters:

- Many patients feel overwhelmed by paperwork, websites and instructions they can't easily interpret.
- **Accessible health information** increases confidence, reduces errors and empowers people to manage their care.

Strategies for Improvement:

- Use **12-point font or larger**, high-contrast colors and easy-to-read layouts.
- Translate materials into **multiple languages**, including Spanish and Haitian Creole in areas like Kent County, Delaware, as Bayhealth did for this survey and other outreach materials.
- Provide **video or audio explanations** for key documents.
- Offer **community health workers or patient navigators** to help explain and reinforce information.

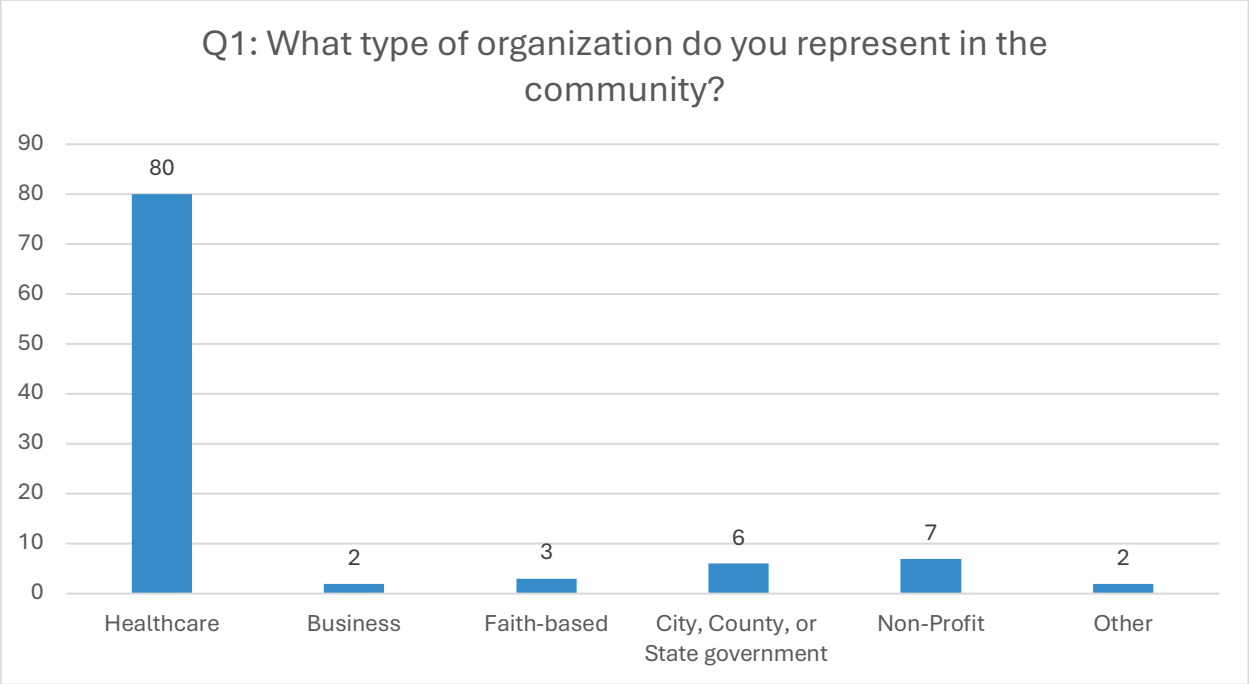
Conclusion

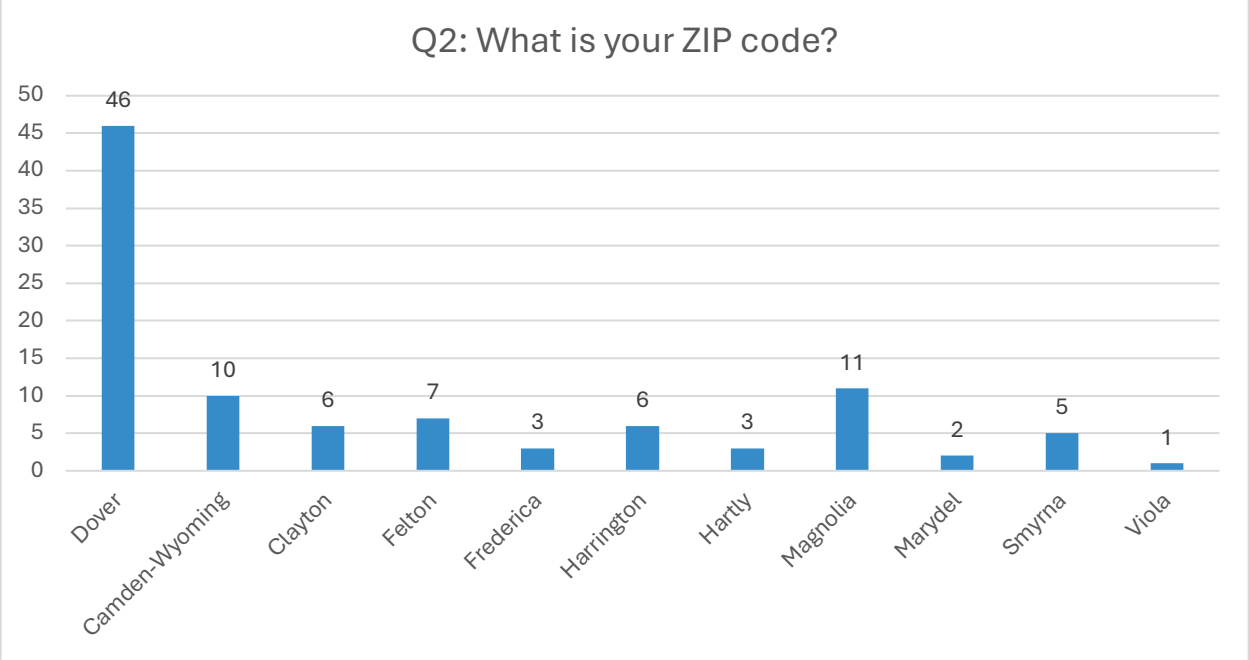
When patients are rushed, confused or excluded from their own care conversations, health outcomes suffer. But when clinicians take time, speak plainly and use tools that meet people where they are—**everyone benefits**.

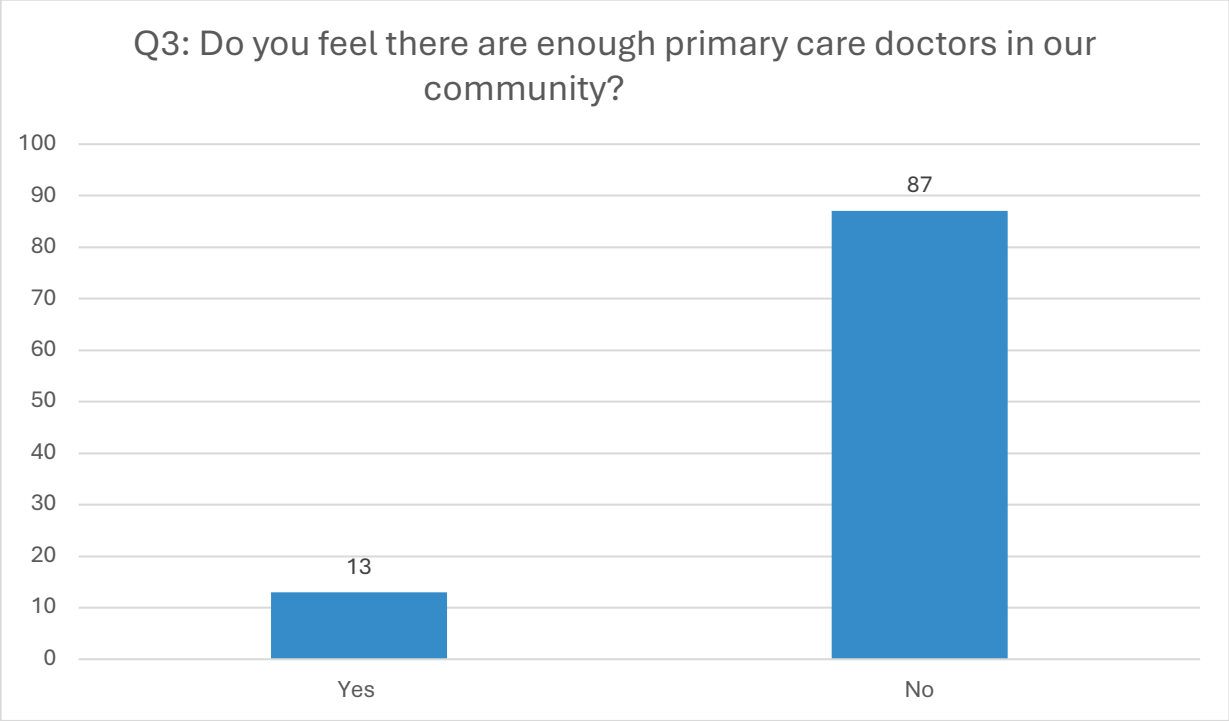
Investing in clearer, more compassionate communication is one of the most powerful ways to improve health equity, trust and outcomes across every community.

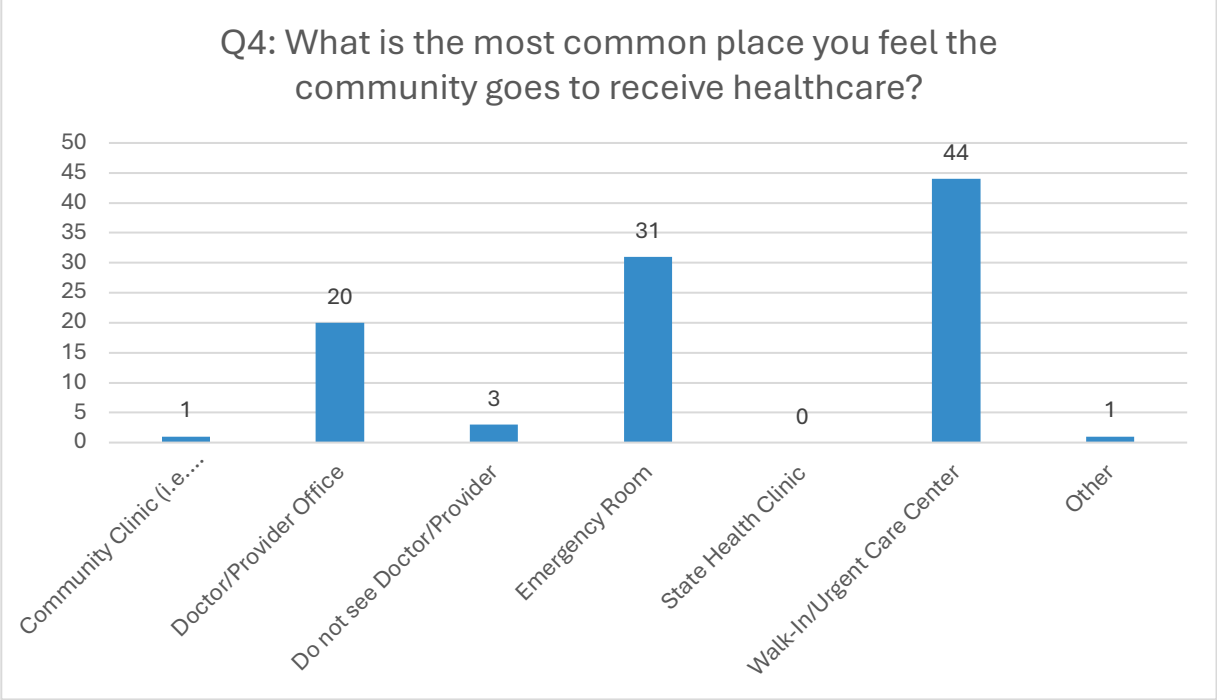
Community Stakeholder Survey Results

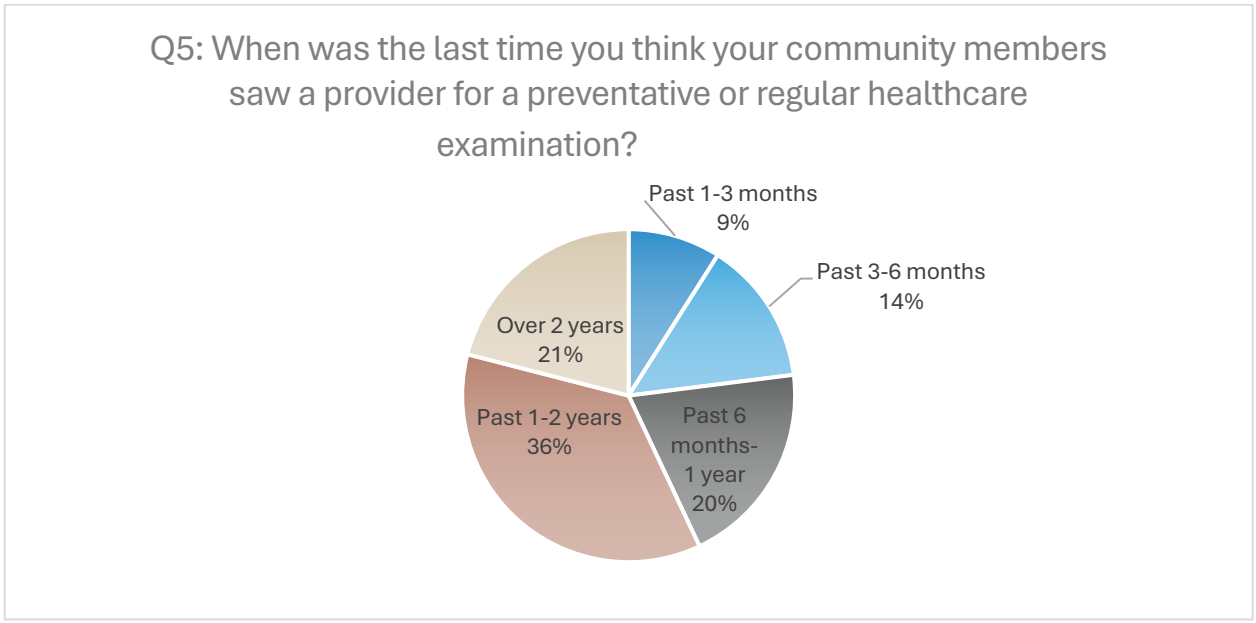
The community stakeholder survey questions were also multiple choice and very much mirrored the community-at-large survey but asked participants to answer the questions based on their roles and knowledge as a community stakeholder who serves members of the community. In total, 100 different community stakeholders responded.

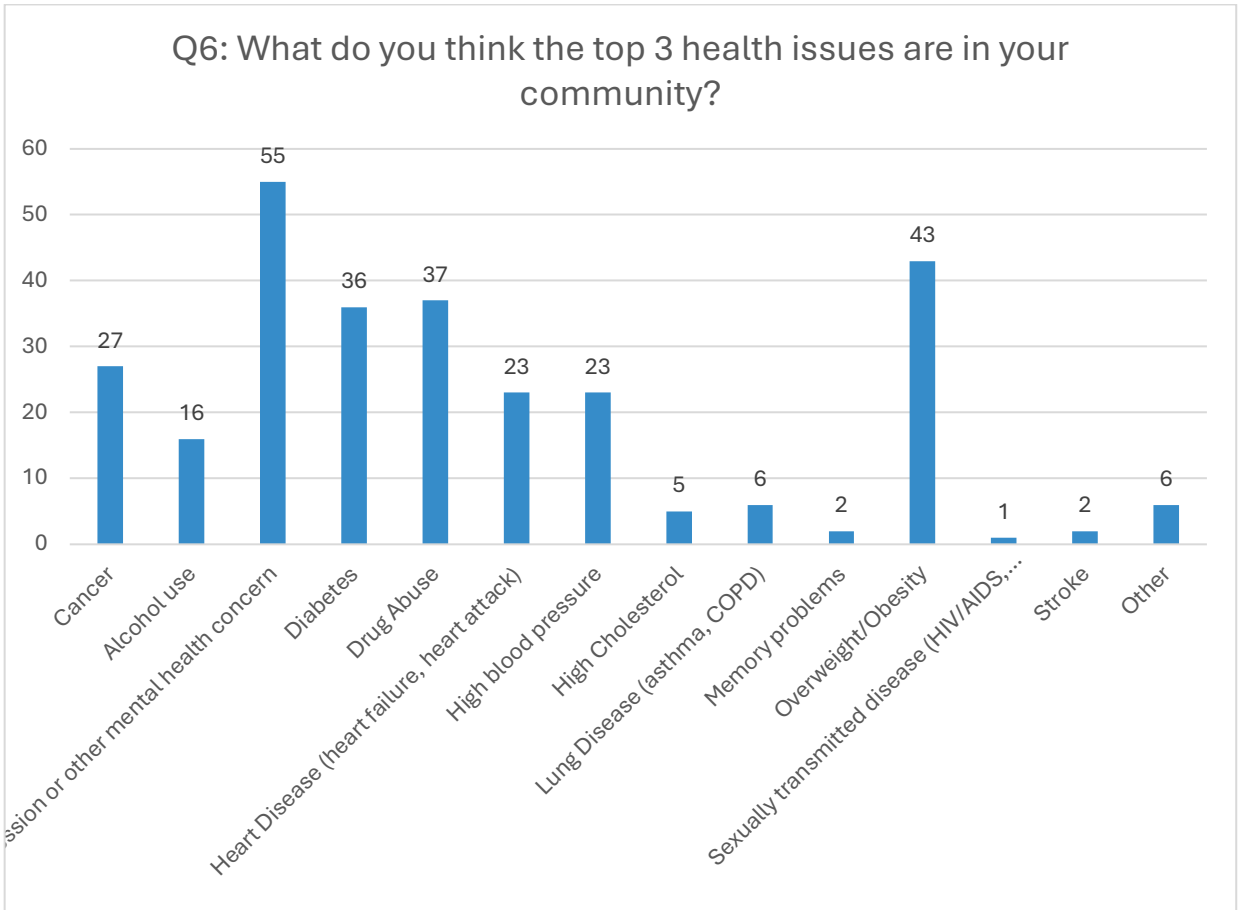


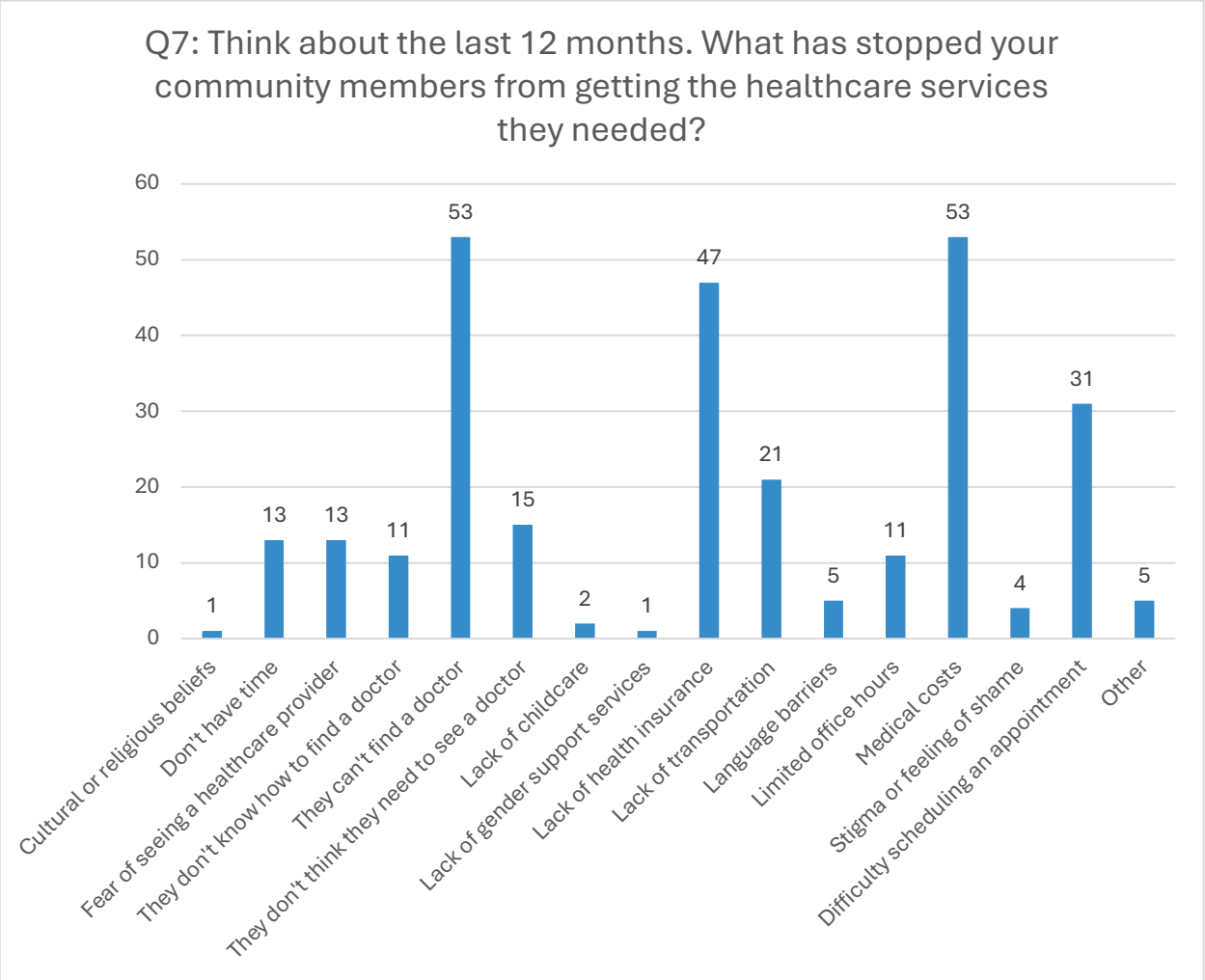


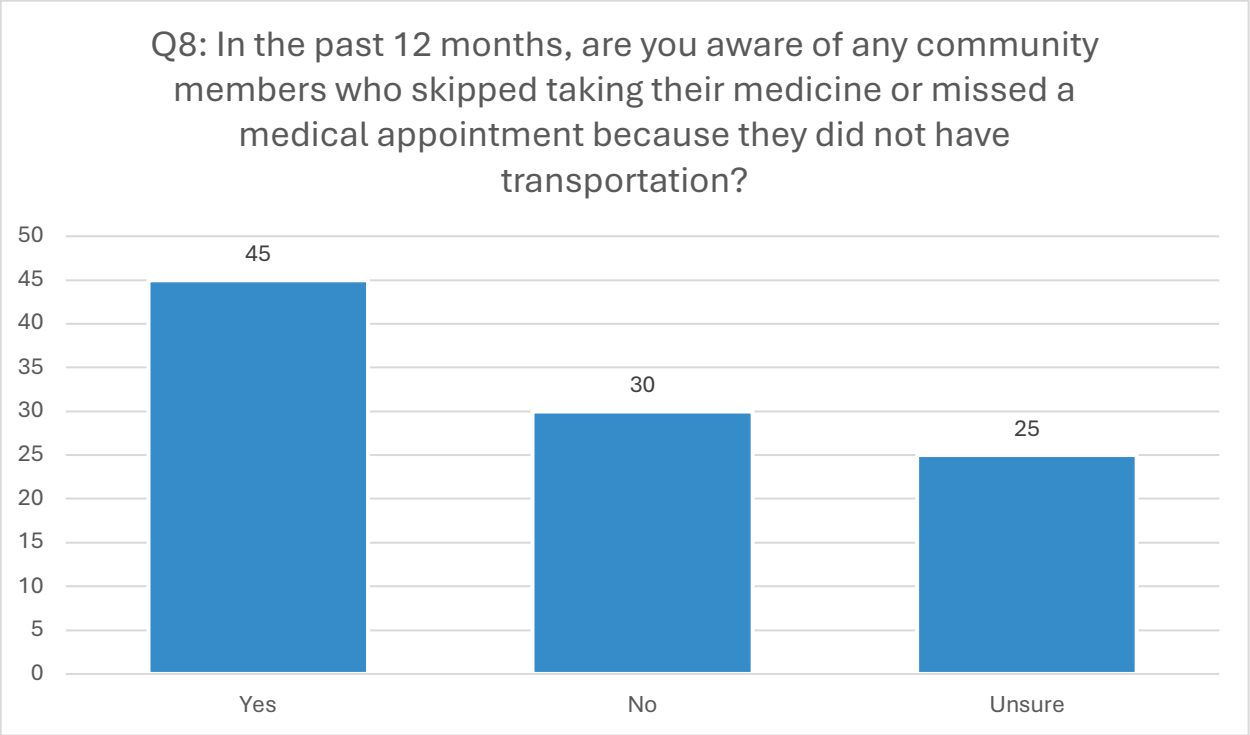

Q3: Do you feel there are enough primary care doctors in our community?
100
90
80
70
60
50
40
30
20
10
0
13
87
Yes
No

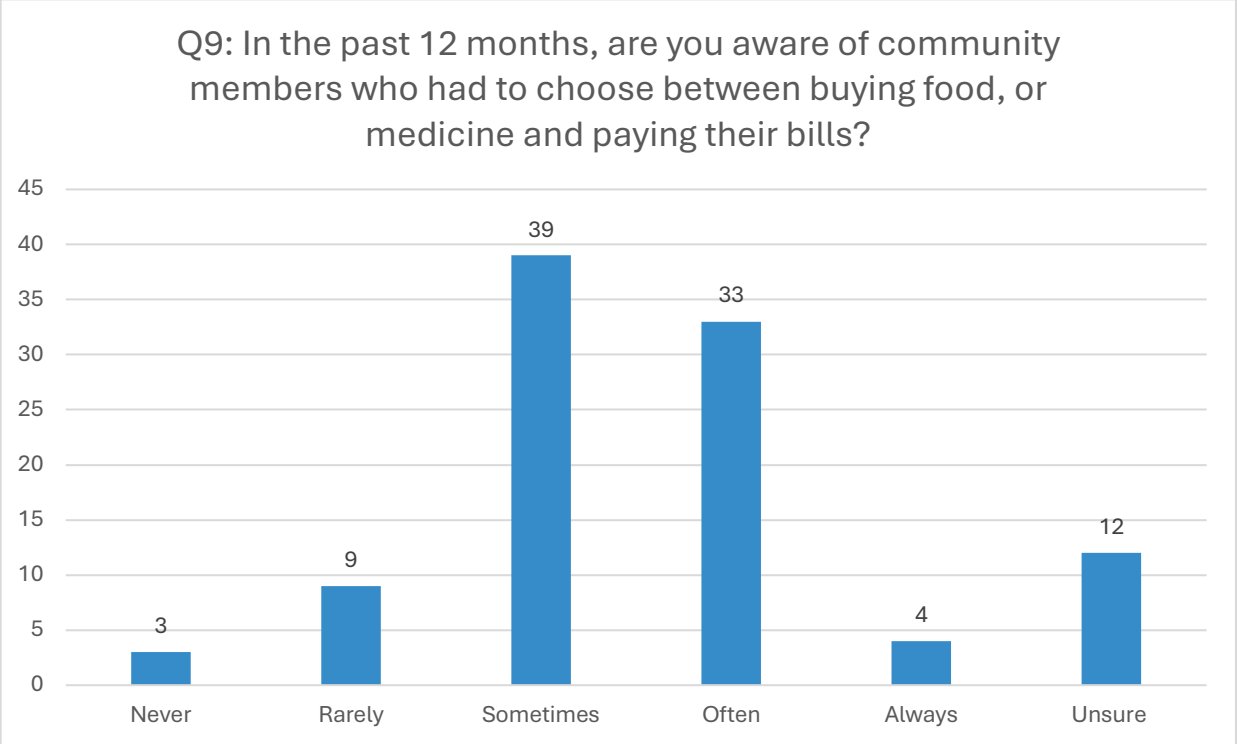

Q4: What is the most common place you feel the community goes to receive healthcare?
50
45
40
35
30
25
20
15
10
5
0
1
20
3
31
0
44
1
Community Clinic (i.e.…
Doctor/Provider Office
Do not see Doctor/Provider
Emergency Room
State Health Clinic
Walk-In/Urgent Care Center
Other

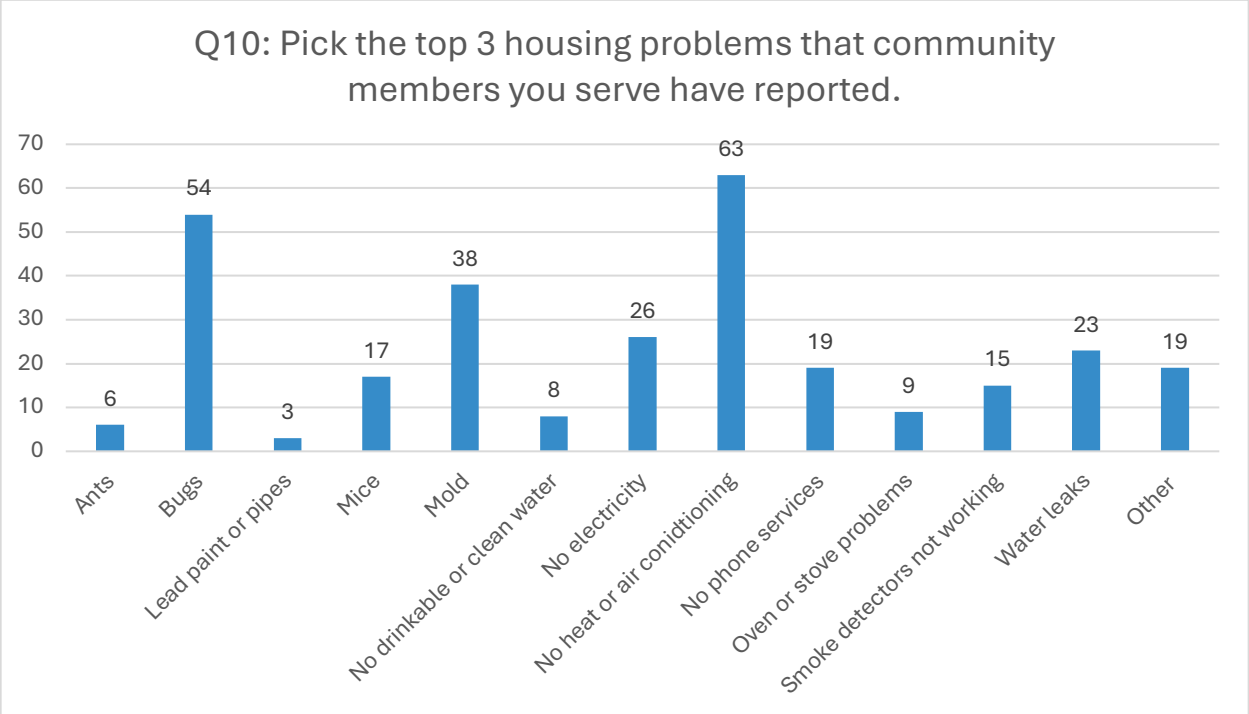

Q5: When was the last time you think your community members saw a provider for a preventative or regular healthcare examination?
Past 1-3 months 9%
Past 3-6 months 14%
Past 6 months-1 year 20%
Past 1-2 years 36%
Over 2 years 21%


Q6: What do you think the top 3 health issues are in your community?
60
50
40
30
20
10
0
27
16
55
36
37
23
23
5
6
2
43
1
2
6
Cancer
Alcohol use
ssion or other mental health concern
Diabetes
Drug Abuse
Heart Disease (heart failure, heart attack)
High blood pressure
High Cholesterol
Lung Disease (asthma, COPD)
Memory problems
Overweight/Obesity
Sexually transmitted disease (HIV/AIDS,...
Stroke
Other


Q7: Think about the last 12 months. What has stopped your community members from getting the healthcare services they needed?
60
50
40
30
20
10
0
1
13
13
11
53
15
2
1
47
21
5
11
53
4
31
5
Cultural or religious beliefs
Don't have time
Fear of seeing a healthcare provider
They don't know how to find a doctor
They can't find a doctor
They don't think they need to see a doctor
Lack of childcare
Lack of gender support services
Lack of health insurance
Lack of transportation
Language barriers
Limited office hours
Medical costs
Stigma or feeling of shame
Difficulty scheduling an appointment
Other


Q8: In the past 12 months, are you aware of any community members who skipped taking their medicine or missed a medical appointment because they did not have transportation?
50
45
40
35
30
25
20
15
10
5
0
45
30
25
Yes
No
Unsure


Q9: In the past 12 months, are you aware of community members who had to choose between buying food, or medicine and paying their bills?
45
40
35
30
25
20
15
10
5
0
3
9
39
33
4
12
Never
Rarely
Sometimes
Often
Always
Unsure



Interpretation of Housing Problem Findings – Kent County, Delaware

These data reflect self-reported housing issues from a sample of **respondents** in Kent County, Delaware. The chart captures various conditions that can compromise both **physical health** and **mental well-being**, especially for vulnerable populations such as children, seniors and people with chronic illnesses.

Public Health Implications

Lack of Climate Control (21%)

- **No heat or air conditioning** is the most reported issue and poses **serious health risks** during extreme temperatures—especially for infants, older adults and those with heart or lung conditions.
- Can contribute to **hypothermia, heat stroke** and **worsening of respiratory conditions** like asthma or COPD.

Pest Infestations (24%)

- **Bugs and mice** were reported by over **1 in 5** residents.

- These can trigger **asthma**, cause **skin infections** and spread **bacterial and viral pathogens**.
- Poor pest control often signals **broader structural and sanitation issues.**

Mold (13%)

- Mold exposure can lead to **serious respiratory problems**, especially in people with asthma or weakened immune systems.
- Also associated with **mental health stress**, fatigue and chronic coughing.

Lack of Electricity, Clean Water and Cooking Facilities

- **No electricity (9%)** can disrupt access to medical devices (e.g., oxygen machines), food storage, lighting and communication.
- **No clean water (3%)** undermines basic hygiene and increases risk of **gastrointestinal illness**.
- **Oven or stove problems (3%)** reduce food access and nutrition.

Life-Safety Issues

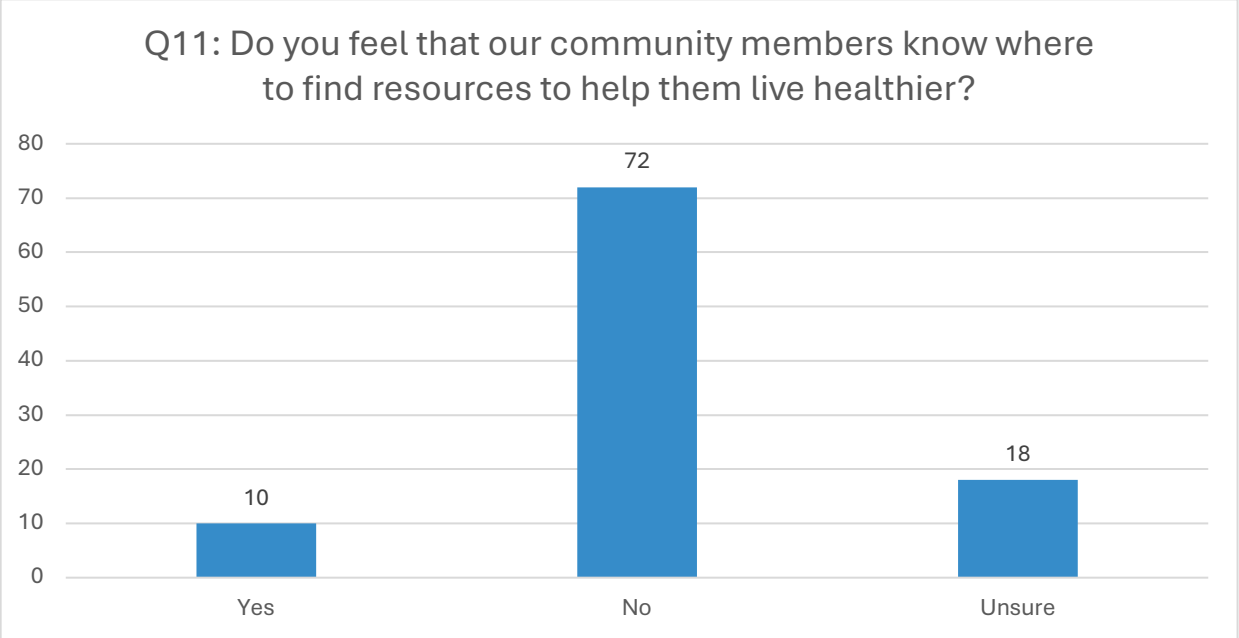
- **Smoke detectors not working (5%)** presents a **direct fire risk**.
- **Lead paint/pipes**, although reported by few, are extremely hazardous—especially to children, where exposure can cause **permanent developmental delays**.

What This Means for Kent County, Delaware

- These findings underscore a **critical link between housing quality and health equity**.
- Many of the reported conditions are **preventable and fixable**, but persist due to lack of landlord accountability, low-income housing stock and limited inspection or enforcement.
- The data suggest a need for:
    - **Increased code enforcement**
    - **Healthy housing initiatives**
    - **Targeted outreach from Community Health Workers (CHWs)**
    - **Cross-sector partnerships** (e.g., Bayhealth, local housing authorities, social service orgs)
    - **Weatherization and home repair programs** for low-income households

Conclusion

Poor housing conditions are more than a nuisance—they are **public health risks** that can lead to chronic illness, poor child development, hospitalizations and even death. Addressing these issues in Kent County will require coordinated action across healthcare, housing and social service systems.



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  - Food
  - Transportation
  - Financial assistance
  - Housing support

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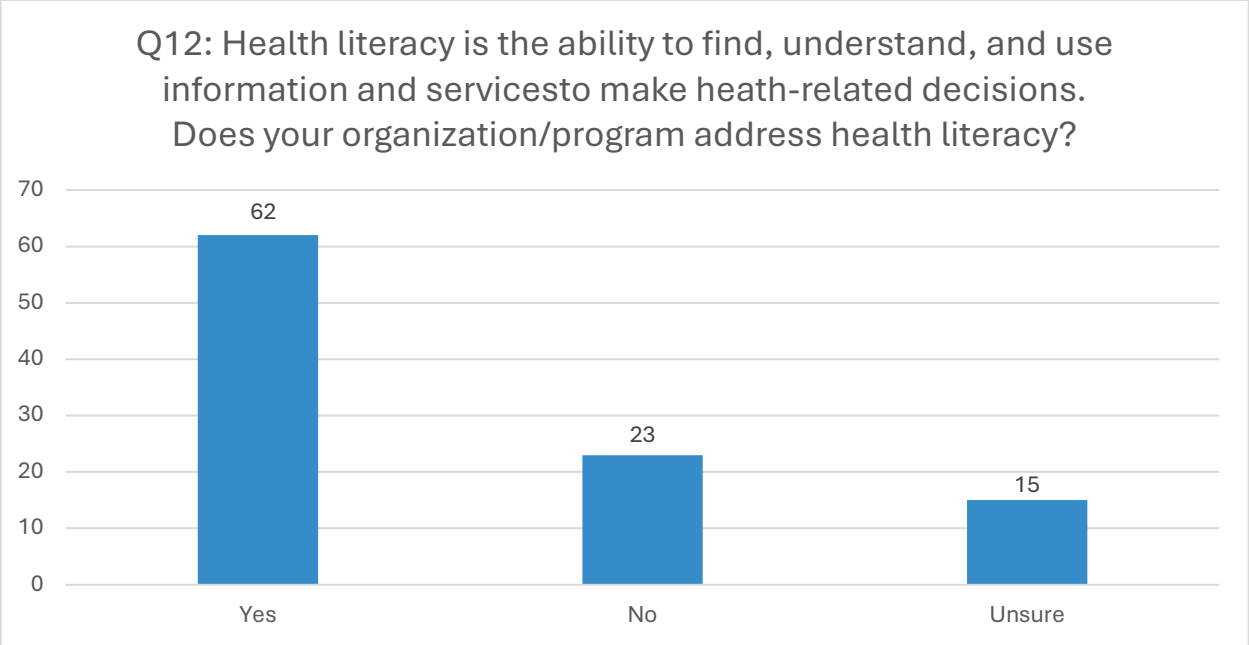
- Offers health education workshops
- Develops **plain-language materials** to help residents better understand their care.

The following questions were asked by all hospitals in Delaware during their community surveys. This standardized approach allows hospitals and the Delaware Healthcare Association (DHA) to gain a clearer understanding of health literacy challenges across the state.



Why Health Literacy Matters

1. Helps People Understand Their Health Conditions

- Individuals with strong health literacy can better grasp **what their diagnosis means**, how it affects them and what steps to take next.
- They are more likely to understand how to **monitor symptoms**, **manage medications** and follow treatment plans.

2. Reduces Preventable Medical Errors

- Misunderstanding medication instructions, hospital discharge papers or appointment schedules can lead to serious errors—like taking the wrong dose or missing a follow-up.
- Health-literate patients are more likely to **ask questions**, verify information and **catch mistakes**.

3. Improves Chronic Disease Management

- Conditions like **diabetes, heart disease and asthma** require regular monitoring and self-care.
- Health literacy helps people:
    - Know when to seek help
    - Follow dietary or activity recommendations
    - Adjust medications correctly

4. Reduces Emergency Room Visits

- People with low health literacy are more likely to use the ER for routine issues because they don't know where else to go or when a problem is urgent.
- Those who understand how to navigate the healthcare system can make better use of **primary care**, **telehealth** and **preventive services**.

5. Promotes Equity

- Health literacy is closely tied to education, language and socioeconomic status. When health information isn't accessible or understandable, it **worsens disparities** in care and outcomes—especially among:
    - People with limited education
    - Non-English speakers
    - Older adults
    - Rural or underserved populations

Local Relevance: Kent County, Delaware

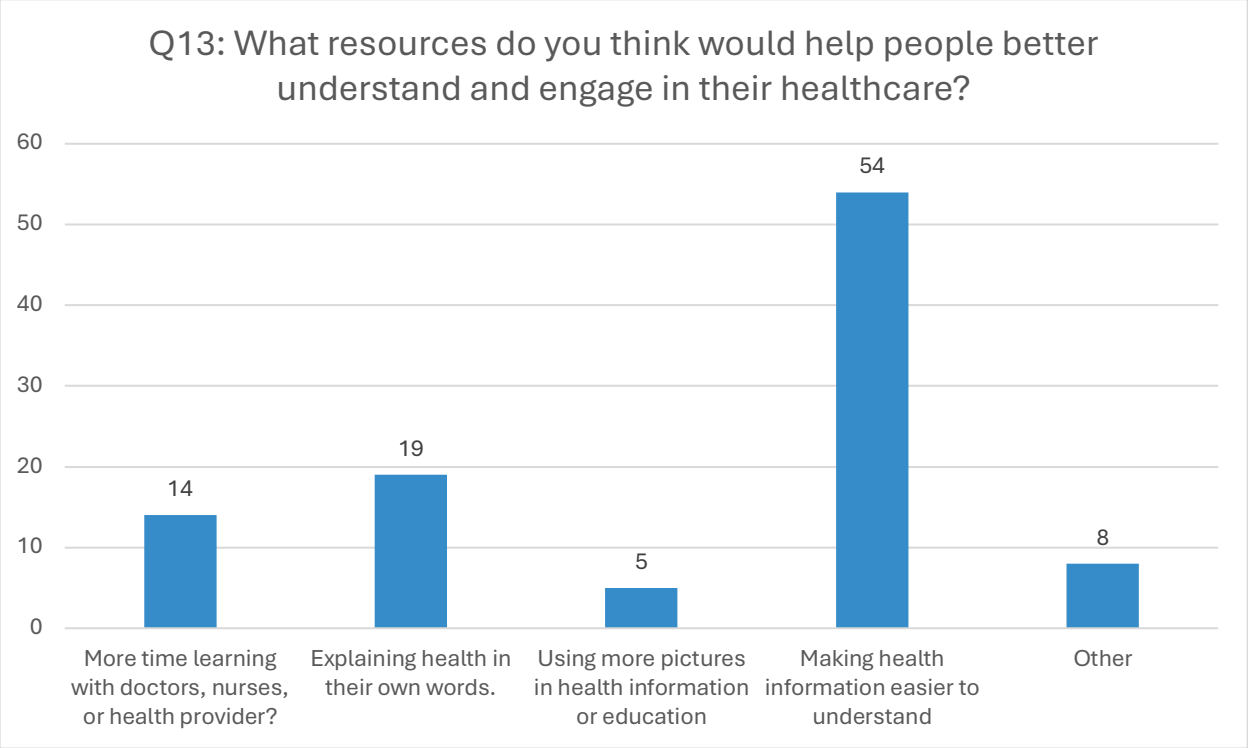
In Kent County, challenges such as low general literacy rates, language barriers and limited access to digital tools make health literacy a critical issue. Efforts like including **health literacy questions in community health needs assessments**, partnering with the **Health Literacy Council of Delaware** and using **plain language communication** are essential to improving community health.

6. Encourages Preventive Care and Healthy Choices

- Understanding **how and when to get vaccines, screenings and checkups** helps people stay healthier, longer.
- Health-literate individuals are also more likely to:
  - Eat healthy
  - Exercise regularly
  - Avoid risky behaviors (e.g., smoking, unsafe sex)

Conclusion

Health literacy is not just a personal skill—it's a shared responsibility among individuals, clinicians and systems. By making health information **clear, accessible and actionable**, we help people live healthier lives, reduce system costs and promote a more equitable healthcare environment.



Health Needs Identified

In the analysis of Kent County Community Health Needs Assessment data from community members and stakeholders, the most important health issues which emerged include:

- Obesity
- Mental health
- Preventable emergency room visits and hospitalizations
- Cost of healthcare
- Access to medical clinicians
- Social determinants of health including homelessness, finances, transportation and housing

In the following appendix, data from various reliable web-based databases and organizations will be presented. The elements shown are focused on the above highlighted health issues which were gleaned from the Kent County Community Health Needs Assessment surveys from community members and stakeholders.

Next Steps

Based on the findings of the 2025 Community Health Needs Assessment (CHNA), Bayhealth will develop and implement targeted strategies to address the identified priority areas. These initiatives may include expanding access to healthcare services, enhancing mental health and substance use treatment, promoting healthy lifestyles and addressing social determinants of health that impact overall well-being.

Appendix B- Objectives and Methodology

Federal and State Requirements

A Community Health Needs Assessment (CHNA) is a systematic process used by hospitals and public health organizations to identify key health priorities, disparities and resource gaps within the communities they serve. Under the Affordable Care Act, all nonprofit hospitals are federally required to conduct a CHNA at least once every three years and develop an implementation strategy to address the identified needs. This requirement, enforced by the Internal Revenue Service (IRS), ensures hospitals remain accountable to the communities they serve and maintain their tax-exempt status.

In Delaware, additional state-level expectations—such as alignment with the Delaware State Health Improvement Plan and collaboration with local stakeholders—reinforce the importance of using CHNAs to promote health equity, guide strategic investments and foster data-driven decision-making across sectors. This assessment fulfills both federal and state requirements and serves as a foundational tool for improving health outcomes throughout Kent County.

Methodology and Data Sources

CHNA is a process for determining the needs in a particular community or geographic area through systematic, comprehensive data collection and analysis. CHNA has long been best practice within the field of public health, focusing on the most vulnerable and where they live to identify those experiencing health disparities and inequalities.

CHNA involves exploring both quantitative and qualitative data and can be broad, examining a community at larger it can focus on a specific issue. Many communities and community organizations regularly conduct broad CHNAs to understand their community and get a pulse of what is most needed to promote community thriving.[xxiii]

Bayhealth realized to meet as many community members as possible where they were, multiple channels were needed to reach the population to get a complete picture of the health needs of those living in Kent County. Online and paper survey forms and well as informational materials were all available in English, Spanish and Haitian Creole.

Community health needs were collected from various sources to gain a complete picture of the community and its needs. This includes the most recent data available from My Healthy Community, the state Department of Health and Social Services and stakeholder survey results.

Appendix C- 2022 CHNA Implementation Plan

As a result of the 2022 Community Health Needs Assessment (CHNA), Bayhealth identified four key priority areas for improvement at the Kent Campus:

1. **Mental Health**
2. **Obesity**
3. **Social Determinants of Health (SDoH)**
4. **Preventable Emergency Room Visits and Hospitalizations**

This summary outlines the progress made in each area, along with the Bayhealth departments involved.

1. Mental Health

Strategy: Implement systemwide behavioral health initiatives.
Key Activities and Results:

- Integrated behavioral health clinicians into primary care practices. (2023)
- Behavioral health navigation services added to four primary care offices, serving ~800 patients. (July 2023–Feb 2024)
- Requested additional FTEs for expansion. (2024)
- Renovated behavioral health rooms in the Emergency Department. (2024)
- Chaplaincy provided counseling and wellness support hospital wide. (Ongoing)
- Recruiting behavioral health social worker for the ED; FY25 budget includes support for ED psychiatric area. (2024)

Involved Departments:
Executive Team, Medical Staff, Patient Care Services, Emergency Department, Population Health, Care Management, Facilities, Risk Management, Patient Experience, Chaplaincy

2. Obesity

Strategy: Partner with community organizations to promote healthier lifestyles.
Key Activities and Results:

- Joined Unite Delaware to connect patients with local services addressing SDoH. (2022)
- Launched 302 Food Rescue in partnership with the Food Bank of Delaware. (2022)
- Established structure for community partnership coordination. (2023)
- Deployed a mobile medical unit to serve patients in local neighborhoods. (2023)
- Distributed low-sugar, low-sodium food boxes to patients with food insecurity. (2023–2024)
- Initiated housing support efforts. (2024)

- Increased healthy food options in cafeterias and resident lounges. (2024)

Involved Departments:
Executive Team, Medical Staff, Patient Care Services, Bariatrics, Food & Nutrition, Pharmacy, Education, Population Health, Marketing & Community Outreach

3. Social Determinants of Health

Strategy: Collaborate with trusted partners to address basic needs.
Key Activities and Results:

- Screened 90% of inpatients for SDoH; ~15% had significant needs (mainly food & transportation).
- Purchased transport van for radiation therapy patients using donor funds. (2022)
- Partnered with local agencies (e.g., Habitat for Humanity) on energy- and housing-related interventions. (2022)
- Oncology piloted food boxes for patients with food insecurity. (2023)
- Expanded food box program to inpatients, outpatients and staff. (2022–2024)
- 884 food boxes distributed as of May 2024.

Involved Departments:
Executive Team, Oncology, Medical Staff, Patient Care Services, Respiratory, Cancer Institute, Finance, Foundation, Clinical Nurse Navigators, Population Health

4. Preventable ER Visits and Hospitalizations

Strategy: Improve access and deliver convenient, preventive care.
Key Activities and Results:

- Launched emergency medicine residency program. (2023)
- Hosted monthly Walk with a Doc events and Ask a Doc sessions. (2023)
- Opened Bayhealth at Blue Hen ambulatory center.
- GME residents provided care at La Red Health Center for Hispanic populations. (2024)
- GME residents participated in multiple community events (e.g., Pride Fest, wellness fairs, sports physicals). (2022–2024)
- Chronic care managers embedded in primary care practices for high-risk patients.
- Introduced Bayhealth at Home app for virtual physician access. (2023)
- Created Virtual Operations Center for optimal patient placement. (2023)
- Embedded mental wellness counselors in Bayhealth Family Medicine. (2023)
- Improved chronic disease metrics and reduced readmissions. (2021–2023)
- Partnered with Unite Delaware to address SDoH; nearly 50% of patients referred had no ED/IP visits in the following 6 months. (2022–2023)
- Referred ~1,000 patients to Unite Delaware in FY24.

Involved Departments:
Executive Team, Medical Staff, GME Program, Bayhealth Medical Group, Liaisons, Population Health, Information Technology

Appendix D- Sources

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[ii] https://www.census.gov/quickfacts/fact/table/kentcountydelaware/BZA210222
[iii] https://uscountymaps.com/kent-county-map-delaware/
[iv] https://www.census.gov/quickfacts/fact/table/kentcountydelaware/BZA210222
[v] https://datausa.io/profile/geo/kent-county-de
[vi] https://www.census.gov/quickfacts/fact/table/kentcountydelaware/BZA210222
[vii] https://whyy.org/articles/black-maternal-health-week-delaware/
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