Sentara Norfolk General Hospital

COMMUNITY HEALTH NEEDS ASSESSMENT 2022

We Improve Health Every Day

SENTARA®

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EXECUTIVE SUMMARY

As an organization, we are driven to improve health every day. And while we meet that mission through the healthcare services we provide to our patients, we understand that our greater purpose must include building trust and listening to the voices of individuals in the community to better understand the specific needs of those we serve. In 2021, Sentara Norfolk General Hospital (SNGH) began conducting the community health needs assessment of the area that we serve. The assessment, completed in 2022, provides us with a picture of the health status of the residents in our communities and provides us with information about health and health-related problems that impact health status.

> *"Sentara Norfolk General is committed to providing services, developing partnership, and supporting innovation within our local community, which supports our mission of improving health every day."*
>
> ***Ciara Jones**, MHA, BSN, RN, CHFN, Clinical Nursing Manager*

Sentara conducts comprehensive community health needs assessments for each of our inpatient hospitals and outpatient surgical centers across Virginia and Eastern North Carolina. The following comprehensive report goes into more detail about the assessment to include an introduction, social and economic factors, demographic and background information, health determinant data and incorporates extensive community survey and outreach. The community health needs assessment incorporates information from a variety of primary and secondary quantitative data sources and more importantly helps us to understand the disparities that exist in vulnerable populations.

We are grateful to the residents, faith-based organizations, businesses, clinics, nonprofits, government agencies, and others who devoted expertise and significant time helping us better understand these priorities identified and know we must be committed to working together to identify solutions. We further understand that the implementation strategies will be most successful by working with residents of the community so that we move closer to achieving health equity for all.

While there are many important community health problems, we are focusing our efforts on the key issues listed below. Considering factors such as size and scope of the health problem, the severity and intensity of the problem, the feasibility and effectiveness of possible interventions, health disparities associated with the need, the importance the community places on addressing the need, and consistency with our mission "to improve health every day," we have identified these priority health problems in our area, all of which have been exacerbated by the COVID-19 pandemic:

SNGH Health Priorities for 2022-2025:

- Behavioral Health
- Chronic Disease
- Social Determinants of Health

OVERVIEW

We Improve Health Every Day

Sentara celebrates more than 130 years in pursuit of its mission - "We improve health every day." Named to IBM Watson Health's "Top 15 Health Systems" in 2018 and 2021, Sentara is an integrated, not-for-profit health system of 12 hospitals in Virginia and Northeastern North Carolina, including a Level I trauma center, the Sentara Heart Hospital, the Sentara Brock Cancer Center, two orthopedic hospitals, and the Sentara Neurosciences Institute. The Sentara family also includes a medical group, Nightingale Regional Air Ambulance, home care and hospice, ambulatory outpatient campuses, advanced imaging and diagnostic centers, a clinically integrated network, the Sentara College of Health Sciences and Sentara Health Plans, comprised of Optima Health Plan and Virginia Premier Health Plan, serving 950,000 members in Virginia, and North Carolina. Sentara has more than 30,000 employees dedicated to improving health in the communities we serve, and was recognized as one of "America's Best Employers" by Forbes in 2018. Sentara is strategically focused on clinical quality and safety, innovation and creating an extraordinary health care experience for our patients and members.

SENTARA AT A GLANCE

- Headquartered in Norfolk, Virginia
- 130-year not-for-profit history
- 12 hospitals
- One medical group
- 3,800+ provider medical staff
- 30,000+ team members
- Sentara Health Plans
- Outpatient campuses
- Urgent care centers
- Advanced Imaging Centers
- Home health and hospice
- Rehabilitation and therapy centers
- Nightingale air ambulance

INTRODUCTION

Sentara Norfolk General Hospital

Serving as a destination medical center in the mid-Atlantic region, Sentara Norfolk General Hospital (SNGH) is one of just five Level 1 trauma centers in Virginia, home to the Nightingale Regional Air Ambulance, the region's first Magnet® hospital and nationally ranked heart program, Sentara Heart Hospital. SNGH, on the Eastern Virginia Medical Campus, is a large 525-bed medical center, which serves as the primary teaching institution for the adjacent Eastern Virginia Medical School (EVMS). Our partnership with EVMS combines the latest innovations in technology, research, and clinical care, to offer advanced diagnostic and therapeutic services. In fact, our Urology program, which is nationally ranked by U.S. News & World Report, is number 40 in the nation and supported by EVMS residents.

SENTARA CARES

Sentara cares about advancing health equity and ensuring that all members of our communities have access to the resources they need to live their healthiest and most fulfilling lives. We are guided by our understanding that our overall health is greatly influenced by where we are born and where we live, learn, work, play, worship, and age. In fact, these environmental factors account for nearly 80 percent of health outcomes, while direct health care accounts for only 20 percent.

Our purpose, then, calls us to address these issues on the ground every day where people live—not just when they are under our care. Only then can we help to eliminate health disparities and promote equitable access to nutritious foods, education, safe and affordable housing, and stable, rewarding job opportunities. We know such disparities cannot be solved solely in the exam room, and they cannot be solved solely by Sentara. However, through our partnerships, we continue to make both immediate impact and lasting change for our communities.

> *"We approach every community and every partner with our ears and our hearts open. We're not here to provide prescriptive solutions. We're here to support and amplify the work of our partners in every way we can to improve more lives and inspire more hope for the future."*
>
> ***Sherry Norquist**, MSN, RN-ACM*
> *Director of Community Engagement & Impact*

COVID-19 RESPONSE

As we embarked on this Community Health Needs Assessment (CHNA) process, the country and Virginia were focused on mitigating the COVID-19 pandemic. The impacts of COVID-19 are likely to affect community health and well-being beyond what is currently captured in available data. Sentara seeks to engage the community as directly as possible in prioritizing needs.

Sentara is committed to always keeping our patients, employees, and community members safe. We have developed extensive safety protocols and guidelines to ensure the patient/member receives the care they need at any Sentara facility. Sentara cares about improving the health and well-being of all individuals and the quality of life enjoyed by everyone in our community. Sentara responds to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. We are committed to supporting, strengthening, and serving our communities.

OUR PROCESS

Sentara developed a primary statistical data profile integrating claims and encounter data to assess the population's use of emergency services, preventive services, chronic health conditions, and cultural and linguistic needs. A secondary statistical data profile was created using advanced data sources to assess population characteristics such as household statistics, age, educational level, economic measures,

mortality rates, incidences rates, and racial and ethnic composition because social factors are important determinants of health. Our assessment includes a review of risk factors including obesity and smoking and other health indicators such as infant mortality and preventable hospitalizations.

Research components for this assessment included data from the following sources:

- Alzheimer's Association
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- National Cancer Institute
- United States Census Bureau
  - American Community Survey 2019: 5-Year Estimates Data Profiles
- Virginia Department of Health
- Virginia Health Information, AHRQ Quality Indicators
- Virginia Department of Medical Assistance Services
- County Health Rankings 2021
- Weldon Cooper Center for Population Studies, UVA
- Sentara Claims Data
- Community Health Needs Assessment Survey
- Community Focus Groups

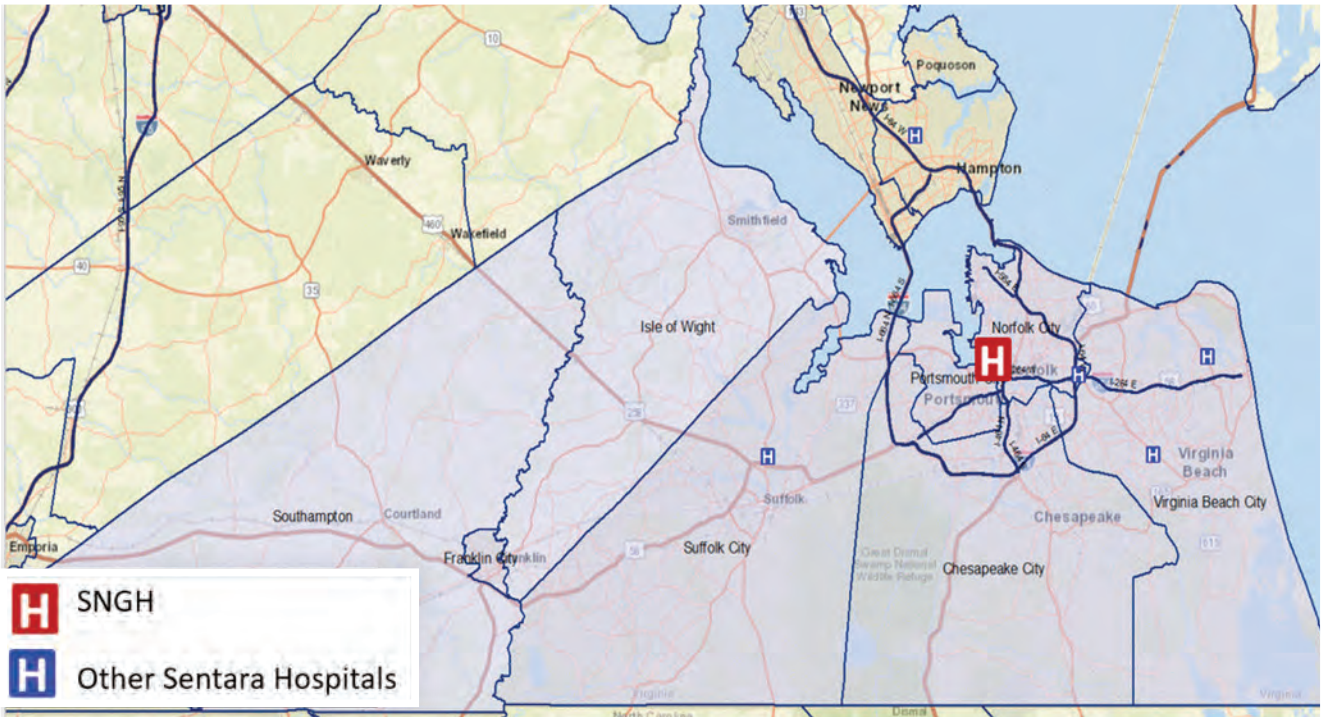
Community input is imperative, so we conducted a survey jointly with Bon Secours Hampton Roads, Children's Hospital of The King's Daughters, Riverside Health System, the Hampton and Peninsula Health Districts, and Three Rivers Health District. The assessment includes survey results from key stakeholders including public health, social services, service providers, and those who represent underserved populations. An additional survey of Hampton Roads residents on key health topics is included. The report also includes findings from focus groups with community members on health issues and barriers to achieving good health.

OUR NEXT STEPS

SNGH works with a number of community partners to address health needs. Using the information from this community health needs assessment, SNGH will develop an implementation strategy to address the identified health problems. SNGH will track the progress of the implementation activities to evaluate the impact of these actions. The implementation progress report for the 2019 CHNA is available at the end of this report.

Information on available resources is available from sources including 2-1-1 Virginia and sentara.com. By using this information, together, we will work to improve the health of the communities we serve.

Your input is important to us so that we can incorporate your feedback into our assessments. You may use our online feedback form available on the sentaracares.com website.

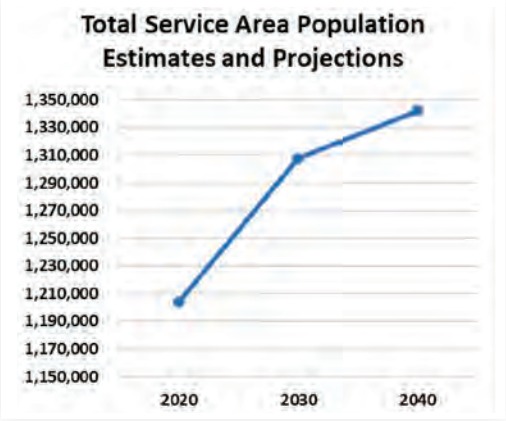


THE SENTARA NORFOLK GENERAL HOSPITAL (SNGH) SERVICE AREA SOURCE: TRUVEN/MARKET EXPERT

COMMUNITY DESCRIPTION

GEOGRAPHY

The service area of SNGH is comprised of eight localities: the Cities of Norfolk, Chesapeake, Virginia Beach, Portsmouth, Suffolk, and Franklin, as well as the Counties of the Isle of Wight and Southampton. The geography of the service area includes two urban centers, Virginia Beach and Norfolk. Some of the localities in the service area are very rural within the 2,015 square mile region (Appendix A).



POPULATION CHANGE

The service area population is enjoying healthy growth, primarily driven by Chesapeake's 10.9% growth since 2010 and Suffolk's 10.3% (Appendix A). Virginia Beach, Portsmouth and Isle of Wight have seen moderate growth, while, Norfolk, Southampton and Franklin have lost population.

COMMUNITY SPECIFIC DEMOGRAPHICS (APPENDIX A)

City of Chesapeake has 249,422 residents with 7.6% of this population living in poverty and 10% uninsured. Of the population in this city, 30.5% are ages 0-19, 12.5% are ages 20-29, 47.4% are ages 30-64, 12.1% are ages 65-84, and 1.3% are aged 85 and over. 91.7% of the residents primarily speak English, while 8.3%

Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219
Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org

speak another language in the home. The ethnicity for this population includes 61.1% white, 30.0% African American, 6.2% Hispanic, and 3.2% Asian.

City of Franklin has 8,180 residents with 18.1% of this population living in poverty and 11% uninsured. Of the population in this city, 31.9% are ages 0-19, 9.7% are ages 20-29, 42.6% are ages 30-64, 23.6% are ages 65-84, and 2.3% are aged 85 and over. 97.3% of the residents primarily speak English, while 2.7% speak another language in the home. The ethnicity for this population includes 36.9% white, 56.7% African American, 1.1% Hispanic, and 1.3% Asian.

City of Norfolk has 238,005 residents with 17.6% of this population living in poverty and 15% uninsured. Of the population in this city, 26.3% are ages 0-19, 22.5% are ages 20-29, 42.7% are ages 30-64, 9.7% are ages 65-84, and 1.2% are aged 85 and over. 89.6% of the residents primarily speak English, while 10.4% speak another language in the home. The ethnicity for this population includes 47.0% white, 41.1% African American, 8% Hispanic, and 3.7% Asian.

City of Portsmouth has 97,915 residents with 15.3% of this population living in poverty and 13% uninsured. Of the population in this city, 30.9% are ages 0-19, 14.0% are ages 20-29, 45.2% are ages 30-64, 13.1% are ages 65-84, and 1.8% are aged 85 and over. 95.4% of the residents primarily speak English, while 4.6% speak another language in the home. The ethnicity for this population includes 39.8% White, 52.9% African American, 4.5% Hispanic, and 4.5% Asian.

City of Suffolk has 94,324 residents with 9.0% of this population living in poverty and 10% uninsured. Of the population in this city, 30.3% are ages 0-19, 10.6% are ages 20-29, 47.2% are ages 30-64, 14.0% are ages 65-84, and 1.5% are aged 85 and over. 94.9% of the residents primarily speak English, while 5.1% speak another language in the home. The ethnicity for this population includes 52.1% white, 42.6% African American, 4.7% Hispanic, and 1.9% Asian.

City of Virginia Beach has 459,470 residents with 8.1% of this population living in poverty and 11% uninsured. Of the population in this city, 28.6% are ages 0-19, 15.4% are ages 20-29, 45.6% are ages 30-64, 12.7% are ages 65-84, and 1.6% are aged 85 and over. 87.5% of the residents primarily speak English, while 12.5% speak another language in the home. The ethnicity for this population includes 66.3% white, 19.0% African American, 8.2% Hispanic, and 6.7% Asian.

County of Isle of Wight has 38,606 residents with 7.6% of this population living in poverty and 10% uninsured. Of the population in this county, 26.1% are ages 0-19, 9.1% are ages 20-29, 48.1% are ages 30-64, 18.5% are ages 65-84, and 1.9% are aged 85 and over. 95.2% of the residents primarily speak English, while 4.8% speak another language in the home. The ethnicity for this population includes 72.7% white 23.2% African American, 3.4% Hispanic, 1.0% Asian.

County of Southampton has 17,996 residents with 12.5% of this population living in poverty and 12% uninsured. Of the population in this county, 22.8% are ages 0-19, 9.0% are ages 20-29, 49.1% are ages 30-64, 19.0% are ages 65-84, and 1.7% are aged 85 and over. 98.4% of the residents primarily speak English, while 1.6% speak another language in the home. The ethnicity for this population includes 62.3% white, 34.7% African American, 2.0% Hispanic, and 0.5% Asian.

Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219
Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019http://demographics.coopercenter.org

POPULATION HIGHLIGHTS

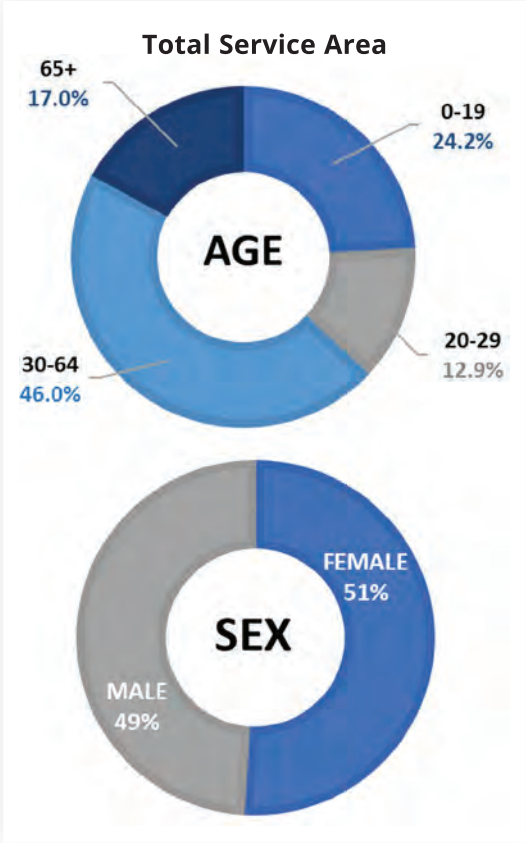
The combined population of the SNGH service area is over 1.2 million people, accounting for 14% of the population of the Commonwealth of Virginia. Virginia Beach is the most populous city in the service region, followed by Chesapeake and Norfolk. Those three cities combined hold 11% of the population of the Commonwealth of Virginia (Appendix A).

Age and Sex

Out of the 1,203,918 community members living in the SNGH service area, most residents are between the ages of 30-64 (Appendix A). There is a slightly higher percentage of residents aged 65+ than the state. Norfolk, Virginia Beach, and Chesapeake have the highest number of the senior population with 117,540 residents aged 65+. Franklin has the highest percentage of the very elderly, aged 85+.

Chesapeake, Suffolk, and Portsmouth have the highest percentage of children. There were 14,979 babies born in the service area in 2019. The majority of the births were in Norfolk and Chesapeake with the highest number being in Virginia Beach, accounting for slightly over 8% of state-wide births.

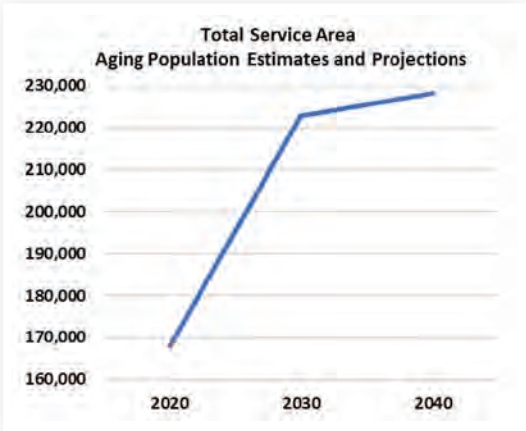
Similar to state demographics, there is a slightly higher percentage of residents born as female in the entire service area with Norfolk and Southampton having slightly over half of the residents born as male.



Aging Population

It is well understood that older individuals are more likely to need more health care services, and a variety of services are targeted to that population. The population of the SNGH service area is projected to be older than the state in 2040. Research shows that the highest utilization of medical services is among elderly populations. Within this service area, the percentage of the very elderly is highest in Portsmouth and Isle of Wight. In 2020, 13.9% of the population living in the service area is age 65+, slightly below the population of Virginia which is 15.9%. By 2030, the population of older adults in the service area is projected to be 18.5%, and by 2040, it increases to 18.9%. This shows the number of older adults increasing in the next 10 years, leading to a higher number of aging adults in the service area.

Isle of Wight is projected to have an increase of 1.3% by 2040. Though, it is important to note the 2040 projected overall population of residents aged 85+ in Isle of Wight being 1,430 is relatively low compared to the 5,707 residents projected for Chesapeake (Appendix A).



Source: Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org

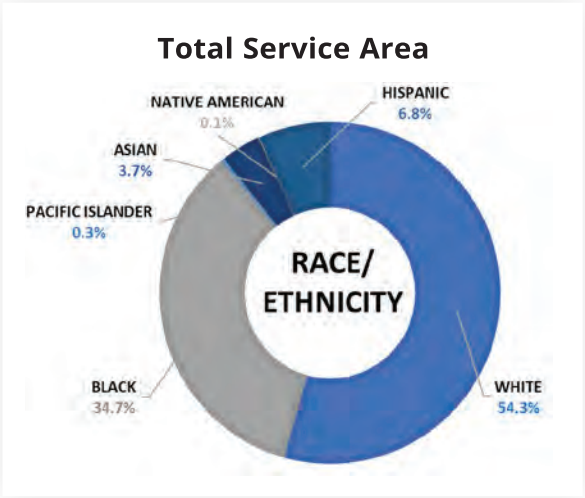
Other Demographic Features

The overall rate of the population who are veterans is higher than that of Virginia or the United States, with 11.4% veterans living in the service area (Appendix A). The median home value is less than that of Virginia as a whole, and the median income and per capita income reflect a lower cost of living. There is a higher percentage of owner-occupied homes in Chesapeake, Suffolk, Isle of Wight and Southampton compared to the state. In the rural communities, fewer households have computers and internet access, impacting remote learning opportunities and outcomes during the COVID-19 pandemic. The population living in the service area has a higher percentage of persons living with a disability than the state, which has a rate of 8%. This is indicated both for children, working age adults and the elderly. Virginia Beach and Chesapeake, however, have a lower percentage of disabilities, 7.8% and 7.9%. Norfolk, Portsmouth, Southampton, and Franklin have a higher percentage of persons living in poverty, and lower percentage of college degrees when compared to the state.

COMMUNITY DIVERSITY PROFILE

Ethnicity

The population of the service area is overwhelmingly white and Black, with Virginia Beach and Norfolk, being the most diverse communities (15% and 12.2% combined non-white or Black) followed by Chesapeake at 9.7% combined (Appendix A). All other localities have no more than 7% combined non-white or Black population. Virginia Beach, Norfolk and Chesapeake have small Asian populations, but no other racial groups are represented in the area in any significant number.



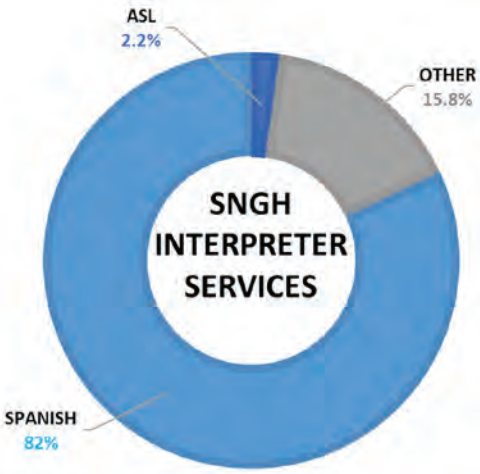
The service area population has a small Hispanic population, with Virginia Beach being home to the largest Hispanic community with 8.2% of the population followed by Norfolk with 8% and Chesapeake with 6.2%. No other community in the service area has more than 5% Hispanic community, with Southampton and Franklin having less than 3%.

Preferred Language

English is the primary language spoken in the service area. As of 2020, 90.9% of the population being served identified as English speaking. Per the 2014 American Community Survey five-year estimates, Spanish was the second language identified in the community being served, with 12,049 community members living in the service area identifying as speaking English less than well (Appendix A).

Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219

Virginia Department of Health Culturally and Linguistically Appropriate Health Care Services; US Census Bureau American Community Survey Five-Year Estimates, 2014 vintage; https://apps.vdh.virginia.gov/omhhe/clas/leppopulation/



Source: SNGH 2021 Sentara Language Line Usage Report

Cultural and Linguistic Needs

It is important to note that non-English-speaking populations are vulnerable. Non-English-speaking populations are disproportionately among the lowest socioeconomic status populations, tend to have poorer health and more disabilities, are often linguistically and culturally isolated, and live with less income and lower education than their English-speaking counterparts. The language barrier makes it difficult for this population to understand, interpret, and implement preventive recommendations.

Departments within Sentara and SNGH continue to work closely with one another to ensure all communication to members is in the preferred language, offering interpreter services when needed. Sentara provides its patients and their families with qualified interpreters for languages other than English, as well as American Sign Language (ASL). In 2021, SNGH had 13,104 requests for interpreter services. The highest percentage of interpreter services were for Spanish speaking individuals.

Health Equity

The CHNA analyzes the differences by race and ethnicity, language needs, age, gender, income, and housing. A dedicated focus on health equity allows for a better understanding of the community needs. Equity continues to be an issue and is rapidly evolving in health care systems as global health crises and ongoing disparities impact local communities. Health equity work highlights awareness, education and access to care, or lack thereof, across racial, ethnic, gender, and geographic groups, and how implicit or unconscious bias among providers affects treatment decisions and outcomes. Where people live can influence educational and occupational opportunities impacting financial stability which affect their well-being and quality of life.

***Inequities** occur when barriers prevent people from reaching their full potential.*

***Health disparities** are the differences in health status between groups of people.*

***Health equity** provides everyone the opportunity to attain their highest level of health.*

Source: American Public Health Association (APHA), apha.org/topics-and-issues/health-equity

The Health Equity team analyzes economic status, access to health care, transportation, and other social determinants of health to identify potential causes of health inequity in our communities. Partnerships are formed with community leaders and organizations, physicians, and all Sentara facilities to achieve more equitable health care.

Priorities include measurement of disparities and factors that contribute to them, and development and implementation of an action plan to reduce disparities in care. This includes screening and diagnosis rates for chronic health issues such as hypertension and diabetes, and prevalence of prostate and breast cancers in communities of color, utilization rates for treatments and development of initiatives for communities of color, immigrants, patients who are unsheltered and other marginalized groups, including LGBTQ+ persons and individuals with disabilities.

SOCIAL DETERMINANTS OF HEALTH

Sentara seeks to transform the lives of our neighbors by focusing on the root factors that affect our health beyond the clinical care we receive.

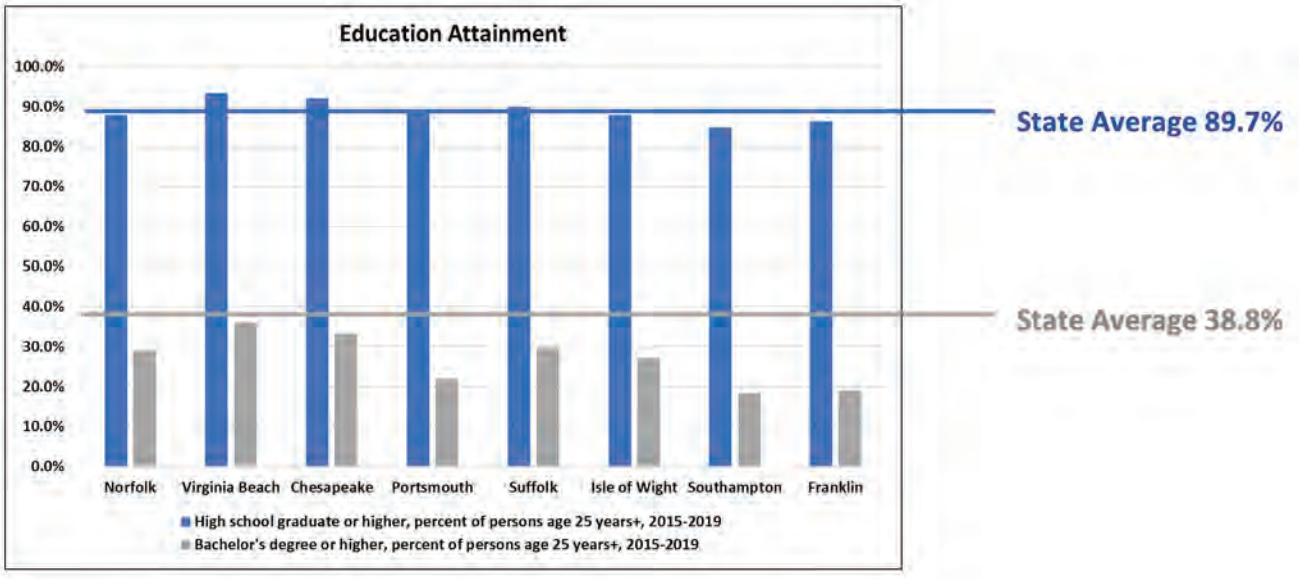
Sentara works to:

- Fill the unprecedented need for behavioral health practitioners in the field and ensure greater access to behavioral health services for children, families, and adults.
- Secure consistent, equitable access to nutritious food — every day and in times of emergency need.
- Support targeted training and development programs for higher-paying skilled careers.
- Develop more robust emergency and scattered housing solutions in our communities.
- Dismantle barriers to accessing health and human services in traditionally underserved populations.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
April 15, 2022
https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Education

Education is the basis for stable employment, and financial stability is the foundation for a sustainable household, which provides for the health needs of family members. Franklin and Southampton have the highest percentage of individuals aged 25+ with less than a high school diploma, while Virginia Beach has the highest percentage of residents with advanced or professional degrees, though still below the state average.



Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219

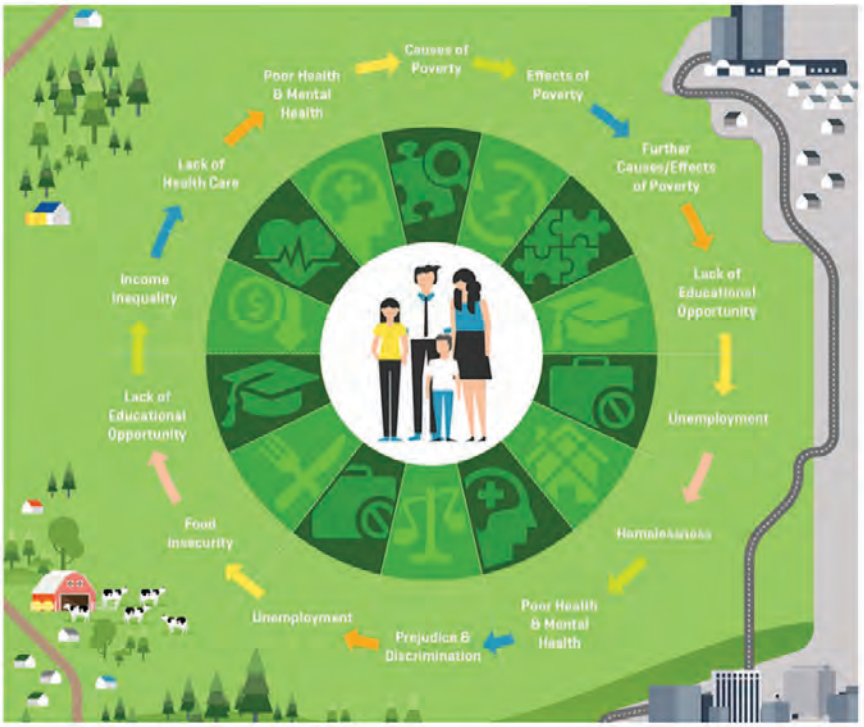
The Cycle of Poverty

Poverty continues because it reproduces existing patterns of circumstances, opportunities, and effects.

The causes of poverty lead to consequences that make it more likely that the individual – or their offspring – will experience poverty in the future.

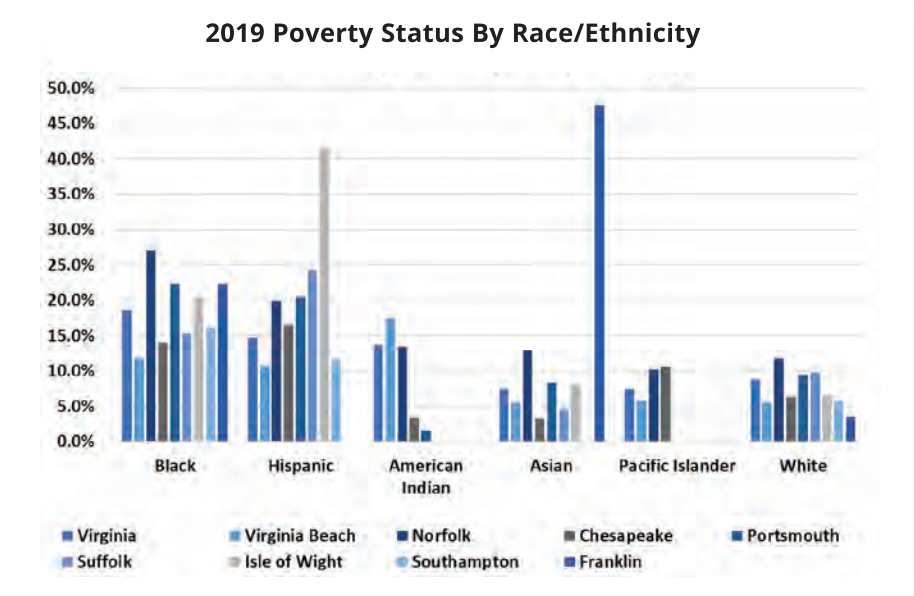
Generational poverty is a vicious cycle in which each generation is unable to escape poverty because of a lack of resources to put toward the effort.

Rural Poverty vs Urban Poverty | Social Workers | AU Online (aurora.edu)



Poverty

While simple poverty rates tell us something about the residents of the service area, by inserting race as a factor we see the racial disparities that constrain residents of the service area in their ability to support and sustain healthy, functioning households for themselves and their children. As with Virginia as a whole, African Americans, Hispanic, and American Indians are more likely to live in poverty compared to white Americans.

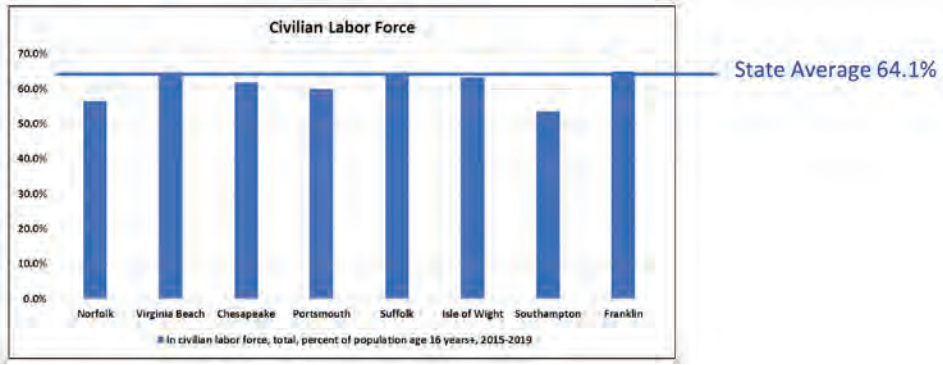


Virginia Beach residents are less likely to live in poverty than other area residents. The poverty rates for Suffolk are closer to the rate for Virginia as a whole. Norfolk, Portsmouth, Southampton, and Franklin residents are more likely to live in poverty than those in other counties by a significant margin, and an even bigger contrast than with residents of the Commonwealth of Virginia.

Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219;

Employment

Central to a healthy community is an economy that supports individuals in their efforts to live well. The service area is slightly above the state average of residents in the civilian labor force. Of those in the civilian labor force, the percentage of female residents is higher than the state average.



Medicaid & FAMIS, Medicare, Medicare & Medicaid Enrollment

Out of the 626,398 members newly enrolled in Medicaid in the Commonwealth of Virginia, 463,967 are below 100% of the federal poverty level and 162,431 are between 101-138% of the federal poverty level. The total service area has a higher percentage of members on Medicaid and FAMIS compared to Virginia with the highest percentage living in Norfolk and Portsmouth. The number of residents living in the service area receiving Medicaid and FAMIS services continues to increase each year, with an increase of 21.7% since January 2020.

In 2019, there were 84,915 community members age 65+ living in the service area receiving Medicare and 7,009 receiving both Medicare and Medicaid. As the aging population grows in this service area, so will the need for these services.

Medicaid and FAMIS 2022/Medicare and Medicaid 65+ 2019

	Virginia	Total Service Area	Virginia Beach	Norfolk	Chesapeake	Portsmouth	Suffolk	Isle of Wight	Southampton	Franklin
Medicaid Enrollment (Below 138% FPL)	626,398	97,483	29,639	26,118	16,579	12,905	6,807	2,335	1,949	1,151
Medicaid Percentage	7.2%	**8.0%**	6.4%	**10.9%**	6.6%	**13.1%**	7.2%	6.0%	**10.8%**	**14.0%**
FAMIS (Below 138% FPL)	1,347,010	193,384	57,745	52,188	34,681	27,393	16,454	4,923	--	--
FAMIS Percentage	15.6%	**16.1%**	12.6%	**21.9%**	13.9%	**27.9%**	14.4%	12.7%	--	--
Children Enrolled in Medicaid/FAMIS (Below 138% FPL)	813,229	115,151	35,689	30,211	21,057	16,132	9,345	2,717	--	--
Children Enrolled in Medicaid/FAMIS Percentage	9.4%	**9.5%**	7.7%	**12.6%**	8.4%	**16.4%**	**9.9%**	7.0%	--	--
65+ Medicaid (Below 138% FPL)	83,149	10,333	2,697	3,161	1,700	1,439	971	365	--	--
65+ Medicaid Percentage	0.9%	0.8%	0.5%	**1.3%**	0.6%	**1.4%**	**1.0%**	0.9%	--	--
65+ Medicare	802,949	84,915	30,733	13,795	18,042	8,095	7,757	4,254	2,239	--
65+Medicare Percentage	64.5%	55.5%	50.5%	53.2%	59.3%	60.2%	61.8%	63.8%	**70.4**	--
65+ Medicare and Medicaid	56,810	7,009	1,349	2,469	971	827	820	373	200	--
65+ Medicare and Medicaid Percentage	4.6%	4.6%	2.2%	**9.5%**	3.2%	**6.2%**	**6.5%**	**5.6%**	**6.3%**	--
Persons in Poverty	9.2%	**9.3%**	8.1%	**17.6%**	7.6%	**15.3%**	9.0%	7.6%	**12.5%**	**18.1%**

Source: Virginia Medicaid Department of Medical Assistance Services; (As of January 15, 2022) https://www.dmas.virginia.gov/data;
US Census Bureau QuickFacts Table 2020; (2020 Small Area Income and Poverty Estimates (SAIPE)); Centers for Medicare & Medicaid Services 2019; Mapping Medicare Data;
-- Suppressed data; FEP: Federal poverty level; FAMIS: Family Access to Medical Insurance Security

COMMUNITY INSIGHT

Having an active, supportive, and engaged community is essential to creating conditions that lead to improved health. The community insight component of this CHNA consisted of two methodologies: community surveys and a series of more in-depth community focus groups partnered with the hospital.

COMMUNITY SURVEY

The community surveys were conducted jointly with Bon Secours Hampton Roads, Children's Hospital of The King's Daughters, Riverside Health System, and the Hampton and Peninsula Health Districts of the Virginia Department of Health to obtain community input.

The survey was conducted with a broad-based group of community stakeholders and community members in Eastern Shore, Middle Peninsula, Peninsula, South Hampton Roads, Western Tidewater, and Northeast region of North Carolina. Surveys were available online and in English and Spanish by paper submission. The survey gathered demographic data such as gender, race, income, zip code and COVID-19 factors. The survey asked respondents for their insight and perspective regarding important health concerns in the community for adults and for children:

- What is important to the health of adults and children?
- What should be improved in the community to keep children and families healthy?
- What should be added or improved in the community to help families be healthy?
- What are the most important health concerns for adults and children?
- How is the community accessing resources for health concerns for adults and children?
- What makes it difficult to access healthcare services for adults and children?

The surveys were made available to the public from December 1, 2021 – February 28, 2022, in paper format and electronically using SurveyMonkey. The survey was distributed to 1,892 stakeholders including individuals representing public health, education, social services, businesses, local government, and local civic organizations.

After the initial survey period, the collaborative recognized that a preponderance of respondents were white females. Sentara leaders partnered with clinical staff at each hospital to encourage survey participation. Sentara staff also attended a Hispanic Women's Health Fair, Feria de Salud de la Mujer, to encourage additional survey participation from Hispanic community members. Thirteen families completed the survey at the event, the information obtained was used for this assessment.

At the completion of the survey period, 1,871 stakeholder surveys and 17,294 community member surveys were completed. It is important to note that not every respondent answered every question in the stakeholder and community member surveys. Most counties did not have an equally distributed response to surveys to represent

the entire service area population. As a result, survey responses should be considered as only one component of information utilized to select health priorities. The most underserved populations' feedback is not adequately reflected in most surveys. Sentara staff performed targeted outreach activities to include individuals who serve the underserved populations to further develop the robustness of the survey response.

> ***"We need to listen to our community and allow them to guide us. Then, we need to focus on the key drivers that are the biggest impact to health outcomes."***
>
> *-Anonymous Stakeholder*

The stakeholders responding to the survey represent multiple organizations, each having unique insight into the health factors that impact the community with 43.85% being healthcare providers and employees of community health centers. The stakeholders represent hospitals, physician offices, city departments of social services, health departments, and community-based non-profit service organizations. The respondents have represented many diverse professional and volunteer fields–from emergency medical providers to pastors and public-school teachers. See Appendix C for the complete survey, the list of types of employers for stakeholder respondents, characteristics of survey respondents and top health concerns.

Demographics of Survey Respondents

Of the 19,165 respondents, just over 10,000 answered the demographic questions. The respondents were 78.5% Caucasian, 14.61% African American, 3.64% Hispanic, 1.81% Asian, and 0.5% Native American. The respondents were 70.7% female, 26.12% male and 0.5% nonbinary, with 2.64% preferring not to answer. The primary language of respondents was English, with 0.8% stating other primary language. Other languages spoken in the home and chosen by respondents included Spanish (1.6%), German (0.5%), Tagalog (0.3%), American Sign Language (0.21%), Arabic (0.2%), Chinese (0.2%), Korean (0.2%), Russian (0.2%), and other (0.3%). The respondents varied with education completed, with 5.7% having completed high school, 17.7% having had some college experience, 10.2% having received an associate degree, 31.6% having received a baccalaureate degree and 33.7% having earned a graduate degree.

Survey Responses

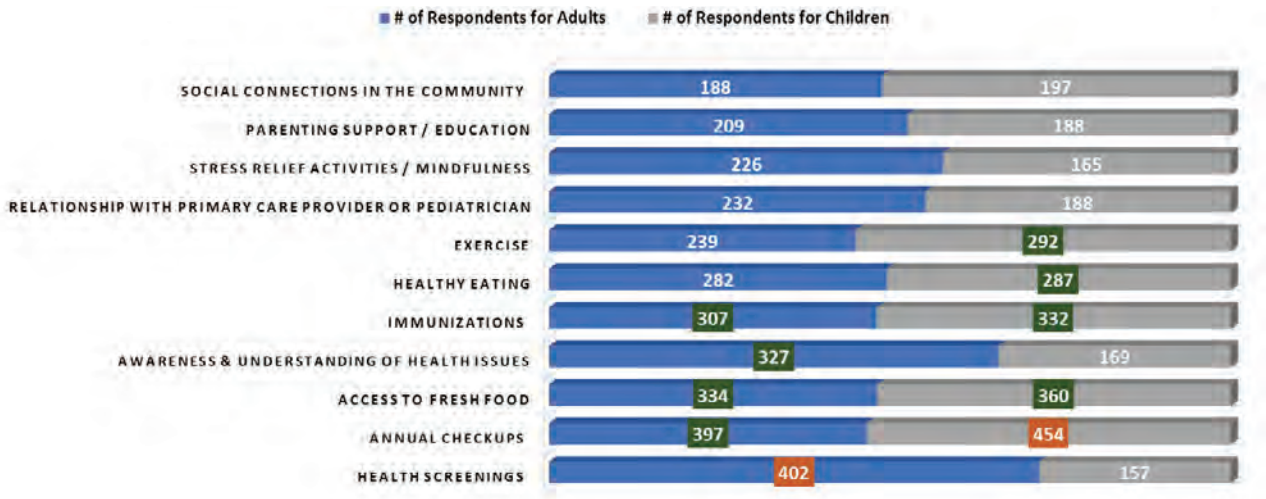
For this CHNA report, we will focus on the below questions asked in the survey. Survey respondents were asked to review a list of common community health issues and select up to three items. The tables below show the answers for each question among stakeholder and community member respondents.

- What is important to the health of adults and children?
- What should be added or improved in the community to help families be healthy?
- What are the most important health concerns for adults and children?
- What makes it difficult to access healthcare services for adults and children?

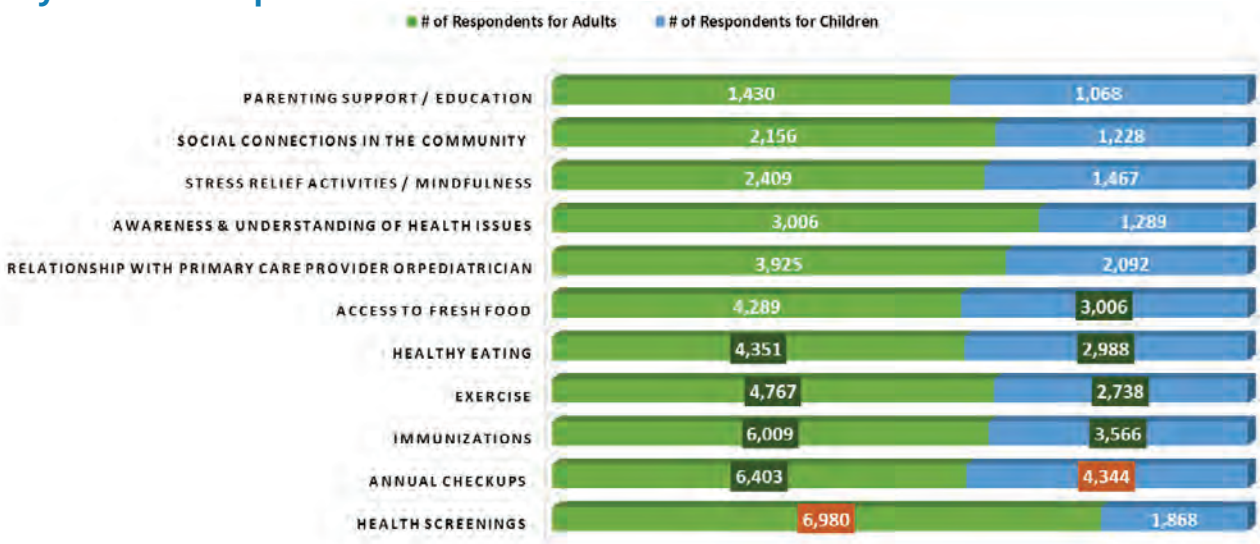
1. What is important to the health of adults and children?

Both stakeholder and community member survey respondents chose health screenings such as mammograms, colonoscopies vision exams, and cholesterol checks, annual checkups for adults and well child visits, and immunizations for flu, Tdap, MMR, and COVID-19 as being important to the health of adults in their communities. Stakeholders and community members chose the same topfive items that are important to the health of children. Respondents chose well visits for adults and children, immunizations, access to fresh food, healthy eating, and exercise.

Stakeholder Responses



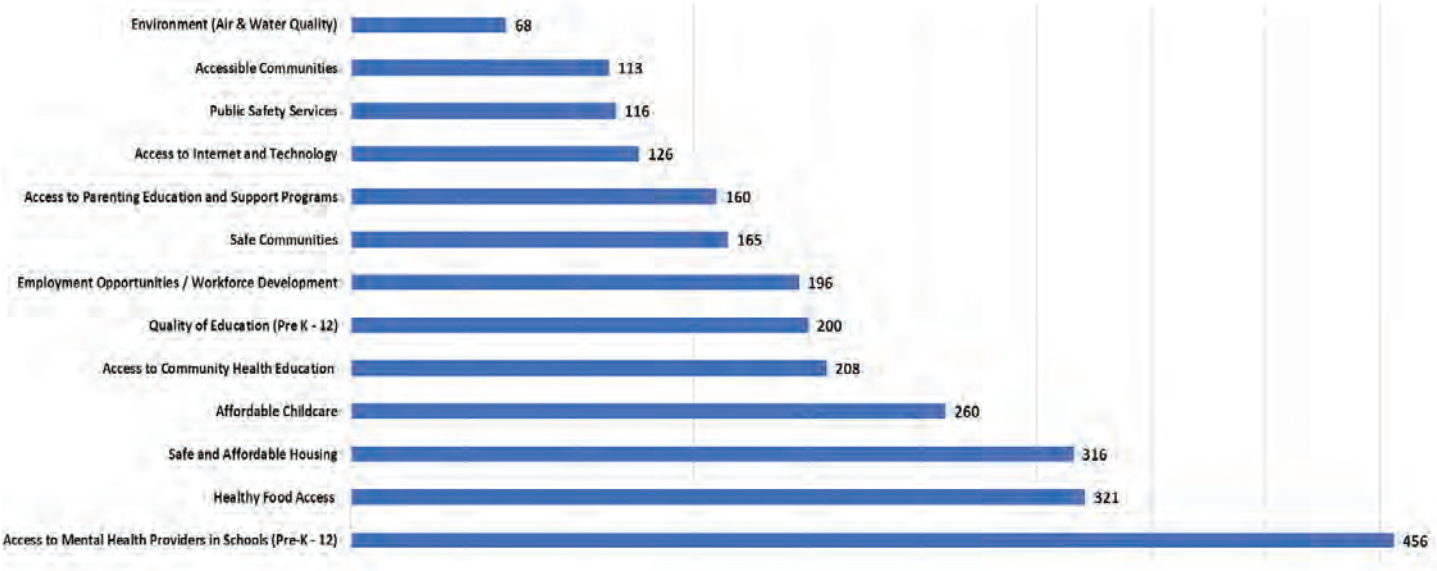
Community Member Responses



2. What should be added or improved in the community to help families be healthy?

Stakeholders and community member survey respondents most frequently chose access to mental health providers in schools (Pre-K-12) as an important area needed to be added or improved in the community. Respondents also chose healthy food access, i.e. fresh foods, community gardens, farmers' markets, EBT, and WIC, and safe and affordable housing.

Stakeholder Responses



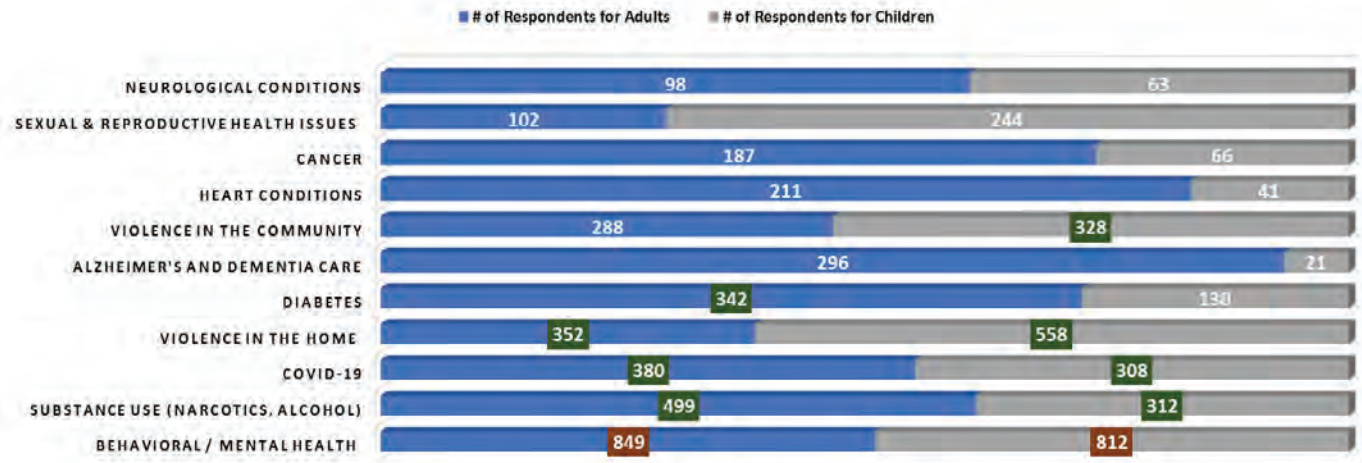
Community Responses

3. What are the most important health concerns for adults and children?

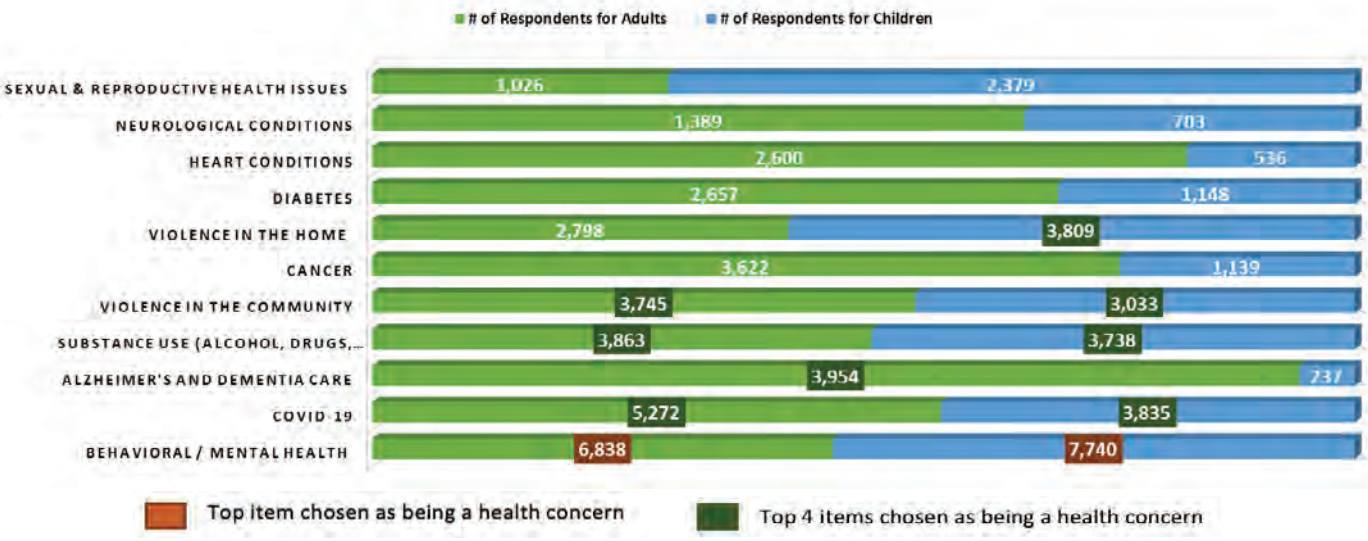
The most frequent response to question three, see above, was behavioral health such asanxiety, depression, psychoses, and suicid), substance use such as narcotics and alcohol, COVID-19, and Alzheimer's and Dementia care. For children, respondents chose behavioral health as defined above, COVID-19, violence in the community, substance use, and sexual and reproductive health issues such as sexually transmitted infections and teen pregnancy as the most pressing health concerns.

Behavioral health was the top identified health concern for both adults and children, along with access to mental health providers in schools (Pre-K-12). Perhaps this is resulting from the COVID-19 pandemic and isolation, as well as substance use and violence in the home and community. Behavioral health being identified as a top concern for children is consistent with the increased understanding that modern children live with a great deal of stress, both mental and physical, and it impacts their health in ways we are just beginning to understand.

Stakeholder Responses



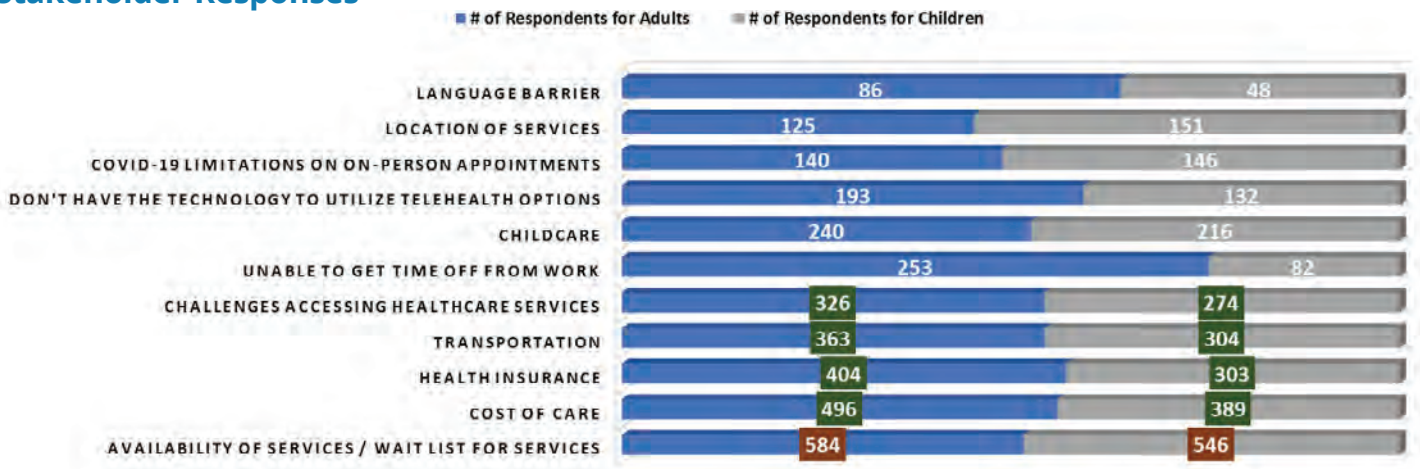
Community Member Responses



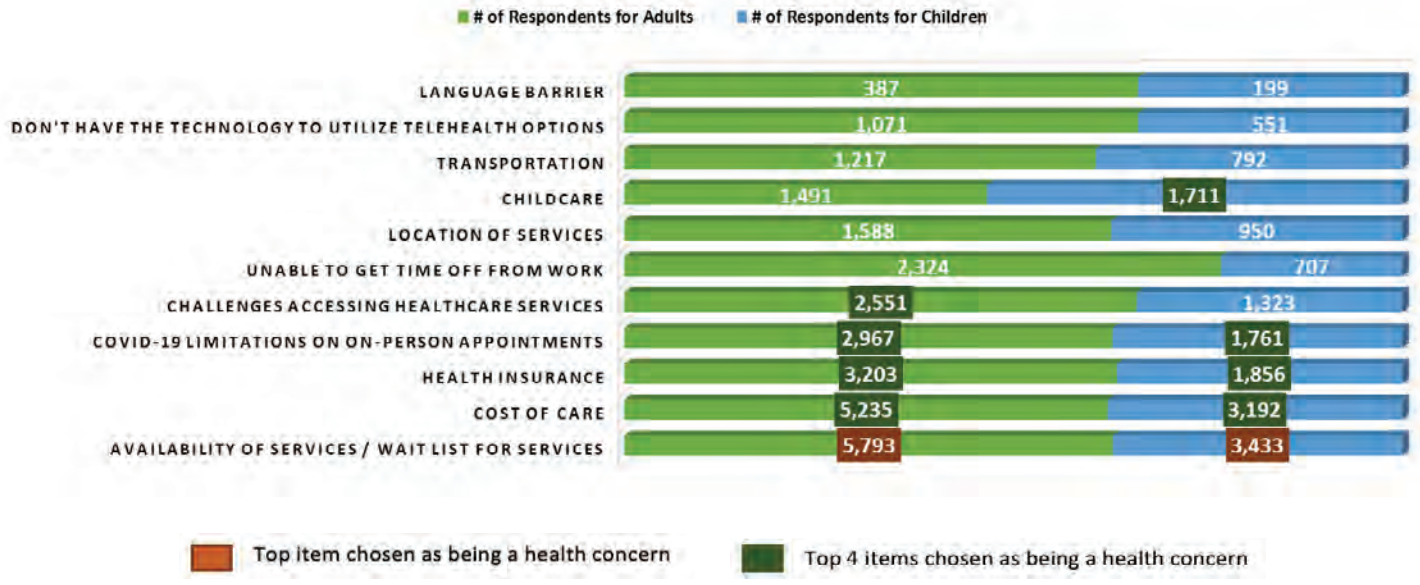
4. What makes it difficult to access healthcare services for adults and children?

When thinking about the barriers communities face to access healthcare services, stakeholder and community members mostly agreed on the top six. For adults, barriers identified wereavailability of services, wait list for services, cost of care, health insurance, challenges accessing healthcare services and unable to get time off from work. For children, barriers were similar to adults, and included availability of services, wait list for services, cost of care, health insurance, challenges accessing healthcare services, as well as childcare. The responses reflect that children face the same challenges in accessing care that adults do, while recognizing the effect of parenting and living conditions, often things over which children have no control.

Stakeholder Responses



Community Member Responses



Survey Results Review

In the 2019 CHNA, survey respondents also chose mental health/behavioral health as a major concern. The pandemic has been shown to have created additional mental health strain on the U.S. population, adding to an existing problem. Over the past several years, Sentara has worked to address this issue which is near the top of every CHNA both over time and across the country.

Access to behavioral and mental health services were the most frequently cited need in our community for children, teens, and adults in our community. Across the survey area, this choice is followed by substance use and COVID-19 for both adults and children, as well as Alzheimer's and dementia care for adults and violence in the home for children. As we understand more about how childhood events impact adult health, the call for these support services is likely to grow stronger. For a more detailed discussion of these effects, follow this link to the Adverse Childhood Experiences (ACES) website: https://www.cdc.gov/violenceprevention/aces/about.html.

While this assessment brings focus to an array of healthcare issues, the monumental issue in 2020-2022 has been the COVID-19 pandemic, caused by the novel coronavirus that entered the country at the end of 2019. Community member respondents were asked about their own personal experience with the disease to see how COVID has impacted community resources and services, and concerns regarding vaccines. Of 10,185 respondents, 91.2% stated adults in the home were vaccinated. Of 9,946 respondents, 24% stated their eligible children were vaccinated and an additional 34.74% planned to vaccinate their eligible children. Of 687 respondents who stated they were not vaccinated, 72.2% worried about the COVID-19 vaccine being harmful or having side effects for adults. Of 1,137 respondents whose children were not vaccinated, 80.04% also worried about the COVID-19 vaccine being harmful or having side effects for children.

The survey explored the many factors in addition to medical care that determine an individual's health. Collectively called the social determinants of health, these factors are increasingly becoming recognized as contributing both directly and indirectly to individual health through processes as different as the effect of household mold on respiratory disease and the effect of stress from unemployment. The effects of social determinants are sometimes subtle, sometimes only discoverable after a health problem is identified, but often important in explaining health status. Respondents were asked to choose three community assets to be strengthened. Their responses included affordable housing and childcare, healthy food access, quality of education, and safe communities.

The top choices of factors impacting access to care were availability of services, wait list for services, cost of care and health insurance. The lack of providers and the unavailability of providers to work extended hours, make access less feasible for those who work outside the home or have other scheduling constraints, and is the most often voiced barrier to care.

Some aspects of access to care impact population segments differentially. Access to care barriers disproportionately impact those with psychosocial barriers to care, such as lack of reliable transportation and limited income. The survey included a question designed to identify which consumers face barriers that might be addressed through specific programming.

COMMUNITY FOCUS GROUPS

In addition to the online surveys for community insight, SNGH carried out a series of more in-depth Community Focus Groups to obtain greater insight from diverse stakeholders.

Methodology

Focus groups were promoted electronically and by word of mouth to hospital patients and visitors, existing hospital and community groups and partner organizations, or sought from other populations in the community, including representatives of underserved communities and consumers of services. The questions below were utilized at each focus group session.

- What are the most serious health problems in our community?
- When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?
- Who has the health problems? What groups of individuals are most impacted by these problems?
- What keeps people from being healthy? In other words, what are the barriers to achieving good health?
- What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?
- How has the COVID-19 pandemic worsened the health issues in our community?
- What more can be done to improve health, particularly for those individuals and groups most in need?

SNGH held six focus group sessions between March and April 2022. The number of participants ranged from 8-30. When possible, representatives from the health department and other local hospitals were invited to attend the sessions.

Focus Groups

1. 3/09/2022 virtual session: Filipino focus
2. 3/30/2022 virtual session: EVMS/Community Leader/Community Member
3. 3/30/2022 virtual session: B.A.M.E (Black Asian, Minority, Ethnic) Focus Group
4. 4/5/2022 in-person session: Veterans of Foreign Wars of the United States of America
5. 4/6/2022 in-person session: Atlantis Apartments, low-income, African American and Latinx residents
6. 4/7/2022 in-person session: LGBTQ+ focus

Demographics

The 99 participants ranged between the ages of 17 over 60. Altogether, the focus group participants were comprised of 48.4% Caucasian, 29.2% African American, 10.1% Asian, 10.1% Hispanic, 1.1% Native American, with 1.1% participants preferring not to answer. The groups were 57.5% female and 34.3% male, and 1.2% nonbinary, with 7.0% preferring not to answer.

Methodology

Each focus group had a facilitator guiding discussions through the seven previously prepared questions. Additional staff took detailed notes to capture the information shared.

Results

Mental health, financial instability, lack of providers and access concerns were brought up in every focus group. For a detailed summary of the focus group sessions see Appendix D. A brief summary of the key findings for each topic is presented in the below tables.

TOPIC	KEY FINDINGS
What are the most serious health problems in our community?	• Anxiety and depression • COPD • High Blood Pressure • Sciatic nerve • Asthma • Dental health • Hypertension • Sexual Health • Cancer • Diabetes • Mental Health • Sickle Cell • Cardiovascular health • Health care expenses • Mold, environmental factors • Smoking and vaping • Chronic pain management • Heart Disease • Obesity • Substance Use
When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?	• Access to food and healthy food • Financial concerns • Understanding how to prepare healthy food • Access to services • Health behaviors • Housing • Social Support • Violence • Education • Peer Counseling • Transportation • Workplace violence

TOPIC	KEY FINDINGS
Who has the health problems? **What groups of individuals are most impacted by these problems?**	• African Americans • Discharged military • Laryngectomees • Under insured • African American Women • Fixed income • Latinx • Uninsured • Aging populations • Gender dysphoria • Low socioeconomic status • Working class • Caregivers • Geriatrics • Low-income populations • Young adults • Chronic disease diagnosis • Homeless • Minorities • Youth • Disabled persons • Indigent • Under educated
What keeps people from being healthy? **What are the barriers they face with taking care of their health and accessing care?**	• Access to doctor • Economic status • Lack of mental health providers • No insurance • Adequate housing • Education • Lack of resources • Poor diet • Affordable health care • Fear • Lack of social support Race • Culture Financial barriers • Loneliness • Time • Drugs • Food insecurity • Mistrust • Transportation

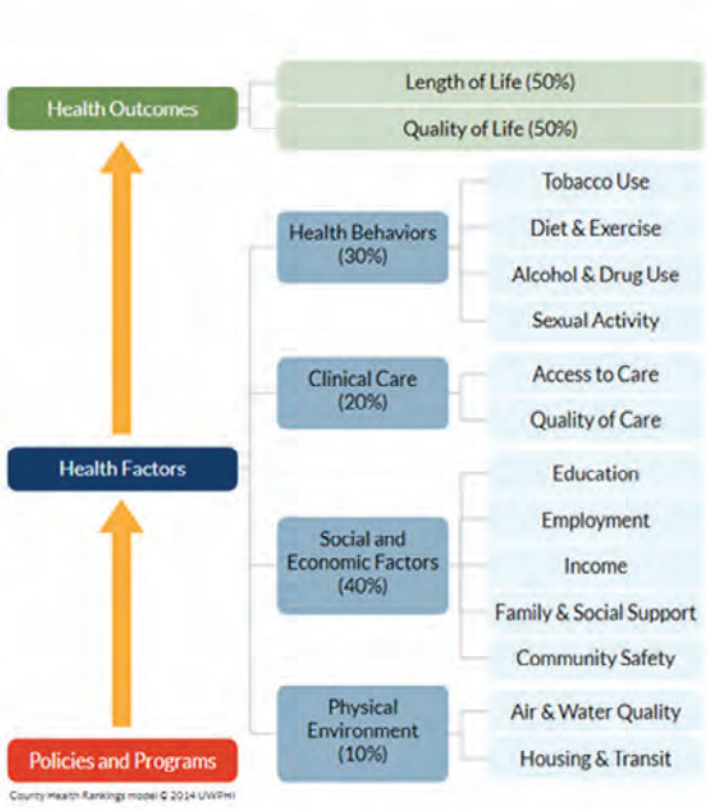
TOPIC	KEY FINDINGS
What is being done in our community to improve health and reduce barriers? **What resources exist in the community?**	• Acute care • Flu clinics • Immunization clinics • Outreach organizations • CHKD children services • Free clinics • LGBT Life Center • PACE program • Church programs • Free N95s • Mobile mamo screening • Sports programs • COVID-19 testing • Health Fairs • New VA facility • Telehealth
How has the COVID-19 pandemic worsened the health issues in our community?	• Access to doctor • Free clinic closure • Scheduling wait lists • Wait times • Depression • Isolation • Substance Use, alcohol use • Weight issues • Food insecurity • Lack of resources

TOPIC	KEY FINDINGS
What more can be done to improve health, particularly for those individuals and groups most in need? **Are there specific opportunities or actions our community could take?**	• Affordable Health care • Culture Conscious Care • Health Fairs • Outreach Programs • Better Access • Fundraisers • Mobile Clinic • Trauma Informed Care • Church Programs • Health Education • Neighborhood Events • Wellness Education • Community Events

HEALTH STATUS INDICATORS

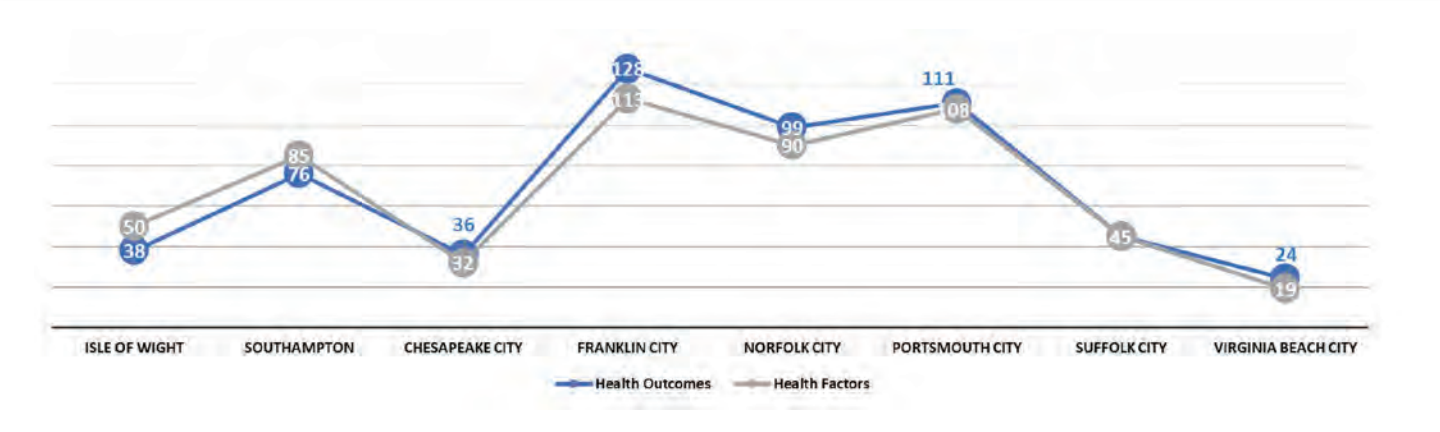
County Health Rankings

Health Indicators were viewed on County Health Rankings. The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors). Explore the Model to learn more about these measures and how they fit together to provide a profile of community health.



- There are many factors that influence how well and how long people live.
- The County Health Rankings model (right) is a population health model that uses data from different sources to help identify areas of concerns and strengths to help communities achieve health and wellness.
- The Rankings provides county-level data on health behavior, clinical care, social and economic and physical environment factors.

The graph below shows the Health Outcomes Rank and Health Factors for the communities in the service area. Virginia Beach City, Chesapeake City, and Isle of Wight rank better for these health outcomes while Franklin City, Portsmouth City, and Norfolk City rank worse out of 133 Virginia counties (Appendix B).



Source: County Health Rankings 2021, Rankings and Documentation;

Health Status Indicators

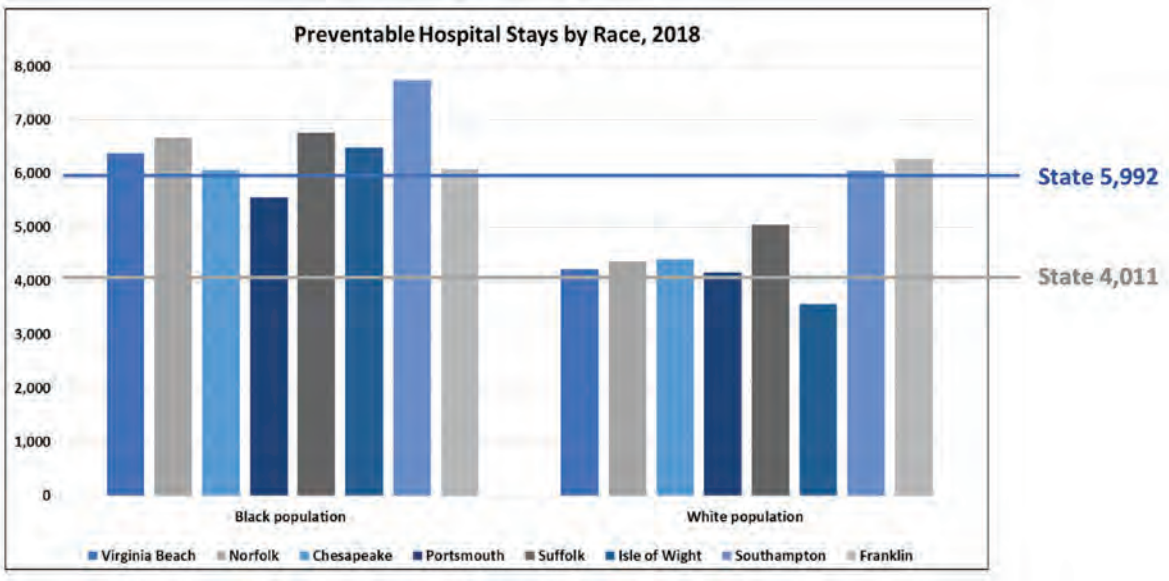
Below are key health status indicators for the counties representing the SNGH Service Area. Links are also included to interactive data dashboards on the Greater Hampton Roads Indicators Dashboard, also known as GHRconnects. Here indicators can be explored for a comparison to other nearby localities, change over time, race/ethnicity, and gender, where available. In addition, more indicators are often available through the link.

The key health status indicators are organized in the following data profiles:

A. Access to Health Services Profile
B. Mortality Profile
C. Hospitalizations for Chronic and Other Conditions Profile
D. Risk Factor Profile
E. COVID-19 Profile
F. Maternal and Infant Health Profile
G. Older and Aging Adults Profile
H. Cancer Profile
I. Diabetes Profile
J. Behavioral Health Profile
K. Community Violence and Gun Violence Profile

ACCESS TO HEALTH SERVICES PROFILE

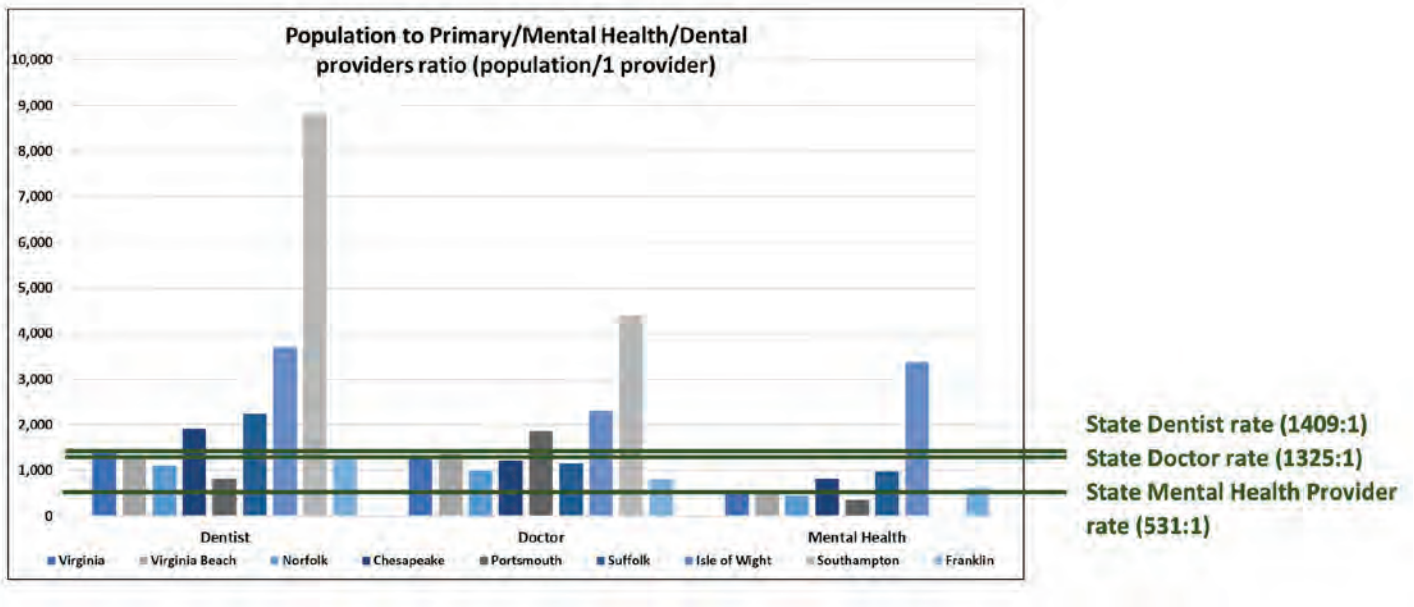
Access to quality and affordable health care is important to an individual's health. Health insurance and local care resources can ensure access to care. If outpatient care in a community is poor, then people may be more likely to overuse the hospital as their main source of care, resulting in unnecessary hospital stays. Typically, areas with higher densities of primary care have lower rates of hospitalizations for these ambulatory care sensitive conditions. Increasing access to primary care is key solution to reducing these unnecessary and costly hospital stays and improving the health of the community.



*Source: County Health Rankings 2021, Rankings and Documentation; *Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees*

Provider Ratio

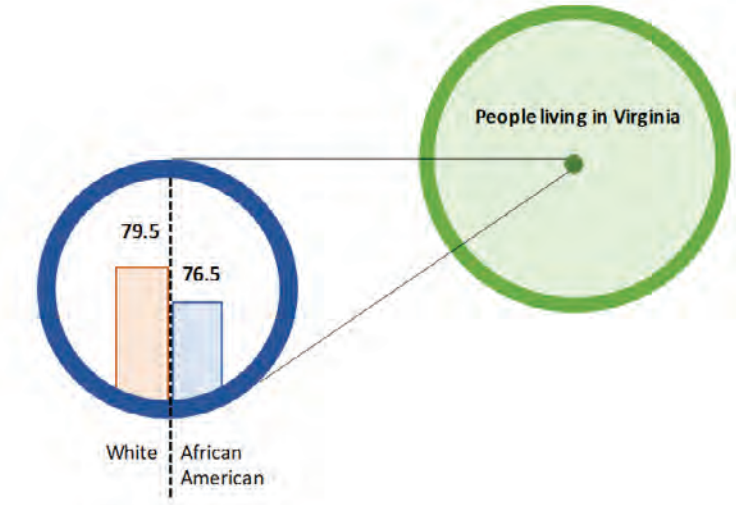
The ratio of primary care and dental care providers were examined in the service area. The ratio for population to primary care providers were higher than the state in some of the localities in the service area, Southampton (4397:1), Isle of Wight (2310:1), Portsmouth (1856:1), and Virginia Beach (1368:1). Chesapeake (1232:1), Suffolk (1154:1), Norfolk (988:1) and Franklin (801:1) had a lower population to provider ratio than the state (1325:1). The population ratio for dental care providers were also higher than the state in some localities, Southampton (8816:1), Isle of Wight (3711:1), Suffolk (2247:1), Chesapeake (1913:1), and Virginia Beach (1293:1). Franklin (1328:1), Norfolk (1103:1) and Portsmouth (828:1) had a lower population to provider ratio than the state (1409:1). (Appendix B). Fewer providers suggests concerns with access to health care, including oral health, throughout the service area. The percentage of people with health insurance was in line with the state percentage in all localities except Norfolk and Portsmouth, where there were higher percentages of uninsured. The preventable hospital stay rate among Medicare beneficiaries was highest in Southampton, followed by Franklin, Suffolk, Norfolk, Portsmouth, and Virginia Beach, which suggest that there may be challenges with access to primary and outpatient care. Data also shows a disparity among African American beneficiaries.



Source: County Health Rankings 2021, Rankings and Documentation;

MORTALITY PROFILE

The life expectancy for a person living in the Commonwealth of Virginia is 79.5. Virginia Beach and Isle of Wight are the only cities with a slightly higher life expectancy than the state (80.5, 79.2). It is important to note there is a disparity with life expectancy among African American populations. The life expectancy disparity for African Americans compared to white populations is anywhere from one year to 2.9 years in the service area (Appendix B).



Leading causes of death in localities of the service area were examined. In 2019, cancer, heart disease, and stroke were the top three causes of death in the service area. In Isle of Wight, Southampton, Chesapeake, Suffolk, and Virginia Beach, cancer was the leading cause of death, followed by heart disease. For Franklin, Norfolk, and Portsmouth, heart disease was the leading cause of death, followed by cancer.

In comparison, accidents were the third leading cause of death in Virginia, with heart disease and cancer being the top causes. In the service area, the crude death rate from all causes was greater than the rate in the state overall. Of the top causes of death, cancer and heart disease were the causes with crude death rates higher than the rates for Virginia.

Leading Causes of Death Per 100,000, Age-adjusted, 2019

	Crude Death Rate	All Causes	Cancer	Heart Disease	Respiratory Diseases	Accidents	Stroke	Alzheimer's Disease	Diabetes	Suicide	Chronic Liver Disease	Hypertension and Renal Disease
Isle of Wight	Prevalence Rate	986.3	231.7	202.1	37.7	62	53.9	48.5	21.6	16.2	18.9	24.3
	Numerator (count)	366	86	75	14	23	20	18	8	6	7	9
Southampton	Prevalence Rate	1,078	238.2	232.5	56.7	62.4	73.7	34	28.4	22.7	5.7	11.3
	Numerator (count)	190	42	41	10	11	13	6	5	4	1	2
Chesapeake City	Prevalence Rate	790	172	161.3	45.3	38.8	46.6	38.8	30.2	17.2	13.5	7.8
	Numerator (count)	1,935	421	395	111	95	114	95	74	42	33	19
Franklin City	Prevalence Rate	1,707	301.2	439.3	37.7	25.1	188.3	87.9	62.8	12.6	25.1	*
	Numerator (count)	136	24	35	3	2	15	7	5	1	2	
Norfolk City	Prevalence Rate	841.6	183.3	188.3	37.1	47.8	49.4	18.1	29.7	13.6	12.8	10.7
	Numerator (count)	2,043	445	457	90	116	120	44	72	33	31	26
Portsmouth City	Prevalence Rate	1,030	204.5	206.6	61.4	62.5	37.1	31.8	44.5	12.7	10.6	16.9
	Numerator (count)	972	193	195	58	59	35	30	42	12	10	16
Suffolk City	Prevalence Rate	872.9	194.3	186.7	45.6	39.1	46.7	30.4	40.2	11.9	10.9	3.3
	Numerator (count)	804	179	172	42	36	43	28	37	11	10	3
Virginia Beach City	Prevalence Rate	735.8	172.7	162.9	34.2	34.9	47.3	25.8	21.8	12.7	10.9	6
	Numerator (count)	3,311	777	733	154	154	213	116	98	57	49	27
Virginia	Prevalence Rate	823	176	176.1	42.9	46.8	44.7	30.8	27.5	13.3	12.1	9.6
	Numerator (count)	70,242	15,024	15,035	3,662	3,993	3,819	2,626	2,351	1,135	1,037	816

Prevalence Rate

450 0

*Data Source: Virginia Department of Health, Division of Health Statistics, Virginia statistics 2019, received 1-13-2019 * Data unavailable*

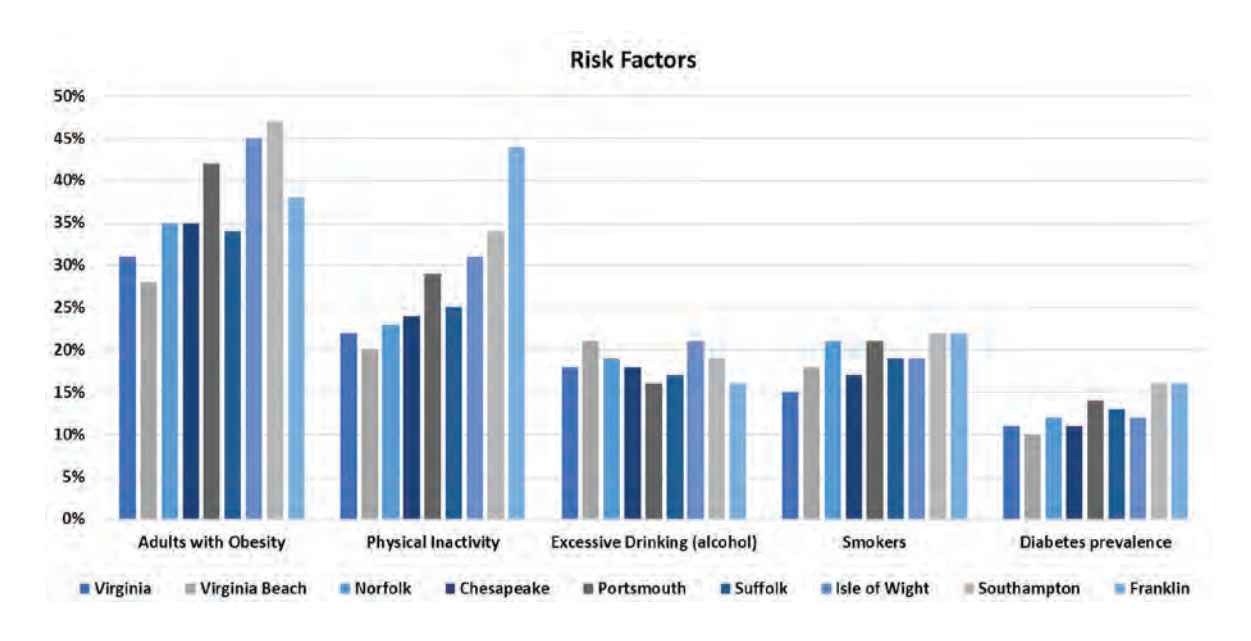
HOSPITALIZATIONS FOR CHRONIC AND OTHER CONDITIONS PROFILE

SNGH examined the age-adjusted hospitalization rates for the service area. For the top conditions seen in hospitals, heart conditions, specifically hear failure, were one of the highest rated conditions in the service area with Franklin having a rate of 132.7 followed by Norfolk with a rate of 73.9, much higher than the state rate of 51.8 per 10,000. Rates for adolescent suicide and self-inflicted harm increased across the service area along with adult mental health and adult suicide and self-inflicted harm. Franklin and Norfolk have the highest rates for these conditions (Appendix B). Across localities, the rates were higher than the Virginia rate (except in Isle of Wight and Southampton County). Other top conditions included diabetes and substance use.

RISK FACTOR PROFILE

The percentages of smokers and people experiencing frequent mental health distress were higher for all localities in the SLH service area as compared to Virginia values. Conversely, the percentage of adults who drink excessively was higher in Virginia Beach and Norfolk as compared to the Commonwealth.

The percentages of obesity and physical inactivity were higher in Norfolk (35%, 23%) and Chesapeake (35%, 24%) compared to the Commonwealth of Virginia (31%, 22%). Virginia Beach percentages for obesity (28%) and physical inactivity (20%) were only slightly better than Norfolk, Chesapeake, and Virginia as a whole. Although access to exercise opportunities was higher in the service area than in the state overall (82%). The percentage of people with food insecurity was highest in Norfolk where it was higher than in the state as a whole Limited access to healthy food was highest in Norfolk at 14%, in sharp contrast to the state at 4% (Appendix B). Obesity is a concern because it increases the risk of diabetes, heart disease, stroke, and some cancers. It is also associated with poor mental health outcomes and reduced quality of life.

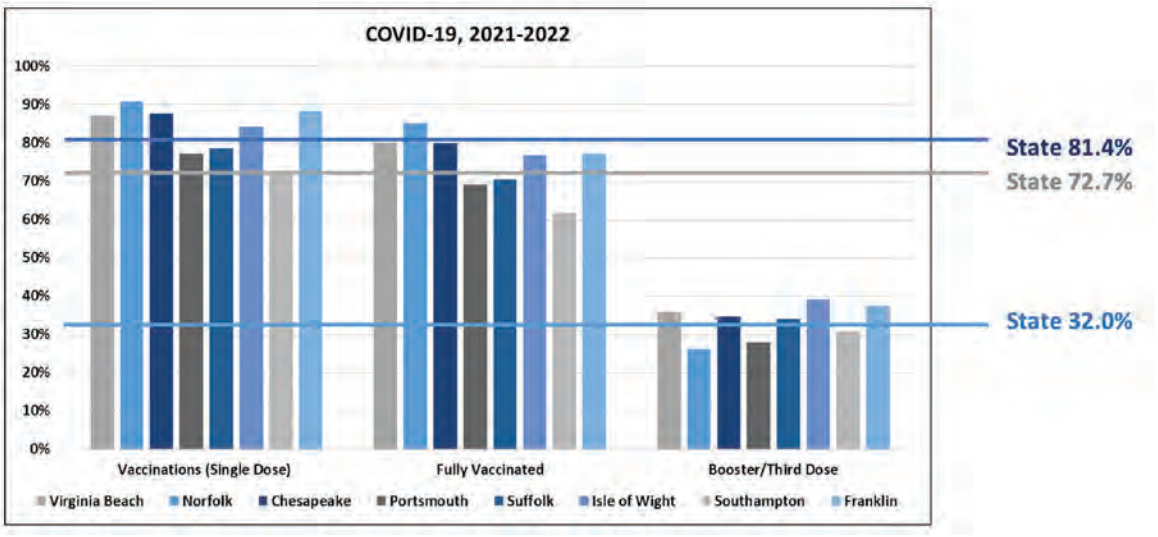


Source: County Health Rankings 2021, Rankings and Documentation

COVID-19 PROFILE

In 2020, the nation faced the COVID-19 pandemic. This contagious disease impacted the health of the service areas. People infected with the virus may experience mild to moderate respiratory illness and recover without medical treatment. However, some people will become seriously ill, requiring medical attention and possible hospitalization. People with underlying medical conditions are at a higher risk for developing serious illness while infected with COVID-19, as well as a higher risk for death (World Health Organization, 2022).

Between August 27, 2020 and April 1, 2022, the Commonwealth of Virginia had 1,669,750 COVID-19 cases and 19,714 deaths. Between March 2021-April 2022, Franklin had the highest rate of cases at 17,860 per 100,000 residents and highest rate of deaths at 268.1 per 100,000 residents. As of April 2022, Norfolk has the highest percentage of residents with a single dose or two doses of the vaccine, and higher than the state percentage.



MATERNAL AND INFANT HEALTH PROFILE

Unsupported and under-supported young families face many negative health outcomes and predict many long-term health challenges as time goes on, so looking at the way families begin can help us understand the current and future health of the community. Compared to Virginia, residents of the service area had high percentages of babies born with low and very low birth weights compared to the Commonwealth, except in Isle of Wight. Franklin, Southampton, Portsmouth, and Norfolk had the highest percentages of low and very low birth weights. The infant mortality rate was also greater in the localities compared to Virginia, except for Isle of Wight and Chesapeake, which had lower values (Appendix B). While teen births are a community concern, the low numbers do not permit meaningful standardization for comparison to state rates. The non-marital birth rate is higher than the Virginia rate in most of the service area.

Source: World Health Organization, Coronavirus disease (COVID-19); Virginia Department of Health, COVID-19 Data in Virginia, Dashboard; Virginia Department of Health Division of Health statistics

OLDER AND AGING ADULTS PROFILE

In many communities, the population of older adults is growing at the fastest rate. Challenges come with an aging population, including health-related factors and other factors that ultimately impact health. Preventable hospital stays among the Medicare population in the service area was higher than in the state as a whole. This indicator reflects that there may be opportunities to improve primary and outpatient care to this population in the service area to this population.

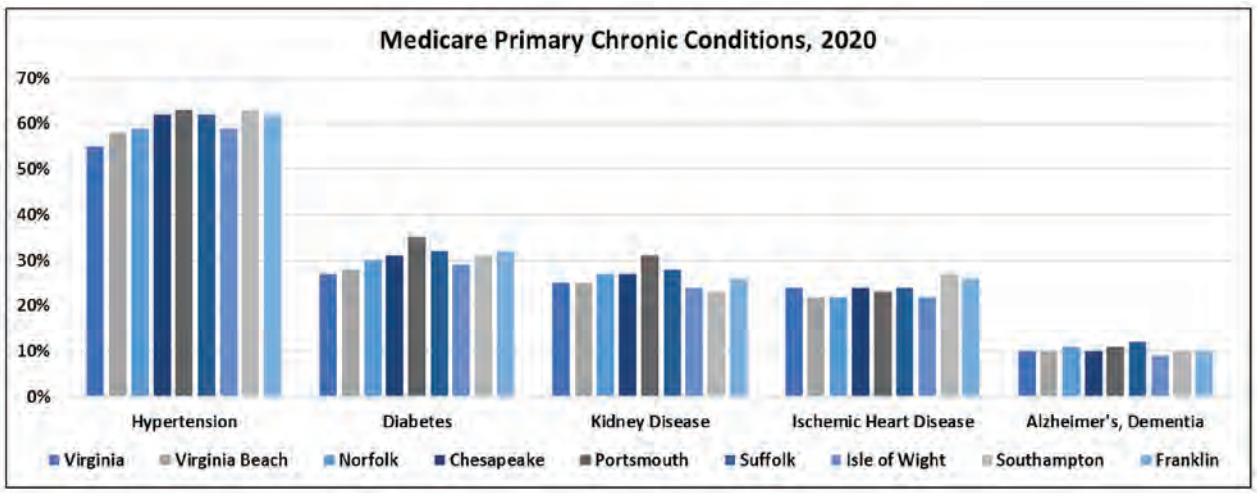
The Medicare population was seen for multiple conditions during 2020. Hypertension and diabetes were the top conditions seen in the services area having higher percentages than the state. Kidney disease and heart conditions also showed high percentages for the Medicare population utilizing hospital services.

The percentage of Medicare beneficiaries treated for Alzheimer's disease or dementia was higher in most of the communities in the service area compared to Virginia with the highest being in Norfolk and Suffolk (Appendix B). Per the Alzheimer's Association, by 2025, there is a projected estimated increase of 26.7% in the prevalence of people age 65+ receiving an Alzheimer's diagnosis in the Commonwealth of Virginia. This is important to note as it will impact the aging populations health, quality of life, health care demand and costs.

1 in 3 seniors dies with Alzheimer's or another dementia. It kills more than breast cancer and prostate cancer combined.

Source: Alzheimer's Association, 2022

Advance Care Plans are for adults to itemize their medical wishes and/or designate someone as their legal medical decision maker in the event they cannot communicate for themself. While many team members working within the health care industry understand the importance and value of Advance Care Plans, it is evident within the acute care setting that our community members may not until it is too late. Currently, within the Commonwealth of Virginia, there are 41,380 active registrants with Advanced Care Plans filed within the USLWR (U.S. Living Will Registry). Sentara has 70,236 active registrants with Advanced Care Plans on file within the USLWR with 23,281 of those completed for residents of service area.



Source: Centers for Medicare & Medicaid Services, Data.cms.gov
Alzheimer's Association, 2022 Alzheimer's Disease Facts and Figures, Virginia Alzheimer's Statistics; Virginia Alzheimer's Commission, AlzPossible Initiative; United States Living Will Registry

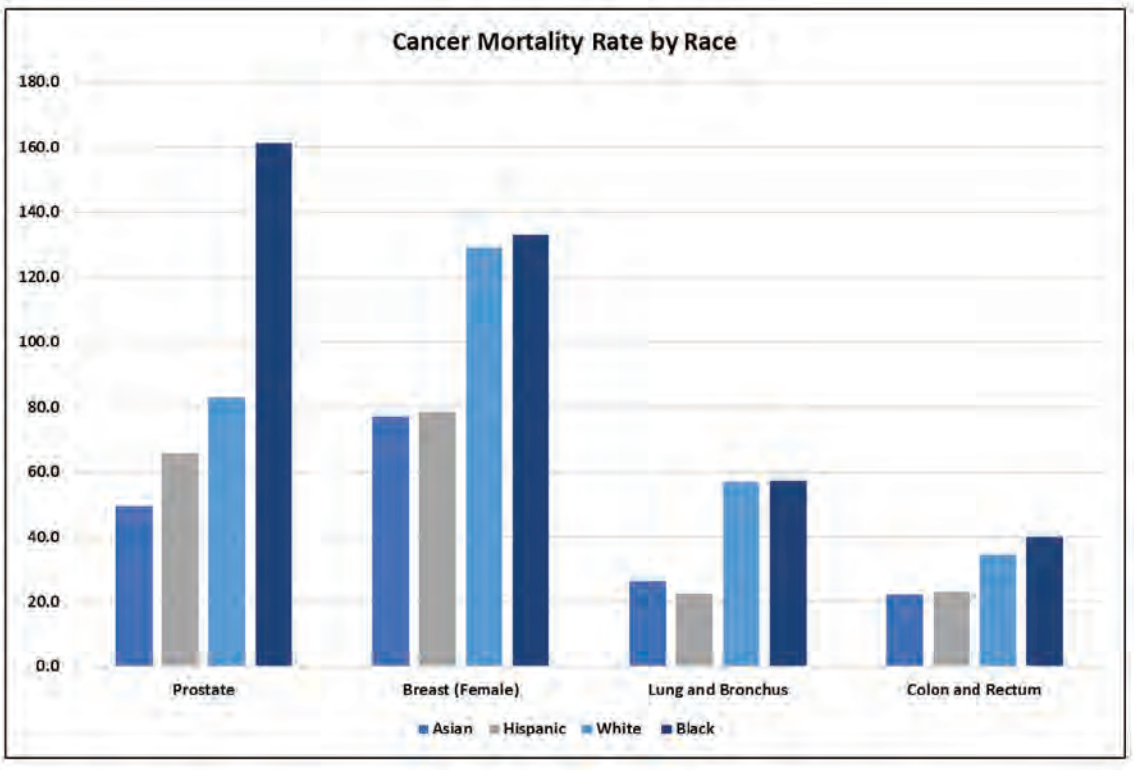
CANCER PROFILE

Death and incidence rates for a variety of cancer types were examined since cancer is the leading cause of death in the service area. Compared to the previous 5-year collective rates for both incidence and mortality for the leading types of cancer, most of the service area is trending down, with fewer cases and lower rates of death. The rates, however, are slightly rising for breast cancer in Virginia Beach and Norfolk. It is important to note the rates are especially rising for the African American population living in the Commonwealth of Virginia as a whole.

Breast cancer is the most common cancer diagnosed among U.S. women and is the second leading cause of death among women after lung cancer.

Source: American Cancer Society

Mortality rates were highest among lung, breast, prostate, and colon cancers, though these are not the only ones where Sentara will focus efforts. Localities with the greatest all cancer incidence rates were Franklin, Portsmouth, and Norfolk, in order of decreasing incidence (Appendix B). The trend is stabilizing in all three cities. Prostate cancer and breast cancer are the leading cause of cancer death for African Americans living in Virginia. See the below graph, which shows the mortality disparities among races. The community outreach programs educating and providing cancer screenings, as well as medical developments, are having an impact. Efforts will need to focus on populations at higher risk of this disease.



Data Source: NIH National Cancer Institute, 2014-2018 Incident Rate Report for Virginia

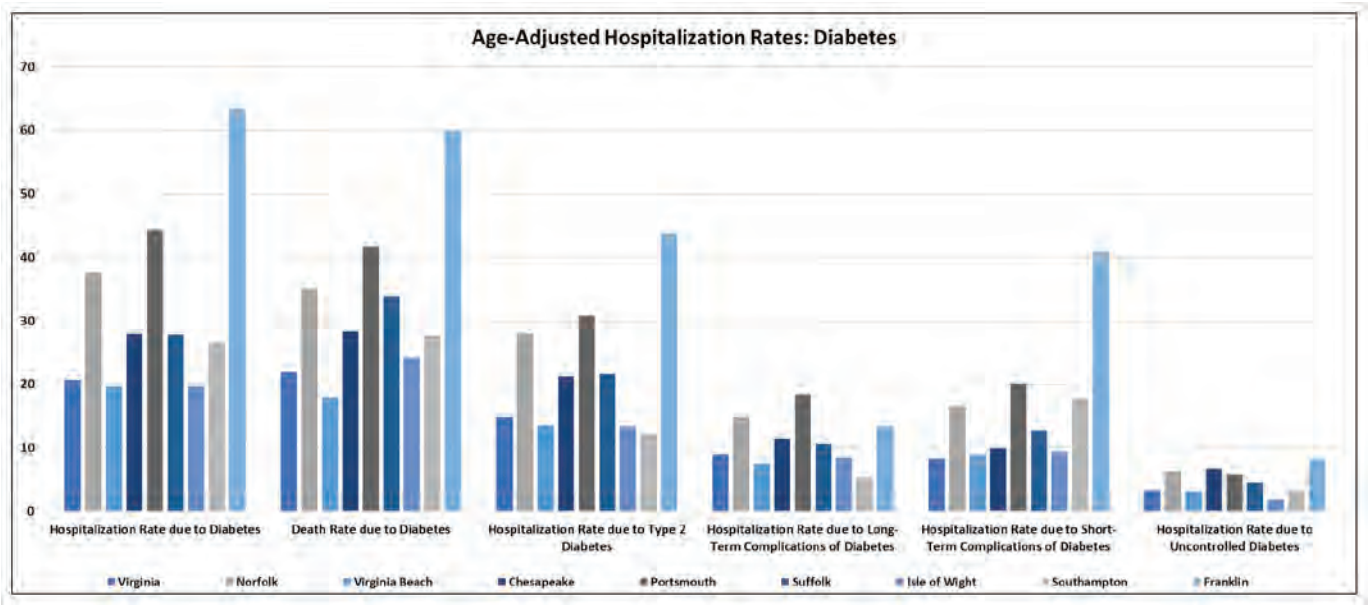
DIABETES PROFILE

According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase in the United States and is the seventh leading cause of death (CDC, 2021). Risk factors such as obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity also remain key risk factors. Diabetes is a top cause of death in the service area. Here we examine additional related indicators.

Diabetes is also associated with increased risk of certain types of cancer, such as liver, pancreas, uterine, colon, breast, and bladder cancer.

Source: CDC, 2019

The percentage of adults with diabetes living in the service area are higher than the state percentage of 8.5%, in Chesapeake, Suffolk, Isle of Wight and Southampton. The death rate due to diabetes in most localities in the service area is also higher than the state, with the highest rate found in Franklin. SNGH examined hospitalization rates due to diabetes and found the age-adjusted hospitalization rates due to diabetes were above the state rates in most localities in the service area, with the highest hospitalization rates also found in Franklin. At 20.7, the age-adjusted hospitalization rate in Franklin was three times the state rate. Localities in the service area have high hospitalization rates compared to the state due to short-term complications from diabetes. Hospitalizations due to long-term complications were highest in Norfolk, Chesapeake, Portsmouth, Franklin, and Suffolk. It is also important to note that the percentage of the Medicare population living in the service area and diagnosed with diabetes is higher than that of the state.



*Data Source: Centers for Disease Control and Prevention, Diabetes; Diabetes Report Card, 2019; Greater Hampton Roads Indicators Dashboard; *Deaths per 100,000 population; **Deaths per 10,000 population*

BEHAVIORAL HEALTH PROFILE

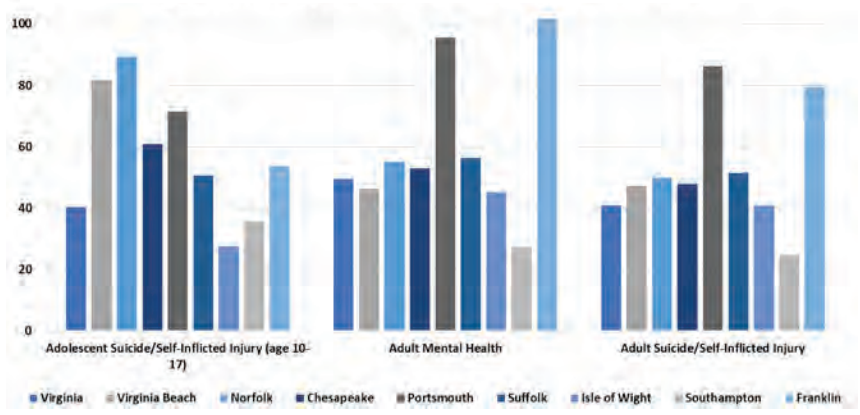
Hospitalization rates due to alcohol/substance, mental health and suicide/self-intentional injury use were examined. Localities in the service area, except Isle of Wight and Southampton, had higher hospitalization rates due to substance use, mental health and suicide/self-intentional injury compared to Virginia rates.

Mental health is becoming an increasing health concern for both adolescents and adults. Between 2018-2020, the rate of adults with a behavioral health diagnosis per 10,000 population was highest in Portsmouth and Franklin, followed by Suffolk, Norfolk, and Chesapeake. Sentara also examined emergency department visits for 2021 to gain a better understanding of the mental health crisis communities have been facing during the COVID-19 pandemic. In 2021, SNGH Emergency Department saw 4,712 adults with a behavioral health diagnosis. Of the 4,712 visits, 20.0% presented with suicidal ideations and 6.2% with major depressive disorder.

The rate of adolescents with a behavioral health diagnosis is highest in Norfolk and Virginia Beach, followed by Portsmouth, Chesapeake, Franklin, and Suffolk. "In early 2021, emergency department visits in the United States for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019" (Office of Surgeon General, 2021). Although SNGH does not see many adolescents in the emergency department due to its proximity to the Children's Hospital of The King's Daughters, in 2021, SNGH saw 16 adolescents with a behavioral health diagnosis. Of the 16 visits, 31.2% presented with suicidal ideations and 12.5% with major depressive disorder. Not all adolescents were given a specific behavioral health diagnosis and some were treated and released the same day.

The rate of patients with a behavioral health diagnosis in this service area is higher than the state overall. The COVID-19 pandemic has worsened mental health among youth and adults, increasing anxiety, depression, and stress. Social distancing, masking, and isolating negatively impacted the most vulnerable patients, increasing emergency department visits due to a lack of mental health providers to assist with therapy and developing coping skills. The service area has fewer mental health providers per person in most localities when compared to the state (531:1). Isle of Wight (3374:1), Suffolk (980:1), and Chesapeake (822:1) have the lowest ratio of providers per person followed by Franklin (613:1), Virginia Beach (541:1) and Norfolk (453:1) (Appendix B). It is also important to note that the mental health workforce is nearing retirement age which will impact provider capacity. There is a need for a more racially and ethnically diverse mental health workforce to better reflect the population (Appendix B).

Age-Adjusted Hospitalization Rates, 2018-2020: Mental Health



Source: Greater Hampton Roads, Community Indicators Dashboard

COMMUNITY VIOLENCE AND GUN VIOLENCE PROFILE

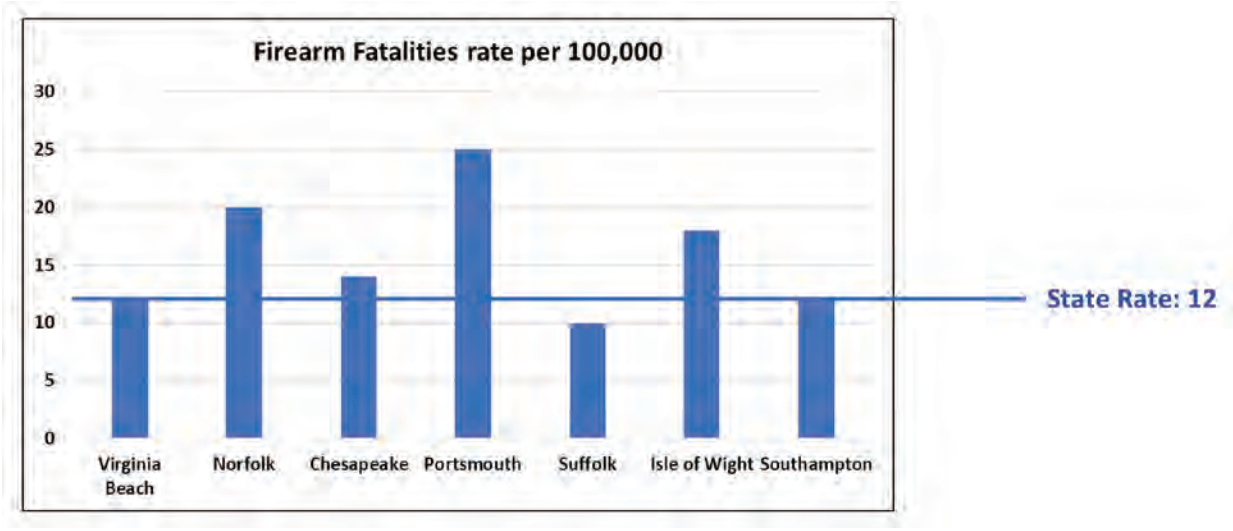
Violent crimes such as gun violence, robbery, or aggravated assault have socio-emotional impact. Physical and emotional symptoms such as sleep disturbances increase in feelings of distress, anger, depression, inability to trust, and significant problems with family, friends, or coworkers can occur. Violent crimes can hinder the pursuit of healthy behaviors such as outdoor physical activities. Chronic stress has been associated with violent crimes and increases prevalence of certain illnesses such as upper respiratory illness and asthma. This can have life-long impact on the health of the individual.

> ***"Firearm injury is a leading cause of death for youth in the United States."***
>
> *Source: Andrews AL, et al. Pediatrics. Feb. 28, 2022*

The violent crime rate was much higher in several localities of the service area compared to the state rate of 207 violent crime offenses per 100,000 population. Per County Health Rankings, Portsmouth and Norfolk have the highest rate of violent crimes (707 and 603), followed by Franklin, Chesapeake, and Suffolk. It is important to note that Portsmouth followed by Norfolk had the highest rates not only in the service area but across all of Hampton Roads (Appendix B).

Gun violence alone is a top contributor to premature death. Deaths due to firearms are considered largely preventable; as a result, gun violence has been identified as a key public health issue by national agencies. A study published by American Academy of Pediatrics (2022) showed an increase in pediatric deaths due to firearms. The study also showed a disparity among African American youth who are "14 times more likely to die of firearm injury compared with their White peers" (Andrews AL, et al. Pediatrics. Feb. 28, 2022).

When deaths were examined for localities within the service area, Portsmouth, Norfolk, Chesapeake, and Isle of Wight had rates higher than the state rate for firearm fatalities per 100,000 population. Portsmouth and Norfolk had the highest rates of death due to firearms.



Source: County Health Rankings 2021, Rankings and Documentation

2019 IMPLEMENTATION STRATEGY PROGRESS REPORT

The previous Community Health Needs Assessment identified several health issues. The SNGH implementation strategy progress report was developed to identify activities to address health needs identified in the 2019 CHNA report through primary and secondary data sources. This section of the CHNA report describes these activities and collaborative efforts.

For reference, the list below includes the 2019 CHNA health needs that were prioritized to be addressed by SNGH in the 2019 implementation strategy.

- Healthy, Connected Communities
- Heart Health
- Women's Health
- Gun Violence, Accidents, and Other Trauma
- Mental Health and Substance Abuse

SNGH is monitoring and evaluating progress to date on its 2019 implementation strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Please note that the 2019 community health needs assessment implementation strategy process was disrupted by COVID-19, which has impacted all of our communities.

STRATEGY PROGRESS

Healthy, Connected Communities

SNGH continues to partner with EVMS and ODU to facilitate the ACC Ambulatory Care Center Inter-Professional Clinic which address social determinants of poor health. SNGH partners with EVMS' Dr. Jason Dukes on quality improvement projects to address uncontrolled hypertension, diabetes, and colorectal screenings. This partnership is supplemented by free blood pressure wrist cuffs from Sentara Health Equity, and free $10.00 ($200 total) Wal-Mart Gift Cards from Sentara Cancer Services through a grant from the American Cancer Society and Ambulatory Care Center.

- SNGH continues to partner with The Pharmacy Connection and Virginia Healthcare Foundation to offer the free Medication Assistance Program to ACC patients. SNGH continues to partner with Aero Care (DME company) to provide free CPAP Machines to ACC patients with Sleep Apnea.
- On September 17, 2021, approximately 20 SNGH Employees partnered with the United Way's Day of Caring to provide volunteer services to the Children's Health Investment Program (CHIP). Over an 8-hour period, the SNGH team assisted in organizing and sorting over 200 bags of essential items for low-income families at the CHIP location in Chesapeake VA.
- SNGH evaluates the current decline in resources for orthopedic needs of ACC patients to implement or redesign programs within ACC to address that need.
- SNGH evaluates the loss of mental health resources and works with community partners to implement programs within ACC to address that need.
- In partnership with Every Woman's Life (EWL), SNGH continues to provide free pap smears and mammograms to eligible women. EWL provides the services in conjunction with the Sentara Mammography van, and ACC provides the space via exam rooms and supplies at cost to EWL reimbursed annually.

- SNGH continues to offer a free Diabetic Teaching Class twice per month, facilitated by ACC Charge RN and Sentara Obici Hospital Clinical Pharmacist.
- SNGH also offers free bereavement support groups and a Head and Neck Cancer Support Group.
- SNGH collaborates with Sentara Medical Group Dermatology Specialist and EVMS Dermatology to provide free skin cancer screenings.
- SNGH continues to evaluate placing a camera in the ACC to do diabetic eye exam pictures.
- SNGH also collaborates with YMCA to provide stroke education to the community.

Heart Health

- As part of COVID-19 response efforts, SNGH partnered with Sentara IT to provide a Heart Healthy educational message to share with the community via social media. This message promoted Heart Month awareness and emphasized the importance of cardiovascular health and wellness. Several online webinars were provided to promote heart healthy habits.
- SNGH nursing team members provided volunteer services for first aid and basic life support education at Norfolk Street Soccer event in 2021.
- Hospital based awareness efforts: Heart shaped cookies and heart healthy handouts with tips on small steps to improve cardiovascular health were provided to SNGH Employees. Clinical Team members encouraged to "wear red" to promote Red Dress Day/ Heart Month awareness to patients and visitors Heart Healthy educational bags were provided to Cardiac patients and visitors throughout Heart Month to promote awareness of heart healthy lifestyle. SNGH sold "Candy Grams" throughout the month of February. A total of 400 "Candy Grams" were sold and all proceeds were provided to the American Heart Association.

Women's Health

- WIC is working with SNGH to provide virtual enrollment for clients. SNGH is working to re-implement in-person WIC enrollment in 2022. SNGH continues to participate in Home Health & Hospice Care community workgroup. SNGH implemented Code Red Cribs for Kids and is participating with Sleep Tight Hampton Roads.
- SNGH continues participation in Virginia Neonatal Perinatal Collaborative. Implementation of Arms of Love program in Special Care Nursery (SCN) for the Neonatal Abstinence Syndrome population was put on hold due to the COVID-19 pandemic. Volunteers are not currently working in SCN due to space constraints. SNGH is still hoping to implement this in the future.
- Actively partnering with CHIP through Moms Matter program, started 2/18/21. SNGH is an active member of Disparities for Women of Color in Pregnancy & Motherhood Task Force, partnering with multiple community agencies to address disparities among black and brown women.

Gun Violence, Accidents, and Other Trauma

- SNGH is participating in the Virginia Hospital Healthcare Association Virginia Hospital-based Violence Intervention Program (HVIP) via receipt of the Collaborative grant from Virginia Department of Criminal Justice Services. SNGH received funding for an additional two years which started July 2021.
- Home visits began when all team members were vaccinated, and COVID-19 numbers decreased. Home visits so far have been welcomed by participants.
- SNGH is also working with Change Healthcare to assist trauma clinic patients in applying for insurance. A system will be developed to hand patients off to a community free clinic when discharged from trauma clinic.

Mental Health and Substance Abuse

- SNGH encourages collaboration and partnerships with community agencies to identify and address gaps in psychiatric and substance abuse services.
- SNGH attends regular standing meetings between SNGH Emergency Department (ED), Behavioral Health (BH), and Norfolk CSB. Leaders regularly collaborate on patient level cases to improve patient outcomes.
- SNGH Nursing and Physician Leaders have also received supportive education from Regional and Local Chief Magistrates. SNGH continues its collaboration with EVMS to increase access to care by having EVMS provide OP psych evaluations at Hofheimer Hall and provide a doctor to co-locate in the SNGH ED to be engaged full time in a collaborative model with the EPT MDs to better manage psych emergencies. Another potential result of this collaboration is a Next Day Walk In Clinic for follow up for those patients discharged from the ED who need follow up evaluations and short term treatment. This concept was just recently approved and SNGH is at the beginning of implementation and recruitment. SNGH also continues ongoing collaboration with VHHA BH Committee on various initiatives.

Sentara continues to improve access to behavioral health resources. In 2021, a behavioral health care center opened to provide follow-up care within seven days of a behavioral health patient discharge from the emergency department or an inpatient behavioral health unit. This clinic started with a focus on Inpatient Behavioral Health Unit and Behavioral Health patients discharged from Sentara Virginia Beach General Hospital, Sentara Independence and Sentara Princess Anne Hospital Emergency Departments. The Behavioral Health Care Center has expanded its services to include other individuals in the community that need behavioral health care. As of March 2022, the Behavioral Health Care Center has seen a total of 1215 patients.

In 2022, the Hampton Roads Behavioral Health Consortium convened as a regional coalition of private and public partners in mental health to address the escalating mental health crisis. The Behavioral Health Consortium will develop a strategic action plan to address prevention, intervention, treatment, workforce, resources, access, education, recovery and eliminating the stigma associated with behavioral health.

Sentara has expanded, and will continue to expand, telepsychiatry within the EDs and is working on expanding Intensive Outpatient Programs and Partial Hospitalization Programs in Hampton Roads. Sentara will continue to partner with community mental health programs to identify alternate placement options for emergency department patients presenting with behavioral health issues.

The Behavioral Health Safety Workgroup is focusing on improving the emergency departments staff and patient safety.

A BHTOC Clinical Patient Management Workgroup focuses on:

- rapid treatment of agitation.
- active treatment of psychiatric illness.
- timely evaluation of medical comorbidities.
- improved coordination and communication around dispositions; and
- improved guidance on the ECO process.

The BHTOC Clinical Patient Management workgroup will continue to improve processes and work toward:

- management of patients with behavioral health needs who are placed on regular medical units.
- provide active treatment for substance intoxication or withdrawal/overdose.

An BHTOC Safety workgroup addresses:

- Working on leader trainings.
- Behavioral Health Consultant and Behavioral Health Safety Workgroup completed priority I & II Emergency Departments site visits and BH Risk Assessments in March 2022.
- Priority III emergency departments site visits and risk assessments will be completed by the Behavioral Health Consultant and BH Safety Workgroup team by May 2022

Cancer Awareness and Prevention

Sentara extends its reach into the community, where life happens. Sentara brings prevention, hope, inspiration, and support to our local community where Sentara is working to reduce the impact of cancer. Cancer educators implement programs focused on cancer prevention, detection, and provide community outreach by hosting and attending screening and education events. In 2021, more than 3,000 individuals participated in these community events.

Sentara is continuing to build the "Living Beyond Cancer" survivorship program to enhance patients' wellbeing and long-term health. This is accomplished through cancer support groups and various education programs on nutrition, physical therapy, and exercise through the Wellness Beyond Cancer program. This free, six-week holistic health program incorporates meditation, yoga and fitness for cancer patients and addresses the needs of the entire individual to strengthen both physically and mentally, providing a sense of peace and balance throughout their journey to wellness. Local cancer screening events for oral, head and neck cancers, FIT testing for colorectal cancer, breast cancer mammography screening and skin cancer screening events are offered around the Hampton Roads area.

In 2022, Sentara plans to continue to remove barriers to wellness for uninsured or underinsured women for mammography, including supplementing traditional measures, such as its mobile mammography van, with more targeted efforts to reach underserved communities, including connecting with faith leaders, providing transportation for those who need it and building trust with patients. New and exciting opportunities await cancer patients in the Hampton Roads area with the opening of the Carrillo Kern Center for Integrative Therapies at the Sentara Brock Cancer Center in Norfolk. It is another way we are working to fulfill our promise to ensure all patients and families have the mind, body and spiritual support they need throughout their cancer journey. Services such as acupuncture, integrative nutrition, yoga, meditation, reiki and garden therapy will be offered to the community. Additionally, cancer screenings will continue to be offered throughout the community, in collaboration with community partners, to continue to bring cancer education and preventative services to the historically underserved.

Sentara

GRANTMAKING AND COMMUNITY BENEFIT

In the 2019 Implementation Strategy process, Sentara and hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grant making, in-kind resources, collaborations, and partnerships. Sentara is focused on supporting organizations and projects that address prominent social determinants of health factors and that promote health equity by eliminating traditional barriers to health and human services. Sentara strongly encourages grant proposals that align with one or more of the following priorities:

- Housing
- Skilled Careers
- Food Security
- Behavioral Health
- Community Engagement

Sentara is aware of the significant impact that our organization has on the economic vitality of our communities. In 2020, Sentara invested nearly $256 million in our communities. Sentara invested $20 million in health and prevention programs, $45 million in teaching and training of health care professionals, $11 million in philanthropic giving and $180 million in uncompensated patient care. In 2021, Sentara invested $245 million in the communities; $16 million in community giving, $23 million in health and prevention programs, $45 million in teaching and training of health care professionals and $167 million in uncompensated patient care.

Clearly, the definition of community health is broader than simply medical care. As more is known about the role of social determinants of health, more opportunities will arise to influence population health through engaging in community building approaches to care. Beyond the scope of SNGH alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. Sentara and SNGH are committed to finding innovative, responsive, and successful strategies to address these challenges, to fulfill our mission to improve health every day.

Community Health Needs Assessment References

Community Demographics

GEOGRAPHIC DATA

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Research Group of the Weldon Cooper Center for Public Service, July 2019, Demographics

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US Census Bureau QuickFacts Table 2020; (2020 Small Area Income and Poverty Estimates (SAIPE))

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Virginia Department of Health Culturally and Linguistically Appropriate Health Care Services; US Census Bureau American Community Survey Five-Year Estimates, 2014 vintage; CLAS

Virginia Medicaid Department of Medical Assistance Services; Data (As of January 15, 2022)

Health Indicators

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ALZHEIMER'S AND DEMENTIA

Alzheimer's Association, Virginia Alzheimer's facts

Virginia Alzheimer's Commission, AlzPossible Initiative

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NIH National Cancer Institute, 2014-2018 Incident Rate Report for Virginia, Cancer Profile; 2014-2018 Mortality Rate Report for Virginia, Cancer Profile

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DIABETES

Center for Disease Control and Prevention, Diabetes

Center for Disease Control and Prevention, Diabetes Report Card 2019

GREATER HAMPTON ROADS

Greater Hampton Roads Community Indicators Dashboard

MATERNAL AND INFANT

Virginia Department of Health Division of Health statistics

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