

Sentara Leigh Hospital and
Leigh Orthopedic Surgery Center

Community Health Needs Assessment 2025

This joint Community Health Needs Assessment report was completed in collaboration between Sentara Leigh Hospital and Leigh Orthopedic Surgery Center, which have the identical service areas of the cities of Chesapeake, Norfolk, and Virginia Beach.



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Executive summary

Sentara Health is proud of our longstanding commitment to the communities served by Sentara Leigh Hospital (SLH) and Leigh Orthopedic Surgery Center (LOSC). We are committed to the cities in our defined service area of Chesapeake, Norfolk, Virginia Beach, and surrounding communities.

In this exciting time, it is even more important that we listen to the voices of individuals in the community to better understand the health needs and priorities of those we serve. The Community Health Needs Assessment (CHNA) provides a view of the region's health through a combination of focus groups, a community survey, as well as data on healthcare utilization and trends.

Work on the 2025 CHNA for SLH and LOSC began in 2024. The priorities identified by community members are consistent with previous assessments, as well as assessments conducted in other communities across the Commonwealth. Residents support continued work to improve access to behavioral health services, resources for chronic disease management, and a broad approach to health that includes initiatives addressing social determinants of health such as housing and food security.

Top priorities



Behavioral health



Chronic conditions



Social determinants of health

Sentara conducts a comprehensive Community Health Needs Assessment every three years for each of our inpatient hospitals and outpatient surgical centers across Virginia and Northeastern North Carolina. This important tool helps to determine community strengths and assets, including community partners, so that we can collectively address the challenges and opportunities identified in this report. These assessments are an essential element in realizing our mission to improve health every day. They help us to identify barriers to health access so we can more effectively address health disparities in our communities and provide the quality healthcare that residents deserve.

Looking at the data

Community demographics of the 938,465 persons living in the service area, which includes the cities of Chesapeake, Norfolk, and Virginia Beach.

Racial profile

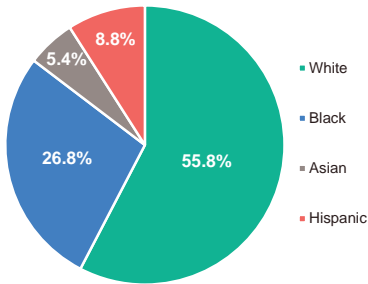


Figure 1

Source: United States Census Bureau

Population by age, 2019-2023

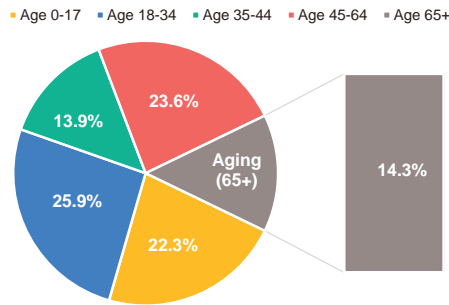


Figure 2

Population change from 2020-2023

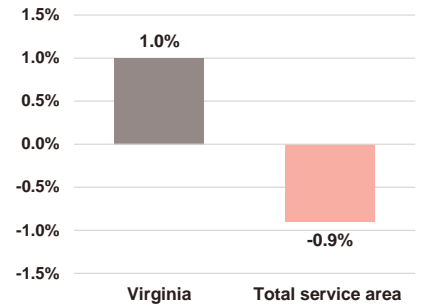


Figure 3

Determinants of health include:

Population in poverty, percentage

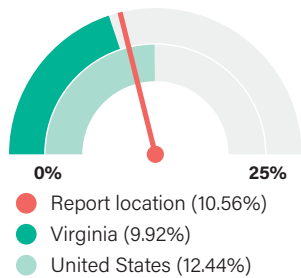


Figure 4

Mental health care provider, rate per 100,000 population

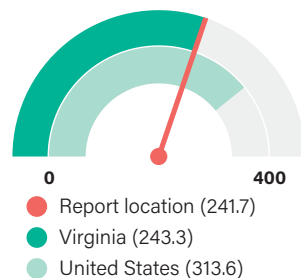


Figure 5

Population with a disability, percentage

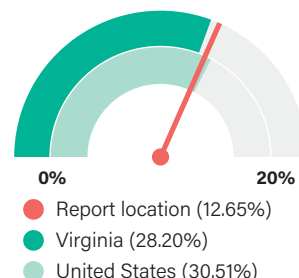


Figure 6

Household where housing costs exceed 30% of income, percentage

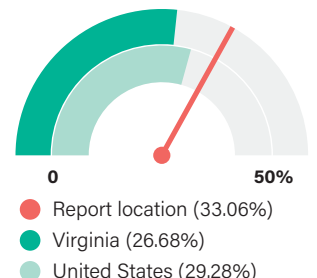


Figure 7

Sources: Virginia's Plan for Well-Being, Virginia Community Health Improvement Data Portal

Top health concerns include:

Avoidable hospitalizations, rate per 100,000 population, 18+

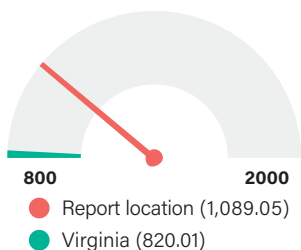


Figure 8

Disease of the heart deaths, rate per 100,000, total population

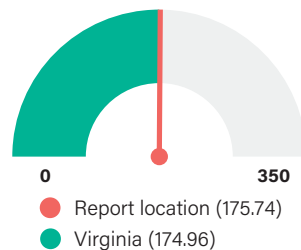


Figure 9

Hospitalizations with hypertension, rate per 100,000, total population

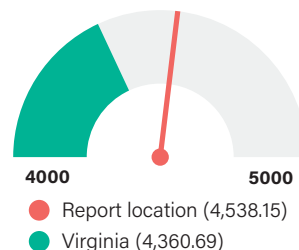


Figure 10

Hospitalizations with drug overdose, rate per 100,000, total population

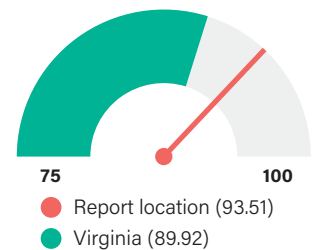


Figure 11

Sources: Virginia's Plan for Well-Being, Virginia Community Health Improvement Data Portal

Key findings

This assessment incorporates community demographics and other factors influencing and contributing to the overall health of our communities. The report uses data on health factors, health outcomes and health indicators from County Health Rankings.¹ These rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. 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 is a population health model that uses data from a variety of sources to identify strengths and areas of concern to help communities achieve optimal health and wellness outcomes.

Demographics

Of the total population in the service area, 55.8% of residents are White, 26.8% are Black, 8.8% are Hispanic, 5.4% are Asian, and 8.8% are multiple races (total exceeds 100% due to rounding and multiple races selected in the census). The age profile for the population closely mirrors, yet slightly differs, from that of the Commonwealth of Virginia. Within the next ten years, the total population in the service area is estimated to increase by almost 6% — an estimated addition of roughly 52,609 residents.³

Social and economic factors

Sentara recognizes that a community’s health outcomes are driven by a variety of factors beyond the clinical care provided in hospitals and other healthcare settings. Keeping this in mind, our CHNA includes information on education, employment, housing, poverty, and public health insurance enrollment of residents in the service area.

Education and employment

Education supports stable employment and financial stability for individuals and their families. As of the

County Health Rankings model

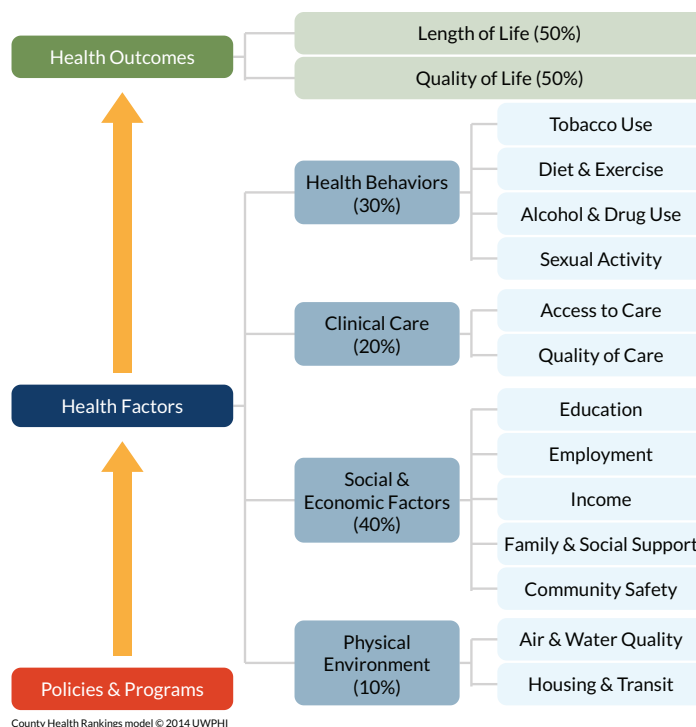


Figure 12

Source: [County Health Rankings model © 2014 UWPHI](#)

2023 U.S. Census, 93.1% of the residents in the service area were high school graduates, compared to 91.3% of Virginia residents. According to the 2019-2023 American Community Survey 47.4% of residents in the service area hold advanced or professional degrees compared to 49.3% statewide.

As of the 2023 U.S. Census, 67.7% of residents in the service area participated in the labor force, above the state average of 65.3%. Of the total service area residents, the percentage of female residents in the civilian labor force (61%) was the same as the state average (61%).

Poverty

Poverty creates barriers to accessing healthcare, healthy foods, and safe living environments, resulting in lower quality of life and negative health outcomes.

As of the 2023 U.S. Census, residents living in the service area were more likely to live in poverty (11.5%) compared to the rest of Virginia (10.2%). The combination of socioeconomic factors and racial inequalities has a negative impact on health outcomes for individuals and

families in this area. Similar to Virginia as a whole, People of Color living in the service area are more likely to live in poverty compared to White residents. In the service area, Black (18.7%), Asian (8.2%), and Hispanic (13.8%) residents experience a higher rate of poverty compared to White residents (7.1%).

Community insight

Community input is imperative, so we conducted a stakeholder and community member survey and held focus groups jointly with Bon Secours Hampton Roads, Children’s Hospital of The King’s Daughters, Riverside Health, and the Hampton and Peninsula Health Districts.

Community survey

From October 1, 2024, to February 28, 2025, we invited over 100 key community partners throughout Virginia to share and complete the survey, which resulted in 1,550 residents living in the service area participating. We appreciate the time and contributions those individuals made to help enhance health and well-being in our community.

Top concerns identified included:

- Mental health
- Newborn health
- Chronic conditions: Asthma, allergies, diabetes, heart conditions, high blood pressure

Top barriers identified included:

- Cost
- Limited or no insurance
- No appointments after 5 p.m.
- Long wait for scheduled appointments
- No appointments for new patients

Focus groups

Hospital leaders conducted community conversations from October through February 2025 to gain more in-depth insights from community stakeholders on their health concerns and healthcare barriers. Leaders

from the collaborative, SLH and LOSC intentionally promoted these focus groups to diverse populations to obtain feedback from participants truly representative of the communities we serve.

Top concerns identified included:

- Mental health: PTSD, anxiety, depression, behavioral health, stress, substance use
- Access to health care: Cost, doctors, transportation, difficulty scheduling appointments
- Chronic conditions: Hypertension, diabetes, high cholesterol, cancer, kidney disease, obesity

Health status

We viewed health status indicators from the 2024 County Health Rankings data and documentation to gain a better understanding of the clinical concerns community members face. When and where data was available, SLH and LOSC paid particular attention to the disparities affecting historically marginalized populations.

Life expectancy for a person living in the Commonwealth of Virginia is 78.7 years. In the communities served by SLH and LOSC, the average life expectancy is 77.7—1 year less than the state average. It is important to note disparities affecting Black residents. The average life expectancy of Black

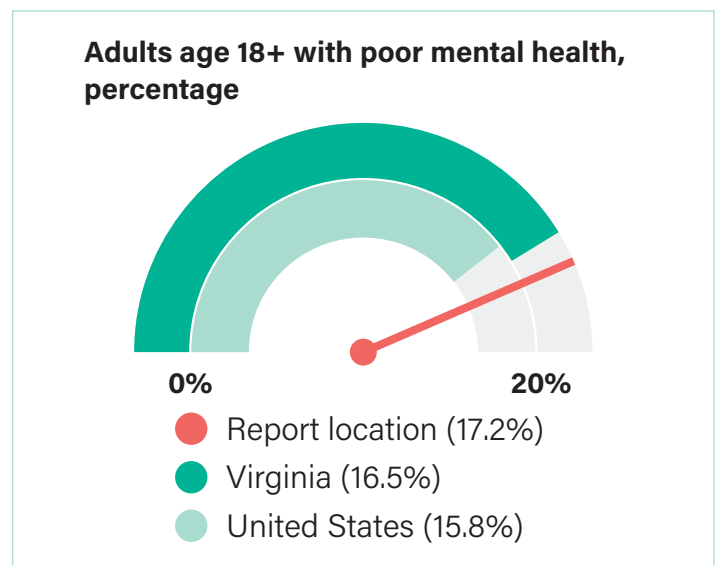


Figure 13 Source: Virginia’s Plan for Well-Being, Virginia Community Health Improvement Data Portal

residents in the service area is 70.3 to 76.2 years— 3.3 to 9.2 years less than White residents in Norfolk (76.4), Chesapeake (77.3), and Virginia Beach (79.5) living in the service area.¹

Access to health services is limited by the low numbers of primary care providers and mental health providers in this community. The need for access to mental health services continues to grow. In 2024, 2,082 adults and 120 youth visited the SLH emergency room for behavioral health concerns. Of those patients, 27.6% of the adults and 42.5% of the youth reported suicidal ideations.







Top health conditions driving hospitalizations at SLH include asthma, hypertension, stroke, diseases of the heart, mental health, and drug overdose. Leading causes of death include heart disease, cancer, accidents, stroke, and COVID-19. Risk factors for chronic conditions include substance use, obesity, limited access to healthy foods, and physical inactivity.

Focus areas

Sentara Cares is the community engagement and impact arm of Sentara Health. Our goal is to advance health and ensure that all members of our communities have access to the resources they need to live their healthiest and most fulfilling lives. We are focusing our resources on the key issues listed below based on identified health disparities, the availability of effective interventions, community input, and alignment with our mission to “improve health every day.”

The remainder of this report provides more detail about the 2025 assessment, including social and economic data, demographic information, and health determinant data. Throughout this document, we have incorporated extensive information obtained through the community survey and stakeholder outreach.

Sentara Cares community benefit and building efforts enhance SLH and LOSC health priorities for 2026-2028

Sentara priorities	Socioeconomic needs	Health needs	SLH and LOSC priorities
	 Housing	 Behavioral and mental health	
	 Food security	 Chronic conditions	
	 Skilled careers	 Social determinants of health	




Table 1 Sentara cares priorities for grant opportunities and SLH and LOSC implementation strategy priorities for 2026-2028.

Endnotes

¹ County Health Rankings & Roadmaps: Rankings Data & Documentation. Accessed October 10, 2024. <https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation>.

² United States Census Bureau. QuickFacts. www.census.gov. Accessed February 13, 2025. <https://www.census.gov/quickfacts/fact/table/mecklenburgcountyvirginia,halifaxcountyvirginia,charlottecountyvirginia,VA/PST045221>.

³ University of Virginia Weldon Cooper Center for Public Service. (2022). Virginia Population Projections. Accessed February 13, 2025. Retrieved from <https://coopercenter.org/virginia-population-projections>.

Introduction

Sentara Health

Sentara Health, an integrated, not-for-profit health care delivery system, celebrates more than 130 years in pursuit of its mission - "we improve health every day." Sentara is one of the largest health systems in the U.S. Mid-Atlantic and Southeast, and among the top 20 largest not-for-profit integrated health systems in the country, with 30,000 employees, 12 hospitals in Virginia and Northeastern North Carolina, and the Sentara Health Plans division which serves more than 1 million members in Virginia and Florida. Sentara is recognized nationally for clinical quality and safety and is strategically focused on innovation and creating an extraordinary health care experience for our patients and members. Sentara was named to IBM Watson Health's "Top 15 Health Systems" (2021, 2018), and was recognized by Forbes as a "Best Employer for New Grads" (2022), "Best Employer for Veterans" (2022, 2023), and "Best Employer for Women" (2020).¹

Sentara Leigh Hospital (SLH)

Sentara Leigh Hospital, located in Norfolk, VA, is a 274-bed acute care facility that opened in 1903 and relocated to its present site in 1977. The facility includes a dedicated orthopedic hospital providing patients access to a full continuum of orthopedic care, from the preoperative phase and surgery to rehabilitation and home care services. Along with being a recognized accredited Primary Stroke Center, and Magnet hospital for nursing excellence, we also specialize in orthopedic and spine care, heart, vascular, maternity care, and general surgery. We are home to the region's only 24-hour hyperbaric oxygen program that helps speed up the healing of carbon monoxide poisoning, wounds that won't heal, infections in which tissues are starved for oxygen, airborne chemical exposures, and scuba diving accidents.²

Sentara at a glance

- **Headquartered in Hampton Roads**
- **Outpatient campuses**
- **135-year not-for-profit history**
- **Urgent care centers**
- **12 hospitals**
- **Advanced Imaging Centers**
- **One medical group**
- **Home health and hospice**
- **3,800+ provider medical staff**
- **Rehabilitation and therapy centers**
- **30,000+ team members**
- **Nightingale Regional Air Ambulance**
- **Sentara Health Plans**

Leigh Orthopedic Surgery Center (LOSC)

Leigh Orthopedic Surgery Center (LOSC) is a single specialty orthopedic surgery center that opened in 2020. The facility is a joint venture between Sentara Health and two local physician-owned orthopedic groups. The second-floor surgical suite features two operating rooms, two procedure rooms and pre- and post-op recovery areas for state-of-the-art outpatient procedures. All of our staff take great pride in living up to the commitments that are our mainstay. We strive to keep our patients safe, informed and involved. We treat our patients with respect, dignity, and compassion. And we will listen and respond to our patients' concerns as we work together to meet their surgical needs.³

Sentara Cares

Our purpose calls us to address healthcare issues every day, where people live—not just when patients are under our care. This broad vision is essential in our work to eliminate health disparities and promote access to nutritious foods, education, safe and affordable housing, and stable, rewarding job opportunities. We know that health disparities cannot be solved solely in the exam room, and they cannot be solved solely by Sentara. Through our partnerships, we continue to make both immediate impact and lasting change for our communities.⁴

Sentara Community Care

Sentara Community Care launched in 2022 to expand access to care and improve the health of communities across the Commonwealth. Leveraging data-driven strategies, we are rapidly expanding this model to meet the needs of Virginians, focusing on uninsured and Medicaid members. We have partnered with community and faith-based leaders to ensure that we can better understand and respond to the community's most pressing needs.

The goal is to reduce traditional barriers to health and wellness by maximizing convenience and providing consistent, embedded medical and wrap-around services in neighborhoods with the greatest needs. Services can include primary care for children and adults, behavioral health and social care services, health and wellness education, food and housing support, and healthcare navigation.

Sentara Community Care launched its three initial programs in Hampton Roads in summer of 2022, and has expanded to serve Harrisonburg, Henrico, Newport News, Northern Virginia, Petersburg/Richmond, and Southside Virginia communities. Since its inception, Sentara Community Care has served more than 6,000 Virginians through its innovative healthcare delivery model.

Now with six community care centers, six mobile care vehicles, school-based telehealth clinics, and numerous strategic partnerships, the Sentara Community Care program continues to extend its reach to provide holistic care in the communities that need it most.

“ 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. ”

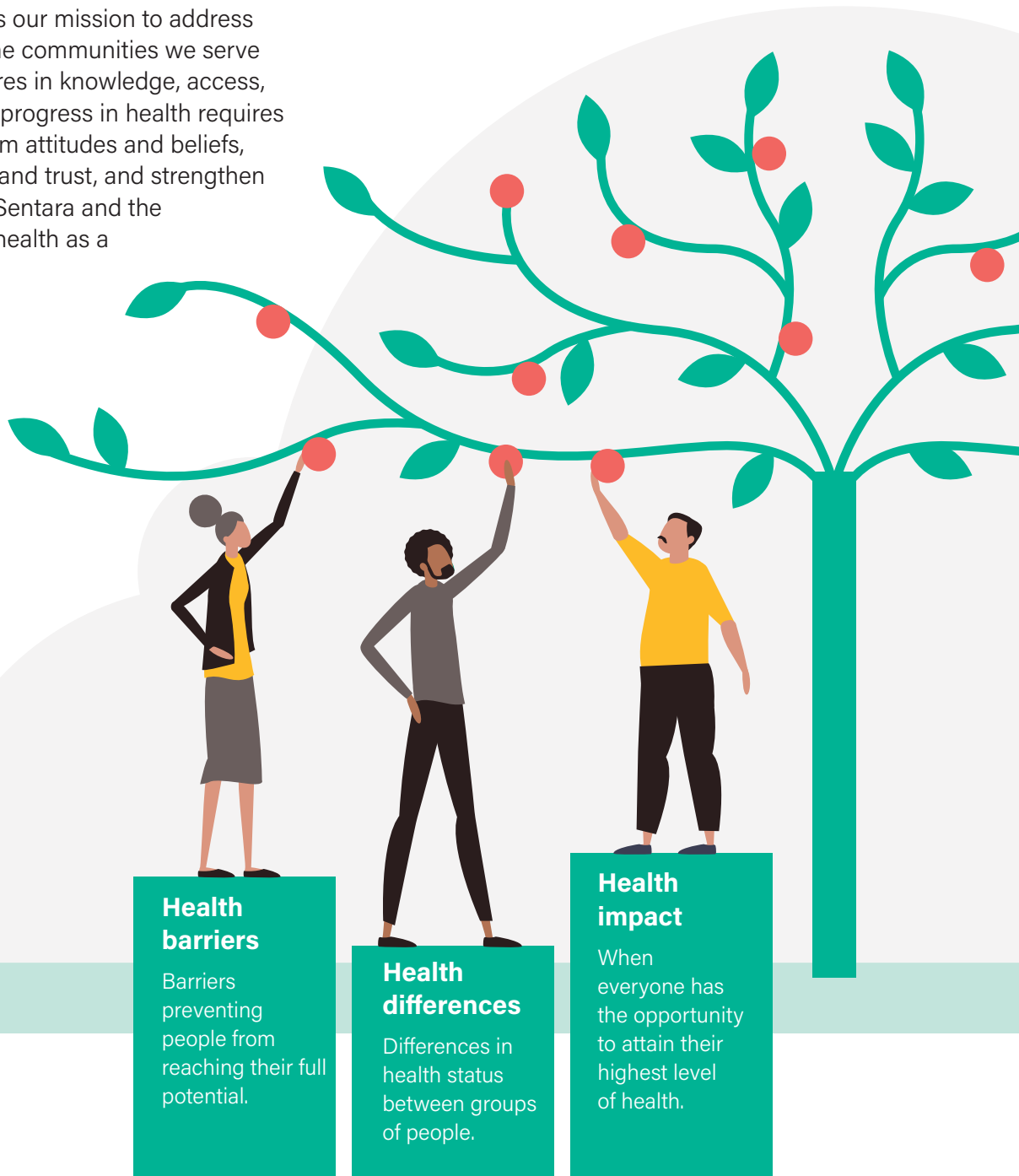
Sherry Norquist, MSN, RN-ACM,
Executive Director of Community
Engagement & Impact



Health impact

By identifying the most pressing health concerns within a community, this assessment prioritizes health interventions and allocates resources to advance health impact based on community insight. Our efforts promote health, enhance awareness, education, and access to care across racial, ethnic, gender, age, language, geographic, and socioeconomic groups. This involves not only examining the health and wellness of a population, it also addresses how hidden tendencies influencing decision-making among clinicians, caregivers, communities, and interested parties impact treatment decisions and outcomes. The shift toward value-based healthcare supports our mission to address health disparities within the communities we serve and to promote gap closures in knowledge, access, and outreach. Meaningful progress in health requires ongoing efforts to transform attitudes and beliefs, improve communications and trust, and strengthen trustworthiness between Sentara and the community, emphasizing health as a core value and priority.

Sentara collaborates with community organizations, faith leaders, academic institutions, government agencies, and clinicians to develop initiatives to address social drivers of health, reduce health disparities, and improve the health and well-being of the communities we serve. Our efforts focus on improving screening and diagnosis rates for health issues, such as hypertension, diabetes and prostate cancer; increasing access to and utilization of treatment; and supporting health initiatives that benefit historically marginalized groups, including immigrant populations, individuals experiencing homelessness, sexual orientation and gender identity (SOGI) populations, and individuals with different [or diverse] abilities.



Assessment	Description
Qualitative data	We survey our community members and hold focus groups to discuss community conditions, health, and needs. We ask our community members about their personal circumstances—like having a safe place to live, healthy and accessible food, social connections, and other daily essentials—and connect them to community resources.
Quantitative data	We collect demographic and health indicator data to identify differences in community and health outcomes. We look at the data to better inform our community health improvement work.

Process overview

Mobilizing for action through planning and partnerships

The National Association of County and City Health Officials (NACCHO) has implemented a community-driven strategic planning process for improving community health called Mobilizing for Action through Planning and Partnerships (MAPP). This framework includes engaging community partners in the collection and review of qualitative and quantitative data from trusted local and national sources. In doing so, participating partners can clearly define the conditions that support or obstruct wellness and identify resources to address obstacles.⁵

We began the MAPP process at SLH and LOSC by engaging community partners, developing support teams, and creating a shared vision with common values. Community partners included Bon Secours Hampton Roads, Children’s Hospital of The King’s Daughters, Riverside Health, and the Hampton and Peninsula Health Districts. Sentara worked collaboratively with these partners to engage community members through survey completion and focus groups, collecting responses to be used for prioritizing health needs. We then collected and analyzed data to identify strategic priorities and formulate goals and strategies to address health concerns.

Our process

Sentara conducts these comprehensive assessments to provide a snapshot of the health status of residents in our communities, including information about key health and health-related challenges and opportunities. Each Community Health Needs Assessment incorporates information from a variety of primary and secondary quantitative data sources to help us to understand the disparities that affect vulnerable populations.

Sentara created a data profile that includes how people use emergency and preventive care, their ongoing health problems, and any cultural or language requirements they might have. A secondary statistical data profile uses advanced data sources to assess population characteristics such as household statistics, age, educational level, economic measures, mortality rates, prevalence rates of chronic illnesses, and racial and ethnic composition. Our assessment includes a review of risk factors, including obesity, smoking, and other health indicators.

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

- Centers for Medicare & Medicaid Services
- County Health Rankings 2024
- National Cancer Institute
- United States Census Bureau
- Virginia Department of Health
- Virginia Medicaid, Virginia Department of Medical Assistance Services
- Virginia’s Plan for Well-Being: Virginia Community Health Assessment
- Weldon Cooper Center for Population Studies, University of Virginia
- CHNA survey and focus groups

Our next steps

Both SLH and LOSC work with a number of community partners to address health needs. Using the information from this assessment, SLH and LOSC will develop an implementation strategy to address the identified health problems. The implementation strategy progress report for the 2022 CHNA is available at the end of this report.

Information on available resources is available from sources like 2-1-1 Virginia and Virginia's Plan for Well-Being. 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 future assessments. You may use our online feedback form available on [sentara.com](https://www.sentara.com).



Endnotes

¹ Sentara Health. About Sentara. Accessed October 10, 2024. <https://www.sentara.com/aboutus.aspx>.

² Sentara Health. Sentara Leigh Hospital. Accessed February 28, 2025. <https://www.sentara.com/hospitalslocations/sentara-leigh-hospital>.

³ Leigh Orthopedic Surgery Center. Accessed February 28, 2025. <https://leighortho.com/>.

⁴ Sentara Cares. Strengthening Communities. Accessed October 10, 2024. <https://sentaracares.com>.

⁵ National Association of County and City Health Officials. Accessed October 10, 2024. Mobilizing for Action through Planning and Partnerships (MAPP). <https://www.naccho.org/#:~:text=Mobilizing%20for%20Action%20through%20Planning%20and%20Partnerships%20%28MAPP%29,health%20issues%20%20and%20identify%20resources%20to%20address%20them>.

Community description

Locality demographics of our community

Both SLH and LOSC are located in the city of Norfolk, but serve the cities of Chesapeake, Norfolk, and Virginia Beach. The SLH and LOSC community includes a total population of 938,465 people who live in the 1,482 square mile report area defined for this assessment according to the U.S. Census Bureau's 2019-2023 American Community Survey five-year estimates.¹ Virginia Beach has the highest population in the service area.

Geography

The SLH and LOSC community is comprised of three cities—Chesapeake, Norfolk and Virginia Beach—and surrounding communities. This community is defined by cities because many health status indicators used in this report are only available at the city level, not at the zip code level, though much of the data incorporates the entire community that SLH and LOSC serves.

Community-specific demographics

As of the 2023 U.S. Census, the Chesapeake population was 253,886, with 8.7% of residents living in poverty and 7.6% uninsured. Age demographics within Chesapeake include 24.3% of residents between the ages of 0-17, 21.7% ages 18-34, 27.0%

ages 35-54, and 26.9% ages 55 and older. English is the primary language for 91.7% of residents. The racial and ethnic profile for the city is 56.2% White, 29.0% Black, 7.4% Hispanic, and 3.7% Asian.

For Norfolk, there is a population of 230,930, with 17.3% of residents living in poverty and 10.5% uninsured. Age demographics within Norfolk include 20.5% of residents between the ages of 0-17, 33.8% ages 18-34, 22.1% ages 35-54, and 23.7% ages 55 and older. English is the primary language for 88.4% of residents. The racial and ethnic profile for the city is 44.0% White, 39.8% Black, 9.9% Hispanic, and 3.7% Asian.

For Virginia Beach, there is a population of 453,649, with 8.4% of residents living in poverty and 7.6% uninsured. Age demographics within Virginia Beach include 22.1% of residents between the ages of 0-17, 24.2% ages 18-34, 25.8% ages 35-54, and 27.9% ages 55 and older. English is the primary language for 87.6% of residents. The racial and ethnic profile for the city is 61.6% White, 39.8% Black, 8.9% Hispanic, and 7.3% Asian.



Looking at the data

Racial and ethnic profile, 2023

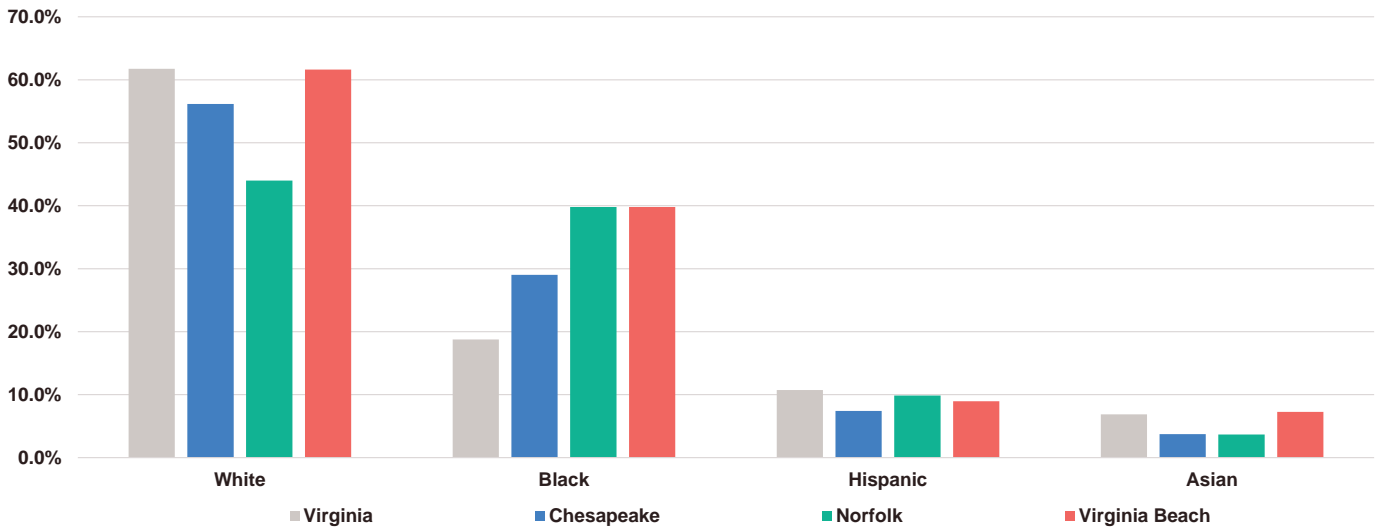


Figure 1 Sources: Virginia’s Plan for Well-Being, U.S. Census Bureau

Population by age, 2019-2023

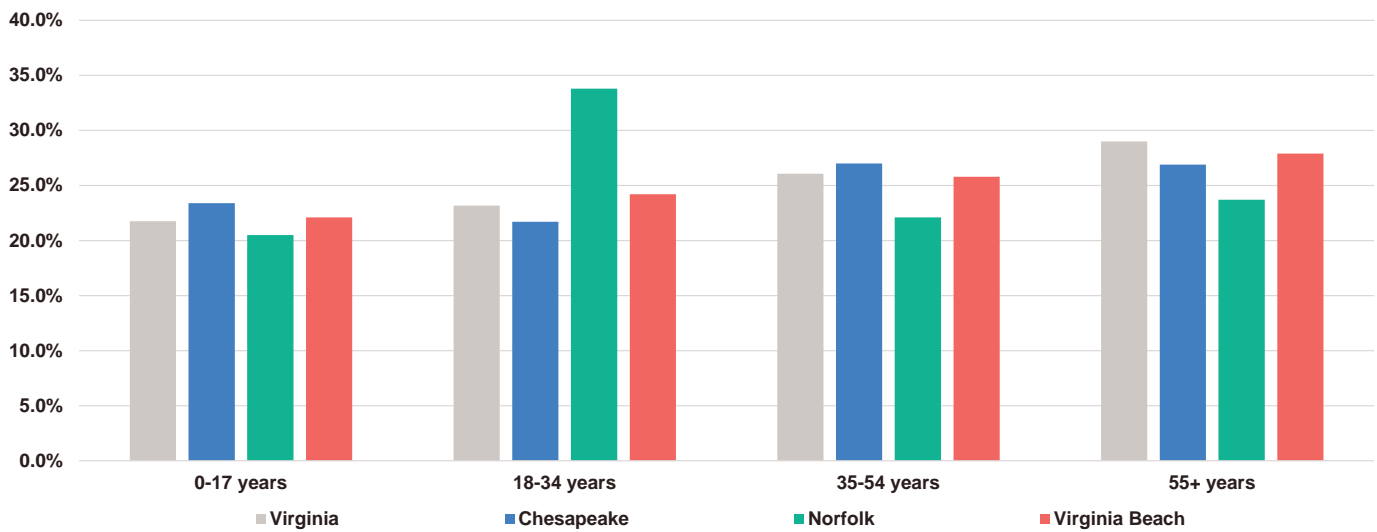


Figure 2 Sources: Virginia’s Plan for Well-Being, U.S. Census Bureau

Median household income, 2023

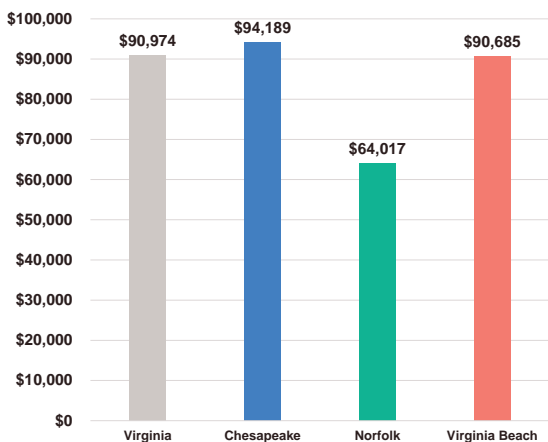


Figure 3 Source: U.S. Census Bureau

Poverty, 2023

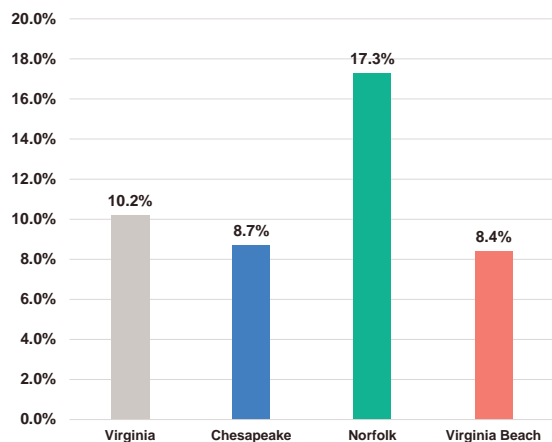


Figure 4 Source: U.S. Census Bureau

Population highlights

Population change

Population projections provide an approximate idea of the expected future population size” and according to the University of Virginia’s Weldon Cooper Center for Public Service, Chesapeake is expected to increase by an estimated 29,000 people, along with Virginia Beach’s estimated growth of 25,000 people, in the next 10 years. However, Norfolk is expecting a loss of an estimated 2,000 people.² These projections are based on “reliable and credible data.”²

Population change, 2025-2035

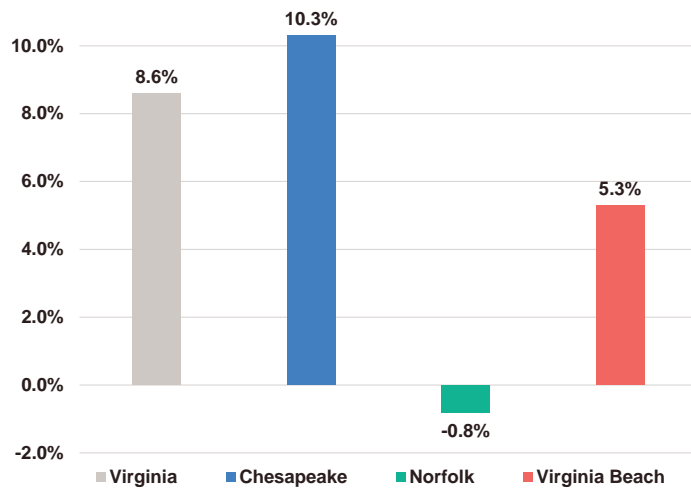


Figure 5 Source: U.S. Census Bureau

Age and sex

Per the 2023 U.S. Census, of the total population of 938,465 people living in the service area, most residents are between the ages of 18-54. The percentage of residents who are children between the ages of 0-17 is 22.3%, which is slightly higher than the state level of 21.9%. Male (49.5%) and female (50.5%) resident percentages are the same as Virginia percentages (49.5% male, 50.5% female), based on sex assigned at birth.

Aging population

Research shows the highest utilization of medical services is among the aging population (ages 65 and older) and the elderly population (ages 85 and older). In 2023, 14.3% of the residents living in the service area were ages 65 and older, compared to 16.3% in Virginia. Per the 2023 U.S. Census, Virginia Beach has

the largest number of adults ages 65 and older in the service area, estimated at 69,726 residents. Estimates indicate the population of aging adults ages 65 and older living in the service area will increase to 21.6% by 2030. Over the next 10 years, the number of aging adults will increase by an estimated 68,000 residents in the service area.²

Other demographic features

According to the 2023 U.S. Census, veterans represent 11.0% of the population in the service area, compared to 12.9% statewide. Norfolk and Virginia Beach have a lower percentage of owner-occupied homes (45.7%, 64.9%) compared to the state overall (66.9%). More households in the service area have computers (96.3%) and internet access (91.9%), increasing access to remote learning, telehealth, and other resources. A lower percentage of the population in the service area is living with a disability (9.4%) compared to the state overall (12.3%). The service area also has a higher percentage of persons living in poverty (11.5%) compared to Virginia overall (10.2%), and a lower percentage of residents with college degrees (47.4%) when compared to the state (49.3%).

Community diversity profile

Race and ethnicity

The population of the service area has a higher percentage of White (55.8%) and Black (26.8%) residents than other races and ethnicities.³ The service area is home to a small Hispanic (8.8%) and Asian (5.4%) population.³

Population with limited English proficiency, 2019-2023

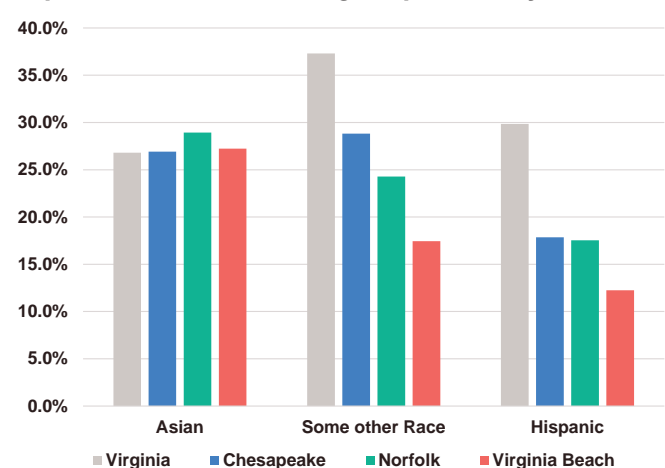
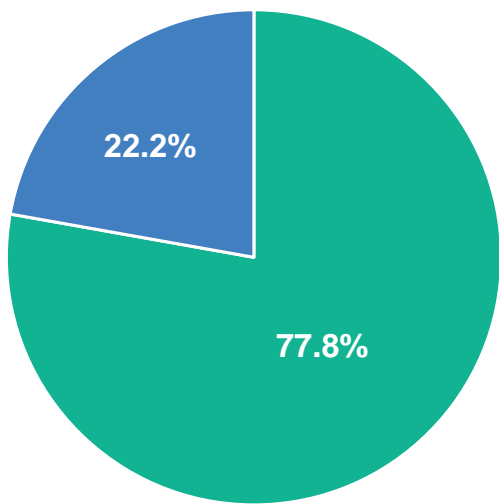


Figure 6 Source: U.S. Census Bureau

Cultural and linguistic needs

English is the primary language spoken in the service area. As of the 2023 U.S. Census, 90.7% of the population in the service area identified as English-speaking. Non-English-speaking populations are disproportionately represented in low socioeconomic groups, have poorer health outcomes, are more likely to have a disability, are often linguistically and culturally isolated, and have lower educational attainment compared to their English-speaking counterparts. Language barriers make it difficult for this population to understand, interpret, and benefit from information about their health.

2024 SLH language utilization



■ Spanish ■ Vietnamese, ASL, Russian, other

Figure 7 Source: U.S. Census Bureau

Sentara is committed to ensuring that all communication with our patients and health plan members is in their preferred language. Sentara provides its patients and their families with qualified interpreters for a variety of languages, including American Sign Language (ASL). In 2024, SLH had 10,442 requests for interpreter services. The highest percentage of interpreter services (77.8%) was for Spanish-speaking individuals, with the second highest percentage being Vietnamese (3.6%), and ASL (3.6%).

Social determinants of health

Sentara recognizes that meaningful improvements in health outcomes requires strategies reaching beyond clinical settings to address the root causes of health inequities.

Sentara works to:

- Meet the unprecedented need for behavioral health practitioners and ensure greater access to behavioral health services for children, families, and adults.
- Secure consistent 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 care and human services in traditionally underserved populations.

Social determinants of health



Figure 8 Source: U.S. Department of Health and Human Services. Healthy People 2030. Accessed May 2, 2023. Source: [Healthy People 2030](#).⁴

Poverty

An examination of poverty rates and racial demographics underscores the racial disparities that impact economic and health outcomes for residents and their families. In Virginia, Black and Hispanic residents in the service area are more likely to live in poverty compared to White residents. At 11.5%, the service area has a higher percentage of residents living in poverty compared to the Commonwealth of Virginia (10.2%).³

Education

Education is the basis for stable employment and financial stability, which in turn supports access to quality healthcare and positive health outcomes. The service area is slightly higher (93.1%) than the statewide percentage (91.1%) of residents who are high school graduates. However, the service area has a lower percentage of college graduates (37.4%) compared to the state overall (41.5%).³

Employment

Per the 2023 U.S. Census, the service area has a slightly higher percentage of unemployed residents (3.0%) compared to Virginia overall (2.9%). The labor force represents 67.7% of total residents. Within the labor force, 63.9% of female residents in the service area are employed, aligned with the state (61.0%).³



Estimated poverty status by race, 2023

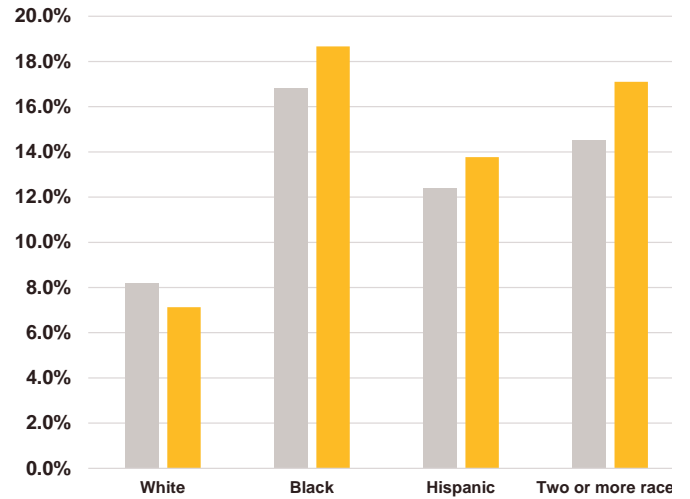


Figure 10 Source: U.S. Census Bureau

Education attainment, age 25+, 2019-2023

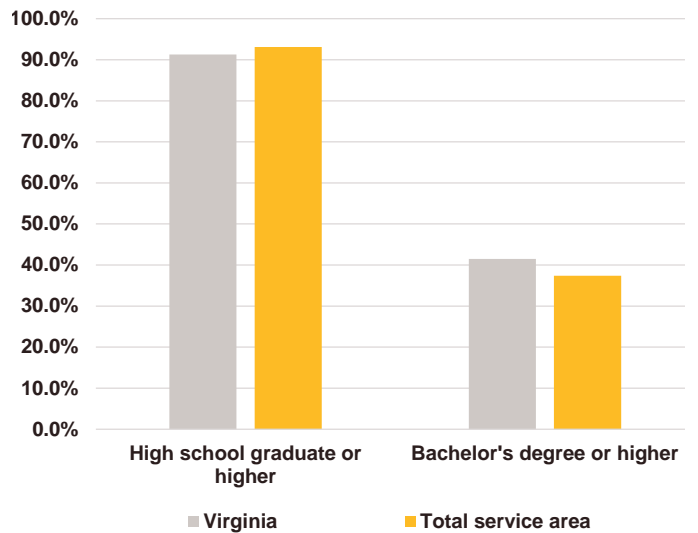


Figure 11 Source: U.S. Census Bureau

Civilian labor force, 2023

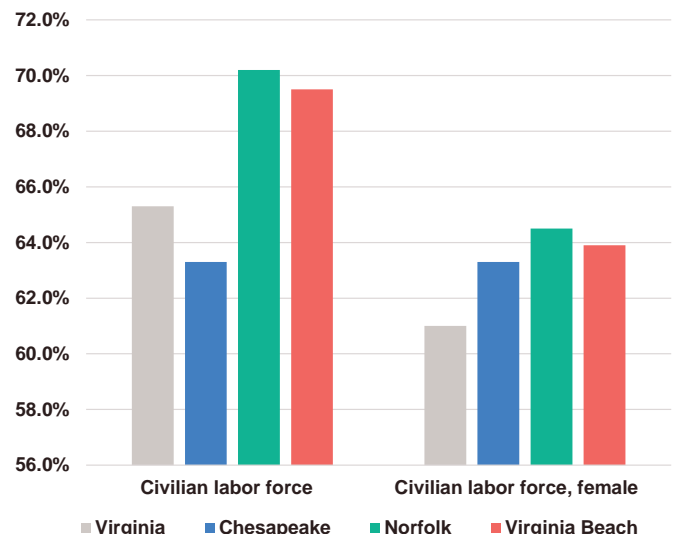


Figure 12 Source: U.S. Census Bureau

Medicaid and FAMIS, Medicare, Medicare and Medicaid

Public health insurance programs play an important role in providing coverage for individuals who qualify based on income, age, or disability. According to the 2023 U.S. Census, 8.3% of residents living in the service area do not have health insurance. A total of 1,994,822 Virginians had health coverage through Medicaid and Family Access to Medical Insurance Security (FAMIS) as of February 11, 2025. This included 214,696 residents living in the service area served by SLH and LOSC.⁶ Medicaid and FAMIS members represent 22.9% of the total population in the service area. The city of Norfolk has the highest rate of Medicaid and FAMIS membership at 33.5%. In comparison, 22.9% of all Virginians have Medicaid or FAMIS health coverage.⁶ Community health workers and enrollment specialists are available to provide guidance and assistance for qualifying individuals and families with enrollment in these government programs.

Population with insurance by provider type, 2022

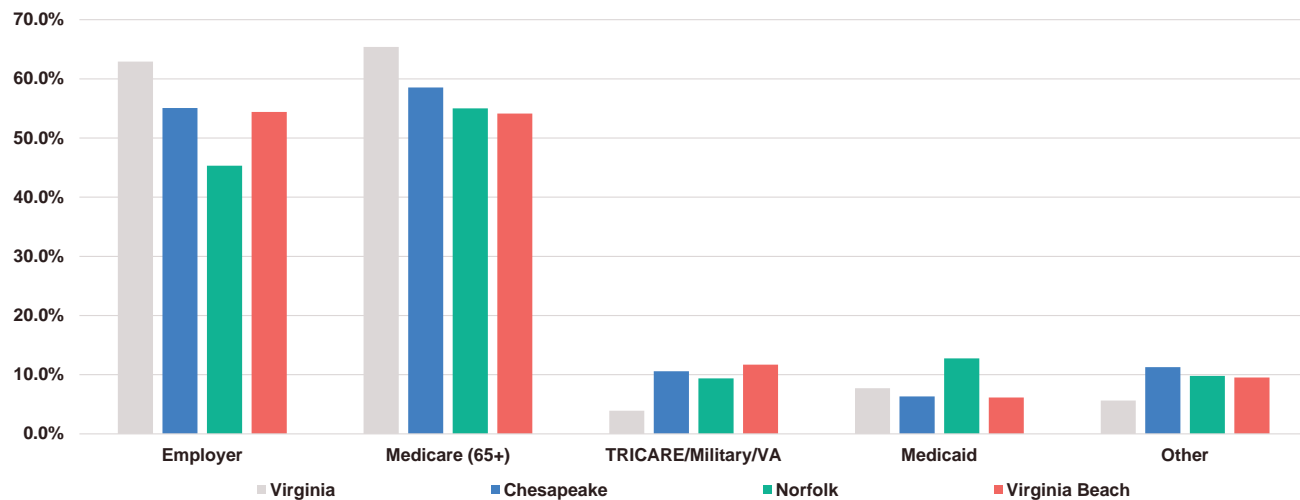


Figure 13 Source: Centers for Medicare & Medicaid Services Data

Endnotes

¹ United States Census Bureau. American Community Survey 5-Year Estimates, 2018-2022. Demographic and Housing Estimates. Accessed November 12, 2024. https://data.census.gov/table?q=United%20States&t=Age%20and%20Sex&g=040XX00US51_050XX00US51550,51710,51740,51800,51810.

² Weldon Cooper Center for Public Service. Virginia Population Projections. Accessed October 10, 2024. <https://www.coopercenter.org/virginia-population-projections#map-01>.

³ United States Census Bureau. QuickFacts. www.census.gov. Accessed February 13, 2025. <https://www.census.gov/quickfacts/fact/table/VA,chesapeakecityvirginia,norfolkcityvirginia,portsmouthcityvirginia,suffolkcityvirginia,virginiabeachcityvirginia/HSG445222#HSG445222>.

⁴ U.S. Department of Health and Human Services. Healthy People 2030. Accessed May 2, 2023. <https://health.gov/healthypeople/priorityareas/social-determinants-health>.

⁵ Aurora University. Social Work and Poverty: Rural vs. Urban Poverty. Access May 2, 2023. <https://online.aurora.edu/infographics/rural-poverty-vs-urban-poverty/>.

⁶ Department of Medical Assistance Services (DMAS) Data. Accessed February 13, 2025. <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>.

⁷ Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 13, 2025. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

Community input

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 focus groups.

Description

A broad range of diverse community members provided input through a community survey and focus groups. We consulted with individuals with firsthand knowledge of the health needs of the community. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations. In addition, we gathered input from community leaders, clients of local service providers, and other individuals representing people who are medically underserved, low income, or who face unique barriers to health (e.g., racial/ethnic minorities and individuals experiencing homelessness).

Methodology

To include a wide range of community perspectives, as well as the views of those who work with or represent underserved populations within the community, SLH and LOSC staff used several methods to identify groups and collect qualitative data.

Working with the Peninsula Community Health Collaborative, and representatives from Bon Secours Hampton Roads, Children’s Hospital of The King’s Daughters (CHKD), Riverside Health, and the Hampton and Peninsula Health Districts, members reviewed the participant lists from previous CHNA reports in the same community. Importantly, the inclusion of service providers and community

members (through surveys and focus groups) allowed us to identify health needs from the perspectives of diverse populations.

Community survey

The community survey was conducted jointly with the Peninsula Community Health Collaborative and included a broad-based group of stakeholders and community members. Electronic surveys, and paper surveys in English and Spanish, were available to the public from October 1, 2024, to February 28, 2025.

The survey was distributed to stakeholders, including individuals representing public health, education, social services, businesses, local government, and local civic organizations. At the completion of the survey period, 1,706 survey responses were received from community members and stakeholders.

After the initial survey period, the collaborative recognized that the majority of respondents were White. Most cities did not have an equally distributed response to surveys to represent the entire population. As a result, survey responses should be considered as only one component of information utilized to select health priorities. Feedback from the most underserved populations is not adequately reflected in most of the surveys. For the full list of questions and responses, see Appendix C.

Demographics of survey respondents

Of the 1,569 SLH and LOSC community respondents, 69.2% identified as White, 19.6% as Black, 4.5% as Asian, 1.4% as Indigenous, and 7.5% as Hispanic.

Survey responses

For this CHNA, we will focus on the survey questions below. Survey respondents were asked to review a list of common community health issues for children (0-17) and adults, and select all that applied to their community. The tables below show the top three answers for the questions among community member respondents.

Top three most important health concerns in your community.

Rank	Overall Responses (n=1,569)	Chesapeake City (n=397)	Norfolk City (n=377)	Virginia Beach City (n=795)
Youth				
1	Mental health	Mental health	Mental health	Mental health
2	Asthma, allergies	Asthma, allergies	Asthma, allergies	Asthma, allergies
3	Obesity	Obesity	Obesity	Obesity
Adults				
1	Mental health	Mental health	Mental health	Mental health
2	Cancer	Cancer	Cancer	Cancer
3	Diabetes	Diabetes	Diabetes	Obesity

Top three barriers to accessing healthcare resources and services in your community.

Rank	Overall Responses (n=1,569)	Chesapeake City (n=397)	Norfolk City (n=377)	Virginia Beach City (n=795)
Youth				
1	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment
2	Cost	Cost	Cost	Cost
3	No appointments available for new patients	No appointments available after 5pm or weekends	Limited or no insurance	Limited or no insurance
Adults				
1	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment
2	Cost	Cost	Cost	Cost
3	No appointments available for new patients	No appointments available for new patients	No appointments available for new patients	No appointments available for new patients

Top three social concerns impacting health in your community.

Rank	Overall Responses (n=1,569)	Chesapeake City (n=397)	Norfolk City (n=377)	Virginia Beach City (n=795)
Youth				
1	Lack of available healthy food	Lack of affordable housing	Lack of available healthy food	Lack of available healthy food
2	Lack of parenting support, education services	Lack of parenting support, education services	Lack of quality schools	Lack of parenting support, education services
3	Lack of affordable housing	Lack of available healthy food	Lack of parenting support, education services	Loneliness, isolation
Adults				
1	Lack of affordable housing	Lack of affordable housing	Lack of affordable housing	Lack of affordable housing
2	Loneliness, isolation	Loneliness, isolation	Loneliness, isolation	Loneliness, isolation
3	Lack of available healthy food	Lack of available healthy food	Lack of available healthy food	Homelessness



Community focus groups

In addition to the online surveys for community insight, SLH and LOSC carried out a series of more in-depth community focus groups to obtain greater insight from diverse stakeholders and community members. Focus groups were promoted electronically and by word of mouth to hospital patients and visitors, existing hospital and community groups, and partner organizations. Input was also sought from other populations in the community, including representatives of underserved communities and consumers of services. In collaboration with CHKD and Bon Secours, SLH and LOSC held 16 focus group sessions between October 2024 and February of 2025. The number of participants in each group ranged from six to 14. Refer to Appendix C for complete notes.

2024 focus groups

- October 14: Filipino Focus, 9 participants
- October 15: SLH Patient Family Advisory Committee, 12 participants
- October 15: SVBGH Patient Family Advisory Committee, 12 participants
- November 12: Reck League, 9 participants
- November 12: Greater Saint Andrews, 9 participants
- November 14: LGBTQ Life Center, 6 participants
- November 14: Girls on the Run, 8 participants

- November 14: HOPES Free Clinic, 7 participants
- November 20: Armed Services YMCA, 7 participants
- November 20: Lee's Friends, 10 participants
- November 22: Urban Discovery Mission, 11 participants
- November 25: Ingleside Elementary Parents Night, 14 participants
- December 5: SPAH Patient Family Advisory Committee, 12 participants
- December 12: Hampton Roads Parenting Network, 8 participants

2025 focus groups

- January 21: Iglesia de Dios de Adonai, group 1, 8 participants
- January 21: Iglesia de Dios de Adonai, group 2, 11 participants

Demographics

The 153 focus group participants ranged in age from 18 to 65 and older. Altogether, participants were 35.3% White, 36.6% Black, 7.8% Asian, 0.7% Indigenous, and 19.0% Hispanic. The group identified as 76.5% female and 23.5% male. Out of the 153 participants, one preferred not to respond to the race and ethnicity question.

Results

Topic	Key findings	
	Children	Adults
<p>What serious health problems are in your community for children (0-17) and for adults (18+)?</p>	<p>Mental and behavioral health</p> <ul style="list-style-type: none"> Anxiety, depression, ADHD, and autism Lack of access to mental health Increase in emotional dysregulation and behavioral health issues Increased vaping among youth Lack of school resources <p>Physical health and chronic conditions</p> <ul style="list-style-type: none"> Increase in obesity Diabetes and hypertension Rise in asthma, eczema, and allergies Respiratory illnesses Limited access to vision care <p>Social and environmental factors</p> <ul style="list-style-type: none"> Increase in developmental delays Safety concerns Food insecurity Lack of structured activities for youth Homelessness and housing instability Limited transportation access 	<p>Mental health and substance abuse</p> <ul style="list-style-type: none"> High rates of depression, anxiety, and stress Substance abuse Postpartum depression and anxiety Increased loneliness and isolation Limited access to mental health services <p>Chronic diseases and physical health</p> <ul style="list-style-type: none"> High rates of hypertension, high cholesterol, heart disease, and diabetes Increase in obesity Stroke, dementia, and Alzheimer's Cancer Gout, arthritis, and orthopedic issues impacting mobility Lack of access to preventive care <p>Social determinants of health and safety</p> <ul style="list-style-type: none"> Housing instability and homelessness Food deserts Unsafe neighborhoods Stress from financial burdens Education gaps Gun violence
<p>What are some of the environmental and social conditions that affect quality of life for children and adults living in your community?</p>	<ul style="list-style-type: none"> Economic struggles Safety concerns Education challenges Health and mental health Technology and socialization Family and social structure Food insecurity Transportation barriers 	<ul style="list-style-type: none"> Economic instability Health care issues Social isolation Transportation barriers Work and family balance Aging population needs Environmental factors
<p>Improving local health systems and community wellness</p>		
<p>What do you think your local health systems (hospitals and primary care) and health departments can do to improve the health and wellness in your community?</p>	<ul style="list-style-type: none"> Enhance health care workforce and access Cost transparency and affordability Care coordination and patient support Accessibility and community outreach 	<ul style="list-style-type: none"> Preventive care and education Technology and communication improvements Emergency preparedness and public health initiatives

Results (cont.)

Topic	Key findings	
Children and adults		
<p>What do you think about the health-related services that are available in your community, including medical care, dental care, and mental health care for children and adults?</p>	<p>General health care access</p> <ul style="list-style-type: none"> ▪ Long wait times ▪ Provider shortage ▪ Insurance barriers ▪ Difficulty navigating the system ▪ Limited transportation ▪ Preventive care lacking <p>Mental health services</p> <ul style="list-style-type: none"> ▪ Severe shortage of providers ▪ Stigma in seeking help ▪ Limited awareness and education ▪ Lack of pediatric mental health access ▪ Need for community-based support <p>Dental care</p> <ul style="list-style-type: none"> ▪ Limited providers accepting insurance ▪ High out-of-pocket costs ▪ Military families face additional barriers 	<p>Pediatric care</p> <ul style="list-style-type: none"> ▪ Limited availability of primary and specialist care ▪ Emergency room as primary care ▪ Military families struggle with relocation ▪ Vaccine access issues <p>Structural and systemic challenges</p> <ul style="list-style-type: none"> ▪ Lack of 24-hour pharmacies ▪ Health care navigation is confusing ▪ Social services and community programs declining ▪ Lack of health education and outreach <p>Adult health care issues</p> <ul style="list-style-type: none"> ▪ Preventive care delayed ▪ Financial barriers ▪ Medicare and Medicaid gaps ▪ Women's health barriers
Challenges		
<p>Do you feel like it is hard to access healthy, fresh food in your community?</p> <p>What keeps you from trying new fresh fruits and/or vegetables?</p>	<ul style="list-style-type: none"> ▪ Affordability ▪ Transportation ▪ Food waste concerns ▪ Education and awareness ▪ Cultural and generational barriers ▪ Food deserts ▪ Sugar and processed food addiction 	<p>Potential solutions and community efforts</p> <ul style="list-style-type: none"> ▪ Education initiatives ▪ Local farmers markets and community gardens ▪ Food banks and pantries ▪ Healthy food incentives ▪ Convenience and meal preparation support
Key strengths identified for children and adults		
<p>What is working in your community that can help residents live healthier lives?</p>	<p>Children and families</p> <ul style="list-style-type: none"> ▪ Recreation centers ▪ Community events ▪ Health care access ▪ Playgrounds and parks ▪ YMCA memberships ▪ Free school lunch programs ▪ School-based health programs ▪ Healthy school initiatives ▪ Kinship care and grandfamilies support ▪ Therapeutic recreation ▪ Food banks and fresh markets 	<p>Adults and seniors</p> <ul style="list-style-type: none"> ▪ Airmen's Attic ▪ Farmers markets ▪ Sentara Heart Center ▪ Interconnected medical records ▪ Senior fitness and social programs ▪ VA services and medical supply delivery ▪ Senior services (Southeastern) ▪ Mobile health clinics and pop-up immunizations ▪ Community partnerships and social support ▪ Post-heart attack support and Ornish Lifestyle Medicine programs ▪ Urban Discovery Ministries

Health status and prioritization

Health indicators

To gain a deeper understanding of our community, we looked at the 2024 County Health Rankings data to view length of life, quality of life, health behaviors, clinical care, social and economic factors, and physical environment. Per the County Health Rankings, “many of the leading causes of death and disease are attributed to unhealthy behaviors.” Below are key health status indicators for the counties representing this community.

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

- Access to health services
- Life expectancy
- Diabetes
- Behavioral health
- Substance use
- Community violence
- Cancer
- Leading causes of death
- Women and infant health
- Older and aging adults

Access to health services

Access to quality and affordable healthcare is important to an individual’s health. Health insurance and local care resources can help to 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 more primary care providers have lower rates of hospitalizations for preventable health issues.

Virginia Beach (1400:1) has fewer doctors to community members compared to the state (1340:1). Increasing access to primary care is a key solution to reducing unnecessary and costly hospital stays and improving the health of the community. It is important to note that Black populations living in Virginia and in this community have higher rates of preventable hospital stays compared to White residents.¹

Preventable hospital stays by rate by race, 2021

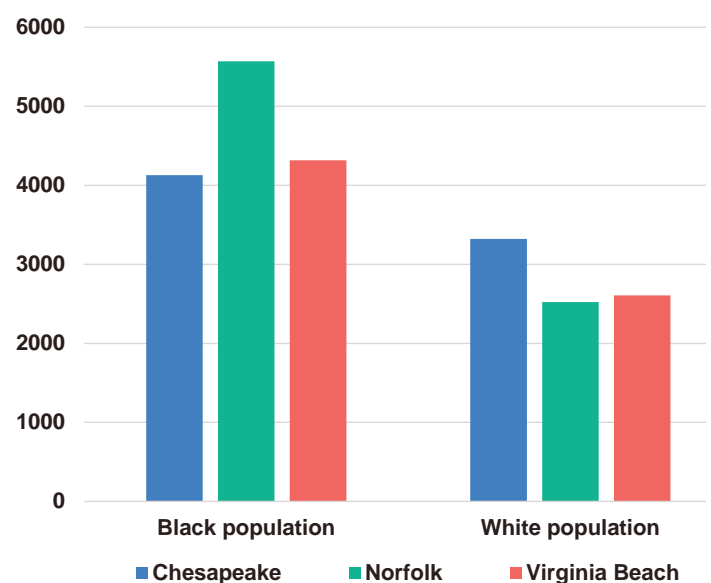


Figure 1 Source: County Health Rankings

Life expectancy

Per the Virginia Department of Health, the life expectancy for a person living in the Commonwealth of Virginia is 78.7 years. At 77.7 years, residents in this community have a lower life expectancy than Virginians overall. It is important to note that there is a racial disparity related to life expectancy specific to Black populations. Per the 2024 County Health Rankings, the life expectancy for Black individuals is up to nine years shorter than White individuals in this service area.

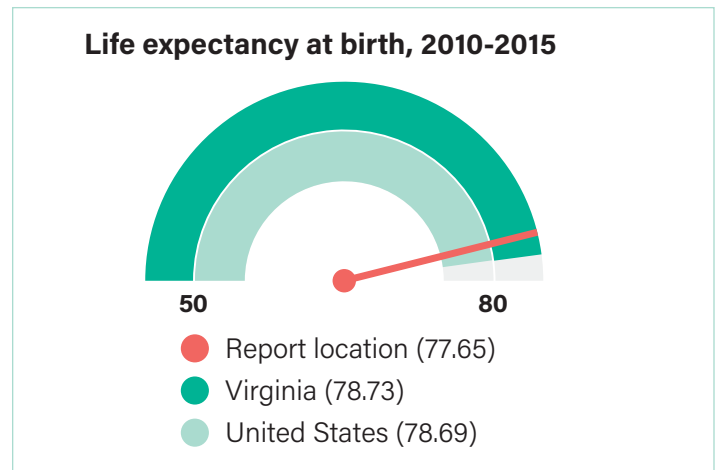


Figure 2 Source: Virginia Department of Health

The leading causes of death by race/ethnicity, 2021-2023			
White	Black	Asian	Hispanic
Heart Disease	Heart Disease	Cancer	Cancer
Cancer	Cancer	Heart Disease	Heart Disease
Stroke	Accidents	COVID-19	Accidents
Accidents	Stroke	Stroke	COVID-19
COVID-19	COVID-19	Diabetes	Stroke

Figure 3 Source: source: CDC Wonder

Leading causes of death

The Virginia Department of Health examined leading causes of death in localities of this community. Between 2021 and 2023, heart disease, cancer, stroke, accidents, and COVID-19 were the top five causes of death in this community.²

Behavioral health, mental health, and substance use

Hospitalization rates due to substance use, drug overdose, mental health, suicide, and self-inflicted injury were examined. In the service area, there were higher hospitalization rates (per 100,000 population) due to drug overdose compared to Virginia rates.² This community also has a higher rate of alcohol-impaired driving deaths, liver disease and cirrhosis compared to Virginia overall.

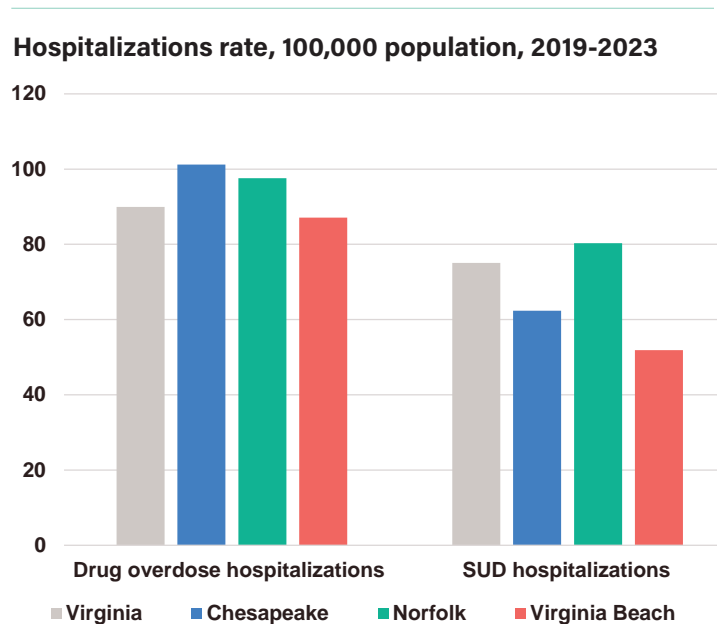


Figure 4 Source: Virginia’s Plan for Well-Being

Mental health is becoming an increasing health concern for both adolescents and adults. Sentara examined emergency department visits in 2024 to gain a better understanding of the mental health crisis communities have been facing since the COVID-19 pandemic. In 2024, the SLH emergency department treated 2,202 adults (age 19+) with behavioral health diagnoses. Of these visits, 27.6% of the patients presented with suicidal ideation, 4.2% with schizophrenia, 4.2% with anxiety disorder, and 4.0% with generalized anxiety disorder. Additionally, SLH saw 120 youth (age 0-18) present with behavioral health diagnoses. Of these visits,

42.5% presented suicidal ideation and 5.0% with anxiety and generalized anxiety disorder. It is important to note that the mental health workforce is nearing retirement age, which will negatively impact provider capacity. There is also a need for greater racial and ethnic representation in the mental health workforce.³

Community violence

Violent crimes such as gun violence, robbery, or aggravated assault have a harmful socio-emotional impact. They can cause physical and emotional symptoms such as sleep disturbances, increased feelings of distress, anger, depression, inability to trust, and significant issues with family, friends, or coworkers. Chronic stress has been associated with violent crimes and increases the prevalence of certain illnesses such as upper respiratory illness and asthma. This can have a life-long impact on the health of the individual.

The firearm fatality rate is higher than the state (13 per 100,000) in the cities of Norfolk (23) and Chesapeake (14). 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 2022 study published by the American Academy of Pediatrics showed an increase in pediatric deaths due to firearms. The study also showed a disparity among Black youth, who are 14 times more likely to die of a firearm injury compared to their White peers.⁴

Substance use and mental health, age 18+

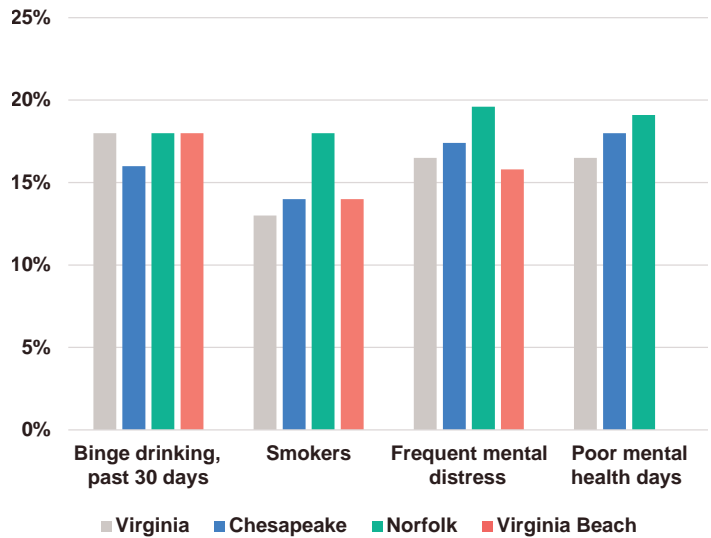


Figure 5 Source: Virginia’s Plan for Well-Being

Firearm fatality rate, 2022

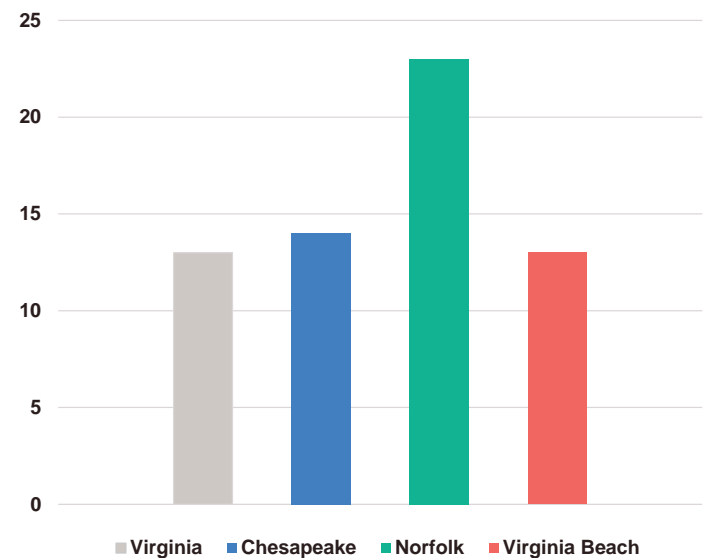


Figure 6 Source: Virginia’s Plan for Well-Being

Cancer

Since cancer is a leading cause of death in this community, death and incidence rates for a variety of cancer types were examined. Compared to the previous three-year rates, 2017-2021, the number of cases and deaths from the most common types of cancer are decreasing in the Commonwealth of Virginia, as well as this community.⁷ It is important to note that the incidence rates of breast cancer are rising for the White and Asian populations living in Virginia. Mortality rates were highest among lung and breast cancers, though declining in this community. Prostate and lung cancers are the leading causes of cancer death for Black populations living in Virginia. Norfolk had the greatest incidence rates for all cancers (455.0).⁵ Medical advancements and community outreach programs providing cancer screenings and education are making strides but, to have the greatest impact, we will need to focus efforts on the populations at highest risk for various cancers.

Maternal and infant health

Unsupported and under-supported young families face many negative health outcomes and many long-term health challenges as time goes on, so looking at the way families begin can help us to understand the current and future health of the community. Fewer mothers in the service area (2.7%) had late or no prenatal care, than in Virginia (5.1%). Though, the service area had slightly higher percentages of preterm births (10.8%) and babies born with low birth weights (9.6%) compared to the Commonwealth (9.5%, 8.5%). The infant mortality rate was also slightly greater in the localities (6.4 per 1,000 births) compared to Virginia (6.2).²

It is also important to note that Black mothers have a higher rate of cesarean sections compared to White mothers. A study completed in 2021 found, "the odds of cesarean-related maternal and neonatal morbidity were significantly higher for non-Hispanic Black and Hispanic women. These findings suggest race as a distinct risk factor for cesarean complications, and efforts to alleviate disparities should highlight cesarean section as an opportunity for improvement in outcomes."⁸

Virginia cancer incidence rate race/ethnicity

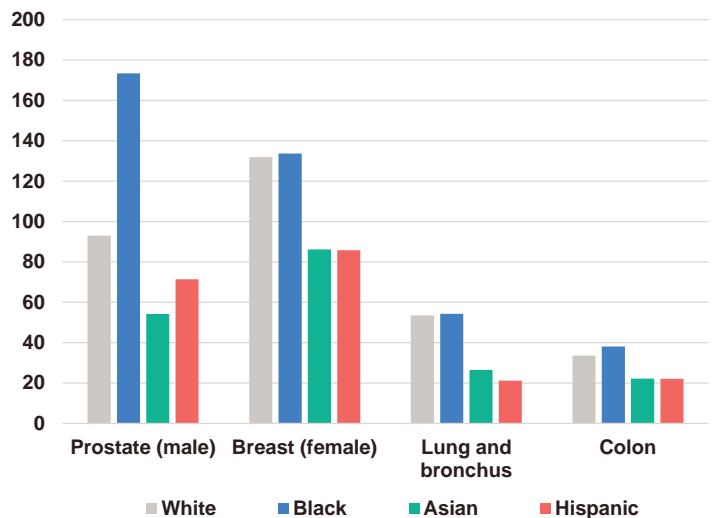


Figure 7 Source: Virginia's Plan for Well-Being

Maternal and infant health, 2020-2022

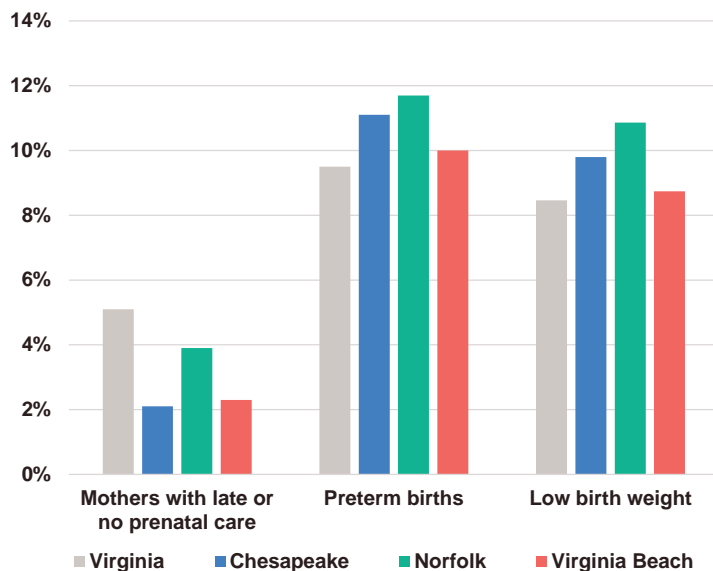


Figure 8 Source: Virginia's Plan for Well-Being



Our rates at SLH for Nulliparous Term Singleton Vertex (NTSV) c-sections are higher than the national standard of 23.9% or less. Focusing on the reduction of NTSV rates is crucial to improve the outcomes of our patients. Any time our pregnant patients go into surgery for a c-section, it increases their risk for complications and mortality. Data from across the nation demonstrates that first-time mothers are at increased risk for complications from birth and that c-sections increase this risk, especially for Black mothers. We are committed to patient education about birth expectations regarding the labor process as more patients are opting for c-sections versus traditional births, as well as looking into current induction practices to improve maternal health, birth, and health outcomes for both mothers and infants.

Diabetes

According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase in the U.S. and is the seventh leading cause of death in the United States. Risk factors such as obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity are also key risk factors. The percentage

NTSV rates for SLH

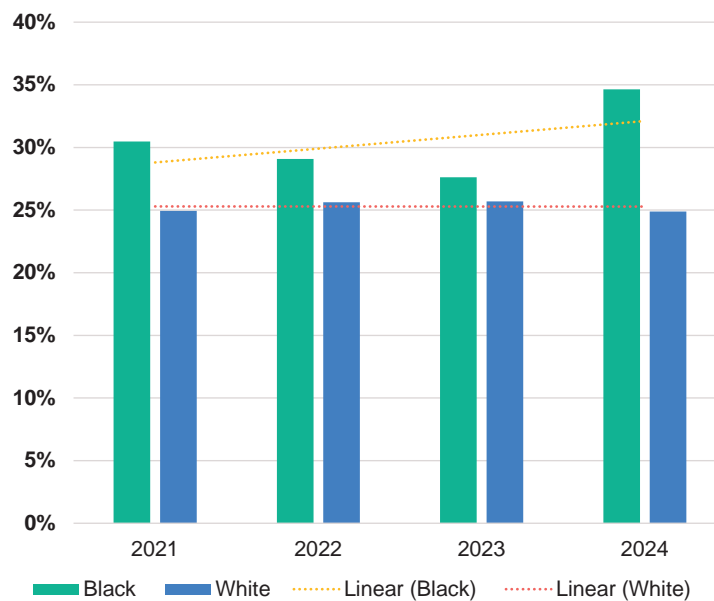


Figure 9 Source: SLH data

of adults living with diabetes in this community is higher than the state percentage of 12.0%. The SLH and LOSC hospitalization rate, 2,212.65 (per 100,000), for diabetes was above the state rate of 2,114.24.²

Older and aging adults

In many communities, older adults are the fastest growing segment of the population. Challenges come with an aging population, including health-related factors and other factors that ultimately impact health. The percentage of Medicare recipients seen for hypertension and diabetes, the top conditions for which patients received hospital treatment in this community, was higher in this service area than in the state overall. The percentage of Medicare beneficiaries treated for Alzheimer’s disease or dementia in this community (7.2%)⁹ is slightly higher than Virginia overall (6%).⁷ These conditions are important to note as they will impact the aging population’s health, quality of life, healthcare demand, and costs.

Both SLH and LOSC are also working with the community to complete advance care plans. These plans are designed for adults to specify their medical wishes and/or designate someone as their medical decision-maker in the event they cannot communicate or advocate for themselves. While many team members working within the healthcare industry understand the importance and value of advance care plans, it is evident within the acute care setting that our community members may not have that same understanding until it is too late. Currently, within Virginia, there are approximately 47,816 active registrants with advance care plans filed within the U.S. Advance Care Planning Registry (formerly U.S. Living Will Registry).⁹ Sentara has approximately 78,044 active registrants with advance care plans on file within the U.S. Advance Care Plan Registry with 1,732 of those completed for residents of the SLH and LOSC community.

Surgical site infections

Surgical site infections (SSIs) occur after surgery and in the part of the body where the surgery took place. Surgical site infections can develop within days of the surgery or even months thereafter. Some patients may be at higher risk for developing an SSI due to their age and underlying medical conditions, such as diabetes and COVID-19 infections. “Data from AHRQ’s Partnership for Patients initiative indicates

Medicare primary chronic conditions, 2022

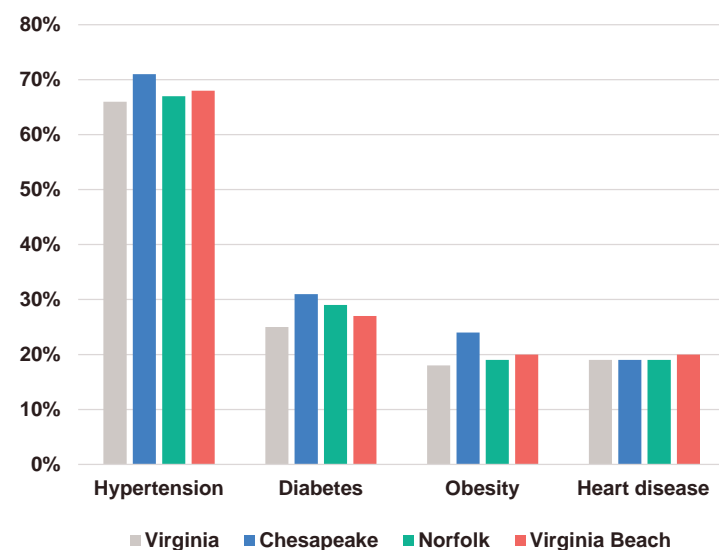


Figure 10 Source: Virginia’s Plan for Well-Being

that the national rate of SSI decreased by 16% between 2010 and 2015, translating into significant benefits for patients (including many lives saved), as well as significant cost savings.”¹⁰ Advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical techniques, and availability of antimicrobial prophylaxis, yet SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death in the inpatient setting.¹¹

SLH and LOSC prioritization

The Forces of Change Assessment (FOCA) focuses on identifying all driving factors that can affect the public health system in a community. The assessment folds into the Mobilizing for Action through Planning and Partnerships model of community health improvement and was used to inform our new CHNA improvement strategy. Extensive secondary quantitative data from publicly available data, as well as primary qualitative data collected from surveys and focus groups, were synthesized and analyzed to identify the communities health needs..

Recommendations

With the completion of the 2025 CHNA, Sentara, SLH and LOSC developed goals to positively impact the community's identified health concerns and socioeconomic needs. We will leverage community partners and resources to identify ways to address these health concerns and create specific priority objectives for the implementation strategy. For 2026-2028, SLH and LOSC will focus on the following:



Improve mental well-being



Improve chronic disease and avoidable health outcomes



Address and invest in social determinants of health

Conclusion

The information presented in this CHNA reveals a community facing a number of health challenges based on the data collected, focus groups, and survey responses. The same challenges can be found in countless communities throughout the country. Beyond the scope of Sentara, SLH and LOSC alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. We are committed to finding innovative, responsive, and successful strategies to address these challenges in order to fulfill our mission to improve health every day.

Endnotes

¹County Health Rankings & Roadmaps: Rankings Data & Documentation. Accessed October 10, 2024. <https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation>.

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³Virginia Health Care Foundation. (January 2022). Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce. Retrieved from <https://www.vhcf.org/wp-content/uploads/2022/01/BH-Assessment-Final-1.11.2022.pdf> on April 11, 2022.

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⁵National Cancer Institute, State Cancer Profiles. Incidence Rates Table. Accessed February 25, 2025. <https://statecancerprofiles.cancer.gov/incidencerates/index.php>.

⁶National Cancer Institute, State Cancer Profiles. Death Rates Table. Accessed February 25, 2025. <https://statecancerprofiles.cancer.gov/deathrates/index.php>.

⁷Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 12, 2025. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

⁸Kern-Goldberger AR, Booker W, Friedman A, Gyamfi-Bannerman C. Racial and Ethnic Disparities in Cesarean Morbidity. Am J Perinatol. 2023 Oct;40(14):1567-1572. doi: 10.1055/s-0041-1739305. Epub 2021 Dec 10. PMID: 34891196.

⁹The U.S. Will Registry. Accessed March 1, 2025. <https://www.theuswillregistry.org/>.

¹⁰Agency for Healthcare Research and Quality (AHRQ). (September 7, 2019). Surgical Site Infections. Retrieved from <https://psnet.ahrq.gov/primer/surgical-site-infections> on August 10, 2022.

¹¹Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP). Accessed January 1, 2025. <https://www.cdc.gov/nhsn/opc/ssi/index.html>

Supplemental resources

2023-2025 Implementation strategy progress summary

The previous CHNA identified several health issues in the service area. The Sentara Leigh Hospital (SLH) and Leigh Orthopedic Surgery Center (LOSC) implementation strategy progress report was developed to document activities addressing health needs identified in the 2022 CHNA report through both primary and secondary data sources.

By identifying the most pressing health concerns within a community, the 2022 assessment assisted in setting priorities for health interventions and resource allocation to advance health based on patient demographic data and community insight.

This section of the CHNA report describes these activities and collaborative efforts. At SLH and LOSC, we are continuing to monitor and evaluate progress towards the 2023 implementation strategies to track activities and document the impact of those strategies in addressing selected CHNA health needs. For reference, the list below includes the 2022 CHNA health needs that were prioritized to be addressed by SLH and LOSC in the 2023 implementation strategy.

- Behavioral health
- Chronic diseases
- Social determinants of health

Behavioral health

Improving the mental and emotional well-being of all living in the Choose an item. SLH and LOSC service area by increasing access to behavioral health services is an important priority. Sentara continues to improve access to behavioral health resources, knowing that one in five adults will have a mental illness severe enough to require treatment, and many more will have emotional and mental health problems that prevent them from fully enjoying their lives.

At Sentara, we offer inpatient treatment services through telepsychiatry. Our adult and senior behavioral health inpatient programs provide diagnostic services and treatment for people ages 18 and older who are in crisis due to mental illness, emotional distress, or destructive behavior patterns. Because our treatment facilities are located within several of our hospitals, patients have access to a full range of both psychiatric and medical care. Sentara will continue to partner with community mental health programs to identify alternate placement options for Behavioral Health Emergency Department patients.

Both SLH and LOSC partnered with Ingleside Elementary School to provide mental health educational sessions for underserved Black children and their families. To further increase community awareness and reduce stigma,

Sentara also partnered with the Virginia Stage Company to support an inspirational play about mental health. "Every Brilliant Thing" is an intimate, interactive performance which continues to be brought to communities throughout Virginia and North Carolina. Between 2022 and 2024, 37 performances were held, reaching 3,871 community members living in the service area.

Sentara, SLH, and LOSC also partnered with Bon Secours, CHKD, Riverside Health, and the Hampton and Peninsula Health District to provide "Hiding in Plain Sight," a youth mental health documentary with local panel discussion at a local middle school to begin the mental health discussion between teens and parents.

Chronic diseases

Sentara brings prevention, hope, inspiration, and support to our local community where SLH and LOSC are working to reduce chronic disease impact. The LOSC team works with patients and their families to provide multiple resources and tools regarding mental health and chronic diseases.

Both SLH and LOSC continued their partnership with Ingleside Elementary School to provide stroke education and additional community health educational resources at a school health fair. Additionally, SLH and LOSC partnered with St. Helena Elementary School to provide education for adults and children on meal prepping, how to develop a balanced diet, as well as education on chronic diseases, healthy growth, obesity, heart disease, and diabetes.

Sentara extends its reach into the community, where life happens, and is working to reduce cancer's impact. Cancer educators implement programs focused on cancer prevention and detection and provide community outreach by hosting and attending screening and educational events. To increase access to preventive resources, Sentara offers a mobile mammography van to provide cancer screenings throughout the community. Staff also provide additional health screening services at community events and low-income, low-access areas throughout the service area, and provide cancer-related support groups for community members.

Social determinants of health

Each hospital has implemented the use of Unite Us, a cross-sector collaboration software establishing a new standard of care that identifies social needs in communities, manages enrollment of individuals in services, and leverages meaningful outcomes data and analytics to further drive community investment.

To increase economic growth, job security, and educational opportunities, SLH and LOSC supported Project Search. This initiative provided an opportunity for low functioning disability students to intern at SLH to cultivate real world job skills in collaboration with Norfolk Public Schools. Both SLH and LOSC also continue to collaborate with multiple colleges and universities to provide fellowships, internships, and preceptorships for health care professionals and students.





Grantmaking and community benefit

In the 2023 implementation strategy process, Sentara and its hospital facilities also supported vulnerable populations through grant making, in-kind resources, collaborations, and partnerships. We are aware of the significant impact that our organization has on the economic vitality of our communities. So, as a system, Sentara will continue to invest in and support organizations and projects that address key social determinants of health. We will continue to promote health impact by working to eliminate traditional barriers to health and human services.

In 2023, Sentara invested more than \$294 million in the communities we serve — \$47 million in community giving, \$13 million in health and prevention programs, \$70 million in teaching and training of health care professionals and \$164 million in uncompensated patient care. In 2024, Sentara invested more than \$329 million in the communities we serve — \$40 million in community giving, \$19 million in health and prevention programs, \$96 million in teaching and training of health care professionals, and \$174 million in uncompensated patient care.

Community health is defined by much more than medical care. As more is known about the role of social determinants of health, more opportunities will arise to influence population health by engaging in community approaches to care. Beyond the scope of SLH and LOSC alone, these opportunities will require active partnerships among local organizations and individuals to create lasting impact. Sentara and SLH and LOSC are committed to finding innovative, responsive, and successful strategies to address these challenges, to fulfill our mission to improve health every day. While we consider proposals that fall outside of the following focus areas, we strongly encourage proposals that align with one or more of the following priorities:



Housing: Partner with agencies and organizations that can creatively address a variety of housing issues.



Food security: Improve food security in our communities through innovative programs.



Skilled careers: Educate people to gain higher paying jobs for more sustainable economic opportunities.

Serving the cities of Chesapeake, Norfolk and Virginia Beach

Sentara Leigh Hospital

830 Kempsville Road
Norfolk, VA 23502

Leigh Orthopedic Surgery Center

6201 E. Virginia Beach Blvd, Suite 200
Norfolk, VA 23502

sentara.com

