

Sentara Norfolk General Hospital  
and Hospital for Extended Recovery

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# Community Health Needs Assessment 2025

This joint Community Health Needs Assessment report was completed in collaboration with Sentara Norfolk General Hospital and the Hospital for Extended Recovery, which have the identical service areas of the cities of Chesapeake, Norfolk, Portsmouth, Suffolk and Virginia Beach.



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# Executive summary

Sentara Health is proud of our longstanding commitment to the communities served by Sentara Norfolk General Hospital (SNGH) and the Hospital for Extended Recovery (HER). We are committed to the cities in our defined service area of Chesapeake, Norfolk, Portsmouth, Suffolk, 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 SNGH and HER 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**



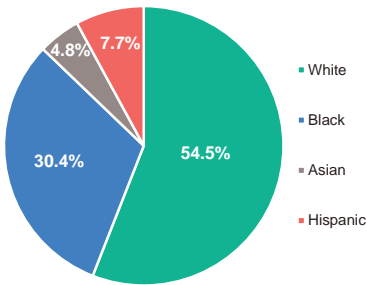
**Social determinants of health**

Sentara conducts a comprehensive Community Health Needs Assessment every three years for each of our inpatient hospitals and outpatient surgical centers across Virginia and Eastern 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.

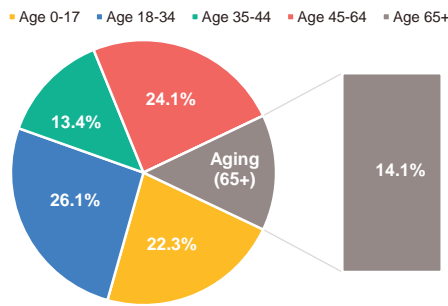
# Looking at the data

**Community demographics** of the 1,135,917 persons living in the service area, which includes the cities of Chesapeake, Norfolk, Portsmouth, Suffolk, and Virginia Beach.

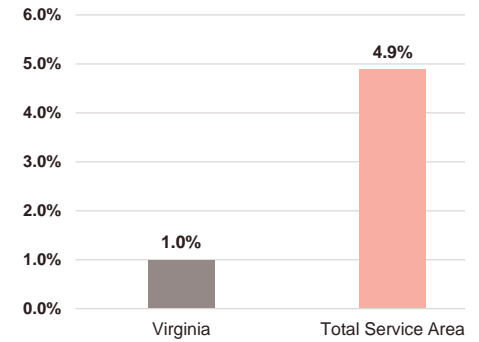
**Racial profile**



**Population by age, 2018-2022**



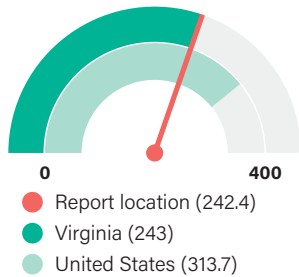
**Population change from 2020-2023**



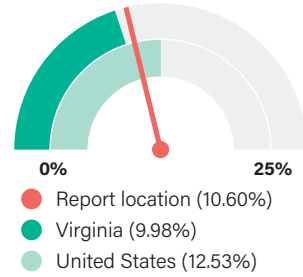
**Figures 1,2,3** Source: United States Census Bureau

## Determinants of health include:

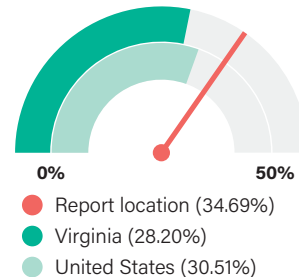
**Mental health care provider, rate per 100,000 population**



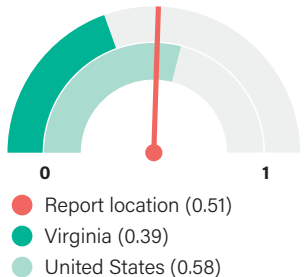
**Population in poverty, percentage**



**Households where housing costs exceed 30% of income, percentage**



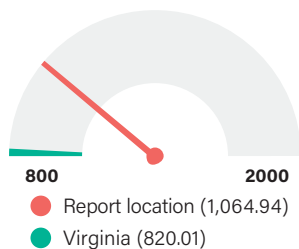
**Social vulnerability index score**



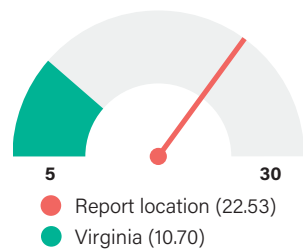
**Figures 4, 5, 6, 7** Sources: Virginia's Plan for Well-Being, Virginia Community Health Improvement Data Portal

## Top health concerns include:

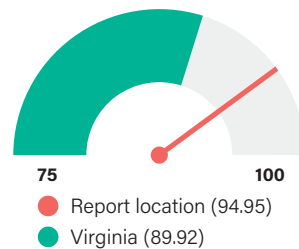
**Avoidable hospitalizations, rate per 100,000 population, 18+**



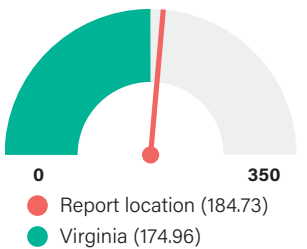
**Hospitalizations with firearm injury, rate per 100,000, total population**



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



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



**Figures 8, 9, 10, 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.<sup>1</sup> 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 (right) 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, 54.49% of residents are White, 30.40% are Black, 7.73% are Hispanic, and 4.76% are Asian (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 five years, the total population in the service area is estimated to increase by 3.6% — an addition of roughly 42,097 residents.<sup>2</sup>

## 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.

## County Health Rankings Model

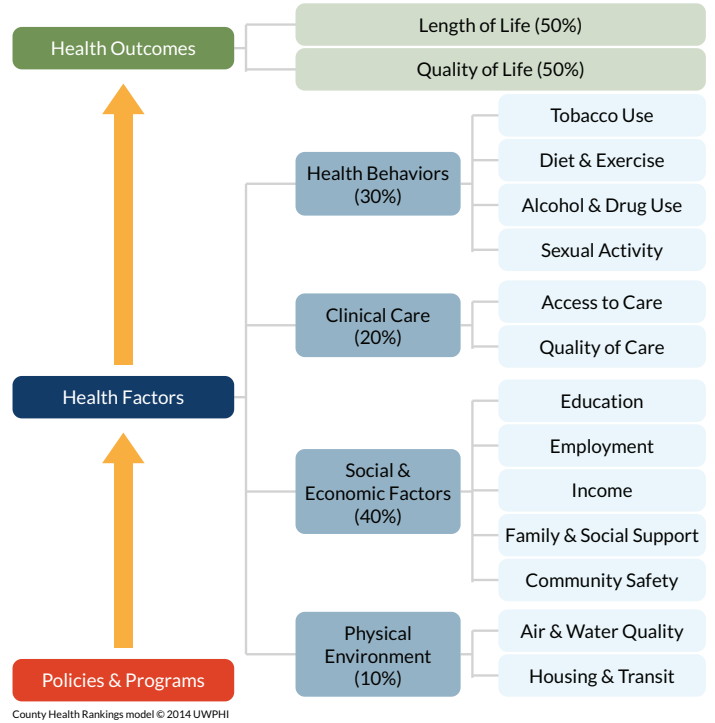


Figure 12

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

## Education and employment

Education supports stable employment and financial stability for individuals and their families. As of the 2023 U.S. Census, 92.45% of the residents in the service area were high school graduates, compared to 91.10% of Virginia residents. According to the American Community Survey, 2022, just 44.9% of residents in the service area hold advanced or professional degrees compared to 48.8% statewide.

As of the 2023 U.S. Census, 67.8% of residents in the service area participated in the labor force, above the state average of 65.3%. Of total service area residents, the percentage of female residents in the civilian labor force (56%) is lower than 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 are more likely to live in poverty (11.9%) compared to the rest of Virginia (10.6%). 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 (20.18%), some other race (13.8%), and Hispanic (7.7%) residents experience a higher rate of poverty compared to White residents (7.3%).

## **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 to December 3, 2024, we invited over 100 key community partners throughout Virginia to share and complete the survey, which resulted in 1,218 residents living in the service area participating. We appreciate the time and contributions these individuals made to help enhance health and well-being in our community.

### **Top concerns identified included:**

- Mental health
- Cancer
- Obesity

### **Top barriers identified included:**

- Long wait for a scheduled appointment
- Cost of healthcare and services
- Appointments unavailable for new patients

## **Focus groups**

Hospital leaders conducted Community Conversations from October through November 2024 to gain more in-depth insights from community stakeholders on their health concerns and healthcare barriers. Leaders from SNGH and HER 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: Anxiety and depression
- Access to health care: Cost, doctors, transportation, emergency services, preventive services
- Chronic conditions: Diabetes, high blood pressure, heart issues, kidney disease

## **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, SNGH and HER paid particular attention to the disparities affecting historically marginalized populations.

Life expectancy for a person living in the Commonwealth of Virginia is 78.1 years. In the communities served by SNGH and HER, the average life expectancy is 75.7—2.4 years less than the state average. It is important to note disparities affecting Black residents. The average life expectancy of Black residents in the service area is 73.2 years—3.6 years less than White residents (76.8 years) living in the service area.<sup>1</sup>

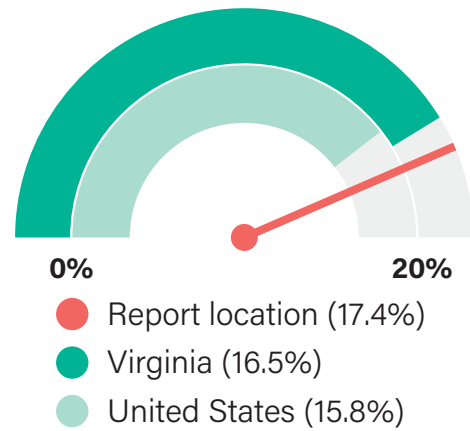
Access to health services is limited by the low numbers of primary care providers and mental health providers in this community. The need for access to mental health services continues to grow. In 2023-2024, 20,080 adults and 2,180 youth visited the SNGH emergency room for behavioral health concerns. Of those patients, 84.2% of the adults and 15.8% of the youth reported suicidal ideations.

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

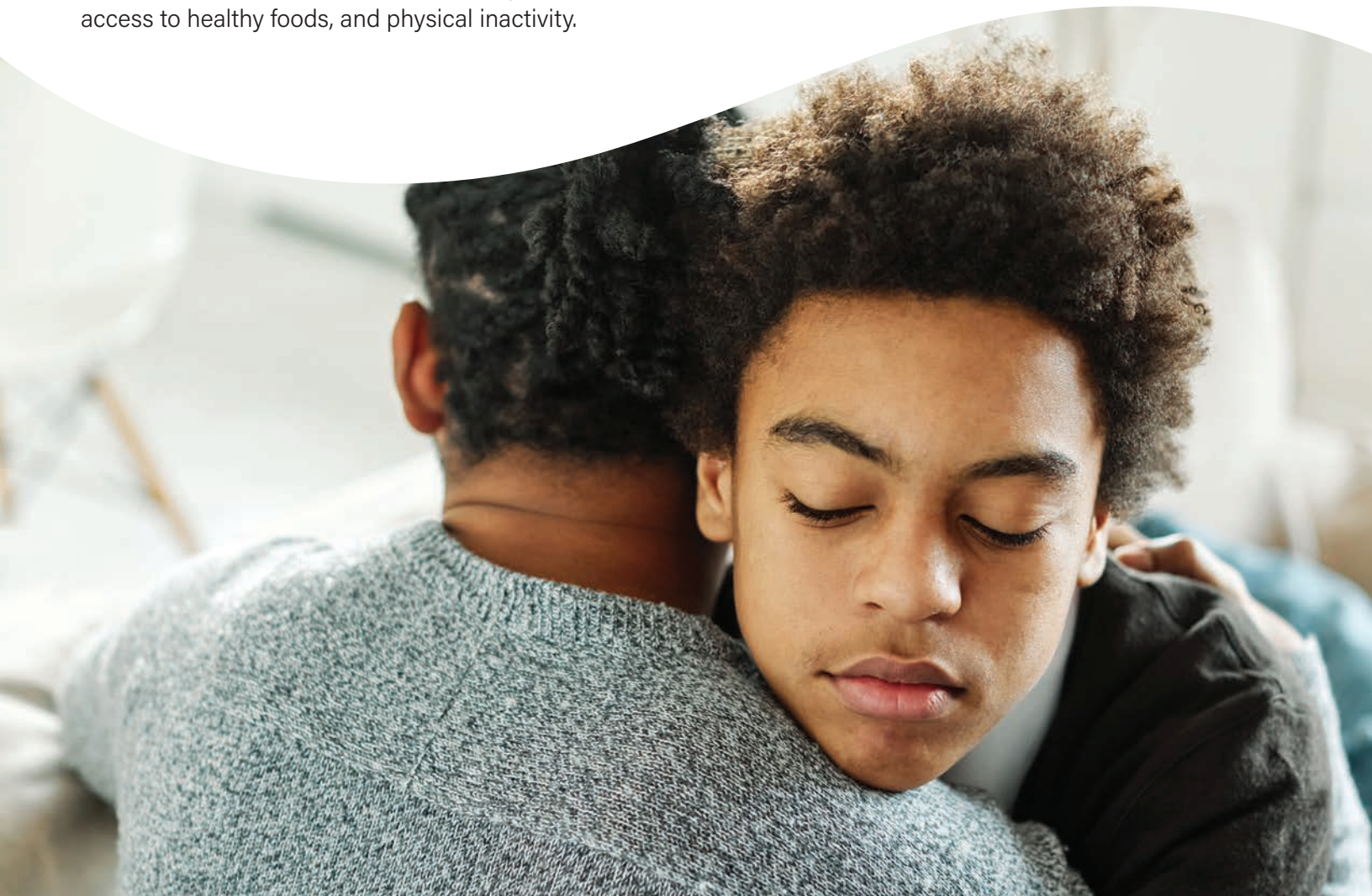
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### Adults age 18+ with poor mental health, percentage



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










## Focus areas

Sentara Cares is the community engagement and impact arm of Sentara Health. Our goal is to advance health impact 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 SNGH and HER health priorities for 2026-2028

Sentara priorities	Socioeconomic needs	Health needs	SNGH and HER priorities
	 Access to care	 Behavioral/mental health	
	 Food security	 Chronic disease	
	 Skilled careers	 Social determinants of health	



**Table 1** Sentara cares priorities for grant opportunities and SHRH implementation strategy priorities for 2024-2025.

## Endnotes

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

<sup>2</sup>United States Census Bureau. QuickFacts. [www.census.gov](https://www.census.gov/quickfacts/fact/table/mecklenburgcountyvirginia,halifaxcountyvirginia,charlottecountyvirginia,VA/PST045221). Accessed October 10, 2024. <https://www.census.gov/quickfacts/fact/table/mecklenburgcountyvirginia,halifaxcountyvirginia,charlottecountyvirginia,VA/PST045221>.

# 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).<sup>1</sup>

### **Sentara Norfolk General Hospital (SNGH)**

Serving as a destination medical center in the Mid-Atlantic region, SNGH is one of just five Level 1 trauma centers in Virginia, home to the Nightingale Regional Air Ambulance, the region's first Magnet<sup>®</sup> hospital and nationally ranked heart program, Sentara Heart Hospital. Located on the Eastern Virginia Medical Campus, SNGH 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.<sup>2</sup>

### **Sentara at a glance**

- **Headquartered in Hampton Roads**
- **Outpatient campuses**
- **130-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 Air Ambulance**
- **Sentara Health Plans**

### **Hospital for Extended Recovery (HER)**

The Hospital for Extended Recovery is a 35-bed long term acute care hospital located inside of SNGH. The hospital opened in November 2001 and was the first hospital within a hospital in the Commonwealth of Virginia. This specialty facility is an acute care hospital specifically designed for patients with medically complex needs who need to stay in an acute care setting for an average of three to four weeks. Though located within SNGH, HER is a separate health facility. The proximity to and affiliation with SNGH, however, provides easy access to a Level 1 trauma center if patient needs change.<sup>3</sup>

“ 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



## 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.<sup>4</sup>

## 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.

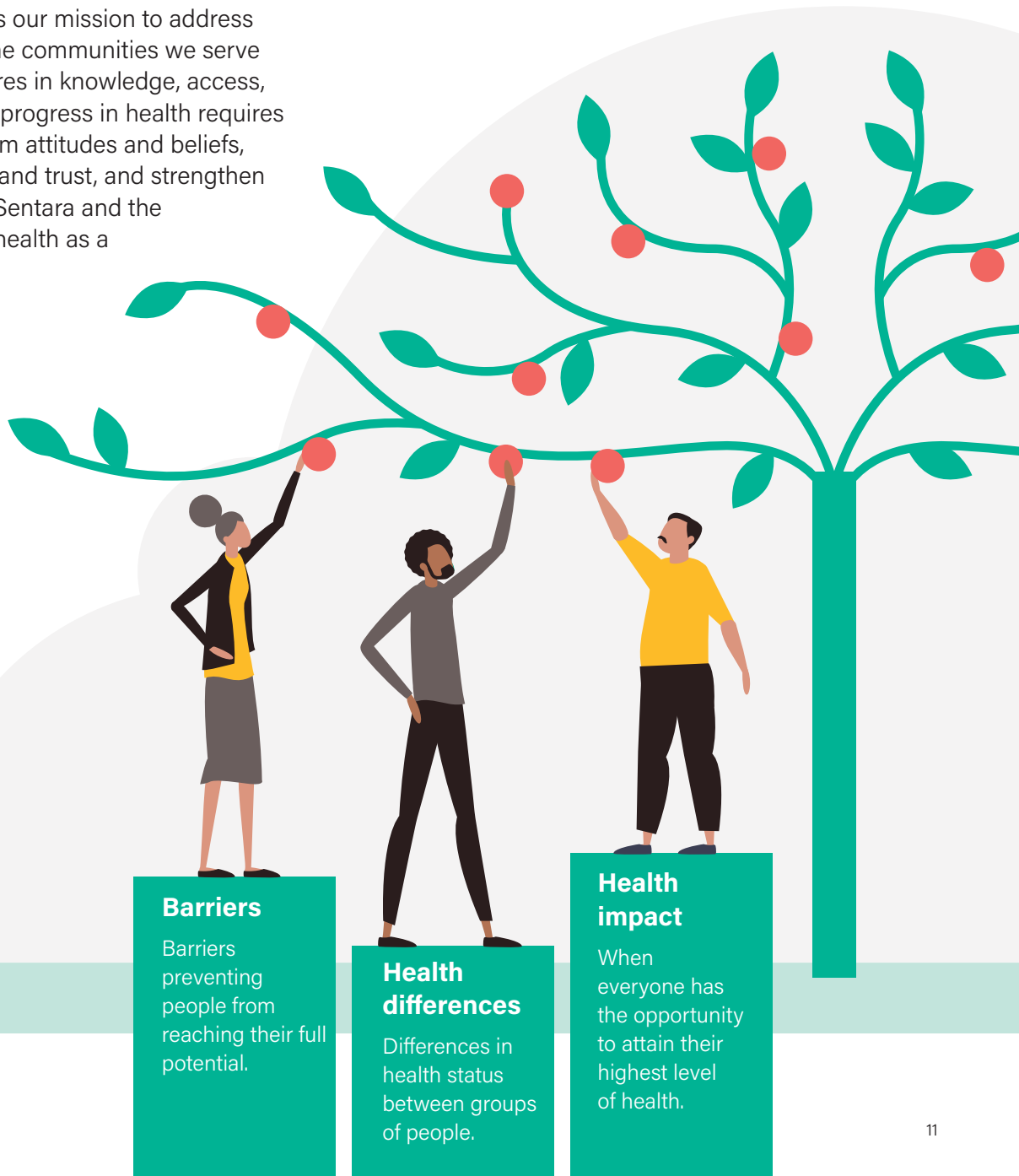
Sentara Community Care launched its three initial programs in Hampton Roads in summer of 2022, and has expanded to serve Harrisonburg, Henrico, Newport News, Northern Virginia, Petersburg/Richmond, and Southside Virginia communities. Since its inception, Sentara Community Care has served more than 6,000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

## 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
<b>Qualitative data</b>	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.
<b>Quantitative data</b>	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 (NACCHO, 2022).<sup>5</sup>

We began the MAPP process at SNGH and HER 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 SNGH and HER work with a number of community partners to address health needs. Using the information from this assessment, SNGH and HER 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://sentara.com).



## Endnotes

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

<sup>2</sup> Sentara Health. Sentara Norfolk General Hospital. Accessed October 10, 2024. <https://www.sentara.com/hospitalslocations/sentara-norfolk-general-hospital>.

<sup>3</sup> Sentara Health. Hospital for Extended Recovery. Accessed October 10, 2024. <https://www.sentara.com/hospitalslocations/hospital-for-extended-recovery>.

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

<sup>5</sup> 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 SNGH and HER are located in Norfolk, Virginia. The SNGH and HER community includes a total population of 1,136,490 people who live in the 1,068.92 square mile report area defined for this assessment according to U.S. Census Bureau American Community Survey 2018-22 5-year estimates.<sup>1</sup> Virginia Beach has the highest population in the service area, followed by Norfolk.

### Geography

The SNGH and HER community is comprised of five cities—Chesapeake, Norfolk, Portsmouth, Suffolk, 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 SNGH and HER serves.

### Community-specific demographics

As of the 2023 U.S. Census, the Chesapeake City population was 253,886, with 8.7% of residents living in poverty and 7.7% uninsured. Age demographics within Chesapeake include 24.1% of residents between the ages of 0-17, 22.3% ages 18-34, 26.9% ages 35-54, and 26.8% ages 55 and older. English is the primary

language for 97.1% of residents. The racial and ethnic profile for the city is 57.3% White, 29.3% Black, 7.1% Hispanic, and 3.7% Asian.

For Norfolk City, there is a population of 230,930, with 18.8% of residents living in poverty and 11.5% uninsured. Age demographics within Norfolk include 20.3% of residents between the ages of 0-17, 34.3% ages 18-34, 21.9% ages 35-54, and 23.5% ages 55 and older. English is the primary language for 96.8% of residents. The racial and ethnic profile for the city is 44.8% White, 40.7% Black, 8.7% Hispanic, and 3.8% Asian.

For Portsmouth City, there is a population of 96,793, with 19.8% of residents living in poverty and 9.0% uninsured. Age demographics within Portsmouth include 23.1% of residents between the ages of 0-17, 26.1% ages 18-34, 23.4% ages 35-54, and 27.4% ages 55 and older. English is the primary language for 98.4% of residents. The racial and ethnic profile for the city is 37.7% White, 51.4% Black, 5.0% Hispanic, and 1.4% Asian.

For Suffolk City, there is a population of 100,659, with 11.6% of residents living in poverty and 7.0% uninsured. Age demographics within Suffolk include 23.6% of residents between the ages of 0-17, 21.6% ages 18-34, 26.4% ages 35-54, and 28.4% ages 55 and older. English is the primary language for 98.3% of residents. The racial and ethnic profile for the city is 48.7% White, 41.6% Black, 4.8% Hispanic, and 1.9% Asian.

For Virginia Beach City, there is a population of 453,649, with 9.9% of residents living in poverty and 8.0% uninsured. Age demographics within Virginia Beach include 22.0% of residents between the ages of 0-17, 24.8% ages 18-34, 25.7% ages 35-54, and 27.5% ages 55 and older. English is the primary language for 96.1% of residents. The racial and ethnic profile for the city is 62.8% White, 18.9% Black, 8.8% Hispanic, and 7.1% Asian.

# Looking at the data

## Racial and ethnic profile, 2022

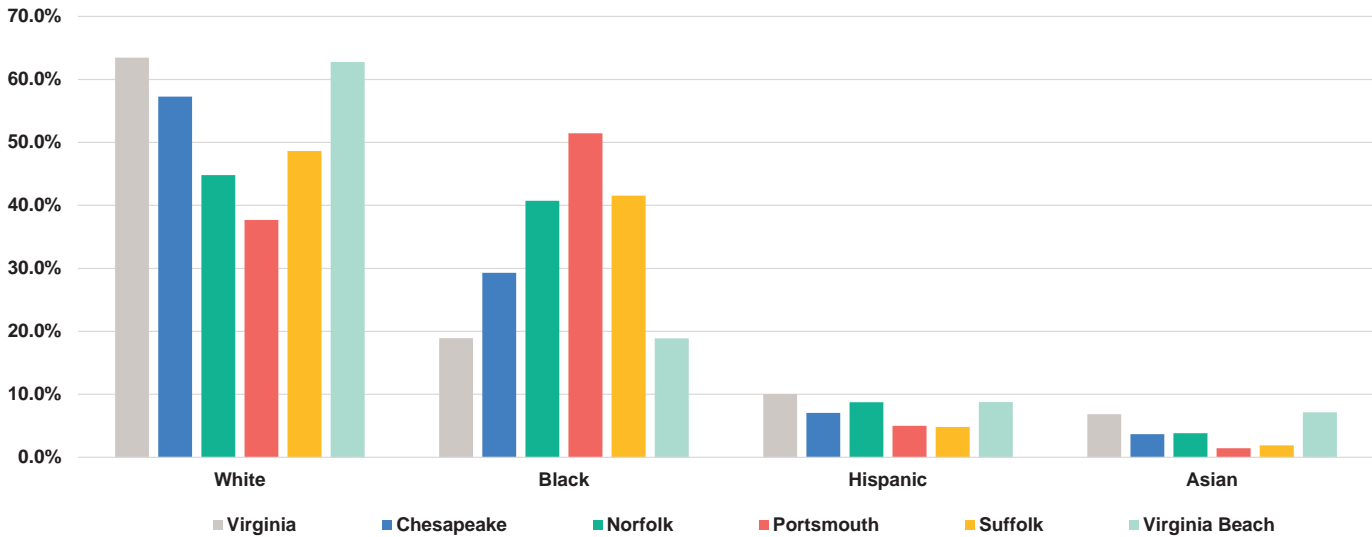


Figure 1 Sources: Virginia's Plan for Well-Being, U.S. Census Bureau

## Population by age, 2018-2022

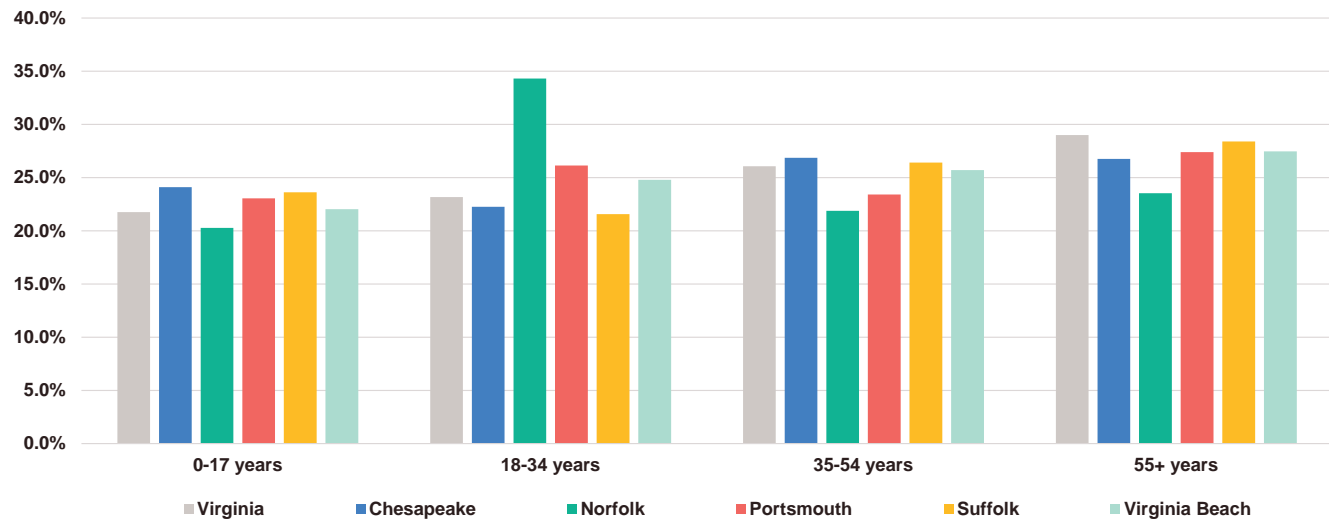


Figure 2 Sources: Virginia's Plan for Well-Being, U.S. Census Bureau

## Median household income, 2022

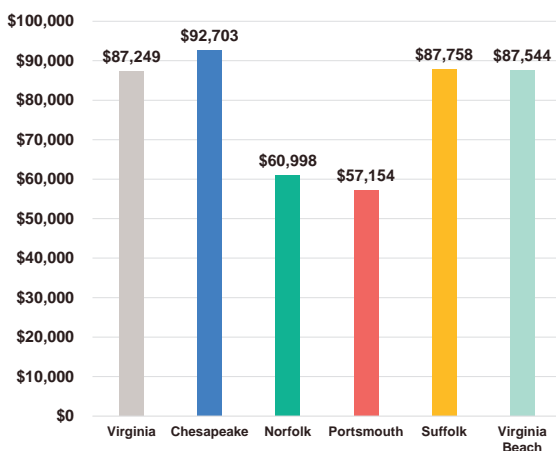


Figure 3 Source: U.S. Census Bureau

## Poverty, 2022

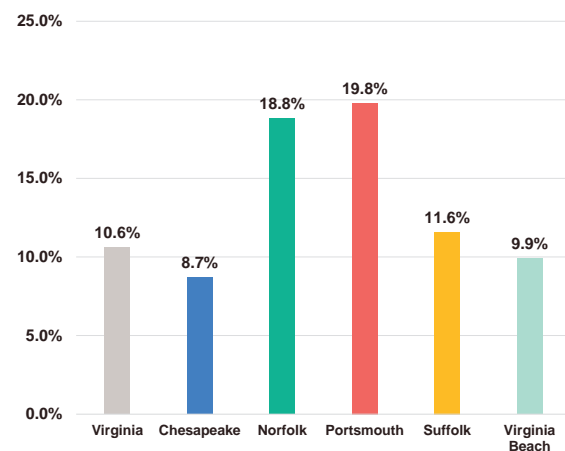


Figure 4 Source: U.S. Census Bureau

## Population highlights

### Population change

Of the five cities, Virginia Beach is expected to have an estimated increase of 30,000 people in the next 10 years. The service area as a whole is expected to see an increase of an estimated 140,000 people over the next 20 years, even with the declining population in the cities of Norfolk and Portsmouth.<sup>2</sup>

#### Population change, 2030-2040

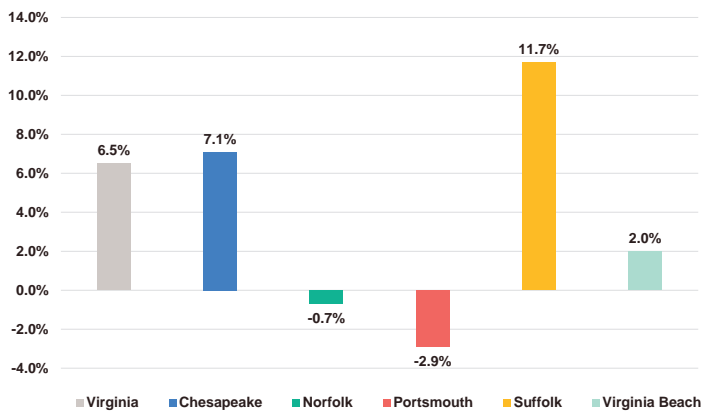


Figure 5 Source: U.S. Census Bureau

### Age and sex

Per the 2023 U.S. Census, of the total population of 1,135,917 people living in the service area, most residents are between the ages of 25-54. The percentage of residents who are children between the ages of 0-17 is 22.3%, slightly higher than the state level of 21.8%. Male (49.5%) and female (50.5%) resident percentages are similar to Virginia percentages (50.5% female, 49.5% male), 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, 14.1% of the residents living in the service area were ages 65 and older, compared to 16.0% in Virginia. Per the 2023 U.S. Census, Virginia Beach City has the largest number of adults ages 85 and older in the service area, with 7,291 residents. Estimates indicate

the population of aging adults ages 65 and older will increase by 19.5% by 2030. Over the next 10 years, the number of aging adults ages 65 and older will increase by an estimated 11,614 residents in the service area.<sup>2</sup>

### Other demographic features

According to the 2023 U.S. Census, veterans represent 11.4% of the population in the service area, compared to 7.6% statewide. The service area has a lower percentage of owner-occupied homes (62.1%) compared to the state overall (66.9%). More households in the service area have computers (95.5%) and internet access (90.5%), increasing access to remote learning, telehealth, and other resources. A slightly higher percentage of the population in the service area is living with a disability (12.7%) compared to the state overall (12.1%). The service area also has a higher percentage of persons living in poverty (11.9%) compared to Virginia overall (10.6%), and a lower percentage of residents with college degrees (35.1%) when compared to the state (41.0%).

## Community diversity profile

### Race and ethnicity

The population of the service area has a higher percentage of White (54.5%) and Black (30.4%) residents than other races and ethnicities.<sup>3</sup> The service area is home to a small Hispanic (7.7%) and Asian (4.76%) population.<sup>3</sup>

#### Population with limited English proficiency, 2018-2022

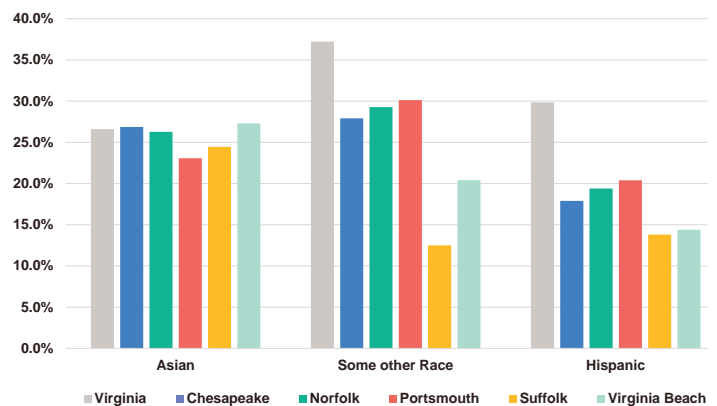
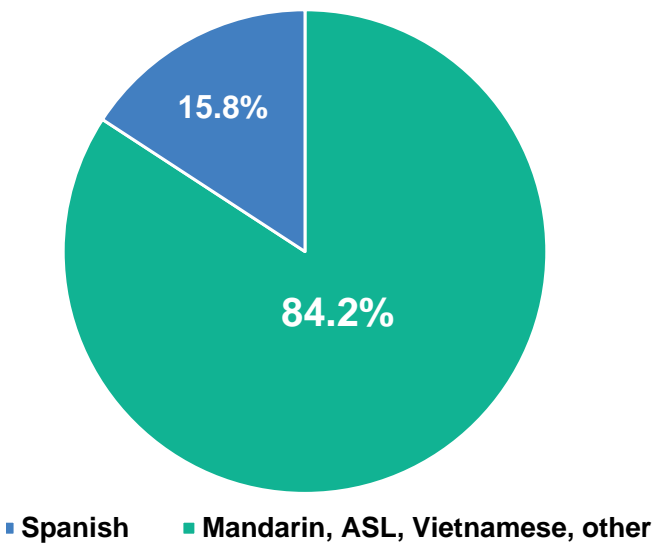


Figure 6 Source: U.S. Census Bureau

## Cultural and linguistic needs

English is the primary language spoken in the service area. As of the 2023 U.S. Census, 97.1% 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 SNGH language utilization



**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, SNGH had 24,195 requests for interpreter services. The highest percentage of interpreter services (84.2%) was for Spanish-speaking individuals, with the second highest percentage being Chinese (Mandarin) (2.3%).

## 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](#).<sup>4</sup>

To understand the population better, SNGH and HER looked at socioeconomic status, including poverty rates, educational attainment, employment, unemployment, and insurance.

## 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.

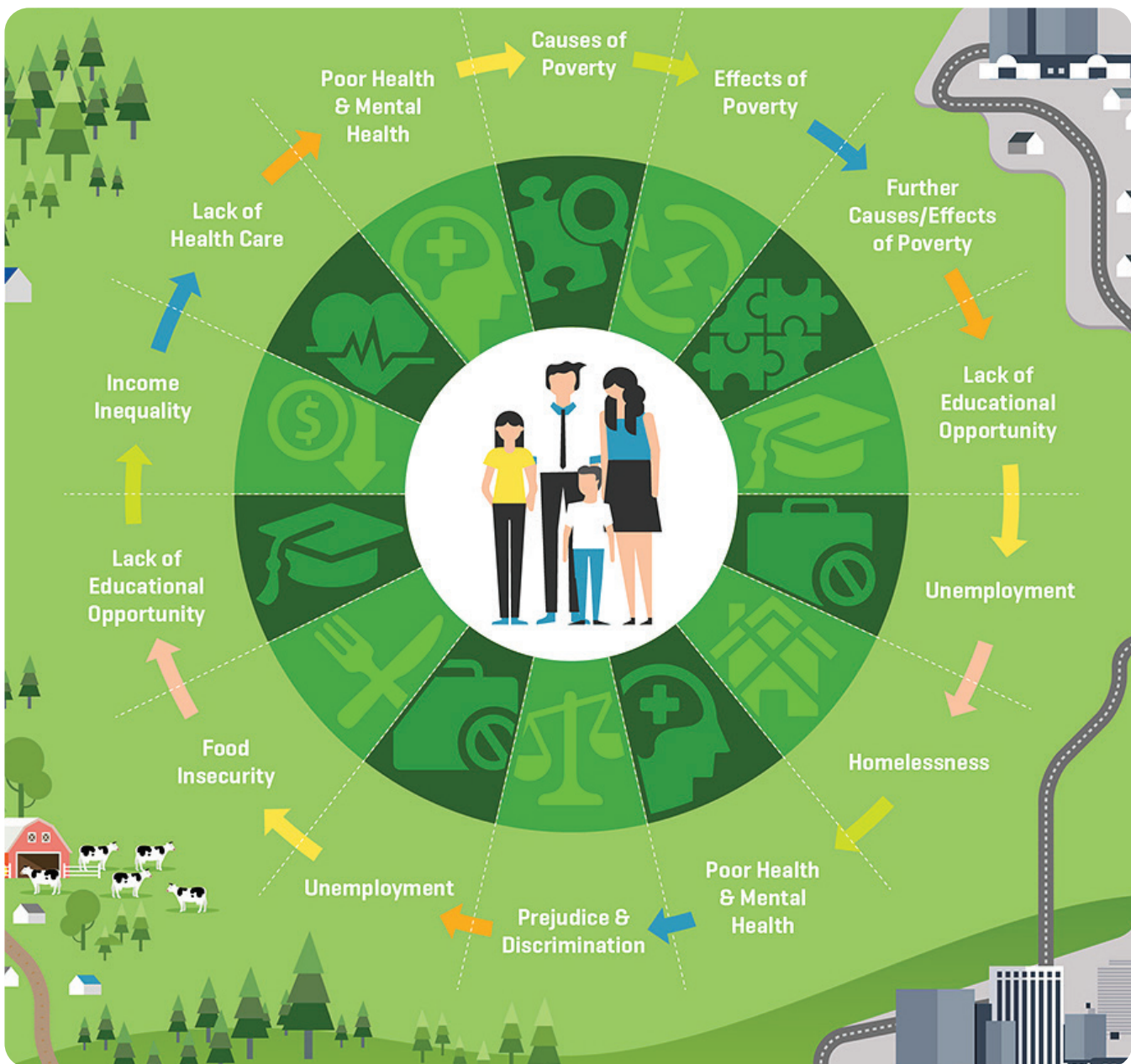


Figure 9 Source: Aurora University

## 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 11.9%, the service area has a higher percentage of residents living in poverty compared to the Commonwealth of Virginia (10.6%).<sup>3</sup>

## 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 (92.5%) than the statewide percentage (91.1%) of residents who are high school graduates. The cities of Norfolk (89.3%) and Portsmouth (89.5%), however, have lower percentages of high school graduates. The service area has a lower percentage of college graduates (35.1%) compared to the state overall (41.1%).<sup>3</sup>

## Employment

Per the 2023 U.S. Census, the service area has a higher percentage of unemployed residents (2.7%) compared to Virginia overall (2.3%). The labor force represents 67.8% of total residents. Within the labor force, 56.0% of female residents in the service area are employed, lower than the state overall (61.0%).<sup>3</sup>

## 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, 8.7% of residents living in the service area do not have health insurance. A total of 2,007,215 Virginians had health coverage through Medicaid and Family Access to Medical Insurance Security (FAMIS) as of November 12, 2024. This included 281,008 residents living in the service area served by SNGH and HER.<sup>6</sup> Medicaid and FAMIS members represent 24.7% of the total population in the service area. The city of Portsmouth has the highest rate of Medicaid

Estimated poverty status by race, 2023

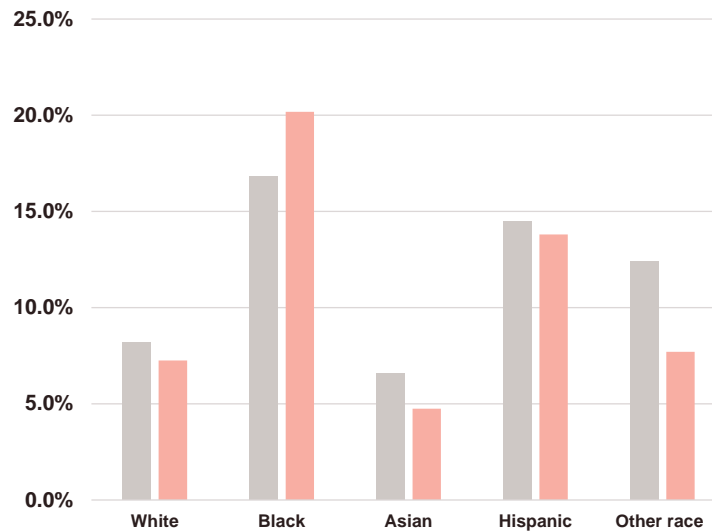


Figure 10 Source: U.S. Census Bureau

Education attainment, age 25+, 2018-2022

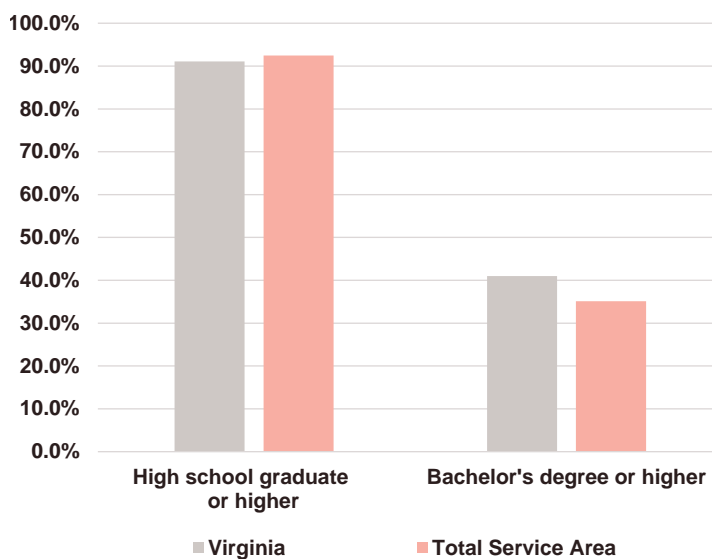


Figure 11 Source: U.S. Census Bureau

Civilian labor force, 2023

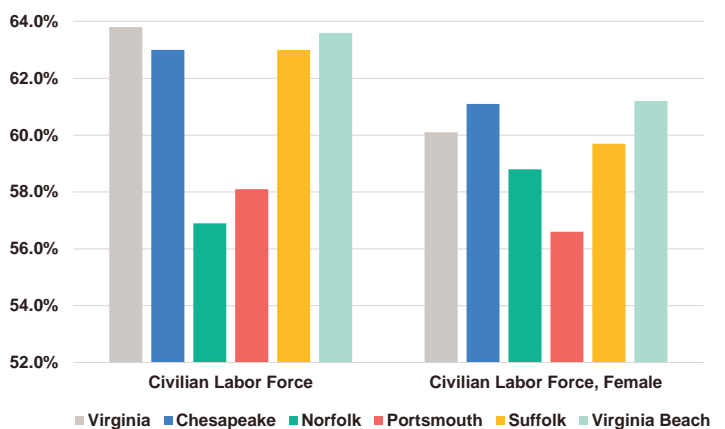


Figure 12 Source: U.S. Census Bureau

and FAMIS membership at 41.7%. In comparison, 23.0% of all Virginians have Medicaid or FAMIS health coverage.<sup>6</sup> Community health workers and enrollment specialists are available to provide guidance and assistance for qualifying individuals and families with enrollment in these government programs.

<b>Medicaid and FAMIS (below 138% FPL) enrollment December 2022</b>					
	<b>Virginia</b>	<b>Total service area</b>	<b>Charlotte county</b>	<b>Halifax county</b>	<b>Mecklenburg county</b>
Medicaid/FAMIS enrollment	2,131,004	27,797	4,347	12,982	10,468
Medicaid/FAMIS percentage	24.7%	36.8%	38.0%	38.5%	34.6%
65+ enrolled in Medicaid/FAMIS enrollment	86,938	1,555	256	762	537
65+ enrolled in Medicaid/FAMIS percentage	1.0%	2.1%	2.2%	2.3%	1.8%
Children enrolled in Medicaid/FAMIS	856,443	9,975	1,581	4,602	3,792
Children enrolled in Medicaid/FAMIS percentage	9.9%	13.2%	13.8%	13.6%	12.5%
Persons with disability enrolled in Medicaid/FAMIS	153,172	2,720	424	1,298	998
Persons with disability enrolled in Medicaid/FAMIS percentage	1.8%	3.6%	3.7%	3.8%	3.3%
<b>Medicare enrollment 2021</b>					
July 1, 2021 census estimates	8,657,365	75,580	11,522	33,758	30,300
65+ Medicare	5,627,287	51,629	6,708	24,589	20,331
65+ Medicare percentage	65.0%	68.3%	58.2%	72.8%	67.1%
65+ Medicare and Medicaid	409,493	6,648	1,575	3,025	2,048
65+ Medicare and Medicaid percentage	4.7%	8.8%	13.7%	9.0%	6.8%
Persons in poverty	10.2%	16.2%	16.9%	16.0%	15.7%

## Endnotes

<sup>1</sup> 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](https://data.census.gov/table?q=United%20States&t=Age%20and%20Sex&g=040XX00US51_050XX00US51550,51710,51740,51800,51810).

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

<sup>3</sup> United States Census Bureau. QuickFacts. www.census.gov. Accessed November 12, 2024. <https://www.census.gov/quickfacts/fact/table/VA,chesapeakecityvirginia,norfolkcityvirginia,portsmouthcityvirginia,suffolkcityvirginia,virginiabeachcityvirginia/HSG445222#HSG445222>.

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

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

<sup>6</sup> Department of Medical Assistance Services (DMAS) Data. Accessed November 12, 2024. <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>.

<sup>7</sup> Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed November 12, 2024. <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., race/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, SNGH and HER 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 December 3, 2024.

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, 1,218 survey responses were received from the SNGH and HER community.

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 1,218 SNGH and HER community respondents, 64.1% identified as White, 22.8% as Black, 5.0% as Asian, 1.6% as Indigenous, and 5.0% 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.**

Youth	Percentage	Total number of responses
Mental health	67.3%	820
Asthma/allergies	50.2%	612
Obesity	39.0%	475

Adults	Percentage	Total number of responses
Mental health	54.4%	662
Cancer	37.8%	461
Obesity	32.8%	399

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

Youth	Percentage	Total number of responses
Long wait for a scheduled appointment	56.5%	688
Cost	42.2%	514
Available appointments for new patients	35.7%	435

Adults	Percentage	Total number of responses
Long wait for a scheduled appointment	56.9%	693
Cost	52.0%	633
Available appointments for new patients	41.5%	505

**Top three social concerns impacting health in your community.**

Youth	Percentage	Total number of responses
Lack of available health food	45.8%	558
Lack of parenting support	38.4%	468
Lack of affordable housing	30.4%	370

Adults	Percentage	Total number of responses
Lack of affordable housing	67.3%	820
Loneliness/isolation	38.3%	466
Lack of available healthy food	29.0%	353



## Community focus groups

In addition to the online surveys for community insight, SNGH and HER 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, SNGH and HER held nine focus group sessions in October and November of 2024. The number of participants in each group ranged from six to 11. Refer to Appendix C for complete notes.

### 2024 focus groups

- October 14: Filipino, 9 participants
- November 7: Portsmouth Senior Station, 10 participants
- November 12: Reck League, 9 participants
- November 12: Greater Saint Andrews, 9 participants
- November 14: Girls on the Run, 8 participants
- November 14: LGBT Life Center, 6 participants
- November 20: Armed Services YMCA, 7 participants
- November 20: Lee's Friends, 10 participants
- November 22: Urban Discovery Ministries, 11 participants

### Demographics

The 79 focus group participants ranged in age from 18 to 65 and older. Altogether, participants were 25% White, 61% Black, 13% Asian, 1% Hispanic, and 1% Native American. The group identified as 86% female and 14% male. Out of the 79 participants, five preferred not to respond to the zip code questions.

# Results

Topic	Key findings	
	Children	Adults
<p><b>What serious health problems are in your community for children (0-17) and for adults (18+)?</b></p>	<p><b>Mental health concern</b></p> <ul style="list-style-type: none"> <li>ADHD</li> <li>Anxiety</li> <li>Depression</li> </ul> <p><b>Access to care</b></p> <ul style="list-style-type: none"> <li>Long referral processes</li> <li>High costs</li> <li>Transportation challenges</li> </ul> <p><b>Social issues</b></p> <ul style="list-style-type: none"> <li>Lack structured activities, recreation</li> <li>Difficulty finding parenting resources</li> </ul> <p><b>Health-specific concerns</b></p> <ul style="list-style-type: none"> <li>Asthma</li> <li>Bronchitis</li> <li>Walking pneumonia</li> </ul>	<p><b>Health and care access</b></p> <ul style="list-style-type: none"> <li>Chronic conditions</li> <li>Access to care</li> <li>Substance use</li> </ul> <p><b>Mental and social health</b></p> <ul style="list-style-type: none"> <li>Generational gaps</li> <li>Community violence</li> </ul> <p><b>Nutrition and lifestyle</b></p> <ul style="list-style-type: none"> <li>Food deserts</li> <li>Food insecurity</li> <li>Sedentary lifestyles</li> </ul> <p><b>Education and resources</b></p> <ul style="list-style-type: none"> <li>School and youth resources needed</li> <li>Health literacy</li> </ul>
<p><b>What are some of the environmental and social conditions that affect quality of life for children and adults living in your community?</b></p>	<p><b>Cost of living and economic struggles</b></p> <ul style="list-style-type: none"> <li>Housing costs</li> <li>Poverty</li> <li>Transportation</li> </ul> <p><b>Violence and safety concerns</b></p> <ul style="list-style-type: none"> <li>Gun violence</li> <li>Unsafe communities</li> <li>Bullying</li> </ul> <p><b>Social isolation and lack of community</b></p> <ul style="list-style-type: none"> <li>Neighborhood challenges</li> <li>Technology overuse</li> </ul> <p><b>Health and mental health concerns</b></p> <ul style="list-style-type: none"> <li>Mental health</li> <li>Latchkey children</li> <li>Healthcare navigation</li> </ul>	<p><b>Economic pressures and cost of living</b></p> <ul style="list-style-type: none"> <li>Housing and rent increases</li> <li>Grocery and childcare prices</li> <li>Healthcare costs</li> </ul> <p><b>Health and healthcare access</b></p> <ul style="list-style-type: none"> <li>Aging populations and cultural barriers</li> <li>Medical mistrust</li> <li>Language barriers</li> <li>Transportation</li> </ul> <p><b>Social and community challenges</b></p> <ul style="list-style-type: none"> <li>Generational poverty and risk behaviors</li> <li>Violence and safety concerns</li> <li>Breakdown of community ties</li> <li>Isolation</li> </ul> <p><b>Education and youth development</b></p> <ul style="list-style-type: none"> <li>Limited resources in schools</li> <li>Food insecurity</li> <li>Bullying and trauma</li> </ul>

# Results (cont.)

Topic	Key findings	
	Children	Adults
<p><b>What do you think about the health-related services that are available in your community, including medical care, dental care, and mental healthcare for children and adults?</b></p>	<p><b>Access to healthcare services</b></p> <ul style="list-style-type: none"> <li>▪ Clinic and provider shortages</li> <li>▪ Urgent care reliance</li> <li>▪ Insurance challenges</li> </ul> <p><b>Mental health accessibility</b></p> <ul style="list-style-type: none"> <li>▪ Stigma and awareness</li> <li>▪ Barriers to care</li> <li>▪ Advocacy needs</li> </ul> <p><b>Pediatric and preventive care</b></p> <ul style="list-style-type: none"> <li>▪ Immunization barriers</li> <li>▪ Specialty care access</li> <li>▪ Preventive care shortfalls</li> </ul> <p><b>Transportation barriers</b></p> <ul style="list-style-type: none"> <li>▪ Getting to appointments</li> <li>▪ Missed opportunities for care</li> </ul>	<p><b>Provider shortages</b></p> <ul style="list-style-type: none"> <li>▪ Mental health access</li> <li>▪ High provider turnover</li> </ul> <p><b>Transportation issues</b></p> <ul style="list-style-type: none"> <li>▪ Struggle with transportation to appointments</li> <li>▪ Services are unreliable and limited</li> </ul> <p><b>Dental and preventive care</b></p> <ul style="list-style-type: none"> <li>▪ Few dental providers accept Medicaid</li> <li>▪ Lack of comprehensive preventive care</li> </ul> <p><b>Health disparities</b></p> <ul style="list-style-type: none"> <li>▪ Black individuals dismissed or treated poorly</li> <li>▪ Maternal health disparities, particularly for Black mothers</li> </ul>
<b>Children and adults</b>		
<p><b>Do you feel like it is hard to access healthy, fresh food in your community?</b></p> <p><b>What keeps you from trying new fresh fruits and/or vegetables?</b></p>	<p><b>Cost of healthy food</b></p> <ul style="list-style-type: none"> <li>▪ Healthy food is more expensive than processed or fast food</li> <li>▪ Limited budget</li> </ul> <p><b>Transportation barriers</b></p> <ul style="list-style-type: none"> <li>▪ Lack of accessible grocery stores</li> <li>▪ Lack of public transit</li> </ul> <p><b>Educational gaps</b></p> <ul style="list-style-type: none"> <li>▪ Lack knowledge about selecting, storing, and preparing healthy foods</li> <li>▪ Stigma and misconception that healthy eating is complicated or unaffordable</li> </ul>	<p><b>Cultural and generational influence</b></p> <ul style="list-style-type: none"> <li>▪ Dietary habits are often influenced by upbringing</li> <li>▪ Generational food preferences</li> </ul> <p><b>Food shelf life and storage</b></p> <ul style="list-style-type: none"> <li>▪ Fresh fruits and vegetables spoil quickly</li> </ul> <p><b>Access to food resources</b></p> <ul style="list-style-type: none"> <li>▪ Despite food banks and pantries, barriers such as limited operating hours, stigma, and eligibility restrictions deter usage</li> </ul>
<b>Key strengths identified for children and adults</b>		
<p><b>What is working in your community that can help residents live healthier lives?</b></p>	<ul style="list-style-type: none"> <li>▪ Affordable and accessible recreation</li> <li>▪ Community-based healthcare support</li> <li>▪ Grassroots and faith-based partnerships</li> </ul>	<ul style="list-style-type: none"> <li>▪ Food resources</li> <li>▪ Senior programs and activities</li> <li>▪ School and workplace wellness programs</li> <li>▪ Community engagement</li> </ul>
<p><b>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?</b></p>	<ul style="list-style-type: none"> <li>▪ Expand workforce and training</li> <li>▪ Enhance community health outreach</li> <li>▪ Improve patient education and advocacy</li> <li>▪ Build trust in underserved communities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reinstate and expand programs for seniors</li> <li>▪ Increase telehealth and local access</li> <li>▪ Focus on emergency preparedness</li> <li>▪ Increase accessibility and affordability</li> </ul>

# 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 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.

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.<sup>1</sup>

Estimated poverty status by race, 2023

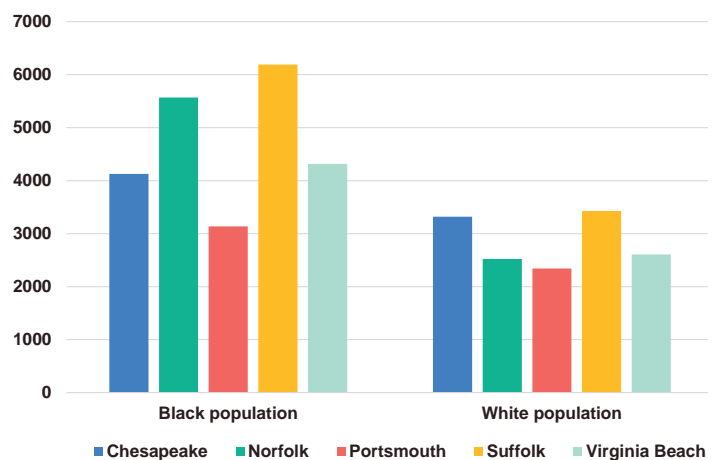


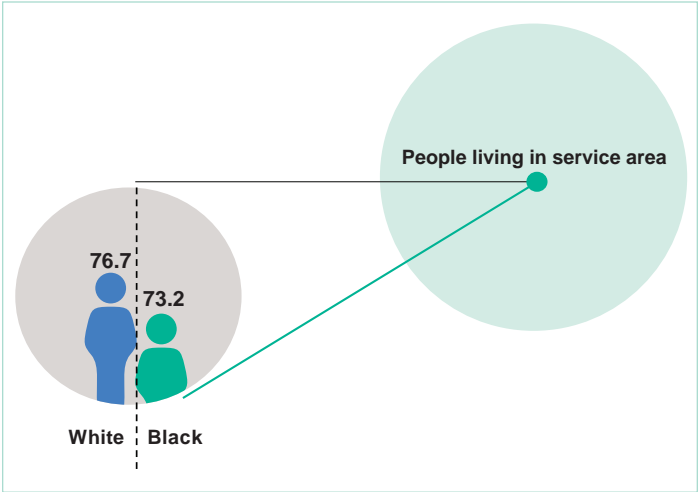
Figure 1 Source: County Health Rankings Data and Documentation

## Life expectancy

Per the County Health Rankings 2024, the life expectancy for a person living in the Commonwealth of Virginia is 78.1. At 75.7 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. The life expectancy for Black individuals is three to six years shorter than White individuals in Virginia.

## Leading causes of death

The Virginia Department of Health examined leading causes of death. In 2022, heart disease, cancer, and COVID-19 were the three leading causes of death in this community, with heart disease, cancer and stroke rates being higher than Virginia rates.<sup>2</sup>



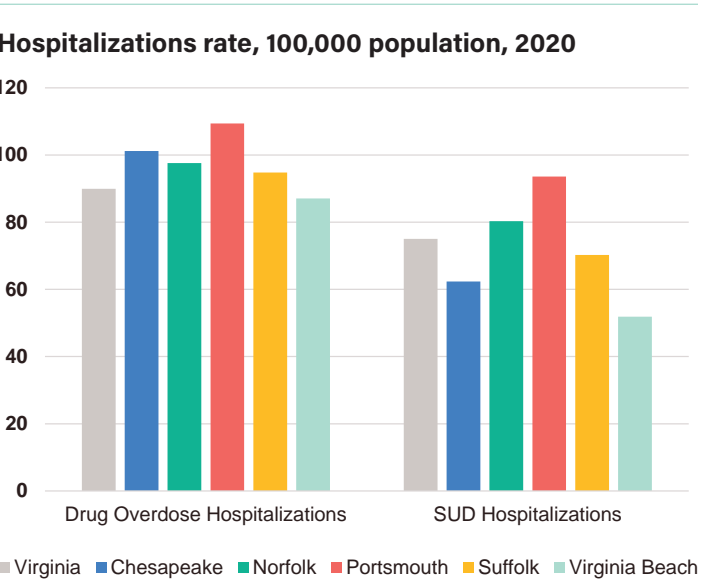
**Figure 2** Source: County Health Rankings Data and Documentation

Virginia	Chesapeake City	Norfolk City	Portsmouth City	Suffolk City	Virginia Beach City
Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
Cancer	Cancer	Cancer	Cancer	Cancer	Cancer
COVID-19	COVID-19	Injury	Injury	COVID-19	COVID-19
Injury	Stroke	COVID-19	COVID-19	Injury	Stroke
Stroke	Injury	Stroke	Stroke	Stroke	Injury

**Figure 3** Source: Virginia Department of Health

## 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 cities of Norfolk and Portsmouth, there were higher hospitalization rates (per 100,000 population) due to substance use disorder (SUD) compared to Virginia rates.<sup>2</sup> Both cities had higher drug overdose death rates (age-adjusted) compared to the state. This community also has a higher rate of alcohol-impaired driving



**Figure 4** Source: Virginia's Plan for Well-Being

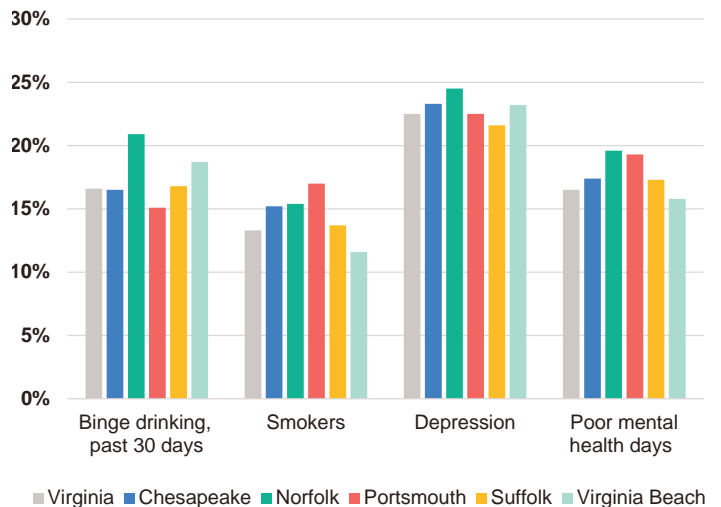
deaths compared to Virginia overall. Mental health is becoming an increasing health concern for both adolescents and adults. Sentara examined emergency department visits for 2024 to gain a better understanding of the mental health crisis communities have been facing since the COVID-19 pandemic. In 2024, the SNGH emergency department treated 4,189 adults (age 19+) with behavioral diagnoses. Of the 4,189 visits, 20.8% of the patients presented with suicidal ideation, 6.1% with schizophrenia, 3.3% with schizoaffective disorder, and 3.1% with bipolar disorder. Additionally, SNGH saw 90 youth (age 0-18) present with a behavioral health diagnosis. Of the 90 visits, 24.4% presented suicidal ideation and 3.3% with bipolar 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.<sup>3</sup>

## 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.

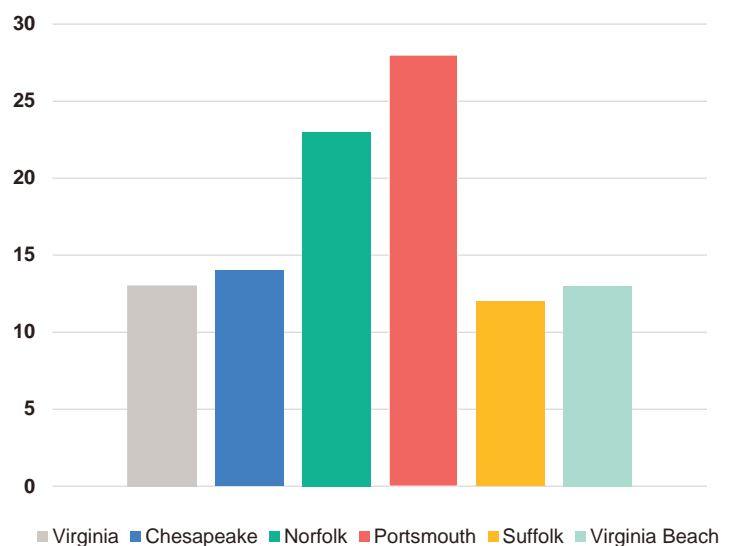
The firearm fatality rate is higher than the state (13) in the cities of Norfolk (23) and Portsmouth (28). Deaths due to firearms are considered largely preventable; as a result, gun violence has been identified as a key public health issue by national agencies. A 2022 study published by the American 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. (Andrews et al., 2022).<sup>4</sup>

**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, 2017-2020, 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.<sup>7</sup> 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. The cities of Norfolk and Suffolk had the greatest incidence rates for all cancers (455.0, 464.4).<sup>5</sup> 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.

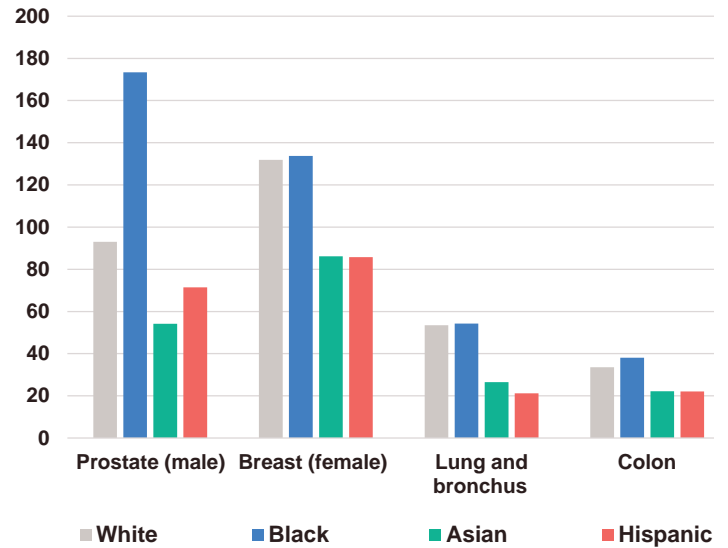
## Women and infant health

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. A greater number of mothers in the service area (28.22%) had late or no prenatal care compared to Virginia. The service area had high percentages of preterm births and babies born with low birth weights compared to the Commonwealth (9.55%, 8.46%). The infant mortality rate was also greater in the localities compared to Virginia (5.98). While teen births (589) are a community concern, the low numbers do not permit meaningful standardization for comparison to state rates.<sup>2</sup>

## Diabetes

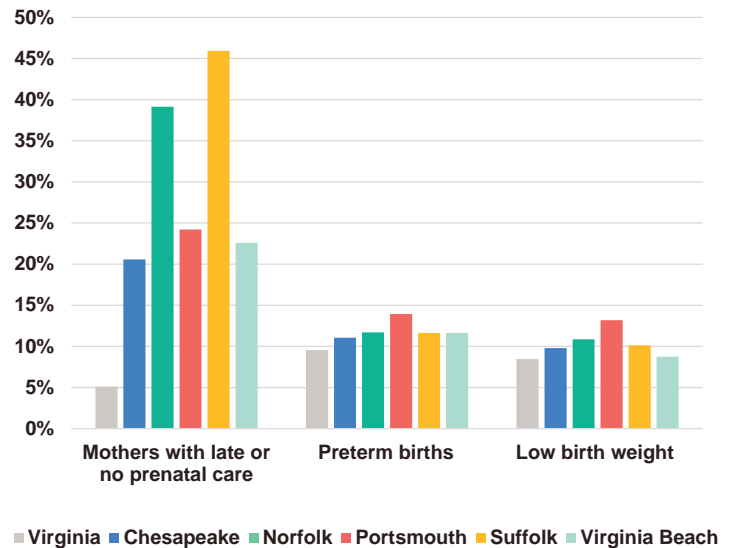
According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase in the U.S. and is the seventh leading cause of death in the United States. Risk factors such as obesity and physical inactivity have played a significant role in this increase, but age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

**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

also key risk factors. The percentage of adults living with diabetes in this community is higher than the state percentage of 12.0%. The SNGH and HER hospitalization rate, 2,367.24 (per 100,000), for diabetes was above the state rate of 2,114.24, with the cities of Portsmouth (3,374.56) and Suffolk (2,896.30) having the highest rates.<sup>2</sup>

“The Community Health Needs Assessment is a process where we can involve the community to assess health needs and prioritize these needs, allowing for improved organizational and community coordination and collaboration.”

Aimee Vergara, CEO, Administrator,  
Hospital for Extended Recovery

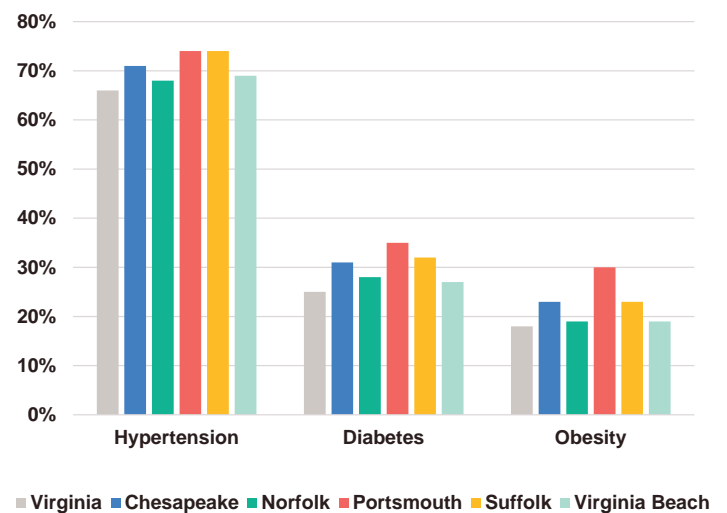


## Older and aging adults

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 being 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%)<sup>9</sup> is higher than Virginia overall (6%).<sup>7</sup> These conditions are important to note as they will impact the aging population’s health, quality of life, healthcare demand, and costs.

Both SNGH and HER 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).<sup>8</sup> Sentara has approximately 78,044 active registrants with Advance Care Plans on file within the U.S. Advance Care Plan Registry with 1,990 of those completed for residents of the SNGH and HER community.

**Medicare primary chronic conditions, 2022**



**Figure 9** Source: Virginia’s Plan for Well-Being

## SNGH and HER 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 community health needs.

## Recommendations

With the completion of the 2025 CHNA, Sentara, SNGH and HER developed goals to positively impact the community's identified health concerns and socioeconomic needs. Sentara, SNGH and HER 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, SNGH and HER 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, SNGH and HER alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. Sentara, SNGH, and HER are committed to finding innovative, responsive, and successful strategies to address these challenges in order to fulfill our mission to improve health every day.

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## Endnotes

<sup>1</sup> County Health Rankings & Roadmaps: Rankings Data & Documentation. Accessed October 10, 2024.

<https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation>.

<sup>2</sup> Virginia's Plan for Well-Being Community Health Improvement Data Portal. Accessed October 10, 2024.

<https://viriniawellbeing.com>.

<sup>3</sup> Virginia 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.

<sup>4</sup> Annie L. Andrews, Xzavier Killings, Elizabeth R. Oddo, Kelsey A.B. Gastineau, Ashley B. Hink; Pediatric Firearm Injury Mortality Epidemiology. *Pediatrics* March 2022; 149 (3): e2021052739. 10.1542/peds.2021-052739. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/35224633/> on April 11, 2022.

<sup>5</sup> National Cancer Institute, State Cancer Profiles. Incidence Rates Table. Accessed November 25, 2024.

<https://statecancerprofiles.cancer.gov/incidencerates/index.php>.

<sup>6</sup> National Cancer Institute, State Cancer Profiles. Death Rates Table. Accessed November 25, 2024.

<https://statecancerprofiles.cancer.gov/deathrates/index.php>.

<sup>7</sup> Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed November 12, 2024. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

<sup>8</sup> The U.S. Will Registry. Accessed December 31, 2024. <https://www.theuswillregistry.org/>.

# Supplemental resources

## 2023-2025 Implementation strategy progress summary

The previous CHNA identified several health issues in the service area. The Sentara Norfolk General Hospital (SNGH) and Hospital for Extended Recovery (HER) 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 the community, the 2022 assessment assisted in setting priorities for health interventions and resource allocation to advance health impact based on patient demographic data and community insight.

This section of the CHNA report describes these activities and collaborative efforts. Both SNGH and HER are monitoring and evaluating progress to date in the 2023 implementation strategies to track implementation 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 SNGH and HER in the 2023 implementation strategy.

- Behavioral health
- Chronic diseases
- Social determinants of health

### **Behavioral health**

Improving the mental and emotional well-being of persons living in the SNGH and HER 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 adults (18+) 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.

We believe that care should extend beyond the physical aspect of treating a disease. That's why SNGH provides a variety of support groups to help patients, their families, and community members cope with the emotional and mental strain that an illness can cause. These free services are available at convenient times and locations for patients and families dealing with cancer, stroke, diabetes, and many other illnesses.

Sentara Norfolk General Hospital held a meeting with The Up Center to discuss improved partnership for consistent mental health assessments and referral processes for women and children. The Up Center

proposed to develop an expanded partnership with Sentara Emergency Departments (EDs), ensuring individuals in need of mental health services can obtain direct referrals from ED staff (clinicians, care-coordination, and physicians). This implementation could potentially prevent delays in access to mental health outpatient resources and may decrease the need for recurring ED admissions.

Both SNGH and HER continue to work with the Hampton Roads Behavioral Health Consortium to identify gaps in services and to identify resource needs for the geriatric population. We are considering Bridge 2 Resources VA as an avenue for creating a shared database of community services that providers, school staff, community members, and parents might find helpful when trying to find and navigate services for children.

To increase community awareness and reduce stigma, Sentara 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 2023 and 2024, there were 40 events reaching 4,154 community members living in the service area.

Sentara and SNGH 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 panel discussion at a local middle school to begin the mental health discussion between teens and parents.

The HER strengthened its partnership with Samaritan House to increase support for their domestic abuse survivors program. To improve social isolation among the aging population, HER partnered with the Norfolk Society for the Prevention of Cruelty to Animals (SPCA) to rehome domestic pets.

HER also partnered with EVMS, Philippines Nurses Association of Virginia and Alzheimer's Association of South Eastern Virginia to provide Alzheimer's support groups to Filipino Alzheimer's patients and their family members. This provides this growing population with additional support, resources and education.

## Chronic disease

Both SNGH and HER are working to reduce the impact of chronic diseases on morbidity and mortality for the community living in the service area by increasing disease management support resources and education. Our hospitals extend their reach into the community, where life happens. Sentara brings prevention, hope, inspiration, and support to our local community where SNGH and HER are working to reduce chronic disease impact.

The Hospital for Extended Recovery works with patients and their families to provide resources, education, and tools so that patients with chronic conditions will have a better understanding of self-management and resources available.

Sentara Norfolk General Hospital provides preventive screenings, health education, and resources at events throughout the community. Sentara is working to increase cancer awareness and access to preventive cancer screenings, including providing mobile mammography screenings within the community to reduce access issues.

Several Sentara stroke coordinators conducted continuing education sessions for local Emergency Management Services personnel. Topics discussed included stroke recognition in the setting of ground level falls, the importance of "last known well," BEFAST stroke recognition, stroke mimics, common anticoagulation medications, and the various tools used for screening versus severity of a stroke.





To further community partnerships, SNGH partnered with the Business and Professionals Ministry of Cathedral of Faith COGIC to present, "All things medical" with Dr. Joanne Williams-Reed, director of professional practice, education, diabetes, and wound care. Two sessions were held to provide education on how to save a life by stopping the bleed after an accident or injury and learning about monitoring blood pressure, as well the importance of maintaining a balanced diet for the prevention of blood pressure related issues.

Sentara Norfolk General Hospital also partners with local low-income schools to provide meal prepping programs for busy adults, teaching adults and children how to develop a balanced diet, along with education on chronic diseases, healthy growth, obesity, heart disease, and diabetes.

## **Social determinants of health**

Sentara Norfolk General Hospital partners with the United Way African American Leadership Society (AALS) to discuss ways in which Sentara and SNGH can expand partnership with AALS to support the planning and implementation of local community-

based educational events. The goal of this partnership is to improve the health and knowledge within the community.

To increase access to resources through collaborative efforts, SNGH met with 21st Century Afterschool Program to discuss a request from St. Helena Elementary School Leadership (located in the underserved Berkely Area of Norfolk) regarding a request to support and organize a program for parents of the students who attend the program. Leaders from SNGH discussed the request and ways that Sentara and SNGH would be able to support this community-based need.

Each hospital has implemented the use of Unite Us, a cross-sector collaboration software that establishes a new standard of care by identifying 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, SNGH and HER continue to collaborate with multiple colleges and universities to provide fellowships, internships, and preceptorships for healthcare professionals and students.

## Grantmaking and community benefit

In the 2023 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 grantmaking, in-kind resources, collaborations, and partnerships.

Sentara is aware of the significant impact that our organization has on the economic vitality of our communities. As a system, Sentara will continue to invest in and support organizations and projects that address prominent social determinants of health. We will continue to promote health 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 healthcare professionals and \$164 million in uncompensated patient care.

Clearly, the definition of community health is broader 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 SNGH and HER alone, these opportunities will require active partnerships among local organizations and individuals to create lasting impact. Sentara, SNGH, and HER are committed to finding innovative, responsive, and successful strategies to address these challenges to fulfill our mission to improve health every day. While we will 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.

“There is no one-size-fits-all solution, and there is no one single entity that can tackle these issues alone. That’s why we’re committed to advancing regional Community Health Improvement Plans developed in partnership with other providers and community leaders. These plans represent the next step in our ability to truly deliver on our mission: We Improve Health Every Day.”

Dr. Jordan Asher, Sentara Health Executive  
Vice President and Chief Physician Executive



# Serving the cities of Chesapeake, Norfolk, Portsmouth, Suffolk, and Virginia Beach

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Hospital for Extended Recovery**

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