Hospital For Extended Recovery

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

We Improve Health Every Day

SENTARA®

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Hospital for Extended Recovery | 2022 Community Health Needs Assessment

EXECUTIVE SUMMARY

We Improve Health Every Day

Sentara Healthcare celebrates more than 130 years in pursuit of its mission — "we improve health every day." Named to IBM Watson Health's "Top 15 Health Systems" in 2018 and 2021, Sentara is an integrated, not-for-profit system of 12 hospitals in Virginia and Northeastern North Carolina, including a Level 1 Trauma center, the Sentara Heart Hospital and the Sentara Healthcare Cardiovascular Research Institute, the Sentara Brock Cancer Center, and the accredited Sentara Cancer Network, two orthopedic hospitals, and the Sentara Neurosciences Institute. The Sentara family also includes a medical group, Nightingale Regional Air Ambulance, home care and hospice, ambulatory outpatient campuses, advanced imaging and diagnostic centers, a clinically integrated network, the Sentara College of Health Sciences and the Optima Health Plan and Virginia Premier Health Plan serving 858,000 members in Virginia, and North Carolina. With more than 29,000 employees and ranked one of Forbes "America's Best Employers" in 2018, Sentara is strategically focused on clinical quality and safety, innovation and creating an extraordinary health care experience for our patients and members.

Sentara at a Glance

- Headquartered in Norfolk, Virginia
- 130-year not-for-profit history
- 12 hospitals
- One medical group
- 3,800+ provider medical staff
- 29,000 team members
- Health plans (Optima Health and Virginia Premier)
- Outpatient campuses
- Urgent care centers
- Advanced Imaging Centers
- Home health and hospice
- Rehabilitation and therapy centers
- Nightingale air ambulance

INTRODUCTION

Hospital for Extended Recovery

The Hospital for Extended Recovery is a 35-bed long term acute care hospital located inside Sentara Norfolk General Hospital. The hospital opened November 2001 and was the first hospital within a hospital in the state of Virginia. This 35-bed specialty facility is an acute care hospital specifically designed for patients with medically complex needs who need to stay in an acute care setting on average of three to four weeks. Though located within Sentara Norfolk General Hospital, the Hospital for Extended Recovery is actually a separate health facility. The proximity to and affiliation with Sentara, however, assures you that if needs change, the benefits of a Level 1 Trauma Center are easily accessible.

> ***"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, Director of Community Engagement & Impact*

SENTARA CARES

Sentara conducts comprehensive community health needs assessments for each of our inpatient hospitals and outpatient surgical hospitals across Virginia and Eastern North Carolina. These assessments provide a snapshot of the health status of residents in our communities, including information about key health and health-related problems and opportunities.

Our assessments include a review of population characteristics such as age, educational level, and racial and ethnic composition because social factors are important determinants of health. The assessments also look at risk factors, such as obesity and smoking, and health indicators, such as infant mortality and preventable hospitalizations. Community participation is important, so the assessment also includes input from community members, local public health departments, the school system, social services, community health centers, free clinics, local governments, and those who represent underserved populations and others through surveys, focus groups, and other means.

COVID RESPONSE

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

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

OUR PROCESS

In 2021, the Hospital for Extended Recovery (HER), as a hospital unit closely associated with Sentara Norfolk General Hospital (SNGH), in collaboration with SNGH, conducted the community health needs assessment of the area that we serve. The assessment provides us with a picture of the health status of the residents in our communities and provides us with information about health and health-related problems that impact health status.

The Community Health Needs Assessment incorporates information from a variety of primary and secondary quantitative data sources.

Sentara developed a primary statistical data profile integrating claims and encounter data to assess the population's use of emergency services, preventive services, chronic health conditions, and cultural and linguistic needs. A secondary statistical data profile was created using advanced data sources to assess population characteristics such as household statistics, age, educational level, economic measures, mortality rates, incidences rates, and racial and ethnic composition because social factors are important determinants of health. Our assessment includes a review of risk factors like obesity and smoking and health indicators such as infant mortality and preventable hospitalizations.

Research components for this Assessment included the following:

- United States Census Bureau
  - American Community Survey 2019: 5-Year Estimates Data Profiles
- Centers for Disease Control and Prevention
- NIH National Cancer Institute
- Virginia Department of Health
- Centers for Medicare & Medicaid Services
- Virginia Medicaid Department of Medical Assistance Services
- County Health Rankings 2021
- GHR Connects
- Weldon Cooper Center for Public Service, UVA
- Sentara Claims Data
- Community Health Needs Assessment Survey
- Community Focus Groups

> ***"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, Administrator, Hospital for Extended Recovery*

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

While HER shares some health data with SNGH, we have conducted separate focus groups that represent those in the community most interested in the scope of the services we offer.

The needs assessment identifies numerous health issues that our communities face. Considering factors such as size and scope of the health problem, the severity and intensity of the problem, the feasibility and effectiveness of possible interventions, health disparities associated with the need, the importance the community places on addressing the need, and consistency with our mission "to improve health every day," we have identified several priority health problems in our area to address in our implementation strategy:

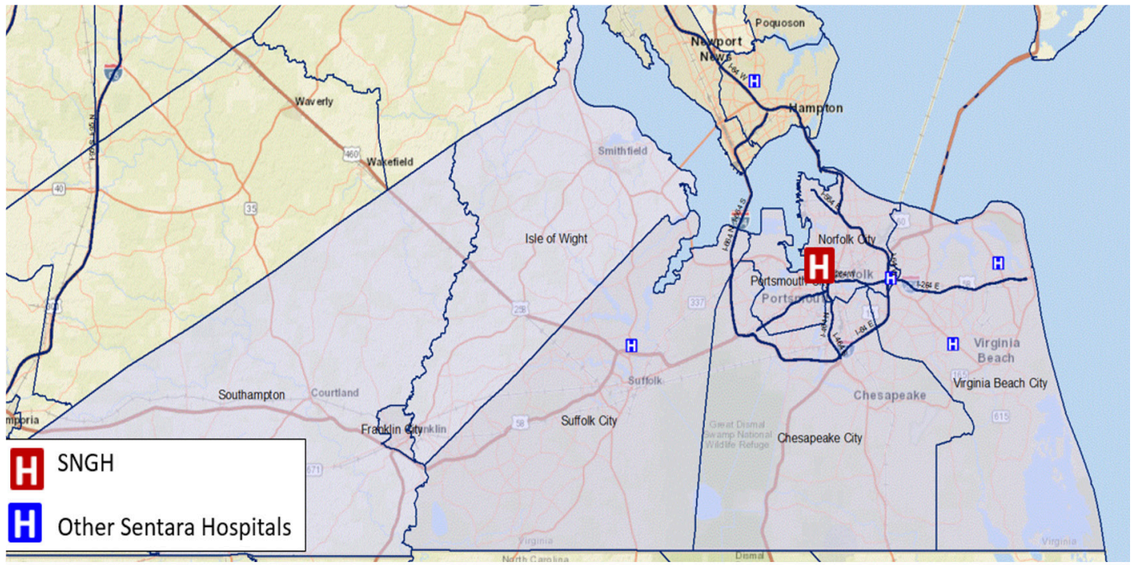
- Behavioral Health
- Chronic Disease
- Social Determinants of Health

OUR NEXT STEPS

HER works with several community partners to address health needs. Using the information from this Community Health Needs Assessment, HER will develop an implementation strategy to address the identified health problems. HER will track the progress of the implementation activities to evaluate the impact of these actions.

Information on available resources is available from sources like 2-1-1 Virginia and Sentara.com. Together, we will work to improve the health of the communities we serve.

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



The Sentara Norfolk General Hospital (SNGH) Service Area | *Source: Truven/Market Expert*

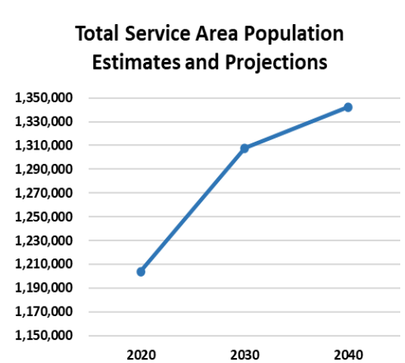
COMMUNITY DESCRIPTION

GEOGRAPHY

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

POPULATION CHANGE

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



Community Specific Demographics (Appendix A)

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

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

City of Norfolk has 238,005 residents with 17.6% of this population living in poverty and 15% uninsured. Of the population in this county, 23.9% are ages 0-19, 22.5% are ages 20-29, 42.7% are ages 30-64, 9.7% are ages 65-84, and 1.2% are aged 85 and over. 89.6% of the residents primarily speak English, while 10.4% speak another language in the home. The ethnicity for this population includes 47.0% White, 41.1% African American, 8% Hispanic, and 3.7% Asian.

City of Virginia Beach has 459,470 residents with 8.1% of this population living in poverty and 11% uninsured. Of the population in this county, 24.7% are ages 0-19, 15.4% are ages 20-29, 45.6% are ages 30-64, 12.7% are ages 65-84, and 1.6% are aged 85 and over. 87.5% of the residents primarily speak English, while 12.5% speak another language in the home. The ethnicity for this population includes 66.3% White, 19.0% African American, 8.2% Hispanic, and 6.7% Asian.

City of Chesapeake has 249,422 residents with 7.6% of this population living in poverty and 10% uninsured. Of the population in this county, 26.7% are ages 0-19, 12.5% are ages 20-29, 47.4% are ages 30-64, 12.1% are ages 65-84, and 1.3% are aged 85 and over. 91.7% of the residents primarily speak English, while 8.3% speak another language in the home. The ethnicity for this population includes 61.1% White, 30.0% African American, 6.2% Hispanic, and 3.2% Asian.

City of Portsmouth has 97,915 residents with 15.3% of this population living in poverty and 13% uninsured. Of the population in this county, 25.9% are ages 0-19, 14.0% are ages 20-29, 45.2% are ages 30-64, 13.1% are ages 65-84, and 1.8% are aged 85 and over. 95.4% of the residents primarily speak English, while 4.6% speak another language in the home. The ethnicity for this population includes 39.8% White, 52.9% African American, 4.5% Hispanic, and 4.5% Asian.

City of Suffolk has 94,324 residents with 9.0% of this population living in poverty and 10% uninsured. Of the population in this county, 26.7% are ages 0-19, 10.6% are ages 20-29, 47.2% are ages 30-64, 14.0% are ages 65-84, and 1.5% are aged 85 and over. 94.9% of the residents primarily speak English, while 5.1% speak another language in the home. The ethnicity for this population includes 52.1% White, 42.6% African American, 4.7% Hispanic, and 1.9% Asian.

City of Franklin has 8,180 residents with 18.1% of this population living in poverty and 11% uninsured. Of the population in this county, 21.8% are ages 0-19, 9.7% are ages 20-29, 42.6% are ages 30-64, 23.6% are ages 65-84, and 2.3% are aged 85 and over. 97.3% of the residents primarily speak English, while 2.7% speak another language in the home. The ethnicity for this population includes 36.9% White, 56.7% African American, 1.1% Hispanic, and 1.3% Asian.

Isle of Wight County has 38,606 residents with 7.6% of this population living in poverty and 10% uninsured. Of the population in this county, 22.4% are ages 0-19, 9.1% are ages 20-29, 48.1% are ages 30-64, 18.5% are ages 65-84, and 1.9% are aged 85 and over. 95.2% of the residents primarily speak English, while 4.8% speak another language in the home. The ethnicity for this population includes 72.7% White, 23.2% African American, 3.4% Hispanic, and 1.0% Asian.

Southampton County has 17,996 residents with 12.5% of this population living in poverty and 12% uninsured. Of the population in this county, 21.2% are ages 0-19, 9.0% are ages 20-29, 49.1% are ages 30-64, 19.0% are ages 65-84, and 1.7% are aged 85 and over. 98.4% of the residents primarily speak English, while 1.6% speak another language in the home. The ethnicity for this population includes 62.3% White, 34.7% African American, 2.0% Hispanic, and 0.5% Asian.

Population Highlights

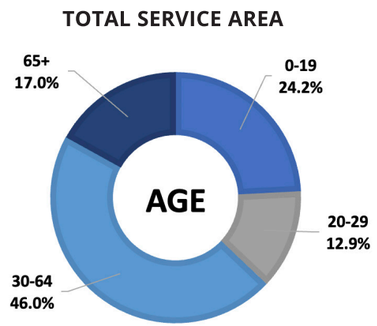
The combined population of the SNGH/HER service area is over 1.2 million people, accounting for 14% of the population of the state of Virginia. Virginia Beach is the most populous city in the service region, followed by Chesapeake and Norfolk. Those three cities combined hold 11% of the population of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

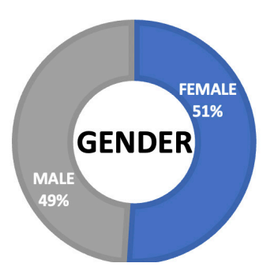
AGE AND GENDER

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

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

Like the state of Virginia, there is a slightly higher percent of residents identifying as female in the entire service area with Norfolk and Southampton having slightly over half of the residents identifying as male.



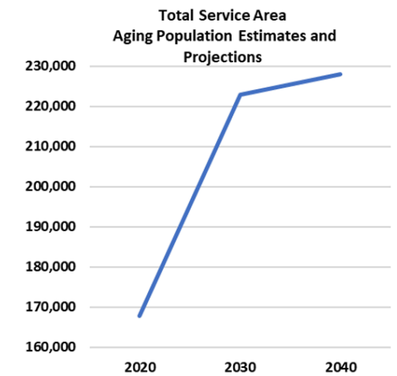


Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219

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

AGING POPULATION

It is well understood that older individuals are more likely to need more healthcare services, and a variety of services which are targeted toward that population. The population of the SNGH/HER service area is projected to be older than the state in 2040. The percent of the very elderly, shown to have the highest utilization of medical services, is highest in Portsmouth and Isle of Wight.



In 2020, 13.9% of the population living in the service area is age 65+, slightly below the population of Virginia which is 15.9%. By 2030, the aging population of the service area is projected to be at 18.5%, and by 2040, increase to 18.9%.

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

OTHER DEMOGRAPHIC FEATURES

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

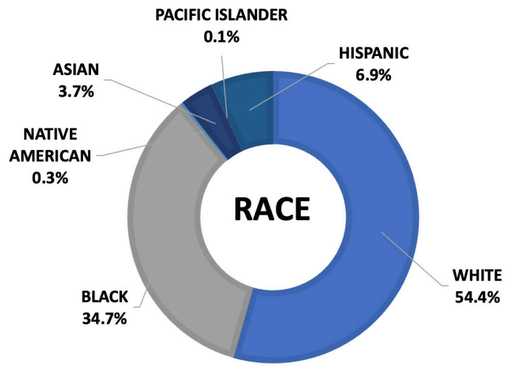
Source: Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org

Community Diversity Profile

ETHNICITY

The population of the service area is overwhelmingly white and black, with Virginia Beach and Norfolk the most diverse communities (15.3% and 12.2% combined non-white or black) followed by Chesapeake at 9.7% combined (Appendix A). All other localities have no more than 7% combined non-white or black population. Virginia Beach, Norfolk and Chesapeake have small Asian populations, but no other racial groups are represented in the area in any significant number.

TOTAL SERVICE AREA



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

PREFERRED LANGUAGE

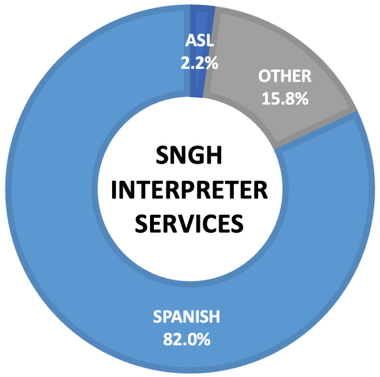
English is the primary language spoken in the service area. As of 2020, 90.9% of the population being served identified as English speaking. Per the 2014 American Community Survey five-year estimates, Spanish was the other language identified in the community being served, with 12,049 community members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

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

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

CULTURAL AND LINGUISTIC NEEDS

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



Source: SNGH 2021 Sentara Language Line Usage Report

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

HEALTH EQUITY

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

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

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

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

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

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

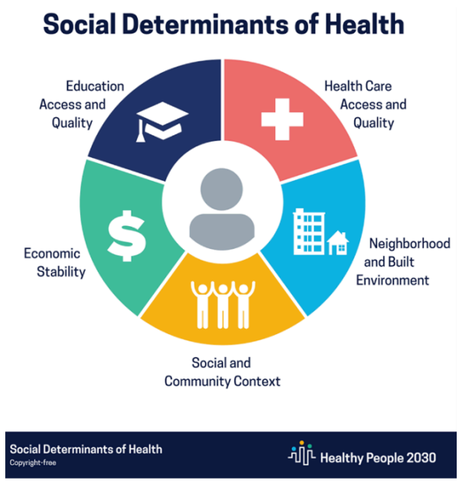
Priorities include measurement of disparities and what factors contribute to them, and development and implementation of an action plan to reduce disparities in care. This includes screening and diagnosis rates for chronic health issues such as hypertension and diabetes, and prevalence of prostate and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

SOCIAL DETERMINANTS OF HEALTH

Sentara is about transforming the lives of our neighbors by focusing on the root factors that affect our health beyond the clinical care we receive.

Sentara works to:

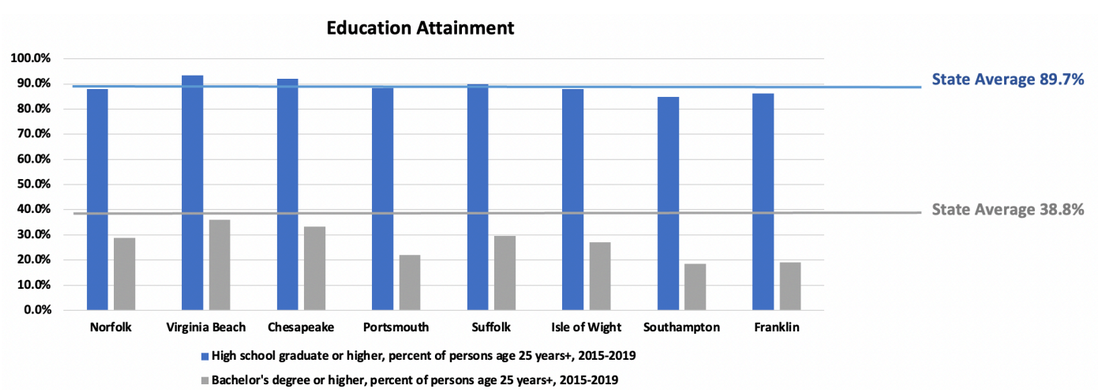
- Fill the unprecedented need for behavioral health practitioners in the field and ensure greater access to behavioral health services for children, families, and adults.
- Secure consistent, equitable access to nutritious food — every day and in times of emergency need.
- Support targeted training and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



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

EDUCATION

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



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

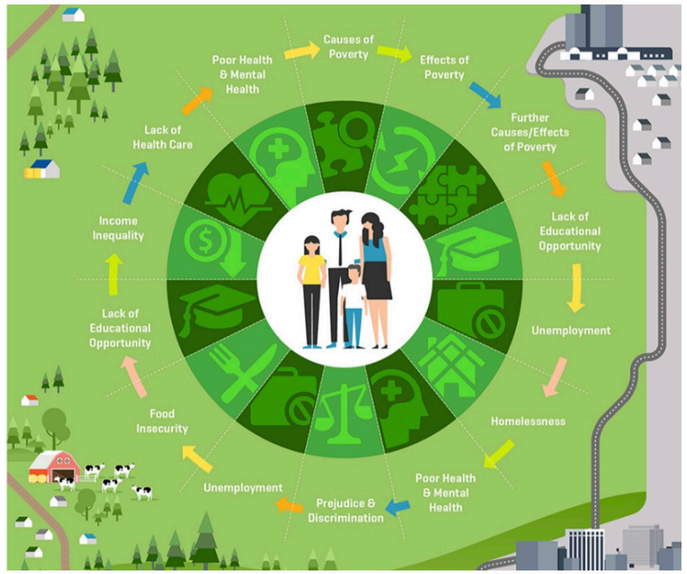
The Cycle of Poverty

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

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

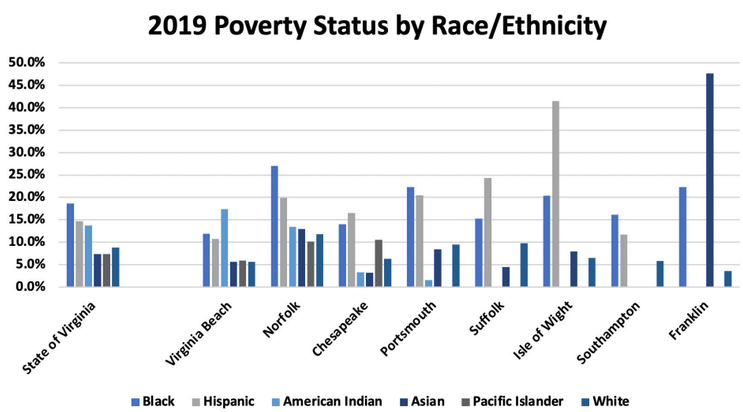
Generational poverty is a vicious cycle in which each generation is unable to escape poverty because of a lack of resources to put toward the effort.

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



POVERTY

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

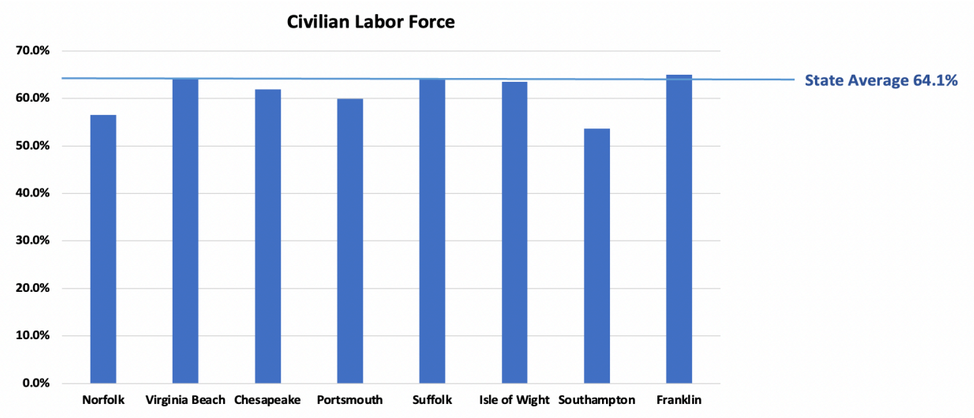


Virginia Beach residents are less likely to live in poverty than other area residents. The poverty rates for Suffolk are closer to the rate for Virginia as a whole. Norfolk, Portsmouth, Southampton, and Franklin residents are more likely to live in poverty than other counties by a significant margin,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

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

EMPLOYMENT

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



MEDICAID & FAMIS, MEDICARE, MEDICARE & MEDICAID ENROLLMENT

Out of the 626,398 members newly enrolled in Medicaid in the state of Virginia in January 2022, poverty level, and 162,431 are between 101-138% of the federal poverty level. The total service area has a higher percent of members on Medicaid and FAMIS compared to Virginia with the highest percentage living in Norfolk and Portsmouth. The number of residents living in the service area receiving Medicaid and FAMIS services continues to increase each year, with an increase of 21.7% since January 2020.

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

Source: Virginia Medicaid Department of Medical Assistance Services; (As of January 15, 2022) https://www.dmas.virginia.gov/data
US Census Bureau QuickFacts Table 2020; (2020 Small Area Income and Poverty Estimates (SAIPE));
US Census Bureau; 2019: ACS 5-Year; Centers for Medicare & Medicaid Services 2019; Mapping Medicare Data;

COMMUNITY INSIGHT

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

COMMUNITY KEY STAKEHOLDER AND COMMUNITY MEMBER SURVEY

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

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

What is important to the health of adults and children?:

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

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

After the initial survey period, the collaborative recognized that a preponderance of respondents were white females. Sentara Healthcare leaders partnered with clinical staff at each hospital to encourage

survey participation. Sentara Healthcare staff also attended a Hispanic Women's Health Fair, Feria de Salud de la Mujer, to encourage additional survey participation from Hispanic community members. Thirteen families completed the survey at the event; the information obtained was used for this assessment.

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

At the completion of the survey period, 1,871 stakeholder surveys and 17,294 community member surveys were completed. It is important to note that not every respondent answered every question in the stakeholder and community member surveys. Most counties did not have an equally distributed response to surveys to represent the entire service area population. As a result, survey responses should be considered as only one component of information utilized to select health priorities. The most underserved populations' feedback is not adequately reflected in most surveys. Sentara Healthcare staff performed targeted outreach activities to include individuals who serve the underserved populations to further develop the robustness of the survey response.

The stakeholders responding to the survey represent multiple organizations and each has unique insight into the health factors that impact the community. The stakeholders represent hospitals, physician offices, city departments of social services, health departments, and community-based non-profit service organizations. The respondents have represented many diverse professional and volunteer fields—from emergency medical providers to pastors and public-school teachers.

Stakeholder survey respondents were asked to identify the type of organization that best represents their perspective on health issues through employment or other affiliation. 1,357 out of 1,871 respondents answered this question with 43.85% being health care providers and community health centers. See Appendix C for the complete Stakeholder and Community Member Surveys, the list of types of employers for stakeholder respondents, characteristics of survey respondents and top health concerns.

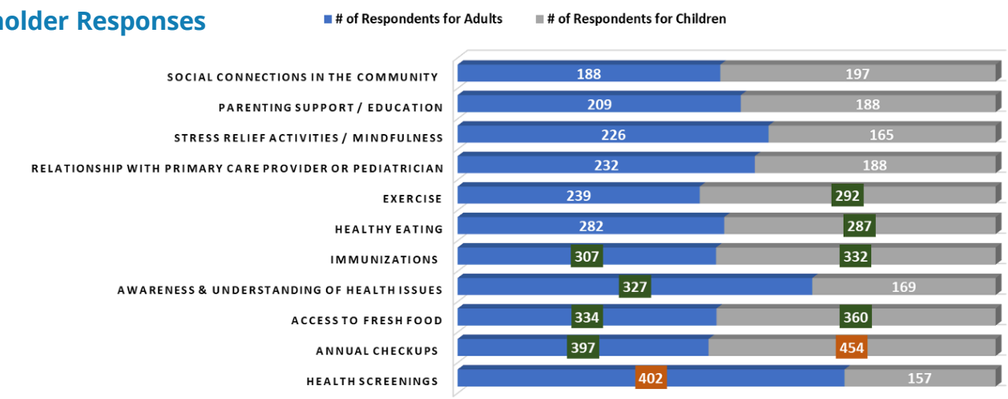
For this CHNA report, we will focus on the below questions asked in the survey. Survey respondents were asked to review a list of common community health issues and select up to three items. The below tables show the answers for each question among stakeholder and community member respondents.

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

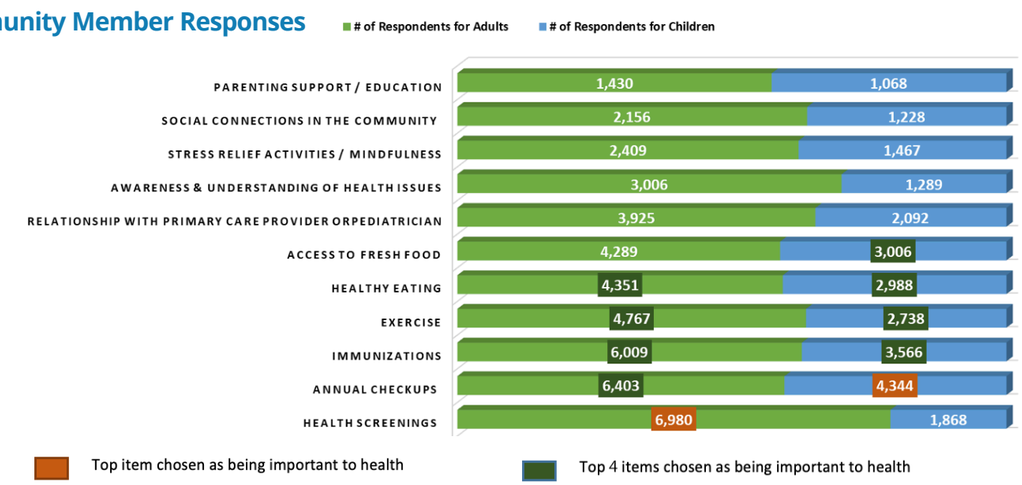
What is important to the health of adults and children?

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

Stakeholder Responses



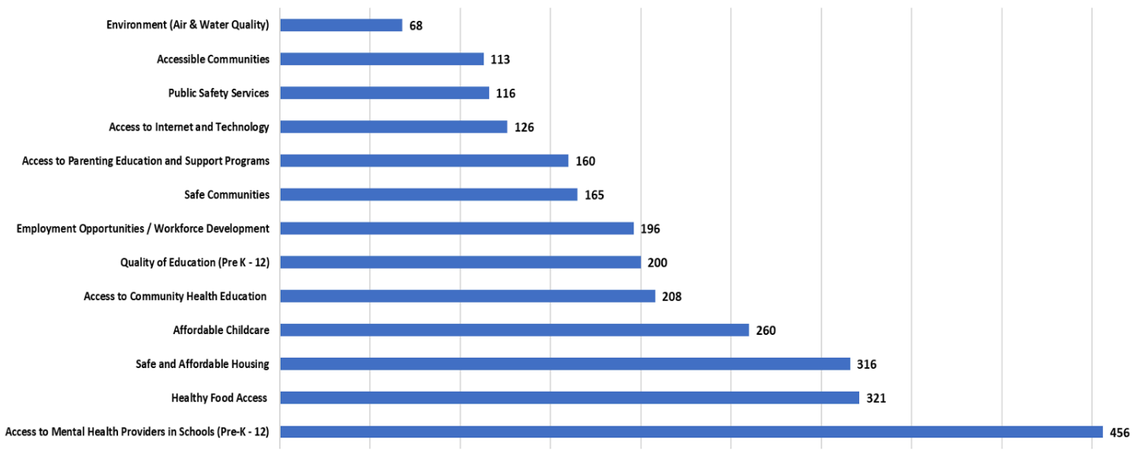
Community Member Responses



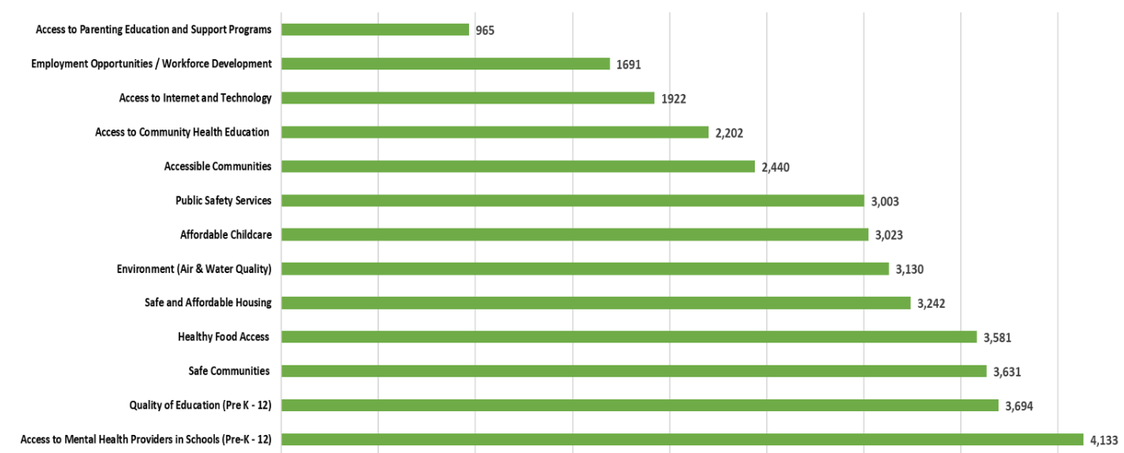
What should be added or improved in the community to help families be healthy?

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

Stakeholder Responses



Community Responses

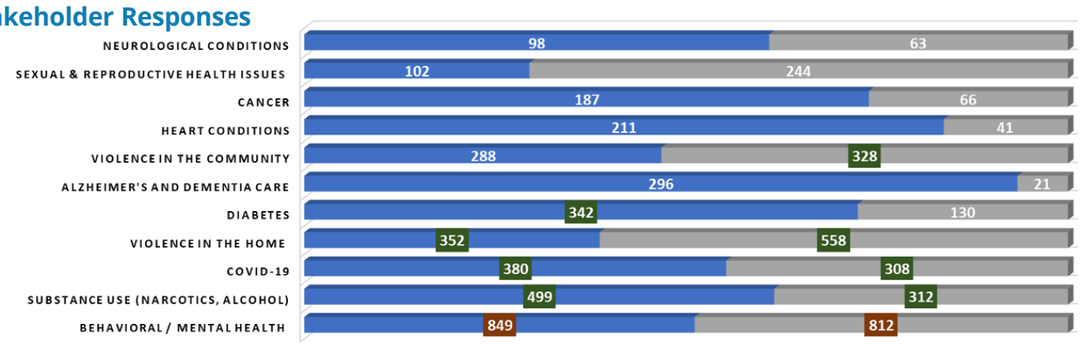


What are most important health concerns for adults and children?

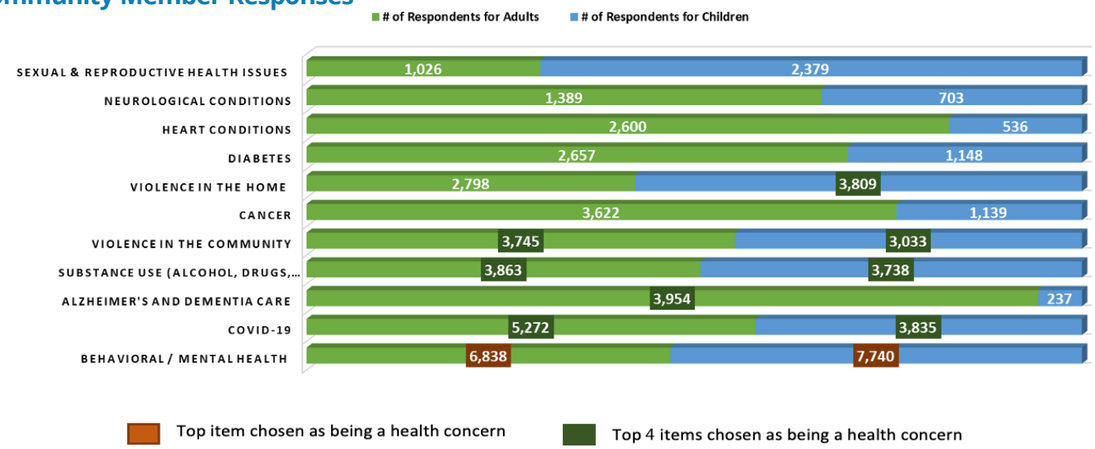
The most frequent response to question 3, see above, was behavioral health (anxiety, depression, psychoses, suicide), substance use (Narcotics, Alcohol), COVID-19, Alzheimer's, and Dementia care. For children, respondents chose behavioral health (anxiety, depression, psychoses, suicide), COVID-19, violence in the community, substance use (Narcotics, Alcohol), and sexual & reproductive health issues (STIs, teen pregnancy) as the most pressing health concerns.

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

Stakeholder Responses



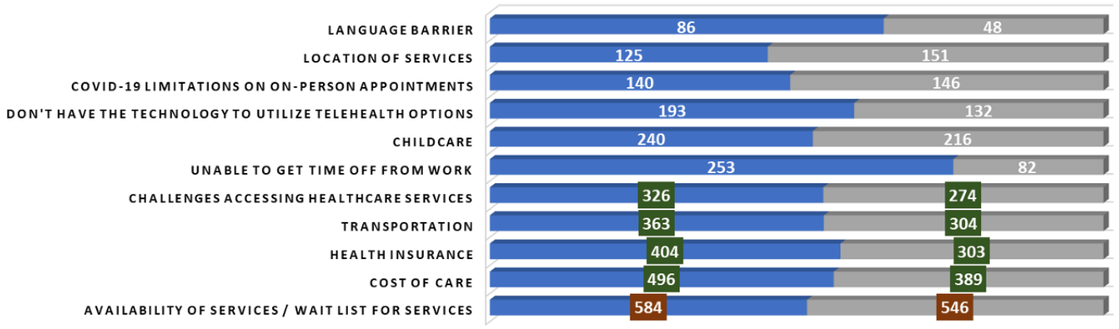
Community Member Responses



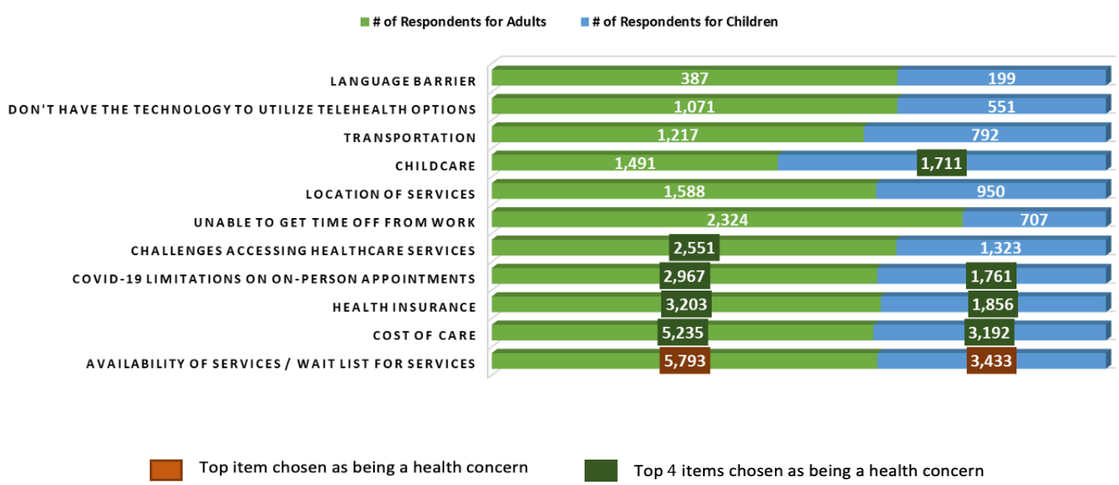
What makes it difficult to access healthcare services for adults and children?

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

Stakeholder Responses



Community Member Responses



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

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

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

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

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

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

COMMUNITY FOCUS GROUPS

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

Focus groups were often drawn from existing hospital and community groups or sought from other populations in the community, including representatives of underserved communities and consumers of services. The questions below were utilized at each focus group session.

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

Hospital for Extended Recovery Focus Groups	
Number of Focus Groups	3
Number of Participants	34
Female	20
Male	7
Unspecified	6
Age (17-30)	3
Age (31-40)	6
Age (41-50)	12
Age (51-60)	1
Age (61+)	6
Unspecified	6
Race/Ethnicity (White)	13
Race/Ethnicity (Black)	6
Race/Ethnicity (Asian)	9
Unspecified	6
Participants with Children	13
Unspecified	7

1. 3/09/2022 Focus Group, virtual session: Filipino focus
2. 3/25/2022 Focus Group, virtual session: Community Member
3. 3/30/2022 Focus Group, virtual session: EVMS/Community Leader/Community Member
o Health Concerns Present (not asked, personally disclosed)
- 2 laryngectomees
- 1 epileptic

A brief summary of the key findings for each topic is presented below.

TOPIC	Key Findings (List of Responses)
What are the most serious health problems in our community?	• Mental Health needs o Lack of providers, long wait lists, some turning patients away o Providers at capacity o Increase since pandemic o Stigma to getting help ▯ Getting better since there is an increase in demand o Need affordable and accessible • Cardiovascular • Heart Disease • Diabetes • Hypertension • Obesity • Asthma and RAD, as a result of COVID • Health literacy • Smoking, Vaping • Food insecurity • Elder Care
When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?	Knowledge, food, behavior=outcomes • Unhealthy behaviors lead to obesity and diabetes o Need to educate and motivate to become healthy • Access to food, healthy food, Food pantry requests are continuing food insecurity continuing • Filipino community: seeing increase in heart conditions, disease heart attacks, open heart surgeries in younger men o Obesity leading to heart conditions o Need knowledge and access to affordable food, nutrition • Decrease in healthcare for low-income and housing • Employment opportunities: employment can help with getting affordable health insurance, but plans need to provide low deductibles otherwise continuing barriers to accessing healthcare • Education, all levels, not just K-12 • Need to focus on preventative care • Lack of income • Food • Social support • Exercise • Violence • Mental health, especially as it related to COVID-19 recovery • Food Deprivation • Adequate housing • Transportation to appointments

TOPIC	Key Findings (List of Responses)
Who has the health problems? What groups of individuals are most impacted by these problems?	• Filipino men, aged 35-50, heart disease • Low-income populations • Younger groups, aged 18-25, increase in Mental Health o Could be due to increase. awareness around self-care in this generation • Men, aged 45-55, increase in Mental Health • School-aged, increase in Mental Health • Those who continue to come in and out of the ED • Under insured and/or not insured • Those with lack of resources that end up having substance abuse tendencies which can lead to mental health issues • Homelessness • Geriatrics • Laryngectomees • Children/pediatrics • Those at risk of losing house/employment • Working population • Caregivers • The elderly population • Obese populations • Diabetics • Several complications from diabetes • Lower income populations • Can't afford healthy food and medications "There are explicit biases or unconscious biases that cause individuals to be at the place where it keeps them from being exposed or having access to care." "A lot of the patients we see have mental health concerns, which have led them to become homeless, which then consider, you know, they're not able to get employed at that point. They're no longer able to obtain food if they're not sure where the resource. So many of our patients are higher risk of having mental health concerns or drug use disorders. And it's just kind of a spiral effect that they're not then able to get the social support to further hopefully, be able to care for themselves and they have no health insurance."

TOPIC	Key Findings (List of Responses)
What keeps people from being healthy? In other words, what are the barriers to achieving good health?	• Affordable healthcare • Adequate housing • Financial barriers • Lack of education and willingness to try o If they don't try, they can't fail • Availability of Mental Health providers • Too difficult to be healthy, become physically active, eat healthy o Challenge with motivation • Older Filipinos make sure everything happens for the family, takes care of everyone else first. If working and taking care of family, healthcare comes last. Do not want negative health outcome to impact family. If need help getting to healthcare, do not want to burden family with asking for assistance. Will ignore health to keep family running smoothly. • Transportation • Sandwich generation—not always available to help parents when trying to take care of own children. • Fear and anxiety about potential diagnosis • Insurance • Finances/income • Poor diet • Food insecurity • High costs of care/education • Reliance on ERs for primary care/no PCPs • Lack of knowledge surrounding where to get resources for help • Understanding/navigating healthcare systems with paperwork • Many are trying to survive just by obtaining housing and food • Education • Medicare/Medicaid patients feeling as if they do not have the appropriate resources/doubt their ability to get healthcare • Lack of education as it relates to exercise • There is a cap on the number of Medicare patients that practices can take • Too busy working to get their insurance • Too many life demands • Unexpected life challenges • Limited life expectancy and going in and out of the hospital instead of utilizing hospice • Laryngectomees are subject to bad medical treatments • Mistrust • Social support • Knowledge deficit related to where to receive the care they need • Not knowing how to use the internet to obtain care

TOPIC	Key Findings (List of Responses)
What is being done in our community to improve health and reduce barriers? **What resources exist in the community?**	• Program offered to elderly—clinician makes home visits quarterly, part of health plan, provides screenings • Health Fairs • Telehealth • FEMA clinics • Free transport for the elderly to medical appointments • PACE clinic • COVID-19 testing and immunization clinics • Healthcare is designed for sick, not the healthy • Not enough is being done • EVMS HOPES and Street Health with student and patient navigators who are trying to bridge the gap between the hospital and the streets • Lots of resources at EVMS but better alignment and communication is needed • Health clinics and fairs • Not a streamlined system • Local clinics in black and brown communities due to transportation and other barriers • Free head and neck cancer screenings • Unite Us • Aunt Bertha • Lost Chord Club • Development of nurse navigator programs for some specialties • Projects in place to create PDFs with maps, easier accessibility, and services that are provided • Online support webinars • Telehealth opportunities being held at Freemason Baptist Church

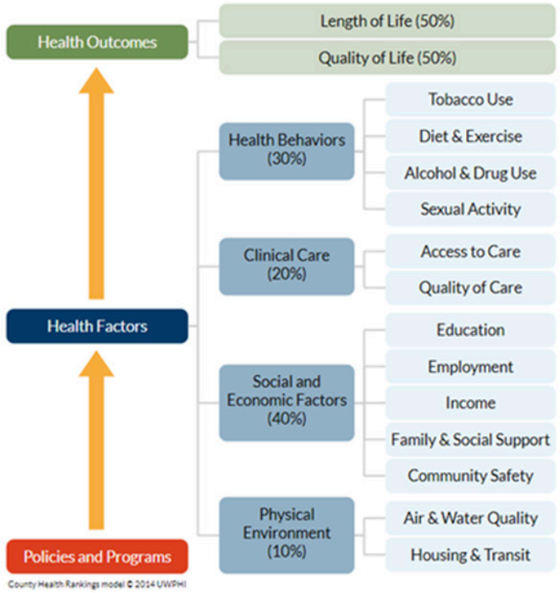
TOPIC	Key Findings (List of Responses)
How has the COVID-19 pandemic worsened the health issues in our community?	• Reluctance to go to ED for illness, chronic disease, emergency situations • Loss: not just death. Loss of freedoms, not by choice. Loss was sudden and quick. Anxiety symptoms exacerbated. Loss of gyms for those who used physical activity as outlet. Increased responsibilities with kids and homeschooling, while working. o "We got a lot taken away from us and it wasn't our choice." o "It wasn't only loss of life, loss of XYZ, but a loss that people had to handle." o "Lost a lot of what we were used to having, and it was sudden and it was quick." • Substance use increased, alcohol use • Isolation, decrease in socialization • People becoming used to sedentary lifestyle, increased obesity • Mental health and the boarding numbers in ERs • Issues in nursing homes and assisted living facilities • Food insecurity • Hesitation to seek care • Divide due to vaccine hesitancy • Waitlist for housing • Mental health concerns due to visitation • Lifting mask wearing and social distancing restrictions • Increased importance of telehealth and accessibility to technology • Delayed selective surgeries that affect life quality • False hope due to loss of COVID-19 funding • Faith based institutions closed due to COVID where resources were provided • Distrust in health providers and government • Increased violence and domestic disputes • More end-stage diseases seen in the hospitals are people who were not going to see their health providers • Shelters and food pantries are overwhelmed because other non-profits closed

TOPIC	Key Findings (List of Responses)

What more can be done to improve health, particularly for those individuals and groups most in need? Are there specific opportunities or actions our community could take?	• Health fairs
	  o Wellness education/Wellness fairs
	• Mentorship
	• Sharing stories
	• Communication with friends and families
	  o Communicate when help is needed
	  o Communicate how to get healthy
	• Health education
	• Fundraisers
	• Outreach programs
	• Church
	• Community champions who can help bridge the gap between community and healthcare
	• Alignment of healthcare systems, community organizations and grassroot stakeholders
	• Socialized medicine like Europe
	• Community service coordinators
	• More awareness of resources that are available
	• Developing educational materials for medical professionals, as well as for laryngectomy patients
	• Local clinics or nurse teams going into communities to support teaching health and examinations
	• Earlier understanding of health in the school systems
	• Further education for residents and medical students in the medical field who are seeing at-risk patients
	• Educate youth
	• Culture conscious care
	• Trauma-informed care
	• Assisting with families who have suffered a loss due to violence
	• Work to reduce wait in ERs
	• Diabetes clinics
	• COVID clinics
	• Telehealth
	• Advertise the need for self-care
	• Non-profit and student at EVMS who is creating an online platform for medical students and residents that is focused specifically on human trafficking and trauma informed care and can be adjusted to focus on other needs.
	• https://www.redflags2freedom.org/

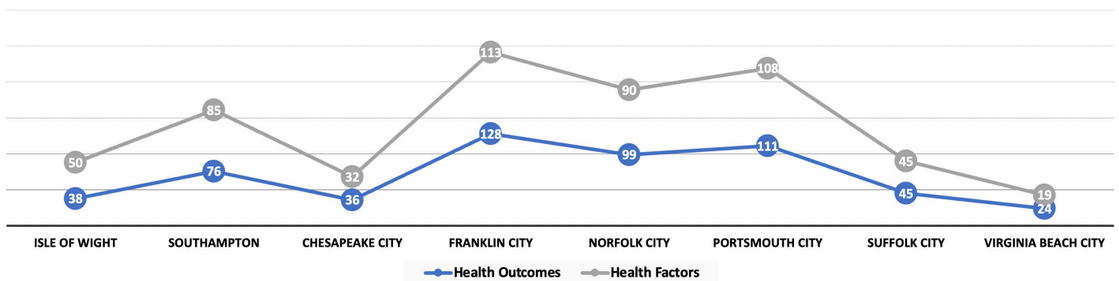
County Health Rankings

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



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

Below shows the Health Outcomes Rank and Health Factors for the communities in the Hospital for Extended Recovery (HER) and Sentara Norfolk General Hospital (SNGH) service area. Virginia Beach City, Chesapeake City, and Isle of Wight rank better for these health outcomes while Franklin City, Portsmouth City, and Norfolk City rank worse out of 133 Virginia counties (Appendix B).



Source: County Health Rankings 2021, https://www.countyhealthrankings.org/

Health Outcomes and Health Factors

Below shows a deeper look at the Health Outcomes and Health Factors for the communities in the HER service area. Virginia Beach City, Chesapeake City, and Isle of Wight rank better for these health outcomes while Franklin City, Portsmouth City, and Norfolk City rank worse out of 133 Virginia counties (Appendix B). It is interesting to note that Isle of Wight ranks good for length of life, quality of life, clinical care, and social and economic indicators, however worse for physical environment and health behaviors compared to Virginia Beach and Chesapeake cities. Looking at what outcomes and factors are impacting the communities being served provide more insight into the root causes leading to poor physical and mental health.

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

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

- Access to Health Services Profile
- Maternal and Infant Health Profile
- Older and Aging Adults Profile
- Mortality Profile
- Cancer Profile
- Hospitalizations for Chronic and Other Conditions Profile
- Risk Factor Profile
- COVID-19 Profile
- Community and Gun Violence Profile

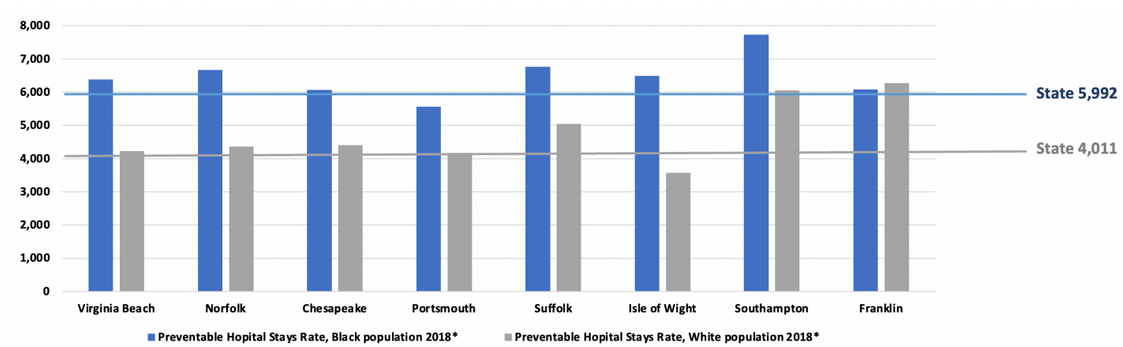
Source: County Health Rankings 2021, https://www.countyhealthrankings.org/app/virginia/2021/overview

ACCESS TO HEALTH SERVICES PROFILE

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

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

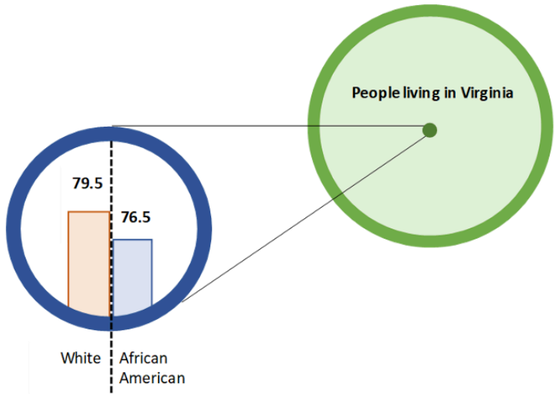
Preventable Hospital Stays by Race, 2018



Source: County Health Rankings 2021, https://www.countyhealthrankings.org/app/virginia/2021/overview ;
**rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.*

MORTALITY PROFILE

The life expectancy for a person living in the state of Virginia is 79.5. Virginia Beach and Isle of Wight are the only cities with a slightly higher life expectancy than the state (80.5, 79.2). It is important to note there is a disparity with life expectancy among African American populations. The life expectancy for African Americans compared to White populations is anywhere from 1 year to 2.9 years less in the service area.



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

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

Leading Causes of Death Per 100,000, Age-adjusted per 100,000 Population

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

Prevalence Rate

450 — 0

Data Source: Virginia Department of Health, Division of Health Statistics, https://www.vdh.virginia.gov/data/, received 1-13-2019

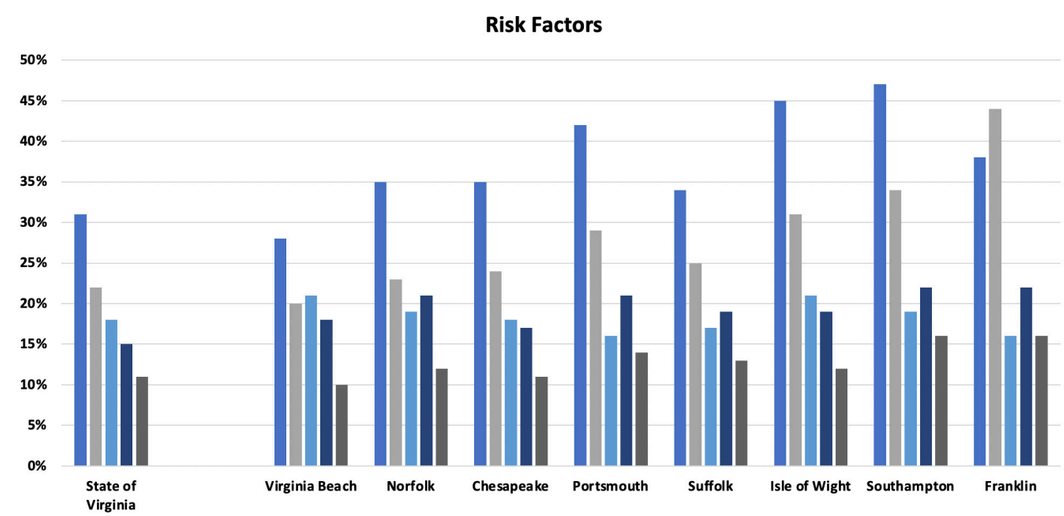
HOSPITALIZATIONS FOR CHRONIC AND OTHER CONDITIONS PROFILE

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

RISK FACTOR PROFILE

Smoking percentages and frequent mental health distress were higher for all localities in the HER/SNGH Service Area compared to Virginia and the United States (US) values. Conversely, the percentage of adults who drink excessively was higher in Virginia Beach, Norfolk, Southampton, and Isle of Wight compared to the state of Virginia and the US, but lower throughout the other localities.

Obesity and physical inactivity percentages were also higher in all localities, except in Virginia Beach, though access to exercise opportunities was higher than the state in Virginia Beach, Norfolk, Chesapeake, and Portsmouth. Food insecurity percentages were highest in Franklin, Portsmouth, and Norfolk and higher than the state percentage of 10%. Limited access to healthy food was highest in Franklin at 28% followed by Southampton at 14%, much higher than the state at 4% (Appendix B). Obesity is a concern because it increases the risk of diabetes, heart disease, stroke, and some cancers. It is also associated with poor mental health outcomes and reduced quality of life.

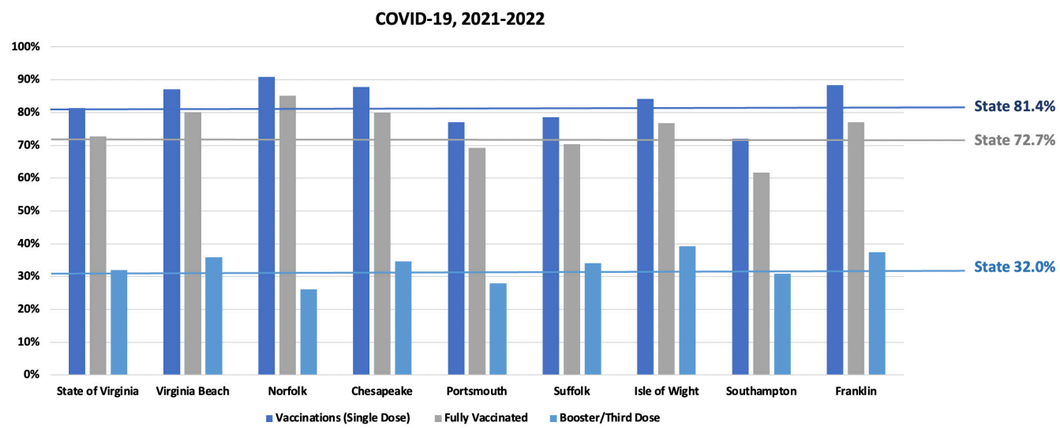


Source: County Health Rankings 2021, Rankings and Documentation

COVID-19 PROFILE

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

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



MATERNAL AND INFANT HEALTH PROFILE

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

Source: World Health Organization, https://www.who.int/health-topics/coronavirus#tab=tab_1
Virginia Department of Health, COVID-19 Data in Virginia, https://www.vdh.virginia.gov/coronavirus/see-the-numbers/COVID-19-in-virginia/COVID-19-vaccine-summary/
Virginia Department of Health Division of Health statistics: https://apps.vdh.virginia.gov/HealthStats/stats.htm#tables

OLDER AND AGING ADULTS PROFILE

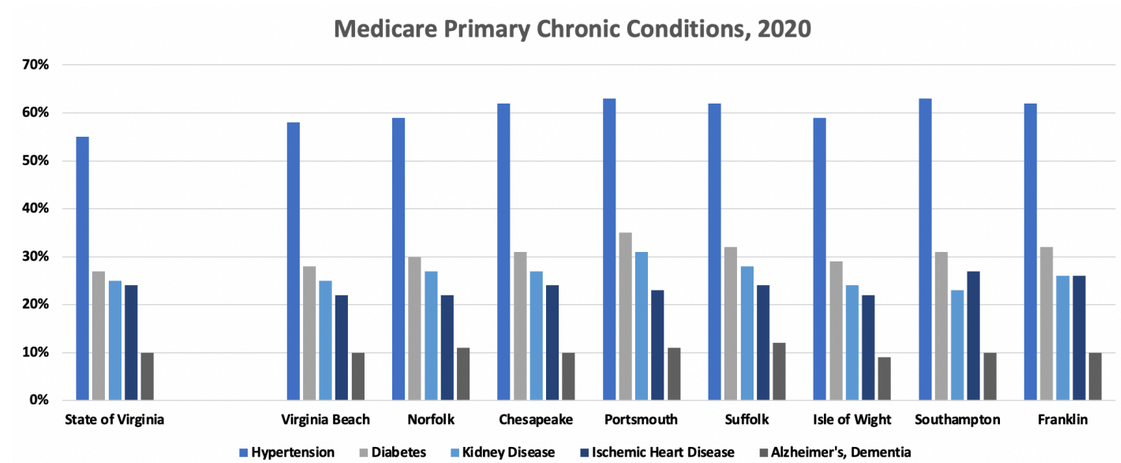
In many communities, the population of older adults is growing at the fastest rate. Challenges come with an aging population, including health related factors and other factors that ultimately impact health. Preventable hospital stays among the Medicare population in the HER/SNGH service area were higher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

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

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

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

Source: Alzheimer's Association, 2022



Source: Centers for Medicare & Medicaid Services, https://data.cms.gov/tools/mapping-medicare-disparities-by-population
Alzheimer's Association, 2022 Alzheimer's Disease Facts and Figures, https://www.alz.org/media/Documents/virginia-alzheimers-facts-figures-2022.pdf
Virginia Alzheimer's Commission, https://alzpossible.org/data-and-data-sets/

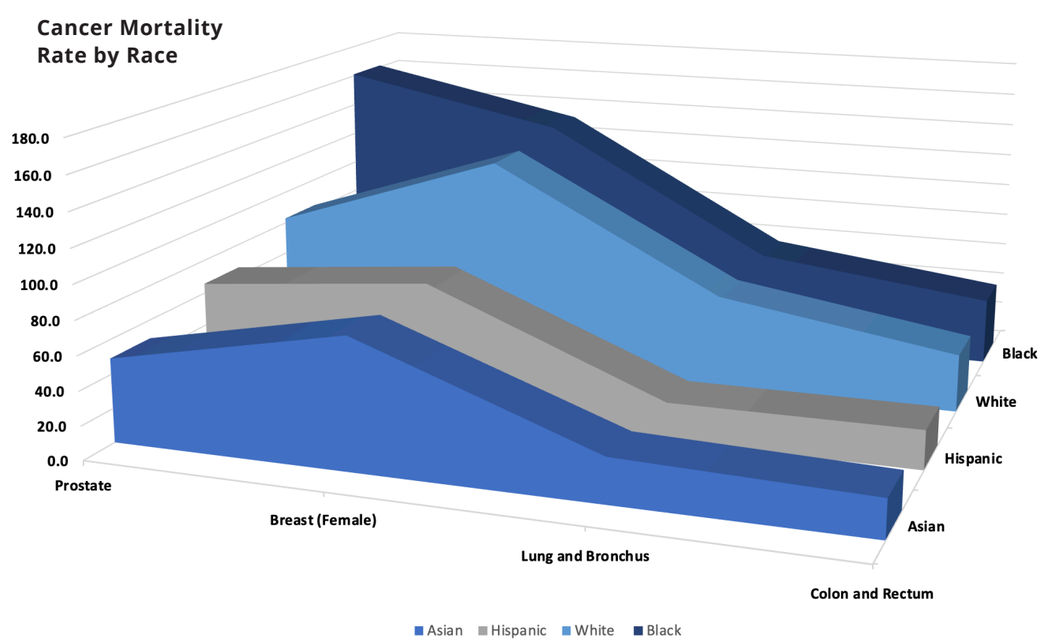
CANCER PROFILE

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

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

Source: American Cancer Society

Mortality rates were highest among lung, breast, prostate, and colon cancers. Localities with the greatest all cancer incidence rates were Franklin, Portsmouth, and Norfolk, in order of decreasing incidence. The trend is stabilizing in all three cities. Mortality rates for African Americans diagnosed with breast cancer is rising compared to previous years (Appendix B). Prostate cancer and breast cancer are the leading causes of cancer death for African Americans living in Virginia. See the below graph showing the mortality disparities among races. The community outreach programs educating and providing cancer screenings, as well as medical developments, are having an impact. Efforts will need to focus on populations at higher risk of this disease.



Data Source: NIH National Cancer Institute, 2014-2018 Incident Rate Report for Virginia: https://statecancerprofiles.cancer.gov/deathrates/index.php

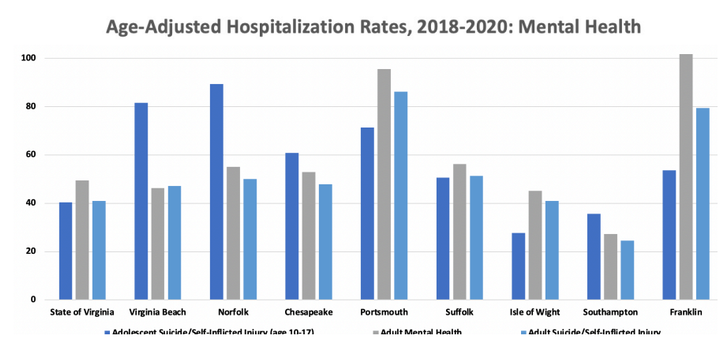
BEHAVIORAL HEALTH PROFILE

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

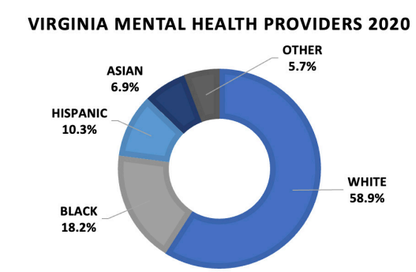
Mental health is becoming an increasing health concern for both adolescents and adults. Between 2018-2020, the adult mental health rate per 10,000 population is highest in Portsmouth and Franklin, followed by Suffolk, Norfolk, and Chesapeake. Sentara Healthcare also examined Emergency Department visits for 2021 to gain a better understanding of the mental health crisis communities have been facing during the COVID-19 pandemic. In 2021, SNGH Emergency Department saw a patient frequency of 4,712 for people aged 18+, with a behavioral health diagnosis. Of the 4,712 visits, 20.0% presented with suicidal ideations and 6.2% with major depressive disorder.

The adolescent mental health rate is highest in Norfolk and Virginia Beach, followed by Portsmouth, Chesapeake, Franklin, and Suffolk. "In early 2021, emergency department visits in the United States for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019" (Office of Surgeon General, 2021). Although SNGH does not see many youth in the emergency department with neighboring Children's Hospital of The King's Daughters, in 2021 SNGH saw a patient frequency of 16 for youth, age 0-17, present with a behavioral health diagnosis. Of the 16 visits, 31.2% presented with suicidal ideations and 12.5% with major depressive disorder.

The mental health rates for this service area are higher than the state. The COVID-19 pandemic has worsened mental health among youth and adults, increasing anxiety, depression, and stress. Loss of freedoms due to social distancing, masking, and isolating negatively impacted the most vulnerable increasing emergency department visits due to a lack of mental health providers to assist with therapy and developing coping skills. The HER/SNGH service area has less mental health providers per person compared to the state. Isle of Wight (3,374:1), Suffolk (980:1), and Chesapeake (822:1) have the lowest ratio of providers per person followed by Franklin (613:1), Virginia Beach (541:1) and Norfolk (453:1) (Appendix B). It is also important to note that the mental health workforce is nearing retirement age which will impact provider capacity. There is a need for a more racial and ethnic diverse mental health workforce to better reflect the diverse population (Appendix B).



Source: Greater Hampton Roads, Community Indicators Dashboard



Source: Virginia Health Care Foundation

COMMUNITY AND GUN VIOLENCE

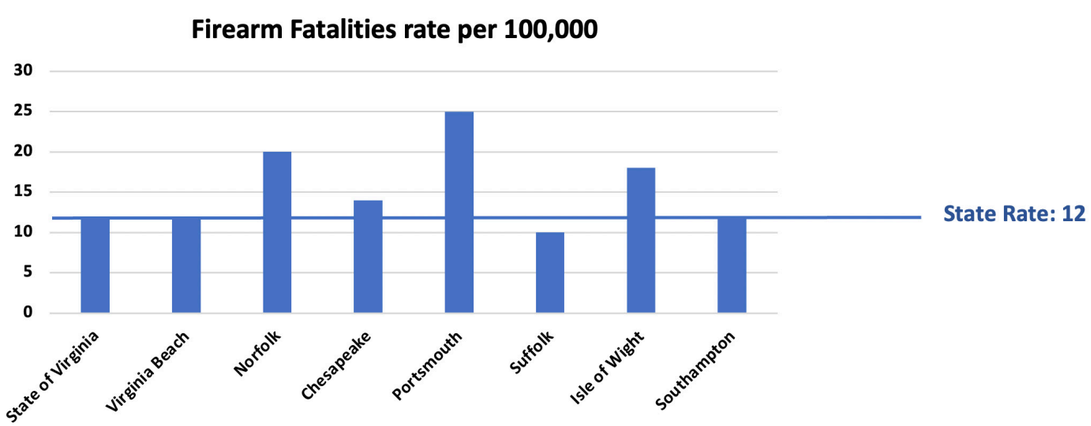
Violent crimes such as gun violence, robbery, or aggravated assault have socio-emotional impact on people. Physical and emotional symptoms can occur such as trouble sleeping, increase in feelings of distress, anger, depression, inability to trust, and significant problems with family, friends, or coworkers.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

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

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

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

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



Source: County Health Rankings 2021, Rankings and Documentation

2019 Implementation Strategy Progress Report

The previous Community Health Needs Assessment identified several health issues. The Hospital for Extended Recovery (HER) Implementation Strategy Progress Report was developed to identify activities to address health needs identified in the 2019 CHNA report through primary and secondary data sources. This section of the CHNA report describes these activities.

For reference, the list below includes the 2019 CHNA health needs that were prioritized to be addressed by HER in the 2019 Implementation Strategy.

- Behavioral Health
- Obesity/Nutrition
- Heart Disease
- Alzheimer's Disease/Dementia

HER is monitoring and evaluating progress to date on its 2019 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Please note that the 2019 Community Health Needs Assessment Implementation Strategy process was disrupted by COVID-19, which has impacted all of our communities.

BEHAVIORAL HEALTH

HER continues to collaborate with the community and agencies to identify needs in behavioral health and substance use prevention. HER supports events which promote behavioral health, such as the Out of the Darkness campaign. Prior to the COVID-19 pandemic, educational forums on behavioral health issues and substance use cessation were held. HER accepted several IV drug use patients from Sentara facilities that require long-term IV antibiotics but were unable to be placed or go home due to IVDA history and central line. HER staff worked with this patient population to ensure they had follow-up appointments with methadone clinics on the day of discharge and resources in the community. HER worked with EVMS psychiatry to ensure patients receive adequate psychiatric care. HER also ensures team members have access to appropriate mental health resources as they continue to work through the COVID pandemic. Staff collected "wishlist" items and $200 for Samaritan House to assist the victims of domestic violence in our community.

2019 Implementation Strategy Progress Report

OBESITY/NUTRITION

HER continues to promote healthy nutrition practices with patients and staff, as well as promotes awareness of the fitness classes offered at Sentara Norfolk General Hospital. Prior to the pandemic, HER supported the following:

- Support the local Meals on Wheels campaign
- Explore options to start a community garden
- Provide education on how to read food labels and promote healthy eating

HER works with the hospital's dietitian to promote healthy nutrition choices while patients are inpatient, and give resources upon discharge. Through the Quality Council and Therapeutics Committee HER staff report any patients requiring additional nutritional and dietitian support and provide resources on discharge. HER collected $1600 for Lee's Friends charity to ensure cancer patients have the nutrition they need while they are undergoing treatment.

Heart Disease: Prior to the COVID-19 pandemic, HER provided blood pressure screenings and heart healthy education to the community at community events and will resume these activities when allowed. HER staff participate in the American Heart Association's Heart Walk and for 2021 attended virtually raising $500 in support of the cause. Will continue providing heart healthy nutrition classes to the community when COVID-19 restrictions allow. HER continues to work with credentialed cardiologists and the Congestive Heart Failure navigator responsible for the cardiovascular/cardiothoracic programs to ensure patients and their families have the appropriate resources on discharge. HER also works to transition patients to the Cardiac rehab program as soon as medically stable.

ALZHEIMER'S DISEASE/DEMENTIA

HER coordinates discharge planning and care with facilities that care for individuals with Alzheimer's Disease and dementia. HER continues to work with the EVMS Gerontologists to ensure the geriatric patient population is receiving appropriate care. HER participated in "The Longest Day" Alzheimer's awareness campaign and fundraiser with the Alzheimer's Association in 2019 and 2021. The pandemic impacted the campaign in 2020. In June of 2021, HER participated in "The Longest Day," supporting the Alzheimer's Association and raising $650 for research and support. Prior to the COVID-19 pandemic, HER provided caregiver support sessions for those caring for loved ones with dementia.

CANCER AWARENESS AND PREVENTION

Sentara Healthcare extends its reach into the community, where life happens. We bring prevention, hope, inspiration, and support to our local community where we are working to reduce cancer's impact. Our cancer educators implement programs focused on cancer prevention, detection, and provide community outreach by hosting and attending screening and education events. In 2021, more than 3,000 individuals participated in community events.

We are continuing to build our "Living Beyond Cancer" survivorship program to enhance our patients' wellbeing and long-term health. We accomplish this through cancer support groups and various education programs on nutrition, physical therapy, and exercise through the Wellness Beyond Cancer program, a free six-week holistic health, meditation, yoga and fitness program for cancer patients aimed to address the needs of the entire individual to strengthen physically and mentally and provide a sense of peace and balance throughout their journey to wellness. We also provided local cancer screening events for oral, head and neck cancers, FIT testing for colorectal cancer, breast cancer mammography screening and skin cancer screening events around the Hampton Roads area.

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

GRANTMAKING AND COMMUNITY BENEFIT

Sentara is focused on supporting organizations and projects that address prominent social determinants of health factors and that promote health equity by eliminating traditional barriers to health and human services. Sentara Healthcare strongly encourages grant proposals that align with one or more of the following priorities:

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

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

Community Health Needs Assessment References

Community Demographics

GEOGRAPHIC DATA

USA.com, Virginia State Population Density

POPULATION DATA

Centers for Medicare & Medicaid Services 2019; Mapping Medicare Data

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

US Census Bureau; 2019: Census - Table Results

US Census Bureau QuickFacts Table 2020, Virginia Quick Facts

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

US Census Bureau, Small Area Income and Poverty Estimates (SAIPE). SAIPE (census.gov)

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

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

Health Indicators

ALZHEIMER'S AND DEMENTIA

Alzheimer's Association, Virginia Alzheimer's facts

Virginia Alzheimer's Commission, AlzPossible Initiative

COUNTY HEALTH RANKINGS

County Health Rankings 2021, Rankings Data & Documentation

County Health Rankings 2021, Overview

CANCER

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

GREATER HAMPTON ROADS

Greater Hampton Roads Community Indicators Dashboard

MATERNAL AND INFANT

Virginia Department of Health Division of Health statistics

Reviews

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

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Virginia Health Care Foundation. Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce (vhcf.org). January 2022.

Notes

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