# Sentara Obici Hospital
# Sentara BelleHarbour Ambulatory Surgery Center
# Sentara Obici Ambulatory Surgery Center

## COMMUNITY HEALTH NEEDS ASSESSMENT 2022

*We Improve Health Every Day*

This joint Community Health Needs Assessment report was completed in collaboration with Sentara Obici Hospital, Sentara BelleHarbour Ambulatory Surgery Center and Sentara Obici Ambulatory Surgery Center, which have the identical service areas of the Cities of Suffolk and Franklin, as well as the Counties of the Isle of Wight, Southampton, Sussex, Surry and Gates County, NC.

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# EXECUTIVE SUMMARY

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

> *"The community health needs assessment provides an excellent framework to further connect with our community and provide a voice to their specific health needs and concerns."*
>
> ***Meredith Moorefield**,*
> *Director of Patient Care*

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

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

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

**Health Priorities for 2022-2025:**

- Behavioral Health
- Chronic Disease
- Social Determinants of Health

# OVERVIEW

## We Improve Health Every Day

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

### SENTARA AT A GLANCE

- Headquartered in Norfolk, Virginia
- 130-year not-for-profit history
- 12 hospitals
- One medical group
- 3,800+ provider medical staff
- 30,000+ team members
- 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

## Sentara Obici Hospital

Sentara Obici Hospital (SOH) is a state-of-the-art facility located on Godwin Boulevard in Suffolk. This 175-bed, full-service hospital continues a legacy of providing residents of Western Tidewater with high-quality, patient-centered care. The hospital fully integrates advanced technologies such as Sentara eCare®, the Sentara electronic medical record system, which gives doctors immediate access to health information via a secure network. Electronic medical records enable better collaboration between physicians, elevating the level of care for patients at Sentara Obici Hospital and across Sentara.

## Sentara BelleHarbour Ambulatory Surgery Center

Sentara BelleHarbour Ambulatory Surgery Center (SBASC), a state-of-the-art outpatient medical center in North Suffolk, is here to provide you and your family with convenient access to quality medical care and services. From family medicine and specialty care to physical therapy and lab and imaging services, to outpatient surgery and 24-hour emergency care, Sentara BelleHarbour is proud to serve the community in North Suffolk.

## Sentara Obici Ambulatory Surgery Center

The Sentara Obici Ambulatory Surgery Center (SOASC) on the campus of Sentara Obici Hospital combines a caring atmosphere with new technologies in a full-service outpatient surgery center. We are able to perform many complex surgeries in an outpatient center without the need for a hospital setting. The outpatient surgical setting offers many advantages, including lower surgical costs, as well as a convenient location and comfortable surgical environment. Board-certified specialists will perform orthopedic, gynecologic, general, ophthalmologic, plastic, podiatry and pain management surgeries and procedures in this convenient, outpatient setting.

## SENTARA CARES

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

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

*"We approach every community and every partner with our ears and our hearts open. We're not here to provide prescriptive solutions. We're here to support and amplify the work of our partners in every way we can to improve more lives and inspire more hope for the future."*

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

## COVID-19 RESPONSE

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

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

## OUR PROCESS

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

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

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

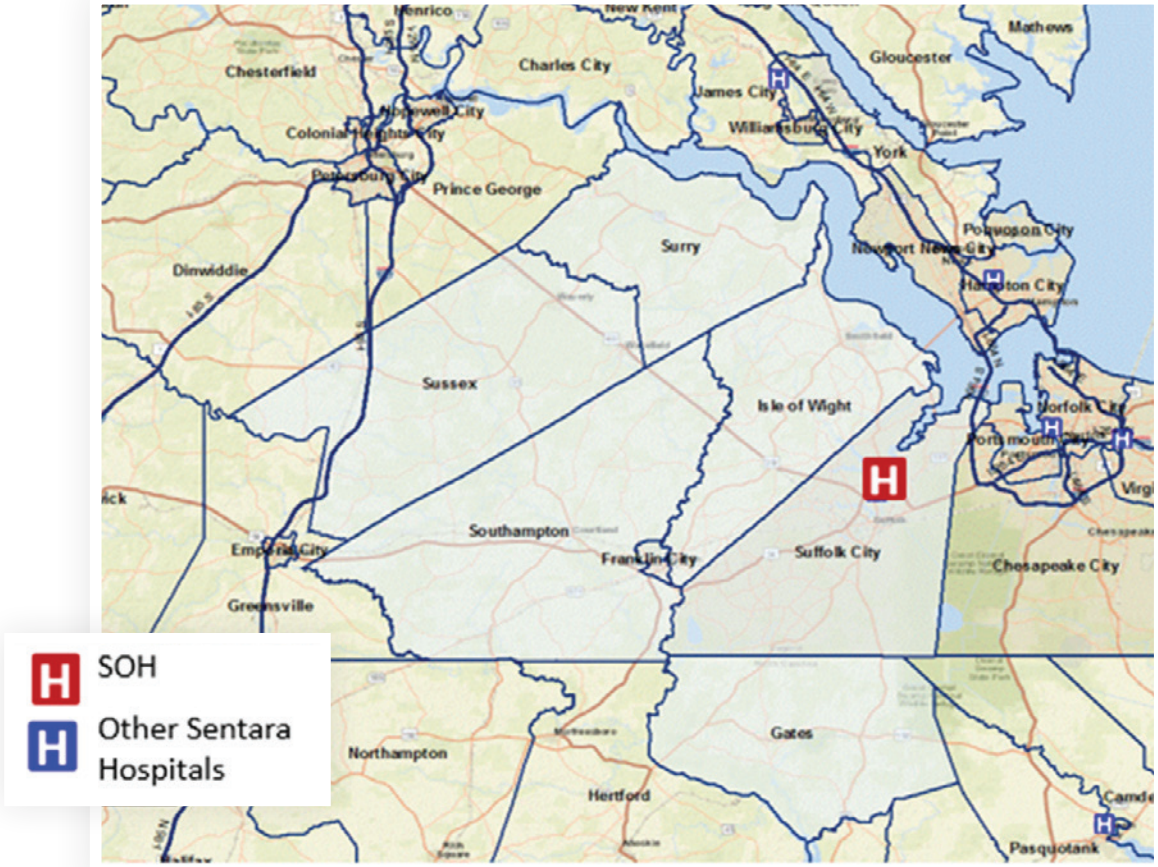
Community input is imperative, so we conducted a survey jointly with Bon Secours Hampton Roads, Children's Hospital of The King's Daughters, Riverside Health System, the Hampton and Peninsula Health Districts, and Three Rivers Health District. The assessment includes survey results from key stakeholders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

## OUR NEXT STEPS

SOH, SBASC, and SOASC work with several community partners to address health needs. Using the information from this community health needs assessment, SOH, SBASC, and SOASC will develop an implementation strategy to address the identified health problems. SOH, SBASC, and SOASC will track the progress of the implementation activities to evaluate the impact of these actions. The implementation progress report for the 2019 CHNA is available at the end of this report.

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

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




*THE SENTARA OBICI HOSPITAL, SENTARA BELLEHARBOUR ASC, SENTARA OBIC ASC SERVICE AREA* ***SOURCE: TRUVEN/MARKET EXPERT***

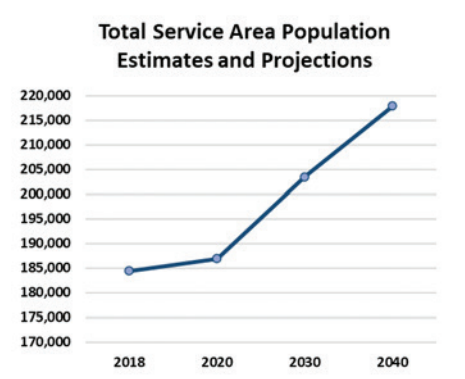
# COMMUNITY DESCRIPTION

## GEOGRAPHY

The service area of SOH, SBASC, and SOASC is comprised of seven localities: the Cities of Suffolk and Franklin as well as the Counties of the Isle of Wight, Southampton, Gates County, NC, Sussex, and Surry. Suffolk is the most populous locality in the service region, followed by Isle of Wight. The other localities, Sussex, Southampton County, The City of Franklin, Surry County and Gates County, NC, are rural with small populations scattered throughout the area.

## POPULATION CHANGE

The Suffolk area has experienced a population growth of 4.6% since 2010. The rural portions of the service area, like much of Virginia and the United States, have experienced population decline– a trend that is projected to continue. The overall service area is enjoying a healthy population growth, primarily driven by Suffolk's 10.3 growth since 2010 and Isle of Wight's growth of 8.6%. The other communities continue to decrease in population.




*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 Office of State Budget and Management; County/State Population Projections*

## COMMUNITY SPECIFIC DEMOGRAPHICS (APPENDIX A)

***City of Franklin*** has 8,180 residents with 18.1% of this population living in poverty and 9% uninsured. Of the population in this city, 27.8% are ages 0-19, 16.0% are ages 20-34, 36.1% are ages 35-64, 17.3% are ages 65-84, and 2.8% are aged 85 and over. 87.5% of the residents primarily speak English, while 12.5% speak another language in the home. The ethnicity for this population includes 66.3% white, 19.0% African American, 8.2% Hispanic, and 6.7% Asian.

***County of Isle of Wight*** has 38,606 residents with 7.6% of this population living in poverty and 9% uninsured. Of the population in this county, 22.4% are ages 0-19, 14.0% are ages 20-34, 43.2% are ages 35-64, 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.

***County of Southampton*** has 17,996 residents with 12.5% of this population living in poverty and 11% uninsured. Of the population in this county, 21.2% are ages 0-19, 13.0% are ages 20-35, 45.2% are ages 35-64, 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.

***City of Suffolk*** has 94,324 residents with 9.0% of this population living in poverty and 9% uninsured. Of the population in this county, 30.3% are ages 0-19, 17.5% are ages 20-34, 40.3% are ages 35-64, 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.

***County of Surry*** has 6,561 residents with 11.6% of this population living in poverty and 10% uninsured. Of the population in this county, 20.2% are ages 0-19, 14.3% are ages 20-34, 43.6% are ages 35-64, 19.8% are ages 65-84, and 1.9% are aged 85 and over. 95.3% of the residents primarily speak English, while 4.7% speak another language in the home. The ethnicity for this population includes 55.2% white, 41.5% African American, 2.7% Hispanic, and 0.5% Asian.

***County of Sussex*** has 10,829 residents with 18.9% of this population living in poverty and 13% uninsured. Of the population in this county, 17.2% are ages 0-19, 22.4% are ages 20-34, 41.5% are ages 35-64, 17.1% are ages 65-84, and 1.7% are aged 85 and over. 95.3% of the residents primarily speak English, while 4.7% speak another language in the home. The ethnicity for this population includes 41.3% white, 56.1% African American, 3.3% Hispanic, 0.6% American Indian, and 0.5% Asian.

***County of Gates, NC*** has 10,478 residents with 13.2% of this population living in poverty and 11% uninsured. Of the population in this county, 17.8% are ages 0-19, 21.7% are ages 20-34, 36.8% are ages 35-64, 19.0% are ages 65-84, and 2.9% are aged 85 and over. 98.2% of the residents primarily speak English, while 1.8% speak another language in the home. The ethnicity for this population includes 65.3% white, 31.2% African American, 2.4% Hispanic, 0.6% American Indian, and 0.3% Asian.

*Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219*
*Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org*
*Office of State Budget and Management; County/State Population Projections; for Gates Count, NC*

## POPULATION HIGHLIGHTS

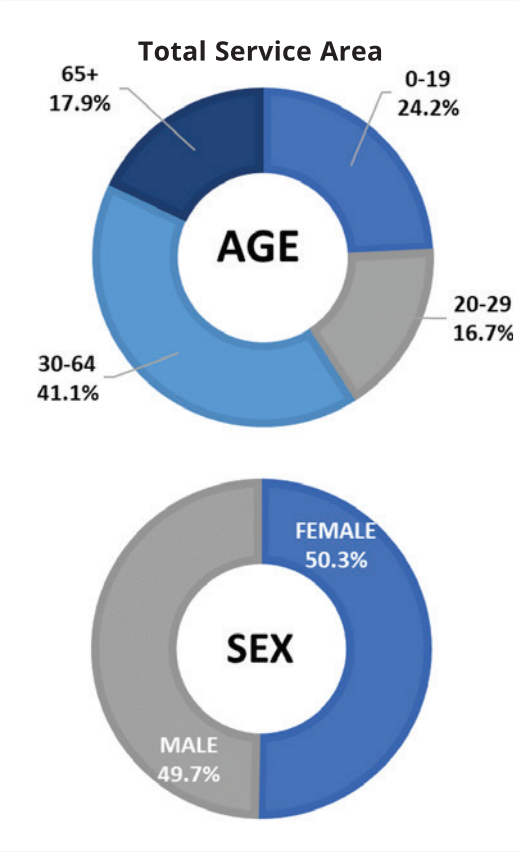
The combined population of the service area is approximately 186,974 people, with 50% of the population concentrated in the City of Suffolk.

### *Age and Sex*

There is a slightly higher percentage of residents aged 65+ than the state overall. Suffolk has the highest number of the senior population with 14,656 residents aged 65+. Out of the 186,974 community members living in the service area, most residents are between the ages of 34-64. The service area has a higher percentage of residents aged 65+ than the state. Gates County, NC and Franklin City have the highest percentage of the very elderly, aged 85+. The service area also has a higher percentage of young adults than the state overall.

Surprisingly, Franklin has the highest percentage of children under the age of 18, higher than the state at over 21.8%. There were 2,023 babies born in the service area in 2020. The majority of the births were in Suffolk.

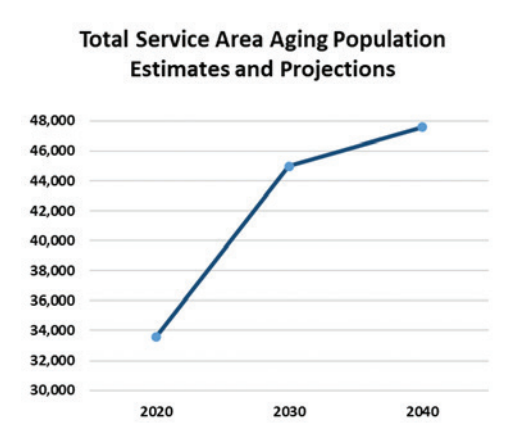
Similar to state demographics, there is a slightly higher percentage of residents born as female in the entire service area with Sussex and Southampton having slightly over half of the residents born as male.




### *Aging Population*

It is well understood that older individuals are more likely to need more health care services, and a variety of services are targeted toward that population. The population of the service area is older than the state average with continued growth of the older population projected into 2040. Research shows that the highest utilization of medical services is among elderly populations. Within this service area, the percentage of very elderly is highest in Franklin City and Gates County, NC.

In 2020, 18% of the population living in the service area was age 65+. In 2020 in the Commonwealth of Virginia, 15.9% of the population was 65+. By 2030, the population of older adults in the service area is projected to be 22.1%. This shows the number of older adults increasing in the next 10 years. The very elderly population in Gates County, NC, is projected to grow by 1.9% by 2040. Despite that projected growth, Gates County is only projected to have 451 residents aged 85+ in 2040, which is relatively low compared to the 2,693 very elderly residents projected for Suffolk.




*Source: Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org; Office of State Budget and Management; County/State Population Projections for Gates County, NC*

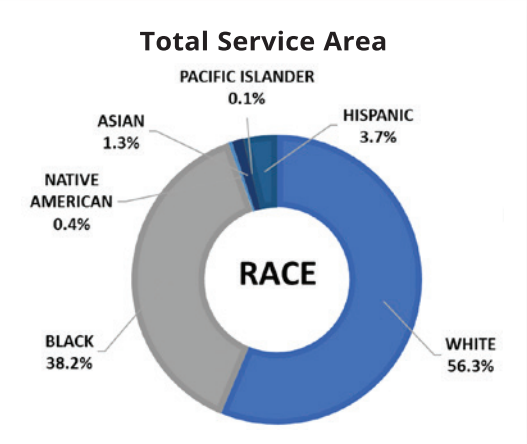
### *Other Demographic Features*

At 10.6%, the percentage of the population who are veterans is higher in the service area than the average in Virginia (7.9%). 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 lower percentage of owner-occupied homes in Franklin compared to the state. In the rural communities, fewer households have computers and internet access, impacting remote learning opportunities and outcomes during the COVID-19 pandemic. A higher percentage of the population has a disability than in the state. This is indicated both for children, working age adults and the elderly. Franklin, Southampton, Surry, Sussex and Gates County, NC have a higher percentage of persons living in poverty, with the service area having a lower percentage of residents with college degrees when compared to the state overall.

## COMMUNITY DIVERSITY PROFILE

### *Ethnicity*

The population of the service area is overwhelmingly white and black, with Suffolk and Isle of Wight being more diverse (7.1% and 5% combined non-white or black respectively) followed by Sussex at 4.4%. All other localities have no more than 4% combined non-white or black population. Suffolk, Isle of Wight, and Franklin Counties have very small Asian populations, but by far the largest point of diversity in the service area is the percentage who identify as multiracial in Franklin (4.1%), which has a higher percentage than the state (3.2%).



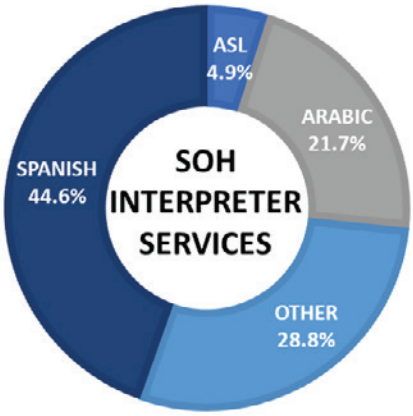

The service area has a small Hispanic population, with Suffolk home to the largest Hispanic community with 4.7% of the population followed by Isle of Wight with 3.4% and Sussex with 3.3%. No other community in the service area has more than approximately 3% Hispanic population, roughly a third of the percentage of the state's Hispanic population at 9.8%.

### *Preferred Language*

English is the primary language spoken in the service area. As of 2020, 95.6% of the population being served identified as English speaking. Per the 2014 American Community Survey five-year estimates, Spanish was the second language identified in the community being served.

### *Cultural and Linguistic Needs*

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




**Source: SOH 2021 Sentara Language Line Usage Report**

Departments within Sentara, SOH, SBASC, and SOASC work closely with one another to ensure all communication to members is in the preferred language, offering interpreter services when needed. Sentara provides its patients and their families with qualified interpreters for languages other than English, as well as American Sign Language (ASL). In 2021, SOH had 1,214 requests for interpreter services. The highest percentage of interpreter services were for Spanish speaking individuals.

### *Health Equity*

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

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.

***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*

Priorities include measurement of disparities and contributing factors 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, prevalence of prostate and breast cancers in communities of color, utilization rates for treatments, and development of initiatives for communities of color, immigrants, patients who are unsheltered and other marginalized groups, including LGBTQ+ persons and individuals with disabilities.

## SOCIAL DETERMINANTS OF HEALTH

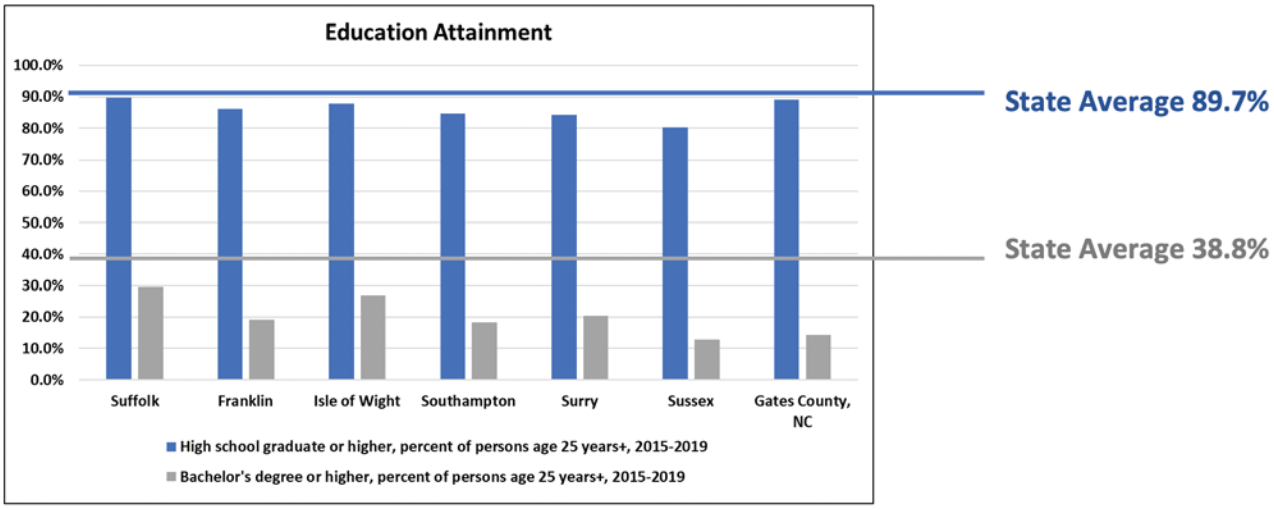
Sentara is about transforming the lives of our neighbors by focusing on the root factors that affect our health beyond the clinical care we receive.

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.

### *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. The Sentara Obici Hospital service area has a lower percentage of individuals aged 25+ with a high school diploma compared to the state overall, while Suffolk has the highest percentage of residents with advanced or professional degrees, though only slightly above 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.

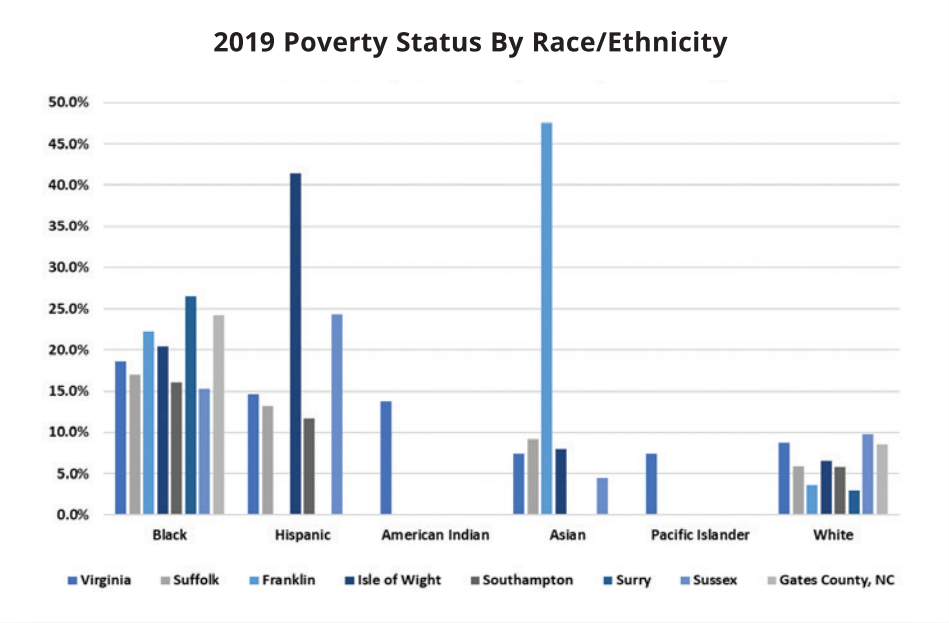
The causes of poverty lead to consequences that make it more likely that the individual – or their offspring – will experience poverty in the future.

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

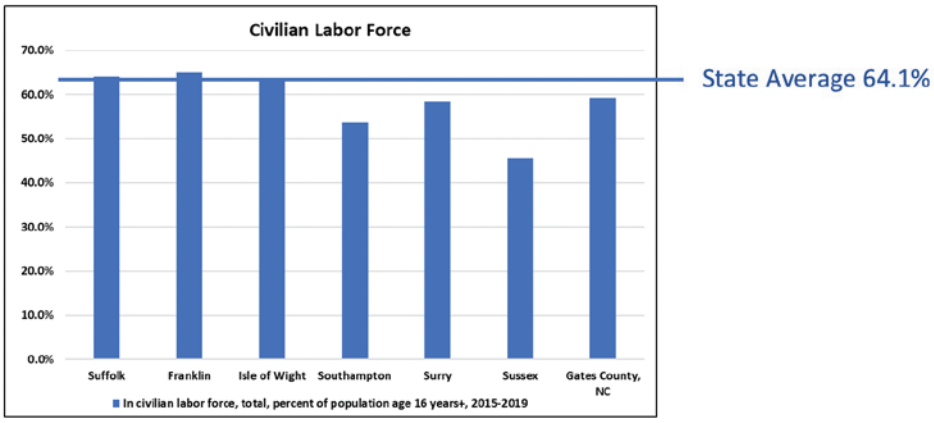



Isle of Wight residents are less likely to live in poverty than other area residents. The poverty rates for Suffolk are closer to the rate for Virginia as a whole. Surry, Sussex, Southampton, Franklin and Gates County, NC residents are more likely to live in poverty than residents of other counties. Franklin and Sussex populations have a higher percentage of persons living in poverty by a significant margin, and an even bigger contrast with the Commonwealth of Virginia overall.

*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. Franklin is slightly above the state average of residents in the civilian labor force. Of those in the civilian labor force, the percentage of female residents is higher than the state in Franklin and Suffolk.




### *Medicaid & FAMIS, Medicare, Medicare & Medicaid Enrollment*

Out of the 626,398 members newly enrolled in Medicaid in the Commonwealth of Virginia, 463,967 are below 100% of the federal poverty level and 162,431 are between 101-138% of the federal poverty level. The total service area has a higher percentage of members on Medicaid compared to Virginia overall, with the highest percentage living in Franklin and Sussex. The number of residents living in the service area receiving Medicaid services continues to increase each year, with an increase of 17.9% since January 2020.

In 2019, there were 27,668 community members age 65+ living in the service area receiving Medicare and 2,057 receiving both Medicare and Medicaid. As the aging population grows in this service area, so will the need for these services.

| Medicaid Enrollment 2022/ Medicare and Medicaid 65+ 2019 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Virginia | Total Service Area | Suffolk | Franklin | Isle of Wight | Southampton | Surry | Sussex | Gates County, NC |
| Medicaid Enrollment (Below 138% FPL) | 626,398 | 17,614 | 6,807 | 1,151 | 2,335 | 1,949 | 627 | 2,304 | 2441 |
| Medicaid Percentage | 7.2% | 9.4% | 7.2% | 14.0% | 6.0% | 10.8% | 9.5% | 21% | 23.0% |
| 65+ Medicare | 802,949 | 27,668 | 7,757 | 9,560 | 4,254 | 2,239 | 4,055 | 1,386 | 1,596 |
| 65+ Medicare Percentage | 64.5% | 67.7% | 61.8% | 75.8% | 63.8% | 70.4% | 61.8% | 74.8% | 70.7% |
| 65+ Medicare/Medicaid | 56,810 | 2,057 | 820 | 388 | 373 | 200 | 387 | 120 | 72 |
| 65+ Medicare/Medicaid Percentage | 4.6% | 5.8% | 6.5% | 3.0% | 5.5% | 6.2% | 5.9% | 6.4% | 3.2% |
| Persons in Poverty | 9.2% | 10.1% | 9.0% | 18.1% | 7.6% | 12.5% | 11.6% | 18.9% | 13.2% |

*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 Estimates; Centers for Medicare & Medicaid Services 2019; Mapping Medicare Data*

# COMMUNITY INSIGHT

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

## COMMUNITY SURVEY

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

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

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

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

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

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

Healthcare providers and community health centers comprised 43.85% of stakeholders responding to the

survey. Additionally, multiple organizations were represented, each having unique insight into the health factors that impact the community. In total, stakeholders represent hospitals, physician offices, city departments of social services, health departments, and community-based non-profit service organizations. The respondents represented many diverse professional and volunteer fields—from emergency medical providers to pastors and public-school teachers. See Appendix C for the complete survey, the list of types of employers of stakeholder respondents, characteristics of survey respondents and top health concerns identified.

> ***"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***

### *Demographics of Survey Respondents*

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

### *Survey Responses*

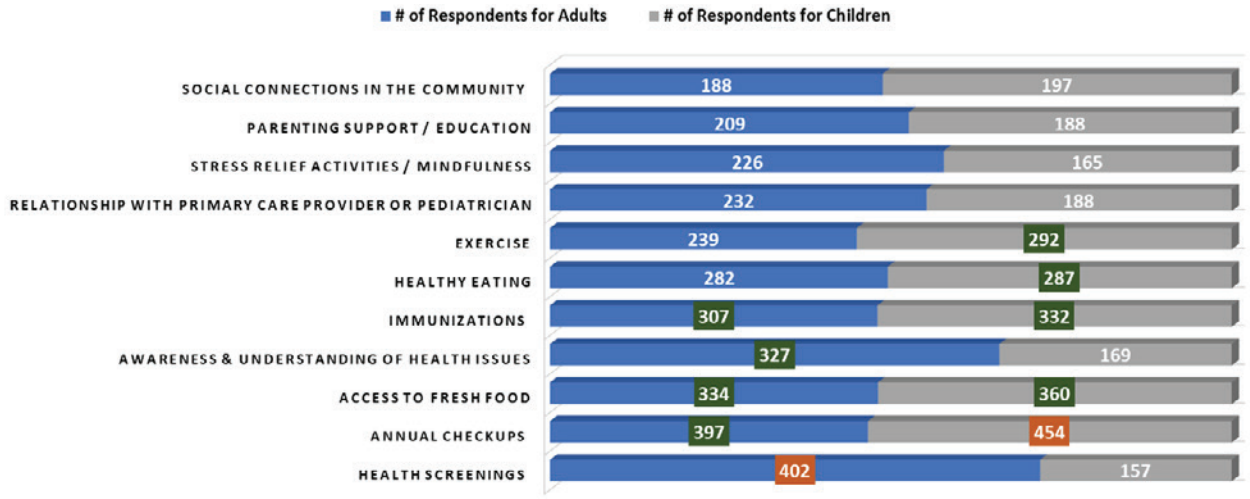
For this CHNA report, we will focus on the below questions asked in the survey. Survey respondents were asked to review a list of common community health issues and select up to three items. The tables below show the answers for each question among stakeholder and community member respondents.

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

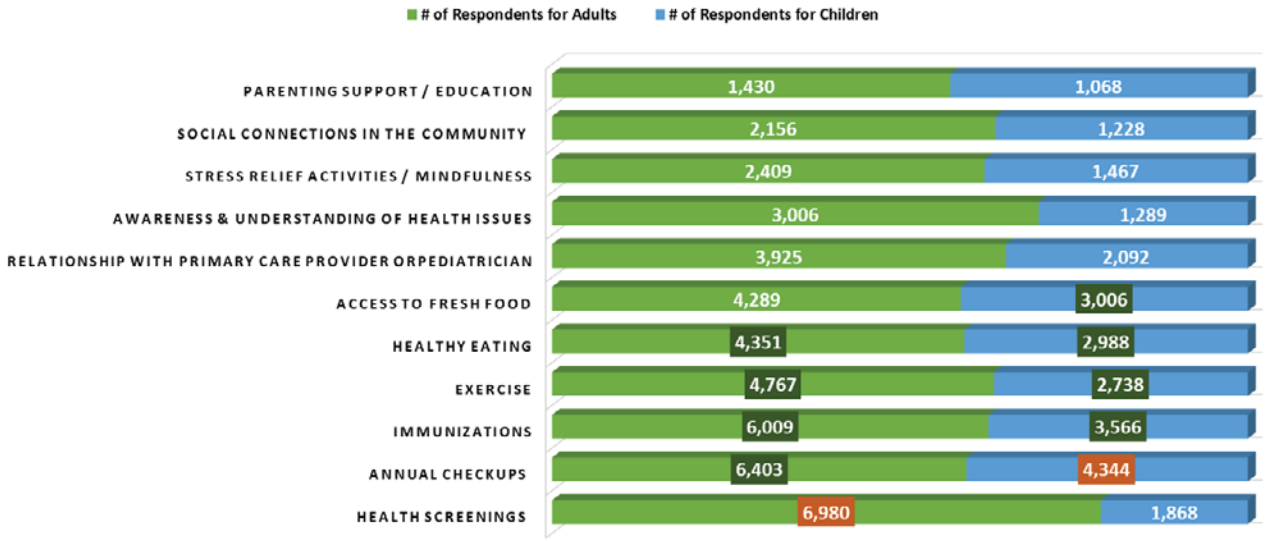
## 1. What is important to the health of adults and children?

Both stakeholder and community member survey respondents chose health screenings such as mammograms, colonoscopies vision exams, and cholesterol checks, annual checkups such as physicals and well child visits, and immunizations such as flu, Tdap, MMR, and 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 such as physicals and well child visits, immunizations for flu, Tdap, MMR, and COVID-19, access to fresh food, healthy eating, and exercise.

### Stakeholder Responses




### Community Member Responses



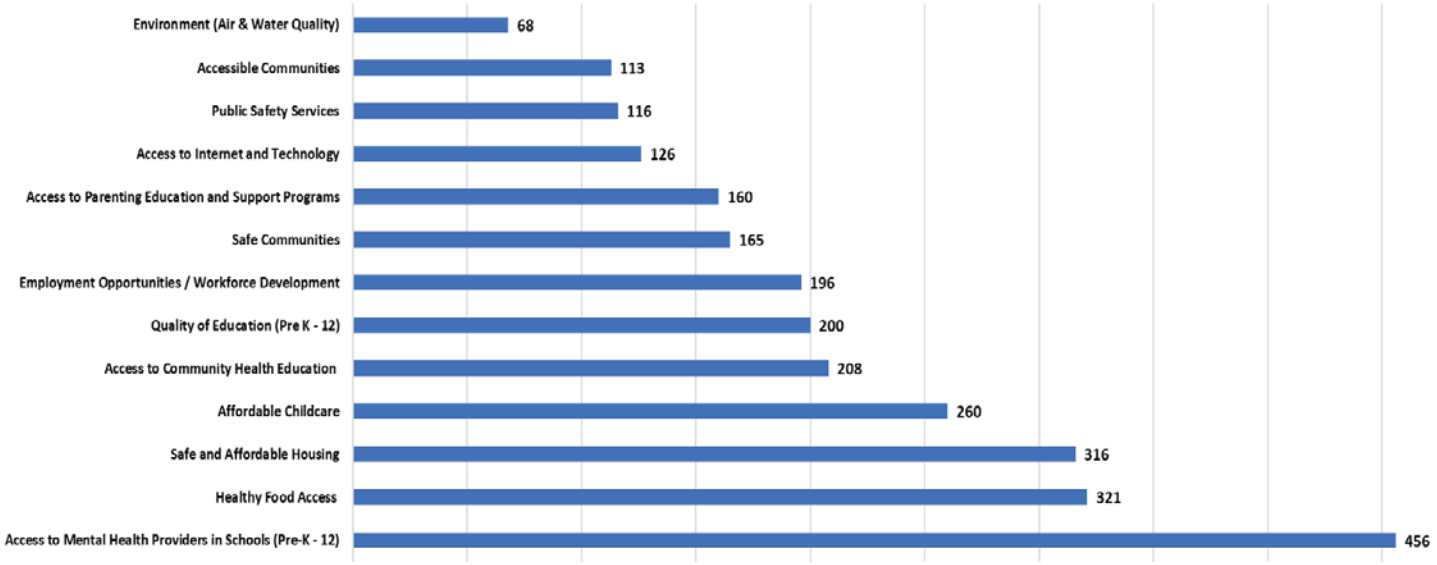

Top item chosen as being a health concern

Top 4 items chosen as being a health concern

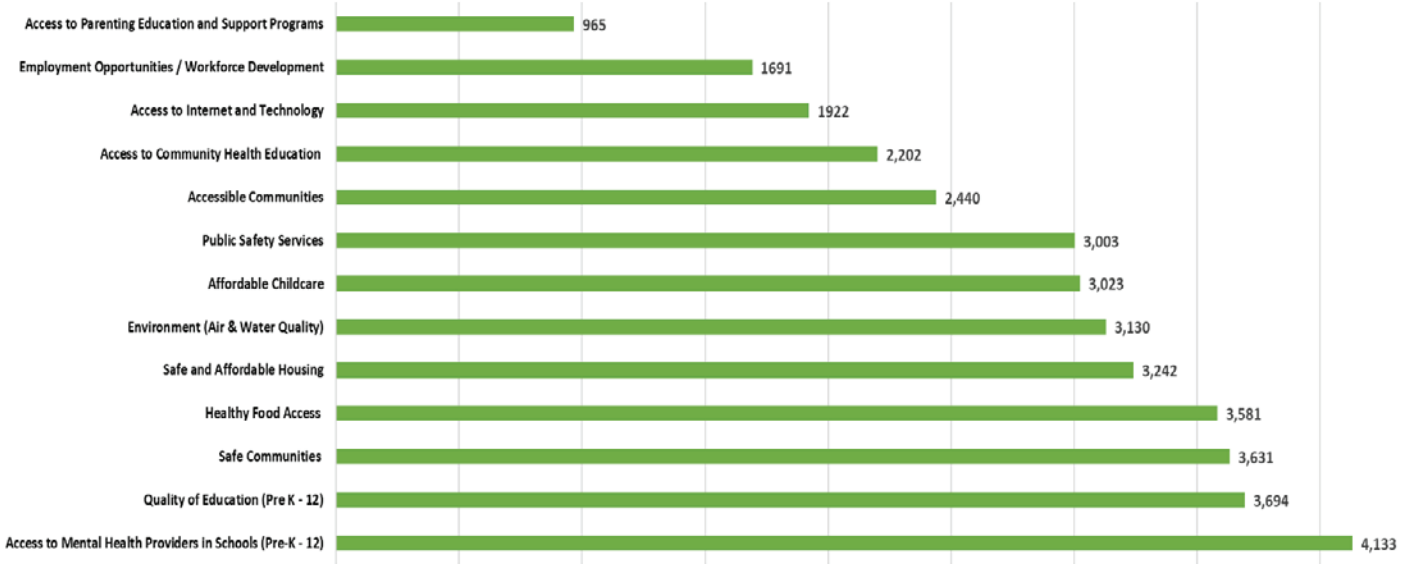
## 2. What should be added or improved in the community to help families be healthy?

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

### Stakeholder Responses




### Community Responses

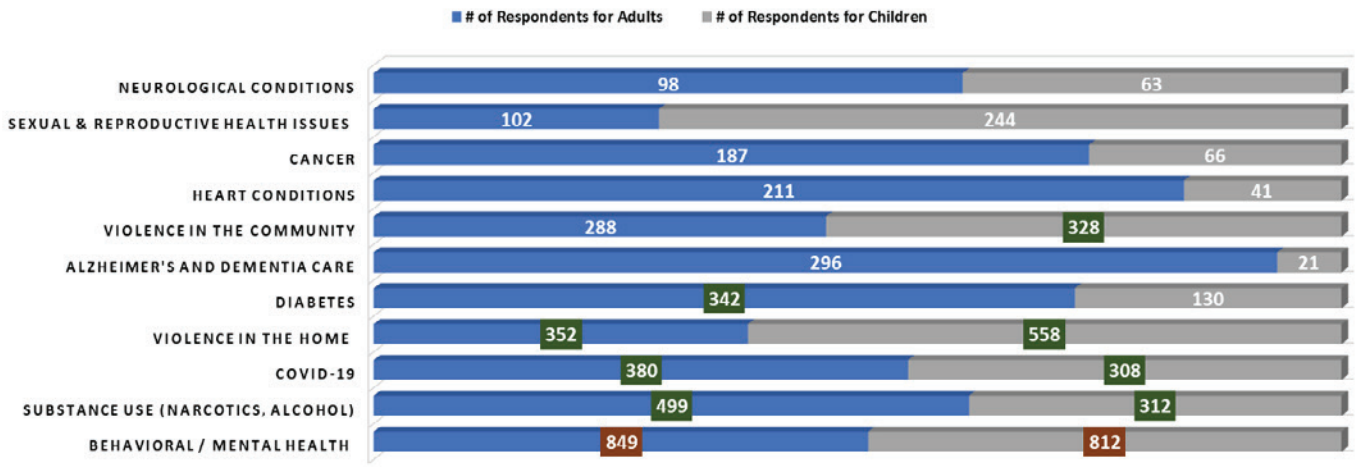


### 3. What are the most important health concerns for adults and children?

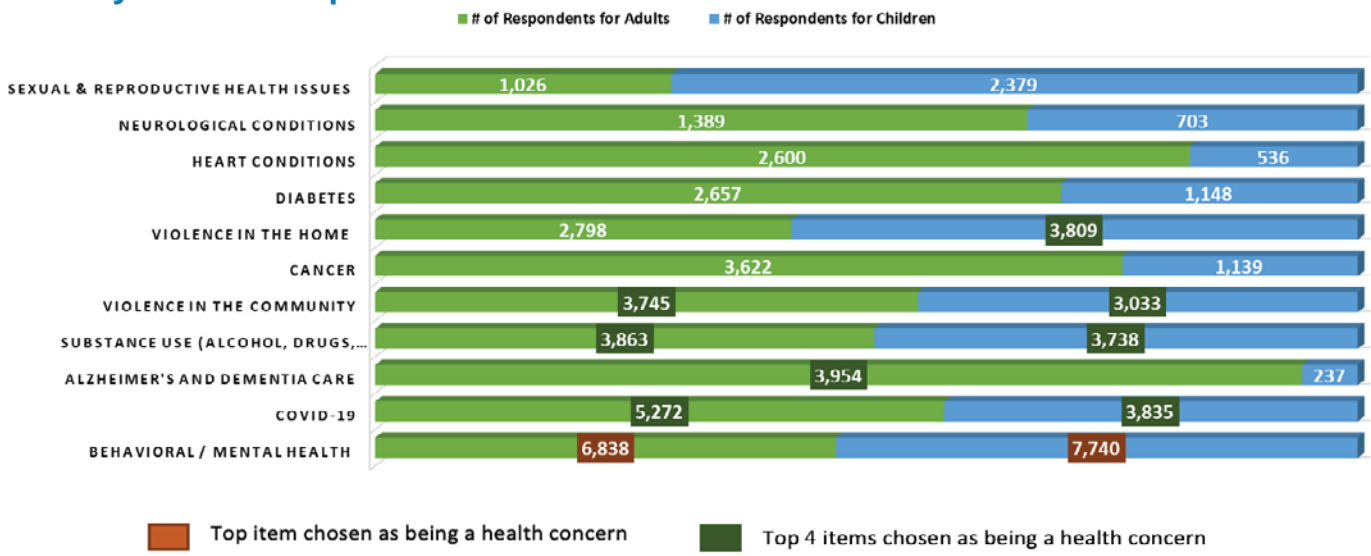
The most frequent response to question 3, see above, was behavioral health, which includes anxiety, depression, psychoses, and suicide, substance use such as narcotics and alcohol, COVID-19, and Alzheimer's and Dementia care. For children, respondents chose behavioral health as defined above, COVID-19, violence in the community, substance use, and sexual and reproductive health issues such as sexually transmitted infections and teen pregnancy as the most pressing health concerns.

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

## Stakeholder Responses



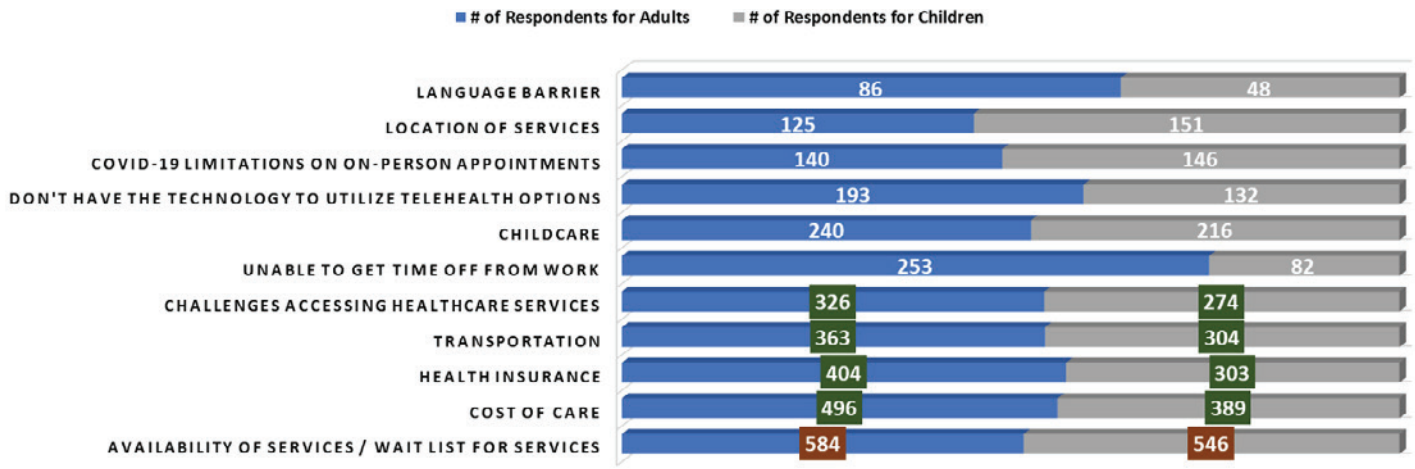

## Community Member Responses



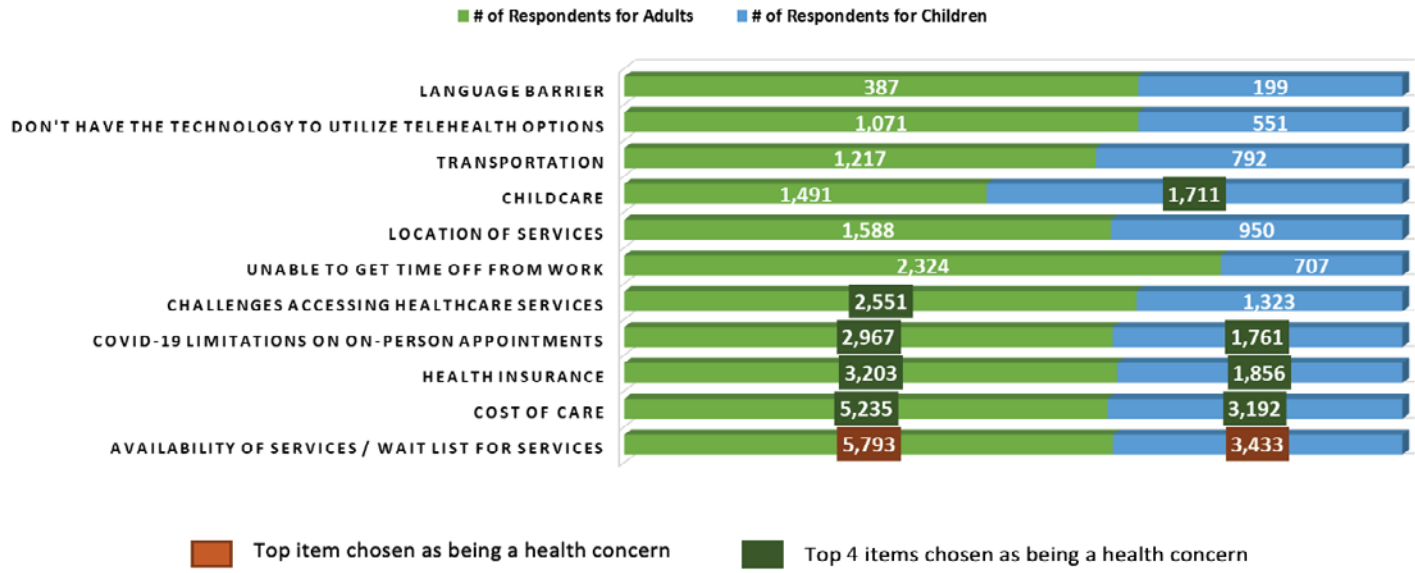
## 4. What makes it difficult to access healthcare services for adults and children?

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

### Stakeholder Responses




### Community Member Responses



As in the current survey, in the 2019 CHNA, survey respondents also chose mental health/behavioral health as a major concern. The pandemic has added additional mental health strain on the U.S. population. Over the past several years, Sentara has worked to address this issue which is near the top of every CHNA both over time and in breadth across the country.

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

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

The survey explored the many factors in addition to medical care that determine an individual's health. Collectively called the social determinants of health, these factors are increasingly becoming recognized as contributing both directly and indirectly to individual health through processes as different as the effect of household mold on respiratory disease and the effect of stress from unemployment. The effects of social determinants are sometimes subtle, sometimes only discoverable after a health problem is identified, yet are 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. Lack of providers and unavailability of providers working extended hours make access less feasible for those who work outside the home or have other scheduling constraints and is the barrier to care voiced most often.

Some aspects of access to care impact population segments differently. Access barriers to care 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, SOH, SBASC, and SOASC carried out a series of more in-depth Community Focus Groups to obtain greater insight from diverse stakeholders and community members.

### *Methodology*

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. 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?

SOH, SBASC, and SOASC held three focus group sessions between March and April 2022. The number of participants ranged from 8-11. When possible, representatives from the health department and other local hospitals were invited to attend the sessions.

### *Focus Groups*

1. 3/9/2022 in person session: Auxiliary Board
2. 3/30/2022 virtual session: Patient Family Advisory Council
3. 4/12/2022 virtual session: Temple Beth El Community Members

### *Demographics*

The 27 participants ranged in age from 17 to over 60. The focus group participants were 63.0% Caucasian and 37.0% African American. The groups included 81.5% female and 18.5% male.

### *Methodology*

Due to the COVID-19 pandemic, most focus groups were held virtually and only in person when safety protocols allowed. Each focus group had a facilitator guiding discussions through the seven previously prepared questions. Additional staff took detailed notes to capture the information shared.

### *Results*

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

| TOPIC | KEY FINDINGS |
|---|---|
| **What are the most serious health problems in our community?** | • Cancer<br>• Dementia<br>• Diabetes<br>• Domestic Violence<br>• Heart Disease<br>• Hypertension<br>• Mental Health<br>• Obesity<br>• Women's Health<br>• Violence |
| **When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?** | • Access to food and healthy food<br>• Education<br>• Housing<br>• Transportation<br>• Access to services<br>• Financial concerns<br>• Lack of options-transportation<br>• Violence<br>• Community Outreach options<br>• Health behaviors<br>• Social SupportViolence |

| TOPIC | KEY FINDINGS |
|---|---|
| **Who has the health problems?**<br>**What groups of individuals are most impacted by these problems?** | • African Americans<br>• Disabled persons<br>• Low-income populations<br>• Under educated<br>• Aging populations<br>• Fixed income<br>• Minorities<br>• Uninsured<br>• Caregivers<br>• Homeless<br>• Rural Communities<br>• Youth |
| **What keeps people from being healthy?**<br>**What are the barriers they face with taking care of their health and accessing care?** | • Access to doctor<br>• Economic status<br>• Lack of mental health providers<br>• Mistrust<br>• Adequate housing<br>• Education<br>• Lack of resources<br>• No insurance<br>• Affordable healthcare<br>• Financial barriers<br>• Lack of social support<br>• Time<br>• Culture<br>• Food insecurity<br>• Loneliness<br>• Transportation |

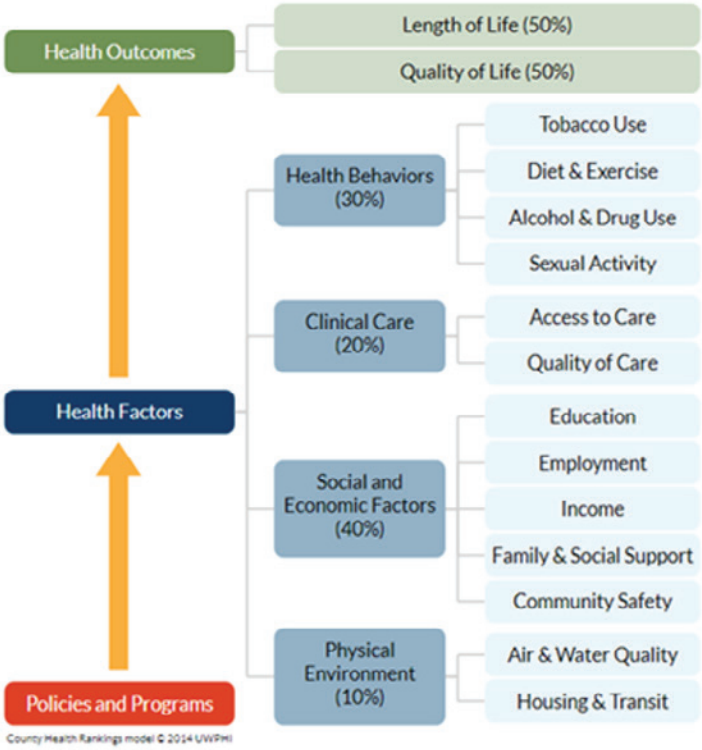
| TOPIC | KEY FINDINGS |
|---|---|
| **What is being done in our community to improve health and reduce barriers?**<br>**What resources exist in the community?** | • Acute care<br>• Flu clinics<br>• Health Fairs<br>• Outreach organizations<br>• Church programs<br>• Food banks and food pantries<br>• Immunization clinics Salvation Army<br>• COVID-19 testing and vaccines<br>• Free clinics<br>• Meals on Wheels<br>• Western Tidewater Free Clinic<br>• Dentistry programs |
| **How has the COVID-19 pandemic worsened the health issues in our community?** | • Access to doctor<br>• Isolation<br>• Reduced physical activity<br>• Virtual Appointments<br>• Delay in screenings<br>• Lack of resources<br>• Scheduling wait lists<br>• Weight Gain<br>• Depression<br>• Misinformation<br>• Substance use, alcohol use<br>• Wait times<br>• Food insecurity<br>• Mistrust in healthcare |

| TOPIC | KEY FINDINGS |
| --- | --- |
| **What more can be done to improve health, particularly for those individuals and groups most in need?**<br>**Are there specific opportunities or actions our community could take?** | • Affordable Healthcare<br>• Community Events<br>• Health Fairs<br>• Outreach Programs<br>• Better Access<br>• Community Navigators<br>• Mobile Clinic<br>• Screening Events<br>• Built Environment<br>• Health Education<br>• Neighborhood Events<br>• Wellness Education |

# HEALTH STATUS INDICATORS

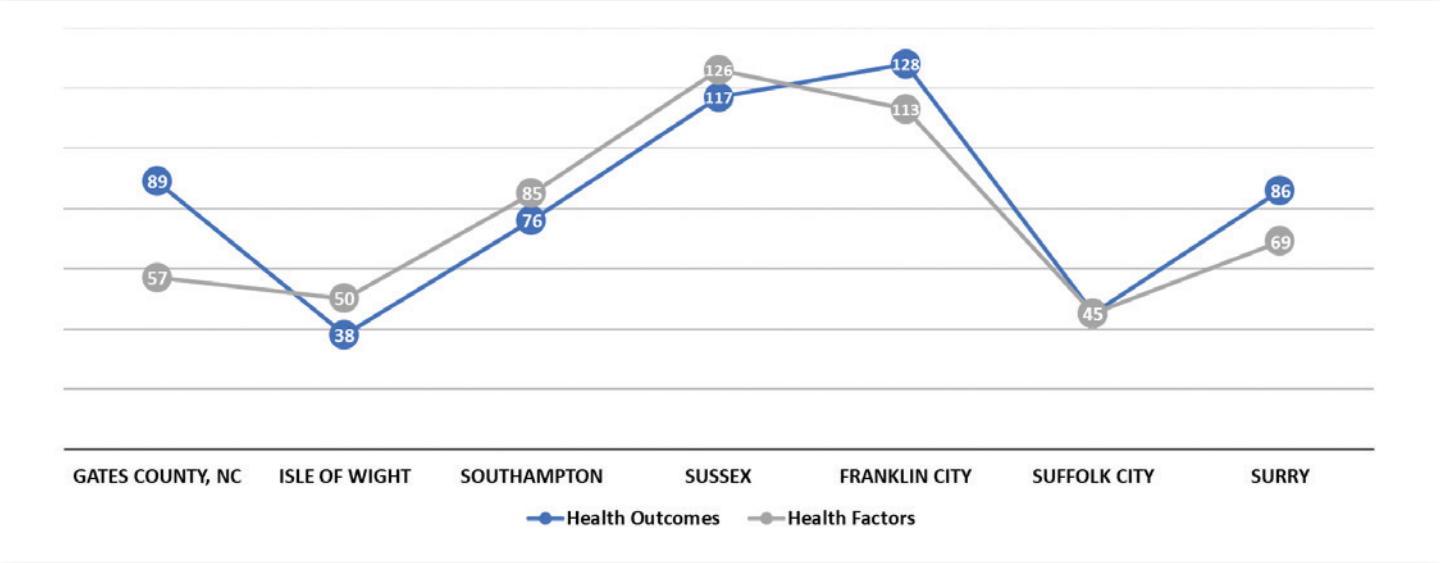
## *County Health Rankings*

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




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

The graph below shows the Health Outcomes Rank and Health Factors for the communities in the service area. Surry, Suffolk, and Isle of Wight rank better for health factors and outcomes while Franklin City, Sussex and Southampton rank worse out of 133 Virginia counties (Appendix B).




*Source: County Health Rankings 2021, Rankings and Documentation;*

## *Health Status Indicators*

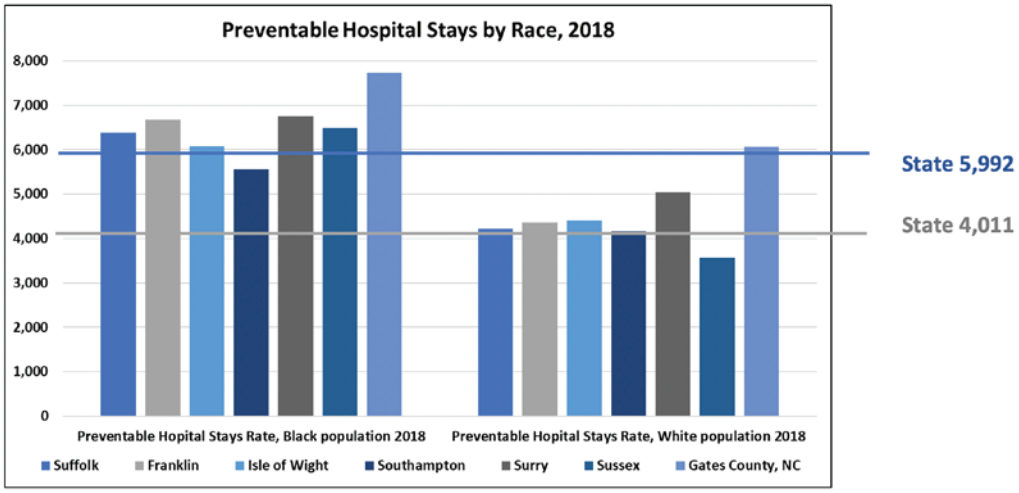
Below are key health status indicators for the counties representing the service area. Links are also included to interactive data dashboards on the Greater Hampton Roads Indicators Dashboard, also known as GHRconnects. There, you can compare indicators like change over time, race/ethnicity, and gender where available, among nearby localities. In addition, more indicators are often available through the link and can be found in Appendix B.

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

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

## ACCESS TO HEALTH SERVICES PROFILE

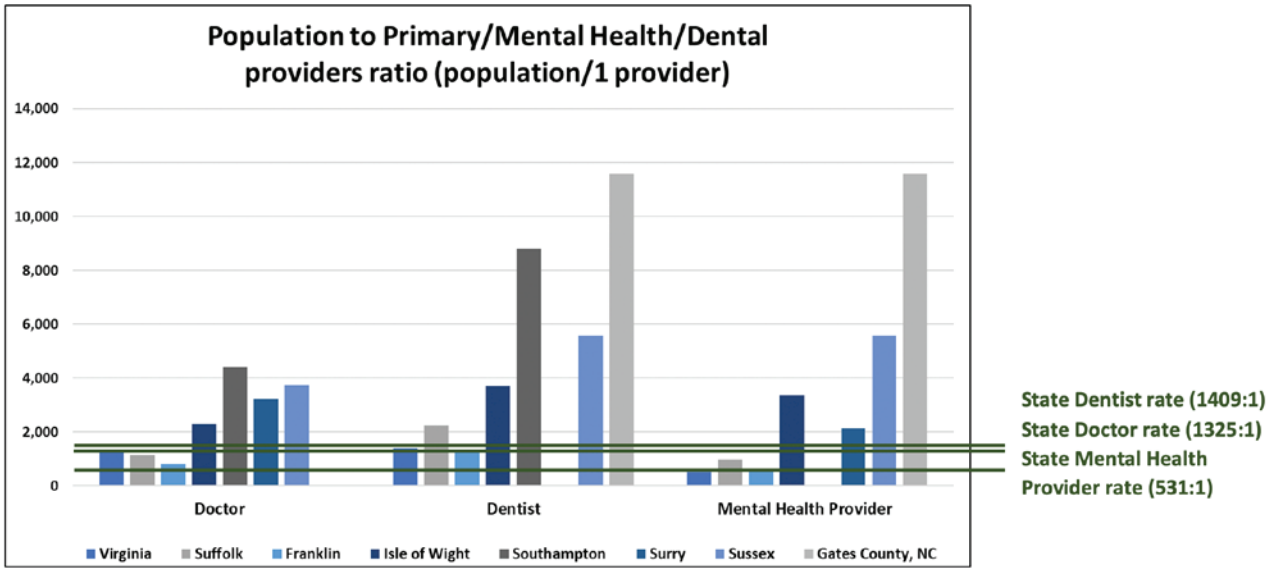
Access to quality and affordable health care is important to an individual's health. Health insurance and local care resources can ensure access to care. If outpatient care in a community is poor, then people may be more likely to overuse the hospital as their main source of care, resulting in unnecessary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




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

### *Provider Ratio*

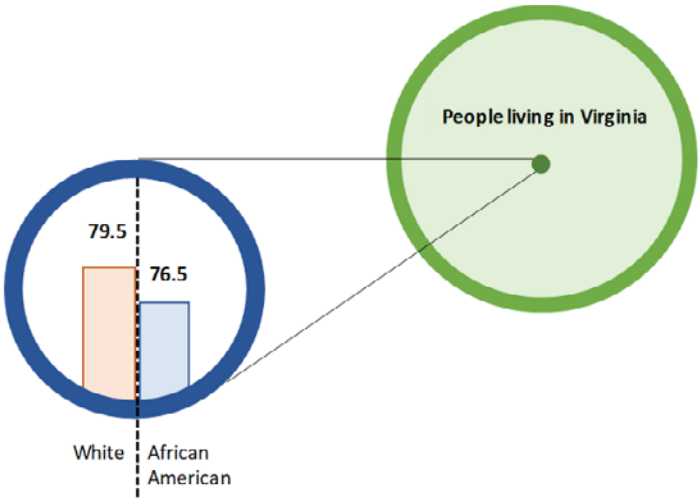
The ratios of primary care and dental care providers were examined in the Sentara Obici Hospital service area. The ratios for population to primary care providers were higher than the state (1325:1) in some of the localities in the service area. The population ratio for dental care providers was also higher than the state in some localities (Appendix B) (1409:1). Fewer providers suggest 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. The preventable hospital stay rate among Medicare beneficiaries was highest in Southampton, followed by Gates County, NC, Southampton, Franklin, and Suffolk, which suggests that there may be challenges with access to primary and outpatient care. Data also shows a disparity among African American beneficiaries.




*Source: County Health Rankings 2021, Rankings and Documentation;*

## MORTALITY PROFILE

The life expectancy for a person living in the Commonwealth of Virginia is 79.5. Isle of Wight is the only city with a slightly higher life expectancy than the state at 80.5. It is important to note that there is a disparity with life expectancy among African American populations. The life expectancy for African Americans is one to 2.2 years shorter than white Americans in the service area (Appendix B).




Leading causes of death in localities of the service area were examined. In 2019, cancer, heart disease, and accidents were the top three causes of death in the service area, as well as in the state. In Isle of Wight, Southampton, Sussex, and Suffolk, cancer was the leading cause of death, followed by heart disease. For Franklin, Surry, and Gates County, NC, heart disease was the leading cause of death, followed by cancer.

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. Data for Gates County were compared to death rates for North Carolina and are not captured in the total service area column.

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

| | Crude Death Rate | All Causes | Cancer | Heart Disease | Respiratory Diseases | Accidents | Stroke | Alzheimer's Disease | Diabetes | Suicide | Chronic Liver Disease | Hypertension and Renal Disease |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Gates County, NC*** | Prevalence Rate | 1,178 | 216.23 | 268.12 | 69.19 | 69.19 | 25.94 | 69.19 | 60.54 | 17.29 | 25.95 | 40.03 |
| | Number of Deaths | 139 | 25 | 31 | 8 | 8 | 3 | 8 | 7 | 2 | 3 | 5 |
| **State of North Carolina*** | Prevalence Rate | 913.8 | 190.34 | 187.43 | 51.59 | 44.65 | 49.61 | 42.98 | 29.81 | 13.01 | 19.01 | 23.34 |
| | Number of Deaths | 95,951 | 19,963 | 19,661 | 5,411 | 4,683 | 5,203 | 4,508 | 3,127 | 1367 | 1,997 | 2451 |
| **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 | 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 | 190 | 42 | 41 | 10 | 11 | 13 | 6 | 5 | 4 | 1 | 2 |
| **Sussex** | Prevalence Rate | 1,344 | 340.5 | 259.9 | 35.8 | 98.6 | 71.7 | 17.9 | 62.7 | 17.9 | 17.9 | 17.9 |
| | Numerator | 150 | 38 | 29 | 4 | 11 | 8 | 2 | 7 | 2 | 2 | 2 |
| **Surry** | Prevalence Rate | 1152.3 | 186.9 | 264.7 | 62.3 | 124.6 | 46.7 | 31.1 | 31.1 | 15.6 | * | * |
| | Numerator | 74 | 12 | 17 | 4 | 8 | 3 | 2 | 2 | 1 | | |
| **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 | 136 | 24 | 35 | 3 | 2 | 15 | 7 | 5 | 1 | 2 | |
| **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 | 804 | 179 | 172 | 42 | 36 | 43 | 28 | 37 | 11 | 10 | 3 |
| **Virginia** | Prevalence Rate | 823 | 176 | 176.1 | 42.9 | 46.8 | 44.7 | 30.8 | 27.5 | 13.3 | 12.1 | 9.6 |
| | Numerator (count) | 70,242 | 15,024 | 15,035 | 3,662 | 3,993 | 3,819 | 2,626 | 2,351 | 1,135 | 1,037 | 816 |

**Prevalence Rate**

450 — 0

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

## HOSPITALIZATIONS FOR CHRONIC AND OTHER CONDITIONS PROFILE

SOH, SBASC, and SOASC examined the age-adjusted hospitalization rates for the service area. For the top conditions seen in hospitals, heart conditions and mental health conditions were the highest rated in the service area with Franklin followed by Suffolk 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 rate for Virginia overall (except in Isle of Wight and Southampton County). Other top conditions included diabetes and substance use.

## RISK FACTOR PROFILE

The percentages of smokers and people experiencing mental health distress were higher for all localities in the service area compared to Virginia and the United States values. Conversely, the percentage of adults who drink alcohol excessively was higher in Southampton and Isle of Wight compared to the Commonwealth of Virginia and the U.S., but slightly lower throughout the other localities.

The percentages of obesity and physical inactivity were also higher in all localities compared to Virginia overall. Food insecurity percentages were highest in Franklin, Surry, Sussex and Gates County, NC, and higher than the state percentage of 10%. Limited access to healthy food was highest in Franklin at 28% followed by Sussex at 18% and 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.

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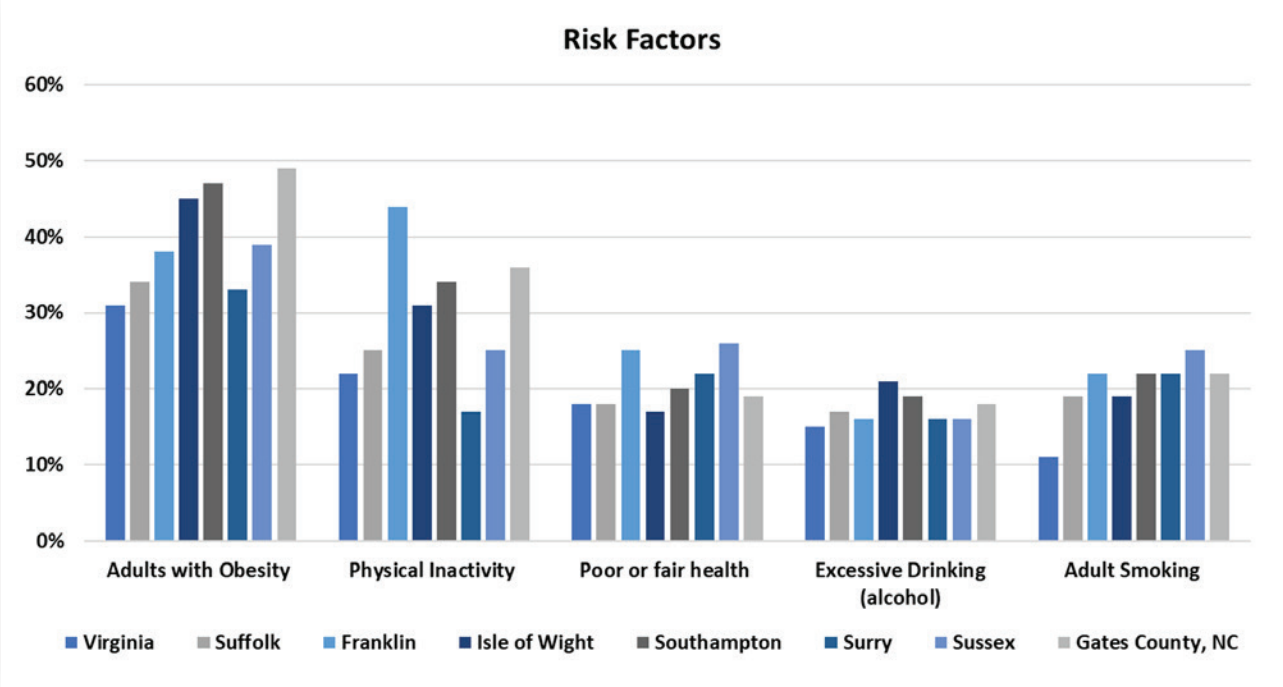
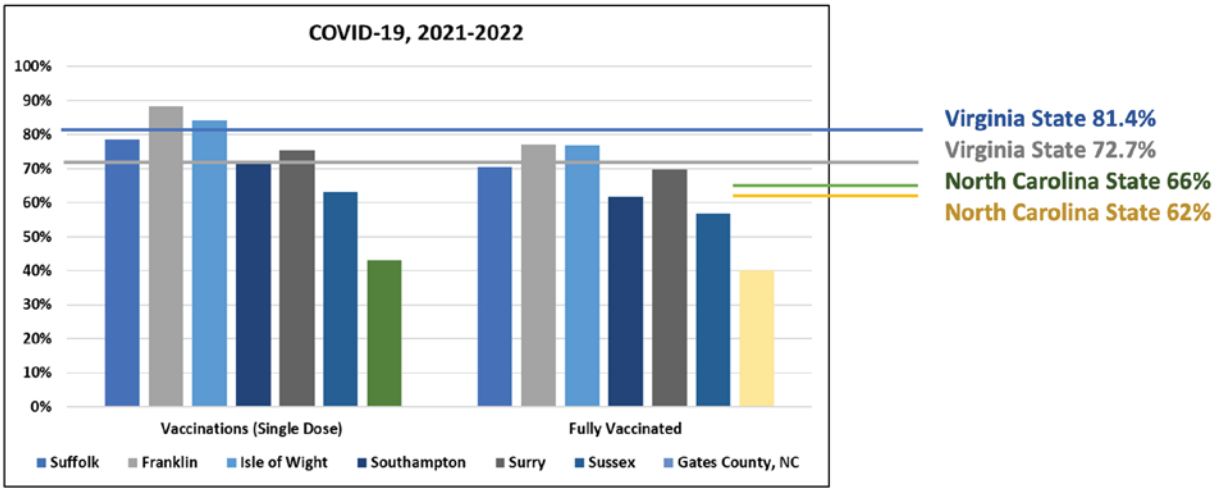



*Source: County Health Rankings 2021, Rankings and Documentation*

## COVID-19 PROFILE

In 2020, the nation faced the COVID-19 pandemic. This contagious disease impacted the health of the 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 and April 1, 2022, the Commonwealth of Virginia had 1,669,750 COVID-19 cases and 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, Franklin 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 the Commonwealth of Virginia, residents of the service area had high percentages of babies born with low and very low birthweights, except for Isle of Wight. Franklin and Southampton had the highest percentages of low and very low birthweights. The infant mortality rate was also greater in the localities compared to Virginia overall, except for Isle of Wight, 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, Coronavirus disease (COVID-19); Virginia Department of Health, COVID-19 Data in Virginia, Dashboard; Virginia Department of Health Division of Health statistics North Carolina DHHS, North Carolina COVID-19 Dashboard*

## OLDER AND AGING ADULTS PROFILE

In many communities, the population of 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. While preventable hospital stays among the Medicare population in the service area were higher than for the state, there may be opportunities to improve primary and outpatient care for this population in the service area.

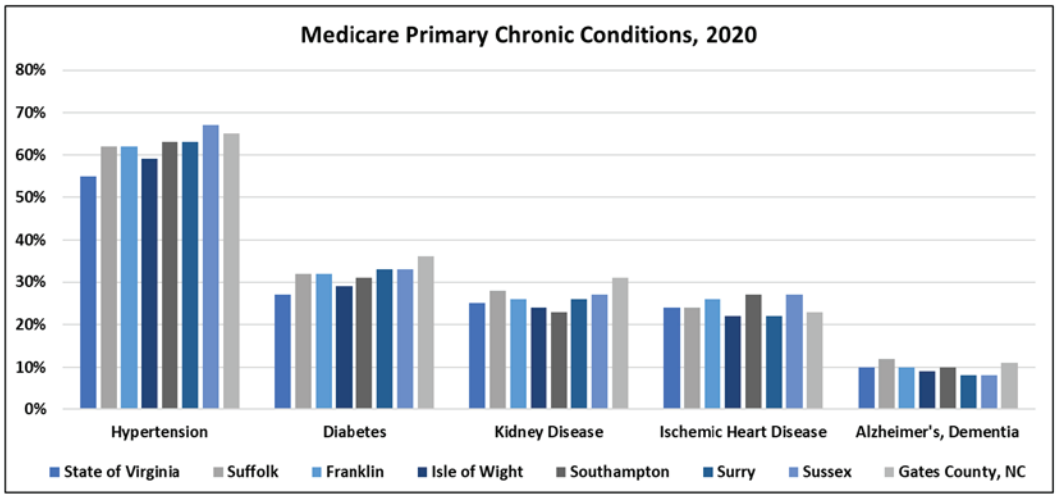
In 2020, hypertension and diabetes were the top conditions diagnosed in Medicare patients in the service area, with a higher percentages than the state. Kidney disease and heart conditions also showed high percentages for the Medicare population utilizing hospital services.

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

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

*Source: Alzheimer's Association, 2022*

Advance Care Plans are for adults to specify their medical wishes and/or designate someone as their legal medical decision-maker in the event they cannot communicate and advocate for themselves. While many team members working within the health care industry understand the importance and value of Advance Care Plans, it is evident within the acute care setting that our community members may not have that same understanding until it is too late. Currently, within the Commonwealth of Virginia, there are 41,380 active registrants with Advanced Care Plans filed within the USLWR (U.S. Living Will Registry). Sentara has 70,236 active registrants with Advanced Care Plans on file within the USLWR with 2,822 of those completed for residents of the service area.




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

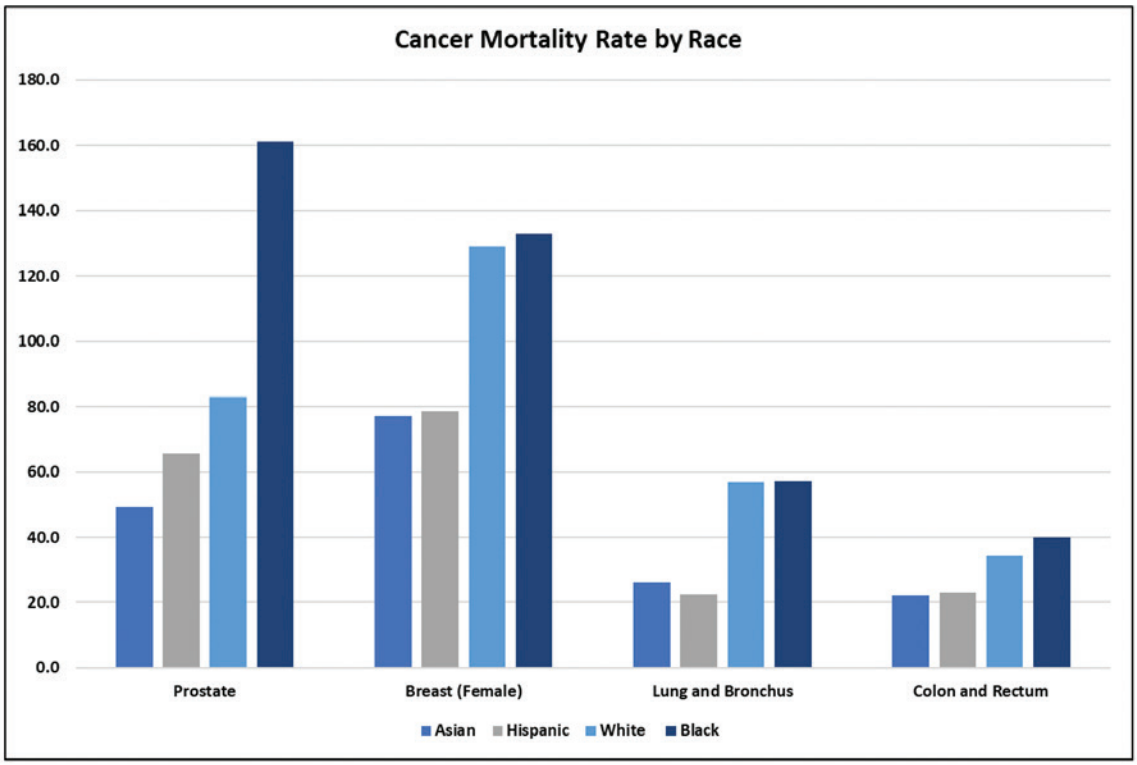
## CANCER PROFILE

Death and incidence rates for a variety of cancer types were examined since cancer is the leading cause of death in the service area. Compared to the previous 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. It is important to note the rates are especially rising for the African American population living in the Commonwealth of Virginia as a whole.

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

*Source: American Cancer Society*

Mortality rates were highest among lung, breast, prostate, and colon cancers, though these are not the only on which Sentara will focus efforts. Localities with the greatest all cancer incidence rates were Franklin followed by Sussex which has a rising rate (Appendix B). Prostate cancer and breast cancer are the leading cause 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, however efforts will need to focus on populations at higher risk of this disease




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

## DIABETES PROFILE

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

The percentage of adults with diabetes living in the Sentara Obici Hospital service area is higher than the state percentage of 8.5%, except for Isle of Wight. The death rate due to diabetes in the service area is also higher than the state, being highest in Franklin. SOH, SBASC, and SOASC examined hospitalization rates due to diabetes and found the age-adjusted hospitalization rates due to diabetes was above the state rate, and highest in Franklin, three times the rate of the state at 20.7. Localities in the service area have high hospitalization rates due to short-term complications of diabetes, and were higher than the state, except in Sussex. Hospitalizations due to long-term complications were highest in Sussex, Franklin, and Suffolk. It is also important to note that the percentage of the Medicare population living in the service area and diagnosed with diabetes is higher than the state overall.

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

*Source: CDC, 2019*

## SURGICAL SITE INFECTIONS PROFILE

Both SBASC and SOASC examined surgical site infections (SSIs). SSIs occur after surgery and in the part of the body where the surgery took place. SSIs can develop within days or even months after surgery. Some patients may be at higher risk for developing an SSI due to their age and underlying medical conditions, such as diabetes and COVID-19 infections. SOH, SBASC, and SOASC will continue to work together to educate patients on the risk factors for SSIs to decrease infection rates.

"Data from AHRQ's Partnership for Patients initiative indicates that the national rate of SSI decreased by 16% between 2010 and 2015, translating into significant benefits for patients (including many lives saved), as well as significant cost savings" (Agency for Healthcare Research and Quality, 2019). Advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, yet SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death in the inpatient setting (National Healthcare Safety Network, OPC-SSI, 2022).

*Data Source: Centers for Disease Control and Prevention, Diabetes; Diabetes Report Card, 2019; Greater Hampton Roads Indicators Dashboard; Agency for Healthcare Research and Quality, Surgical Site Infections*

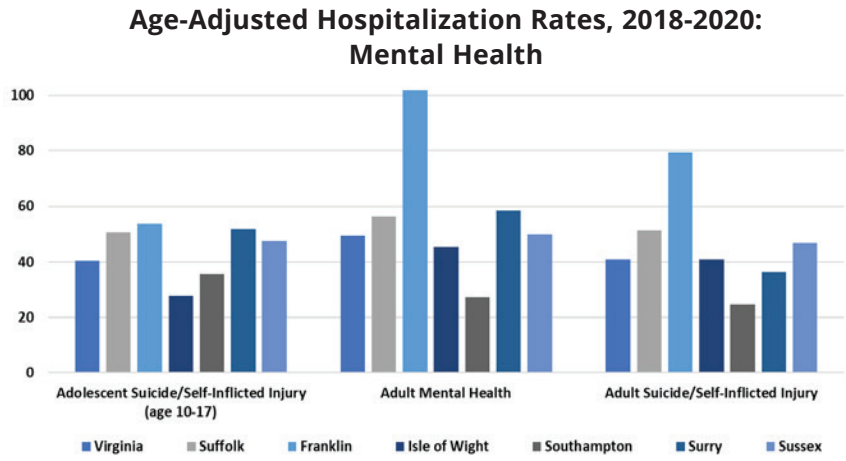
## BEHAVIORAL HEALTH PROFILE

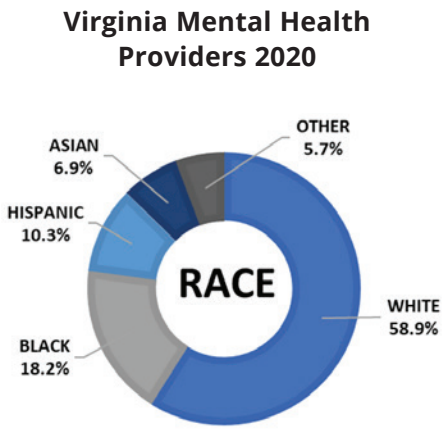
Hospitalization rates due to alcohol/substance use, mental health and suicide/self-intentional injury were examined. Localities in the service area, except Isle of Wright and Southampton, had higher hospitalization rates due to substance use, mental health and suicide/self-intentional injury compared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

Mental health is becoming an increasing health concern for both adolescents and adults. Between 2018 and 2020, the adult mental health rate per 10,000 population was highest in Franklin, followed by Surry, Suffolk and Sussex. Sentara also examined emergency department visits for 2021 to gain a better understanding of the mental health crisis communities have been facing during the COVID-19 pandemic. In 2021, SOH emergency department saw a patient frequency of 1,339 for people, aged 18+, with a behavioral health diagnosis. Of the 1,339 visits, 19.4% presented with suicidal ideations and 8.2% with major depressive disorder.

The adolescent mental health rate is highest in Franklin, Surry, and Suffolk, followed by Sussex. "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). In 2021, SOH saw a patient frequency of 175 for youth, age 0-17, present with a behavioral health diagnosis. Of the 175 visits, 34.2% presented with suicidal ideations and 7.4% with mental disorder.

The mental health rates for this service area are higher than the state overall. The COVID-19 pandemic has worsened mental health among youth and adults with increasing anxiety, depression, and stress. Loss off 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 development of coping skills. The service area has fewer mental health providers per person compared to the state. Gates County, NC (11,562:1), Sussex (5,580:1), Isle of Wight (3,374:1), Surry (2,141:1), have the lowest ratio of providers per person followed by Suffolk (980:1), and Franklin (613:1), (Appendix B). It is also important to note that the mental health workforce is nearing retirement age which will negatively impact provider capacity. There is a need for a more racially and ethnically diverse mental health workforce to provide racially concordant care (Appendix B).




*Source: Greater Hampton Roads, Community Indicators Dashboard; Source: Virginia Health Care Foundation*

## COMMUNITY VIOLENCE AND GUN VIOLENCE PROFILE

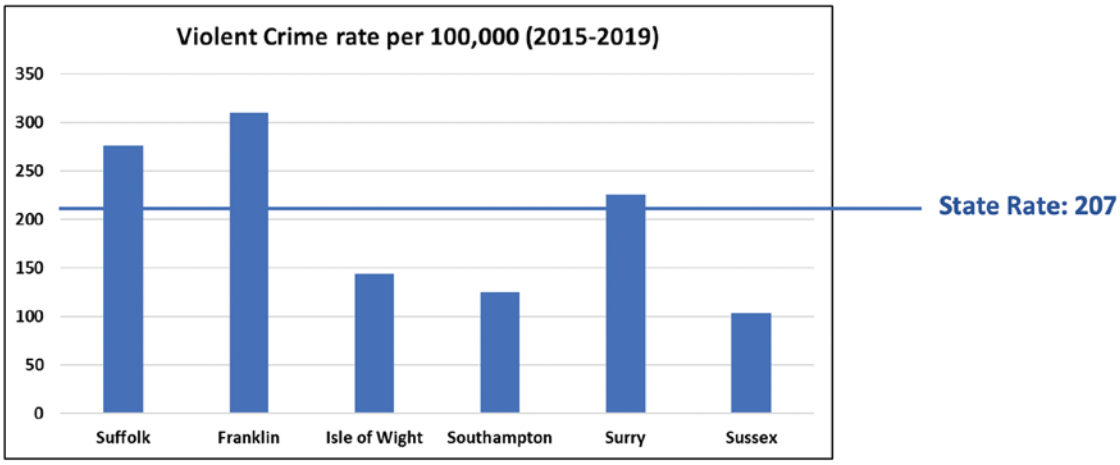
Violent crimes such as gun violence, robbery, or aggravated assault have a socio-emotional impact. Physical and emotional symptoms such as sleep disturbances increase in feelings of distress, anger, depression, inability to trust, and significant problems with family, friends, or coworkers can occur. Violent crimes can hinder the pursuit of healthy behaviors such as outdoor physical activities. Chronic stress has been associated with violent crimes and increases prevalence of certain illnesses such as upper respiratory illness and asthma. This can have a 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 rate of violent crime was much higher in some localities in the service area compared to the state rate of 207 violent crime offenses per 100,000 people. Per County Health Rankings, Franklin and Suffolk have the highest rate of violent crimes (310 and 276).

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

When deaths were examined for localities within the service area, Isle of Wight had rates higher than the state rate for firearm fatalities per 100,000 population.




*Source: County Health Rankings 2021, Rankings and Documentation *Data unavailable for Gates County, NC*

# 2019 IMPLEMENTATION STRATEGY PROGRESS REPORT

The previous CHNA identified several health issues. The SOH, SBASC, and SOASC implementation strategy progress report was developed to identify activities that address health needs identified in the 2019 CHNA report through primary and secondary data sources. This section of the CHNA report describes these activities and collaborative efforts.

SOH, SBASC, and SOASC are 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.

## Sentara Obici Hospital

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

- Chronic Disease (including Diabetes, Heart Disease, Cancer)
- Mental health & Substance Abuse
- Nutrition (to include Obesity and Hunger)

SOH developed strategies to address multiple health problems. Dr. Mike Genco, Chief Medical Officer, and Sherri Dupart, Manager of Pharmacy Services, are both active members of the Western Tidewater Free Clinic board. SOH supported multiple COVID-19 education events. SOH provided education and outreach to community groups and presented COVID-19 updates and education to local groups at East End Baptist Church and Suffolk Rotary in 2021. SOH continues to offer drive-thru flu events. In 2021, these events were held at SOH, BelleHarbour, and St. Luke's campus. At these events, 794 community members were vaccinated. In 2021, SOH supported National Night Out and offered a COVID-19 vaccine clinic to community members. However, employee attendance was limited due to COVID-19. Educational materials were provided for attendees with approximately 1,000 community members in attendance. SOH also continues to support the United Way Day of Caring. In 2021, five employees donated time to perform service activities at For Kids in Suffolk. Activities included deep cleaning, organizing a food pantry and supply room, deep cleaning toys, and laying mulch in flower beds. Sentara sponsored the Isle of Wight County Fair and provided COVID-19 vaccine information to participants. SOH supports Women's Health Education. SOH was the only hospital in the system to maintain childbirth classes through the pandemic, transitioning to a virtual model which was very well-received by the community. In 2021, SOH provided flu vaccines and colorectal cancer education at the Isle of Wight Senior Fair. There were 52 free flu vaccines provided to community members. Also in 2021, four SOH leaders participated in the Habitat for Humanity Frontline Hero Build for a site located in Suffolk, VA. SOH also continues its partnership with the American Red Cross to host Blood Drives at SOH and Sentara BelleHarbour campus SOH developed strategies to address multiple health problems.

### *Chronic Disease (including Diabetes, Heart Disease, Cancer)*

Due to the COVID-19 pandemic, some implementation strategies were put on hold. Unfortunately, SOH's expansion of the Transition Clinic to broaden the scope on disease processes and increased volumes, aimed at decreasing readmissions and improving self-care was canceled and the clinic closed due to the pandemic. SOH continues to support the Community Health Outreach Program (CHOP) which provides services for patients below the federal poverty line in need of at-home health care because of chronic diseases like diabetes or heart failure. In 2021, a community colorectal cancer education event with Dr. Glanville took place. SOH also provided a Flu-FIT event for colorectal cancer screenings which were offered to qualified individuals at Western Tidewater drive-thru flu clinics. SOH also filmed an educational video on colorectal cancer screenings with Dr. Pramod Malik. The video was circulated on social media for community education in 2021 and used by a community educator at community events.

### *Diabetes*

The community health outreach program continued providing services for patients below the federal poverty line in need of at-home health care due to diabetes. SOH continued collaboration with Western Tidewater Diabetes Collaborative, and when possible, assisted with community diabetic education and screening events. Most activities were placed on hold due to the pandemic.

### *Heart Disease*

The community health outreach program continued providing services for patients below the federal poverty line in need of at-home healthcare due to heart disease. Due to the pandemic, support groups were placed on hold. When available, SOH participates in AHA programs and events (Get with the Guidelines, Run-Walk for Health, Heart Chase).

### *Mental health & Substance Abuse*

Due to the COVID-19 pandemic, some strategies were put on hold such as exploring implementation of a drug take back program or coordination with other community programs, and providing screenings at community events. SOH continued to support the Inpatient Psych Unit. SOH Emergency Department (ED) Expansion was completed in 2022 and includes the addition of two psych safe rooms for psychiatric patients holding in the ED. With decreased state psych beds, there was an increase in psych holds in the Emergency Departments. SOH also implemented tele-psych on inpatient units to support increased referrals.

Sentara continues to improve access to behavioral health resources. In 2021, a Behavioral Health Care Center opened to provide follow-up care within seven days of being discharged for a behavioral health need from the emergency department or an inpatient behavioral health unit. This clinic started with a focus on patients discharged from the Inpatient Behavioral Health Unit at Sentara Virginia Beach General Hospital, Sentara Independence and Sentara Princess Anne Hospital Emergency Departments. The Behavioral Health Care Center has expanded its services to include other individuals in the community that need behavioral health care. As of March 2022, the Behavioral Health Care Center has seen a total of 1,215 patients.

In 2022, the Hampton Roads Behavioral Health Consortium convened as a regional coalition of private

and public partners in mental health to address the escalating mental health crisis. The Behavioral Health Consortium will develop a strategic action plan to address prevention, intervention, treatment, workforce, resources, access, education, recovery and eliminating the stigma associated with behavioral health.

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

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

A Behavioral Health Tactical Operations Committee (BHTOC) Clinical Patient Management Workgroup focuses on:

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

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

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

A BHTOC Safety workgroup addresses:

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

### *Nutrition (to include Obesity and Hunger)*

SOH collaborates with community partners to improve the health of the community members living in the service area. In 2021, SOH assisted with the Nutrition as Cancer Prevention community education event. SOH continues to partner with Healthy Suffolk to support community pantry at Chorey Park apartments and SOH leaders attended opening event. SOH continues to support Suffolk Meals on Wheels. Suffolk Meals on Wheels headquarters is located at SOH with office space provided free of charge, and meals are prepared by the SOH Food Services team.

## Sentara BelleHarbour Ambulatory Surgery Center

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

- Chronic Disease, including Cancer and Arthritis
- Mental Health and Substance Abuse
- Healthy Lifestyle

### *Chronic Disease, including Cancer and Arthritis*

SBASC continues to collaborate closely with SOH for this strategy. Due to the COVID-19 pandemic, some implementation strategies were put on hold. Unfortunately, SOH's expansion of the Transition Clinic to broaden the scope on disease processes and increased volumes, aimed at decreasing readmissions and improving self-care was canceled and the transition clinic closed due to the pandemic. SOH continues to support the Community Health Outreach Program (CHOP), which provides services for patients below the federal poverty line in need of at-home healthcare because of chronic diseases like diabetes or heart failure. In 2021, a community colorectal cancer education event with Dr. Glanville took place. SOH also provided a Flu-FIT event for colorectal cancer screenings, which were offered to qualified individuals at Western Tidewater drive-thru flu clinics. SOH also filmed an educational video on colorectal cancer screening with Dr. Pramod Malik. The video was shared on social media for community education in 2021 and used by a community educator at community events.

### *Mental Health and Substance Abuse*

SBASC continues to collaborate closely with SOH for this strategy. Due to the COVID-19 pandemic, some strategies were put on hold such as the strategy to explore the implementation of the drug take back program or coordination with other community programs, as well as providing screenings at community events. SOH continued support of SOH Inpatient Psych Unit. SOH Emergency Department (ED) Expansion was completed in 2022 and includes the addition of 2 psych safe rooms for psychiatric patients holding in the ED. With decreased state psych beds, there was an increase in psych holds in the Emergency Departments. SOH implemented tele-psych on inpatient units to support increased referrals.

### *Healthy Lifestyle*

SBASC continues to collaborate closely with SOH for this strategy. SOH collaborates with community partners to improve the health of the community members living in the service area. In 2021, SOH assisted with the Nutrition as Cancer Prevention community education event. SOH continues to partner with Healthy Suffolk to support community pantry at Chorey Park apartments and SOH leaders attended opening event. SOH continues support of Suffolk Meals on Wheels. Suffolk Meals on Wheels headquarter is located at SOH with meals prepared by the SOH Food Services team.

## Sentara Obici Ambulatory Surgery Center

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

- Chronic Diseases
- Dental/Oral Health Care Services
- Mental Health and Substance Abuse
- Access to Healthcare

### *Chronic Diseases*

SOASC continues to collaborate closely with SOH for this strategy. Due to the COVID-19 pandemic, some implementation strategies were put on hold. SOASC continues to identify SOASC patients with uncontrolled chronic conditions and provides information about the risks of conditions and proper management. Sentara Obici ASC encourages patients to follow-up with their primary care providers. SOASC created and maintains a community resource board highlighting resources for:

- Dental care
- Mental Health/Substance Abuse
- Nutrition
- Community Events

### *Dental/Oral Health Care Services*

SOASC continues to provide education to families regarding proper dental care for the pediatric community.

### *Mental Health and Substance Abuse*

SOASC continues to collaborate closely with SOH for this strategy. SOASC continues to provide mental health resources and education on the community resource board.

### *Access to Health Care*

SOASC continues to collaborate closely with SOH for this strategy. SOASC continues to provide patients with a cost estimate for their surgery ahead of the date of service.

## Sentara

### GRANTMAKING AND COMMUNITY BENEFIT

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

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

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

Clearly, the definition of community health is broader than simply medical care. As more is learned 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 SCH, COASC and PWSC alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. Sentara, SCH, COASC and PWSC 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*

#### ADVANCE CARE PLANNING

The United States Will Registry, https://www.theuswillregistry.org/

#### ALZHEIMER'S AND DEMENTIA

Alzheimer's Association, Virginia Alzheimer's facts
Virginia Alzheimer's Commission, AlzPossible Initiative

#### CANCER

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

#### COUNTY HEALTH RANKINGS

County Health Rankings 2021, Rankings Data & Documentation
County Health Rankings 2021, Overview

#### COVID-19

Virginia Department of Health, COVID-19 Data in Virginia, Dashboard
World Health Organization, Coronavirus disease (COVID-19)

DIABETES

Center for Disease Control and Prevention, Diabetes

Center for Disease Control and Prevention, Diabetes Report Card 2019

GREATER HAMPTON ROADS

Greater Hampton Roads Community Indicators Dashboard

MATERNAL AND INFANT

Virginia Department of Health Division of Health statistics

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