



2025 Community Health Needs Assessment

Bon Secours — Hampton Roads
SUFFOLK, VA

2025 Community Health Needs Assessment

Bon Secours — Hampton Roads

Adopted by the Bon Secours — Hampton Roads Board of Directors,
September 23, 2025

As part of Bon Secours Mercy Health, Bon Secours — Hampton Roads is honored to uphold nearly two centuries of dedication to the communities we serve. This commitment has continually evolved to address the most pressing needs in each community as identified by the input of residents, businesses and other community members.

Every three years, we conduct a comprehensive Community Health Needs Assessment (CHNA) to identify the most pressing needs in our community. The most recent assessment, completed by Bon Secours — Hampton Roads, incorporates robust quantitative and qualitative data. This process guides our strategic planning, community investment and community benefit initiatives. The following document provides a detailed CHNA specific to Bon Secours — Hampton Roads.

Guided by our Mission to extend the compassionate ministry of Jesus, Bon Secours remains steadfast in improving the health and well-being of our communities and bringing good help to those in need — especially people who are poor, underserved and dying.

Bon Secours — Hampton Roads has identified the greatest needs within our community by listening to its local voices. We gather input from our partners and neighbors through open forums, surveys and additional engagement strategies. This ensures that our outreach, prevention, education and wellness resources are strategically aligned to deliver the greatest impact.

To share feedback or request a printed CHNA copy, please email Phyllita Bolden, community health director, at Phyllita_bolden@bshsi.org.

Bon Secours — Hampton Roads

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Bon Secours CHNA
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Executive Summary

Market Summary

Bon Secours — Hampton Roads is located in the southeastern region of Virginia. With a population of over 1.7 million people, Hampton Roads covers an area of 3,730 square miles. Bon Secours — Hampton Roads operates four hospitals in the area, including Maryview Medical Center, Mary Immaculate Hospital, Southampton Medical Center and Harbour View Medical Center. There are also several medical group practices and acute care facilities.

Collaborating Partners

Bon Secours — Hampton Roads thanks the following organizations for collaborating to conduct the needs assessment:

- Children's Hospital of the King's Daughters
- Riverside Health System
- Sentara Healthcare
- Virginia Department of Health – Peninsula and Hampton Health Districts

ToXcel, LLC was commissioned to contribute consultant services to support data collection, qualitative and quantitative data analysis, and report development.

Overview

The needs assessment (CHNA) for Bon Secours — Hampton Roads looked at changes within the region and differences in community health outcomes across jurisdictions. We sought community input on health needs, resources and priorities using various sources, including:

- Community Health Surveys
- Community focus groups
- Interviews with Care-A-Van patients
- Meetings with Bon Secours Community Advisory Boards

Additional health indicator data were collected through:

- Virginia Health Information
- Virginia Department of Health
- County Health Rankings and Roadmaps
- Behavior Risk Factor Surveillance System

- National Center for Health Statistics
- Centers for Medicare and Medicaid Services
- National Cancer Institute

Data was examined across qualitative and quantitative sources to identify themes and issues that were consistently raised as priorities by multiple sources. This process identified significant health needs discussed in depth in this report, including:

- Economic instability
- Housing insecurity
- Food Insecurity
- Community violence
- Alcohol and substance use
- Loneliness and social isolation
- Access to care
- Chronic health conditions
- Mental health
- Sexual health
- Maternal and child health

Prioritized Health Needs

Following data collection and analysis, the Community Health Director shared key themes and findings from the CHNA with hospital leaders and community advisory boards from Maryview Medical Center, Mary Immaculate Hospital, Southampton Medical Center. Harbour View Medical Center opened on May 6, 2025, and has not yet established a community advisory board.

These stakeholders identified the following priority issues based on the magnitude and severity of the health need, as well as the opportunity for Bon Secours–Hampton Roads to develop a programmatic intervention that builds on existing community resources and needs. In this way, Bon Secours can focus its resources to address critical health needs that affect many across the community.

The priority health needs identified* include:

- Violence in the community
- Chronic disease
- Mental health

Our Mission

Our mission is to extend the compassionate ministry of Jesus by improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved.

Our Vision

Inspired by God's hope for the world, we will be a ministry where associates want to work, clinicians want to practice, people seek wellness and communities thrive.

Our Values

Human Dignity

We commit to upholding the sacredness of life and being respectful and inclusive of everyone.

Integrity

We commit to acting ethically and modeling right relationships in all of our individual and organizational encounters.

Compassion

We commit to accompanying those we serve with mercy and tenderness, recognizing that "being with" is as important as "doing for."

Stewardship

We commit to promoting the responsible use of all human and financial resources, including Earth itself.

Service

We commit to providing the highest quality in every dimension of our ministry.



Facilities Description

This combined CHNA report includes the following hospitals: Bon Secours Mary Immaculate Hospital, Bon Secours Maryview Medical Center, Bon Secours Southampton Medical Center, and Bon Secours Harbour View Medical Center. The facilities are described in more detail below.

Bon Secours Mary Immaculate Hospital

Bon Secours Mary Immaculate Hospital (Mary Immaculate) has served the Hampton Roads region for over 60 years. Mary Immaculate Hospital was originally founded as Elizabeth Buxton Hospital at the turn of the twentieth century and opened in the eastern part of Newport News, near what is now the Monitor-Merrimac Bridge Tunnel. In 1952, the Bernardine Franciscan Sisters, Order of St. Francis, assumed the sponsorship of the hospital and renamed it Mary Immaculate Hospital. Recognizing the demographic trends occurring on the Peninsula, the Sisters made plans to relocate the hospital to an area where limited healthcare services were available and in the early 1980s, the hospital was relocated to its current campus in Newport News. In 1996, through a joint venture arrangement, Mary Immaculate Hospital became a 'member' of the Bon Secours Health System and was renamed Bon Secours Mary Immaculate Hospital. Mary Immaculate is now a 123-bed not-for-profit, acute care facility licensed in the state of Virginia and serving approximately 465,000 residents. Mary Immaculate provides a comprehensive array of inpatient and outpatient services.

Bon Secours Maryview Medical Center

Bon Secours Maryview Medical Center has served the western Hampton Roads region since 1945. Maryview Medical Center was founded when the federal government recognized a need in Portsmouth for a facility that would serve the healthcare needs of shipyard workers. With a small staff, the 150-bed, 30-bassinet Glenshellah Hospital opened its doors to serve residents of the community on March 4, 1945. When the war ended in 1945, the hospital dedicated its mission to caring for polio victims. At the request of the Diocese of Richmond, the Daughters of Wisdom answered the call and came to Portsmouth from Canada to operate the facility. It was renamed Maryview Medical Center in honor of the Virgin Mary and the Waterview area of Portsmouth, where the hospital is located. In 1984, Bon Secours Health System agreed to sponsor Maryview Medical Center and continue operating the acute care facility in the Catholic tradition established by the Daughters of Wisdom.

Bon Secours Maryview Medical Center (Maryview) is a 346-bed not-for-profit, acute care facility licensed in the state of Virginia and serving approximately 432,200 community residents. Maryview provides a comprehensive array of inpatient and outpatient services, including cardiac surgery, EP, catheterization/vascular labs, orthopedics, and spine, 54 54-bed acute adult behavioral health unit, emergency department, interventional radiology, 25 25-bed inpatient acute rehab unit, 14 outpatient comprehensive physical therapy locations, outpatient endoscopy, and diagnostic imaging women's imaging center.

Bon Secours Southampton Medical Center

Bon Secours Southampton Memorial Center (Southampton), Franklin/Southampton's first medical facility, began in the home of Dr. Raiford in the small community of Sedley and later became Raiford Hospital. Southampton Medical Center opened in 1963 on its current site and joined Bon Secours Mercy Health on January 1, 2020. Bon Secours — Southampton is a 219-bed not-for-profit, acute care facility licensed in the state of Virginia and serving approximately 63,477 residents. Southampton has 90 licensed general acute care beds and 129 post-acute beds (13 skilled care and 116 long-term beds). In addition, Southampton operates a 24-hour emergency services department and a 129-bed long-term care facility.

Bon Secours Harbour View Medical Center

Bon Secours Harbour View Medical Center opened on May 6, 2025, as an expansion to the existing Bon Secours Health Center at Harbour View, which opened in 1999. For more than 25 years, Bon Secours has addressed the growing needs of the Western Hampton Roads community. Bon Secours was the first health system in the region to respond to the population growth in Western Hampton Roads by establishing the Bon Secours Health Center at Harbour View, and as a result, has helped to improve access to outpatient health care services in this community since 1999. Within 10 years of opening, Bon Secours Health Center at Harbour View had expanded to include a free-standing emergency department and additional outpatient services to meet the needs of this growing community. In 2022, Bon Secours broke ground on the construction of the new Bon Secours Harbour View Medical Center, which integrates the new hospital services with the existing outpatient services into one medical campus.

Bon Secours Harbour View Medical Center operates 18 inpatient beds and four operating rooms, along with an emergency room and numerous outpatient departments, including imaging and lab services.

Community Served by Hospitals

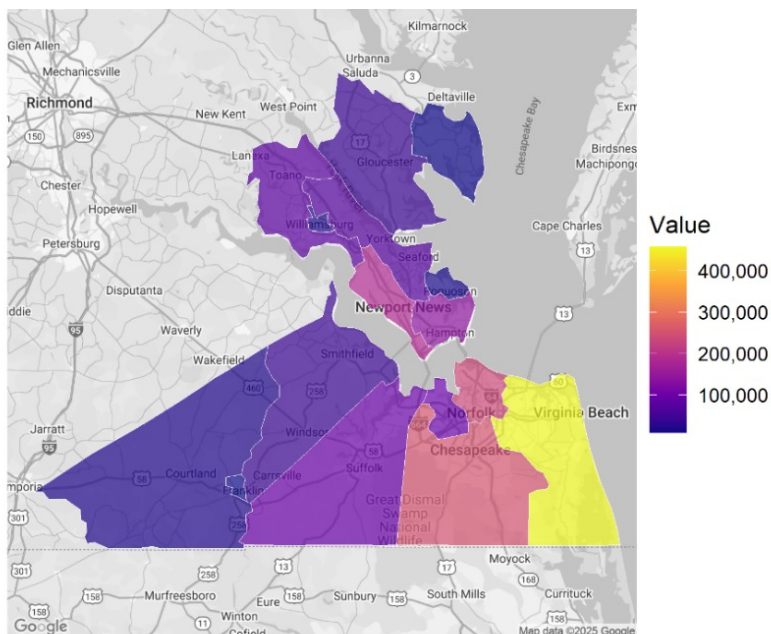
Hampton Roads, shown in Figure 1, is located in the southeastern region of Virginia, which comprises these municipalities:

- Chesapeake
- Franklin
- Gloucester County
- Hampton
- Isle of Wight
- James City County
- Mathews County
- Newport News
- Norfolk
- Portsmouth
- Poquoson
- Southampton County
- Suffolk
- Virginia Beach
- Williamsburg
- York County

This area is officially recognized as the Virginia Beach-Norfolk-Newport News Metropolitan Statistical Area. The population of Hampton Roads is 1.7M and covers an area of over 3,730 square miles. Hampton Roads contains urban, suburban and rural communities.

Figure 1. Jurisdictions and Populations of Community Served by Bon Secours — Hampton Roads

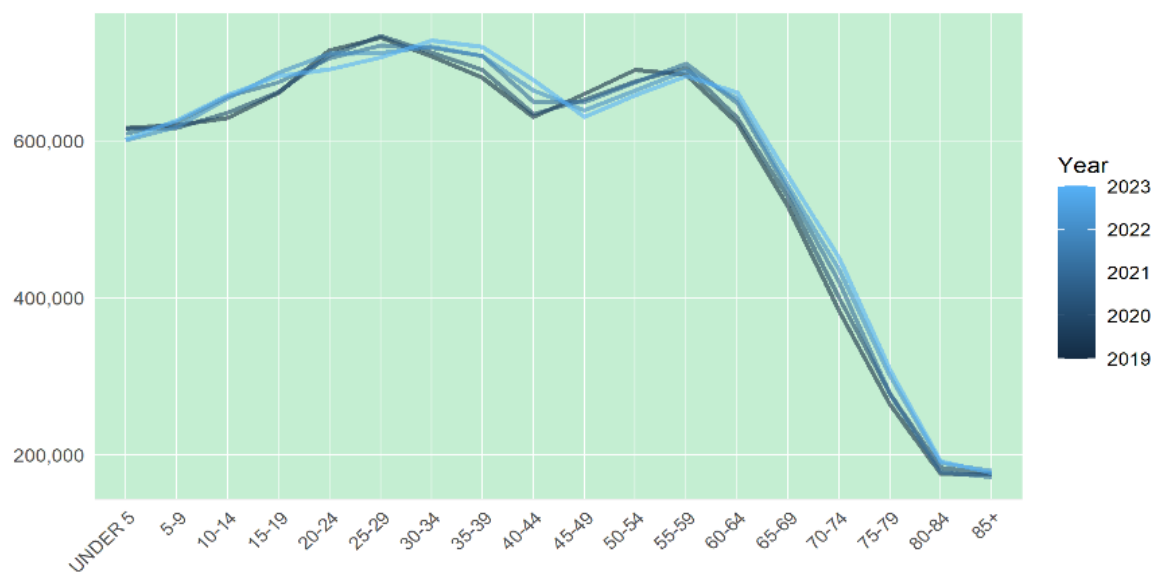
Source: American Community Survey 5-Year Estimates, Table B01001



2023

According to the American Community Survey, 63.5% of the community served is White; 34.4% is Black, 9.3% is two or more races, 8.7% is Hispanic or Latino and 4.2% is Asian. The age demographic across the area has stayed consistent over the last five years (see Figure 2).

Figure 2. Regional Population by Age Group



Source: American Community Survey 5-Year Estimates, Table B01001

Joint CHNA

This is a "joint CHNA report," within the meaning of Treas. Reg. §1.501(r)-3(b)(6)(v), by and for Bon Secours — Hampton Roads, including Maryview Medical Center, Mary Immaculate Hospital, Southampton Medical Center and Harbour View Medical Center. This report reflects the hospitals' collaborative efforts to assess the health needs of the community they collectively serve. Each of the hospitals included in this joint CHNA report defines its community as the same.

Process and Methods

Collaborating Partners

Bon Secours — Hampton Roads thanks the organizations listed below for their collaboration as part of the CHNA Collaborative, a working group that came together to plan and conduct the needs assessment:

- Children’s Hospital of the King’s Daughters
- Riverside Health System
- Sentara Healthcare
- Virginia Department of Health – Peninsula and Hampton Health Districts

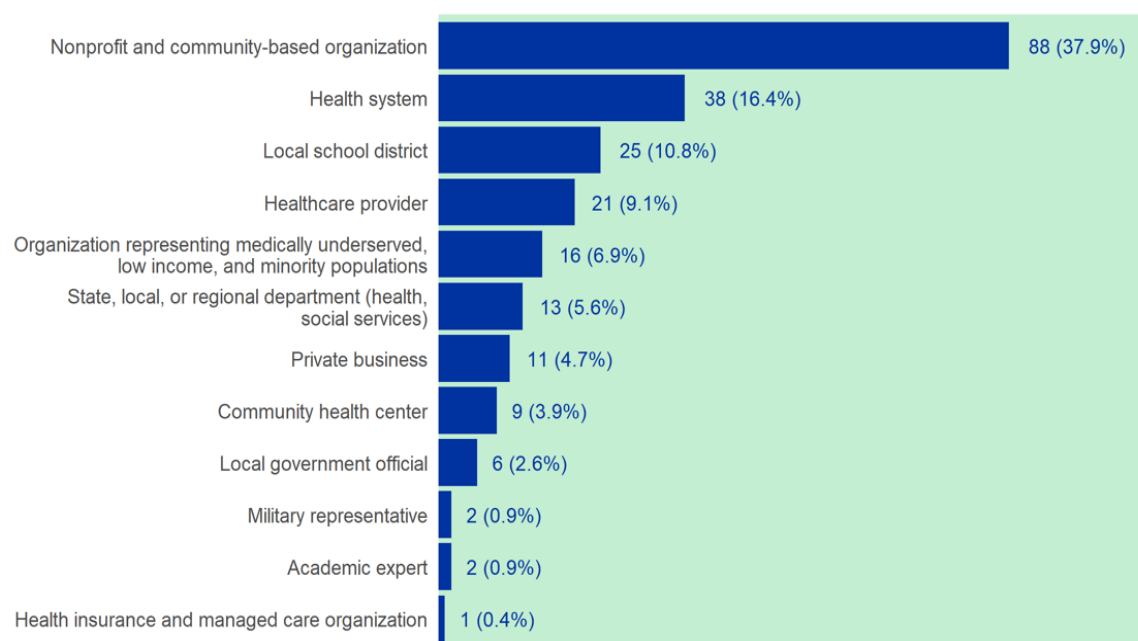
From January 2024 to April 2025, staff from each organization met to discuss various elements of the CHNA. Together, they developed and disseminated a Community Health Survey and planned focus groups to be held across areas of the community they collectively served.

Process and Methods to Conduct the Community Health Needs Assessment

This section describes the process and methods used to conduct the CHNA for Bon Secours — Hampton Roads. It discusses the process involved in quantitative and qualitative data collection, including the analysis of health indicators and the process for gathering community input through a Community Health Survey, community advisory board meetings, focus groups and interviews with Care-A-Van patients.

Community Health Survey

The CHNA collaborative launched a community survey that ran from October 2024 through February 2025. Of participants who completed the survey, 4,832 individuals and 233 organizations responded. Organizational responses included representatives from health departments, social service and mental health agencies, school systems, community health centers, and a wide range of non-profit and community-based organizations, including many who represent medically underserved, minority, or low-income populations. Figure 3 illustrates the organizations who participated in the survey. Many of these organizations are also listed in Table 1.



Source: Community Health Survey

Figure 3. Types of Organizations Represented in the Survey (n=233)

To identify significant health needs when analyzing the survey data, any issues or concerns raised by more than 30% of individual participants or organizations were flagged and considered in more detail. Some survey responses also informed issues raised through other community input (e.g., questions about barriers to accessing health care and resources).

The Community Health Survey results are included in Appendix A.

Community Input: Focus Groups, Community Advisory Boards and Care-A-Van Interviews

Along with the Community Health Survey, Bon Secours — Hampton Roads sought extensive community input through its community advisory boards, focus groups and interviews with Care-A-Van patients. The locations and number of people who participated are outlined in the following section on community input.

At all of the community advisory board meetings, focus group meetings, and Care-A-Van interviews, notetakers took comprehensive notes. The CHNA Collaborative used ChatGPT to initially identify focus group themes. ToXcel, LLC then reviewed the themes and conducted further exploration and analysis through ChatGPT to provide more data analysis

and quality assurance. ToXcel, LLC then conducted a thematic analysis of the community advisory board meetings, Care-A-Van interview data and focus group themes. The resulting analysis provided a rich picture of health issues and concerns felt by the community, and a strong consensus around pressing health priorities. Many of these health needs were also reflected in the health indicator analysis and Community Health Survey, which further reinforced the validity of the analysis. More detailed summaries of this data are included in Appendices B-D and discussed in the Community Input section.

Health Indicators

The health indicator analysis first extracted publicly available data from external sources to analyze and better understand how different health needs may have changed since the last CHNA. Using the most recent data available when possible, data was examined by race, gender and age over a five-year period to understand how health issues impacted populations differently.

Significant health needs were flagged from the Bon Secours — Hampton Roads service area. The data revealed worse health outcomes or conditions than the State of Virginia's average. Significant health needs were also identified based on health disparities related to geographic location, gender, race or age differences.

Specific data sources are listed in the External Sources section. Highlights from the health indicator analysis are included throughout this report, particularly when describing specific significant health needs. The full health indicator analysis is included in Appendix E.

External Sources

The following external sources provided secondary sources for data included in the health indicator analysis:

- American Community Survey 5-Year Estimates
- Behavior Risk Factor Surveillance Survey
- Centers for Medicaid & Medicare Services
- County Health Rankings & Roadmaps
- National Cancer Institute
- National Center for Health Statistics
- Virginia Department of Education
- Virginia Department of Health, Division of Health Statistics
- Virginia Health Information

Community Input

From October 2024 through February 2025, a broad array of community input was sought through Bon Secours community advisory board meetings, focus groups hosted by organizations across the service area, and interviews conducted with indigent patients. These patients received medical services through the Bon Secours Care-A-Van, a mobile health unit that provides primary care to those with limited access to care.

Through meetings and interviews, Bon Secours worked to ensure that medically underserved populations, minority or low-income populations, or both provided input on health needs, priorities and existing resources. More details about the participants are outlined below. No written comments were received on the previous 2022 CHNA.

Community Advisory Board (CAB) Input

- Locations: Maryview Medical Center and Southampton Memorial Hospital
- 38 Community Advisory Board Members

Community Focus Groups

- 26 focus groups were conducted across Norfolk, Portsmouth, Suffolk, Virginia Beach, Newport News, Hampton and Williamsburg. They included:
 - Ingleside Elementary Parents Night
 - Lee's Friends'
 - Reck League
 - Urban Discovery Mission
 - Fatherhood Mentoring
 - Hampton Roads Parenting Education Network
 - Peninsula Pastoral Counseling Center
 - Horizons
 - Senior Station
 - St. Marks Missionary Baptist
 - Portsmouth Partnership
 - Delta Sigma Theta
 - Filipino Focus
 - Girls on the Run
 - Greater Saint Andrews
 - LGBT Life Center

- Sentara Leigh Hospital Patient & Family Advocate Council
- Sentara Princess Anne Hospital Patient and Family Advisory Council
- Sentara Virginia Beach General Hospital Patient and Family Advisory Council
- Sentara Williamsburg Patient & Family Advocate Council
- Hispanic Circle of Parents
- Achievable Dreams
- Hampton Roads Community Action Plan
- Iglesia de Dios de Adonai (two groups)
- Pruden Center
- Armed Services YMCA
- Sentara Williamsburg Patient & Family Advocate Council
- 274 participants

Interviews with Care-A-Van Patients

- Van locations: Chesapeake, Franklin, Norfolk, Newport News, Hampton, Portsmouth, Suffolk, Virginia Beach
- 39 low-income patients



Information and Data Considered in Identifying Potential Needs

Table 1 lists how state or local health or other departments or agencies provided input through this CHNA process. These organizations serve the broader community, including low-income or minority populations, and have a strong understanding of the health needs of that community.

Table 1: Input from Health Departments and Other City/County Agencies

Health Departments and Other City/County Agencies	Date of data/information
Virginia Department of Health (VDH)	- October 2024 – February 2025 – Survey participant - December 2024 – February 2025 – Data extracted from VDH website on sexually transmitted infections, teen pregnancy, maternal and child health
Peninsula and Hampton Health Districts	CHNA Collaborative Member
Chesapeake Health Department	October 2024 – February 2025 – Survey participant
City of Hampton	October 2024 – February 2025 – Survey participant
City of Newport News	October 2024 – February 2025 – Survey participant
City of Virginia Beach Public Schools	October 2024 – February 2025 – Survey participant
Hampton Newport News Community Services Board (HNNCSB)	October 2024 – February 2025 – Survey participant
James City County Dept. of Social Services	October 2024 – February 2025 – Survey participant
James City County Neighborhood Development	October 2024 – February 2025 – Survey participant
James City Volunteer Rescue Squad	October 2024 – February 2025 – Survey participant
Mathews County School Board	October 2024 – February 2025 – Survey participant

Health Departments and Other City/County Agencies	Date of data/information
Middlesex Department of Social Services	• October 2024 – February 2025 – Survey participant
Newport News Department of Human Services	• October 2024 – February 2025 – Survey participant
Newport News Public Schools	• October 2024 – February 2025 – Survey participant
Northampton County Sheriff's Office	• October 2024 – February 2025 – Survey participant
Portsmouth Public Schools	• October 2024 – February 2025 – Survey participant
Suffolk Public Schools	• October 2024 – February 2025 – Survey participant
Virginia Beach City Public Schools	• October 2024 – February 2025 – Survey participant
Western Tidewater Community Services Board (CSB)	• October 2024 – February 2025 – Survey participant
York County School Division	• October 2024 – February 2025 – Survey participant

Table 2 outlines other input received through the CHNA process from organizations that serve at-risk, medically underserved, low-income or minority populations. Many other community organizations participated in the Community Health Survey.

Table 2. Input from Organizations that Serve at Risk, Medically Underserved, Low-Income or Minority Populations

Community, Organization, and Stakeholder Input*	Date of Data/Information	Nature and Extent of Input	At Risk, Medically Underserved, Low-Income, or Minority Populations Represented by Organization
Children's Hospital of the King's Daughters	January 2024 – April 2025	CHNA collaborative member	Serves medically underserved, low-income and minority populations
Riverside Health System	January 2024 – April 2025	CHNA collaborative member	Serves medically underserved, low-income and minority populations
Sentara Healthcare	January 2024 – April 2025	CHNA collaborative member	Serves medically underserved, low-income and minority populations
Filipino Focus	Oct. 14, 2024	Hosted focus group for members and participated	Minority populations represented by the organization
Hampton Roads Parenting Education Network	Dec. 12, 2024	Hosted focus group for members and participated	Community partner network of organizations that serves at risk, low-income and minority populations
HOPES Free Clinic	Nov. 14, 2024	Hosted focus group for members and participated	At risk, medically underserved, low-income and minority populations represented by organization
Iglesia de Dios de Adonai	Feb. 1, 2025	Hosted focus group for members and participated	Serves low-income and minority populations
Ingleside Elementary	Dec, 12, 2024	Hosted focus group for members and participated	Elementary school hosts parents' nights attended by minority populations
Lee's Friends	Nov. 20, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
Reck League	Nov. 12, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
Urban Discovery Mission	Nov. 22, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
Fatherhood Mentoring	Jan. 28, 2025	Hosted focus group for members and participated	Low-income and minority populations represented by the organization

Community, Organization, and Stakeholder Input*	Date of Data/ Information	Nature and Extent of Input	At Risk, Medically Underserved, Low-Income, or Minority Populations Represented by Organization
Horizons	Jan. 30, 2025	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
Senior Station	Nov. 7, 2024	Hosted focus group for members and participated	Low income and minority populations represented by the organization
St. Marks Missionary Baptist	Dec. 3, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
Portsmouth Partnership	Dec. 11, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
Delta Sigma Theta	Nov. 21, 2024	Hosted focus group for members and participated	Minority populations represented by the organization
Pruden Center	Nov. 14, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
Armed Services YMCA	Nov. 20, 2024	Hosted focus group for members and participated	Low-income populations represented by organization
Girls on the Run	Nov. 14, 2024	Hosted focus group for members and participated	Low-income populations represented by organization
Greater St. Andrews	Nov. 12, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organization
LGBT Life Center	Nov. 14, 2024	Hosted focus group for members and participated	At risk, medically underserved, low-income and minority populations represented by organization
Sentara Leigh Hospital Patient and Family Advisory Council	Oct. 15, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organizations
Sentara Princess Anne Hospital Patient and Family Advisory Council	Dec.5, 2024	Hosted focus group for members and participated	Low-income and minority populations represented by the organizations
Sentara Virginia Beach General Hospital Patient and Family Advisory Council	Oct. 15, 2024	Hosted focus group for members and participated	Low income and minority populations represented by the organizations
Achievable Dream	Dec. 9, 2024	Hosted focus group for members and participated	Low income and minority populations represented by the organizations

Community, Organization, and Stakeholder Input*	Date of Data/ Information	Nature and Extent of Input	At Risk, Medically Underserved, Low-Income, or Minority Populations Represented by Organization
Peninsula Pastoral Counseling Center	Jan. 21, 2025	Hosted focus group for members and participated	Serves medically underserved, low income and minority populations
Hampton Roads Community Action Program	Nov. 25, 2024	Hosted focus group for members and participated	Low income and minority populations represented by the organizations
Sentara Williamsburg Patient & Family Advocate Council	Feb. 5, 2025	Hosted focus group for members and participated	Low income and minority populations represented by the organizations
Bon Secours Southampton Memorial Hospital Community Advisory Board	Nov. 15, 2024 March 28, 2025	Hosted focus group for members and participated. Reviewed CHNA data and participated in the prioritization process.	Low income and minority populations represented by organizations attending
Bon Secours Maryview Medical Center Community Advisory Board	Oct. 30, 2024 March 13, 2025	Hosted focus group for members and participated. Reviewed CHNA data and participated in the prioritization process.	Low income and minority populations represented by organizations attending
Bon Secours Mary Immaculate Hospital Community Advisory Board	April 15, 2025	Reviewed CHNA data and participated in the prioritization process.	Low income and minority populations represented by organizations attending

Significant Community-Identified Health Needs

This section discusses the significant health needs identified through the CHNA process. The data sources used to inform the selection of significant health needs include the Community Health Survey, health indicator analysis and discussions with hospital community advisory boards, focus groups and Care-A-Van clients. There was a high level of consensus across these different data sources about health needs facing the community that Bon Secours — Hampton Roads serves.

Social Determinants of Health Needs — Community Level Needs that Impact Health and Well-being

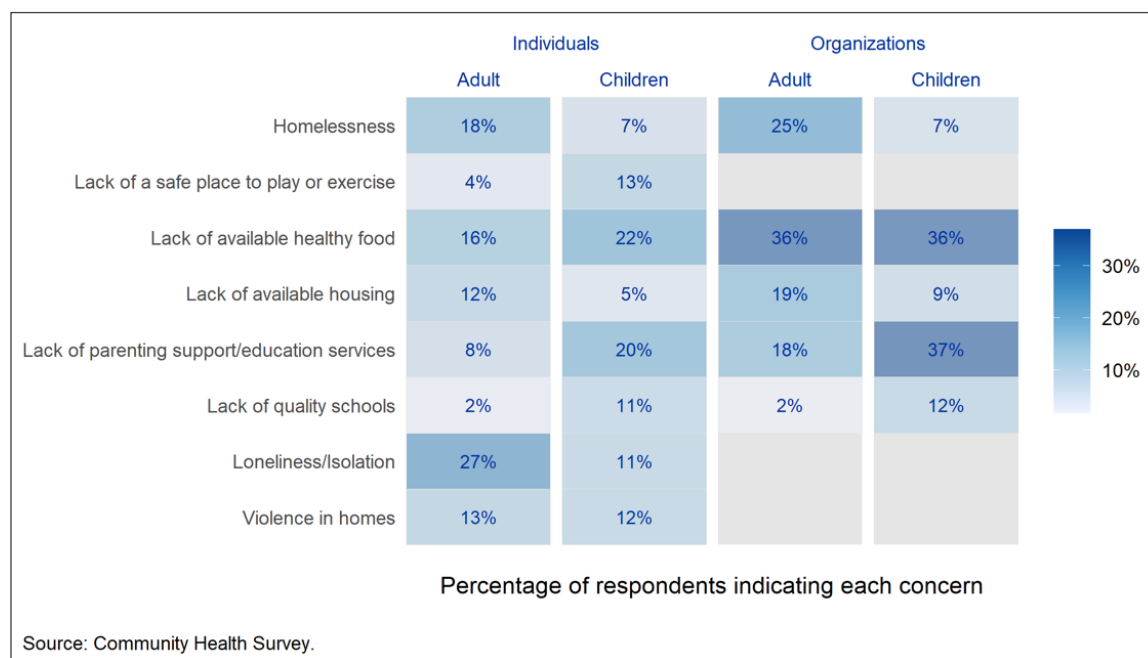
Social determinants of health are structural, environmental or systemic conditions that impact the health and quality of life of communities or populations. In this section, the following social determinants of health needs will be discussed in more depth:

- Economic instability
- Housing insecurity
- Food insecurity
- Community violence

In the Community Health Survey, participants were asked about the top concerns facing the community. Their responses are shown below in Figure 4. Several of the prioritized concerns are social determinants of health, including homelessness, lack of available housing and lack of available healthy food. These issues are discussed later in this section with additional context provided by other data collected through the CHNA process, including focus groups, stakeholder interviews and health indicator data. Homelessness and housing are discussed in the section on housing insecurity. Lack of available healthy food is included in the section on food insecurity.

Individuals also overwhelmingly identified loneliness and isolation as a major concern. Loneliness and isolation are discussed later in the Social Health Needs section.

Figure 4. Survey question: Select the Top Three Social Concerns Impacting Health



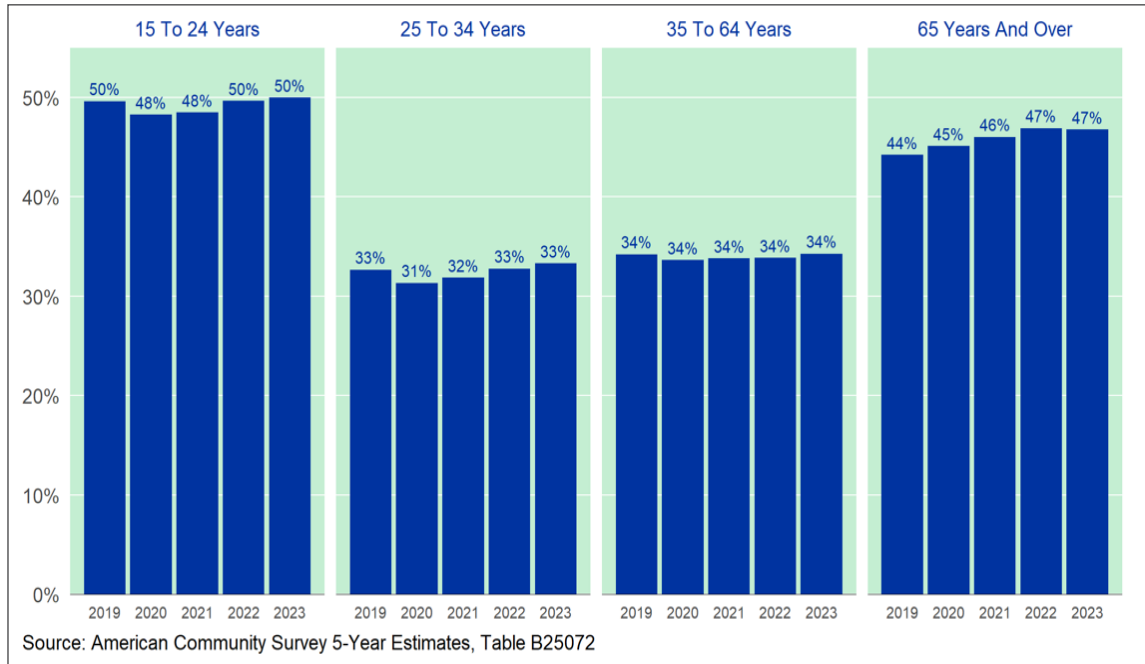
Economic instability

Focus groups and Care-A-Van participants described low wages, lack of job opportunities and the high cost of living as major contributors to stress and poor health. Community members discussed how the high cost of living, coupled with low wages and lack of job opportunities lead to financial stress within the community that Bon Secours — Hampton Roads serves. Many participants shared how health can become a secondary concern when combined with the reality of stressors related to immediate needs in their lives, such as food, housing and economic stability.

Capacity and adequacy of service levels

The health indicators and statistics highlighted in this section describe some of the data related to economic instability. Figure 5 shows the percentage of all families in poverty across each jurisdiction in the Bon Secours community served.

Figure 5. Percent of All Families in Poverty, 2023



Certain jurisdictions have much higher poverty rates than others, and most have higher poverty rates than the Virginia average. For many of the significant health needs identified through this CHNA, jurisdictions with higher poverty rates also have more negative health outcomes. Figure 6 highlights regional differences in income. It shows the percentage of children who receive free or reduced lunch by jurisdiction.

Figure 6. Percentage of Children Eligible for Free or Reduced Lunch by Jurisdiction, 2024

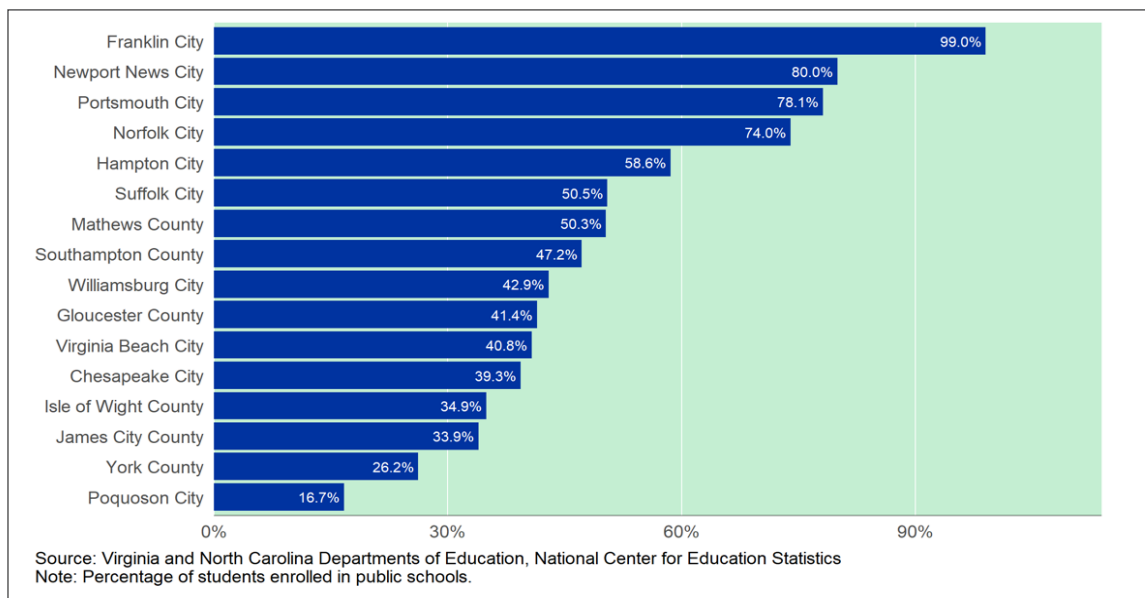
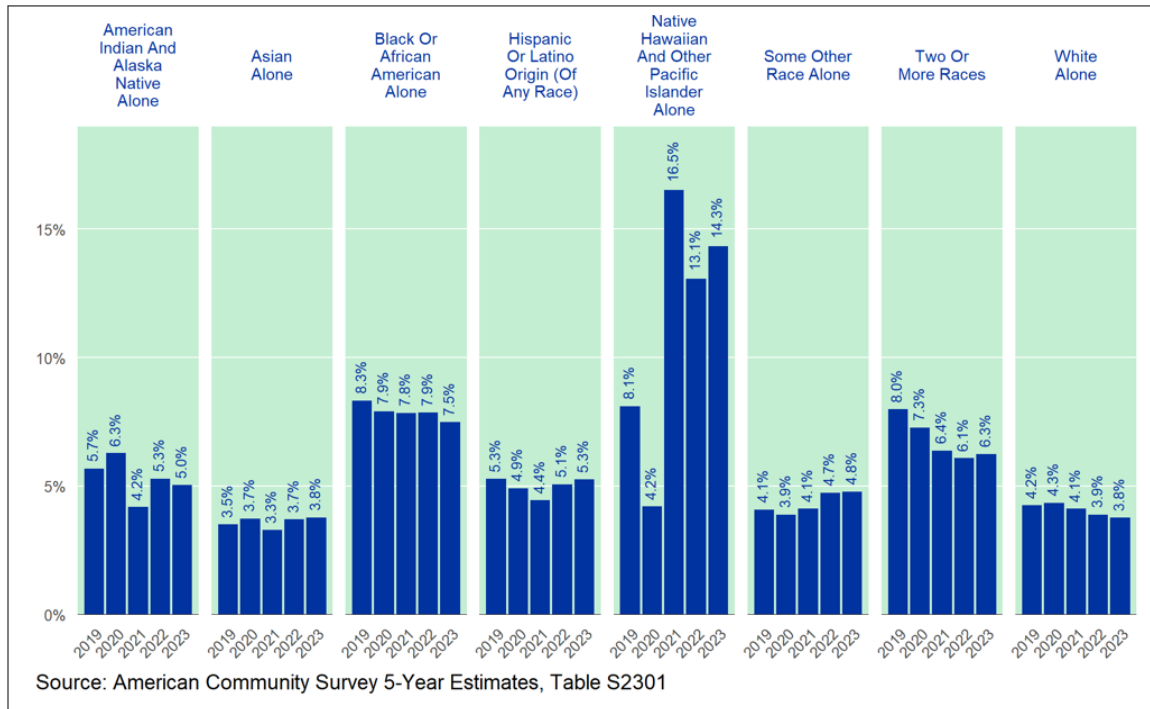


Figure 7 shows unemployment by race for the Bon Secours service area. It highlights that unemployment differences are experienced more by some races, such as Black or African Americans, than by Whites. As a comparison, according to the U.S. Bureau of Labor Statistics, in 2024, Virginia's annual unemployment rate was 2.9%.

Figure 7. Unemployment Rate by Race, 2019-2023



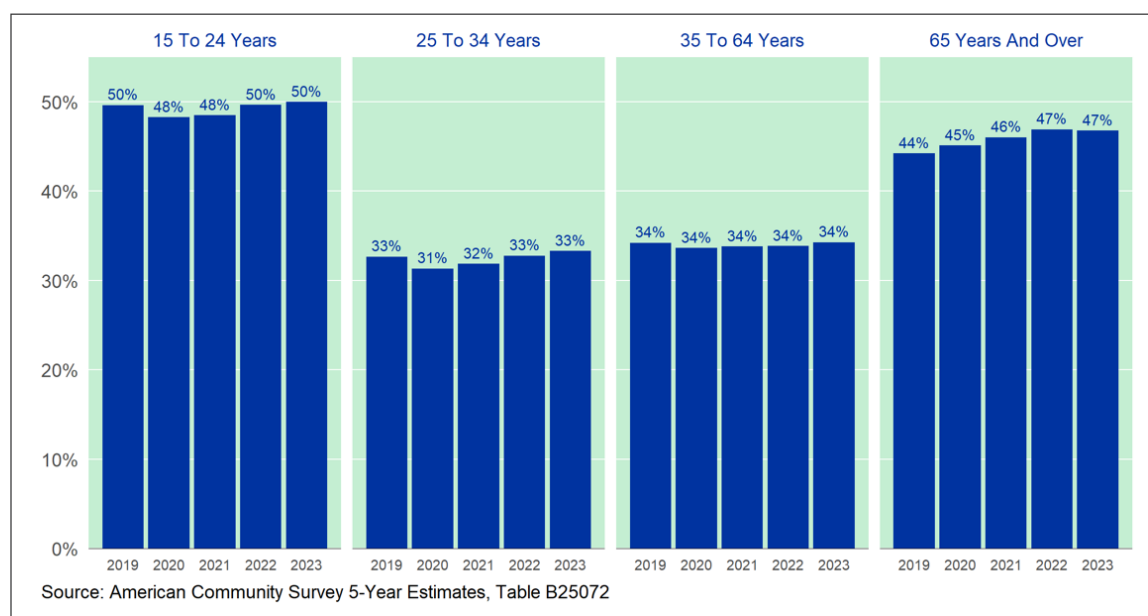
Housing insecurity

Focus groups and Care-A-Van interviews consistently described the stress of high housing costs, limited affordable housing stock and the visible presence of homelessness. Participants explained that rent consumes such a large share of income that families must cut back on food, health care and transportation. Seniors and veterans were noted as especially vulnerable to housing insecurity. Housing insecurity was described as a community-wide crisis with ripple effects on safety, mental health and children's well-being.

Capacity and adequacy of service levels

Figure 8 shows the percentage of households by age group that pay more than 35% of their household income towards rent. Households aged less than 24 and older than 65 are most affected by high rent rates compared to their annual income.

Figure 8. Percentage of Households Paying More Than 35% of Household Income for Rent by Age, 2019-2023



Food insecurity

Community members across focus groups emphasized the challenge of affording and accessing healthy food. Participants described how the high cost of living coupled with low wages makes healthy food less attainable. Fast food often becomes the more feasible, but far less healthy, option. Care-A-Van interviewees reinforced this theme. They noted that the high cost of healthy food and the lack of nearby grocery stores push families toward unhealthy eating habits. They also highlighted the need for farmers' markets and food pantries as added support for families who were struggling to access healthy foods.

Capacity and adequacy of service levels

Figure 9 shows the percentage of people with low income who have less access to a grocery store and limited ability to access healthier foods, especially if transportation is a barrier. The majority of jurisdictions in the community served have more people with less access than the Virginia average.

Figure 9. Percentage of People with Low Incomes and Who Do Not Live Close to a Grocery Store, 2023

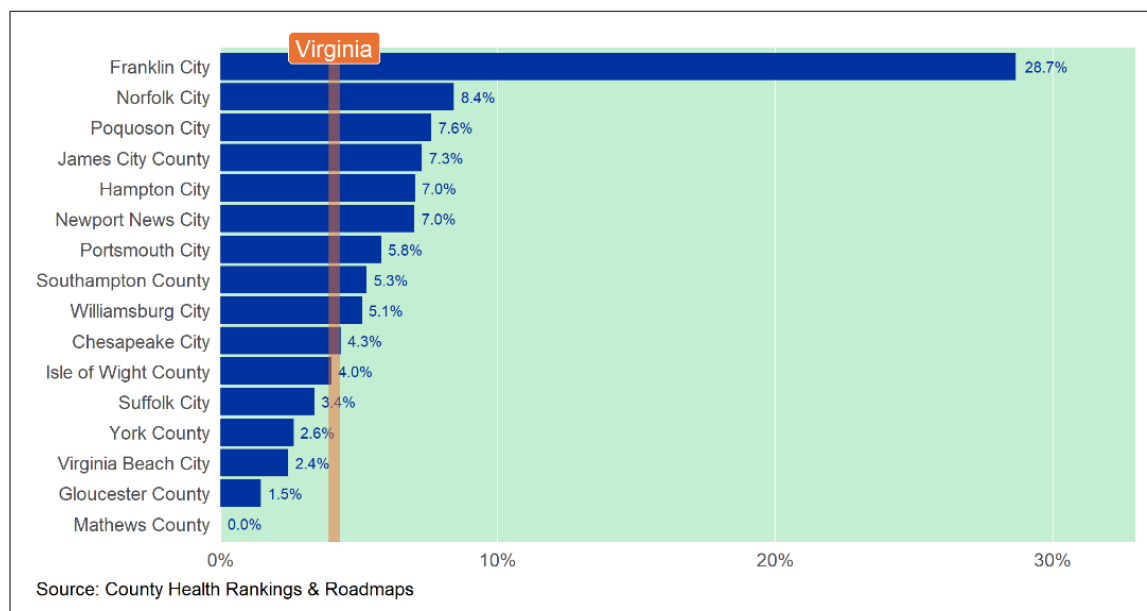
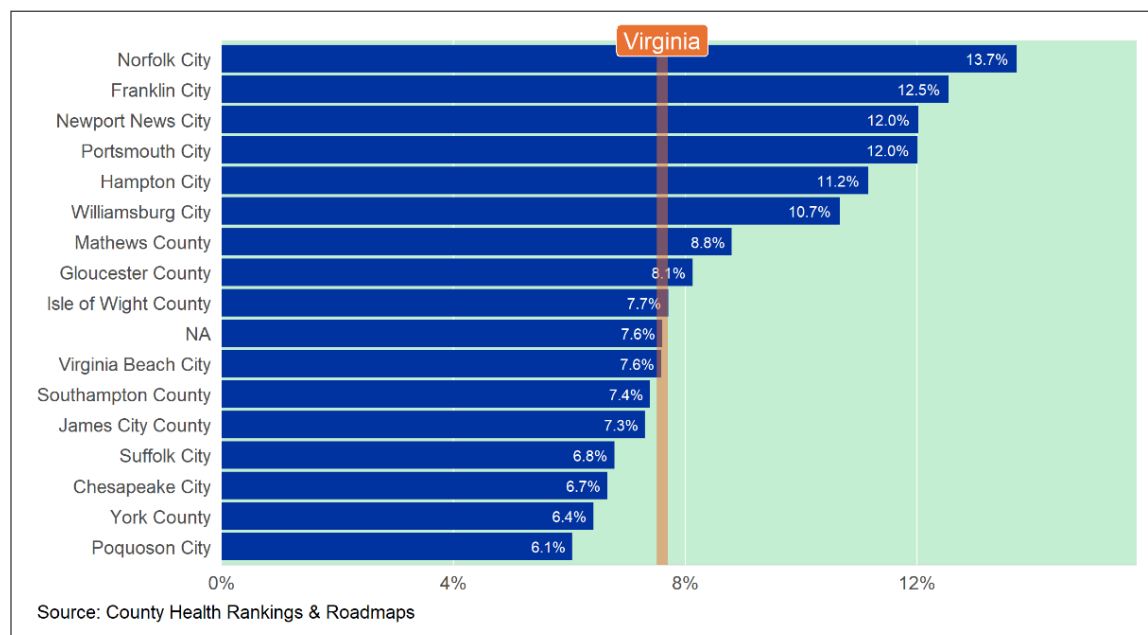


Figure 10 highlights how some jurisdictions, such as Norfolk, have a much higher percentage of people without a reliable source of food than the Virginia average or other jurisdictions that Bon Secours serves.

Figure 10. Percentage of People without a Reliable Source of Food, 2023



Community violence

Community members consistently identified violence — both within neighborhoods and in homes — as a pressing barrier to health and well-being. Participants described unsafe neighborhoods, gun violence and youth exposure to crime as major stressors. Many tied violence to broader issues such as poverty, lack of youth engagement opportunities and deteriorating housing conditions. Some participants reported that fear of crime limited their use of parks and outdoor spaces, which in turn reduced opportunities for exercise and social connection.

Capacity and adequacy of service levels

Health data seems to confirm these perceptions. Homicide and firearm-related death rates in several Hampton Roads jurisdictions are significantly higher than Virginia averages (Figures 11 and 12). Some jurisdictions in the community that Bon Secours serves are significantly more affected than others.

Figure 11. Rates of Deaths Due to Firearms, 2023

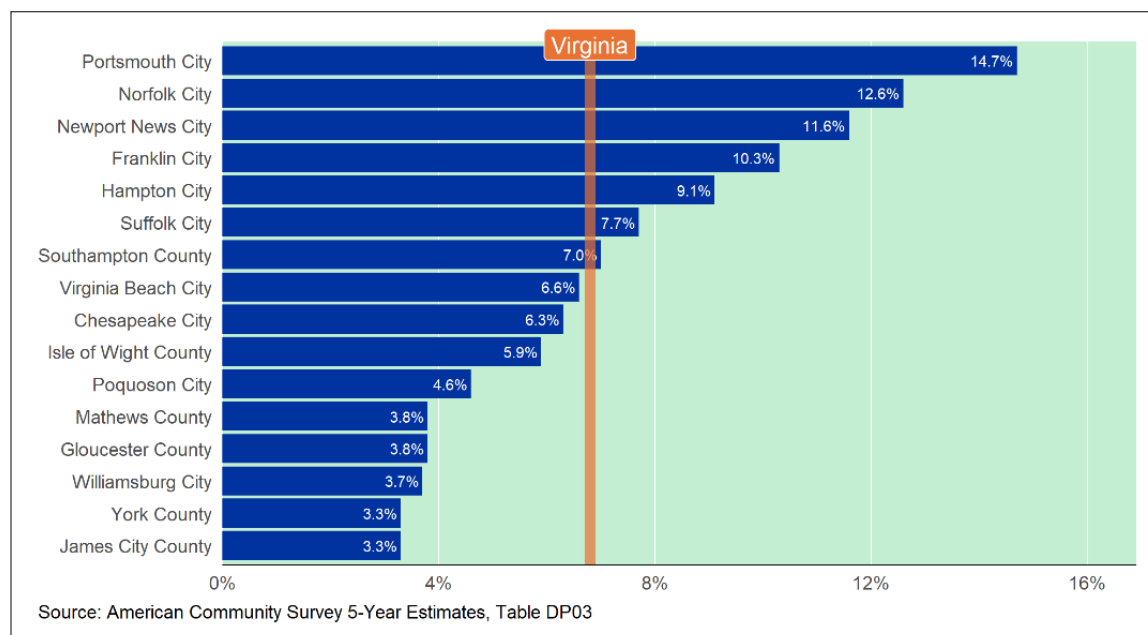
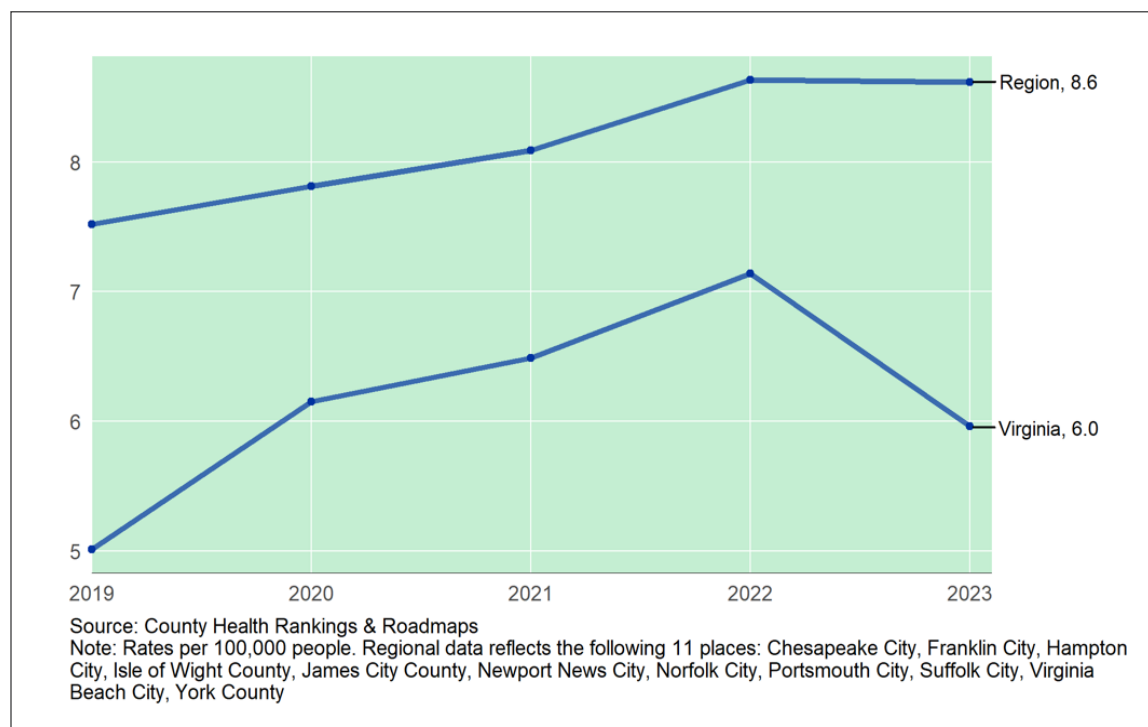


Figure 12. Rates of Homicide, 2019-2023



Social Health Needs — Individual Level Non-Clinical Needs

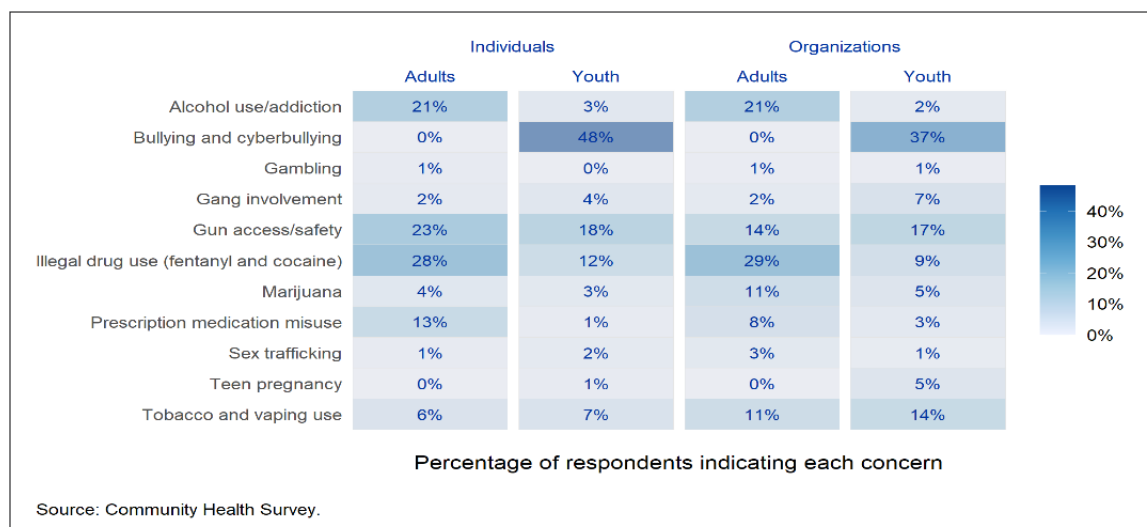
Social health needs are non-clinical, personal circumstances that directly affect an individual's ability to maintain their personal health or access care. They often result from or are influenced by some of the social determinants of health. In this section, the following social health needs will be discussed in more depth:

- Alcohol and substance use
- Loneliness and social isolation

Alcohol and substance use

In the Community Health Survey, shown in Figure 13, individuals and organizations identified illegal drug use and alcohol use and addiction as the substance use issues of greatest concern.

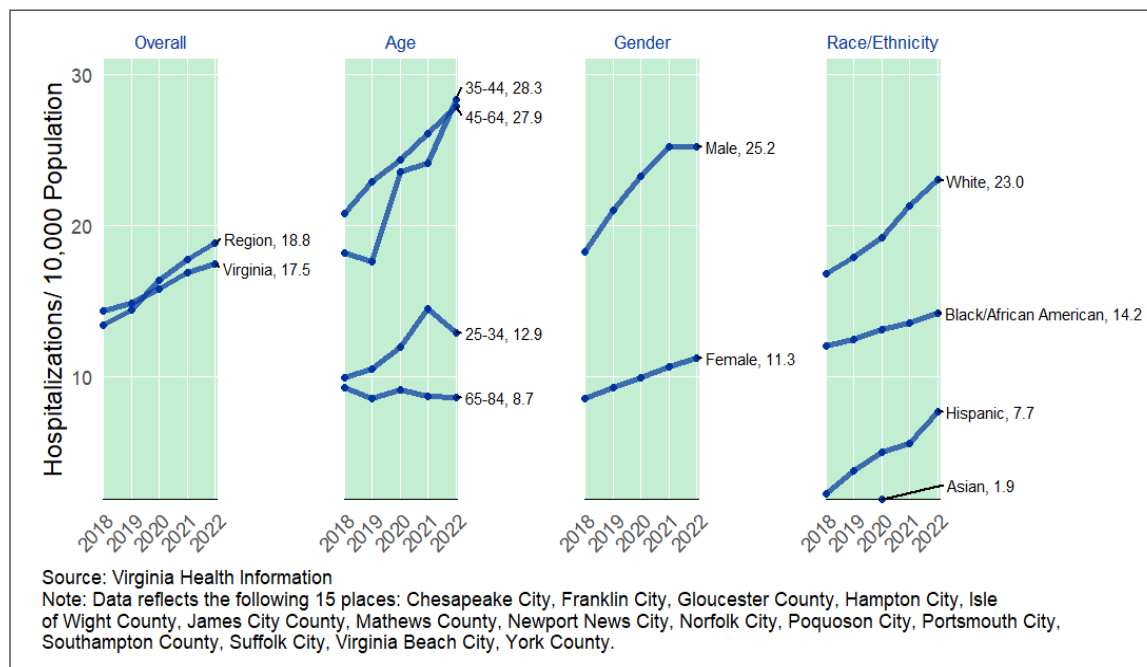
Figure 13. Survey Question: Select the ONE Greatest Concern for Adults and Children



Capacity and adequacy of service levels

Hospitalization rates due to alcohol abuse, substance use and opioid use all continue to rise among most demographic groups. Figure 14 shows hospitalization rates due to adult alcohol use. Rates are similarly rising for substance use and opioid use, except that Blacks are nearly just as impacted as Whites (available in Appendix E).

Figure 14. Age-Adjusted Hospitalization Rate Due to Adult Alcohol Use, 2018-2022



Loneliness and social isolation

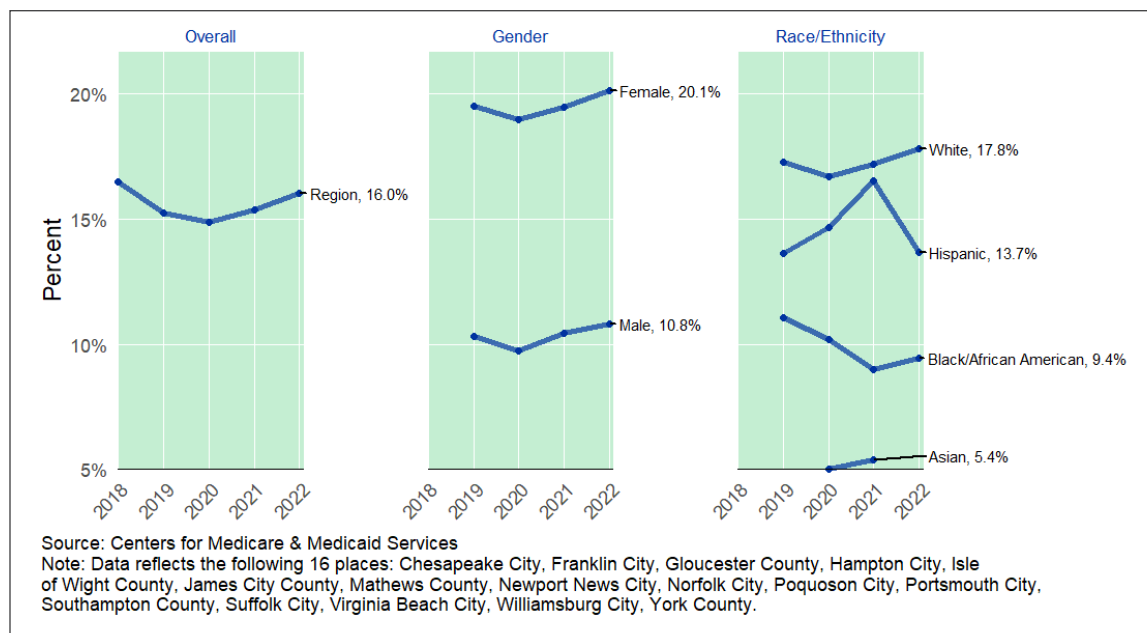
Focus groups highlighted loneliness and social isolation, particularly among older adults, as a key factor affecting health. Among Community Health Survey participants, 27% of individuals identified social isolation as one of their top social concerns (previously shown in Figure 4). Participants in focus groups discussed the impact of dwindling social networks, the loss of longtime community members and the challenges of maintaining independence as they age.

Feelings of loneliness were described as having both emotional and physical consequences, such as worsening chronic conditions or less motivation to seek medical care. Participants felt there was a lack of social programs and support services for aging adults, which left many feeling their needs were unmet by the health care system.

Capacity and adequacy of service levels

Given the concerns about isolation and depression that older adults reported during focus groups, statistics related to depression in the Medicare population were analyzed (Figure 15). These rates are rising slightly among Whites and Blacks, as well as Asians.

Figure 15. Depression Among Medicare Population, 2018-2022



Significant Clinical Health Needs

In this section, the following clinically significant health needs will be discussed in more depth:

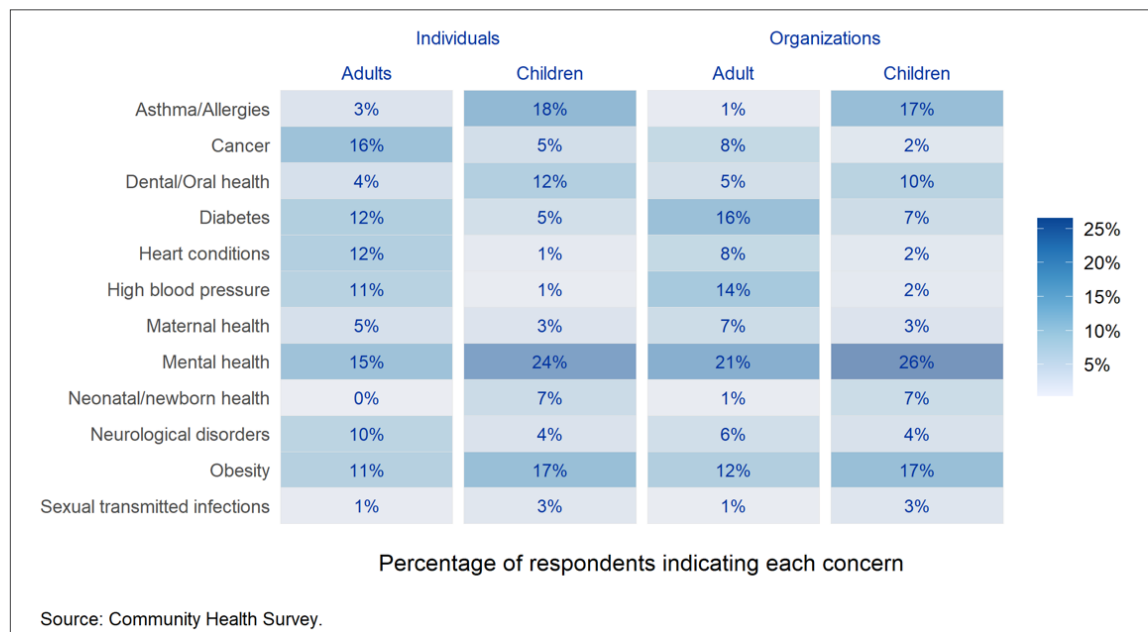
- Access to care
- Chronic health conditions
- Mental health
- Sexual health
- Maternal and child health

In the Community Health Survey, participants responded to a question asking them to prioritize health issues, shown in Figure 16. Of participants who responded, the top health concerns for adults (i.e., selected by at least 10% of organizations or individuals) included:

- Mental health
- Cancer
- Diabetes
- Heart conditions
- High blood pressure
- Obesity
- Neurological disorders

Of the top concerns listed above, the vast majority are chronic health conditions. Other significant clinical health needs were identified through a combination of community input, regional or demographic disparities or both in health outcomes identified through the health indicator analysis.

Figure 16. Survey Question: Select the Top Three Health Concerns for Adults and Children



Access to care

Access to care was discussed in-depth at many of the focus group discussions. Community advisory board, focus group and Care-A-Van interview participants described sometimes feeling that getting a needed appointment was an insurmountable task.

They mentioned long wait times for both primary care and specialty services, citing that wait times can extend for months and prevent some from getting routine checkups. Others required reliance on emergency departments for non-urgent needs.

Care-A-Van clients often mentioned the need for more specialists directly in the community to help residents get the care they need without having to travel.

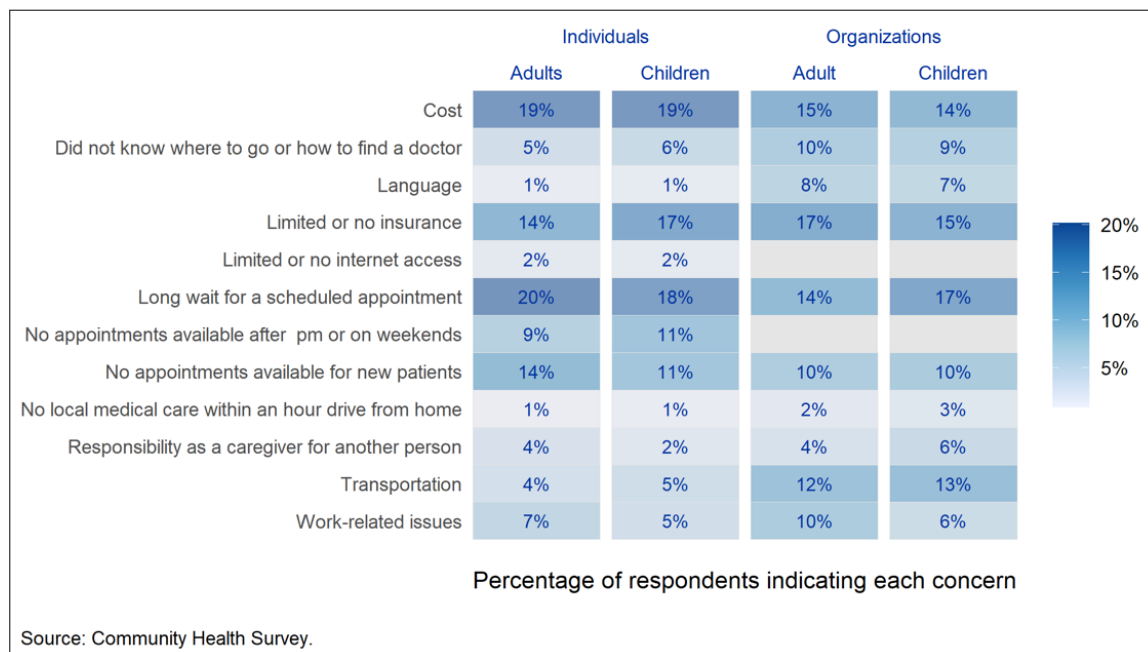
The most mentioned specialty services needed were:

- Mental health treatment
- Dentistry
- Substance abuse treatment
- Medication management

Along with a perceived shortage of providers, participants talked about numerous logistical challenges involved in making the appointment and getting there, including limited transportation options. Many participants shared that even when appointments were available, navigating the scheduling process — often involving confusing online systems that required lengthy phone calls — added to their frustration and stress. Many felt that these barriers prevented them from addressing health concerns until they became emergencies.

In the Community Health Survey, the cost of care, long waits for appointments and limited or no insurance emerged as barriers to accessing health care resources and services (Figure 17). Since 44% of survey participants were over 65, priorities around limited insurance and appointment availability may relate to providers who take Medicare, especially given that 92.2% of residents in the Bon Secours service area have access to some form of health insurance.

Figure 17. Survey Question: Select the Top Three Barriers to Accessing Health Care Resources and Services



Health literacy and system navigation

Health literacy and the ability to navigate the health care system are other important aspects of access to care. A large number of participants expressed frustration with the complexity of the health care system. They described problems understanding insurance requirements, completing extensive paperwork and navigating digital platforms like patient portals.

These administrative hurdles were seen as major barriers to receiving care, particularly for those with lower levels of health literacy or limited familiarity with technology. Participants noted that the lack of clear, accessible information often leaves them feeling lost or overwhelmed when trying to advocate for their own health.

Some Care-A-Van interview participants felt there were helpful resources and services available to the community. But many felt that they were not being advertised effectively and that a greater understanding of available resources and services could improve access and usage.

Cultural and trust barriers

Focus group participants discussed past negative experiences with health care providers related to cultural differences and their impact on influencing trust in the health care system. Many participants recounted instances of perceived bias or dismissiveness by health care providers, which have led to lingering mistrust — particularly among communities of color. Language barriers and cultural misunderstandings further complicated these interactions, making some individuals reluctant to seek care or fully disclose their health concerns.

Capacity and adequacy of service levels

Figure 18 shows the ratio of population to dentists, mental health providers and primary care physicians. This ratio can indicate the degree of difficulty people may or may not have in accessing care. Smaller ratios of providers per capita indicate that there are more providers available for people who need them. In this case, the region's averages are close to Virginia's average.

Figure 18. Access to Care (population per provider), 2019-2023

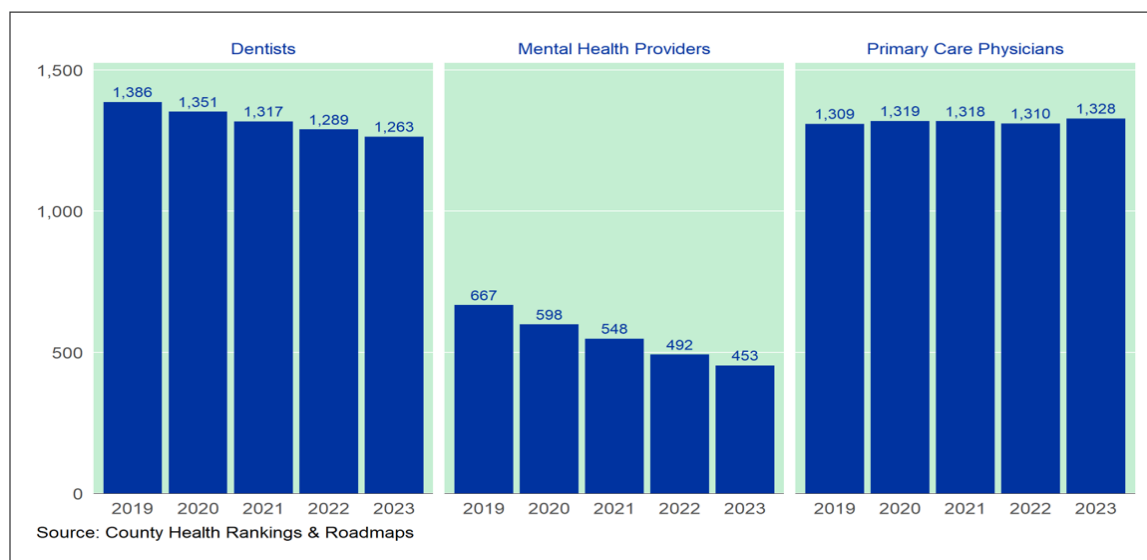
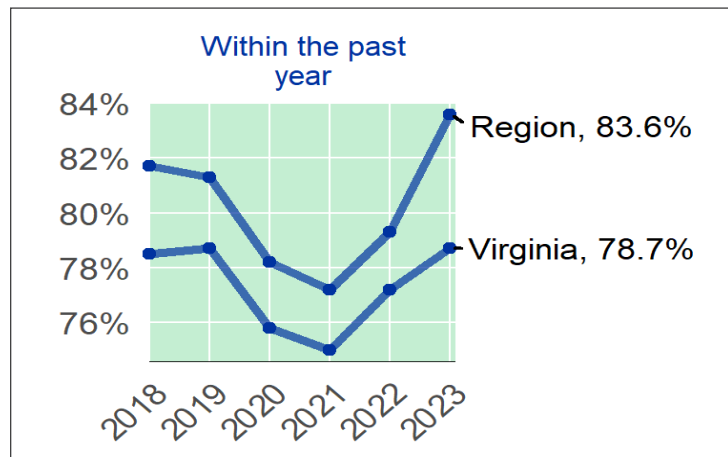


Figure 19 shows that more residents in the Hampton Roads region went to a routine checkup in the last year than the Virginia average.

Figure 19. Length of Time Since Last Routine Checkup, 2018-2023



Chronic health conditions

There were repeated concerns about preventing and managing chronic disease. Chronic diseases such as diabetes, heart disease and cancer are among the top causes of disability and death in the Hampton Roads area.

Adults in the focus groups frequently mentioned chronic health conditions, including:

- Diabetes
- Hypertension
- Heart disease
- Kidney disorders
- Obesity

They emphasized the significant ripple effect of these conditions on their daily lives — impacting work, family responsibilities and overall quality of life. Participants spoke about the challenges of maintaining a consistent treatment regimen, managing multiple medicines and coordinating care among several specialists. The chronic nature of these diseases was underscored by the emotional toll and the financial strain associated with ongoing medical appointments, tests and treatments.

Participants also emphasized the need to focus on prevention — in terms of preventing the conditions and treating them early so they didn't escalate. Some Care-A-Van interview participants identified a lack of safe places for physical activity as a barrier to the community's health. They also discussed the importance of and need for nutrition education to support better health. This would include teaching people where to purchase healthy food, how to prepare it and how nutrition impacts health.

Capacity and adequacy of service levels

The graph in Figure 20 shows age-adjusted hospitalization rates for adults 18 years and older due to diabetes. It's segmented by age, gender and race/ethnicity. Cases include a primary diagnosis of Type 1 and Type 2 diabetes. Cases of gestational diabetes are excluded. Differences in hospitalization rates for diabetes suggest that diabetes may not be as well-controlled among certain demographic groups. They also suggest potential issues related to access to care — either primary care or specialists, ability to access medication or access to healthy food and places to exercise. The differences can also be indicators of potential needs related to primary care, education, medicine management or prevention.

Figure 20. Age-Adjusted Hospitalization Rate Due to Diabetes, 2018-2022

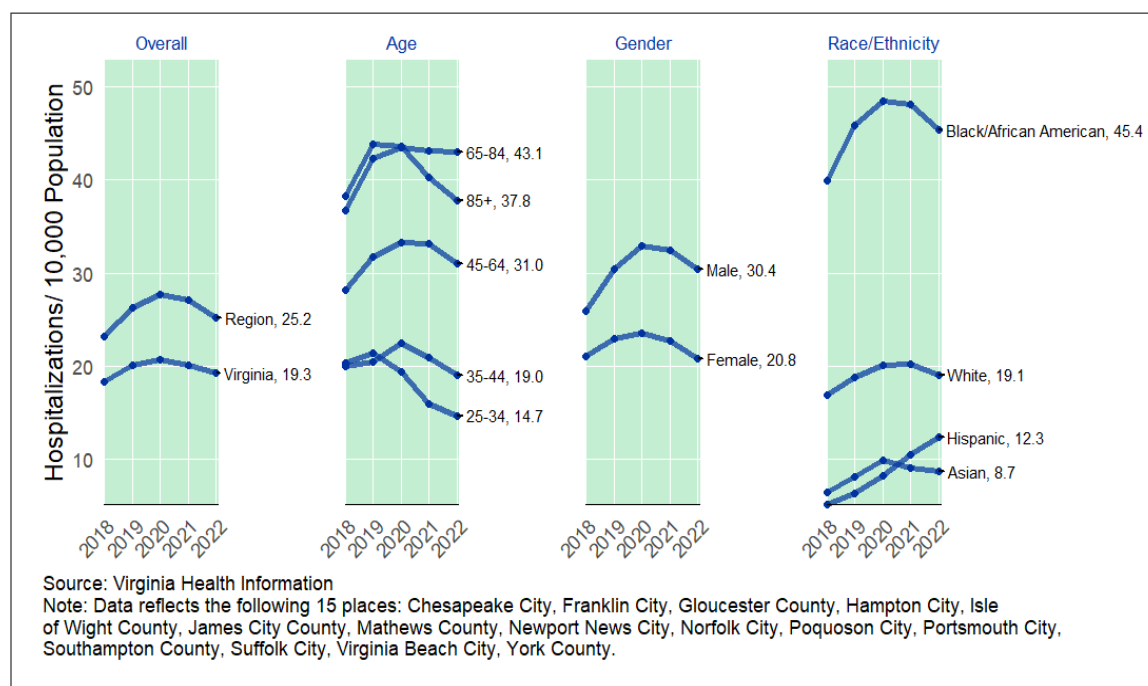


Figure 21 shows the age-adjusted incidence rate for all cancer sites in cases per 100,000 population.

Figure 21. All Cancer Incident Rate, 2018-2021

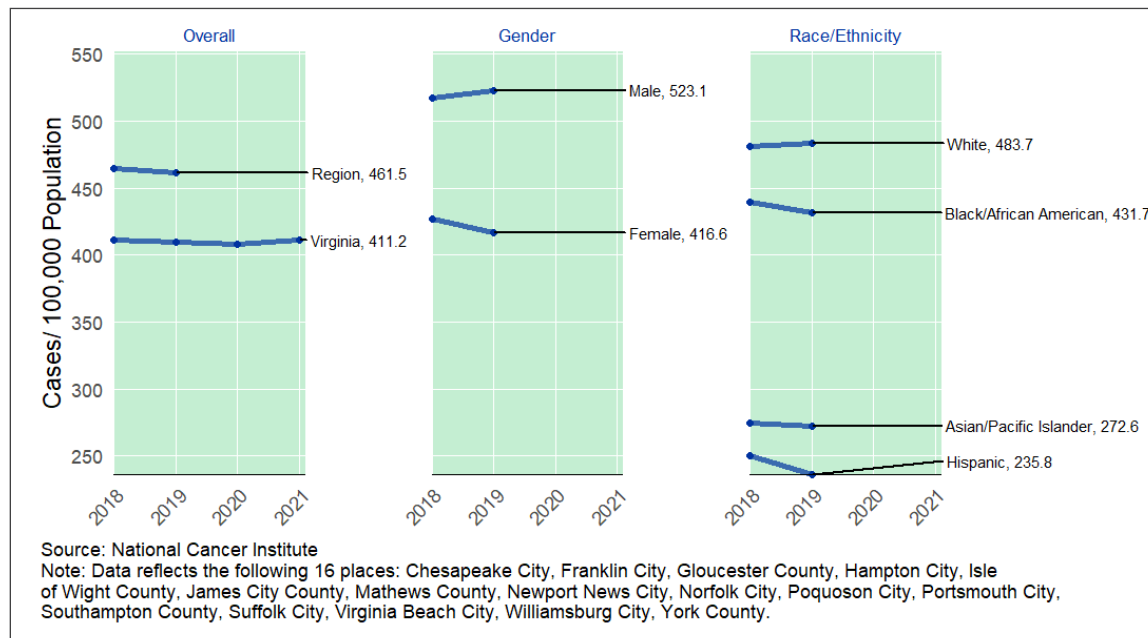
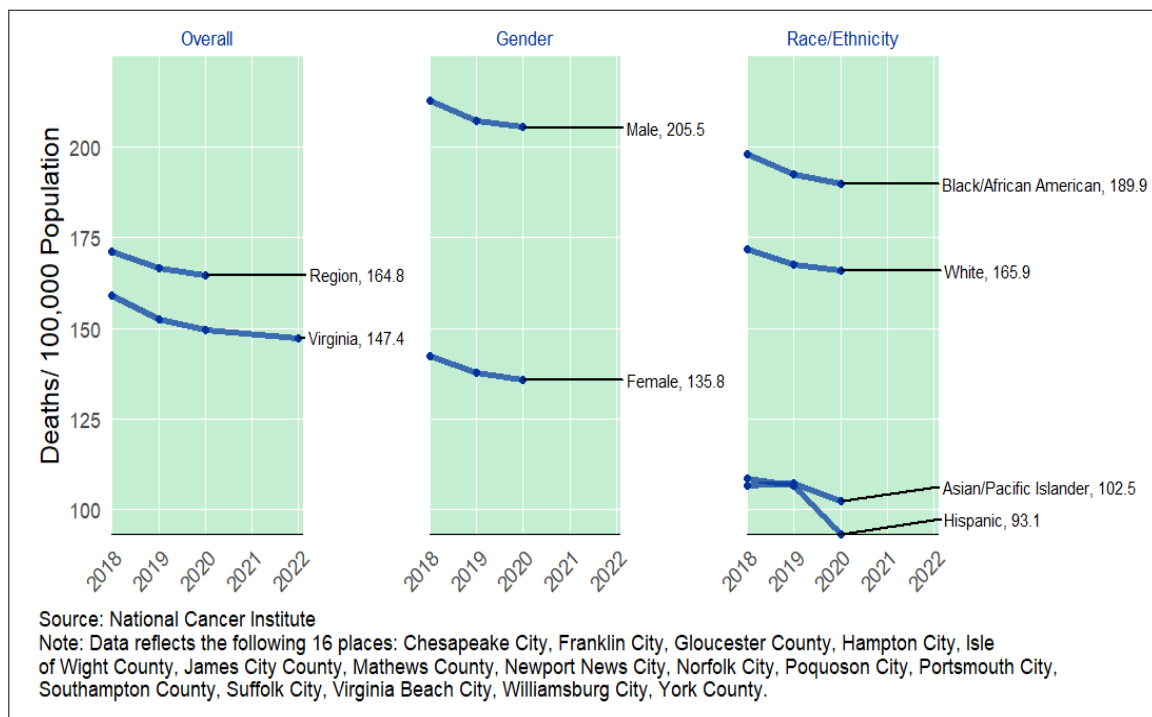


Figure 22 shows the rates of people dying from cancer. In both figures, the regional rates are higher than Virginia's rates. However, there are differences between who is affected by incidence and treatment. While whites have a higher incidence of cancer, more Blacks are dying from cancer. These graphs could indicate potential differences in when screenings are sought out, access to screenings, access to treatments, severity of cancer or a combination of these things.

Figure 22. Age-Adjusted Death Rate Due to Cancer, 2018-2022



Additional health indicator data related to different chronic conditions can be found in Appendix E.

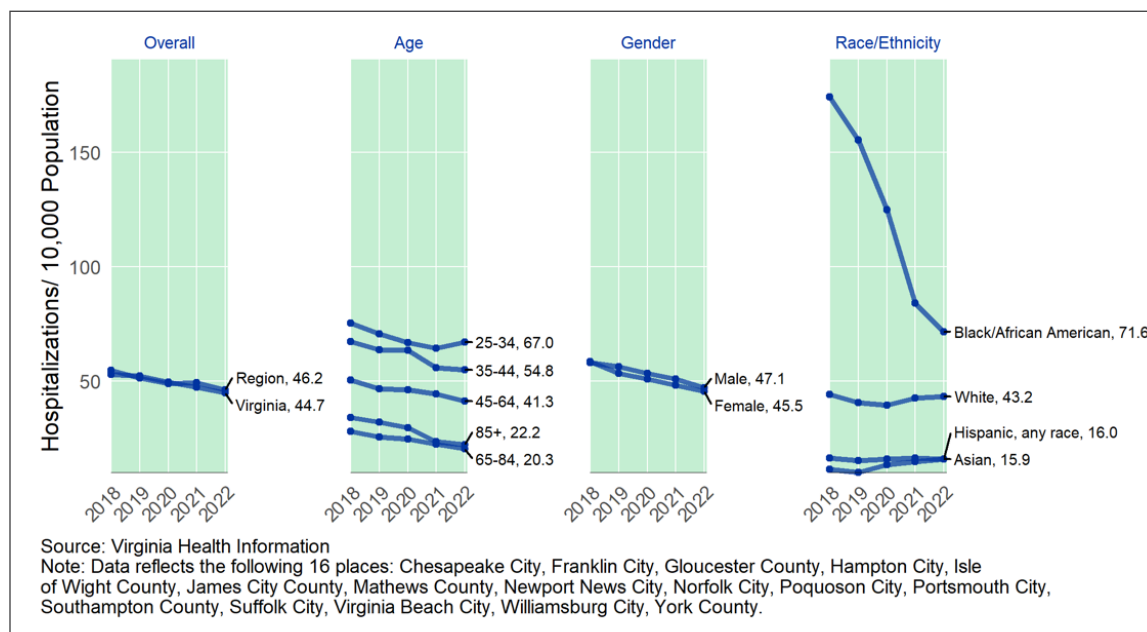
Mental health

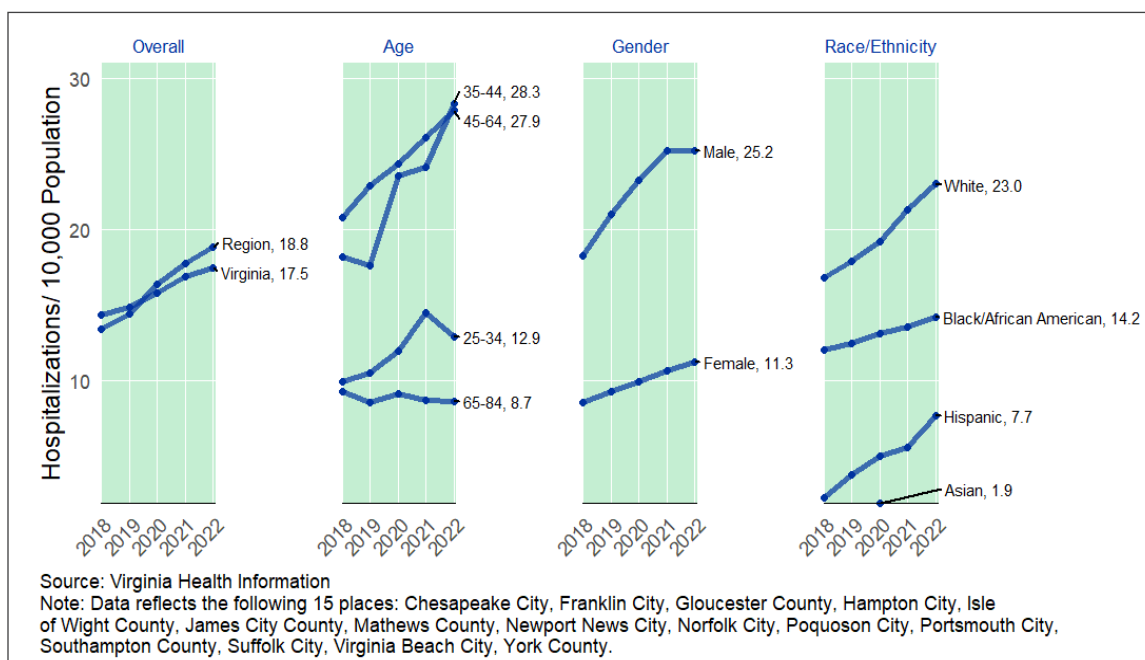
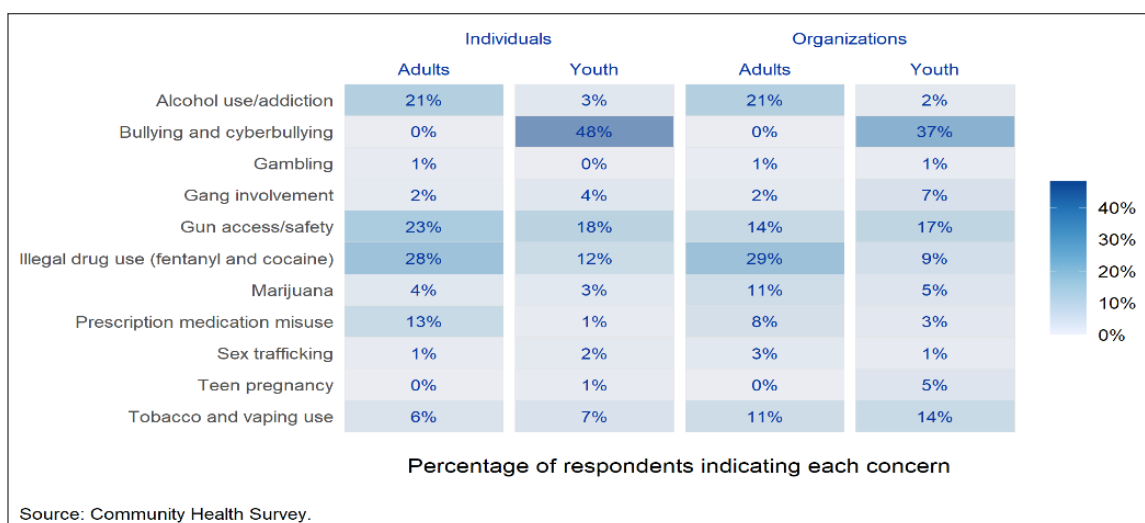
Mental health impacts physical health, emotional health and quality of life. In the Community Health Survey, community members prioritized mental health as one of the top two health concerns (as previously shown in Figure 16). Mental health was also prioritized as the top health concern by organizations who participated in the survey. Focus groups discussed the lack of mental health services available and long waiting lists for appointments. The previous section on loneliness and isolation discussed dwindling social networks, challenges in maintaining independence and loss of friends and community. These issues may be tied to concerns about mental health and exacerbate the problem.

Capacity and adequacy of service levels

The service levels of mental health providers were highlighted previously in Access to Care. Over the last five years, the ratio of mental health providers per capita has been decreasing, which indicates that there are more providers available for people who need them. Figure 23 shows age-adjusted hospitalization rates due to adult mental health. It indicates that adult mental health rates seem to be improving. These statistics may reflect mental health improvement since COVID-19. There are particularly marked improvements among Blacks/ African Americans.

Figure 23. Age-Adjusted Hospitalization Rate Due to Adult Mental Health, 2018-2022





Sexual health

Sexually transmitted infections (STIs) were not an issue raised by the community during focus groups, community advisory board meetings or through Care-A-Van interviews. It was among the lowest issues prioritized in the Community Health Survey question that asked participants to prioritize health issues (see Figure 9). However, it's included in the CHNA as a significant clinical health need given the higher rates of STIs among the Hampton Roads service area compared to Virginia, as highlighted in the health indicator analysis.

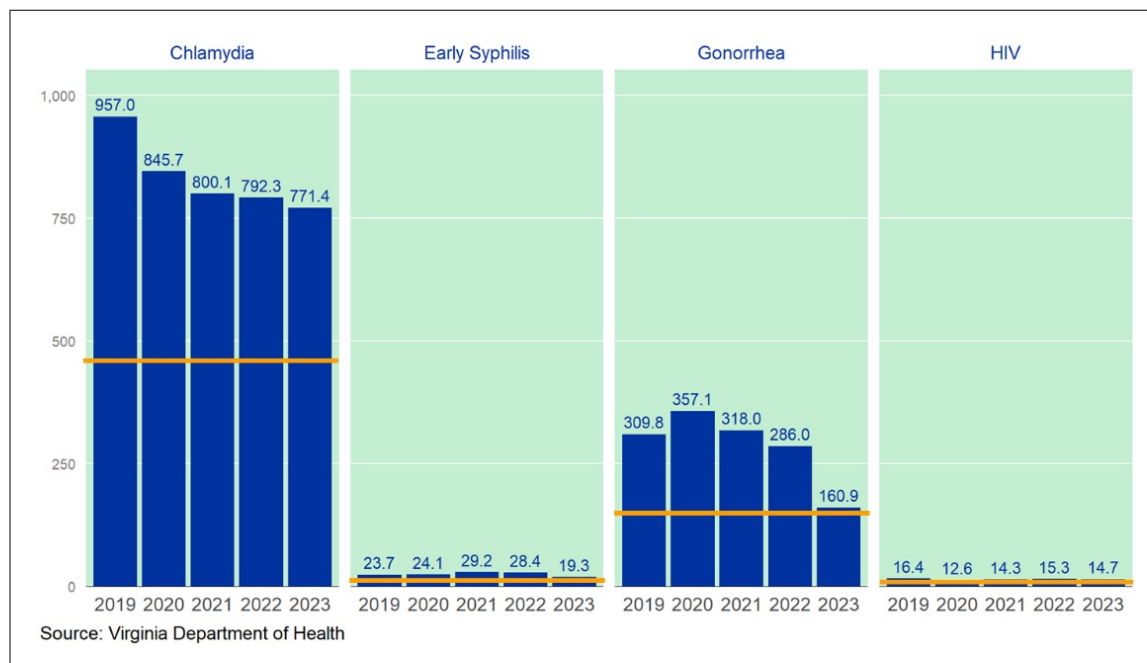
Capacity and adequacy of service levels

This data in Figure 24 shows newly diagnosed STI cases for chlamydia, early syphilis, gonorrhea and HIV. In all cases, the regional average is higher than Virginia's average. This is particularly the case for chlamydia. The rates for all four STIs have been consistently falling in the last few years.

Virginia's average rates of newly diagnosed cases per 100,000 people are listed below and indicated by the orange line in Figure 24.

- Chlamydia: 473.0
- Early Syphilis: 17.9
- Gonorrhea: 155.7
- HIV: 11.0

Figure 24. Rates of Newly Diagnosed STI Cases (Cases per 100,000 population), 2019-2023



Maternal and infant health

Maternal and child health were not issues raised by the community during focus groups, community advisory board meetings or through Care-A-Van interviews. They were also among the lowest issues prioritized in a Community Health Survey question that asked participants to prioritize health issues (see Figure 9). Data is included here as a significant clinical health need given the regional and demographic disparities highlighted in the health indicator analysis.

Capacity and adequacy of service levels

Figure 25 indicates the infant mortality rate per 1,000 as well as low birthweight babies. For both infant mortality and low birthweight babies, Virginia and regional rates are similar. There are substantial health outcome differences among white and Black babies, which could be potential indicators of a number of health factors, including access to prenatal care.

Figure 25. Rates of Infant Mortality and Low Birthweight Babies (Cases per 1,000 live births), 2018-2022

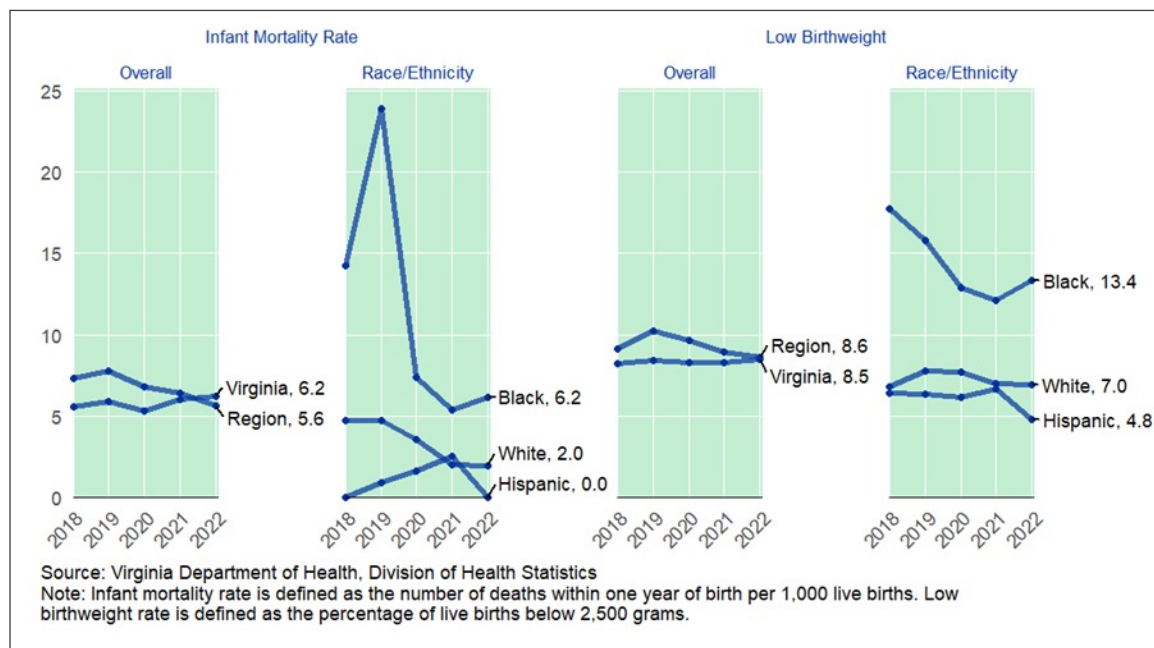
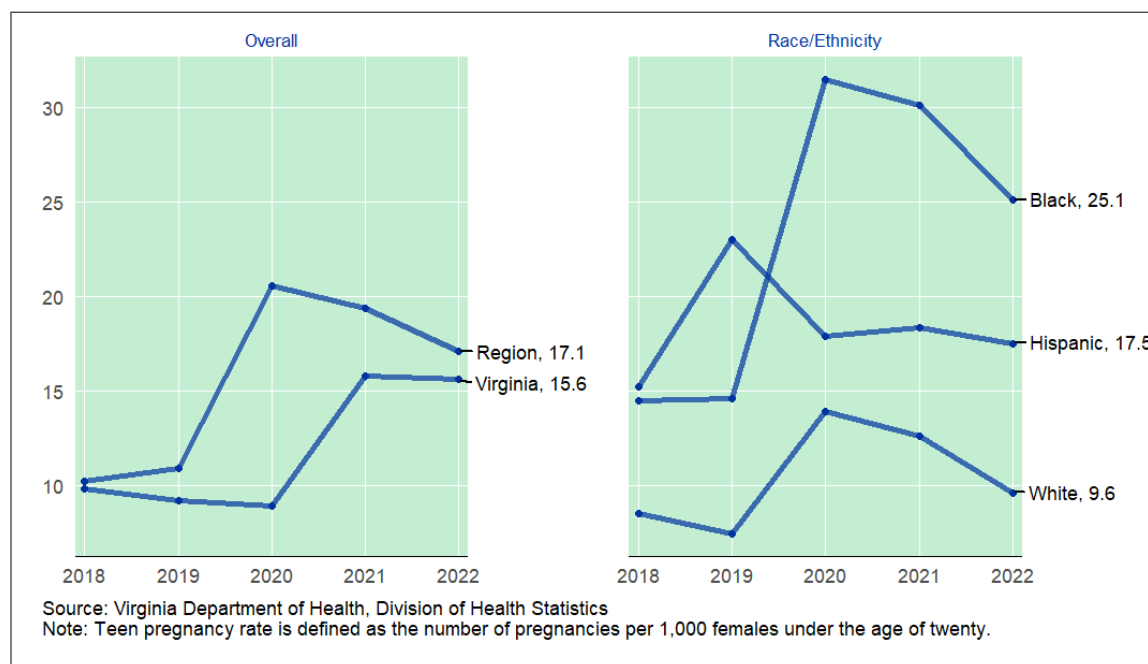


Figure 26 shows teen pregnancy rates. In this case, the regional rates are slightly higher than Virginia's rates. There are also large differences among demographic groups in terms of who is most affected by teen pregnancy.

Figure 26. Teen Pregnancy Rate (per 1,000 females under 20), 2018-2022



Resources Available

Due to the considerable and complex nature of the community-identified significant health needs, there are several organizations within the Bon Secours — Hampton Roads service area that may be available to address one or more of the needs identified in this report. The resources are organized into three categories: Health Care Facilities & Services, Health Departments, and Other Local and National Resources.

Health Care Facilities and Services

Bon Secours — Hampton Roads Health System (Maryview, Southampton Medical Center, Mary Immaculate, Harbour View)

- Services/Resources: Provides acute inpatient care, specialty services (cardiology, oncology, bariatric, glycemic control, chronic disease management), emergency and trauma care, maternal and child health, behavioral health units (MMC and SMC) and mobile primary/preventive care.

- Community programs: Care-A-Van (mobile community health clinic), Community Health Hub, Passport to Health Program, FEAST (Nutrition Education Program), Healthy Food Pantry, Mobile Mini Food Pantry (Ride alongside the Care-A-Van), Community Learning Garden, Children Bereavement Program – KidZN’Grief, Community Education Programs, Diabetes Education, Stroke Prevention.
- Needs Addressed: Access to Care, Chronic Health Conditions, Maternal & Child Health, Mental Health, Alcohol & Substance Use, Sexual Health, Food Insecurity, Loneliness & Social Isolation, Community Violence

Sentara Healthcare

- Services/Resources: Regional health system with multiple hospitals and outpatient facilities providing comprehensive inpatient/outpatient services, trauma, maternal and child health, mental health, substance use treatment and wellness programs.
- Needs Addressed: Access to Care, Chronic Health Conditions, Maternal & Child Health, Mental Health, Alcohol & Substance Use

Children’s Hospital of the King’s Daughters (CHKD)

- Services/Resources: Specialty pediatric hospital offering inpatient and outpatient pediatric care, maternal-fetal health, pediatric mental and behavioral health, and chronic illness management.
- Needs Addressed: Chronic Health Conditions, Maternal & Child Health, Mental Health, Alcohol & Substance Use

Veterans Affairs Medical Center (Hampton)

- Services/Resources: Provides comprehensive medical, mental health and rehabilitative care to veterans, including primary care, specialty clinics, behavioral health, substance use treatment and rehabilitation.
- Needs Addressed: Access to Care, Chronic Health Conditions, Mental Health, Alcohol & Substance Use

Hampton Roads Community Health Centers (HRCHC)

- Services/Resources: Federally Qualified Health Center offering primary care, pediatrics, OB/GYN, behavioral health, dental and preventive services for uninsured and underinsured populations.
- Needs Addressed: Access to Care, Chronic Health Conditions, Maternal & Child Health, Sexual Health, Mental Health

Lackey Clinic

- Services/Resources: Faith-based free clinic offering primary care, chronic disease management, specialty services (psychiatry, nephrology, rheumatology), dental, optometry, behavioral health counseling, pharmacy and 24/7 virtual urgent care.
 - Needs Addressed: Access to Care, Chronic Health Conditions, Mental Health, Alcohol & Substance Use

Olde Towne Medical & Dental Center

- Services/Resources: Community health clinic providing primary care for adults and children, behavioral health, dental, optical, OB/GYN, immunizations, specialty care, medication assistance and case management with referrals for housing, food and violence prevention.
 - Needs Addressed: Access to Care, Maternal & Child Health, Sexual Health, Chronic Health Conditions, Mental Health, Housing Insecurity, Food Insecurity, Community Violence

HELP Clinic (Richard F. Clark HELP Clinic)

- Services/Resources: Volunteer-driven clinic offering free medical exams, diabetic counseling, specialty referrals, dental care, pharmacy services and counseling. Provides food pantry, bag lunches, clothing, showers, laundry, mail/document assistance, financial aid and transitional housing support.
 - Needs Addressed: Access to Care, Chronic Health Conditions, Food Insecurity, Housing Insecurity, Economic Instability

HOPES Free Clinic (EVMS – Norfolk)

- Services/Resources: Student-run free clinic offering primary and specialty care (dermatology, ENT, gynecology, ophthalmology, orthopedics, sports medicine, pain management, women's health). Includes a mental health clinic for uninsured and undocumented patients. Provides case management referrals.
 - Needs Addressed: Access to Care, Chronic Health Conditions, Maternal & Child Health, Sexual Health, Mental Health

Health Departments and Community Service Boards

Virginia Department of Health

Local Health Districts: Norfolk Health District, Portsmouth Health District, Chesapeake Health District, Virginia Beach Health District, Western Tidewater Health District (serves Suffolk, Franklin, Isle of Wight County, Southampton County), Peninsula Health District (serves Newport News and Williamsburg), Hampton Health District

- Services/Resources: Provide immunizations, maternal/child programs (WIC, MIECHV, newborn screening, Safe Sleep Virginia), sexual health (HIV prevention, STI treatment, PrEP), harm reduction, violence prevention, suicide prevention, chronic disease prevention and public health clinics.
 - Needs Addressed: Maternal & Child Health, Sexual Health, Food Insecurity, Community Violence, Mental Health, Alcohol & Substance Use, Chronic Health Conditions, Access to Care

Community Services Boards (CSB)

Local CSBs: Norfolk, Portsmouth, Chesapeake, Western Tidewater, Hampton-Newport News

- Services/Resources: Public behavioral health agencies providing outpatient and inpatient mental health treatment, substance use services, crisis stabilization, developmental services and outreach.
 - Needs Addressed: Mental Health, Alcohol & Substance Use, Community Violence, Access to Care

Other Local and National Resources

(Note: Some of these organizations are grouped based on service provided and demographic group served.)

ACCESS Partnership

- Services/Resources: Referral network connecting uninsured and underinsured residents with medical providers, behavioral health and social services. Coordinates chronic disease care and helps with medication access.
 - Needs Addressed: Access to Care, Chronic Health Conditions, Mental Health

American Diabetes Association / American Heart Association

- Services/Resources: Provide education, advocacy, screenings and community programs to prevent and manage diabetes and cardiovascular disease.
- Needs Addressed: Chronic Health Conditions

Foodbank of Southeastern Virginia & Eastern Shore / Virginia Peninsula Foodbank

- Services/Resources: Provide emergency food, mobile pantries, SNAP outreach and nutrition programs. Work with schools and community partners to address hunger and nutrition disparities.
- Needs Addressed: Food Insecurity, Economic Instability, Chronic Health Conditions

ForKids / Union Mission Ministries / Virginia Supportive Housing

- Services/Resources: Offer emergency shelters, transitional housing, supportive housing, eviction prevention, workforce readiness and case management.
- Needs Addressed: Housing Insecurity, Economic Instability, Mental Health

Samaritan House / YWCA South Hampton Roads

- Services/Resources: Provide shelter, advocacy, counseling, hotlines and education programs for survivors of domestic violence and trafficking.
- Needs Addressed: Community Violence, Housing Insecurity, Maternal & Child Health, Mental Health

Healthy Families Virginia / Nurse-Family Partnership / Parents as Teachers / CHIP of South Hampton Roads

- Services/Resources: Evidence-based home visiting programs offering parenting education, child screenings, health referrals and family support. Address caregiver mental health and reduce isolation.
- Needs Addressed: Maternal & Child Health, Mental Health, Loneliness & Social Isolation

NAMI Coastal Virginia

- Services/Resources: Peer-led mental health education and support organization. Offers family and individual support groups, crisis intervention and stigma reduction.
- Needs Addressed: Mental Health, Loneliness & Social Isolation

Senior Services of Southeastern Virginia / Prime Plus / Peninsula Agency on Aging / Geriatrics Life Care

- Services/Resources: Provide senior-focused services including meals, transportation, caregiver support, social opportunities, case management and advocacy.
 - Needs Addressed: Loneliness & Social Isolation, Chronic Health Conditions, Economic Instability

Alcoholics Anonymous / Narcotics Anonymous / American Addiction Treatment Center / Peninsula Community Opioid Response

- Services/Resources: Offer peer recovery, outpatient/inpatient treatment, medication-assisted therapy, harm reduction and overdose prevention.
 - Needs Addressed: Alcohol & Substance Use, Mental Health



Prioritization of Health Needs

To prioritize needs, a thematic analysis was completed by examining data collected across all data sources — the Community Health Survey, focus groups, community advisory meetings, Care-A-Van interviews and the health indicator analysis. Significant health needs were identified within each data set and across all the data and community input collected. Individual and organization priorities for health needs (shown earlier in Figure 9) from the Community Health Survey were also reviewed separately and factored into the prioritization process. The survey included input on health priorities from health departments and organizations representing minority populations and medically underserved communities.

For the vast majority of the significant health needs identified and discussed in this report, there was large agreement across all data sources.

ToXcel, LLC developed a presentation that shared key findings for each of the data sets and highlighted themes across data sets. With input from hospital leadership, Bon Secours — Hampton Roads elected to identify priorities based on the following criteria:

- Magnitude: number of people impacted by problem
- Severity: the rate or risk of morbidity and mortality
- Opportunity for program intervention

These criteria allow Bon Secours — Hampton Roads to focus its resources to address critical health needs that affect many across the community.

From March 2025 to April 2025, the Community Health Director facilitated meetings to share the findings and discuss which health needs to prioritize. The meetings included hospital administrative and medical leadership, hospital community advisory boards and board of directors.

These Community Advisory Boards each have a range of organizations representing vulnerable, low-income, and other medically underserved populations. Organizations include:

- Bon Secours Medical Group
- City of Franklin
- Colonial Kidney
- Franklin Baptist Church
- Franklin City Public Schools
- Franklin-Southampton Chamber of Commerce
- Old Dominion University
- Paul D Camp Community College

- Roots & Wings Pediatrics
- Southampton Medical Center
- Southampton Academy
- Southampton Public Schools
- Southeastern Virginia Health System
- Southside Diabetes
- The Children's Center
- The Village at Woods Edge
- US Acute Care Solutions
- Virginia Department of Health
- Western Tidewater Free Clinic

Prioritized Health Needs

The following health needs were prioritized through this process.

Violence in the Community

Community violence was identified as a priority health need given the wide-ranging impact it has on the physical health, mental and emotional health, and quality of life of Hampton Roads residents.

Chronic Disease

Chronic health conditions rose as a priority across all data sets. Preventing and providing additional support to manage chronic diseases will have an important impact on the community served.

Mental Health

Improving mental health and increasing access to mental health services will be an important focus for Bon Secours over the next three years. While data supported a positive trend in mental health improvement, there is still work to be done. Community members and older people reported feeling socially isolated and felt their mental health was declining, which impacted their physical health.

Significant Health Needs Not Prioritized

Access to Care

Access to care will be addressed through the prioritized health needs of chronic disease and mental health.

Substance Use and Abuse

There are a number of existing community programs that focus on substance use and abuse. Bon Secours will also continue its work in this area through its Behavioral Health Unit at Maryview Medical Center and Detox Unit at Southampton Medical Center.

Sexual Health

There are other community programs that prioritize this area of work, including area health departments and the LGBTZQ Life Center.

Maternal and Child Health

There are other community programs that prioritize this area of work, including local health departments.



Progress and Impact

Neighborhood and Built Environment — Violence in the Community

Strategies	Progress
Establish Kidz'NGrief, Portsmouth, VA	2023: Identified and engaged four community partners to support the Kidz'Grief program. Volunteer recruitment efforts began in 2024. 2024: Delivered two Kidz'NGrief afterschool programs at Portsmouth Public Elementary Schools with two volunteers supporting the program. 2025: In April 2025 and May 2025, two more after-school program sites were established. Special sessions serve youth of all ages, from elementary through high school.
Establish partnerships with existing and experienced community violence organizations in Portsmouth.	2023: Met with 12 elected officials and community influencers to advocate for violence reduction in the community. Participated in four community programs and activities that support violence reduction in the community. Hosted two coalition meetings at the Community Health Hub. 2024: Established four additional partnerships with community violence prevention organizations and sponsored one event focused on violence reduction. 2025: Planning two public events for summer and fall 2025.

Economic Stability – Workforce Development

Strategies	Progress
Work with national, regional and local partners to promote economic stability for vulnerable populations in Portsmouth.	2023: Partnered with national and local LISC (Local Initiatives Support Corporation) to determine the elements necessary to operate an FOC (Financial Opportunity Center). Met with four community-based programs to explore program delivery partnerships. Delivered one economic stability program at the Community Health Hub. 2024: Established four metrics of success to activate LISCs FOC model. Pivoted to providing individual classes vs. FOC model. Provided four budgeting classes for youth preparing to enter the workforce, incorporating pre-test and post-test. Provided mock interviews to support at-risk youth in developing essential job readiness skills. 2025: Partnered with Hampton Roads Workforce Council and participated in four regional hiring events. Two classes offered to promote job readiness focusing on skills such as resume writing and interview preparation.

Health Care Access – Mental and Behavioral Health, including substance use disorders

Strategies	Progress
Undertake mapping exercise to understand depth and efficacy of community-based substance abuse and behavioral health services in the city of Portsmouth and engage with partner delivery organizations to share mapping results.	2023: Conducted research into community mental health resources and identified three digital platforms for accessing community-based substance health services in Portsmouth. Completed 10 engagements with community partners to gain a comprehensive understanding of the services and programs they offer. 2024: Shared results of the asset map with 12 partner organizations, including leaders of Maryview Medical Center Behavioral Health department. Developed mental health resource list for community organizations and community members to improve access to support services.
Become an information resource center for addiction services and begin new service offerings at the HUB in Portsmouth, VA with one newly established partner.	2023: Explored potential collaboration for a program, Alcoholics Anonymous, at the Community Health Hub. 2024: Established Alcoholics Anonymous at the Community Health Hub. Established data tracking for Alcoholics Anonymous and Narcotics Anonymous programs. Hosted two new partner organizations, MAB Wellness and Your Wellness Inc., to collaborate on addressing mental health and substance abuse within the community at The Community Health Hub. 2025: Sponsored one mental health awareness event, Mental Health Walk, focused on promoting education and reducing stigma around mental health.

Health Care Access – Chronic Health Conditions

Strategies	Progress
Deepen internal and external partnerships to expand access to care and chronic disease management services on/through the Care-A-Van.	2023: Established eight departmental referral sources from internal partners to increase visits on the Care-A-Van. Established 11 external referral sources to increase visits on the Care-A-Van by 10%. Designed three chronic disease management education sessions for target population. Established three chronic disease-oriented baseline measures for quality improvement outcomes for the years 2024 and 2025. 2024: Care-A-Van patient volume increased by 24%. Implemented three educational programs on chronic disease management. Care-A-Van patient volume increased by 3% over the course of 2024. 2025: Implemented two educational programs on chronic disease management.
Grow passport to health offerings at the hub.	2023: Established coordinated schedule of health education offerings in the Passport to Health program at the Hub. Established Passport to Health participant tracking process. Established baseline quality measures for Passport to Health participants. 2024: Expanded one Passport to Health program to include at least one additional wellness offering. Implemented one passport to health participant tracking process. 2025: Improve health outcomes for 15% of Care-A-Van patients in three key areas: foot exam, eye exam and micro albumin. Improve health outcomes for 15% of Passport to Health participants.



Appendix

Appendix A: Community Health Survey

Appendix B: Focus Group Summary

Appendix C: Community Advisory Board Themes

Appendix D: Care-A-Van Interview Analysis

Appendix E: Health Indicator Analysis

Appendix A

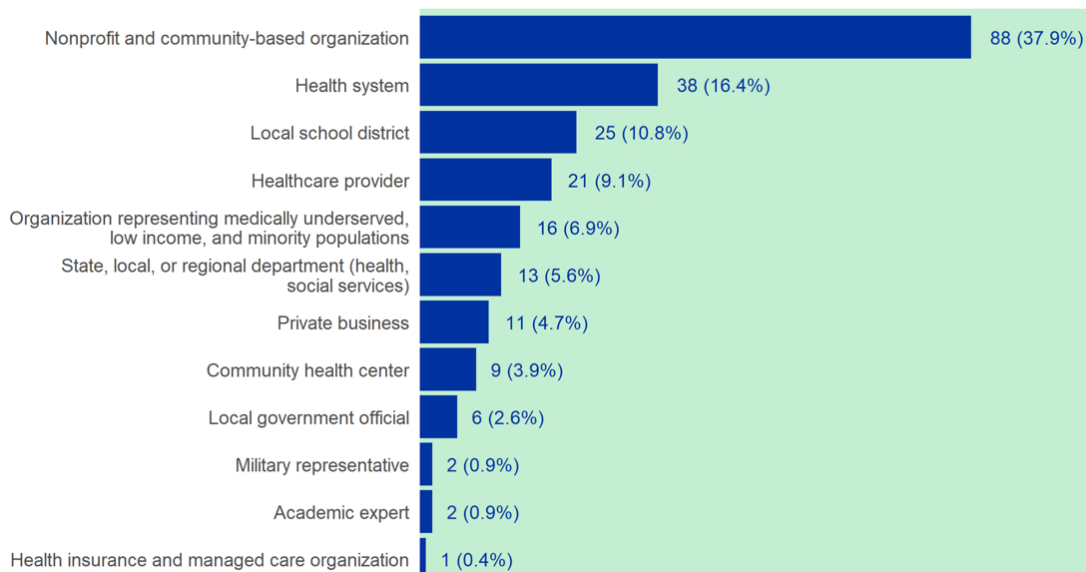
Community Health Survey

The CHNA collaborative launched a Community Health Survey that ran from October 2024 to February 2025. Of participants who completed the survey, 4,832 individuals and 233 organizations responded. Organizational responses included representatives from health departments, social service and mental health agencies, school systems, community health centers and a wide range of nonprofit and community-based organizations, including many who represent medically underserved, minority or low-income populations. This appendix provides an analysis of the survey responses by question. It includes a demographic description of participants as well as the findings from the survey.

Respondent Demographics

Respondent Type	Count
Individuals	4,832
Organizations	233

Types of organizations represented in the survey (N=233)

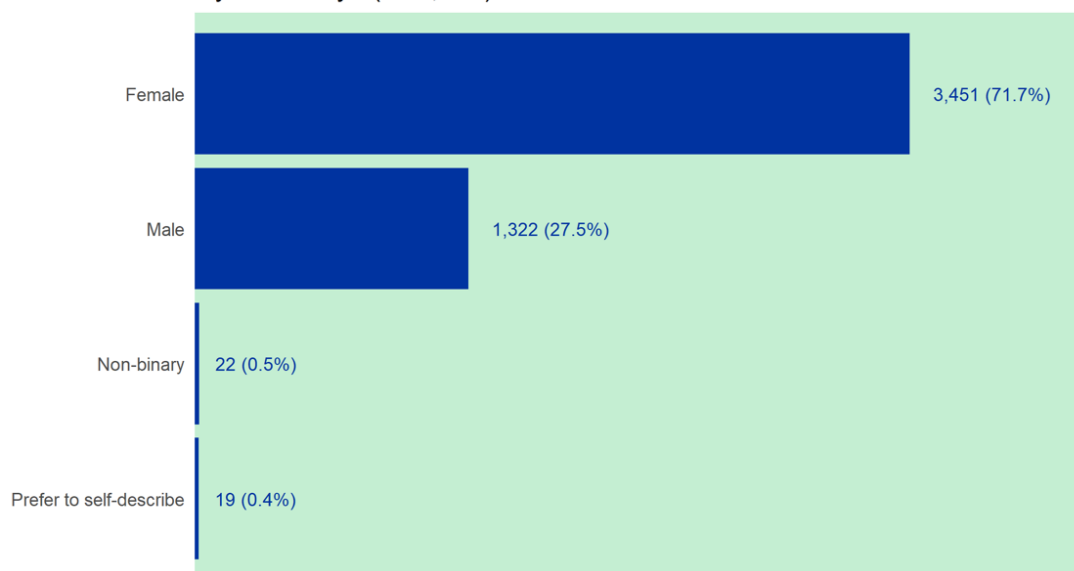


Source: Community Health Survey

Survey Respondents by Jurisdiction

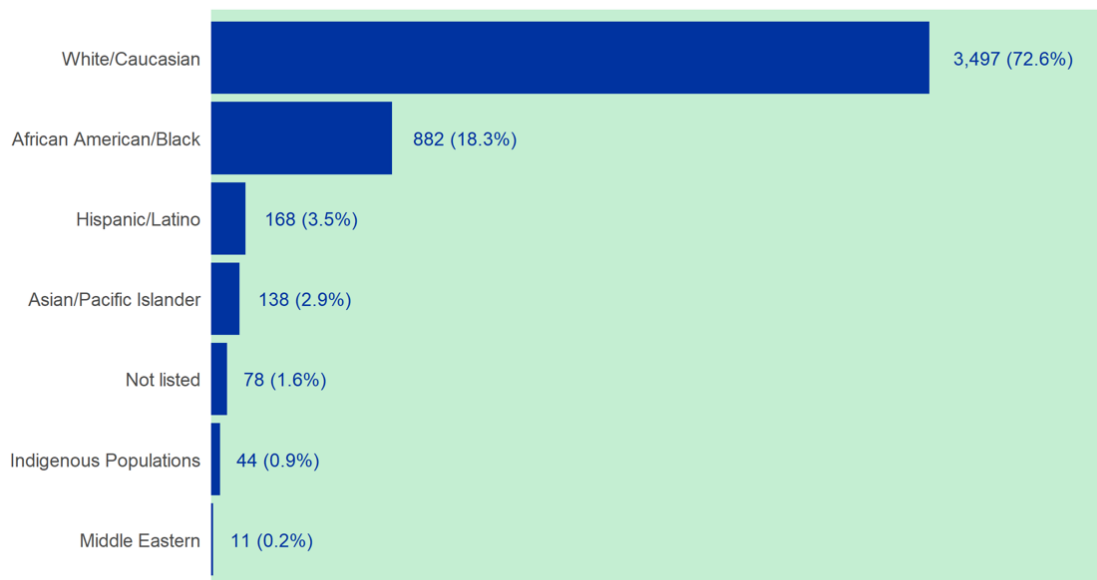
County	Respondents	Population	Survey %	Population %
Chesapeake City	373	251,153	7.7%	14.3%
Franklin City	23	8,212	0.5%	0.5%
Gloucester County	62	39,228	1.3%	2.2%
Hampton City	604	137,334	12.5%	7.8%
Isle of Wight County	48	39,444	1.0%	2.3%
James City County	848	80,046	17.5%	4.6%
Mathews County	6	8,517	0.1%	0.5%
Newport News City	706	184,774	14.6%	10.5%
Norfolk City	329	235,037	6.8%	13.4%
Poquoson City	83	12,556	1.7%	0.7%
Portsmouth City	122	97,299	2.5%	5.6%
Southampton County	21	17,988	0.4%	1.0%
Suffolk City	183	96,638	3.8%	5.5%
Virginia Beach City	747	457,066	15.5%	26.1%
Williamsburg City	180	15,564	3.7%	0.9%
York County	497	70,590	10.3%	4.0%

Gender: How do you identify? (N=4,814)



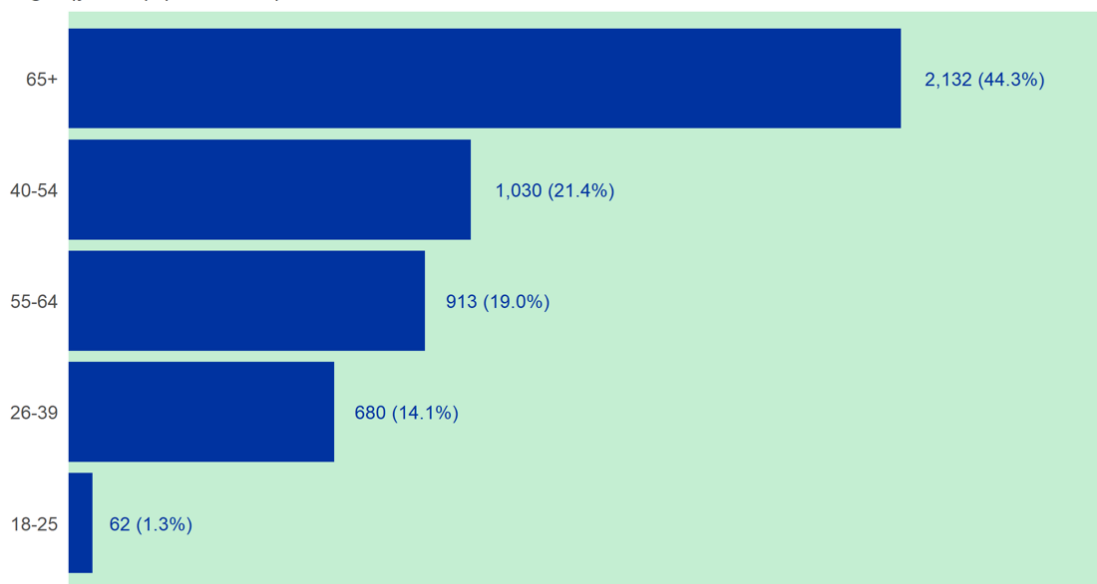
Source: Community Health Survey

Race (limit two selections) (N=4,818)



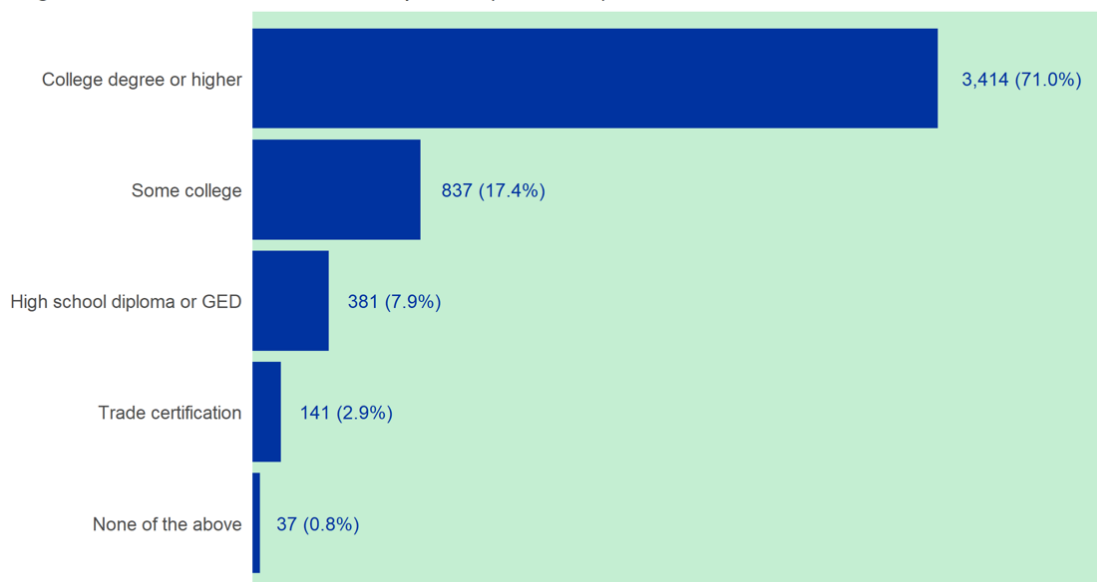
Source: Community Health Survey

Age (years) (N=4,817)



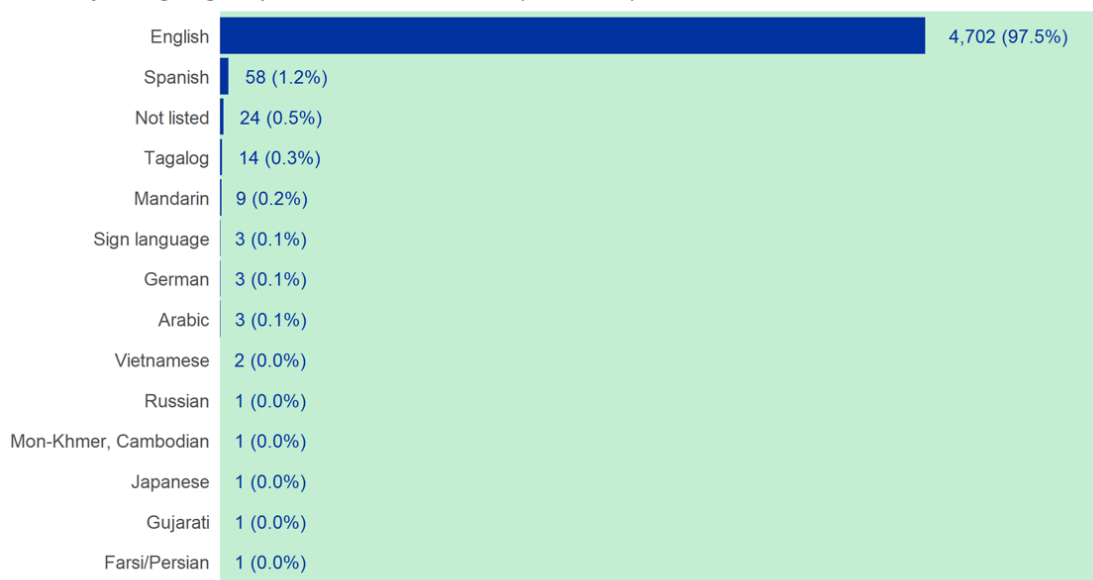
Source: Community Health Survey

Highest Level of Education Completed (N=4,810)



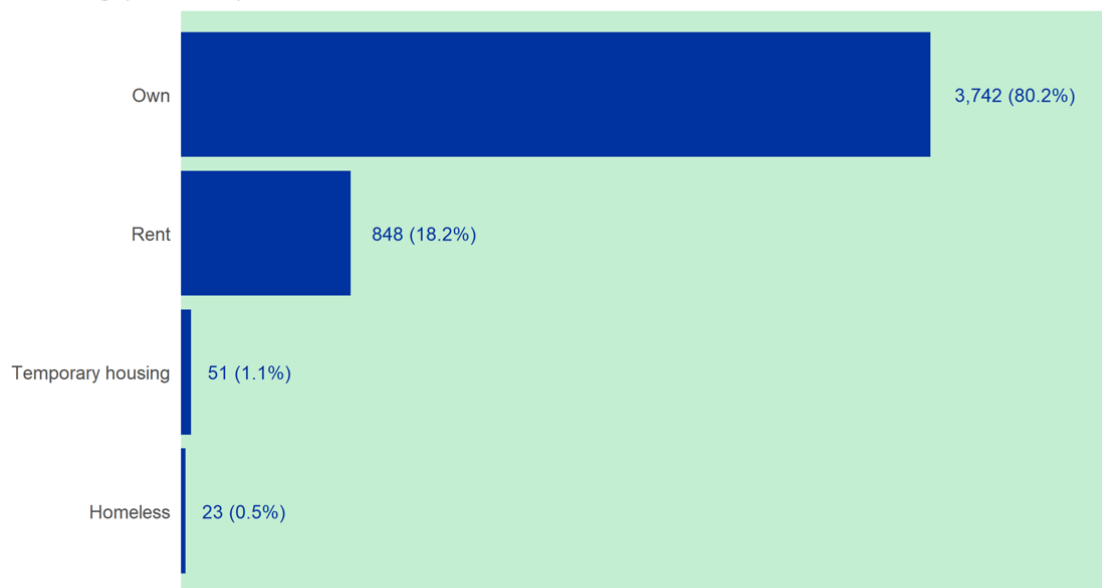
Source: Community Health Survey

Primary Language Spoken in Your Home (N=4,823)



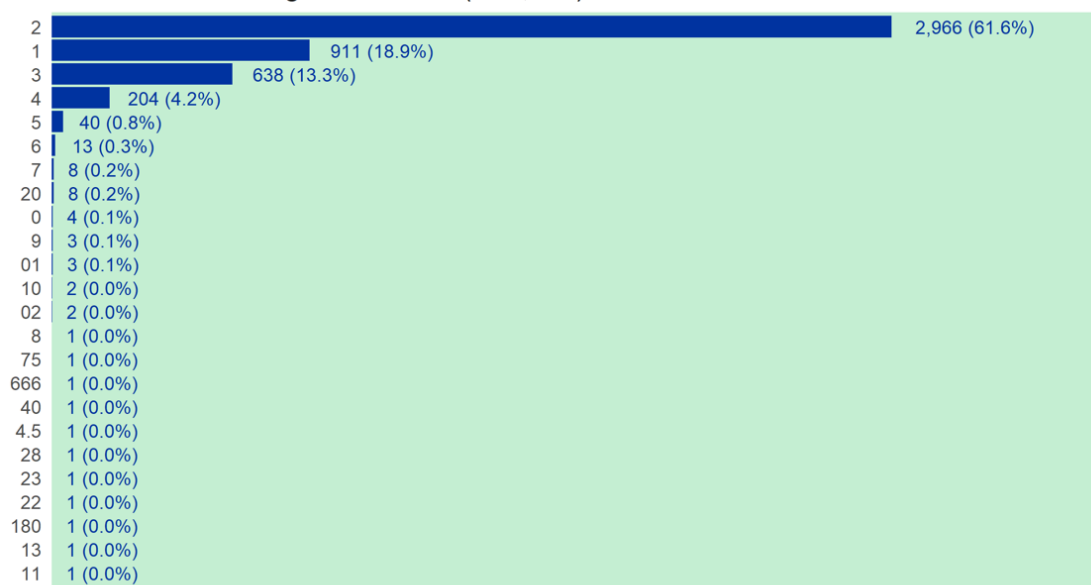
Source: Community Health Survey

Housing (N=4,664)



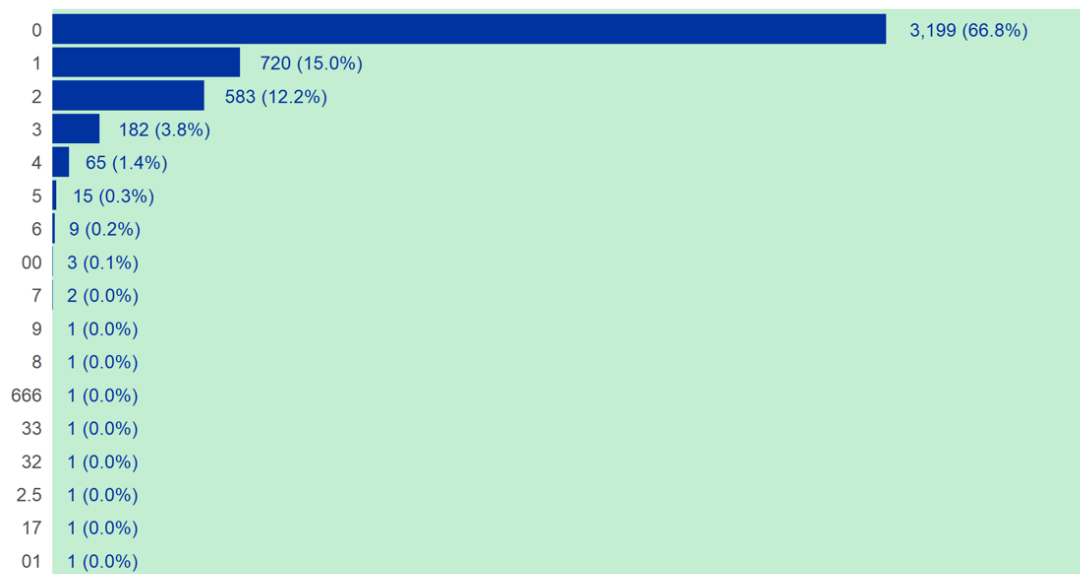
Source: Community Health Survey

Number of Adults Living in the Home (N=4,813)



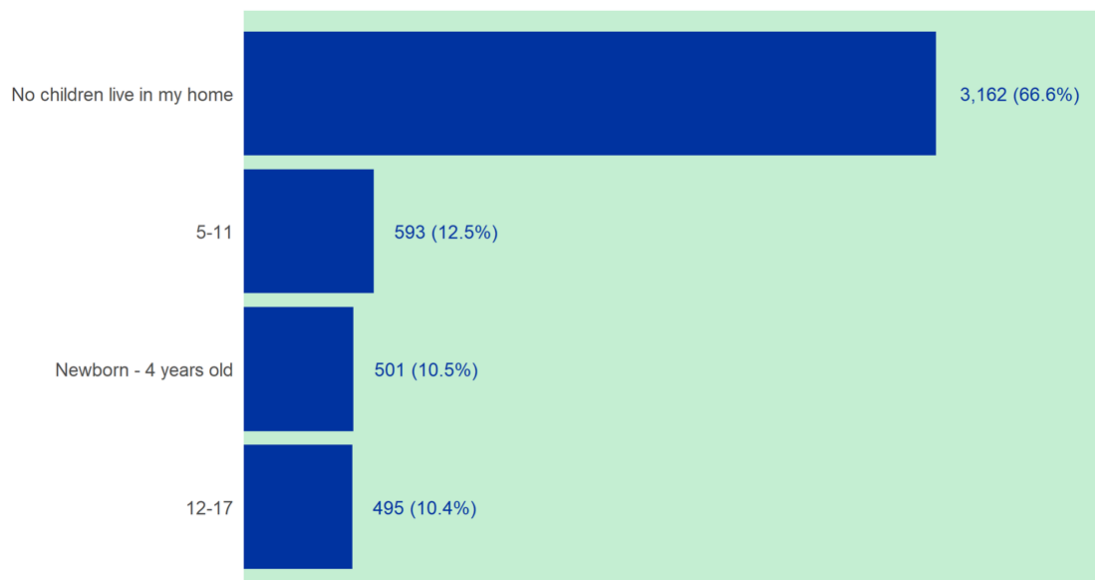
Source: Community Health Survey

Number of Children (0-17) Living in the Home (N=4,786)



Source: Community Health Survey

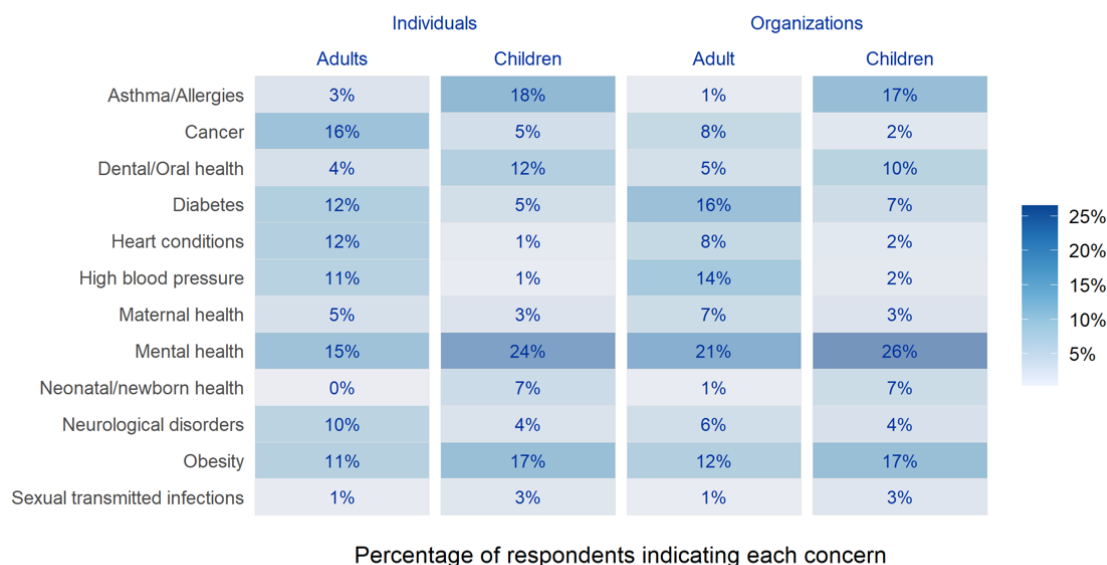
Age Range of Children (N=4,751)



Source: Community Health Survey

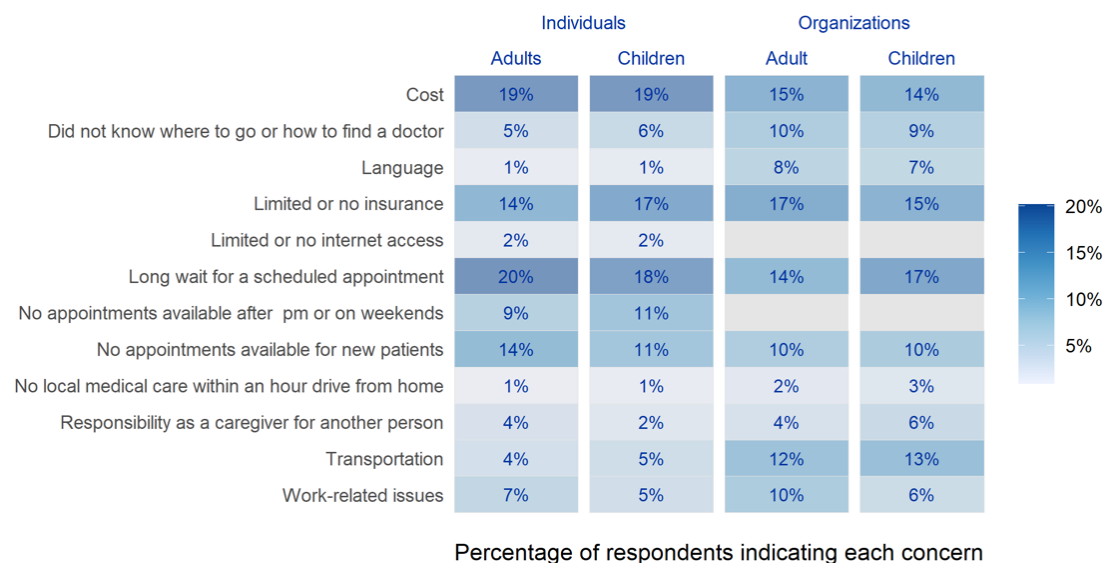
Findings

Top 3 most important health concerns



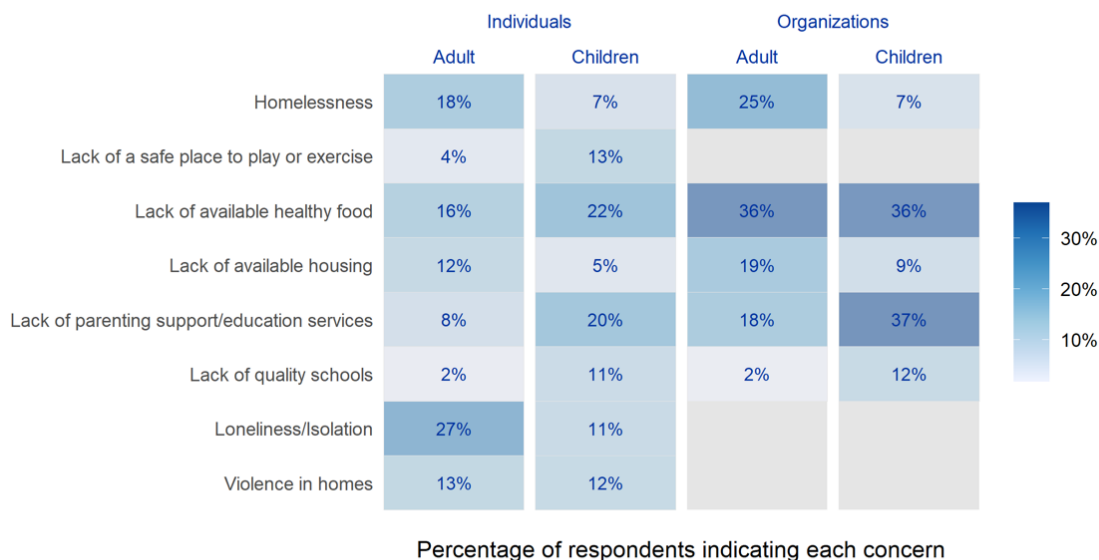
Source: Community Health Survey.

Top 3 barriers to accessing healthcare resources and services



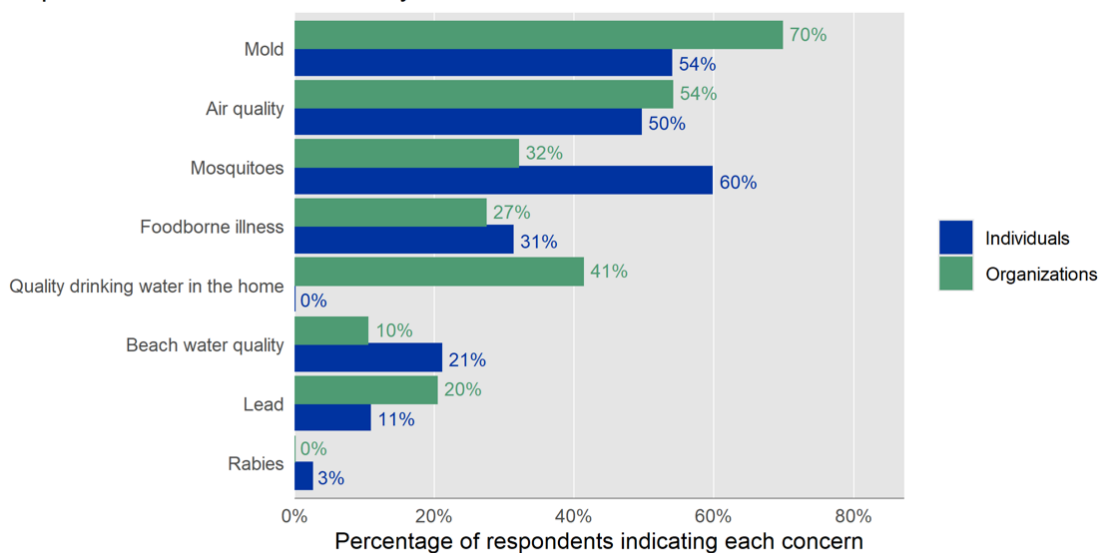
Source: Community Health Survey.

Top 3 social concerns impacting health



Source: Community Health Survey.

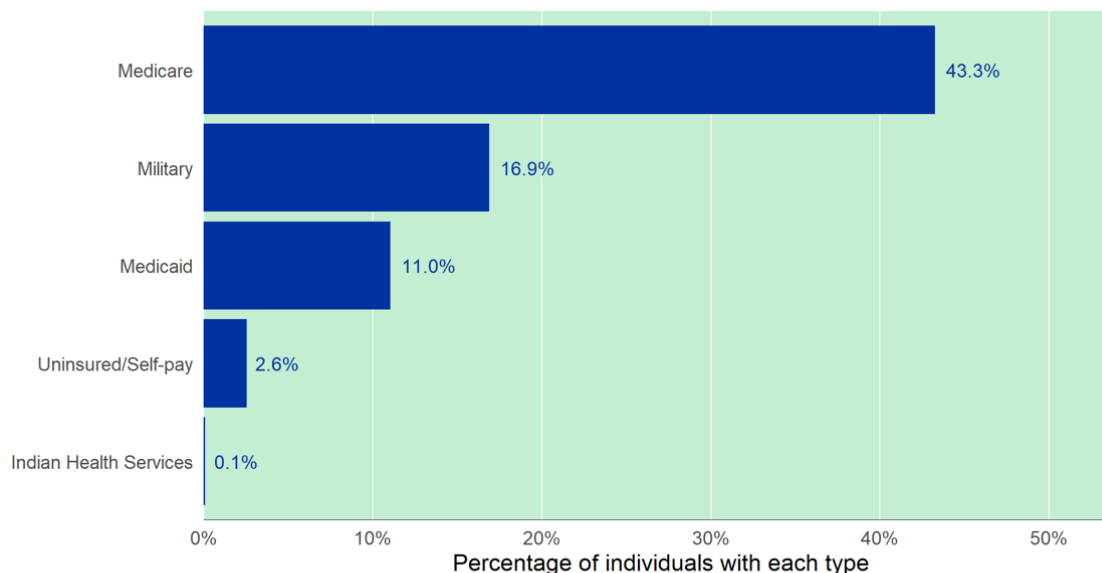
Top Environmental Health Safety Concerns



Source: Community Health Survey.

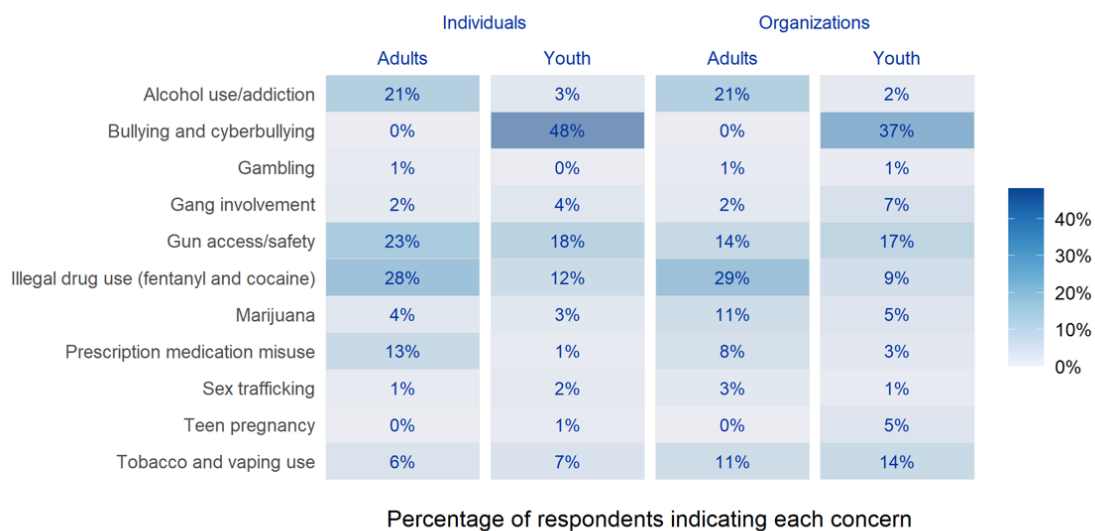
Note: Respondents were asked to identify top three concerns.

Medical Insurance Status



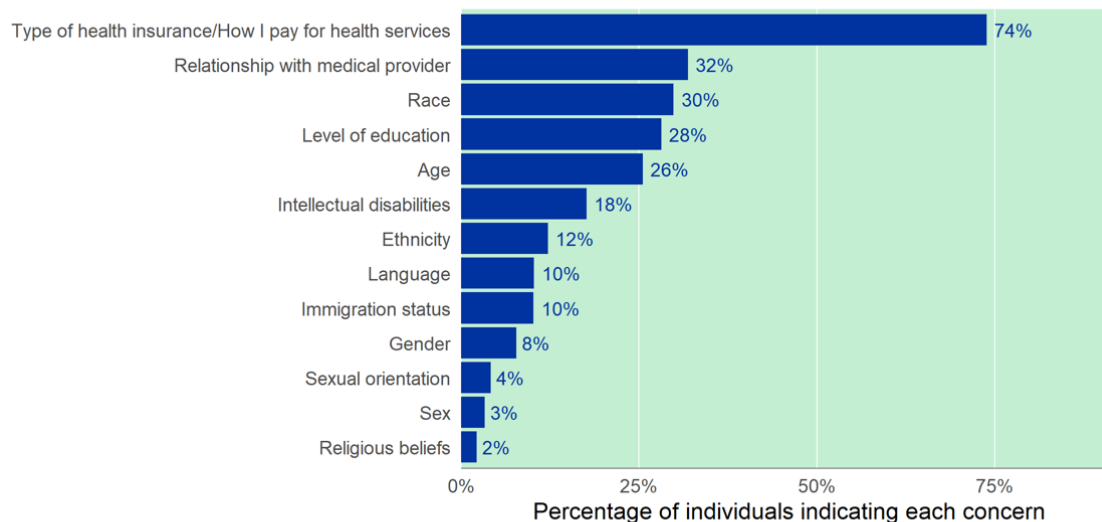
Source: Community Health Survey

Greatest concern for adults and children/youth (ages 0-17), among individuals and organizations



Source: Community Health Survey.

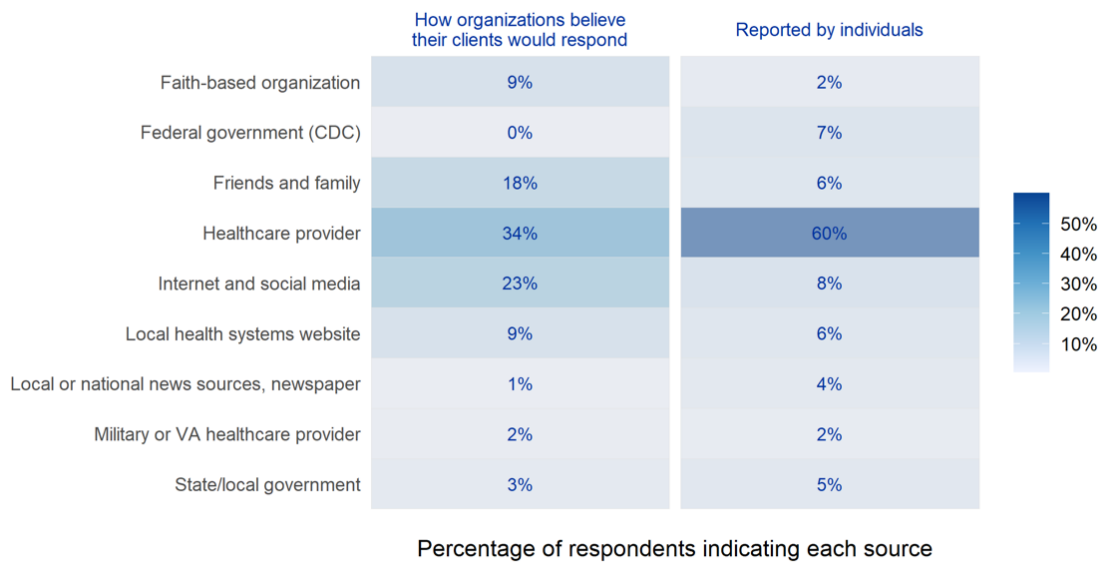
Top personal factors that impact the quality of healthcare that youth and/or adults receive



Source: Community Health Survey.

Note: Respondents were asked to identify top three concerns.

Most trusted source of information



Source: Community Health Survey.

Appendix B

Focus Group Summary

From October 2024 to February 2025, a broad array of community input was sought across the community Bon Secours serves through focus groups hosted by organizations in its service area. Through these focus group meetings, Bon Secours worked to ensure that medically underserved populations, minority and low-income populations provided input on health needs, priorities and existing resources. Overall, 26 focus groups were held in collaboration with organizations across Norfolk, Portsmouth, Suffolk, Virginia Beach, Newport News, Hampton and Williamsburg. The focus groups included 274 participants.

For the data analysis, the CHNA Collaborative used ChatGPT to initially identify focus group themes based on copious notes taken during focus groups by 1 – 3 notetakers. ToXcel, LLC then reviewed the themes and conducted further exploration and analysis through ChatGPT to provide additional quality assurance and further examination of the data. Notetaker notes from all the focus groups can be made available upon request.

Demographic information about the participants is listed by focus group below. A discussion of the themes identified from the focus groups is then outlined in four sections:

- Health Needs and Priorities
- Existing Community Resources
- Organizations, Programs and Partnerships
- Recommendations for Improvement

Demographics

This section includes outlines of where each group was located, as well as the demographics and zip codes of participants.

HamptonRoads		
Filipino Focus (virtual, 10/14/2024)		
Total: 9	Zip codes: 23457 (2), 23456 (2), 23518 (2), 23452 (2), 23320	
Gender: Male: 4 Female: 5	Race/Ethnicity Asian: 9	Ages 26-39: 1 40-54: 6 55-64: 2

Hampton Roads Parenting Education Network (HR, virtual, 12/12/2024)		
Total: 8	Zip codes: 23454 (2), 23325, 23320, 23602, 23322, 23453, 23507	
Gender: Male: 4 Female: 5	Race/Ethnicity White: 6 Black: 1 Hispanic: 1	Ages 26-39: 1 40-54: 3 55-64: 2 65+: 2

HOPES Free Clinic (11/14/2024)		
Total: 7	Zip codes: 23666, 23513, 23504, 23502, 23462 (3)	
Gender: Male: 4 Female: 5	Race/Ethnicity Hispanic: 7	Ages 18-25: 1 26-39: 3 40-54: 2 55-64: 1

Iglesia de Dios de Adonai 1 (02/01/2025)		
Total: 8	Zip codes: 23324, 23452, 23451 (2), 23513 (4)	
Gender: Male: 2 Female: 6	Race/Ethnicity Asian: 9	Ages 26-39: 3 40-54: 3 55-64: 1 65+: 1

Iglesia de Dios de Adonai 2 (02/01/2025)		
Total: 11	Zip codes: 23320 (2), 23503, 23508 (3), 23324, 23518, 23509, 23185, 23504, 23320	
Gender: Male: 3 Female: 8	Race/Ethnicity Hispanic: 11	Ages 18-25: 1 26-39: 6 40-54: 3 65+: 1

Norfolk		
Ingleside Elementary Parents Night (Norfolk, in-person, 12/12/2024)		
Total: 14	Zip codes: 23502 (13), 23523	
Gender: Male: 3 Female: 11	Race/Ethnicity White: 1 Black: 12 Prefer not to say: 1	Ages 18-25: 1 26-39: 8 40-54: 3 55-64: 2
Lee's Friends' (Norfolk [VB], in-person, 11/20/2024)		
Total: 10	Zip codes: 23507, 23324, 23454, 23456, 23464, 23503, 23452, 23455, 23505	
Gender: Male: 4 Female: 5	Race/Ethnicity White: 6 Black: 3 Native American: 1	Ages 55-64: 3 65+: 7
Reck League (Norfolk, in-person, 11/12/2024)		
Total: 9	Zip codes: 23513, 23504, 23321, 23510, 23462, 23320, 23509	
Gender: Male: 1 Female: 8	Race/Ethnicity White: 1 Black: 8	Ages 55-64: 3 65+: 6
Urban Discovery Mission (Norfolk, in-person, 11/22/2024)		
Total: 11	Zip codes: 23510 (9), 23504, 23513	
Gender: Male: 1 Female: 10	Race/Ethnicity Black: 11	Ages 18-25: 1 26-39: 6 40-54: 3 65+: 1

Portsmouth		
Fatherhood Mentoring (Portsmouth, in-person, 1/28/2025)		
Total: 22	Zip codes: 23707, 23518, 23701, 23325, 23324, 23704, 23321, 23454, 23451, 23703, 23702, 23664	
Gender: Male: 19 Female: 3	Race/Ethnicity Black: 21 Indigenous: 2	Ages 18-25: 1 26-39: 2 40-54: 11 55-64: 5 65+: 3
Horizons (Portsmouth, in-person, 1/30/2025)		
Total: 8	Zip codes: 23701 (3), 23703 (2), 20702, 23704, 23707	
Gender: Male: 3 Female: 5	Race/Ethnicity Black: 6 Asian: 1 2 Races, Black and Indigenous: 1	Ages 26-39: 1 40-54: 2 55-64: 3 65+: 2
Senior Station (Portsmouth, in-person, 11/07/2024)		
Total: 10	Zip codes: 23704, 23703, 23508, 23701	
Gender: Male: 4 Female: 5	Race/Ethnicity Prefer not to say	Ages 55-64: 1 65+: 9
St. Marks Missionary Baptist (Portsmouth, in-person, 12/03/2024)		
Total: 6	Zip codes: 23321, 23323, 23704	
Gender: Male: 1 Female: 5	Race/Ethnicity Black: 6	Ages 55-64: 1 65+: 5
Portsmouth Partnership (Portsmouth, in-person, 12/11/2024)		
Total: 11	Zip codes: 23425, 23669, 23320, 23452, 23666, 23704, 23702, 23435	
Gender: Male: 2 Female: 8 Self-describe: 1	Race/Ethnicity Black: 11	Ages 18-25: 1 26-39: 5 40-54: 2 55-64: 3

Suffolk		
Delta Sigma Theta (Suffolk, in-person, 11/21/2024)		
Total: 7	Zip codes: 23434 (3), 23435, 23321, 23703, 23325	
Gender: Female: 7	Race/Ethnicity Black: 7	Ages 40-54: 2 55-64: 3 65+: 2

Pruden Center (Suffolk, in-person, 11/14/2024)		
Total: 17	Zip codes: 23434 (17)	
Gender: Male: 6 Female: 11	Race/Ethnicity White: 6 Black: 11	Ages 26-39: 4 40-54: 7 55-64: 5 65+: 1

Virginia Beach		
Armed Services YMCA (Virginia Beach, in-person, 11/20/2024)		
Total: 7	Zip codes: 23503, 23455	
Gender: Male: 1 Female: 2	Race/Ethnicity White: 5 Black: 1 Hispanic: 1	Ages 26-39: 7

Girls on the Run (Virginia Beach, in-person, 11/14/2024)		
Total: 8	Zip codes: 23320, 23464, 23185, 23451, 23456, 23518, 51254, 23323	
Gender: Female: 8	Race/Ethnicity White: 6 Black: 2	Ages 26-39: 4 40-54: 4

Greater Saint (Virginia Beach, in-person, 11/12/2024)		
Total: 9	Zip codes: 23464 (5), 23325 (2), 23455, 23462	
Gender: Female: 9	Race/Ethnicity Black: 9	Ages 40-54: 2 55-64: 2 65+: 5

Virginia Beach		
LGBT Life Center (Virginia Beach [Norfolk], in-person, 11/14/2024)		
Total: 6	Zip codes: 23518 (2), 23502, 23321, 23324, 23464	
Gender: Male: 1 Female: 5	Race/Ethnicity White: 1 Black: 4 Asian: 1	Ages 18-25: 1 26-39: 2 40-54: 3
Sentara Leigh Hospital Patient and Family Advisory Council (Virginia Beach, in-person, 10/15/2024)		
Total: 12	Zip codes: 23464 (8), 23455 (2), 23462, 23518	
Gender: Male: 4 Female: 8	Race/Ethnicity White: 8 Black: 3 Asian: 1	Ages 65+: 12
Sentara Princess Anne Hospital Patient and Family Advisory Council (Virginia Beach, in-person, 12/5/2024)		
Total: 12	Zip codes: prefer not to say	
Gender: Male: 3 Female: 9	Race/Ethnicity White: 9 Black: 2 Hispanic: 1	Ages 26-39: 1 40-54: 1 55-64: 1 65+: 9
Sentara Virginia Beach General Hospital Patient and Family Advisory Council (Virginia Beach, in-person, 10/15/2024)		
Total: 12	Zip codes: 23518, 23453, 23452, 23456 (6), 23451 (3)	
Gender: Male: 5 Female: 7	Race/Ethnicity White: 11 Asian: 1	Ages 26-39: 1 40-54: 2 65+: 9

Newport News

Achievable Dream, in person, 12/9/2024

Total: 7	Zip codes: 23188,23187,23608,23168	
Gender: Male: 2 Female: 5	Race/Ethnicity Hispanic:1 Black: 16	Ages 6-39: 3 40-54: 1 55-64: 2 65+: 1

Peninsula Pastoral Counseling Center, in-person, 1/21/2025

Total: 8	Zip codes: 23606	
Gender: Male: 6 Female: 2	Race/Ethnicity White: 7 Black: 1	Ages 40-54: 2 55-64: 5 65+: 1

Hampton Roads Community Action Program (HRCAP), in person, 11/25/2024

Total: 16	Zip codes: 23061,23063,23669,23663,23605,23693,23325,23513,23664,23661,23508,23434,23662,23666	
Gender: Male: 1 Female: 15	Race/Ethnicity White: 2 Black: 10 Indigenous: 1 Hispanic: 1 Native American: 1	Ages 18-25: 2 26-39: 5 40-54: 3 55-64: 5 65+: 1

Williamsburg

Sentara Williamsburg Patient & Family Advocate Council, in-person, 2/5/2025

Total: 9	Zip codes: 23188,23187,23608,23168	
Gender: Male: 5 Female: 4	Race/Ethnicity White: 6 Black: 2	Ages 40-54: 1 55-64: 2 65+: 6

Health Needs and Priorities

Focus group participants identified the following health needs and priorities.

Access to Health Care & Provider Shortages

Participants described a health care landscape where securing an appointment feels almost like an insurmountable task. They noted that wait times for both primary care and specialty services can extend for months, causing some to forgo routine checkups or to rely on emergency departments for non-urgent needs. The shortage of providers was compounded by logistical challenges such as limited transportation options. Many participants conveyed that even when appointments were available, navigating the scheduling process — often reliant on confusing online systems or lengthy phone calls — added to the frustration and stress. The data reveals a clear picture of a system that is stretched thin, leaving many feeling that their health concerns go unaddressed until they become emergencies.

Chronic Health Conditions

The management of chronic illnesses emerged as a persistent concern. Adults frequently mentioned conditions such as diabetes, hypertension, heart disease, kidney disorders and obesity. These conditions were not discussed in isolation but were described as having a significant ripple effect on daily life — impacting work, family responsibilities and overall quality of life. Participants spoke about the challenges of maintaining a consistent treatment regimen, managing multiple medications and coordinating care among several specialists. The chronic nature of these diseases was underscored by the emotional toll and the financial strain associated with ongoing medical appointments, tests and treatments. This theme illustrates how chronic conditions are deeply embedded in the community's day-to-day struggles.

Mental Health & Emotional Well-being

Mental health discussions were both vivid and personal. Adults recounted experiences of depression, anxiety and stress that were often intertwined with their physical health challenges. The burden of chronic illness, combined with external stressors such as financial hardship and caregiving responsibilities, contributed to a sense of emotional overload. Many participants described feeling that the mental health services available to them were either too few or difficult to access in a timely manner. There was also a recurrent sentiment that mental health was sometimes marginalized compared to physical health, leaving individuals feeling unsupported in their emotional struggles. The narratives reveal that mental health issues are not just an individual concern but are woven into the fabric of everyday life in the community.

Social Determinants & Environmental Challenges

Economic instability, food insecurity and unsafe neighborhood conditions were frequently cited as key factors affecting health. Participants painted a picture of how financial stress, coupled with the high cost of living and inadequate access to nutritious foods, creates an environment where health becomes a secondary concern. Many recounted how the inability to afford quality food or reliable transportation limits their access to health care and other essential services. Additionally, unsafe or deteriorating community environments — characterized by crime, poor housing conditions and a lack of community resources — were described as contributing to stress and a sense of vulnerability. This theme highlights that health is not only determined by medical care but also by the broader social and environmental context in which individuals live.

Health Literacy & System Navigation

A significant number of adults expressed frustration with the complex nature of the health care system. They described difficulties understanding insurance requirements, completing extensive paperwork and navigating digital platforms like patient portals. These administrative hurdles were seen as a major barrier to receiving care, particularly for those with lower levels of health literacy or limited familiarity with technology. Participants noted that the lack of clear, accessible information often leaves them feeling lost or overwhelmed when trying to advocate for their own health. This theme underscores the need for communication that is both straightforward and tailored to the community's diverse needs.

Social Isolation & Aging Concerns

For many older adults, social isolation was a recurring issue. Participants discussed the impact of dwindling social networks, the loss of longtime community members, and the challenges of maintaining independence as they age. Feelings of loneliness were described as having both emotional and physical consequences, such as worsening chronic conditions or decreased motivation to seek medical care. The lack of robust, age-appropriate social programs and support services left many feeling abandoned by a system that they perceived as not fully attentive to their unique needs. This theme brings to light how social isolation can compound other health challenges and diminish overall well-being.

Cultural & Trust Barriers

Historical experiences and cultural differences emerged as critical factors influencing trust in the health care system. Many participants recounted instances of perceived bias or dismissiveness by health care providers, which have led to lingering mistrust — particularly among communities of color. Language barriers and cultural misunderstandings further complicate these interactions, making some individuals reluctant to seek care or fully disclose their health concerns. The data reveal a sentiment that the health care system sometimes fails to honor the unique cultural identities of its patients, which in turn hinders effective communication and trust-building.

Existing Community Resources

The following community resources were raised frequently by focus group participants.

Mobile & Community-Based Health Services

Participants frequently mentioned mobile clinics and health vans, such as Bon Secours Care-A-Van, which travel to neighborhoods, schools and churches. These services — ranging from basic health screenings and dental checkups to mental health consultations — are highly valued for reaching underserved areas. For example, several groups noted that when a mobile clinic comes to a community event or a church, it provides immediate access to services that would otherwise require long drives or waiting months for an appointment. Although appreciated, many participants stressed that these mobile services are too few in number to meet the demand.

Faith-Based and Nonprofit Initiatives

Local churches and nonprofit organizations play a central role in filling gaps in health and wellness support. Participants described food pantries run by churches, programs like Mercy Chef that deliver hot meals directly to residents' cars and community gardens that offer fresh produce. These initiatives not only help address food insecurity but also foster a sense of community and trust. Many participants expressed gratitude for these grassroots efforts, noting that they create safe spaces for health education, support and even mental health outreach, especially for low-income families and seniors.

School & Youth Programs

Schools and after-school programs emerged as key venues for delivering health resources to children. Participants highlighted that schools often serve as hubs for physical activity, nutrition education and even mental health services. For instance, some focus groups praised initiatives like free lunch programs, structured afterschool activities and "Be Well" challenges that incentivize healthy behaviors among students and teachers alike. However, they also pointed out inconsistencies — while some schools are well-resourced, others struggle to meet even basic health and wellness needs.

Hospital & Health System Partnerships

Some groups spoke positively about the partnerships between local hospitals and community organizations. These collaborations have resulted in programs that bring specialists to local sites (like community centers or churches) and provide preventive screenings, vaccinations and chronic disease management. Participants noted that partnerships involving health systems such as Sentara or Lee's Friends have been beneficial — but also that these partnerships need to be expanded to reduce long wait times and improve continuity of care, especially in underserved neighborhoods.

Telehealth and Digital Innovations

Telehealth services have been mentioned as a modern solution to reduce transportation barriers and improve appointment access. Some participants appreciated the convenience of virtual visits for routine consultations or follow-up care. However, there was also a clear cautionary note: Many community members struggle with digital literacy or lack access to reliable internet and devices. As a result, while telehealth is seen as a promising resource, its reach is currently limited by technology and accessibility challenges.

Organizations, Programs and Partnerships

Focus group participants specifically mentioned several community organizations, programs and partnerships that benefited their community. These resources are described in this section.

Mercy Chef

Participants spoke highly of Mercy Chef for its innovative approach to food assistance. They noted that Mercy Chef delivers hot meals directly to residents' cars on specific days (for example, Wednesdays, Fridays and Saturdays). This service is especially valued in neighborhoods where transportation is a barrier or grocery stores are too far away. Many felt that having food brought directly to their doorstep not only alleviated immediate hunger but also helped foster a sense of community support during challenging times.

Obici Healthcare Foundation

Several participants mentioned the Obici Healthcare Foundation as a key partner in supporting local health initiatives. They appreciate that this foundation helps fund programs aimed at bringing mobile clinics and health screenings to underserved neighborhoods. The foundation's involvement was seen as instrumental in bridging gaps — particularly in areas where traditional health care facilities are few and far between — and in supporting broader community outreach efforts.

CHKD (Children's Hospital of the King's Daughters)

CHKD was repeatedly cited as an important provider in pediatric care. Focus group members acknowledged that CHKD plays a significant role in caring for children with serious illnesses and even in transitioning care as children age. However, some participants also expressed concerns about continuity of care once children reach a certain age or if their conditions require long-term, specialized management. Despite these challenges, CHKD remains a trusted name in the community for pediatric health services.

Jencare / Centerwell

Local initiatives like Jencare and Centerwell were mentioned as providing more accessible care options in Virginia Beach. Participants valued these services because they bring health care closer to home, reducing travel and wait times. By offering a local alternative to larger hospital systems, these initiatives help address immediate needs and build trust within the community.

BCBS Beach Bag Program

The BCBS Beach Bag Program was brought up as an example of how health care partnerships can extend beyond clinical services. Participants noted that this initiative distributes essential items and information directly to residents, helping to reinforce a connection between the health care system and community members. Such programs are appreciated for their proactive approach to health promotion and resource sharing.

Glennen Center for Geriatrics, EVMS

For the aging population, the Glennen Center for Geriatrics at EVMS was highlighted as a critical resource. Participants praised the center for its focus on the unique needs of seniors — addressing issues like chronic disease management, mobility challenges and the need for specialized geriatric care. This center's role in supporting older adults was seen as essential for maintaining quality of life and reducing social isolation.

AARP and Seniors Aging Gracefully (SAG)

Organizations like AARP and Seniors Aging Gracefully (SAG) were frequently mentioned as vital for supporting older residents. Participants described these groups as offering fitness classes, social events and companion programs that help reduce isolation. They also provide practical resources — such as health screenings and wellness education — that empower seniors to stay active and informed about their health.

Healthy Harvest / Neighborhood Harvest

On the nutrition front, programs like Healthy Harvest and Neighborhood Harvest were recognized for their role in improving access to fresh produce. Participants noted that these initiatives often partner with schools and community organizations to establish mobile food pantries, community gardens and affordable farmers' markets. By doing so, they directly address food deserts and promote better nutrition through access and education.

Early Head Start

Some focus groups recommended partnering with Early Head Start to support early childhood development. While not discussed in depth, Early Head Start was viewed as a potential resource to bolster health and wellness by offering support and education for young families, which in turn could have long-lasting impacts on children's health.

IC Norcom

IC Norcom was mentioned as a local high school partner that helps connect residents with health education and resources. Participants appreciated the role of such organizations in disseminating information and helping individuals navigate the complex health care system, especially those who might be less familiar with digital tools.

Urban Discovery Ministries and Portsmouth Partnership

Urban Discovery Ministries and Portsmouth Partnership emerged as important community-based organizations that facilitate engagement and resource coordination. Participants described these groups as acting like a bridge — connecting residents with available services, disseminating critical health information and fostering community relationships. They were valued for their local presence and their ability to address issues in a culturally sensitive manner.

Lee's Friends and LGBT Life Center

For specific populations, organizations like Lee's Friends and the LGBT Life Center were highlighted for their tailored approaches. Participants appreciated that these organizations provide culturally relevant support, including health care navigation, mental health services, and community-building activities. They help fill gaps that might be overlooked by larger, more generalized systems and ensure that the needs of diverse community members are met.

Recommendations for Improvement

Focus group participants made the following recommendations to improve health and quality of life in their communities.

Expanding Provider Capacity & Reducing Wait Times

A recurring recommendation was to increase the number of available providers. Participants suggested hiring more primary care physicians, specialists and mental health professionals in local clinics. They emphasized that reducing wait times would decrease the need for non-urgent visits to emergency departments. Several focus groups recommended creating incentive programs to encourage health care workers to practice in underserved areas, thereby strengthening the local capacity to deliver timely care.

Enhancing Transportation & Accessibility

Transportation barriers emerged as a significant obstacle. Many participants recommended developing dedicated transportation services — such as community shuttles or partnerships with rideshare programs — to help residents get to appointments, grocery stores and community centers. They also suggested that mobile clinics be more widely deployed, especially in areas where public transit is limited. These recommendations point to a need for both improved infrastructure and creative community solutions to bridge geographic gaps.

Simplifying System Navigation & Boosting Health Literacy

Complex health care systems were a major source of frustration. Participants called for simplifying administrative processes, such as reducing the volume and complexity of paperwork and making digital patient portals more intuitive. They recommended the appointment of health navigators or community health workers who can help individuals understand insurance details, complete forms and schedule appointments. Enhancing health literacy through community workshops and school programs was seen as a critical step toward empowering residents to better advocate for their own care.

Strengthening Community Partnerships

Many focus groups stressed the importance of coordinated, cross-sector collaborations. Recommendations included forming stronger partnerships between hospitals, local health departments, schools, churches and nonprofit organizations. Participants believed that integrated efforts — such as joint health fairs, shared resource lists and coordinated outreach programs — could leverage the strengths of each partner to create a more comprehensive safety net for health and wellness. In several discussions, participants mentioned that when local entities work together, it builds trust and results in more culturally sensitive care.

Increasing Access to Healthy Foods & Nutrition Education

Food insecurity and poor nutrition were frequently cited as challenges that affect both adults and children. Participants recommended expanding community gardens, mobile food pantries and affordable farmers' markets, particularly in food desert areas. In addition to increasing access to fresh produce, they advocated for nutrition education initiatives — such as cooking classes and workshops on meal planning — that teach families how to prepare healthy, budget-friendly meals. Some focus groups also suggested that local organizations work together to offer recipes and demonstrations, which could help shift community habits toward healthier eating.

Expanding Mental Health & Social Support Services

The need for improved mental health services was a consistent theme. Participants recommended increasing the availability of counseling services and support groups in schools and community centers and through faith-based organizations. They also proposed integrating mental health support with primary care services to reduce stigma and ensure a more holistic approach to health. Moreover, there was a call for more culturally competent mental health professionals who understand the community's unique experiences and can build trust with patients.

Focusing on Preventive & Holistic Care

Preventive care was widely recommended as a way to address long-term health issues before they become emergencies. Participants suggested regular community health screenings, vaccination drives and health fairs that provide education on chronic disease prevention. They emphasized a holistic model of care — one that addresses physical, mental and social health simultaneously. Ideas such as wellness challenges, community exercise programs and stress reduction classes were seen as proactive ways to improve overall health outcomes.

Improving Transparency & Communication

Clear and transparent communication from health care providers was another frequent recommendation. Participants wanted detailed, accessible information on cost, available services and how to navigate the system. They proposed the use of multiple communication channels — such as community meetings, flyers and social media — to ensure that everyone, including those with low digital literacy, is informed. Regular updates on resource availability and changes in service offerings were also suggested to build trust and reduce confusion.

Workforce Development & Infrastructure Investments

Finally, many participants called for investments in the health care workforce and infrastructure. They stressed that attracting and retaining health care professionals through improved training, better compensation and supportive work environments is essential. Upgrading facilities in underserved areas — such as modernizing clinics and establishing more local health centers — was seen as crucial to providing high-quality, accessible care. In addition, participants recommended investments in digital infrastructure to support both telehealth and patient education initiatives.

Appendix C

Community Advisory Board Themes

Bon Secours worked to ensure that medically underserved populations, minority and low-income populations provided input on health needs, priorities and existing resources through input from its Community Advisory Boards. The Community Advisory Boards are councils that include patients, family members, community leaders and hospital associates. The council aims to improve health care services by incorporating patient and family perspectives. The Community Advisory Board gives patients and families a voice in decision-making and improved health care experiences. The council also supports health care providers to have a better understanding of patient needs and enhanced patient satisfaction and outcomes.

Community Advisory Board meetings were held at Maryview Medical Center and Southampton Memorial Hospital. In total, 38 advisory board members participated. Notetakers took detailed notes at each of the meetings. ToXcel, LLC, then conducted a thematic analysis of the notes.

More information about the participants is included below, as well as the themes of the discussion.

Location and Participants	Themes
Maryview Medical Center, Portsmouth, VA 15 Participants Gender • Female: 11 • Male: 4 Age • Most (8/14 who answered) were between 40-54 years old Race/Ethnicity • Black/African American: 9 • White/Caucasian only: 5 • White/Caucasian and Asian/Pacific Islander: 1	Health and Wellness • Predominant Health Issues: Chronic disease, gun violence, mental health and substance abuse. • Systemic Factors: Factors that stifle the community's ability to improve health outcomes: lack of health education, lack of public safety, poverty, mistreatment of mental health concerns and mistrust of institutions. • Disparities in Access and Care: Vulnerable groups, particularly African Americans and those in poverty, face significant barriers to health care, including mental health services and preventive care. Social Determinants of Health • Housing Insecurity: Housing is not affordable or available to meet the needs of the community. • Political Implications: There are concerns that city officials do not genuinely care about the health of the community. Some want action, such as legislation allowing for more affordable housing. Access to Care • Health Care System and Cost: Accessing adequate care is difficult due to the cost and complicated nature of the health care system. Many do not receive preventive care and suffer worse health outcomes as a result. • Wait Times for Appointments: The wait time to see a medical professional, especially a specialist, is prohibitively long. • Availability of Specialists: Some must travel far to be able to access certain specialists. Healthy Foods • Feasibility of Eating Healthy: Healthy food is often expensive and often requires time to prepare. The convenience of fast food often outweighs the health benefits of healthy food. • Food Deserts: People that live in a food desert have limited access to healthy foods, and often end up purchasing food in corner stores, which typically do not offer fresh produce.

Location and Participants	Themes
Southampton Memorial Hospital, Franklin, VA 23 Participants Gender • Female: 20 • Male: 3 Age • Most (19/23) were between 40-64 years old Race/Ethnicity • N/A	Health and Wellness • Children's Mental Health: Children experiencing depression and anxiety because of their high-pressure environment, particularly since the start of the pandemic. • Adults' Stress and Health: Stress and competition with each other impacts mental health, which impacts cardiovascular disease, diabetes and high blood pressure. Need to address mental health concerns. Social Determinants of Health • Economic Stress: Families cannot afford essentials (i.e., food, rent, medicine) and have to choose what to prioritize. • Transportation: Missed appointments due to lack of access to reliable transportation. • Pandemic Effects: Many rely on telehealth to access appointments; barriers will arise if Medicare stops covering telehealth. • Revitalization: Need to increase workforce. Establish a career and technology area. Access to Care • Mental Health: Unaddressed mental health concerns can lead to a variety of other health issues. Lack of mental health providers means many people do not access care, and those that can access it do not receive it regularly. • Overload on Emergency Care: Many people end up in the emergency room for care because there are no urgent care clinics in the community, and because they do not receive preventive care. There needs to be a process to follow up with patients who went to the ER to continue their care. • Food as Medicine: People are accessing food distribution through the library. • Navigating Health Care System: Aspects of the health care system that pose challenges: automated calls, lack of appointments at times when working parents are available, eligibility requirements to make appointments. These are particularly challenging for seniors. • Pharmacy Availability: The number of pharmacies in the community has decreased, meaning people cannot easily access their medications. • Lack of Providers: Inadequate number of providers and specialists in the community means people have to travel to access appointments. It is especially difficult for seniors. Need to incentivize providers to stay in the area by increasing housing.

Location and Participants	Themes
Continued from previous page...	Healthy Foods • Feasibility of Eating Healthy: Healthy food is more expensive and takes more time to cook. Cheap, microwaveable food is more feasible. • Education: Lack of education on fresh produce: health benefits and preparation methods. • Food Banks: Food banks in the community make a positive impact. Open Discussion • Parks and Rec Success: Parks and recreation are positive aspects of the community. Trails, YMCA, city Parks & Rec programs, camps, youth leagues, etc. • Library Success: People are benefiting from library programming for children and adults, especially in the summer. • Infrastructure Successes: Newly constructed walkable areas are positive influences in the community.

Appendix D

Care-A-Van Interview Analysis

From October 2024 to February 2025, a broad array of community input was sought across the Bon Secours community service area, including through interviews conducted with indigent patients who received medical services through the Bon Secours Care-A-Van, a mobile health unit that provides primary care to those with less access to care. Through these interviews, Bon Secours worked to ensure that medically underserved populations, minority and low-income populations provided input on health needs, priorities and existing resources. Demographic information about participants is included below, as well as results from survey questions and a qualitative thematic analysis of open-ended questions.

Demographics

There were 43 participants with 4 surveys excluded due to non-responses. Participants responded to interview questions while waiting for their appointments.

Variable	<i>n</i>	%
Gender		
Male	16	41
Female	23	59
Age		
17-25	4	10
26-30	1	3
31-40	4	10
41-50	10	26
51-60	7	18
61+	13	33
Background/Heritage		
Asian American/Pacific Islander/Native Hawaiian	1	3
African American	22	56
Hispanic/Latino	5	13
White/European	3	8
Other	0	0
Don't know	0	0
Prefer not to say	8	21

Care-A-Van Interview Locations

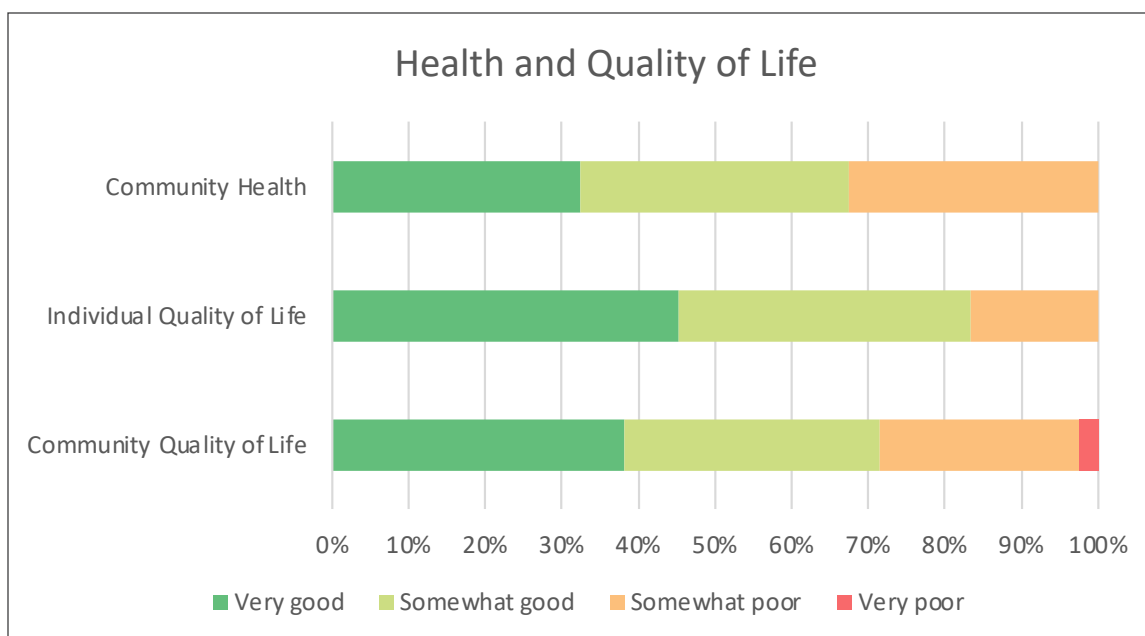
The table below outlines the different jurisdictions where the Care-A-Van interviews were conducted and the number of participants by location.

City	Participants
Portsmouth	13
Newport News	11
Chesapeake	10
Norfolk	4
Suffolk	4
Virginia Beach	4
Franklin	2
Hampton	1

Perceived Quality of Life and Health

Participants were asked questions about their quality of life and the overall health of their community.

Variable	Very good		Somewhat good		Somewhat poor		Very poor	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
How would you describe your overall quality of life?	19	45	16	38	7	17	0	0
How would you describe the overall quality of life of your community?	13	38	14	33	11	26	1	2
How would you describe the overall health of your community?	13	33	14	35	13	33	0	0



Themes

The following open-ended questions were included with the interviews:

- What helps you and others in your community be healthy?
- What is keeping you and others in your community from being healthy?
- In your opinion, what are the greatest health needs among people in your community?
- How are these needs being addressed in your community?
- What additional community support and services are needed?
- How else could we improve the health of people in your community?

ToXcel, LLC conducted a thematic analysis of the open-ended questions and identified the following themes:

- Health and Wellness
- Social Determinants of Health
- Access to Health Care
- Healthy Foods

These themes are discussed in more detail below.

Health and Wellness

- **Exercise and Physical Activity:** Exercise and physical activity were identified as key factors in the health of their community, though the extent to which people engage in these activities is unclear. Some interview participants felt that physical activity was helping to maintain the health of the community, while others identified a lack of safe places for physical activity. The lack of safe places to exercise was identified as a barrier to the community's health.
- **Recreational Facilities:** Recreational facilities provide a safe place for youth to engage in physical activity, learn life skills and express creativity. Interview participants felt there is a need for additional community recreation centers or additional offerings within existing ones. Youth could use these centers to engage in physical activity (e.g., boxing, dance, ballet), learn life skills (e.g., computer skills, etiquette classes), and express creativity (e.g., art, dance). Additional volunteers may be needed to staff these centers. One suggestion for improving access was to offer income-based scholarships at the Y on Granby Street.
- **Chronic Disease:** Obesity, high blood pressure and diabetes were raised as health concerns throughout the community.
- **Health Education:** Interview participants talked about the need for more education about how to maintain a healthy lifestyle. They felt it was important to encourage people to prioritize health in their lives, especially by receiving preventive care. Stakeholders felt that the Care-A-Van could be utilized as a source of health education throughout the community. Education on healthy living should start in childhood.

Social Determinants of Health

- **Economic Challenges:** High cost of living coupled with low wages and lack of job opportunities have led to financial stress within the community. Interview participants shared ideas for addressing economic concerns, including increasing job opportunities, especially for youth; raising wages; lowering the cost of living; lowering the cost of medications; and offering increased financial assistance.
- **Fostering a Sense of Community:** An increased sense of community and care for each other can directly impact others' lives and help improve health outcomes.
- **Housing Concerns:** Homelessness is a concern among the community, and interview participants felt more affordable housing was needed. Interview participants felt that increased affordable housing is particularly needed for veterans and seniors.

- **Transportation:** Interviewees emphasized that more access to transportation is a critical need, especially to health care facilities and grocery stores. This need is especially high among seniors.
- **Violence:** Interview participants expressed concerns about crime and violence (especially gang violence) and indicated a need for increased public safety measures.

Access to Health Care

- **Health Care Affordability:** The cost of health care, both preventive and emergency, is prohibitively high. Free health care and more affordable health insurance can help improve access.
- **Health Care Availability:** Not only is health care expensive, but it is also not available enough within the community. There is a need for more providers and more appointments, and a health care facility in the direct neighborhood.
- **Preventive Care:** The community is not receiving adequate preventive care, due to the high cost of appointments and the limited number of providers. Interview participants felt that increased preventive care, such as through annual well visits, could help members of the community stay healthy and avoid more serious health issues. They shared their perceptions that many people do not receive preventive care and instead end up in the Emergency Room as a result of untreated or unnoticed health concerns. Some interview participants felt that health fairs could help people get preventive care and identify concerns they were unaware of.
- **Specialized Care:** In addition to preventive care, there is a need for more specialists directly in the community to help residents get the care they need without having to travel. Interview participants indicated a need for specialized services such as dentistry, optometry, mental health treatment, substance abuse treatment, imaging and lab capabilities, gynecology, sleep medicine, physical therapy, mammography screenings, medication management, adult care and grief counseling.
- **Care-A-Van:** The Care-A-Van is a crucial resource for the community and is very successful in removing barriers to accessing care. There is a need for additional vans and expanded services offered by the Care-A-Van to ensure all community members can access care.

Healthy Foods

- **Barriers to Purchasing Healthy Food:** Interview participants felt that the high cost of healthy food was the biggest barrier to healthy eating. They also indicated difficulty finding healthy food and identified a need for more ways to find fresh food, such as farmers' markets. Participants also felt that groceries were already expensive, and opting to purchase the healthier options available is a choice that many cannot afford.
- **Food Banks and Pantries:** Food banks and pantries are successful in helping people access food. The occasional food trucks for people in need are also helpful in this effort.

- **Nutrition Education:** Interview participants felt that lack of knowledge about healthy food can be addressed through education that teaches people where to purchase healthy food, how to prepare it and how nutrition impacts health. They felt that many people in their communities are not knowledgeable about nutrition and are therefore less inclined to purchase healthy food. Providing nutritional education could help encourage people to purchase and eat healthy food.
- **Eating Habits:** Interview participants shared that unhealthy eating and poor nutrition are habits that many in the community have developed and have difficulty breaking.

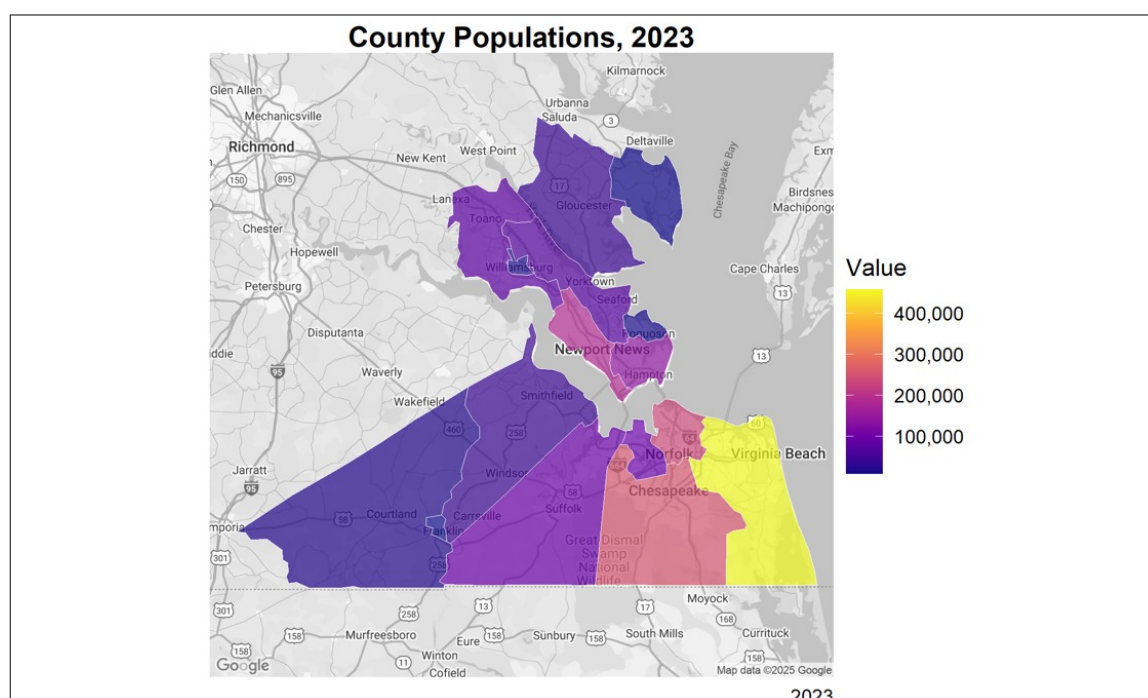
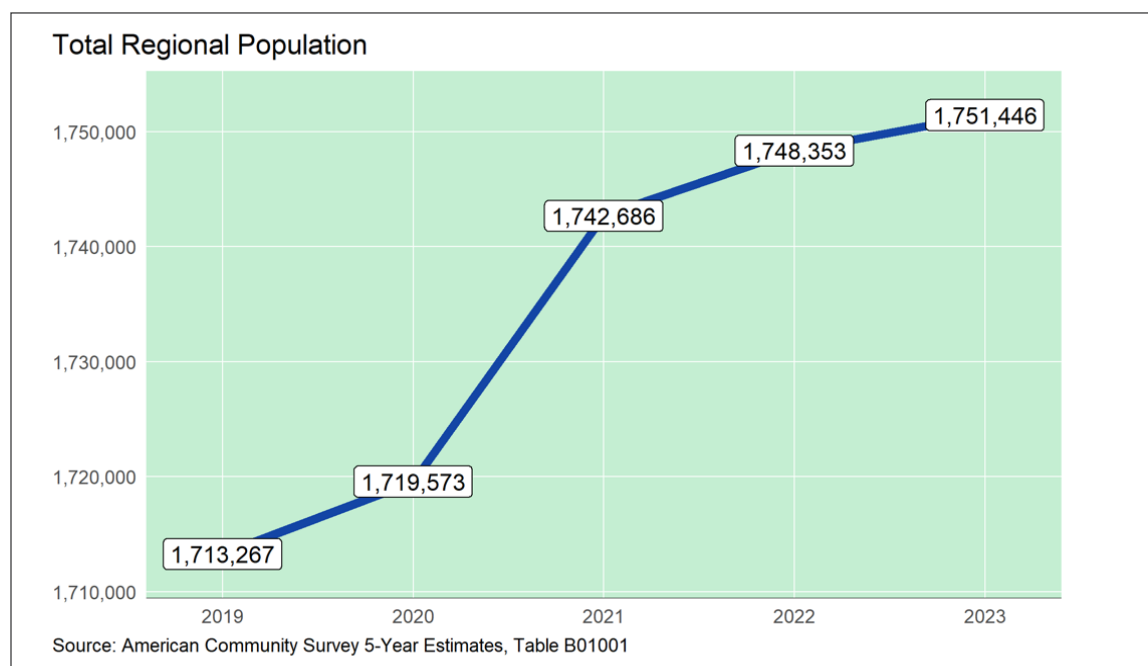
Additional Topics

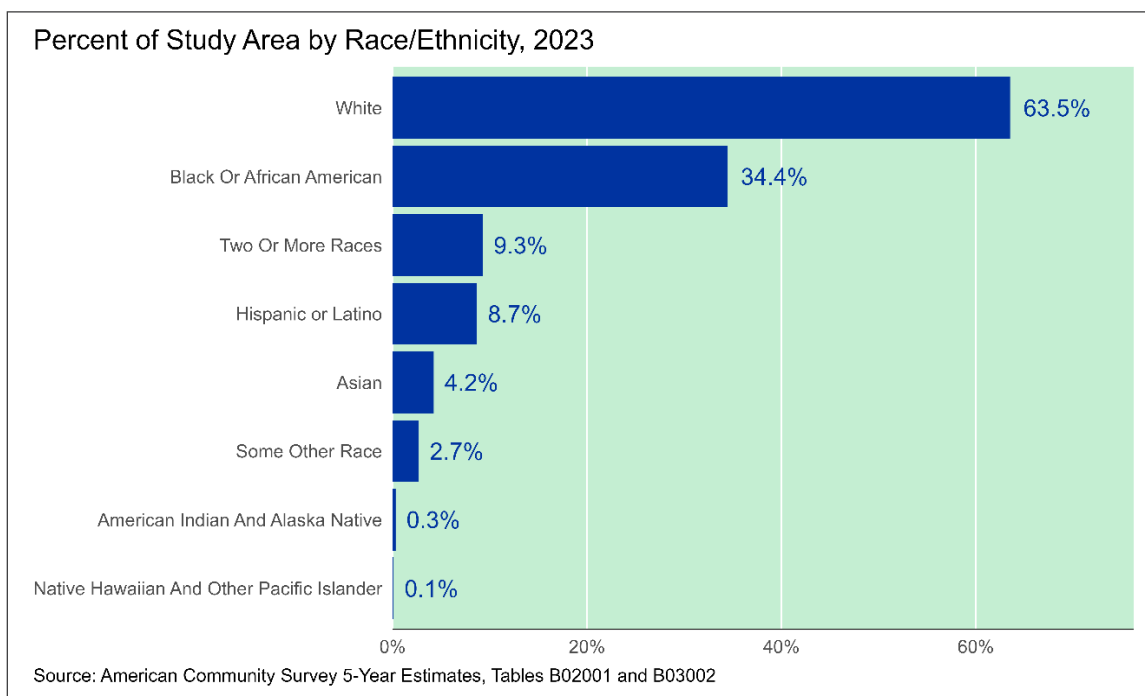
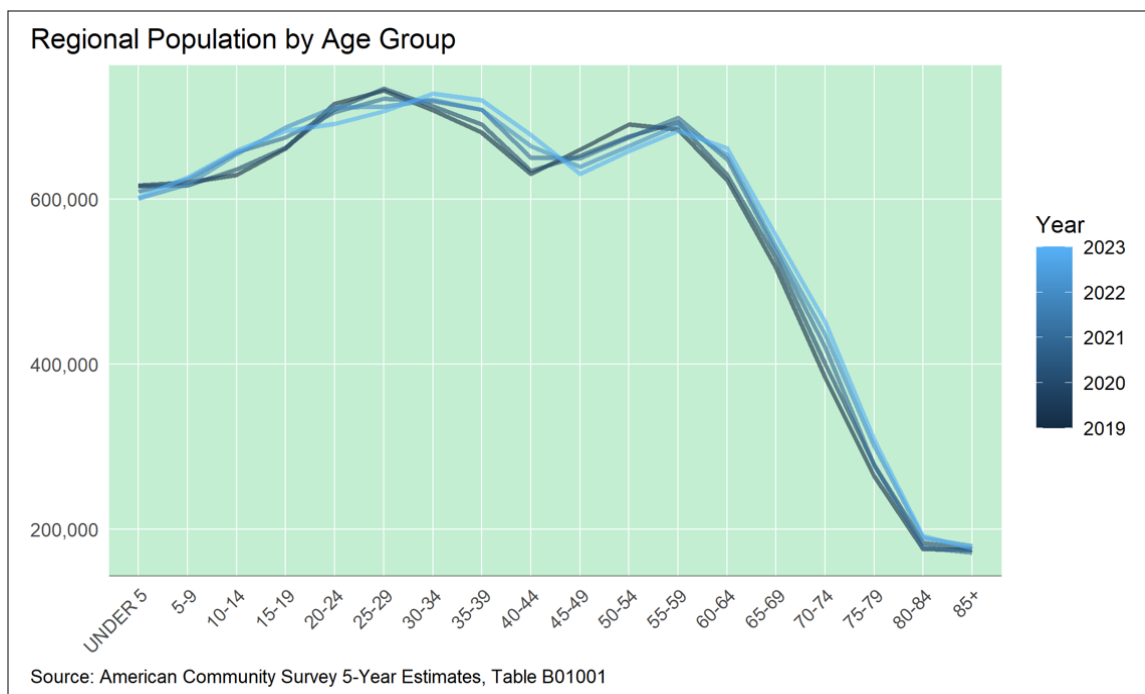
- **Communication about Resources:** While some interview participants felt that there were helpful resources and services available to the community, many felt that they were not being communicated effectively. They felt that promotion of resources and services is needed to ensure people are aware of their options. Interview participants shared that places where communication about resources has been successful are through the church and with flyers and brochures on the community bulletin board. They felt that information about available services such as the Care-A-Van, free health care, mental health care and services for seniors should be disseminated to the community more frequently. There is confusion among the community about who to call for help and what is available to them.
- **Needs Going Unaddressed:** Many felt that the health needs identified throughout the survey were not being addressed and expressed frustration with the lack of action being taken.
- **Religious Values:** Interview participants expressed that religion and related values such as love and kindness have a positive impact on community members' perception of health.
- **Societal Issues:** Some interviewees reported that societal issues, such as fear, hate, and the police, are negatively contributing to community health.

Appendix E

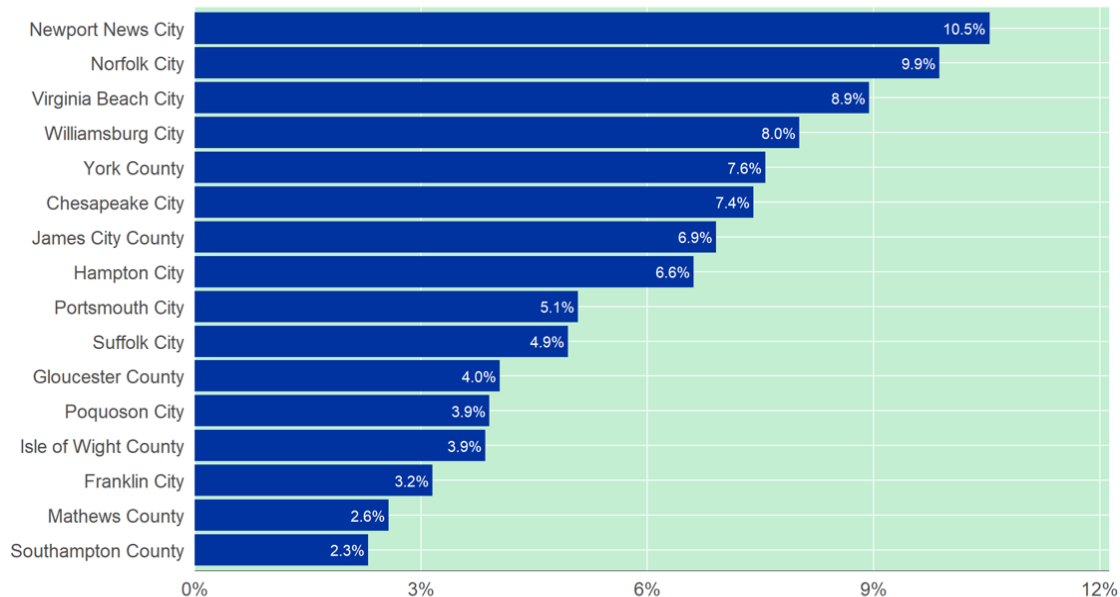
Health Indicator Analysis

Demographics



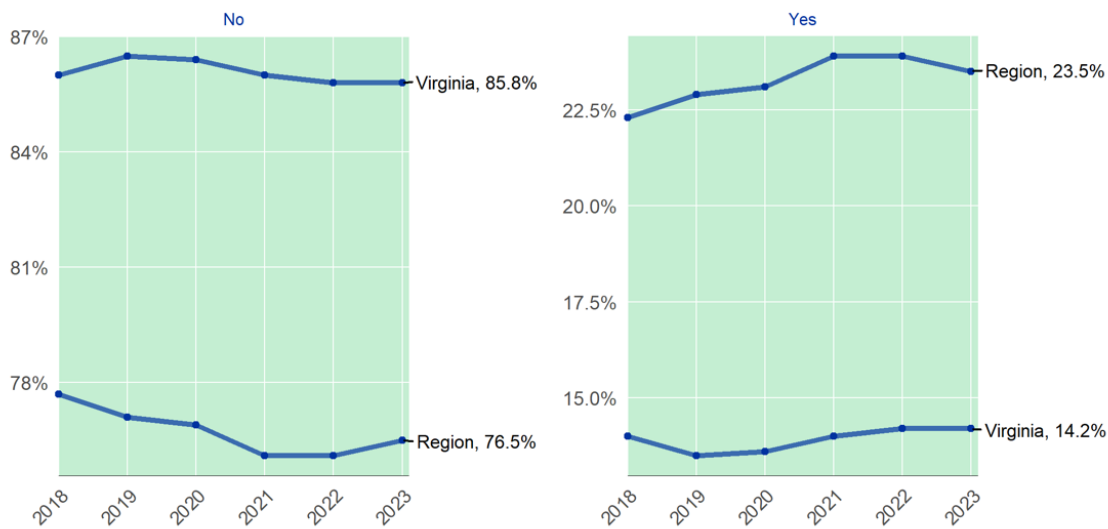


Percent of Study Area that is Hispanic or Latino, 2023



Source: American Community Survey 5-Year Estimates, Table B03002

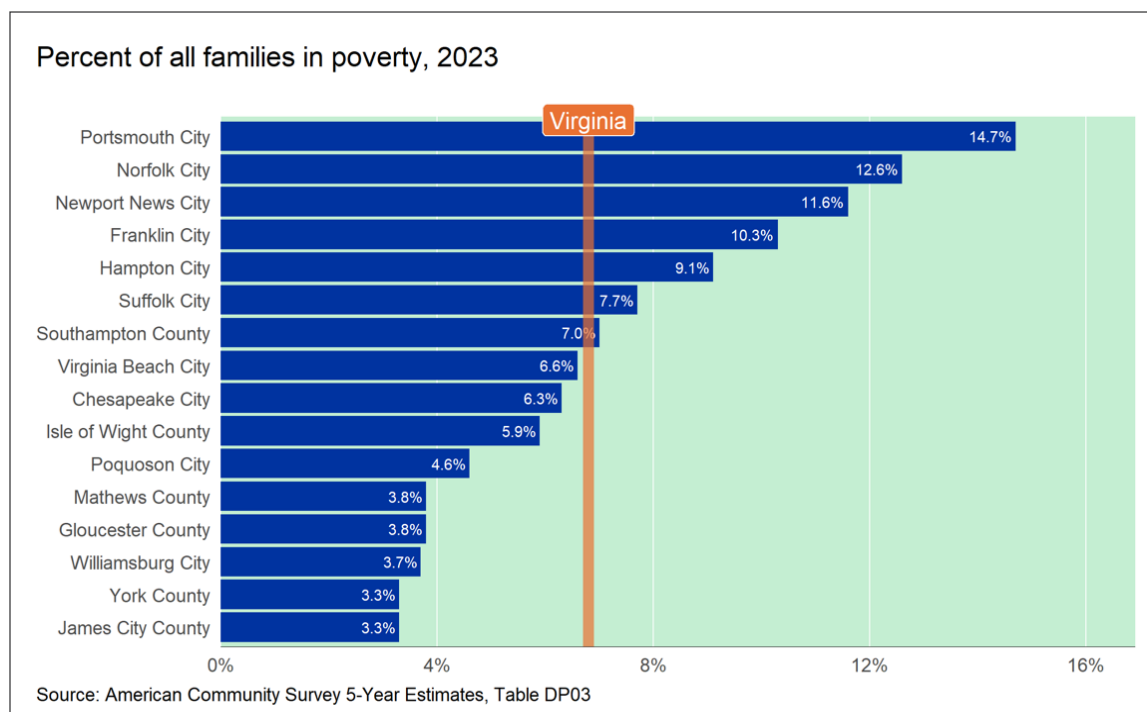
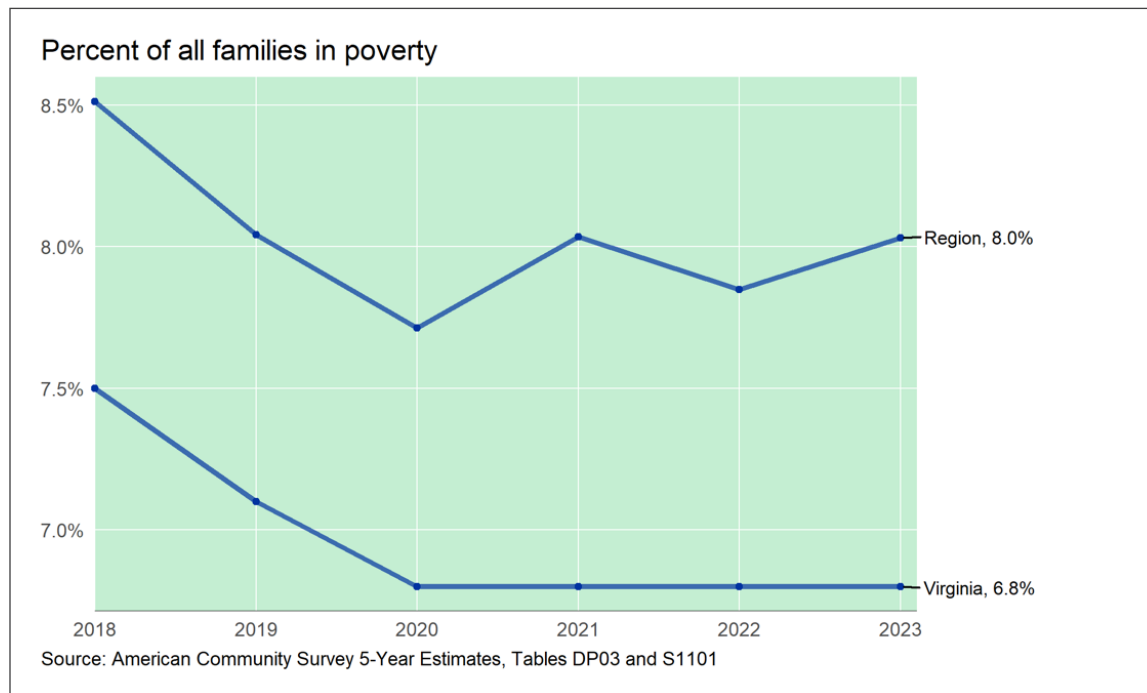
Have you ever served on active duty in the United States Armed Forces? Age-adjusted Prevalence



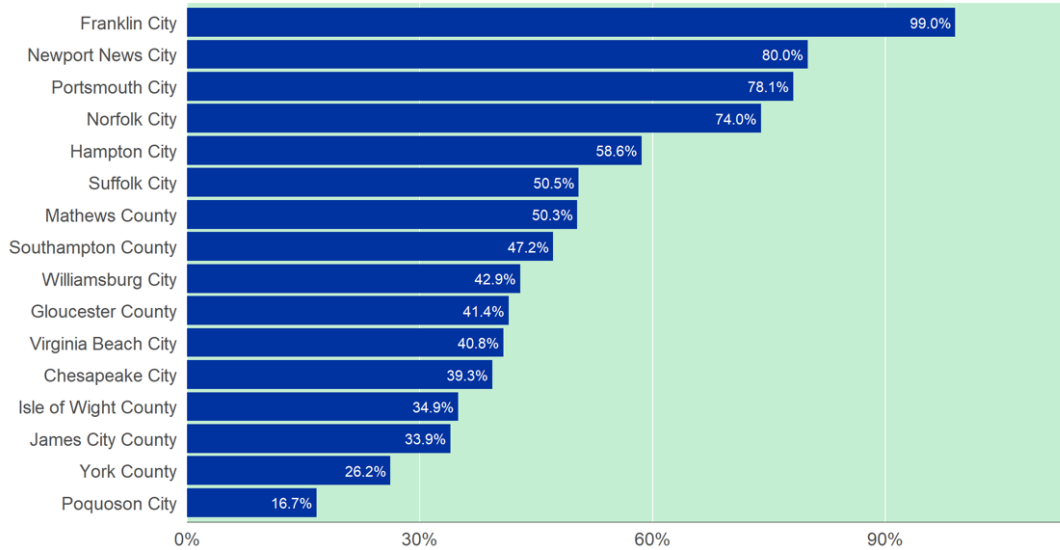
Source: BRFSS

Social Determinants of Health

Economic Insecurity

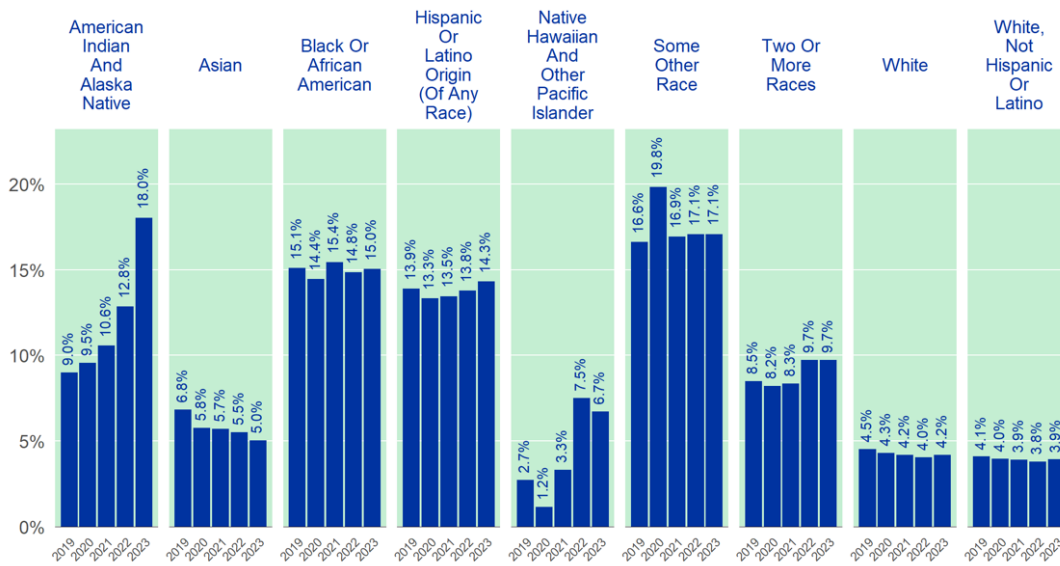


Percentage of children eligible for free or reduced lunch, 2024



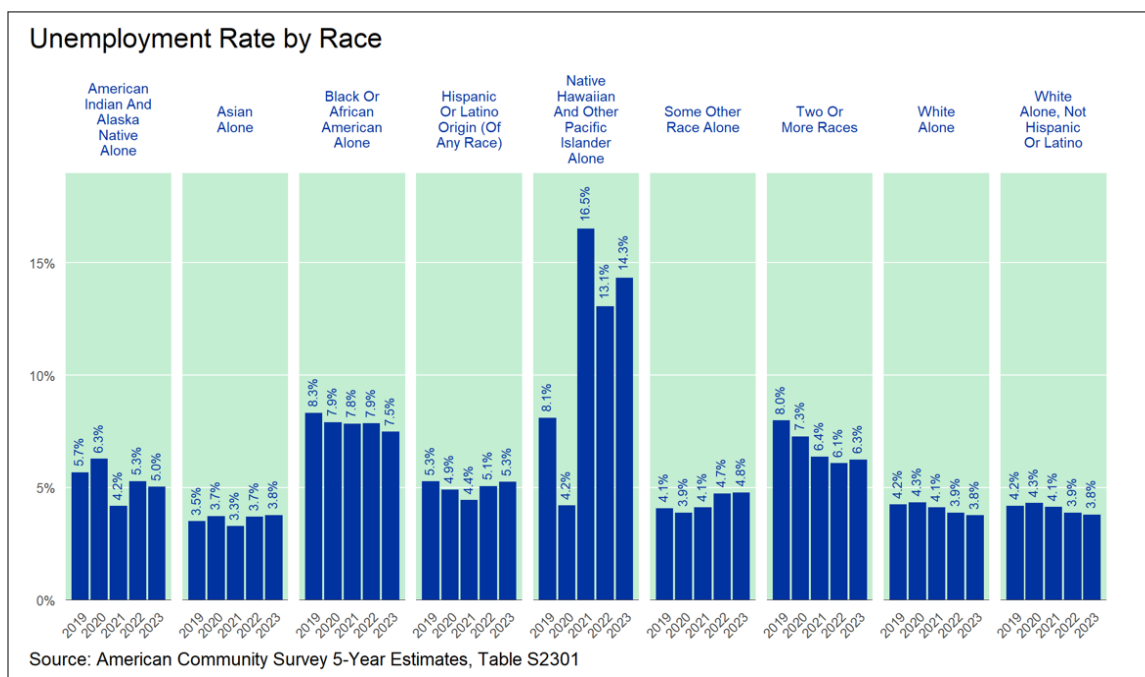
Source: Virginia and North Carolina Departments of Education, National Center for Education Statistics
 Note: Percentage of students enrolled in public schools.

Percent of Families Below Poverty Level

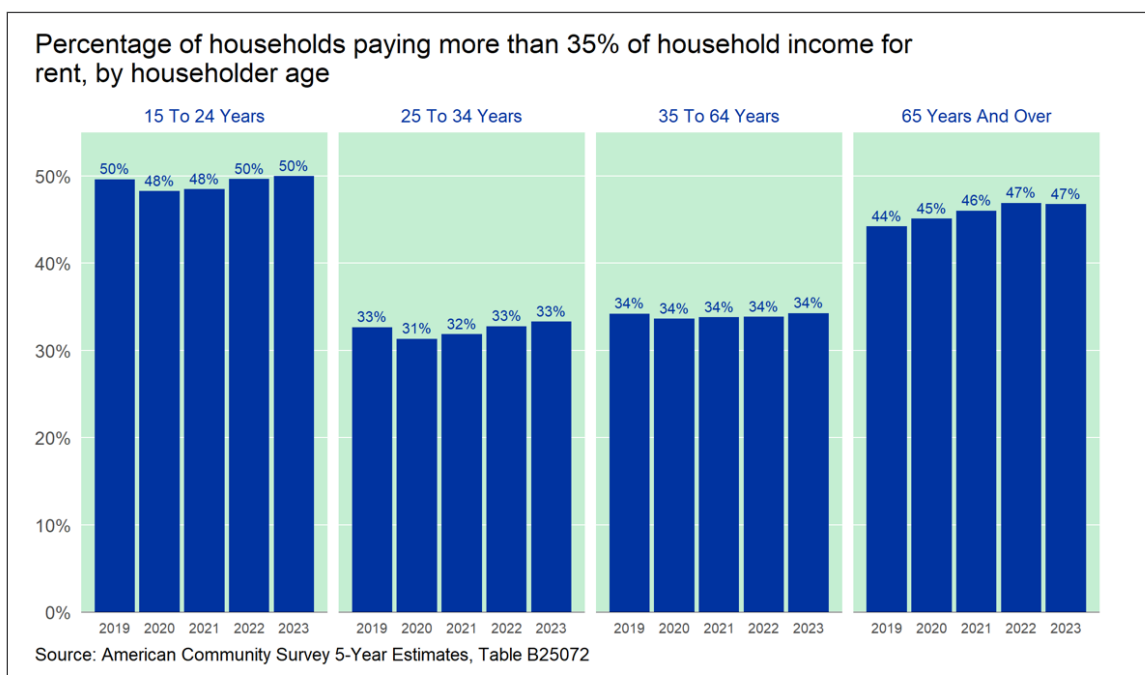


Source: American Community Survey 5-Year Estimates, Table S1702

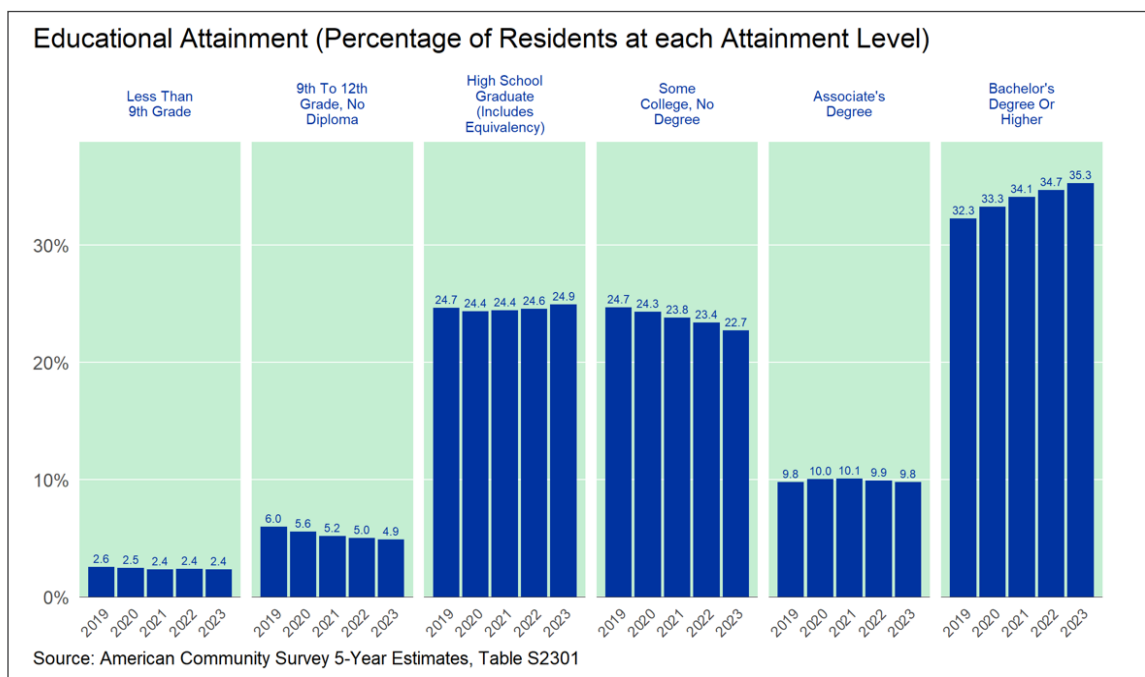
Unemployment



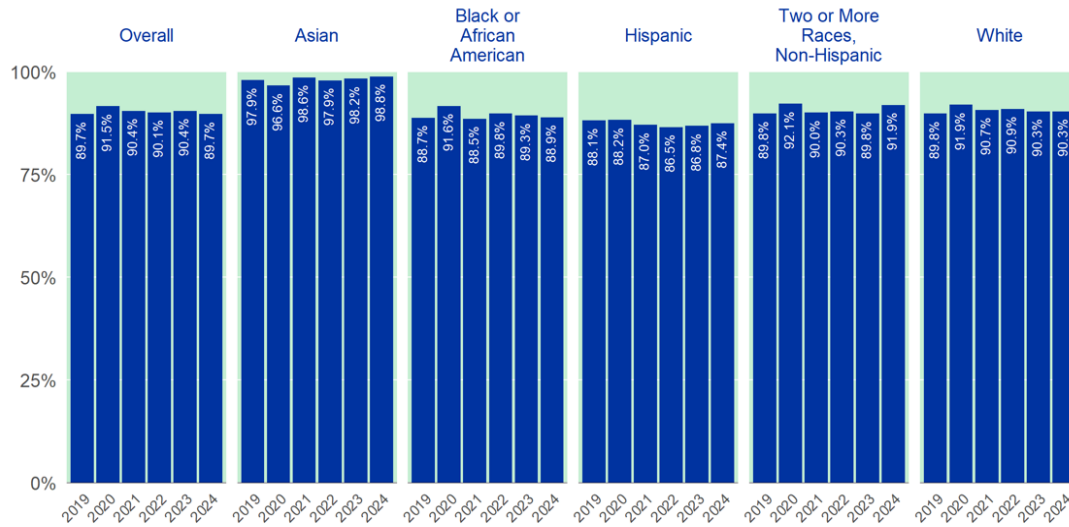
Housing



Education

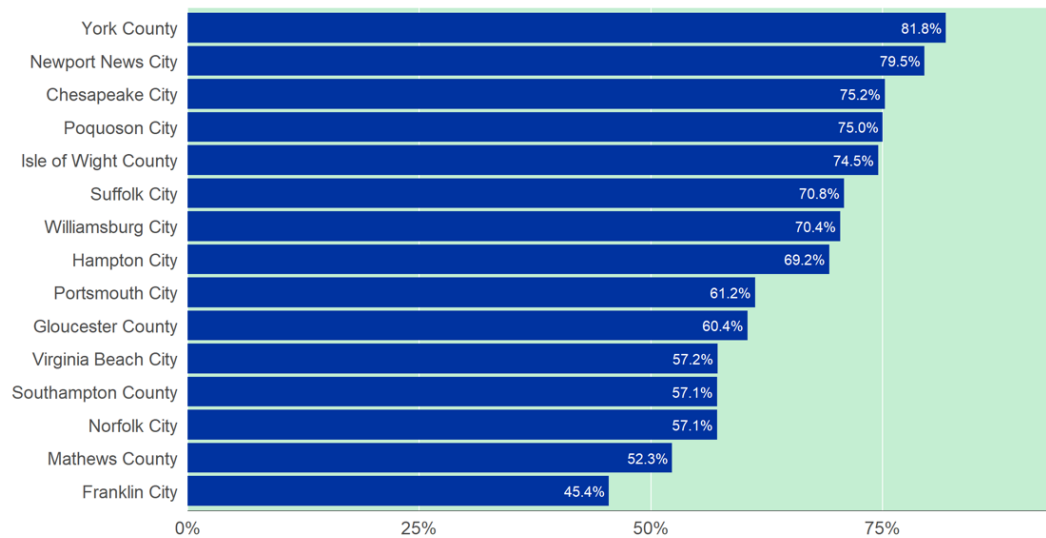


Average Percentage of Students in Study Area who Graduated On Time (4yrs) by Race



Source: Virginia Department of Education, NC Dept of Public Instruction
 Note: 'Average' represents a simple average across counties, not weighted by student populations.

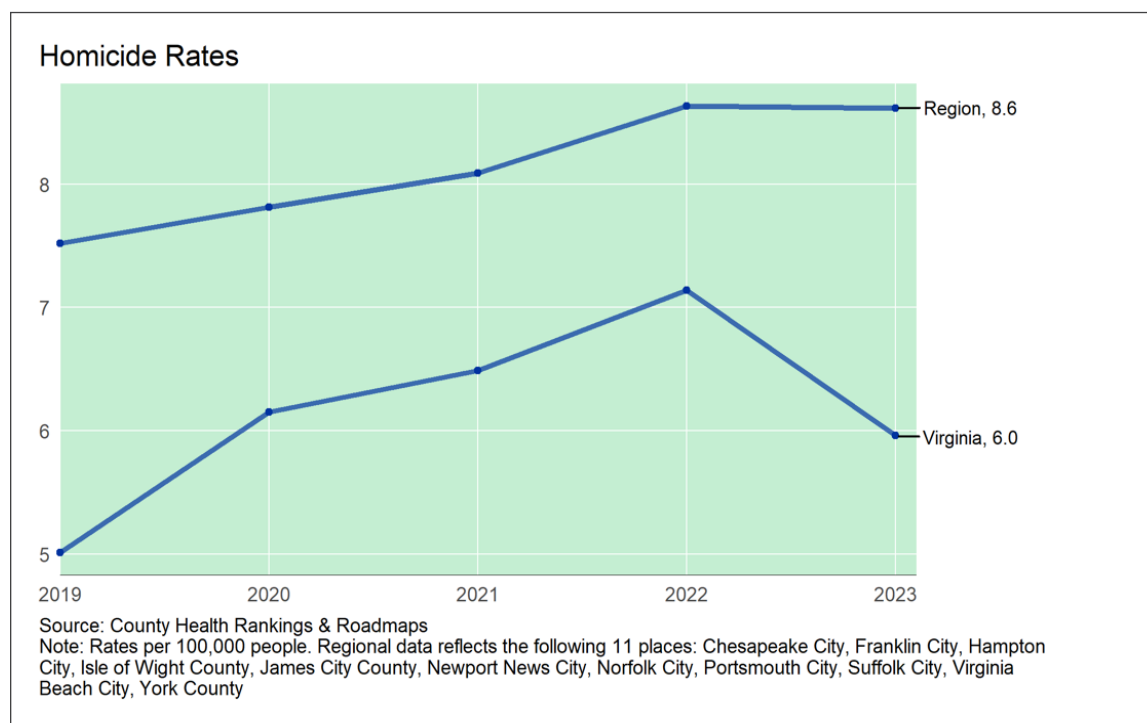
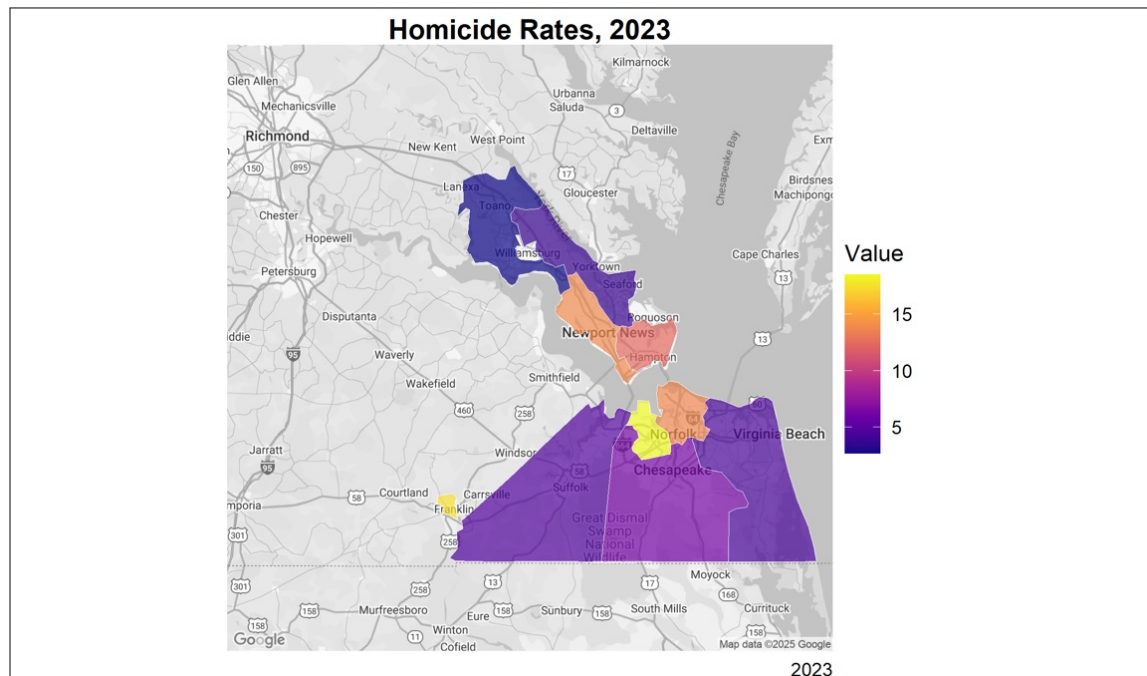
Percentage of youth with IEPs graduating from HS with a regular diploma, 2022



Source: VA Dept. of Edu.

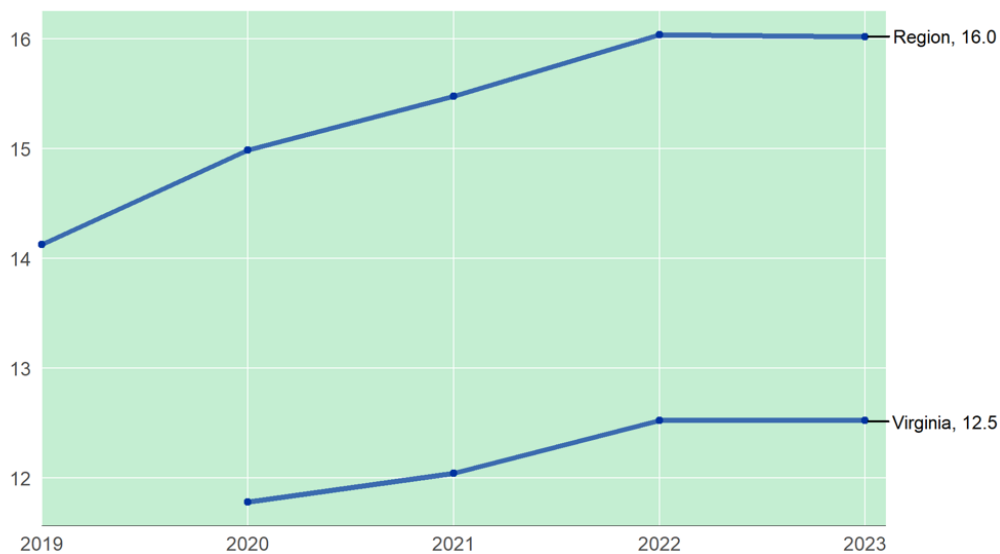
Community Violence

Homicide



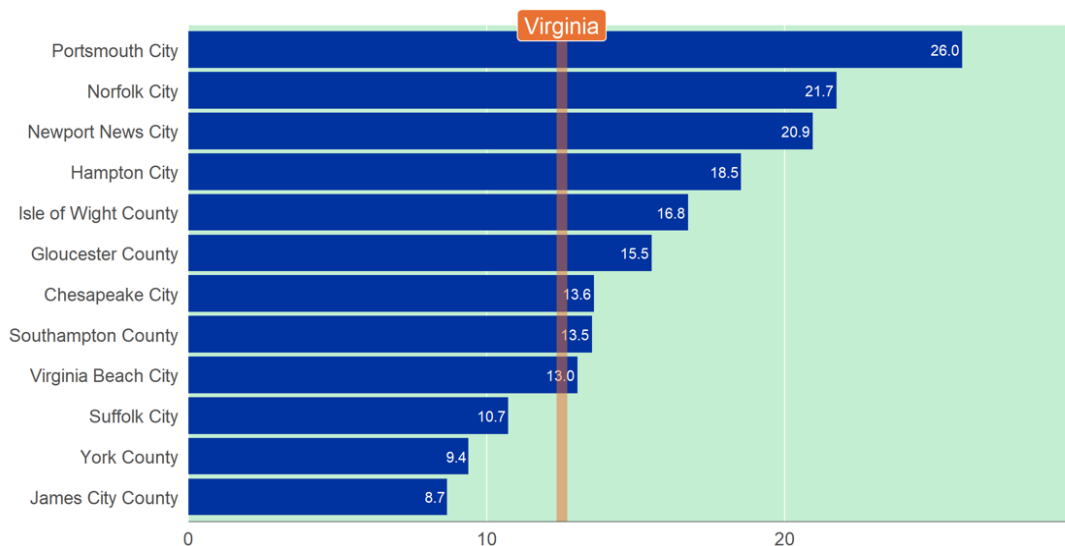
Gun Violence

Rates of Deaths due to Firearms



Source: County Health Rankings & Roadmaps
Note: Rates per 100,000 people.

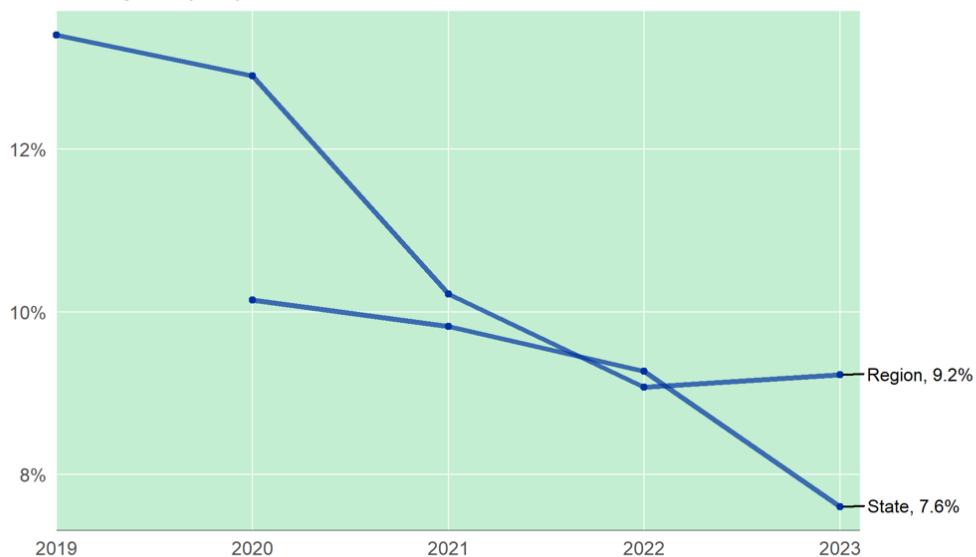
Rates of Deaths due to Firearms, 2023



Source: County Health Rankings & Roadmaps
Note: Rates per 100,000 people.

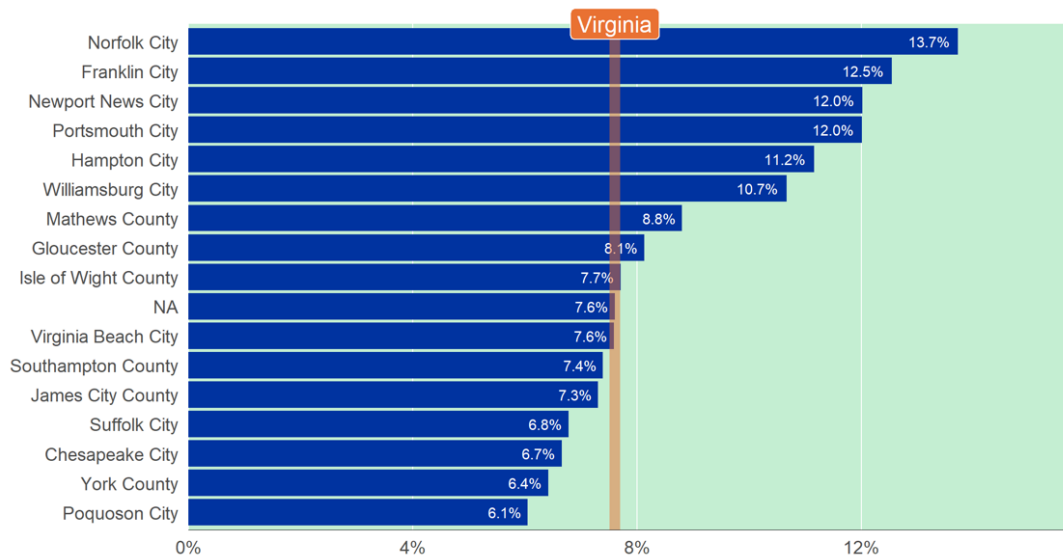
Food Insecurity

Percentage of people without a reliable source of food



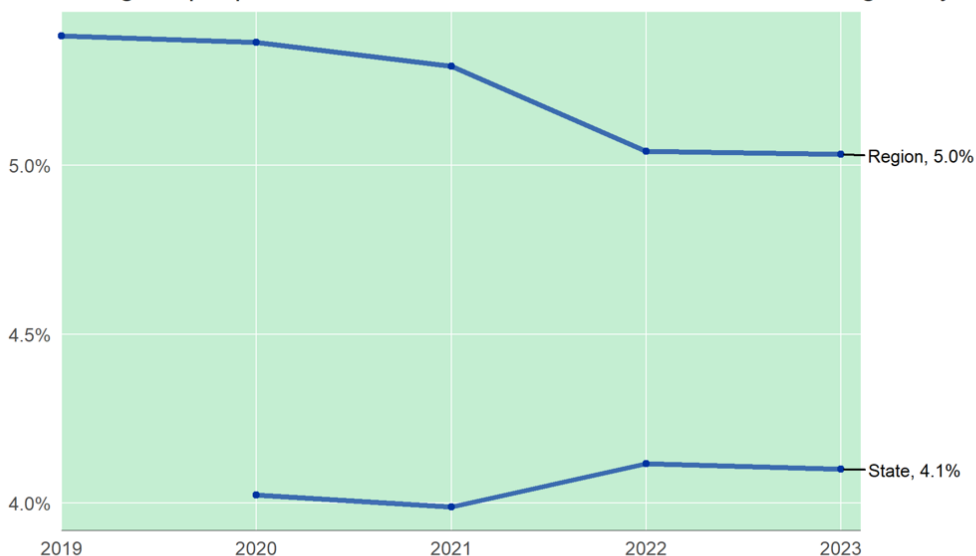
Source: County Health Rankings & Roadmaps

Percentage of people without a reliable source of food, 2023



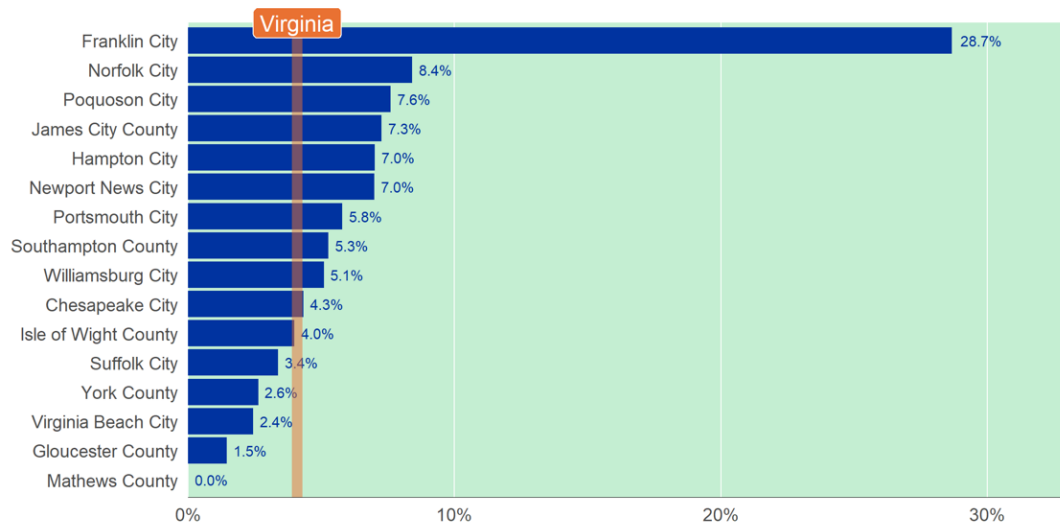
Source: County Health Rankings & Roadmaps

Percentage of people with low incomes and who do not live close to a grocery store



Source: County Health Rankings & Roadmaps

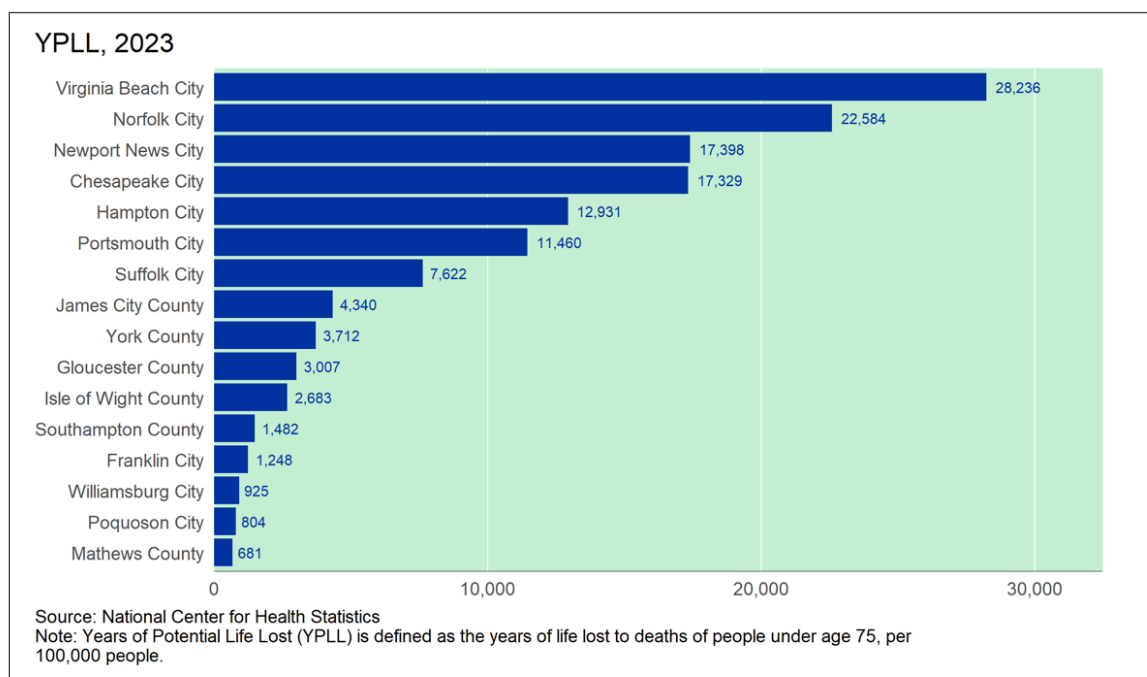
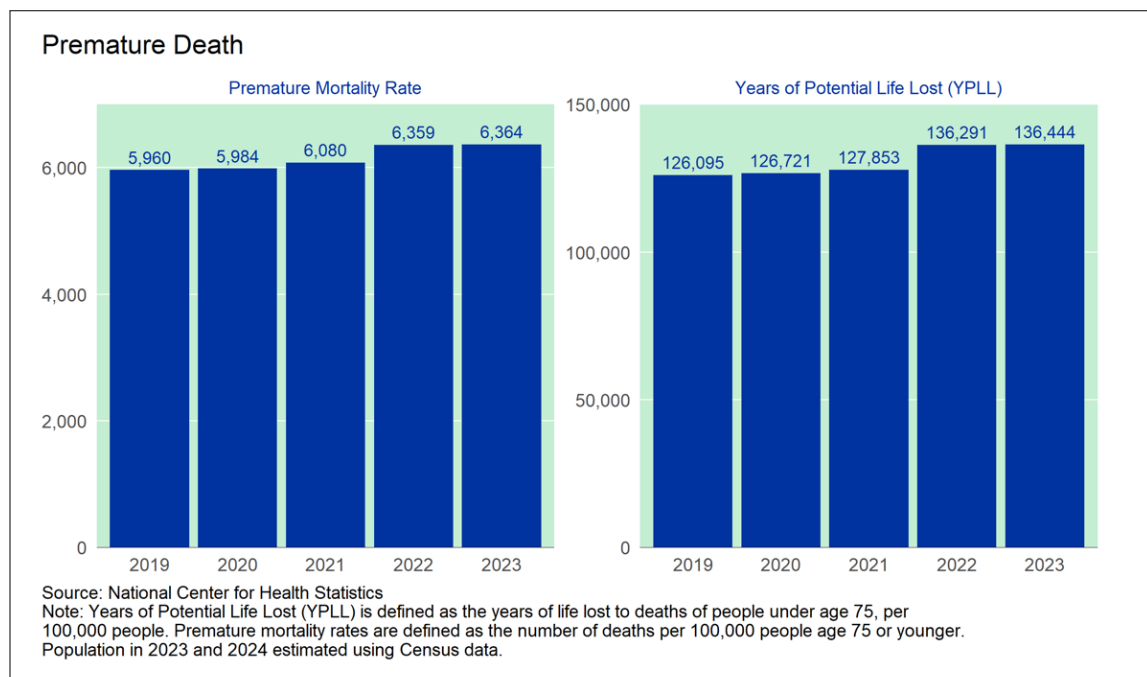
Percentage of people with low incomes and who do not live close to a grocery store, limiting their ability to access healthy foods, 2023



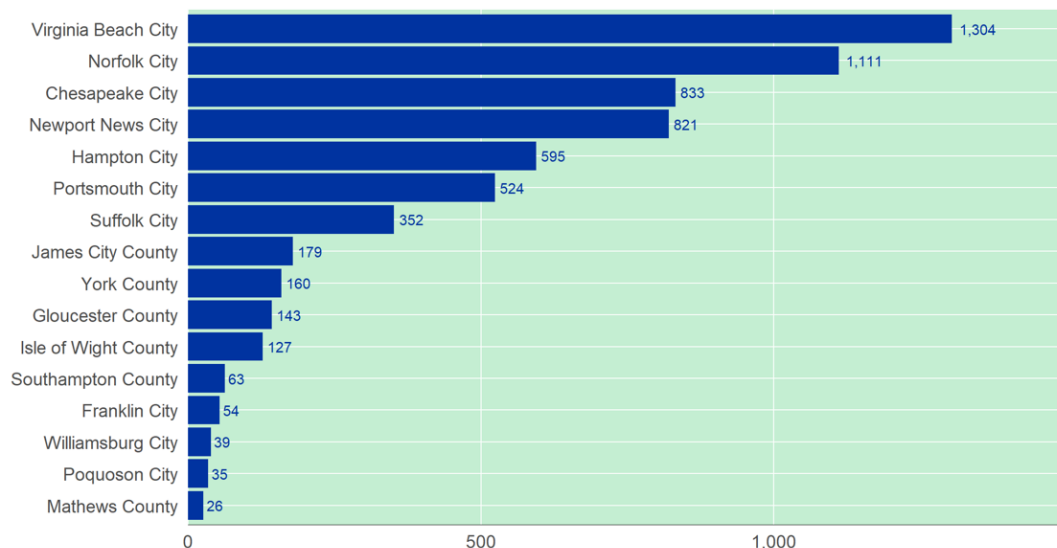
Source: County Health Rankings & Roadmaps

Mortality

Premature Death and Years of Potential Life Lost



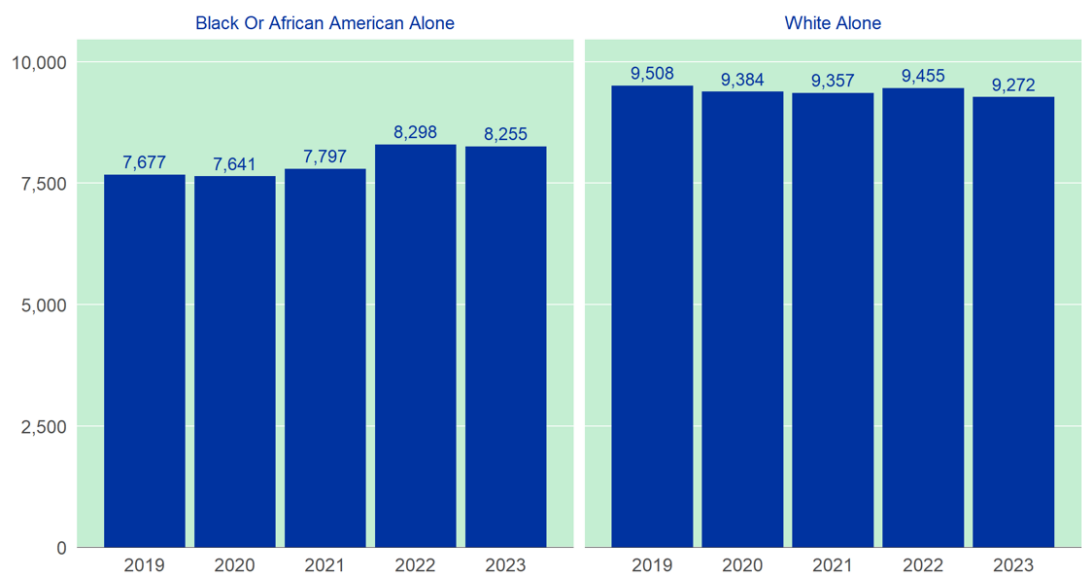
Premature Mortality, 2023



Source: National Center for Health Statistics

Note: Premature mortality rates are defined as the number of deaths per 100,000 people age 75 or younger.

Regional Premature Mortality Rates by Race

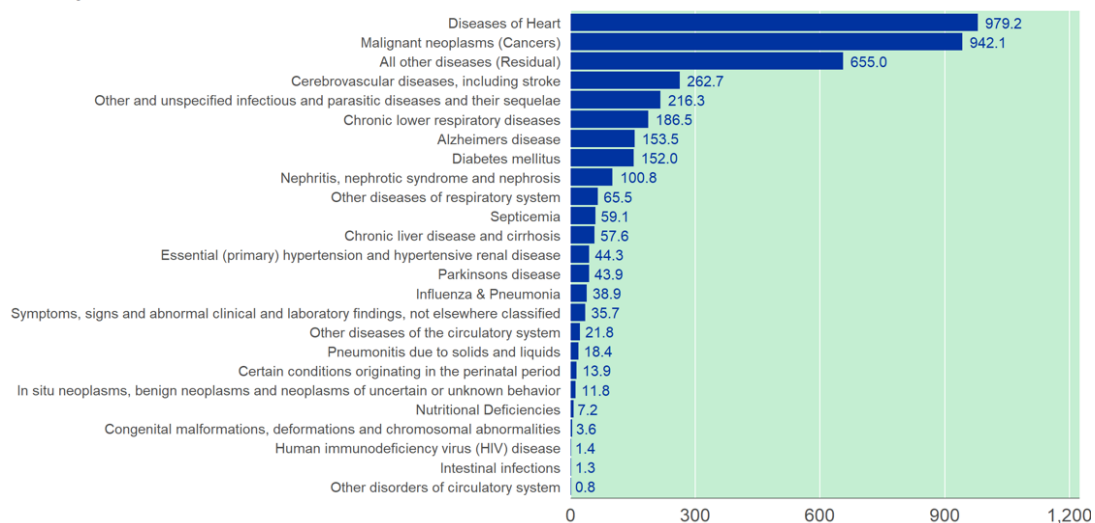


Source: National Center for Health Statistics

Causes of Death

Mortality Rate by Cause (per 100,000 people), 2018-2022 (total)

Non-Injuries

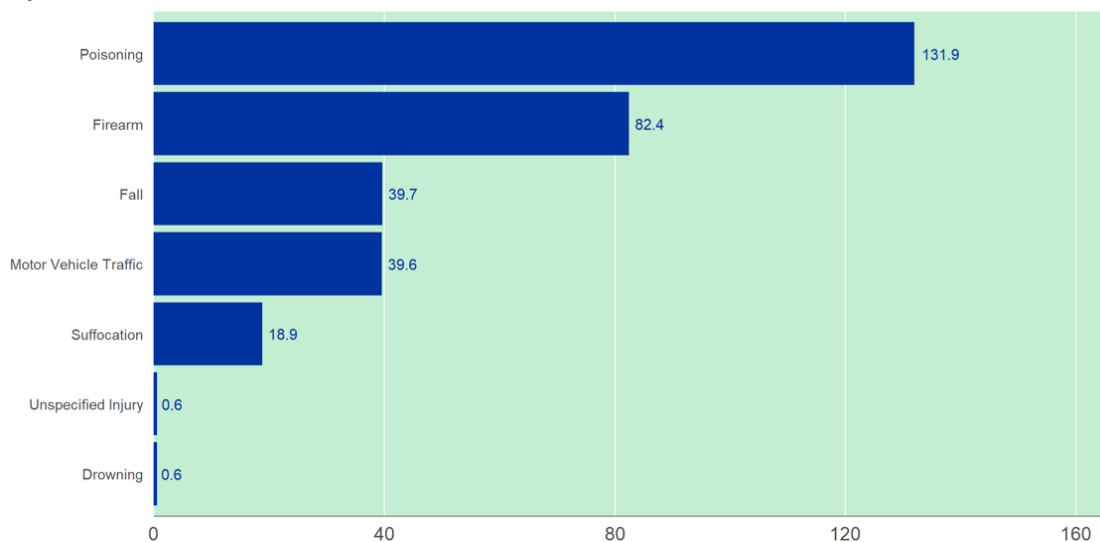


Source: CDC

Note: All deaths over the period 2018-2022, divided by the average population during the same time.

Mortality Rate by Cause (per 100,000 people), 2018-2022 (total)

Injuries

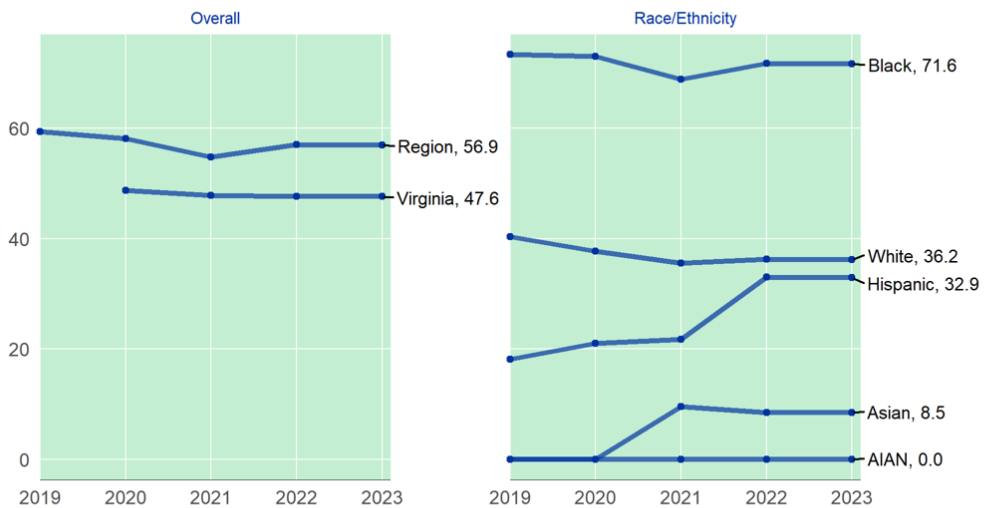


Source: CDC

Note: All deaths over the period 2018-2022, divided by the average population during the same time.

Child Mortality

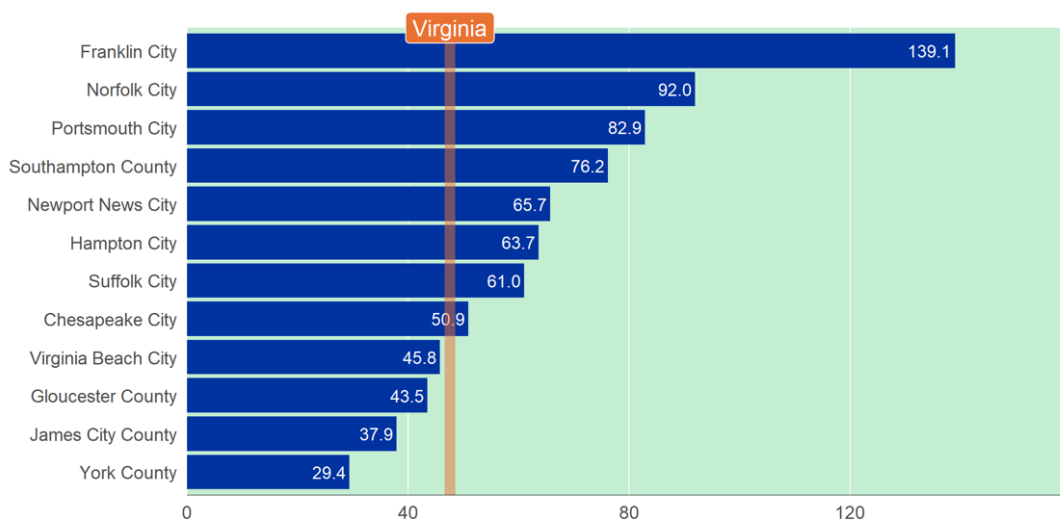
Child Mortality Rate in Service Area by Race/Ethnicity



Source: County Health Rankings & Roadmaps

Note: Child population defined as under 20 years. Rates per 100,000 children. Data not available for Isle of Wight County, Mathews County, Poquoson City, or Williamsburg City.

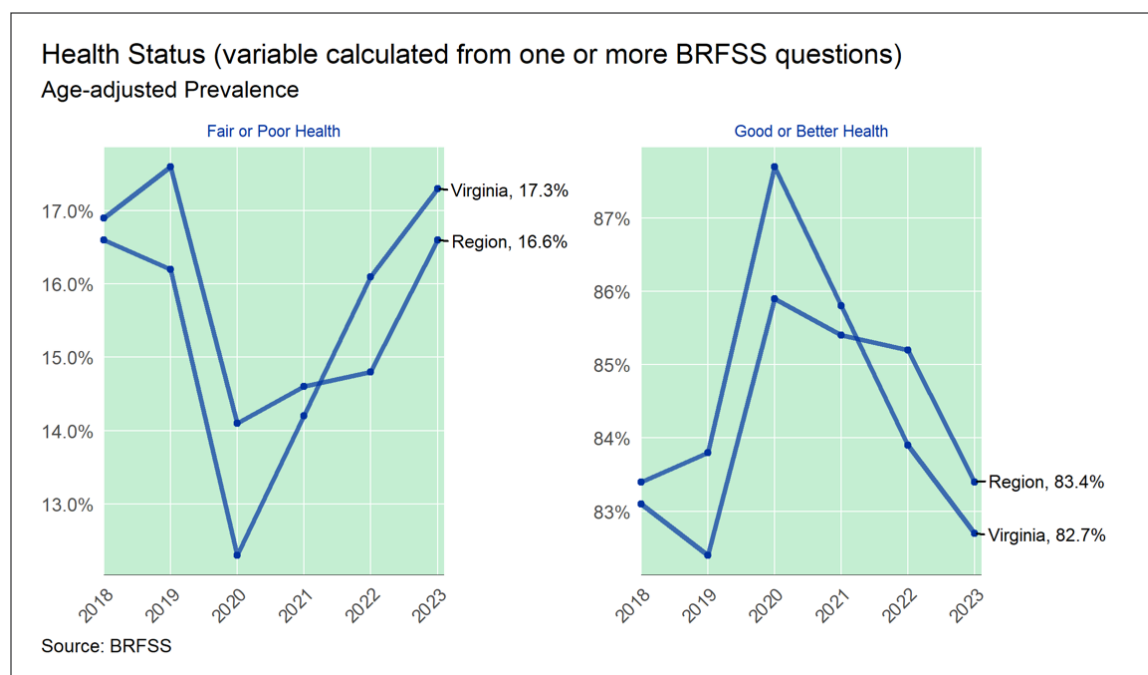
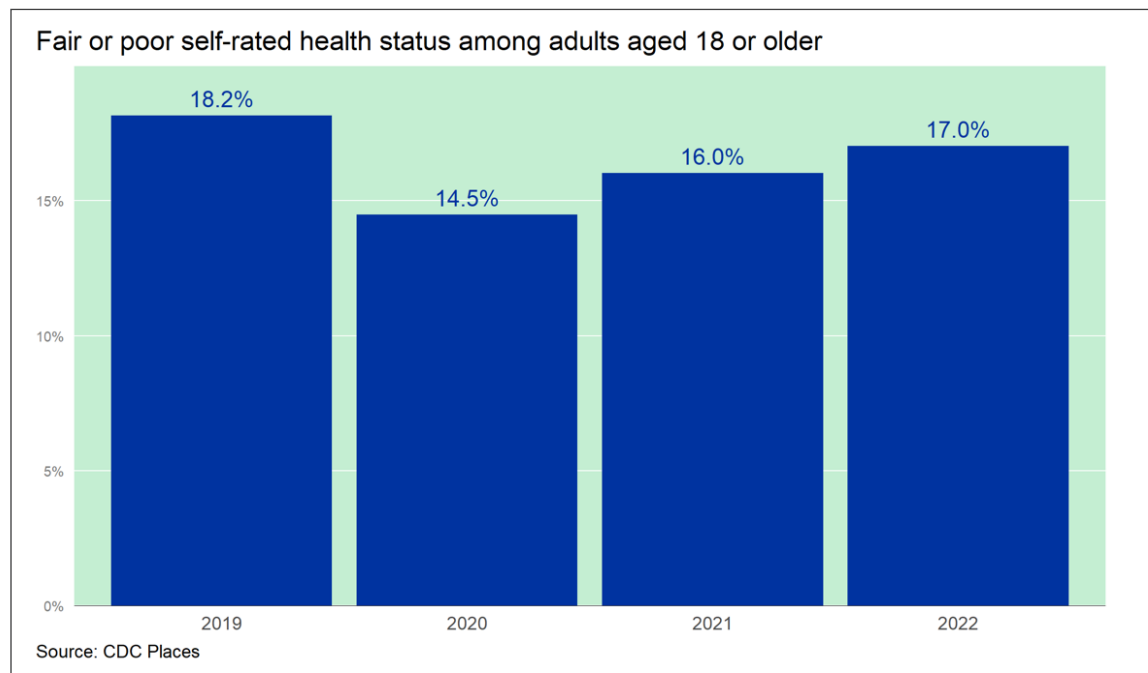
Child Mortality Rate, 2023



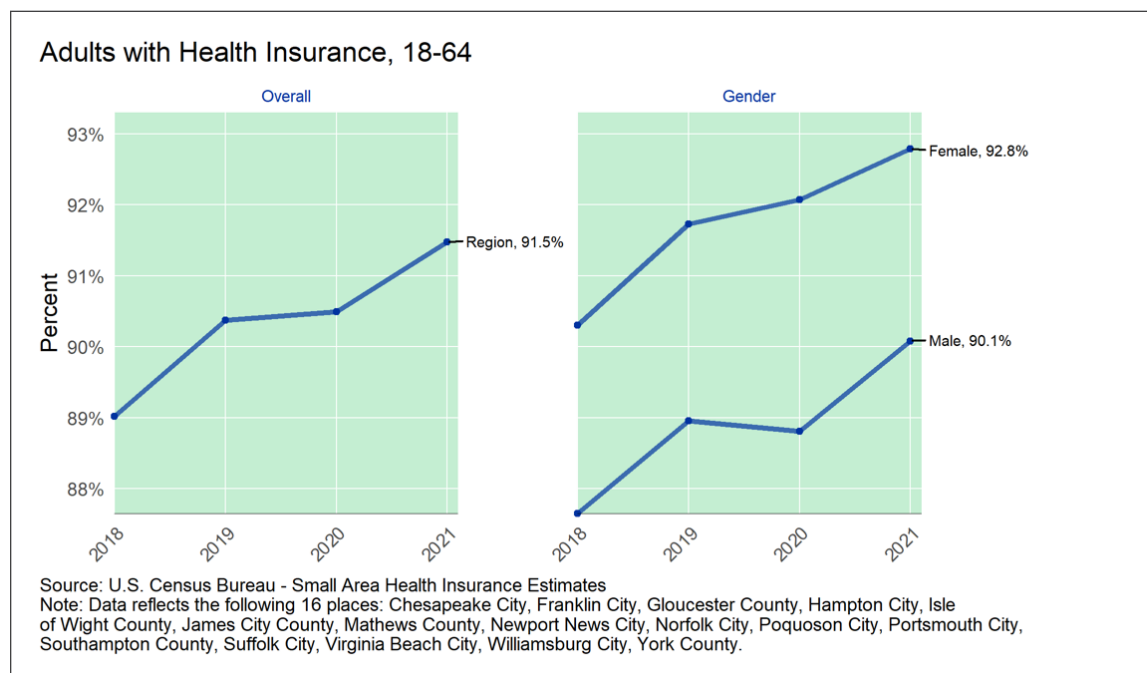
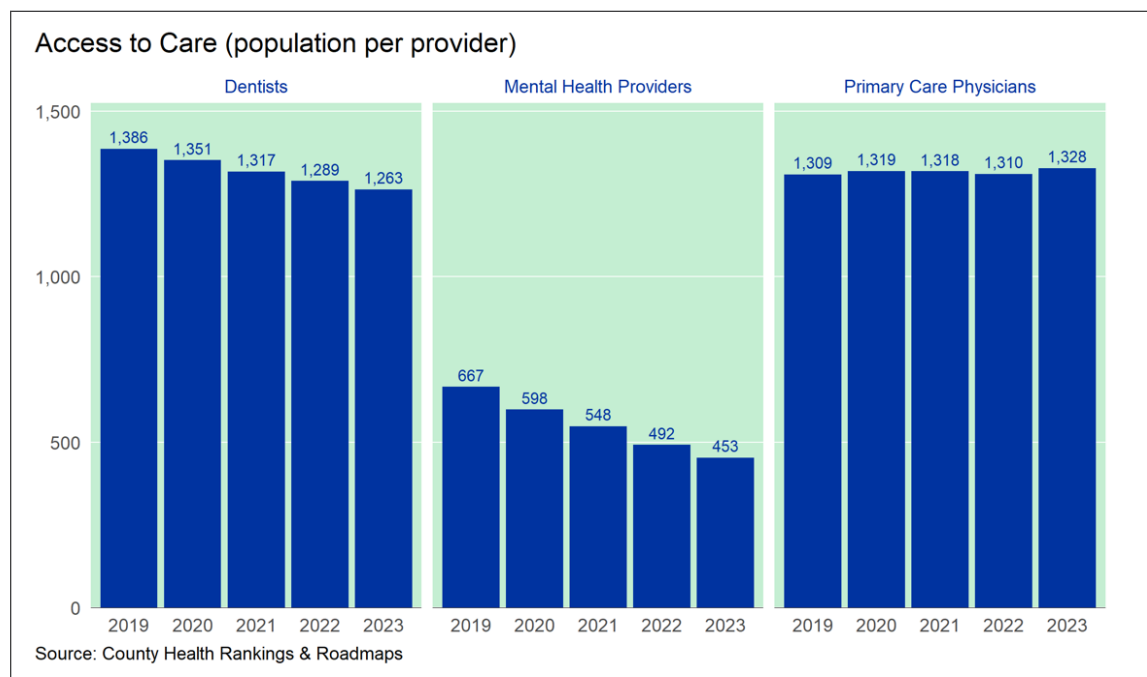
Source: County Health Rankings & Roadmaps

Note: Child population defined as under 20 years. Rates per 100,000 children. Data not available for Isle of Wight County, Mathews County, Poquoson City, or Williamsburg City.

Overall Health



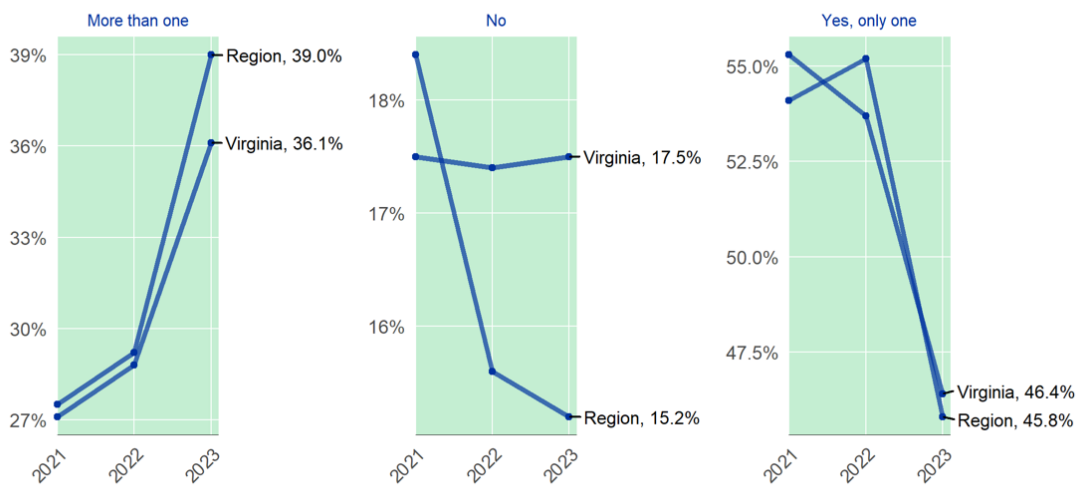
Access to Care



Preventive Care

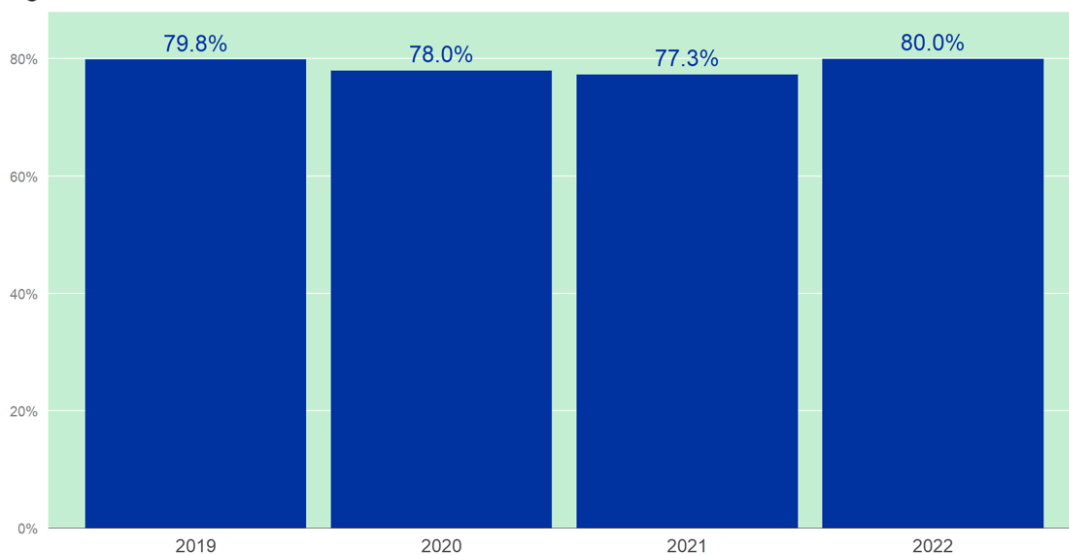
Do you have one person (or a group of doctors) that you think of as your personal health care provider?

Age-adjusted Prevalence



Source: BRFSS

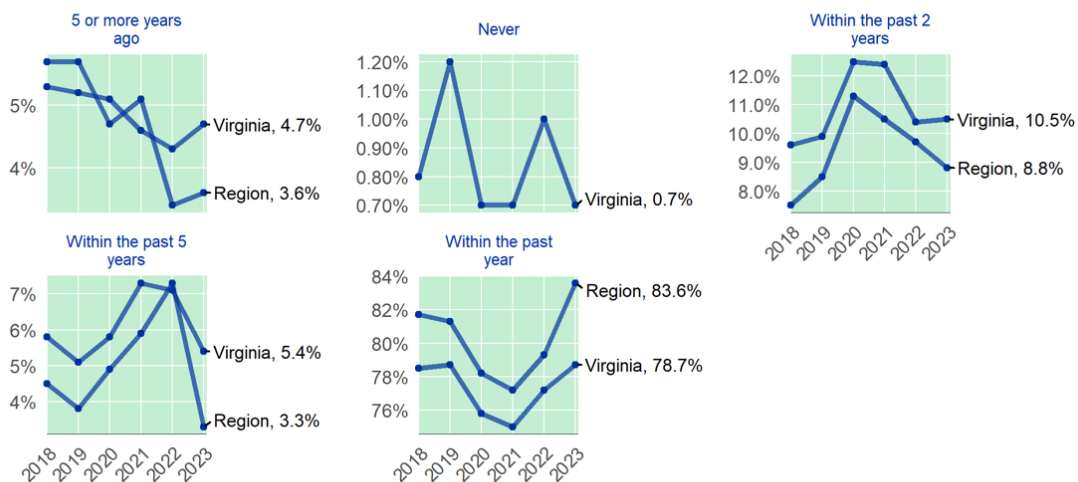
Visits to doctor for routine checkup within the past year among adults aged 18 or older



Source: CDC Places

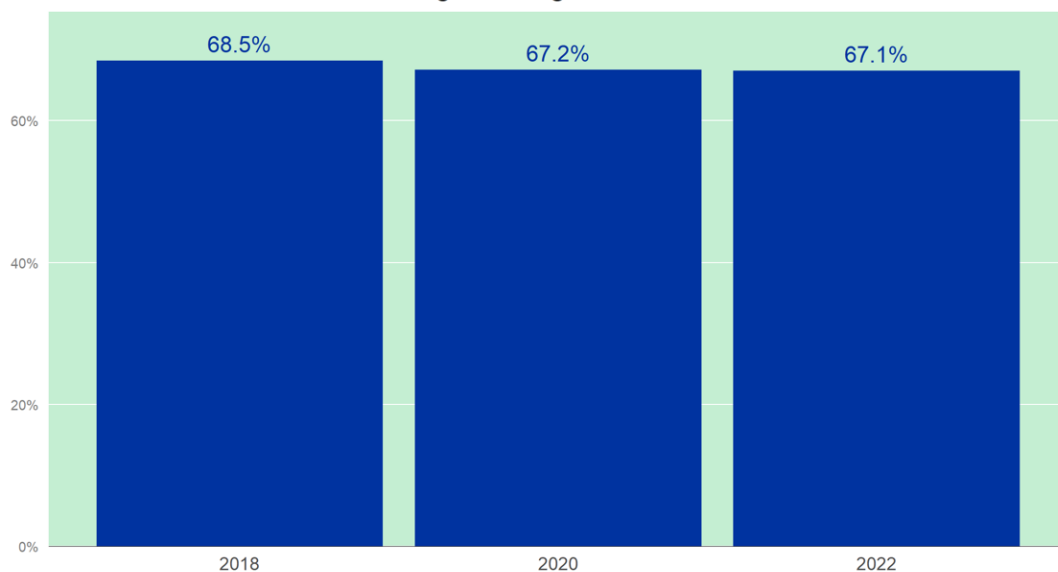
About how long has it been since you last visited a doctor for a routine checkup?

Age-adjusted Prevalence



Source: BRFSS

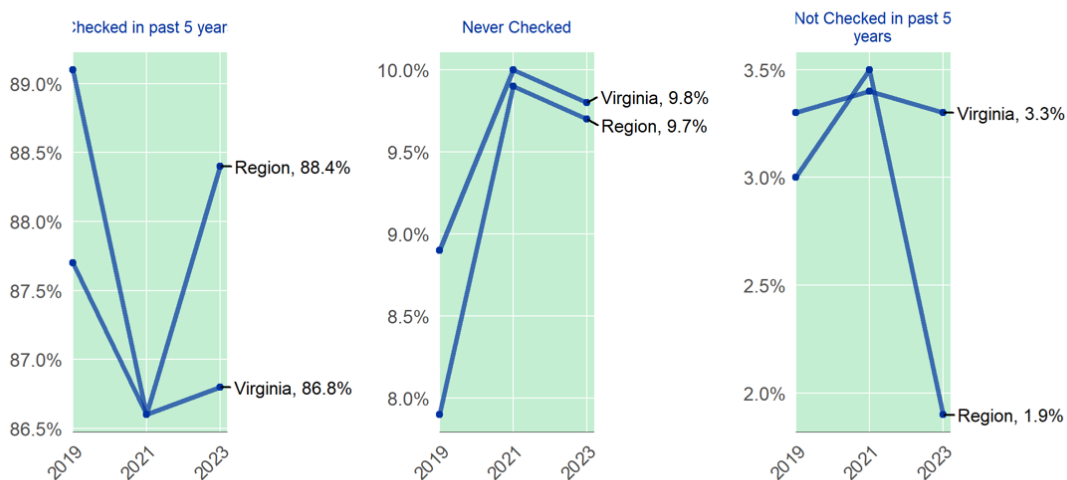
Visits to dentist or dental clinic among adults aged 18 or older



Source: CDC Places

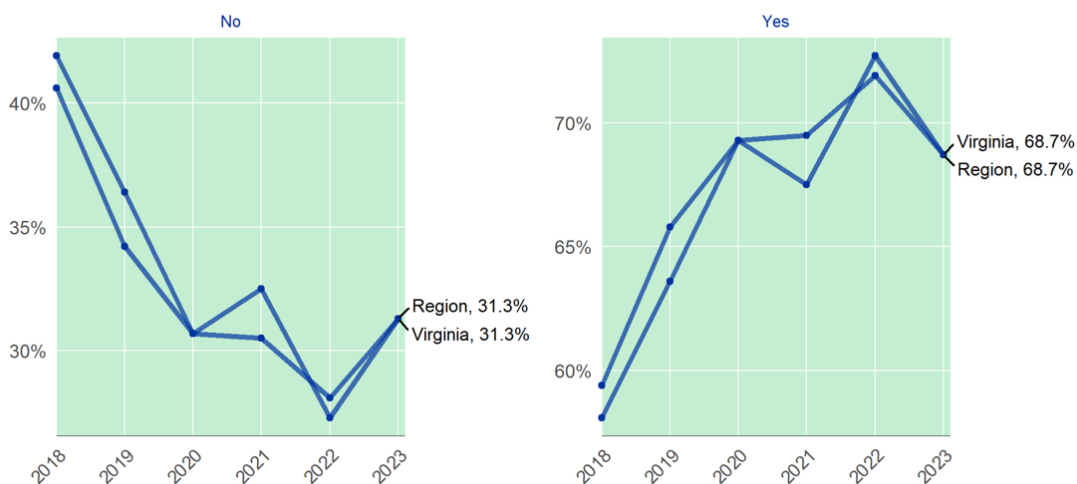
Adults who have had their blood cholesterol checked within the last five years (variable calculated from one or more BRFSS questions)

Age-adjusted Prevalence



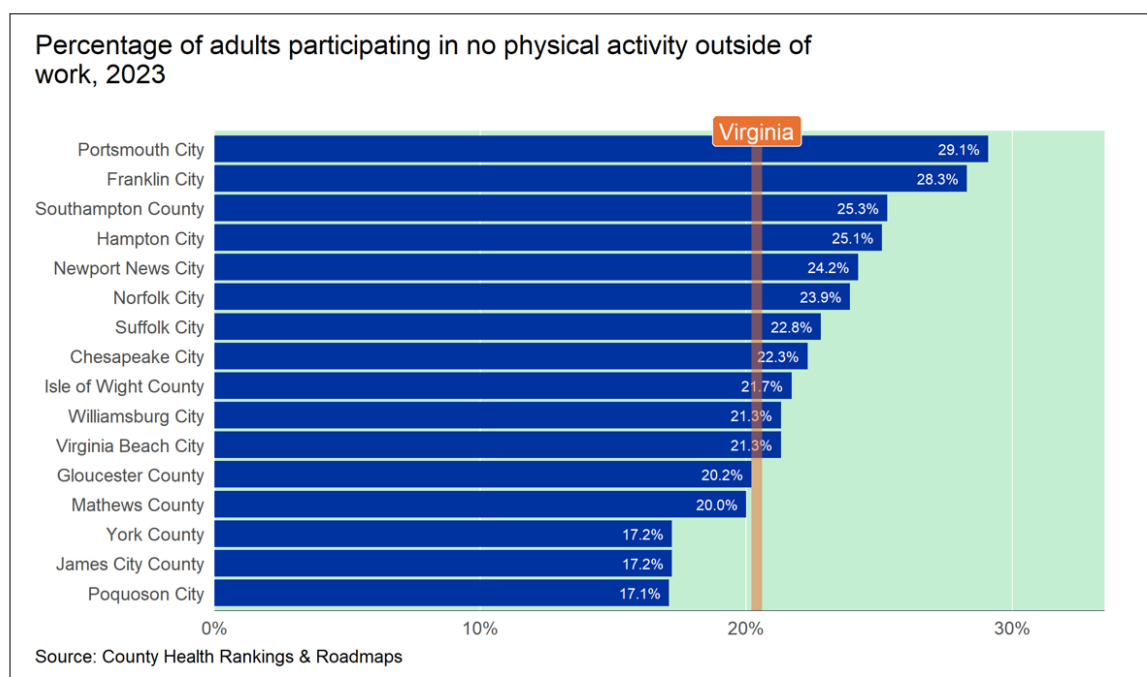
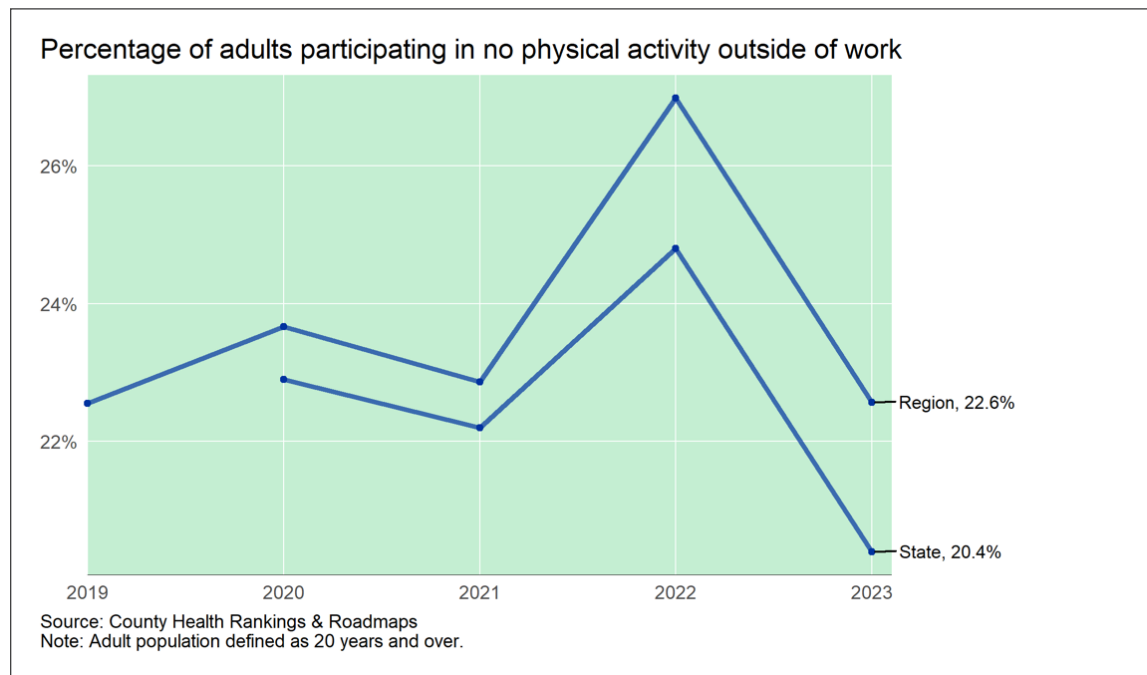
Adults aged 65+ who have had a flu shot within the past year (variable calculated from one or more BRFSS questions)

Age-adjusted Prevalence



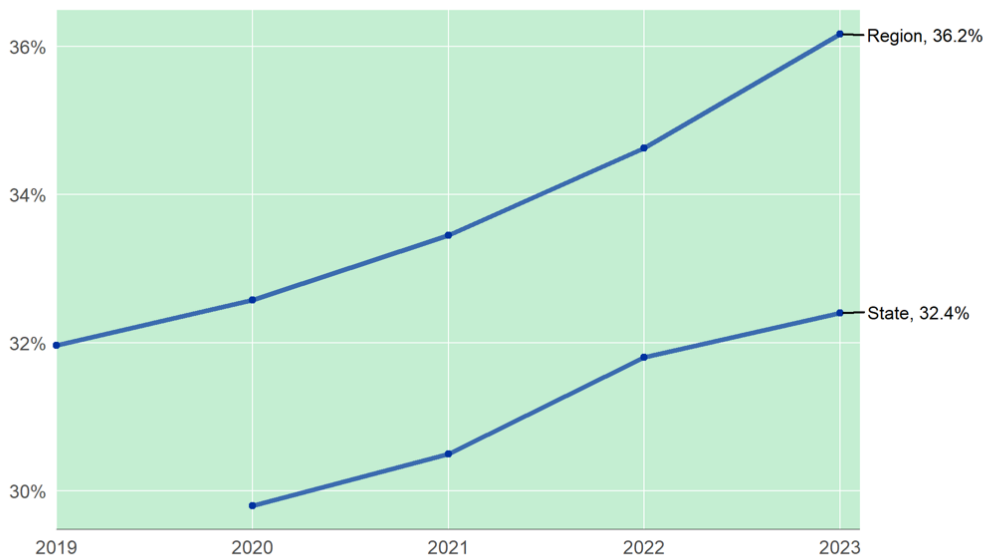
Chronic Health Conditions

Physical Activity



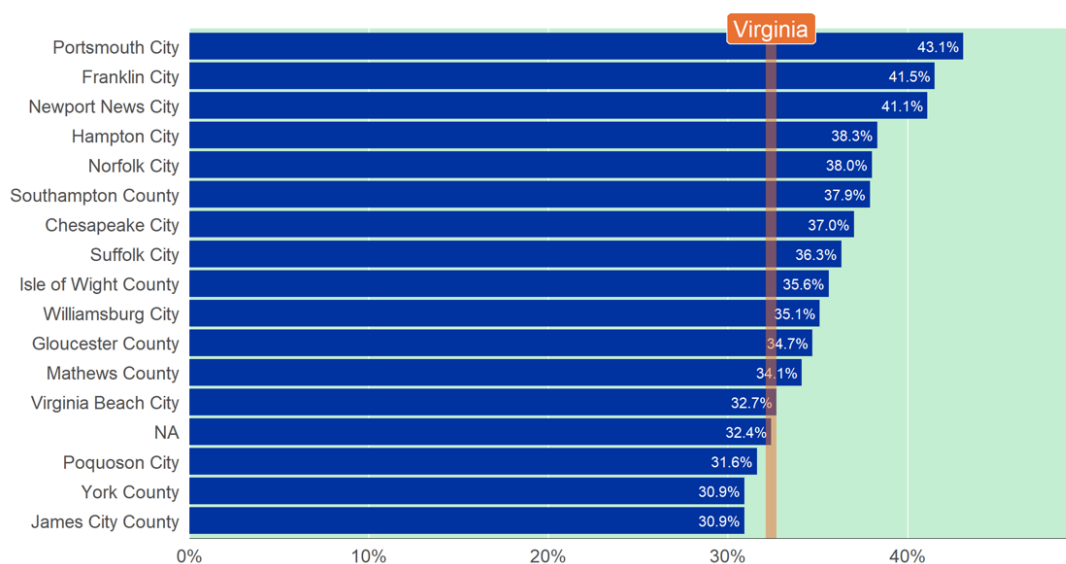
Obesity

Percentage of adults with a BMI of 30 or greater



Source: County Health Rankings & Roadmaps

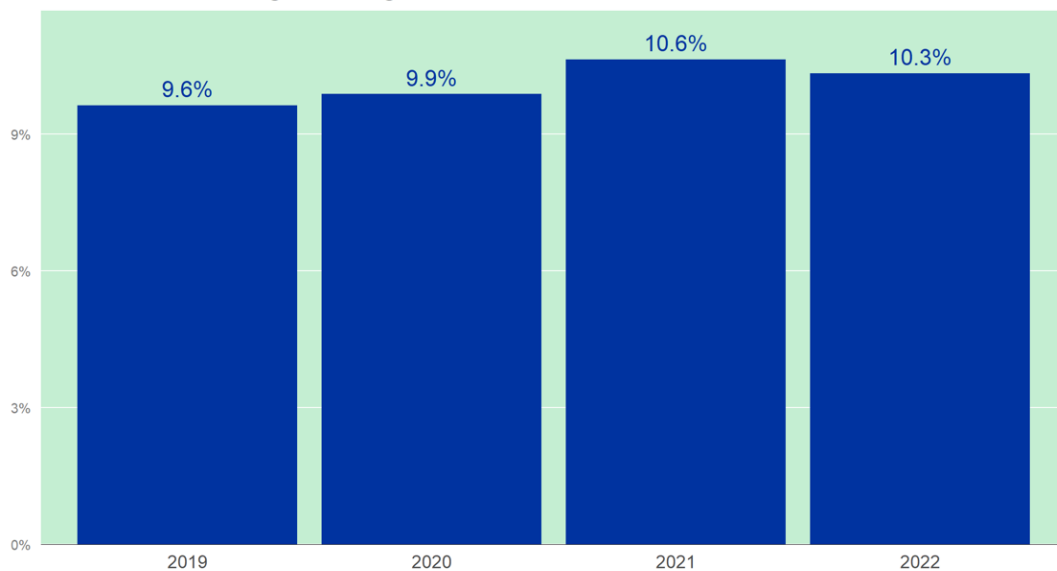
Percentage of adults with a BMI of 30 or greater, 2023



Source: County Health Rankings & Roadmaps

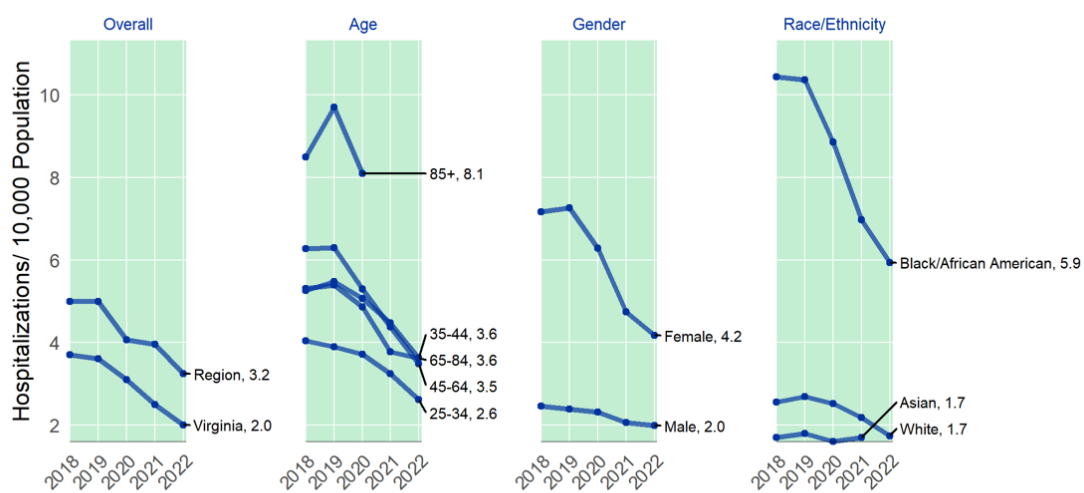
Asthma

Current asthma among adults aged 18 or older



Source: CDC Places

Age-Adjusted Hospitalization Rate due to Adult Asthma

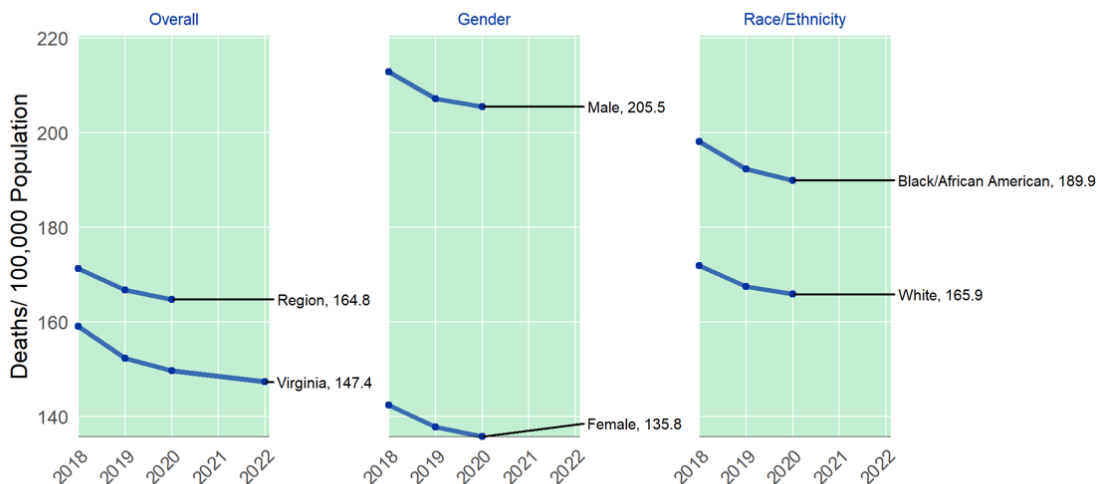


Source: Virginia Health Information

Note: Data reflects the following 12 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Newport News City, Norfolk City, Portsmouth City, Suffolk City, Virginia Beach City, York County.

Cancer

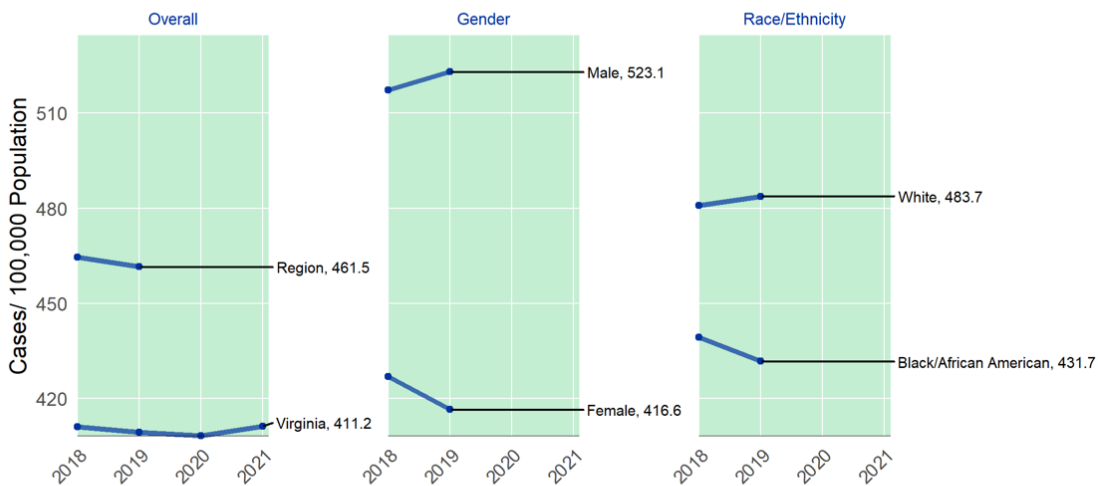
Age-Adjusted Death Rate due to Cancer



Source: National Cancer Institute

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

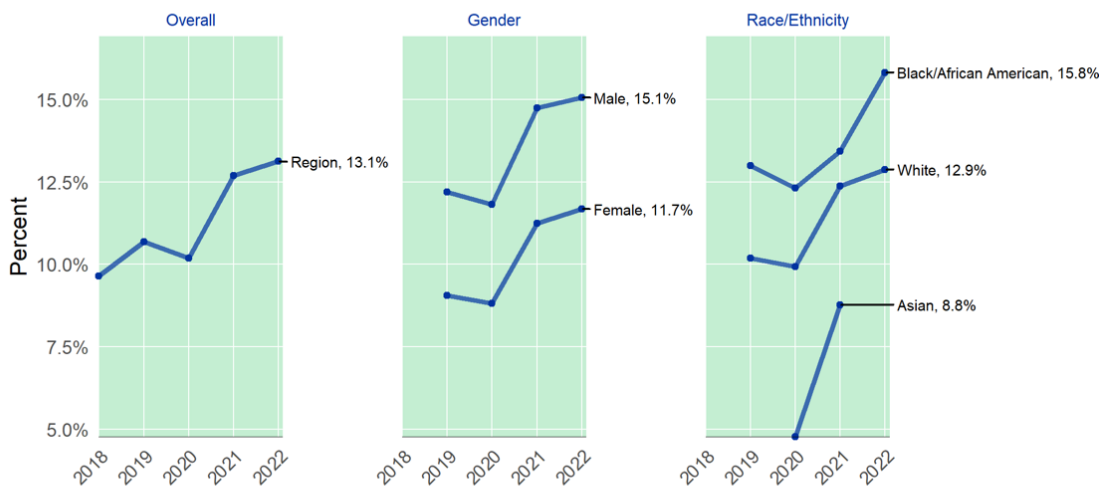
All Cancer Incidence Rate



Source: National Cancer Institute

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

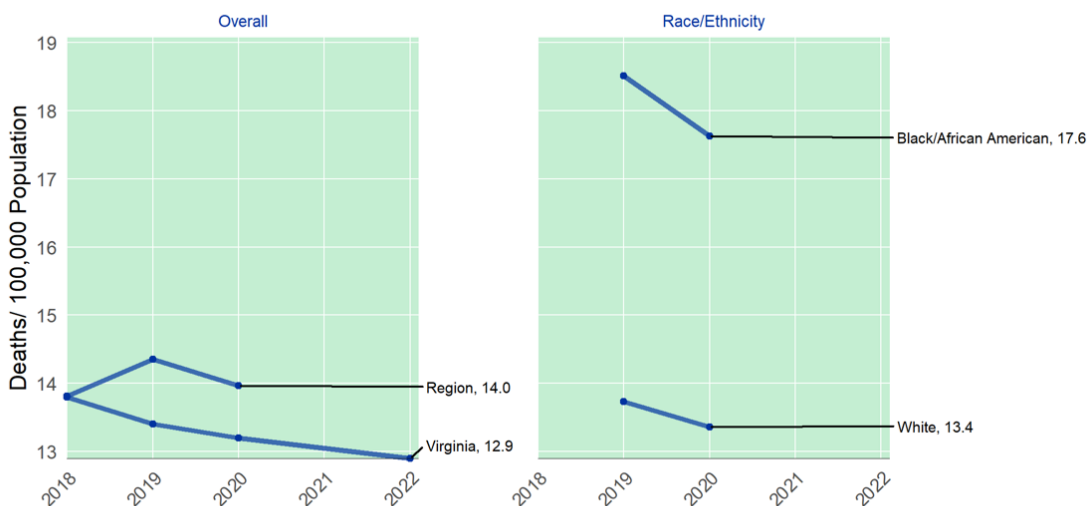
Cancer, Medicare Population



Source: Centers for Medicare & Medicaid Services

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

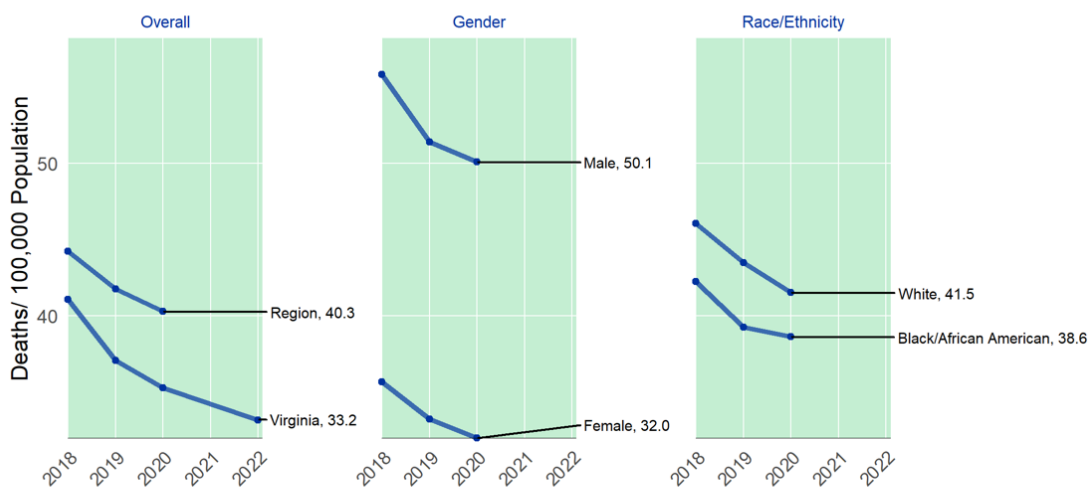
Age-Adjusted Death Rate due to Colorectal Cancer



Source: National Cancer Institute

Note: Data reflects the following 11 places: Chesapeake City, Gloucester County, Hampton City, Isle of Wight County, James City County, Newport News City, Norfolk City, Portsmouth City, Suffolk City, Virginia Beach City, York County.

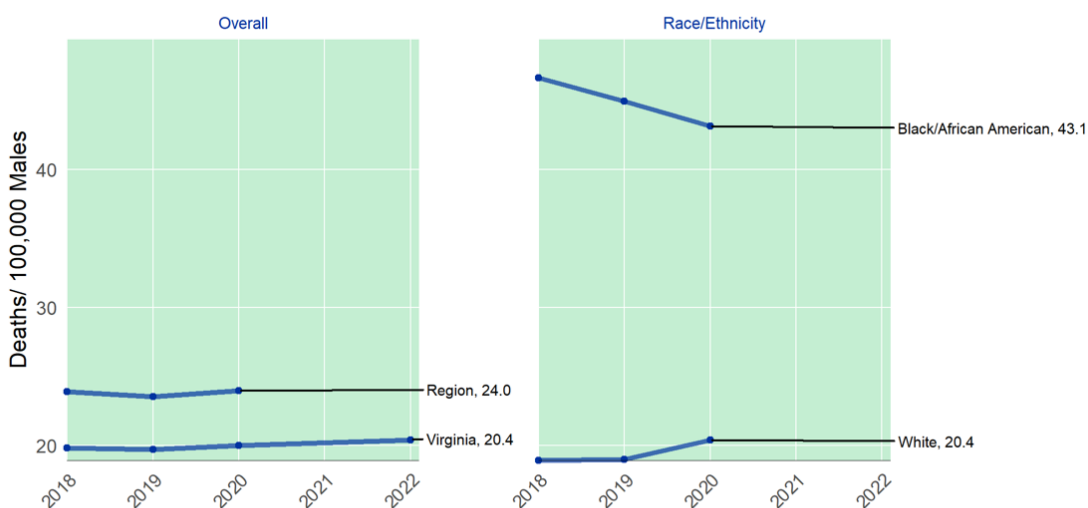
Age-Adjusted Death Rate due to Lung Cancer



Source: National Cancer Institute

Note: Data reflects the following 15 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, York County.

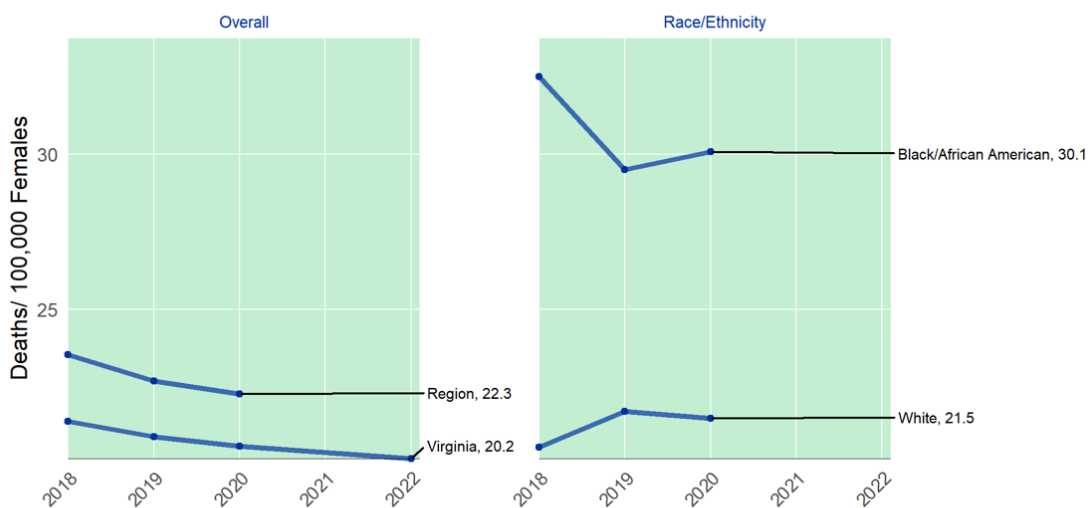
Age-Adjusted Death Rate due to Prostate Cancer



Source: National Cancer Institute

Note: Data reflects the following 11 places: Chesapeake City, Gloucester County, Hampton City, Isle of Wight County, James City County, Newport News City, Norfolk City, Portsmouth City, Suffolk City, Virginia Beach City, York County.

Age-Adjusted Death Rate due to Breast Cancer

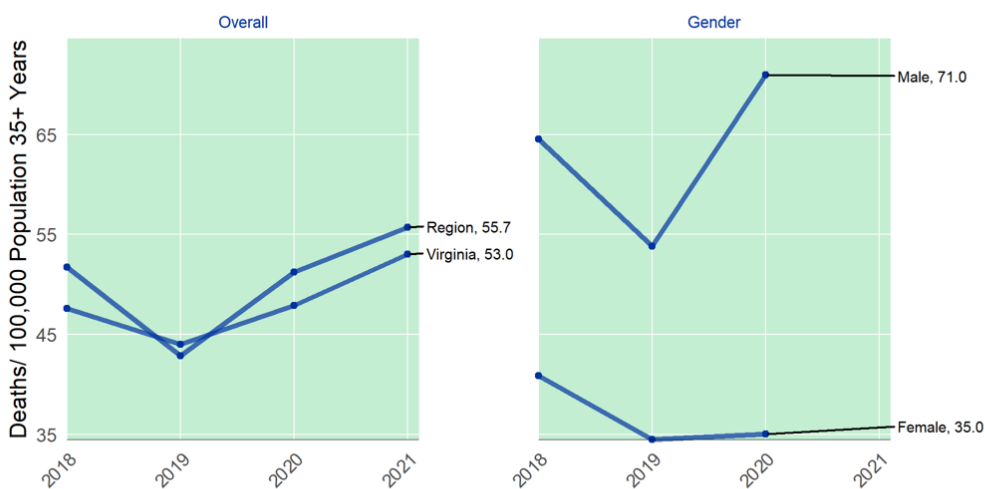


Source: National Cancer Institute

Note: Data reflects the following 11 places: Chesapeake City, Gloucester County, Hampton City, Isle of Wight County, James City County, Newport News City, Norfolk City, Portsmouth City, Suffolk City, Virginia Beach City, York County.

Heart Disease

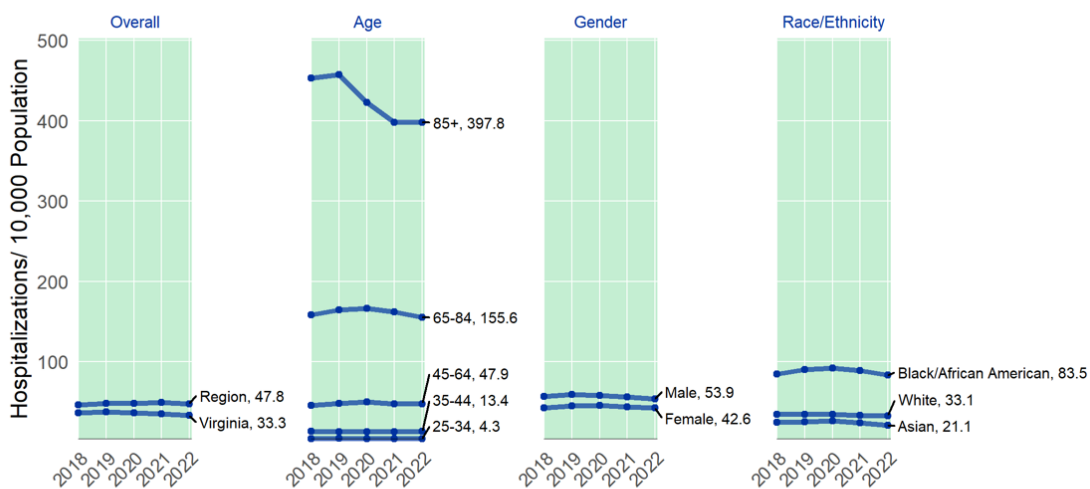
Age-Adjusted Death Rate due to Heart Attack



Source: National Environmental Public Health Tracking Network

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

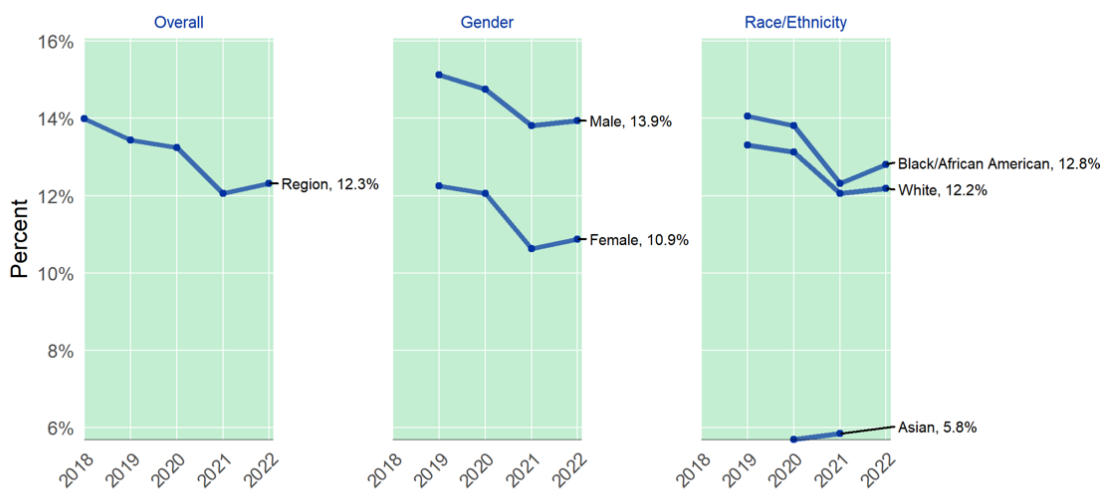
Age-Adjusted Hospitalization Rate due to Heart Failure



Source: Virginia Health Information

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

Heart Failure, Medicare Population

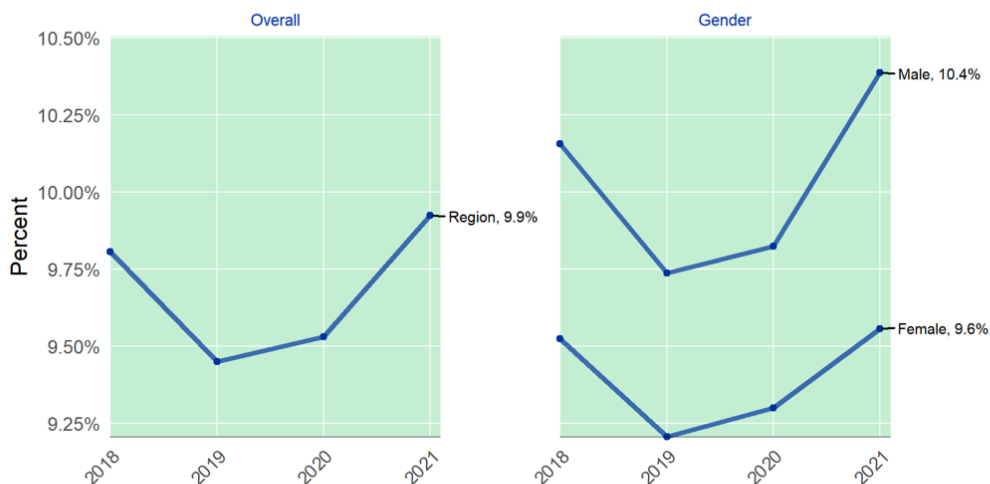


Source: Centers for Medicare & Medicaid Services

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

Diabetes

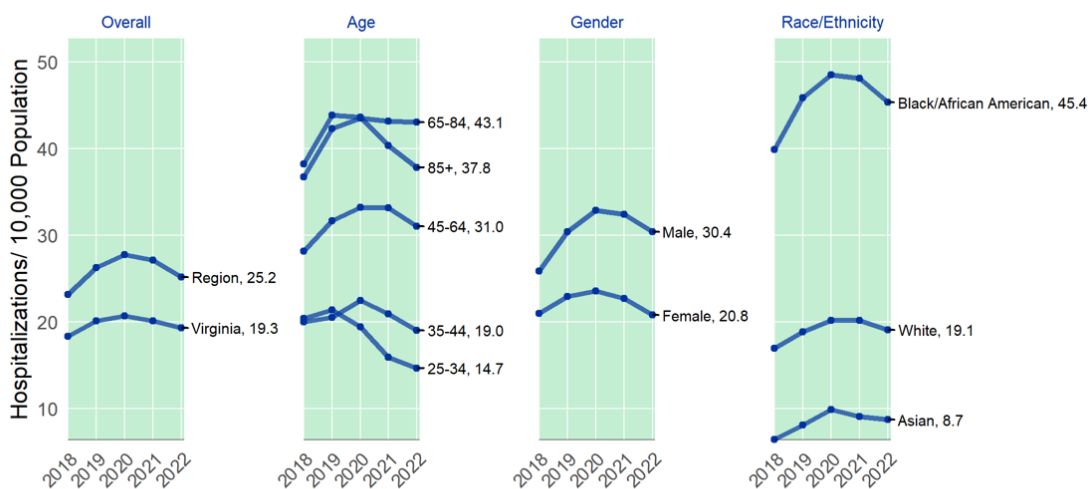
Adults 20+ with Diabetes



Source: Centers for Disease Control and Prevention

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

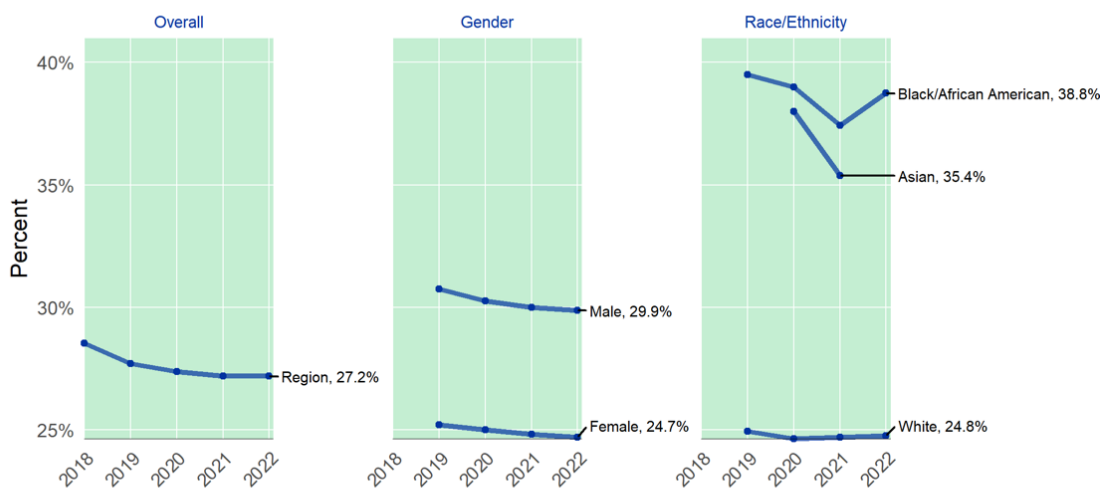
Age-Adjusted Hospitalization Rate due to Diabetes



Source: Virginia Health Information

Note: Data reflects the following 15 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, York County.

Diabetes, Medicare Population



Source: Centers for Medicare & Medicaid Services

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

Stroke

Stroke, Medicare Population

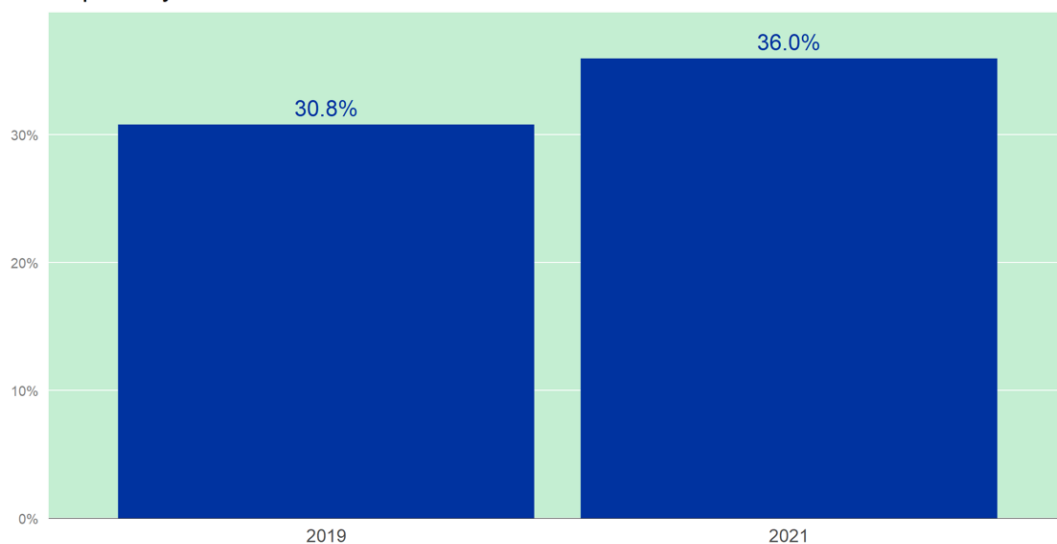


Source: Centers for Medicare & Medicaid Services

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

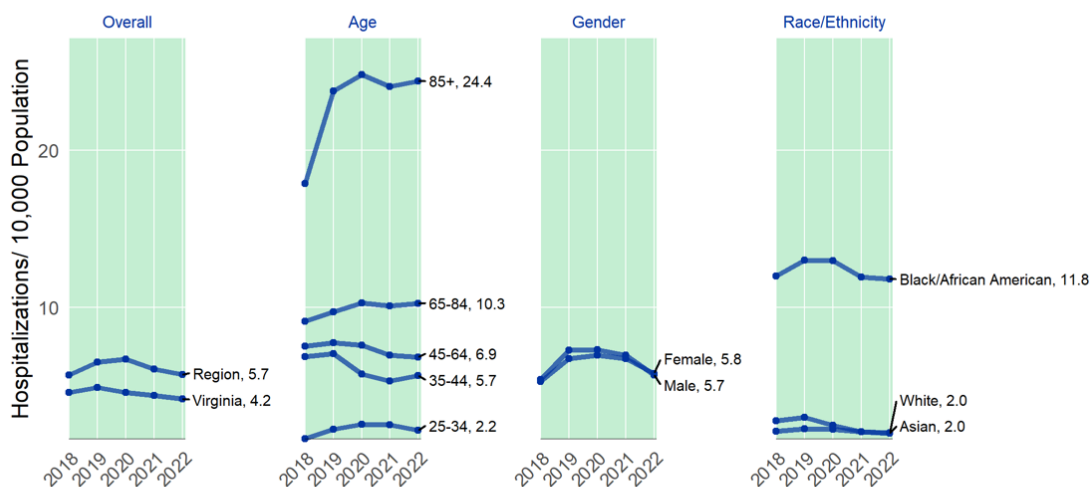
Hypertension

High cholesterol among adults aged 18 or older who have been screened in the past 5 years



Source: CDC Places

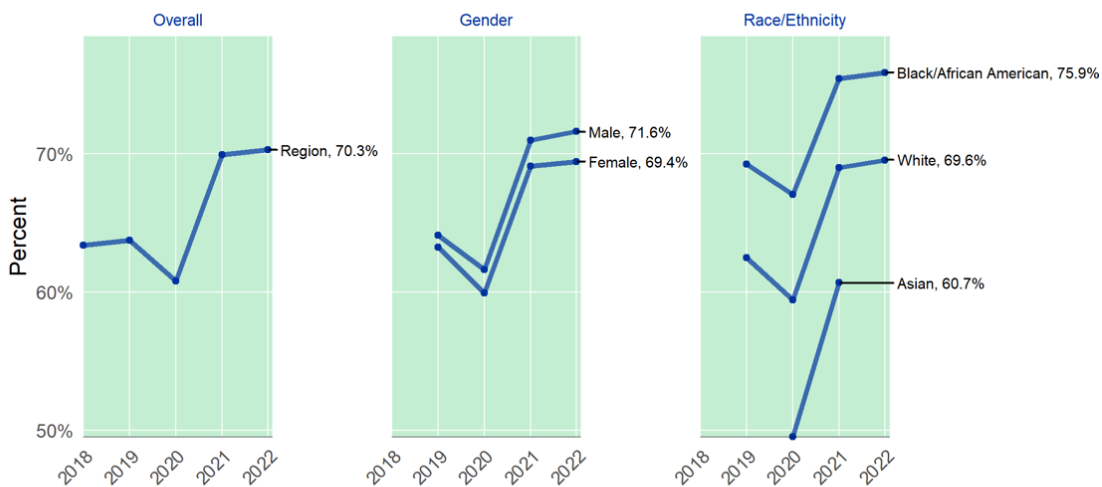
Age-Adjusted Hospitalization Rate due to Hypertension



Source: Virginia Health Information

Note: Data reflects the following 13 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Newport News City, Norfolk City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, York County.

Hypertension, Medicare Population

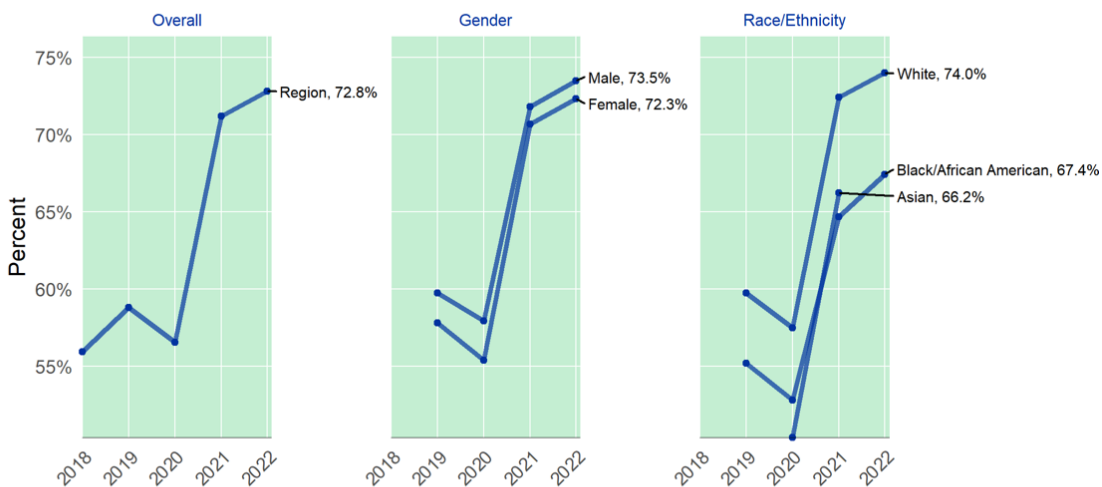


Source: Centers for Medicare & Medicaid Services

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

Hyperlipidemia

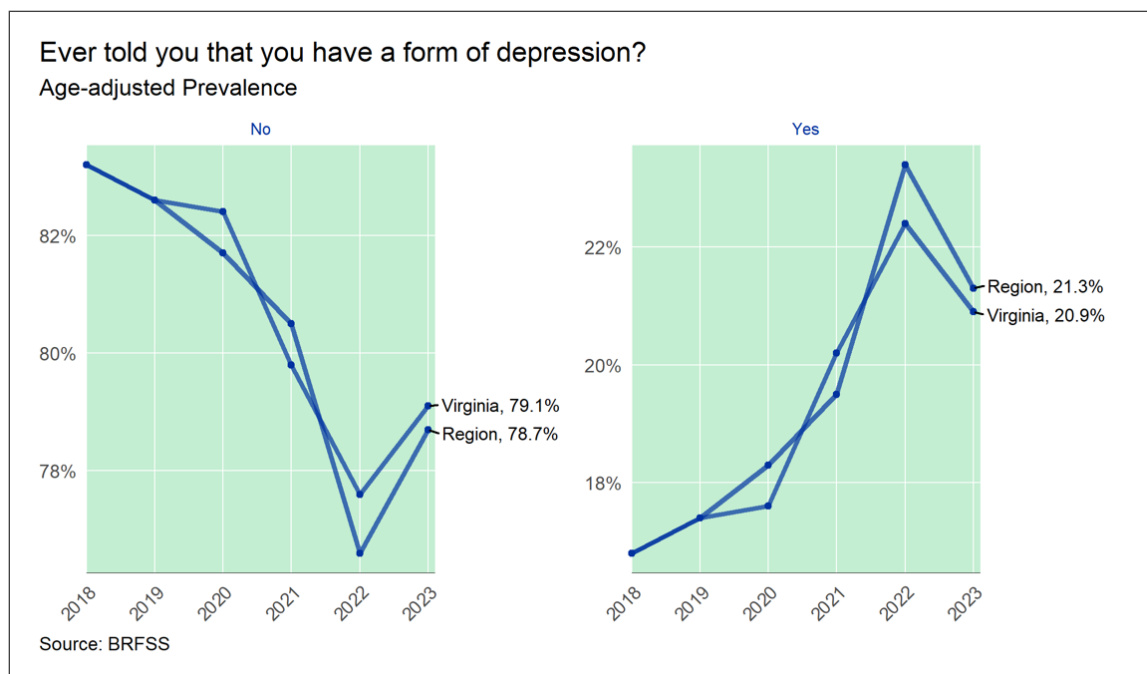
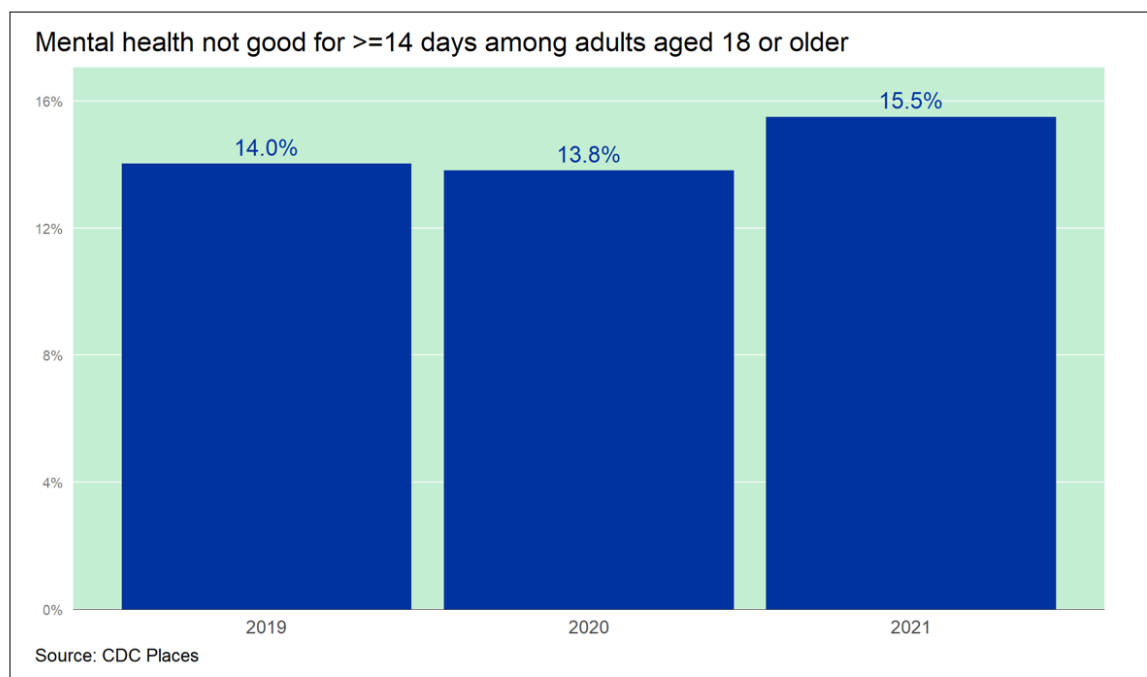
Hyperlipidemia, Medicare Population



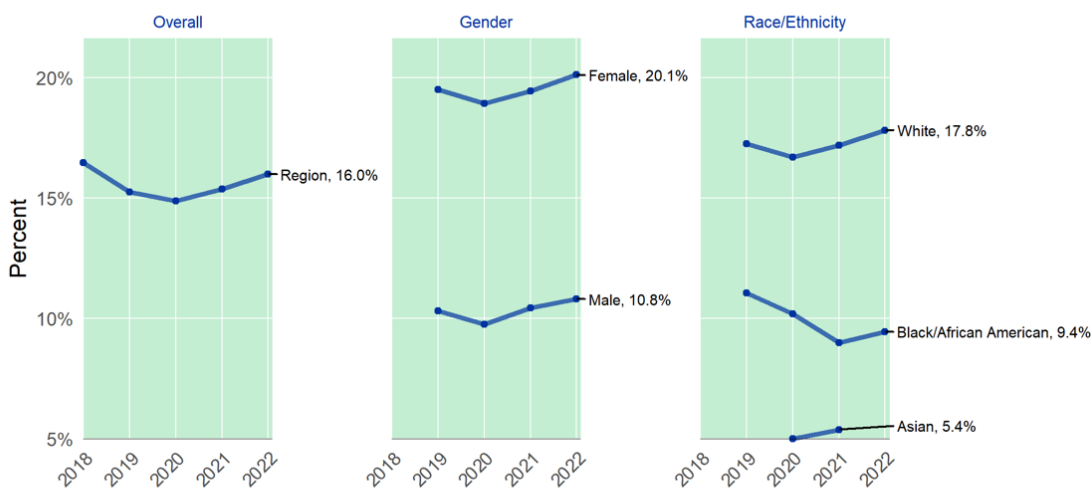
Source: Centers for Medicare & Medicaid Services

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

Mental Health



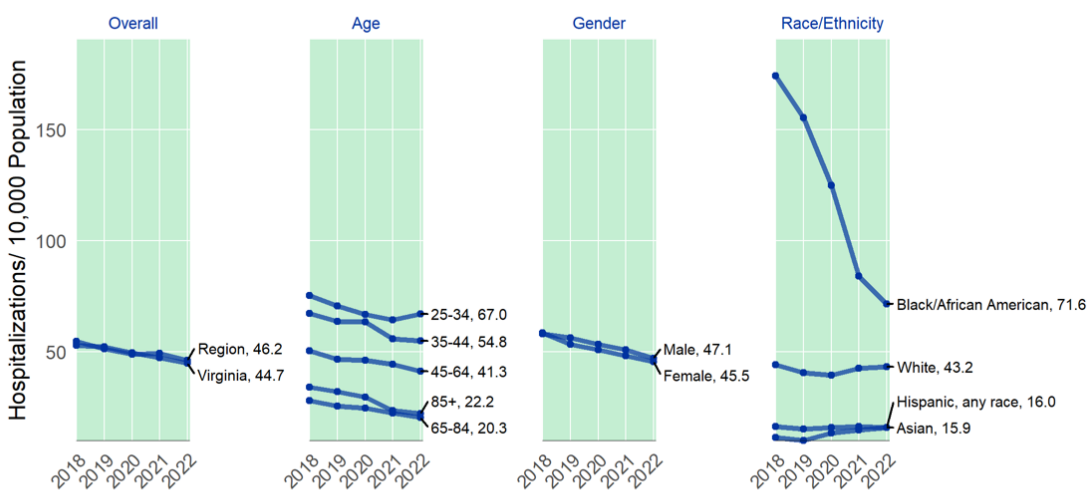
Depression, Medicare Population



Source: Centers for Medicare & Medicaid Services

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

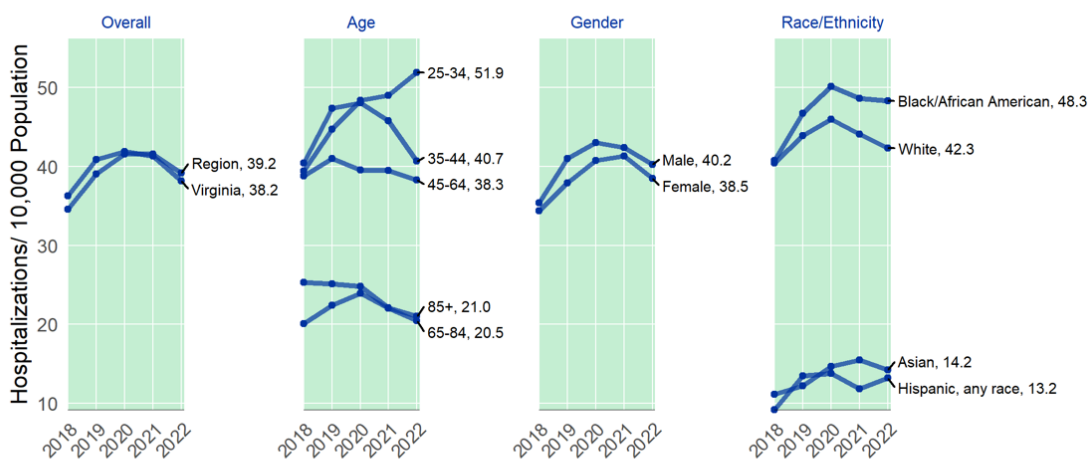
Age-Adjusted Hospitalization Rate due to Adult Mental Health



Source: Virginia Health Information

Note: Data reflects the following 16 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, Williamsburg City, York County.

Age-Adjusted Hospitalization Rate due to Adult Suicide and Intentional Self-inflicted Injury



Source: Virginia Health Information

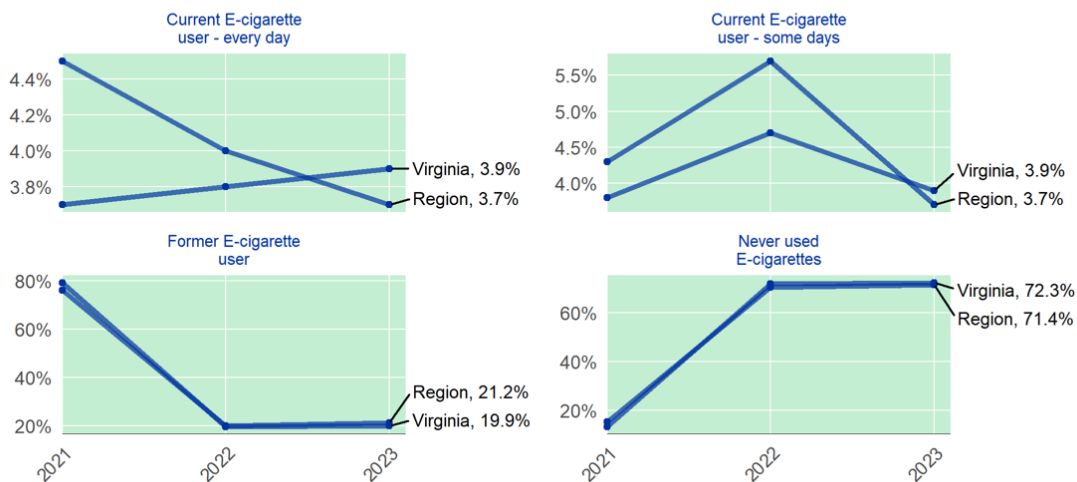
Note: Data reflects the following 15 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Mathews County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, York County.

Substance Use and Abuse

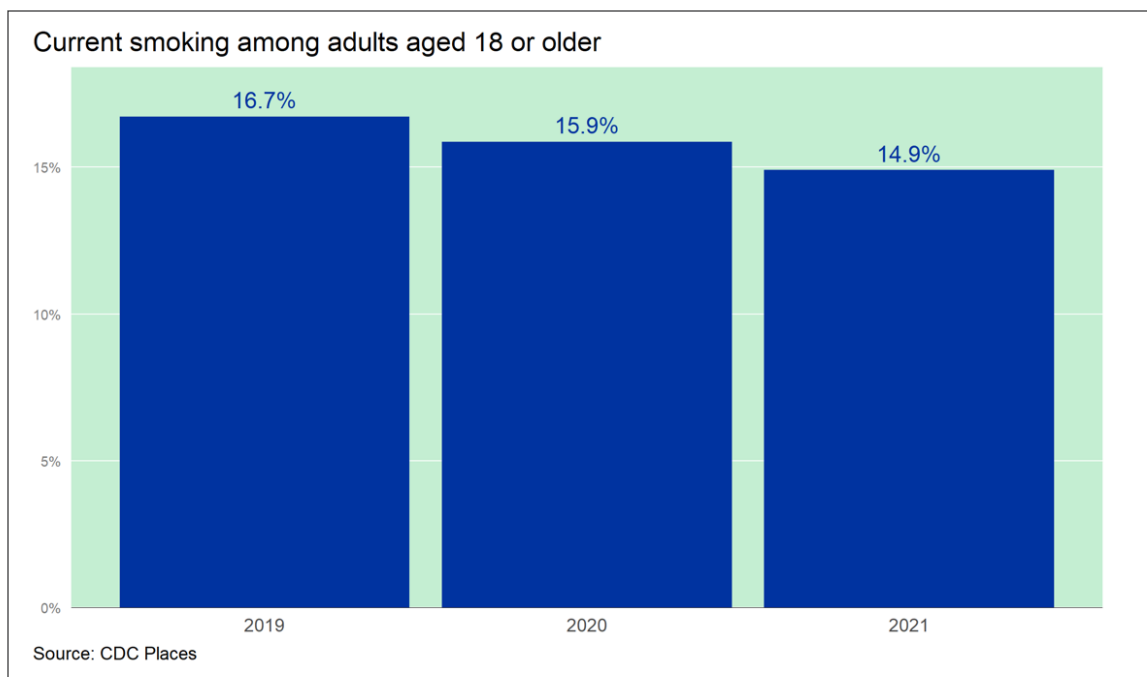
Tobacco

Do you now use e-cigarettes or other electronic vaping products every day, some days, or not at all?

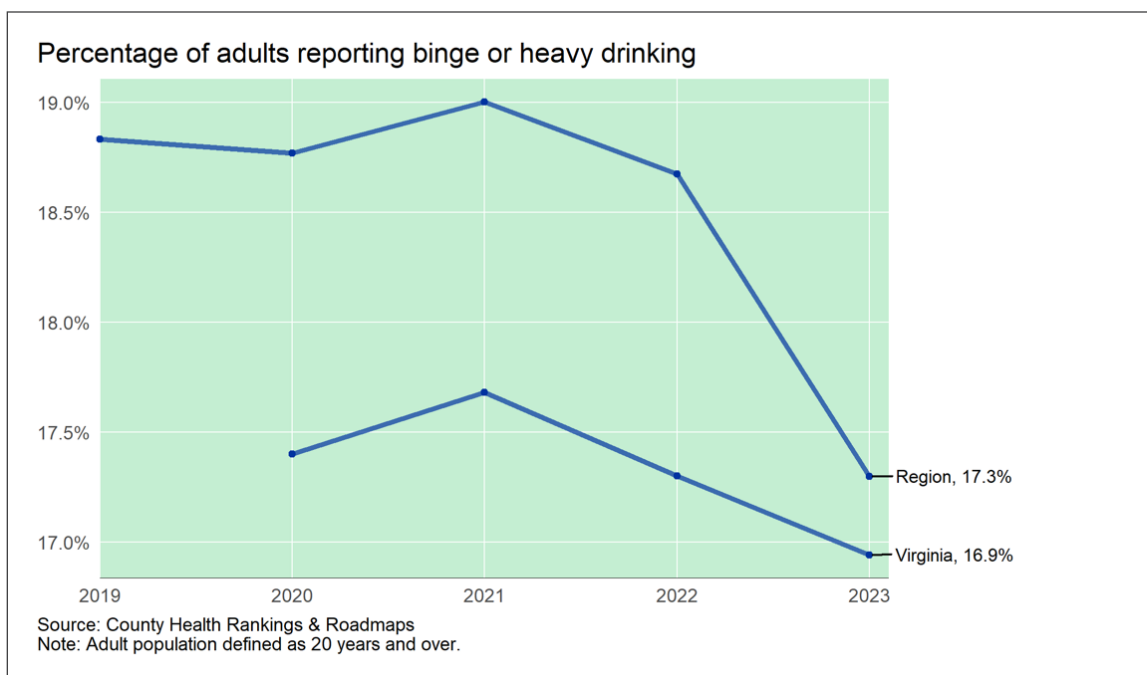
Age-adjusted Prevalence



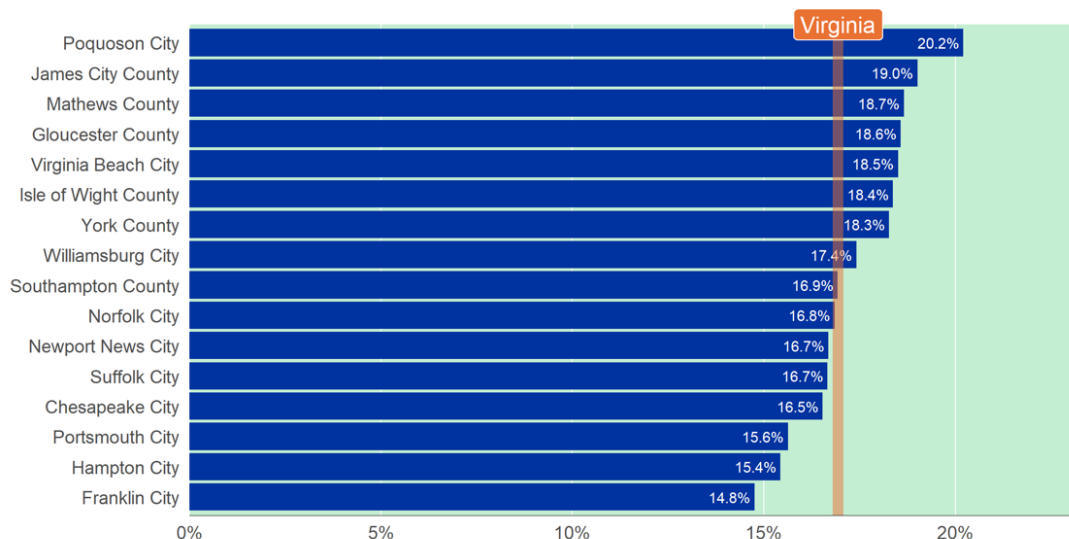
Source: BRFSS



Alcohol Consumption



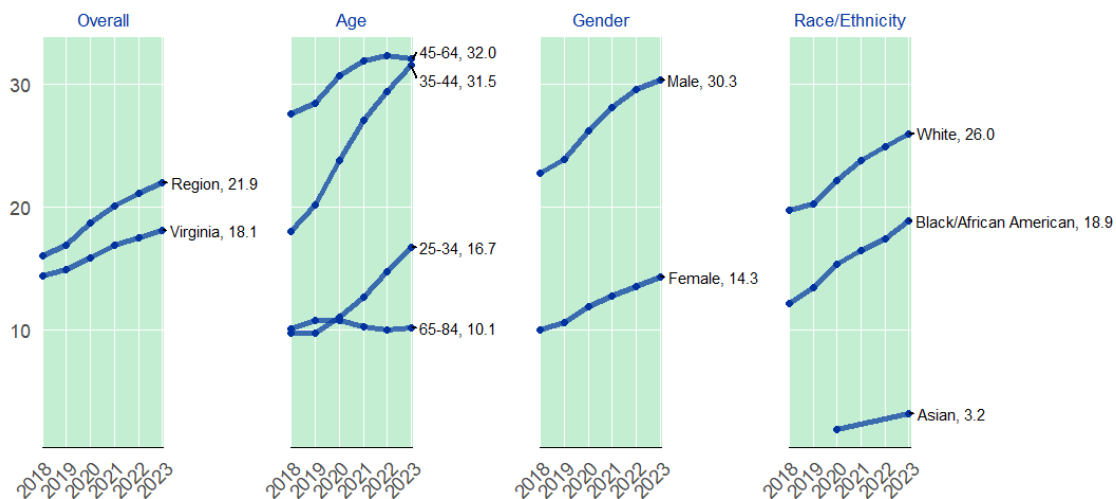
Percentage of adults reporting binge or heavy drinking, 2023



Source: County Health Rankings & Roadmaps
Note: Adult population defined as 20 years and over.

Age-Adjusted Hospitalization Rate due to Adult Alcohol Use

Hospitalizations per 10,000 population aged 18 years and older

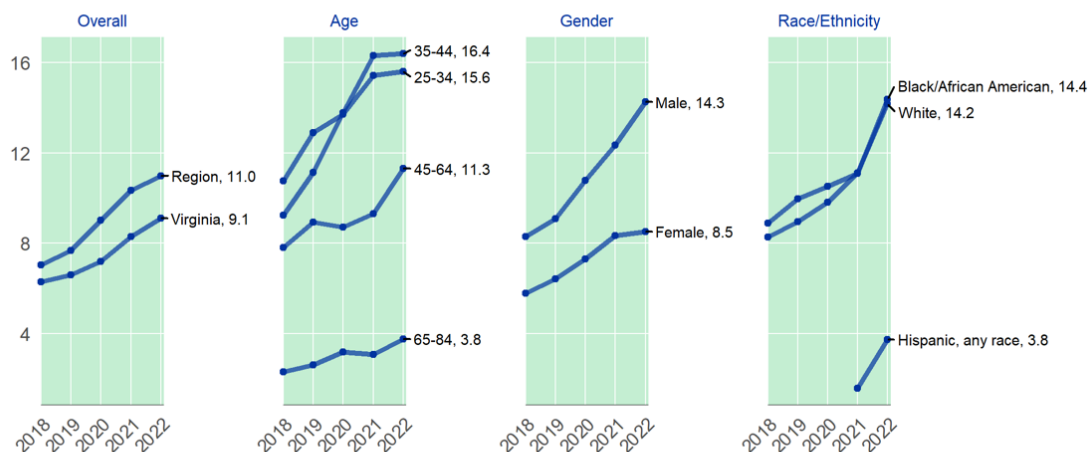


Source: Virginia Health Information
Note: Regional data reflects the following 6 places: Chesapeake City, Isle of Wight County, Norfolk City, Portsmouth City, Suffolk City, Virginia Beach City.

Substance Use

Age-Adjusted Hospitalization Rate due to Substance Use

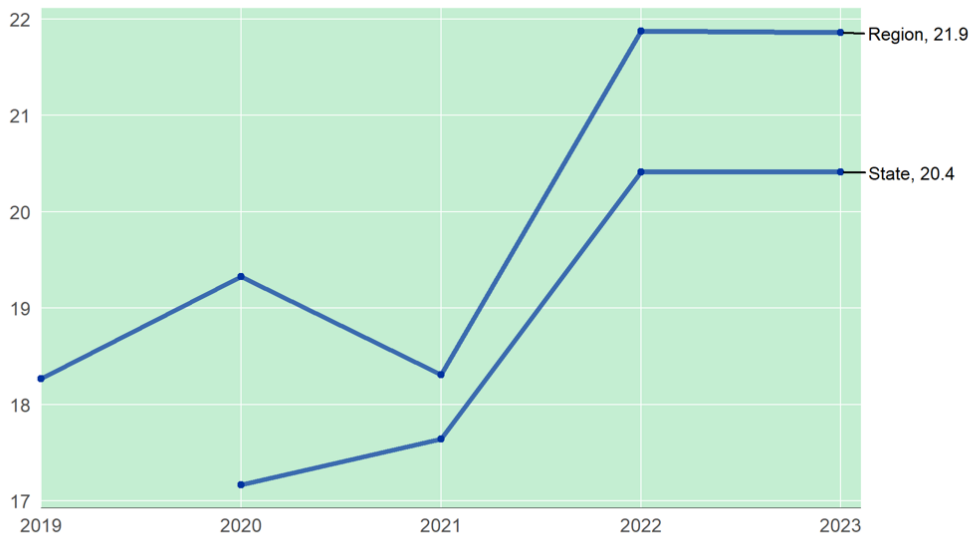
Hospitalizations per 10,000 population aged 18 years and older



Source: Virginia Health Information

Note: Regional data reflects the following 14 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, York County.

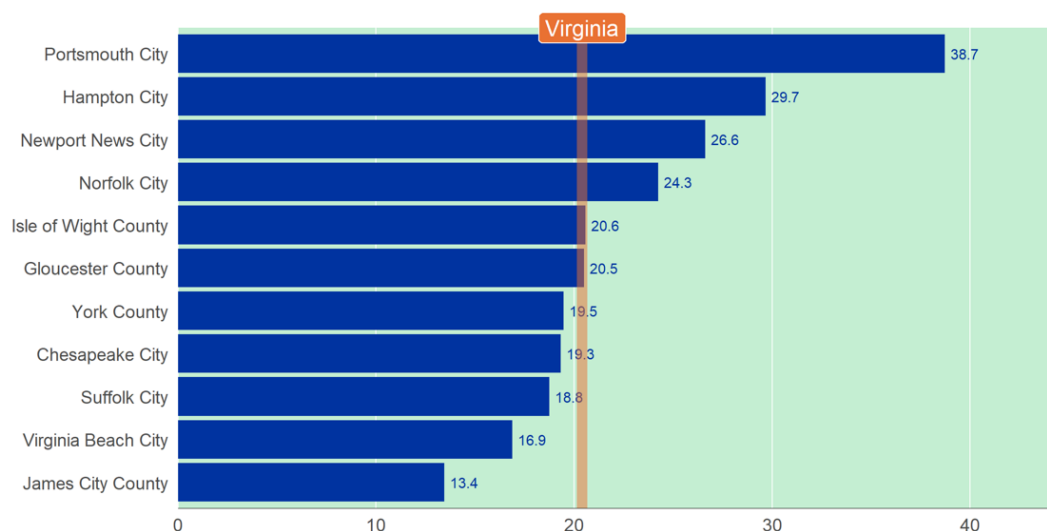
Rate of drug overdose deaths



Source: County Health Rankings & Roadmaps

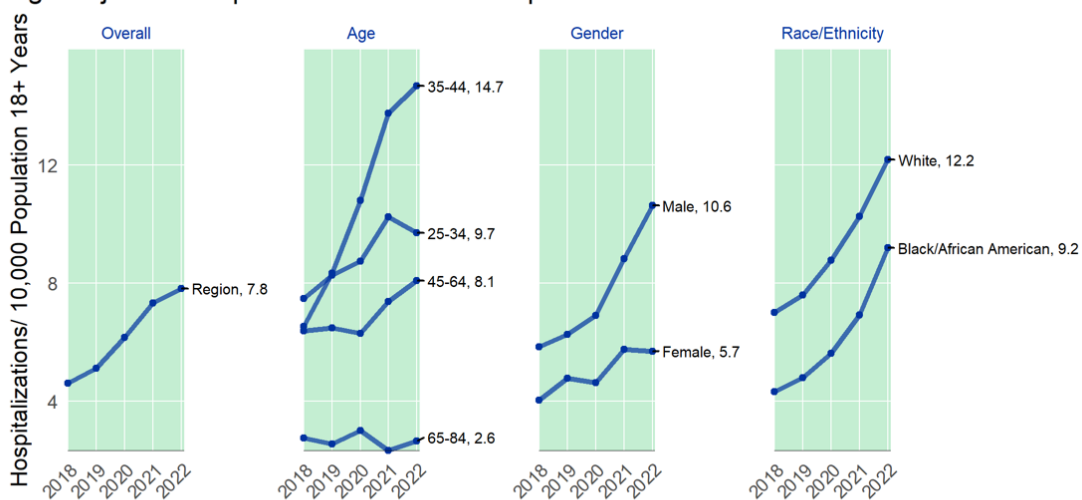
Note: Rate defined as crashes per 100,000 people.

Rate of drug overdose deaths, 2023



Source: County Health Rankings & Roadmaps
Note: Rate defined as crashes per 100,000 people

Age-Adjusted Hospitalization rate due to Opioid Use

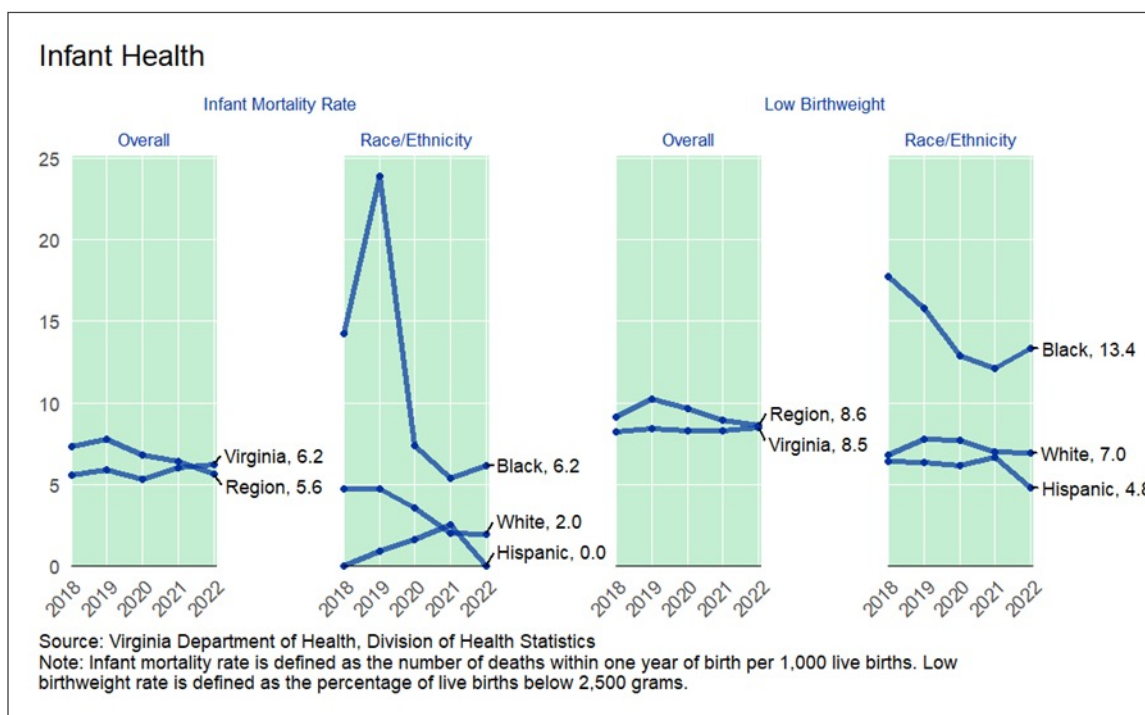
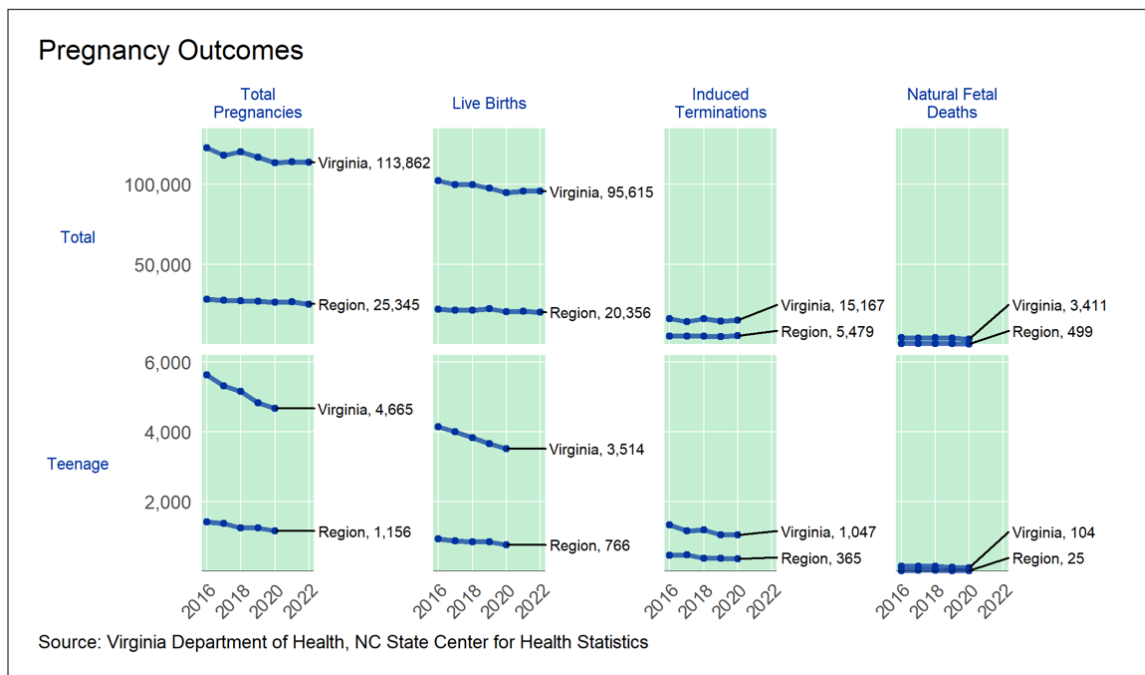


Source: Virginia Health Information

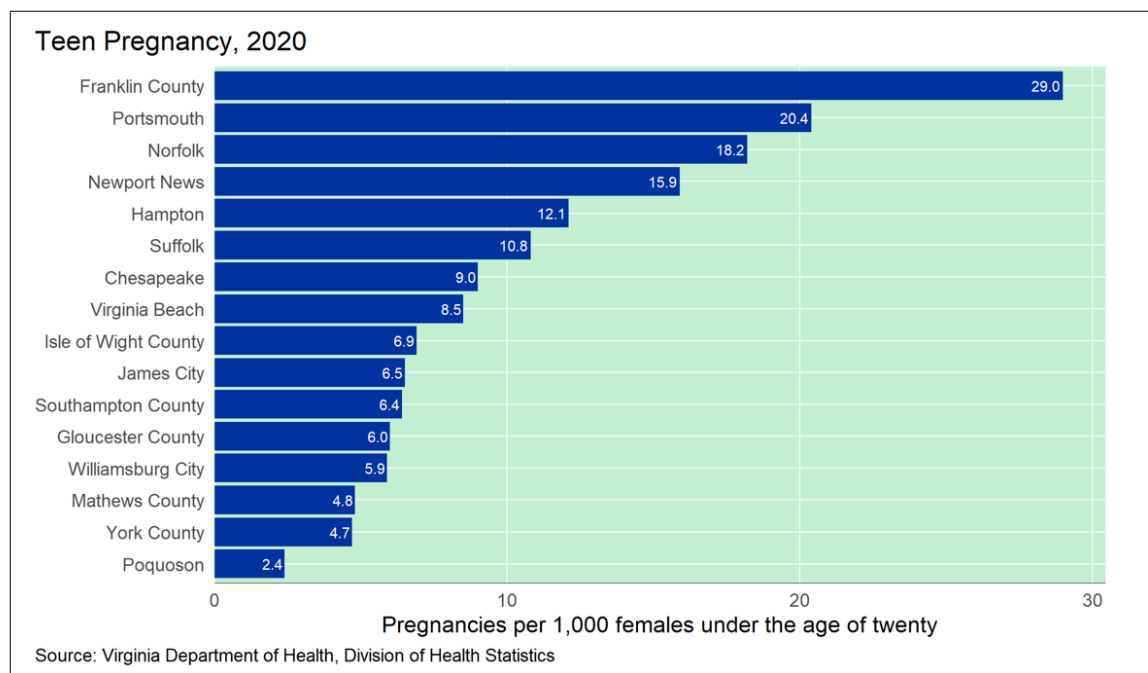
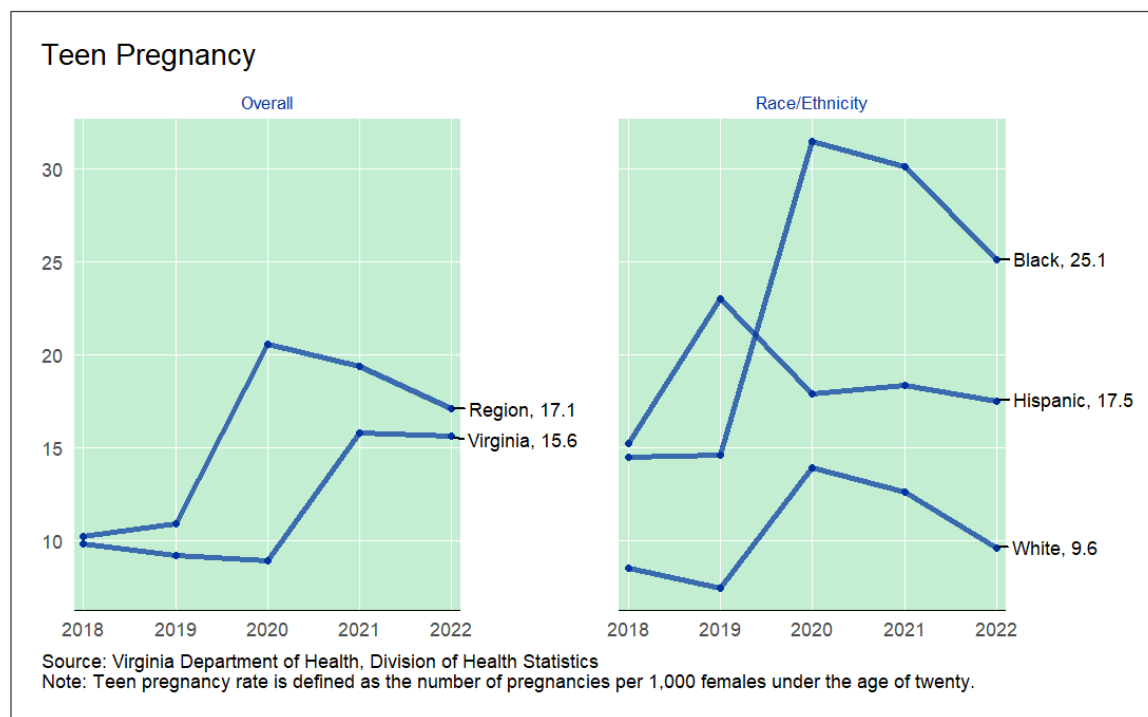
Note: Data reflects the following 14 places: Chesapeake City, Franklin City, Gloucester County, Hampton City, Isle of Wight County, James City County, Newport News City, Norfolk City, Poquoson City, Portsmouth City, Southampton County, Suffolk City, Virginia Beach City, York County.

Maternal and Infant Health

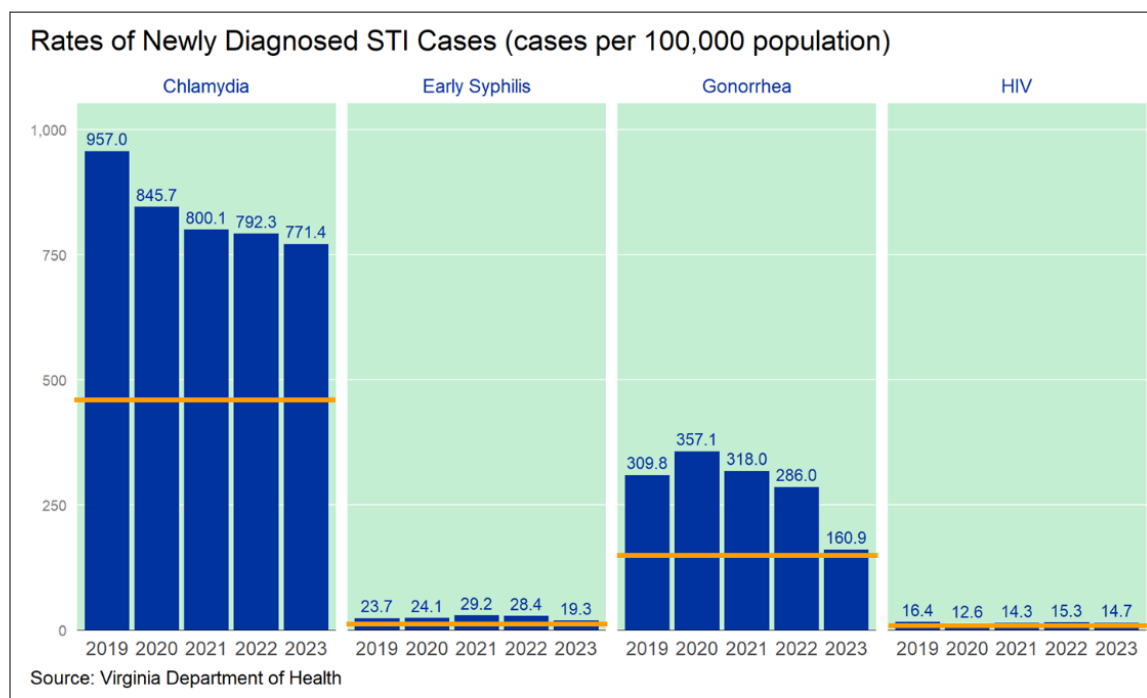
Pregnancy Outcomes



Teen Pregnancy



Sexually Transmitted Infections



Virginia Rates of Newly Diagnosed Cases

- Chlamydia: 473.0
- Early Syphilis: 17.9
- Gonorrhea: 155.7
- HIV: 11.0

Shown by ORANGE line

Board Approval

The Bon Secours — Hampton Roads 2025 Community Health Needs Assessment was approved by the Bon Secours — Hampton Roads Board of Directors on September 23, 2025.

Board Signature: _____



Date: September 23, 2025

For further information or to obtain a hard copy of this Community Health Needs Assessment (CHNA), please contact Phyllita Bolden, phyllita_bolden@bshsi.org

Bon Secours CHNA Website:

<https://www.bonsecours.com/about-us/community-commitment/community-health-needs-assessment>



Bon Secours — Hampton Roads

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Suffolk, VA 23435

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bonsecours.com

[Bon Secours CHNAs](#)