



2025 Community Health Needs Assessment

Bon Secours Richmond Market

RICHMOND, VA

2025 Community Health Needs Assessment

Bon Secours Richmond Health System

Adopted by the Bon Secours Richmond Board of Directors
September 23, 2025

As part of Bon Secours Mercy Health, Bon Secours Richmond 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 residents, businesses and other community partners.

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 Richmond, 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 Richmond.

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 Richmond 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 Becky Clay Christensen at rebecca_christensen@bshsi.org, Sean O'Brien at sean_obrien@bshsi.org and Kerrissa MacPherson at kerrissa_macpherson@bshsi.org.

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Bon Secours CHNA
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Executive Summary

Market Summary

Bon Secours Richmond is one of the largest employers in the region. As a not-for-profit health system, we employ more than 10,000 people, including more than 470 providers in the Bon Secours Medical Group.

Our health system includes:

- Chester Emergency Center
- Memorial Regional Medical Center
- Rappahannock General Hospital
- Richmond Community Hospital
- Short Pump Emergency Center
- Southern Virginia Medical Center
- Southside Emergency Care Center
- Southside Medical Center
- St. Francis Medical Center
- St. Mary's Hospital
- Westchester Emergency Center

Together, these facilities provide compassionate medical care through seven acute hospitals, as well as primary, specialty and ambulatory care sites across a diverse region.

The Bon Secours Richmond Community Health team focuses on serving uninsured and marginalized populations. We provide care that respects each person's culture and life experience. By fostering trusting relationships, our team supports patients who may have difficulty accessing care through traditional health care settings.

In partnership with community nonprofits and local churches, our community health work now includes primary and specialty care, preventive medicine and education, behavioral health and referral services, and support for victims of interpersonal and community violence. We also invest in programs that address social drivers of health, including:

- Financial literacy
- Food access
- Housing
- Out-of-school time
- Pathways to sustainable careers
- Post-incarceration re-entry
- Transportation

Collaborating Partners

We thank the following organizations for their collaboration in the CHNA process. Their input played an important role in identifying the community's needs:

- Bay Aging
- Boys to Men
- Cameron Foundation
- Central Virginia Health Services
- City of Richmond (Office of Children and Families)
- Community Coalition of Sussex
- Community Foundation of Greater Richmond
- Diversity Richmond
- Housing Resource Line
- La Casa de la Salud
- Latinos In Virginia Empowerment Center
- NextUp RVA
- Partnership for Housing Affordability
- REAL LIFE
- RVA Rapid Transit
- Sportable
- St. Joseph's Villa
- Virginia Center for Inclusive Communities
- Virginia Community Health Workers Association
- Virginia Commonwealth University Health System (Department of Community Health)
- Virginia Dental Association Foundation
- Virginia Department of Health
- Virginia Health Catalyst
- YMCA of Greater Richmond

Virginia Department of Health (Chesterfield County Health District, Crater Health District, Richmond/Henrico Health District and the Three Rivers Health District)

Overview

Living conditions, opportunities and many social and structural factors shape the true health of a community. This Community Health Needs Assessment (CHNA) examines qualitative input from community members, nonprofit leaders, public health and government agency leaders, physicians, advanced practice clinicians, Bon Secours associates and a diverse Community Health Advisory Group. We paired this feedback with publicly available data on health and social conditions in the Bon Secours Richmond area and survey responses from more than 2000 community members between September 2024 and March 2025. Together, this information provides a clear picture of key health concerns in our community.

Community input came from four main initiatives:

- Completing over 15 interviews with key community leaders with expertise in topics identified as high priorities
- Conducting a community engagement survey with over 2000 responses
- Convening a Community Health Advisory Group over 7 meetings
- Holding six focus groups on specific topics

We also analyzed quantitative data from the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS) and the U.S. Census Bureau.

In Spring 2025, Bon Secours Richmond Community Health leadership and Advisory Group members reviewed this information and identified common themes. These discussions led to the consolidation of findings into three prioritized needs.

Prioritized Health Needs

Opportunity & Access (Clinical Health Need)

- Insufficient opportunities for generating wealth, which perpetuates generational cycles of poverty and can lead to poor health outcomes (e.g., affordable housing, financial literacy)
- Insufficient access to affordable primary and specialty care, resulting in health care that does not honor the dignity of everyone we serve (e.g., chronic disease management, rural access)

Systemic Solutions (Social Driver of Health Community Need)

- Traditional health care and community responses are often reactive “short-term fixes.” However, the root causes of health needs can also be recognized and addressed (e.g., housing, mental health, violence, discrimination, addiction, etc.)

Community Representation (Social Health Individual Need)

- Insufficient career pathways for low-income individuals from the communities we serve (e.g., Community Health Workers, workforce pipelines)
- Unbalanced community representation in determining proposed solutions for addressing health needs (e.g., staff that is not representative of the communities served, board service, community engagement processes)



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

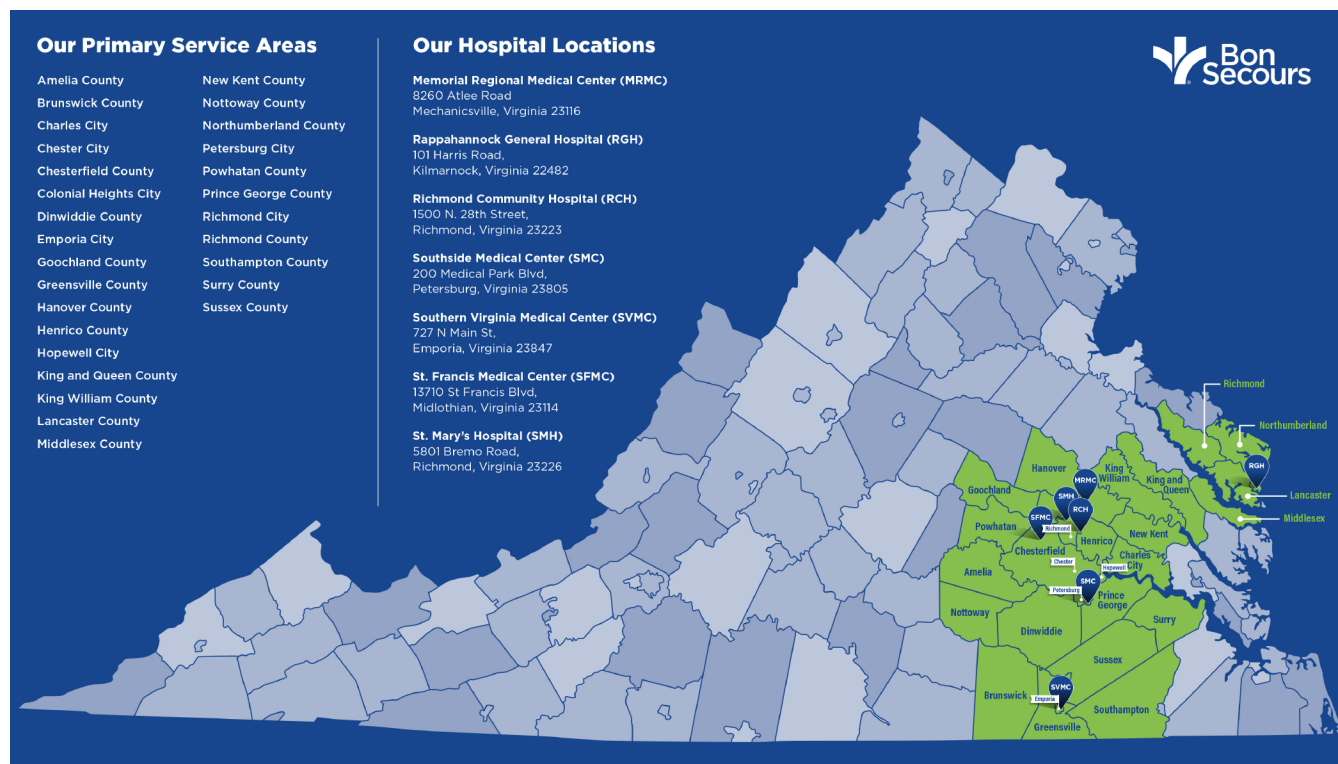
We commit to promoting the responsible use of all human and financial resources, including Earth itself.

Service

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



Facilities Description



The Bon Secours Richmond Health System includes seven acute hospital facilities serving the entire Bon Secours Richmond market area. Our acute hospital facilities are listed below:

Memorial Regional Medical Center

Memorial Regional Medical Center, which has served the greater Mechanicsville area since 1998, continues the legacy of Richmond Memorial Hospital, originally founded in 1947 to accommodate the shortage of hospital facilities after World War II. The hospital is nationally recognized for clinical excellence, particularly in stroke and cardiac care, ranking among the top 10 percent of hospitals in the country for cardiac surgery and overall cardiac care. Memorial Regional provides a comprehensive range of services, including emergency care, surgery and diagnostic services, ensuring that residents in Hanover, Henrico, King and Queen, King William, New Kent counties and the City of Richmond have access to top-tier medical care.

Rappahannock General Hospital

Founded in 1977, Rappahannock General Hospital (RGH) has been a cornerstone of health care in the Northern Neck and Middle Peninsula. Since its acquisition by Bon Secours in 2014, it has evolved into a critical access facility. With 25 licensed beds for acute care and 10 beds for behavioral health, RGH provides essential inpatient services alongside a variety of outpatient programs, such as oncology and physical therapy. Serving the residents of Lancaster, Middlesex and Northumberland counties and occasionally extending to Richmond, RGH plays a key role in ensuring that patients in the Northern Neck and Middle Peninsula have access to quality health care.

Richmond Community Hospital

Richmond Community Hospital (RCH) is an urban hospital with 104 beds, offering emergency care, inpatient and outpatient behavioral health services, and a full imaging department in Richmond's East End. Established in 1903, it was the first facility in Richmond designed to serve African American patients in historic Jackson Ward. Later relocated to its current site in Church Hill by a dedicated group of Black physicians, RCH remains a symbol of inclusion in medicine. Acquired by Bon Secours in 1995, the hospital offers a comprehensive range of services, including a 40-bed unit for acute psychiatric care, 24-hour emergency psychiatric evaluation and additional access points on its urban campus for outpatient and urgent care needs, serving the City of Richmond.

Southern Virginia Medical Center

Acquired by Bon Secours in 2020, Southern Virginia Medical Center is an 80-bed acute care hospital serving more than 50,000 residents of Emporia, Greenville, and surrounding counties, including Brunswick, Southampton and Sussex. The hospital offers a range of inpatient and outpatient services, including emergency care, surgery and diagnostic imaging, ensuring that residents of these rural communities have access to high-quality medical care and advanced treatments without needing to travel far from home.

Southside Medical Center

Southside Medical Center, a 300-bed facility on a 50-acre campus, has served Petersburg, Hopewell, Colonial Heights, and surrounding areas for years. Acquired by Bon Secours in 2020, the hospital is home to nearly 400 physicians representing more than 40 specialties and provides comprehensive services such as cancer care, rehabilitation and specialized imaging. Additionally, Southside operates outpatient centers and three professional schools across the Tri-Cities region, ensuring that health care needs are met for the Prince George, Dinwiddie, Sussex, Surry and Southern Chesterfield communities.

St. Francis Medical Center

Completed in 2005, St. Francis Medical Center offers a full spectrum of services, including emergency care, surgery, cardiology, orthopedics, oncology and women's services. Located in Midlothian, the hospital serves Chesterfield and the surrounding counties, including Powhatan, Amelia and Cumberland/Nottoway. With 185 beds, St. Francis is well-equipped to meet the health care needs of its growing and aging population.

St. Mary's Hospital

Opened in 1966, St. Mary's Hospital is Bon Secours' flagship hospital in Richmond and is the first desegregated hospital in the region. Founded by the Sisters of Bon Secours, the hospital was built with a vision of providing inclusive care regardless of race or religion. Over the past nearly 60 years, St. Mary's has grown into a 391-bed acute care facility, serving the Richmond metropolitan area with a broad range of services, including emergency care, surgery, cardiac and orthopedic care, as well as women's health and pediatrics. As a tertiary and quaternary care hub for the Bon Secours Richmond market, St. Mary's plays a vital role in serving not only the City of Richmond but also surrounding counties such as Chesterfield, Goochland, Hanover and Henrico, with a continued commitment to compassionate, high-quality care.

Our Primary Service Areas

Amelia County	King William County
Brunswick County	Lancaster County
Charles City	Middlesex County
Chester City	New Kent County
Chesterfield County	Nottoway County
Colonial Heights City	Northumberland County
Dinwiddie County	Petersburg City
Emporia City	Powhatan County
Goochland County	Prince George County
Greensville County	Richmond City
Hanover County	Richmond County
Henrico County	Southampton County
Hopewell City	Surry County
King and Queen County	Sussex County



Community Served by Hospital

Bon Secours Richmond is one of the region's largest employers. As a not-for-profit health system, we employ more than 10,000 people, including more than 470 providers as part of the Bon Secours Medical Group. Bon Secours Richmond includes St. Mary's Hospital, Memorial Regional Medical Center, Richmond Community Hospital, St. Francis Medical Center, Rappahannock General Hospital, Southside Medical Center, Southern Virginia Medical Center, Westchester Emergency Center, Chester Emergency Center, Short Pump Emergency Center and Southside Emergency Care Center.

Combined, the 24-locality service area covered by the CHNA survey consists of Bon Secours Richmond's primary and secondary service area. This service area includes the following zip codes:

22432, 22435, 22437, 22454, 22460, 22469, 22472, 22473, 22480, 22482, 22488, 22503, 22504, 22511, 22514, 22520, 22529, 22539, 22546, 22548, 22560, 22572, 22576, 22578, 23002, 23005, 23009, 23011, 23015, 23023, 23024, 23027, 23030, 23032, 23038, 23039, 23043, 23047, 23059, 23060, 23063, 23065, 23069, 23070, 23071, 23075, 23079, 23083, 23084, 23085, 23086, 23089, 23091, 23092, 23093, 23102, 23103, 23106, 23108, 23110, 23111, 23112, 23113, 23114, 23116, 23117, 23120, 23124, 23126, 23129, 23139, 23140, 23141, 23146, 23147, 23148, 23149, 23150, 23153, 23156, 23160, 23161, 23168, 23169, 23173, 23175, 23176, 23177, 23180, 23181, 23185, 23192, 23219, 23220, 23221, 23222, 23223, 23224, 23225, 23226, 23227, 23228, 23229, 23230, 23231, 23233, 23234, 23235, 23236, 23237, 23238, 23284, 23294, 23298, 23315, 23430, 23801, 23803, 23805, 23821, 23824, 23827, 23828, 23829, 23830, 23831, 23832, 23833, 23834, 23836, 23837, 23838, 23839, 23840, 23841, 23842, 23843, 23844, 23845, 23846, 23847, 23850, 23851, 23856, 23857, 23860, 23866, 23867, 23868, 23870, 23872, 23874, 23875, 23876, 23878, 23879, 23881, 23882, 23883, 23884, 23885, 23887, 23888, 23889, 23890, 23891, 23893, 23894, 23897, 23898, 23899, 23919, 23920, 23922, 23930, 23938, 23950, 23955, 23966, 23974

This geographic region includes 1,443,045 people (2023 data). It comprises 55% Non-Hispanic White, 29% Non-Hispanic Black, 4% Asian, 8% Hispanic or Latino, 4% Two or more races, and <1% Native American or Pacific Islander/Native Hawaiian. The population is 51% Female, 49% Male, with 21% aged 0-17, 30% aged 18-39, 32% aged 40-64, and 17% aged 65+. Please see Appendix A for additional information about the external sources consulted in this section.

JOINT CHNA

§1.501(r)-3(b)(6)(i)

This is a “joint CHNA report,” within the meaning of Treas. Reg. §1.501(r)-3(b)(6)(v), by and for Bon Secours Richmond Health System, including Memorial Regional Medical Center, Rappahannock General Hospital, Richmond Community Hospital, Southern Virginia Medical Center, Southside Medical Center, St. Mary’s Hospital and St. Francis Medical Center. This report reflects the hospitals’ collaborative efforts to conduct an assessment of the health needs of the community they serve. Each hospital included in this joint CHNA report defines its community to be the same as the other included hospitals. The assessment included seeks and receives input from that community.

Population Totals

Indicator Description

This indicator shows the total population for each locality (county/city) in the CHNA Service Area.

Indicator Importance

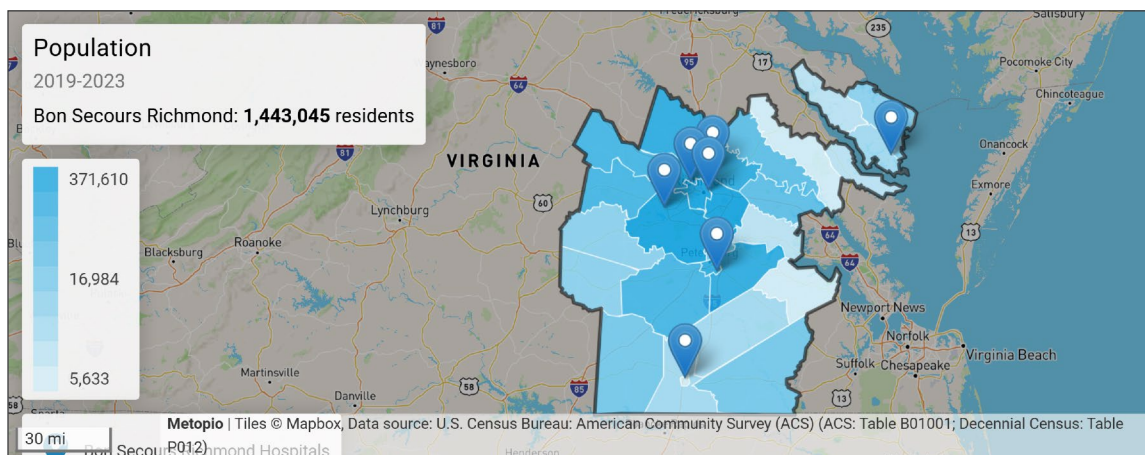
Population totals are important for determining rates of health conditions.

Indicator Source

American Community Survey (Table B01001)

What the data shows

- The population for the total CHNA Service Area is 1,411,715.
- The highest population density surrounds the Metro Richmond area, while the lowest population density occurs in more rural localities.



Race and Ethnicity Demographics

Indicator Description

This indicator shows race and ethnicity percentages among the population of the CHNA Service Area.

Indicator Importance

The race and ethnicity composition of a population provides vital information about the overall health of a community.

Indicator Source

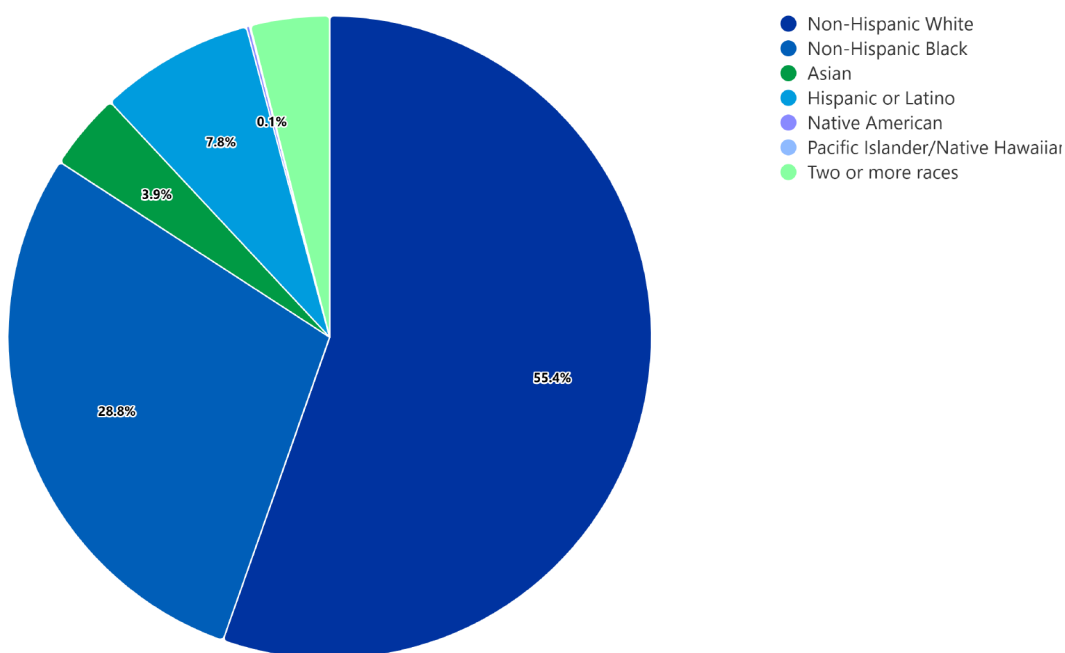
American Community Survey (Table B01001)

What the data shows

- This data represents persons who self-selected these categories on the 2020 Census. It is important to note that while the Census is meant to capture all individuals living in our communities, it often underrepresents the most vulnerable persons. Non-Hispanic White is the largest resident population, followed by Non-Hispanic Black, for the CHNA Service Area.

Population by Race/Ethnicity

Bon Secours Richmond, 2019-2023



Created on Metopio | metop.io | Data source: U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

Age Demographics

Indicator Description

This indicator shows age distribution within the CHNA Service Area.

Indicator Importance

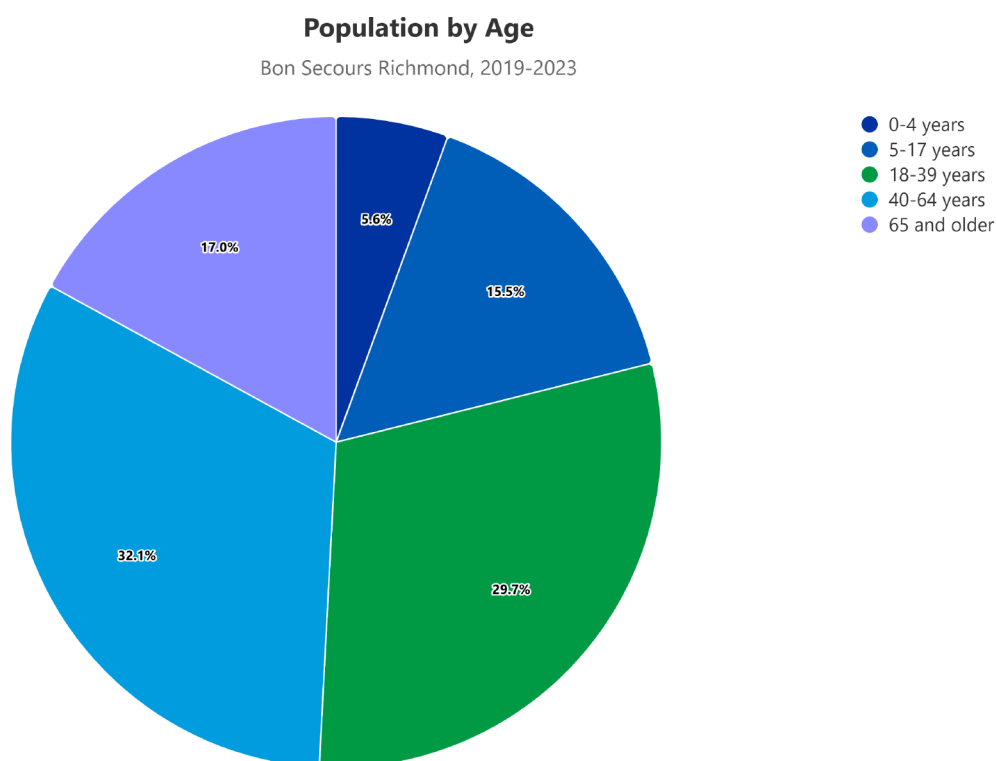
Understanding the age structure of a population is important in planning for the future of a community. Communities with a large aging population will have significantly different needs than communities with a large youth population.

Indicator Source

American Community Survey (Table B01001)

What the data shows

- With the largest population in the CHNA Service Area being 40-64 years old, there is a significant number of people who will be moving into the 65+ category over the next 10-25 years.



Created on Metopio | metop.io | Data source: U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001; Decennial Census: Table P012)
Population: Average population over the time period.

Income Demographics

Indicator Description

This indicator shows the median household income at the census tract level. Household income is defined as the sum of money received over a calendar year by all household members 15 years and older.

Indicator Importance

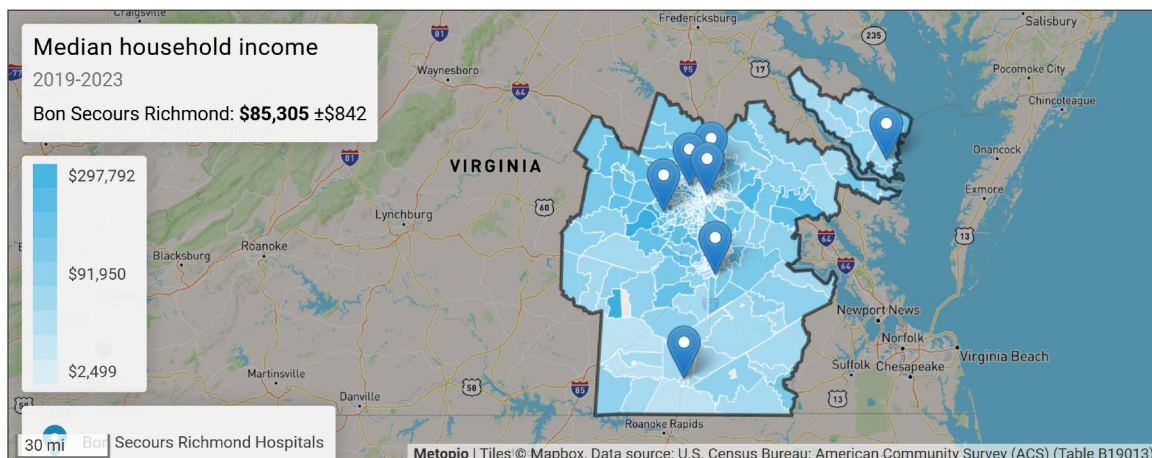
Median household income is an important driver of health. Communities with higher poverty rates often experience poorer health. Higher median household incomes are often associated with higher educated residents and lower unemployment rates.

Indicator Source

American Community Survey (Table B19013)

What the data shows

- Households living in the cities represented in the CHNA Service Area, on average, have lower median household income when compared to the counties in the same CHNA Service Area.
- The median household income in the CHNA Service Area is \$85,771.



Poverty Rate

Indicator Description

This indicator shows the percentage of individuals living below the federal poverty level at the census tract level.

Indicator Importance

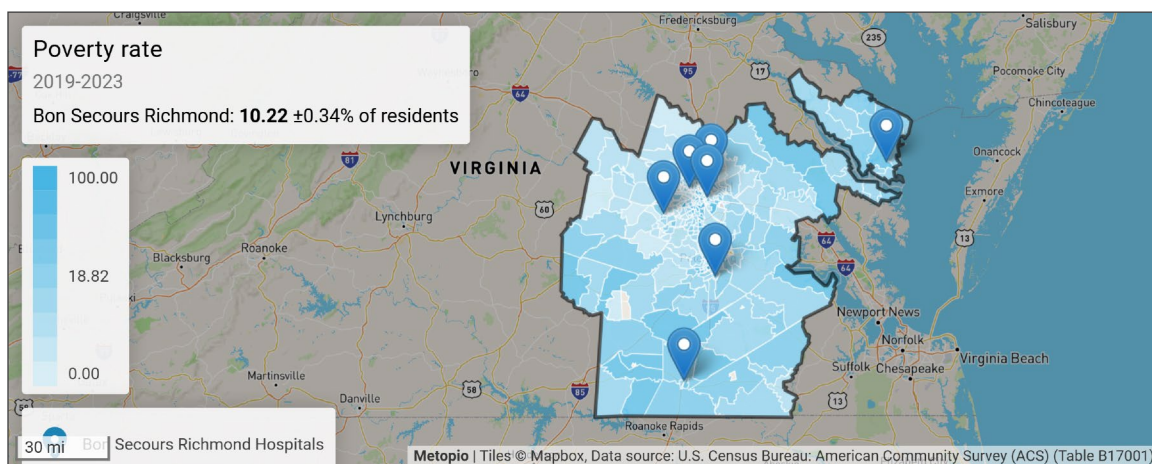
Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Communities with higher poverty rates often experience poorer economic conditions. Poverty is an underlying root cause of poorer health.

Indicator Source

American Community Survey (Table B17001)

What the data shows

- The CHNA Service Area poverty rate is 10.12%, with significant variances in different cities and counties, including in different parts of the same county.



High School Graduation (Educational Attainment)

Indicator Description

This indicator shows the percentage of residents 25 years or older with at least a high school diploma (or GED).

Indicator Importance

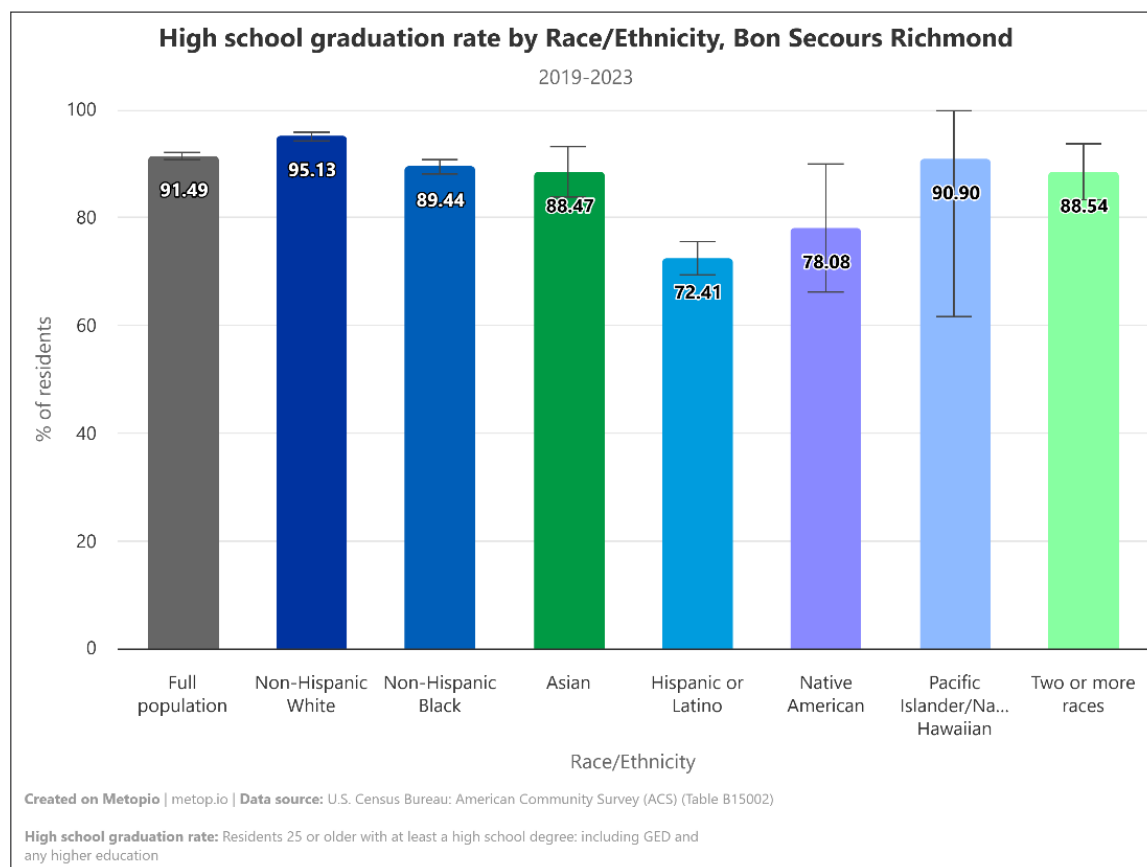
High School graduation is a critical measure of overall health. Obtaining a high school diploma leads to increased employment opportunities, higher wages, and economic stability.

Indicator Source

American Community Survey (Table B15002)

What the data shows

- There is a significant disparity among the Hispanic or Latino population when compared to other races and ethnicities.



Life Expectancy

Indicator Description

This indicator shows the estimated life expectancy in years of residents living in the CHNA Service Area at the census tract level.

Indicator Importance

This data represents the average number of years a person is expected to live, based on the locality where they live.

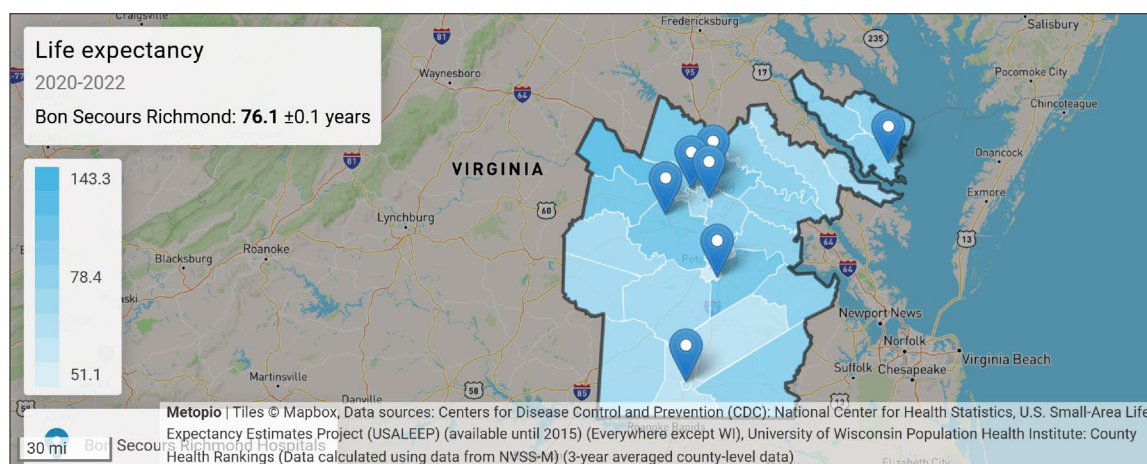
Indicator Source

Centers for Disease Control (CDC), National Center for Health Statistics, U.S. Small Area Life Expectancy Estimates Project (USALEEP)

What the data shows

- Darker shaded regions are associated with a higher estimated life expectancy. Conversely, lighter shaded regions are associated with a lower estimated life expectancy.
- The urban and rural localities in the CHNA Service Area have lower life expectancy than the surrounding suburban areas.
- Life expectancy rates often trend conversely to poverty level rates.

Note: The most recent publicly available data is for 2010-2015 and may not represent the most up-to-date trends.



Process and Methods

Process and Methods to Conduct the Community Health Needs Assessment

Living conditions, opportunities and a variety of social and structural drivers shape the health of a community. This CHNA combines input from community members, nonprofit leaders, public health and government agency leaders, physicians, advanced practice clinicians, Bon Secours associates and a diverse Community Health Advisory Group. We paired this input with publicly available data on health and social conditions in the Bon Secours Richmond area, along with survey responses from more than 2000 community members between September 2024 and March 2025. Together, this information provides a snapshot of key community health needs.

To obtain input from the community, four initiatives were advanced between September 2024 and April 2025: a Community Health Advisory Group was regularly convened, a community engagement survey was conducted, six focus groups on specific topics were held, and over 15 interviews were performed with key informant community leaders with expertise in topics identified as high priorities in the survey responses and the focus groups, and a need prioritization process was conducted. Quantitative data, including data from the Center for Disease Control (CDC), Centers for Medicare and Medicaid Services (CMS), and Census data (American Community Survey), was also collected and analyzed and specific metrics and grouped themes from all quantitative data was included in the information presented to the Community Health Advisory Group for inclusion in the significant need identification and prioritization process.

Community Health Advisory Group

The Community Health Advisory Group helped Bon Secours Richmond Community Health leaders interpret survey data. This diverse group included nonprofit, health care and public health department leaders across the Bon Secours Richmond Health System market. The group reflected the CHNA service area in gender, race and geography and offered an inclusive perspective on the community served by Bon Secours hospitals.

The group met seven times, helping to:

- Develop the community survey and key informant interview questions
- Interpret survey results
- Identify significant and prioritized needs
- Emphasize values to guide successful implementation of community health improvement programs and collaborations

These conversations examined systemic, cultural and bias-driven barriers that affect progress on social drivers of health. Please see Appendix G for additional details and a list of all Community Health Advisory Group members.

Community Health Survey

A 20-question survey was conducted between September 2024–March 2025 in the Bon Secours Richmond service area. All residents in the primary service area were eligible to participate in English or Spanish.

The survey was shared through:

- Emails to community partners, including nonprofits and safety-net clinics
- Bon Secours social media
- Bon Secours associates (who are also community members)
- Local public health districts
- Patients, including QR code posters in hospital entrances and waiting rooms
- The snowball method, which encourages participants to share the link with others
- Paper copies shared by Community Health Workers and partners for those preferring non-digital access

In 2025, these efforts resulted in 2,184 completed surveys, with 188 (8.6%) in Spanish and 1,996 (91.4%) in English. Not all respondents answered every question.

Focus Groups

Six Focus groups were held in Spring 2025, with more than 50 participants. The topics were chosen based on survey results to explore health and social needs in more detail. The focus groups covered housing, transportation, community violence, women’s health, mental health and the Latinx community.

Responses from attendees aligned with survey findings and added significant qualitative context. The focus group questions are included in Appendix D. Themes and quotes appear in Appendix E.

Key Informant Interviews

To deepen understanding of root causes, the Community Health team conducted more than 15 interviews with community, nonprofit and government leaders. Areas of expertise included transportation, maternal and child health, housing, the Latinx community and other top health concerns identified by survey respondents. These interviews helped interpret and clarify survey and focus group findings into categories and themes for the Community Health Advisory Group’s prioritization process. (Questions for these interviews appear in Appendix D; themes and quotes are in Appendix E. Interviews were anonymized for privacy.)

External Sources

Social Vulnerability Index

Indicator Description

The Social Vulnerability Index was created to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during and after a hazardous event, such as a natural disaster, disease outbreak, or chemical spill. SVI indicates relative vulnerability by ranking places on 15 social factors, including unemployment, minority status, and disability and combining the rankings into a single scale from the 0th percentile (lowest vulnerability) to 100th percentile (highest vulnerability). This map shows the Social Vulnerability Index at the census tract level.

Indicator Importance

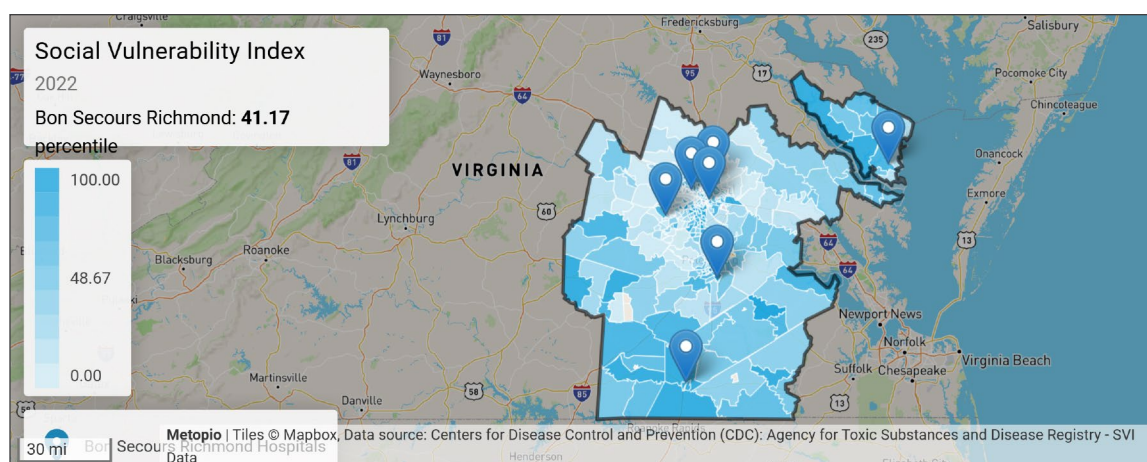
This index captures in a single number the most vulnerable localities across the CHNA Service Area.

Indicator Source

Centers for Disease Control and Prevention (CDC); Agency for Toxic Substances and Disease Registry

What the data shows

- The CHNA Service Area overall value is 41.17, with significant variance in different locales across the service area. The highest vulnerability areas are in some rural communities and some urban communities, with the lowest vulnerability areas in suburban communities.



Self-Reported Poor Mental Health

Indicator Description

This indicator shows the self-reported poor mental health of residents living in the CHNA Service Area at the census tract level. It represents the percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Indicator Importance

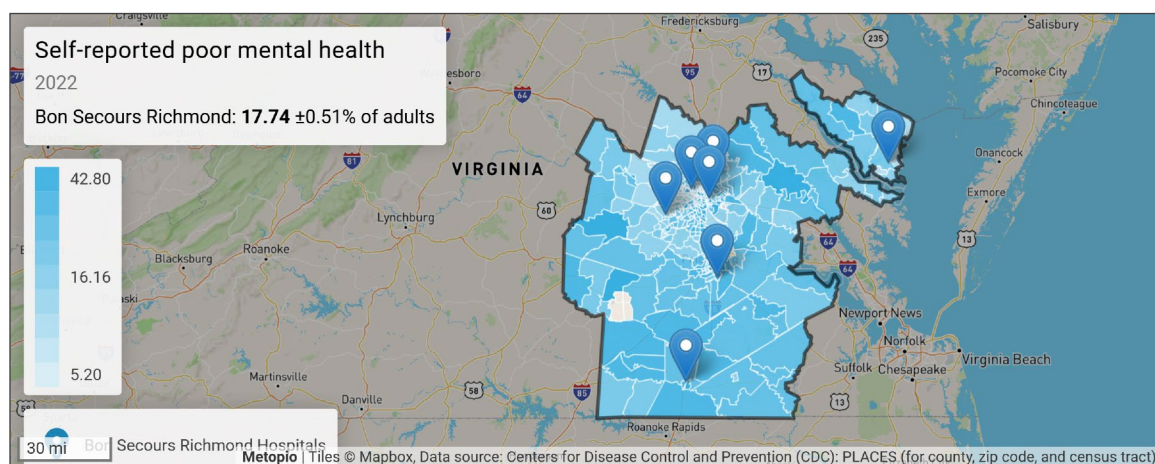
Mental health has a profound impact on public health, influencing various aspects of a community's well-being and functioning. It impacts physical health, social relationships, economic stability and overall societal safety. Unaddressed mental health issues can lead to increased rates of chronic illnesses, substance abuse, suicide and homelessness, placing a strain on health care systems and resources. Furthermore, mental health conditions can affect productivity, education and employment outcomes, impacting the local economy and individual lives.

Indicator Source

Centers for Disease Control and Prevention (CDC): PLACES data

What the data shows

- Darker shaded regions are associated with higher self-reports of poor mental health. Conversely, lighter shaded regions are associated with lower self-reports of poor mental health.



Seniors Living Alone

Indicator Description

This indicator shows the percent of residents aged 65 and older who live alone at the census tract level. It does not include those living in group homes, such as nursing homes.

Indicator Importance

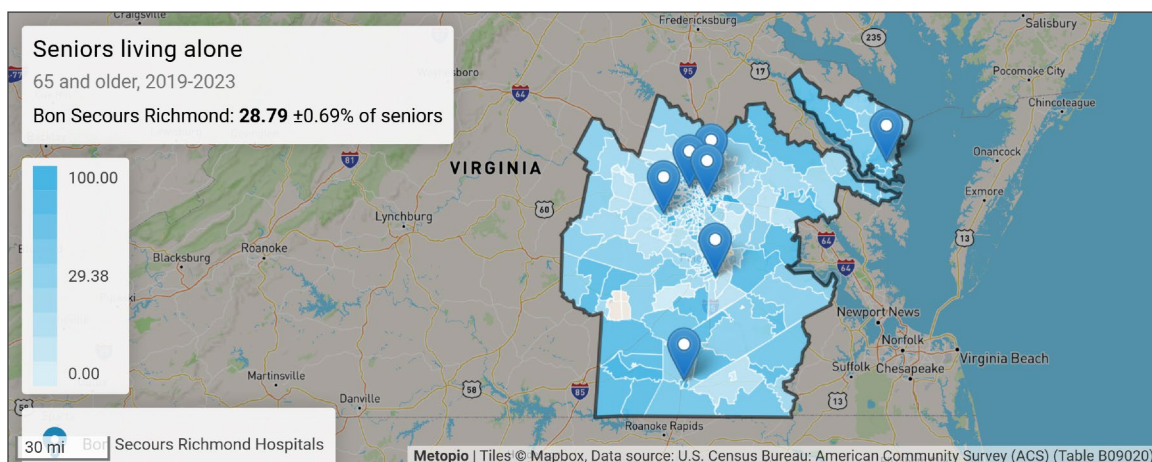
Many older adults report desiring to “age in place,” but this can require additional social and community supports to promote ongoing good health.

Indicator Source

American Community Survey (Table B09020)

What the data shows

- Darker shaded regions are associated with higher percentages of older adults living alone. Conversely, lighter shaded regions are associated with lower percentages of older adults living alone.
- Many older adults are living in rural areas that may have limited health care access and limited transportation access.



Coronary Heart Disease

Indicator Description

This indicator shows the percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have angina or coronary heart disease. The data shown is age-adjusted and is shown at the county level.

Indicator Importance

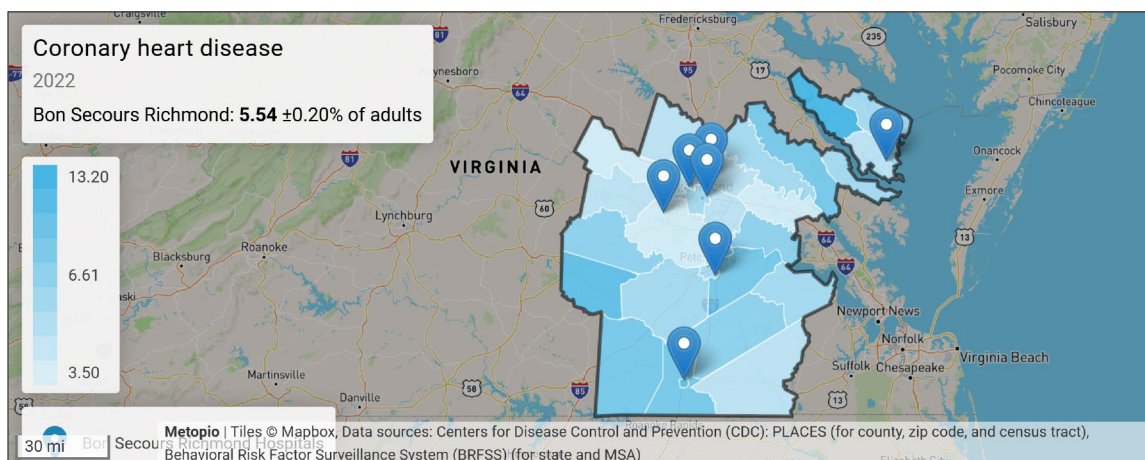
Coronary heart disease (CHD) is a major public health concern due to its high prevalence, mortality rate, and significant economic burden. It's the leading cause of death in many countries, impacting individuals, families and health care systems.

Indicator Source

Centers for Disease Control and Prevention (CDC) PLACSE data; Behavioral Risk Factor Surveillance System (BRFSS)

What the data shows

- Darker shaded regions are associated with higher percentages of coronary heart disease. Conversely, lighter shaded regions are associated with lower percentages of coronary heart disease.



Chronic Obstructive Pulmonary Disease (COPD)

Indicator Description

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse or other health professional that they have chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis. The data shown is age-adjusted and is shown at the county level.

Indicator Importance

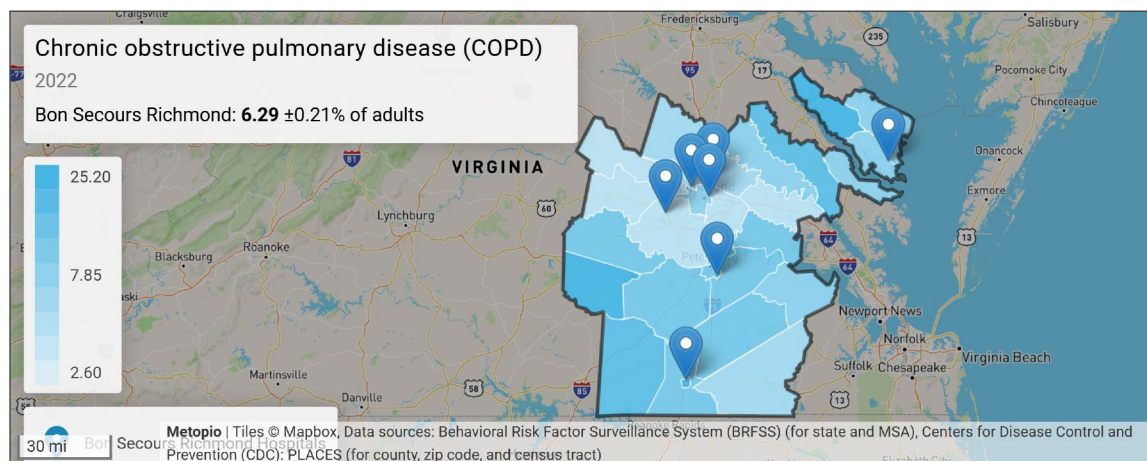
COPD is a significant public health concern due to its high prevalence, associated costs and negative impact on quality of life. As a chronic, progressive disease, COPD contributes to disability and mortality, placing a heavy burden on health care systems and individuals.

Indicator Source

Centers for Disease Control and Prevention (CDC) PLACES data; Behavioral Risk Factor Surveillance System (BRFSS)

What the data shows

- Darker shaded regions are associated with higher percentages of COPD. Conversely, lighter shaded regions are associated with lower percentages of COPD.



High Blood Pressure (Hypertension)

Indicator Description

Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse or other health professional that they have high blood pressure (hypertension). Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included. This data is shown at the county level.

Indicator Importance

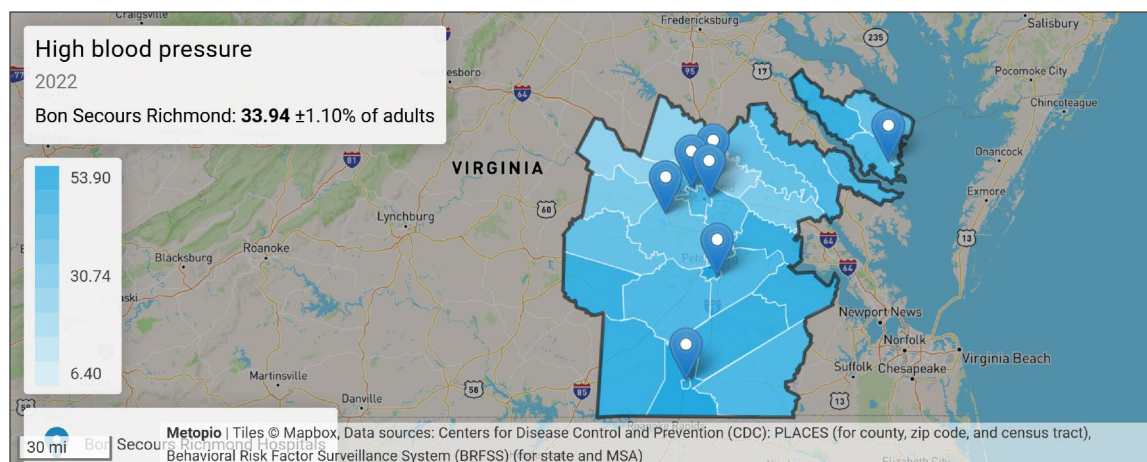
High blood pressure (hypertension) is a significant public health concern due to its high prevalence and strong association with cardiovascular disease, stroke, and premature death. It's a leading risk factor for several chronic diseases, making its control and prevention crucial for public health.

Indicator Source

Centers for Disease Control and Prevention (CDC) PLACES data; Behavioral Risk Factor Surveillance System (BRFSS)

What the data shows

- Darker shaded regions are associated with higher percentages of high blood pressure (hypertension). Conversely, lighter shaded regions are associated with lower percentages of high blood pressure (hypertension).



Current Asthma (Adults)

Indicator Description

Percent of adults (civilian, non-institutionalized population) who answer “yes” to both of the following questions: “Have you ever been told by a doctor, nurse or other health professional that you have asthma?” and the question “Do you still have asthma?” This data is shown at the county level.

Indicator Importance

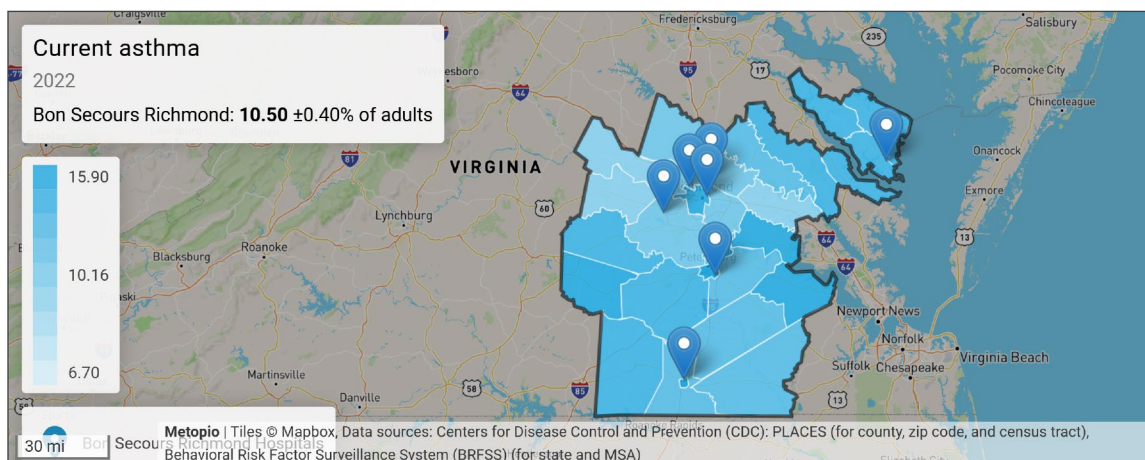
Asthma is a significant public health concern because it’s a common chronic disease with substantial impact on individuals and society. It can lead to significant health complications, including emergency room visits and hospitalizations, and also contributes to absenteeism from work and school. Additionally, asthma can have a significant economic burden due to health care costs and lost productivity.

Indicator Source

Centers for Disease Control and Prevention (CDC) PLACES data; Behavioral Risk Factor Surveillance System (BRFSS)

What the data shows

- Darker shaded regions are associated with higher percentages of asthma. Conversely, lighter shaded regions are associated with lower percentages of asthma.
- Asthma rates are lower in suburban counties and higher in urban and rural counties.



Alzheimer's in Medicare Beneficiaries

Indicator Description

Percent of Medicare beneficiaries with Alzheimer's disease, ages 65 and older, shown at the county level.

Indicator Importance

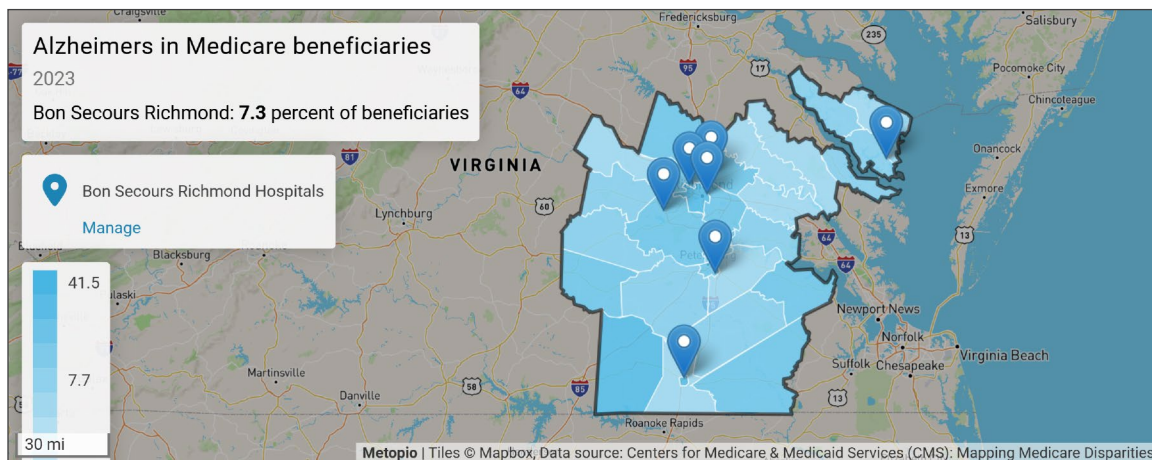
Alzheimer's disease is a crucial public health issue due to its substantial prevalence, increasing health care costs, and significant impact on individuals, families, and society. It's a leading cause of dementia, affecting millions and driving up the cost of health care and long-term care.

Indicator Source

Centers for Disease Control and Prevention (CDC) Mapping Medicare Disparities data

What the data shows

- Darker shaded regions are associated with higher percentages of Alzheimer's. Conversely, lighter shaded regions are associated with lower percentages of Alzheimer's.
- Asthma rates are lower in suburban counties and higher in urban and rural counties.



Depression in Medicare Beneficiaries

Indicator Description

Percentage of Medicare beneficiaries reported with depression, ages 65 and older, shown at the county level.

Indicator Importance

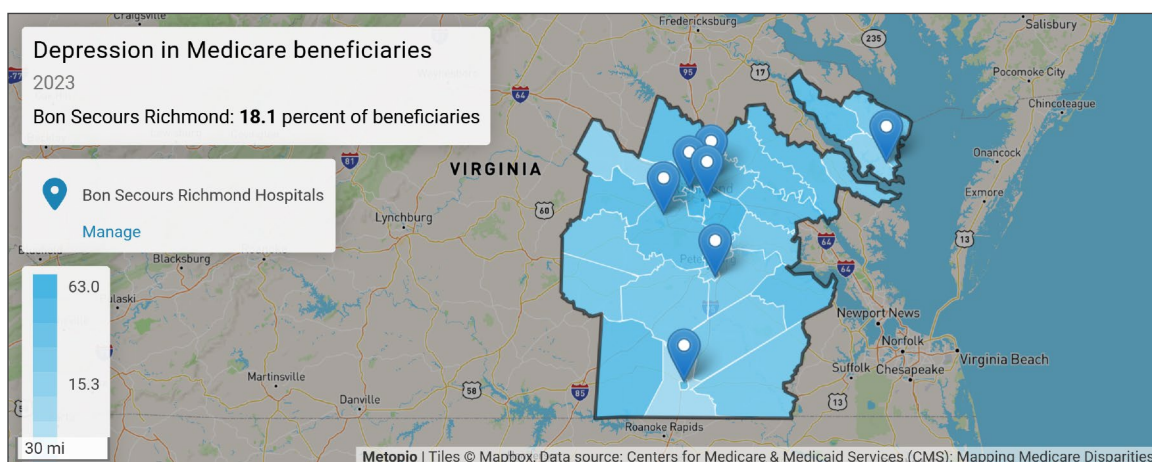
Depression in older adults is a significant public health concern because it's linked to increased mortality, morbidity and health care costs, as well as a higher risk of suicide. Untreated depression in older adults can lead to chronic physical health issues, social isolation, and reduced quality of life.

Indicator Source

Centers for Disease Control and Prevention (CDC) Mapping Medicare Disparities data

What the data shows

- Darker shaded regions are associated with higher percentages of depression. Conversely, lighter shaded regions are associated with lower percentages of depression.



Housing Cost Burden

Indicator Description

Households spending more than 30% of their income on housing are considered housing cost-burdened. Includes both renters (rent) and owners (mortgage and other owner costs). For renters, costs include any utilities or fees that the renter must pay, but do not include insurance or building fees. This data is shown at the county level.

Indicator Importance

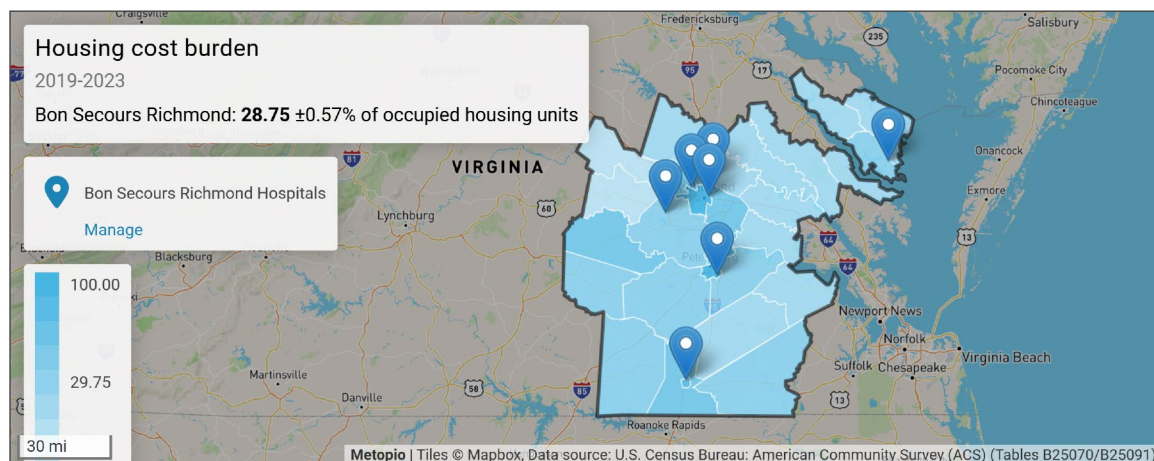
Housing cost burden is crucial for public health because it impacts physical and mental well-being, particularly among vulnerable populations. It can lead to inadequate housing conditions, stress, and increased vulnerability to health issues like homelessness and chronic diseases.

Indicator Source

American Community Survey (Tables B25070/B25091)

What the data shows

- Darker shaded regions are associated with higher percentages of housing cost burden. Conversely, lighter shaded regions are associated with lower percentages of housing cost burden.



Eviction Filing Rate

Indicator Description

An eviction filing is the result of a landlord filing a case in court to have a tenant removed from a property. This does not include voluntary move-outs or evictions that take place outside of the legal system. Over the course of a year, a landlord may file multiple evictions against the same household, and all those filings would be included here. This data is shown at the county level.

Indicator Importance

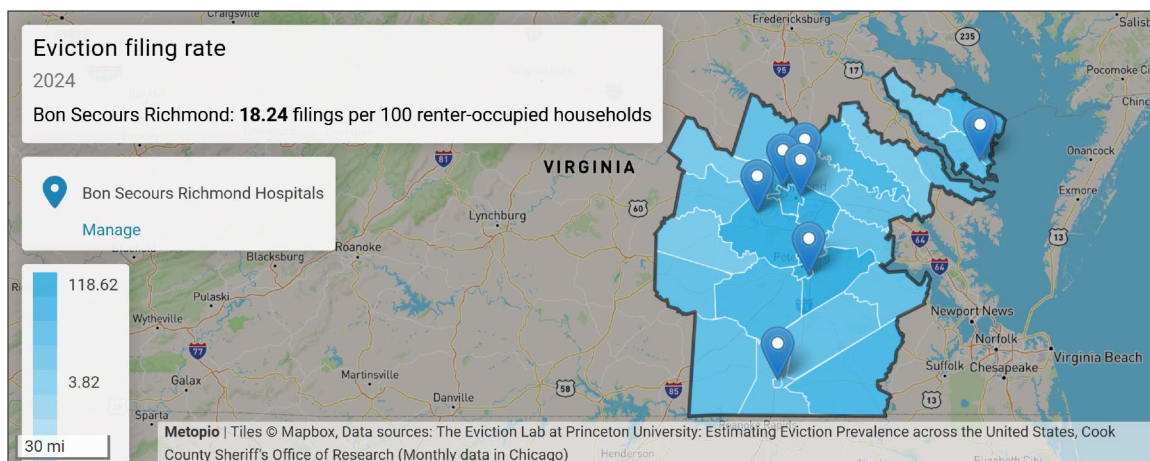
Evicted adults report significantly worse mental health, have higher suicide mortality and have higher rates of mental health hospitalizations, making evictions a significant public health concern.

Indicator Source

The Eviction Lab at Princeton University: Estimating Eviction Prevalence across the United States.

What the data shows

- Darker shaded regions are associated with higher eviction filing rates. Conversely, lighter shaded regions are associated with lower eviction filing rates.



Food Insecurity

Indicator Description

Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. This data is shown at the county level.

Indicator Importance

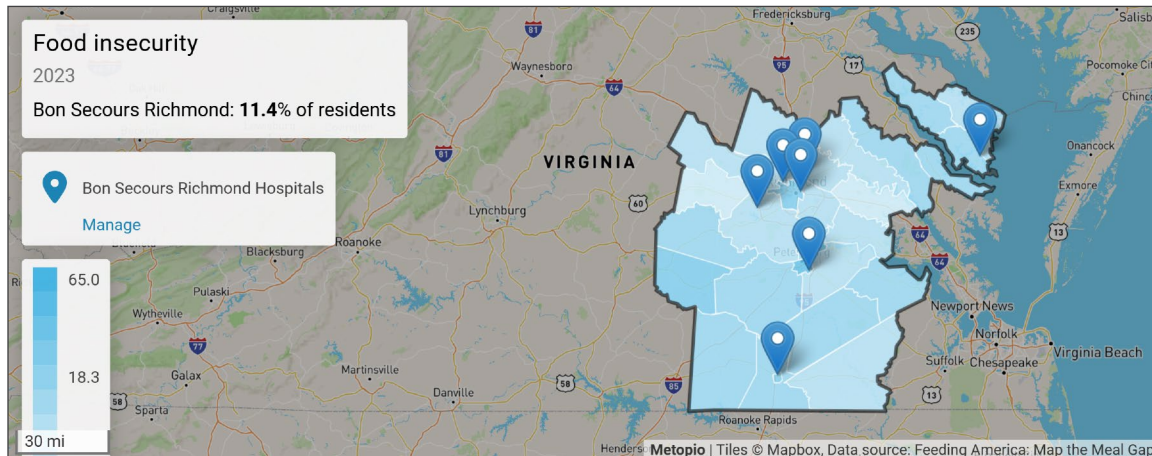
Food insecurity is a significant public health issue due to its strong association with adverse health outcomes. It's linked to poorer diets, increased risk of chronic diseases like diabetes and heart disease and a range of other health problems, including mental health issues and infectious diseases.

Indicator Source

Feeding America: Map the Meal Gap

What the data shows

- Darker shaded regions are associated with higher food insecurity. Conversely, lighter shaded regions are associated with lower food insecurity.



Note: All data contained in these maps and charts is available upon request in map, chart, or table format, and additional indicators may be available upon request. Please email Kerrissa_macpherson@bshsi.org to request.

Community Input

We received three written comments submitted formally. All comments went through a comment review process to determine if they were:

- From a community member or stakeholder in the CHNA service area
- If they provided feedback specific to the CHNA

Two of the comments did not appear to come from individuals connected to the CHNA service area. None of the comments included feedback about the CHNA process or CHNA report. The review showed that no actionable or constructive written comments were received regarding the 2022 CHNA. We will continue reviewing comments for future CHNAs.

Additional community input is summarized in the Process and Methods section. No other community input was received outside of the advisory group, survey, focus groups and key informant interviews.

Collaborating Partners

Bon Secours Richmond thanks the following organizations for their collaboration as part of the process of conducting the needs assessment:

- | | |
|---|---|
| ▪ Bay Aging | ▪ Sportable |
| ▪ Boys to Men | ▪ St. Joseph's Villa |
| ▪ Cameron Foundation | ▪ Virginia Center for
Inclusive Communities |
| ▪ Central Virginia Health Services | ▪ Virginia Community Health
Workers Association |
| ▪ City of Richmond
(Office of Children and Families) | ▪ Virginia Commonwealth University
Health System (Department of
Community Health) |
| ▪ Community Coalition of Sussex | ▪ Virginia Dental
Association Foundation |
| ▪ Community Foundation of
Greater Richmond | ▪ Virginia Health Catalyst |
| ▪ Diversity Richmond | ▪ YMCA of Greater Richmond |
| ▪ Housing Resource Line | ▪ Virginia Department of Health
(Chesterfield County Health District,
Crater Health District, Richmond/
Henrico Health District and the
Three Rivers Health District) |
| ▪ La Casa de la Salud | |
| ▪ Latinos In Virginia
Empowerment Center | |
| ▪ NextUp RVA | |
| ▪ Partnership for Housing Affordability | |
| ▪ REAL LIFE | |
| ▪ RVA Rapid Transit | |

Information and Data Considered in Identifying Potential Need

Data Source	Date of data/information
Cameron Foundation	- Member of CHNA Advisory Group, 2024-25 - Shared 2023 Community Health Needs Assessment for Southern Chesterfield County, City of Hopewell, City of Colonial Heights, City of Petersburg, Dinwiddie County, Sussex County and Prince George County
Chesterfield County Health District	- Member of CHNA Advisory Group, 2024-2025 - Shared 2023 Chesterfield County Community Health Assessment and 2024 Powhatan County Community Health Assessment
Crater Health District	- Member of CHNA Advisory Group, 2024-2025 - Shared 2023 Community Health Assessments for Dinwiddie County, Greenville County and the City of Emporia, City of Hopewell, City of Petersburg, Prince George County, Surry County and Sussex County
Richmond/Henrico Health District	- Member of CHNA Advisory Group, 2024-2025 - Shared 2024 City of Richmond/Henrico County Community Health Assessment
Three Rivers Health District	- Member of CHNA Advisory Group, 2024-2025 - Shared 2023 Community Health Assessment for Essex County, Gloucester County, King and Queen County, King William County, Matthews County, Middlesex County, Lancaster County, Northumberland County, Richmond County and Westmoreland County
Virginia Commonwealth University (VCU) Health System	- Member of CHNA Advisory Group, 2024-25 - Shared 2024 VCU Tappahannock Hospital Community Health Needs Assessment for Essex County, King and Queen County, King William County, Lancaster County, Northumberland County, Richmond County, and Westmoreland County, the 2024 VCU Community Memorial Hospital Community Health Needs Assessment for Brunswick County, Charlotte County, Lunenburg County, Mecklenburg County, Nottoway County, and Warren County (in North Carolina), and the 2023 VCU Health System Community Health Needs Assessment for City of Colonial Heights, Charles City County, Chesterfield County, Henrico County, City of Hopewell, New Kent County, City of Petersburg and the City of Richmond.

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
Bay Aging	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Bon Secours Richmond Health System Associates & Providers	2025	Focus Groups, Key Informant Interviews	At risk, Medically Underserved, Low Income or Minority
Boys to Men	2025	Focus Groups	At risk, Medically Underserved, Low Income or Minority
Cameron Foundation	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Central Virginia Health Services	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
City of Richmond, Office of Children and Families	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Community Coalition of Sussex	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Community Foundation of Greater Richmond (River Counties Community Foundation)	2025	Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Diversity Richmond	2024-2025	Member of Advisory Group	At risk, Medically Underserved, Low Income or Minority
La Casa de La Salud	2024-2025	Member of Advisory Group, Key Informant Interview, Focus Group	At risk, Medically Underserved, Low Income or Minority
Latinos in Virginia Empowerment Center	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
NextUP RVA	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Partnership for Housing Affordability	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Partnership for Housing Affordability (Housing Resource Line)	2025	Focus Group	At risk, Medically Underserved, Low Income or Minority

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
REAL LIFE	2024-2025	Member of Advisory Group, Key Informant Interview, Focus Group	At risk, Medically Underserved, Low Income or Minority
RVA Rapid Transit	2024-2025	Member of Advisory Group, Key Informant Interview, Focus Group	At risk, Medically Underserved, Low Income or Minority
Sportable	2025	Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
St. Joseph's Villa	2024-2025	Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Center for Inclusive Communities	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Community Health Workers Association	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Commonwealth University Health System (Department of Community Health)	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Dental Association Foundation	2025	Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Health Catalyst	2025	Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
YMCA of Greater Richmond	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Department of Health (Chesterfield County Health District)	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Department of Health (Crater Health District)	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Department of Health (Richmond Henrico Health District)	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority
Virginia Department of Health (Three Rivers Health District)	2024-2025	Member of Advisory Group, Key Informant Interview	At risk, Medically Underserved, Low Income or Minority

*Individuals or organizations staffed by fewer than five people may not be named to protect anonymity.

Significant Community Identified Health Needs

The following prioritization of health issues and root causes reflects a yearlong CHNA engagement process, and significant health needs were identified by analyzing publicly available data, survey results and qualitative feedback from the Community Advisory Group, focus groups and key informant interviews. While there are current service providers address many of these health needs, many are already at capacity. The prioritized needs identified as significant aim to more adequately meet the community's needs.

Prioritization methodology and Community Advisory Group discussion, focus group themes and key informant interviews reaffirmed survey findings. These sources also revealed significant connections between identified health needs. (Note: Survey results were considered alongside recurring themes in key informant interviews and focus groups, with extra attention given to needs most often cited across all sources.)

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

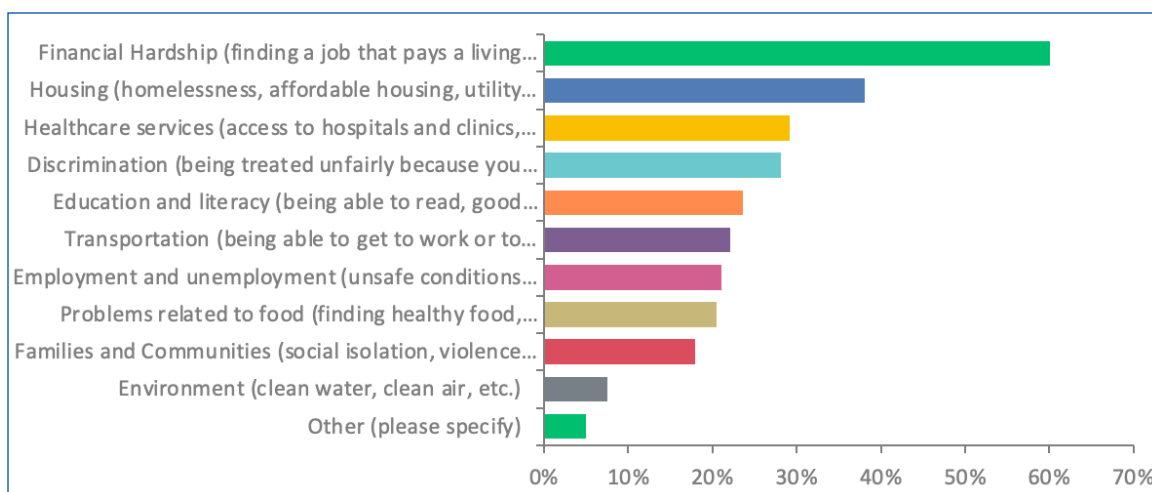
Respondents to the 2025 CHNA Survey were asked to select up to 3 social drivers of health needs facing their community. Responses were as follows:

Social Driver of Health Needs — as identified by the community in the 2025 CHNA Survey*

Social drivers of health were identified by the community as root causes of health needs in the CHNA Service Area. The interconnectedness of social drivers of health was of particular interest to the Community Health Advisory Group.

Financial hardship (finding a job that pays a living wage, being able to pay the bills, etc.)	60.03%
Housing (homelessness, affordable housing, utility payments, etc.)	38.05%
Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)	29.21%
Discrimination (being treated unfairly because you are different in some way, like racism or ageism)	28.11%
Education and literacy (being able to read, good schools)	23.63%
Transportation (being able to get to work or to health care appointments)	22.12%
Employment and unemployment (unsafe conditions at work or cannot find a job)	21.11%
Problems related to food (finding healthy food, paying for food, etc.)	20.51%
Families and Communities (social isolation, violence between people that know each other, crime)	17.90%
Environment (clean water, clean air, etc.)	7.51%

*Respondents could select up to three social drivers of health needs facing their community



Significant need	How each need is currently serviced	Capacity and adequacy of current service level
Financial Hardship (finding a job that pays a living wage, being able to pay the bills, etc.)	Presence of and Bon Secours partnerships with Financial Opportunity Centers, Richmond Office of Community Wealth Building, organizations providing emergency financial assistance	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Housing (homelessness, affordable housing, utility payments, etc.)	Bon Secours investment in affordable housing developers and organizations, home ownership education and initiatives, virtual support such as Housing Resource Line and the Homeless Connection Line, organizations that provide ongoing supportive housing and case management, emergency shelters, organizations providing emergency financial assistance	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)	Bon Secours partnerships and investments in area Safety Net Clinics, Bon Secours Care-A-Van providing primary and specialty care for the uninsured, participation and leadership in collaboratives focused on access across the service area, utilization of Unite Us online platform to facilitate patient access to essential community resources	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.

Significant need	How each need is currently serviced	Capacity and adequacy of current service level
Discrimination (being treated unfairly because you are different in some way, like racism or ageism)	Bon Secours trauma-informed care collaborative (including educational opportunities for Bon Secours associates), Age-Friendly initiatives across Bon Secours hospitals, Bon Secours leadership trainings focused on the dignity of all associates and patients, Bon Secours investment in partners focused on fostering unity through community-building activities	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Education and literacy (being able to read, good schools)	Bon Secours investment in out of school programming and wrap-around social support for students and their families	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Transportation (being able to get to work or health care appointments)	Bon Secours investment in organizations advocating for public transportation access and pedestrian/cyclist safety	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Employment and unemployment (unsafe conditions at work or cannot find a job)	Presence of and Bon Secours partnerships with Financial Opportunity Centers, Richmond Office of Community Wealth Building, organizations providing emergency financial assistance, partnerships with school systems and community colleges to build workforce pipelines to essential health care roles	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Problems related to food (finding healthy food, paying for food, etc.)	Bon Secours investment in organizations providing healthy food access and emergency food, Bon Secours investment in local community-based farms, Bon Secours investment in and programming on healthy cooking	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.

Significant need	How each need is currently serviced	Capacity and adequacy of current service level
Families and Communities (social isolation, violence between people that know each other, crime)	Bon Secours investment in community building events and programs (including the Sarah Garland Jones Center for Healthy Living and the Petersburg Center for Healthy Living), Bon Secours investments and partnerships with organizations disrupting community violence, Bon Secours Violence Response Team patient care and family support across the Bon Secours Richmond service area	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Environment (clean water, clean air, etc.)	Bon Secours investment in urban green spaces, and partnerships and collaborations with local health districts across the Bon Secours Richmond service area	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.



Social Health Needs — Individual Level Non-Clinical Needs

In the Community Survey, focus groups, key informant interviews and Community Health Advisory Group discussions, the topics of violence, discrimination and access to health care came up repeatedly. As a result, survey questions related to all three topics are included below:

- Experiences of Violence
- Discrimination while receiving Health Care Services
- Access to Health Care Services

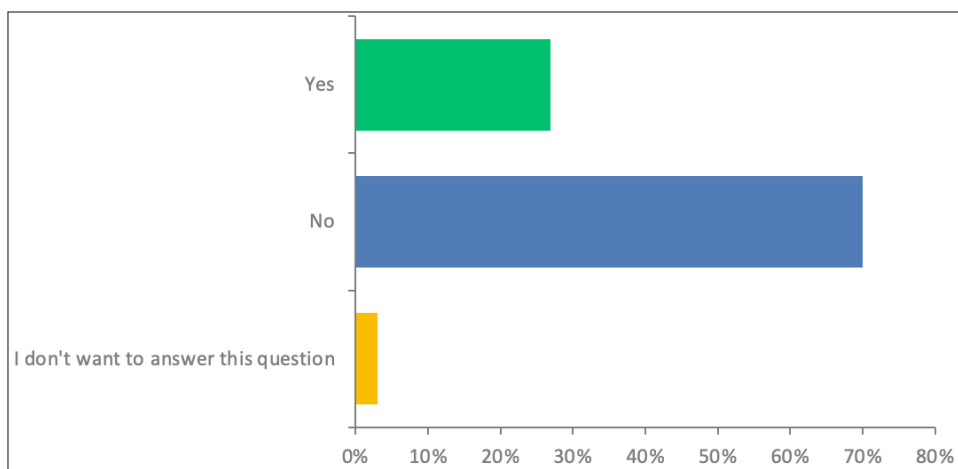
Respondents to the 2025 CHNA Survey were asked to answer questions about experiences of violence and experiences of discrimination. Responses were as follows:

Social Health Needs — as identified by the community in the 2025 CHNA Survey*

Violence

Respondents with Experiences of Violence Y/N	Percentage
Yes	26.96%
No	70.05%
I don't want to answer this question	2.99%

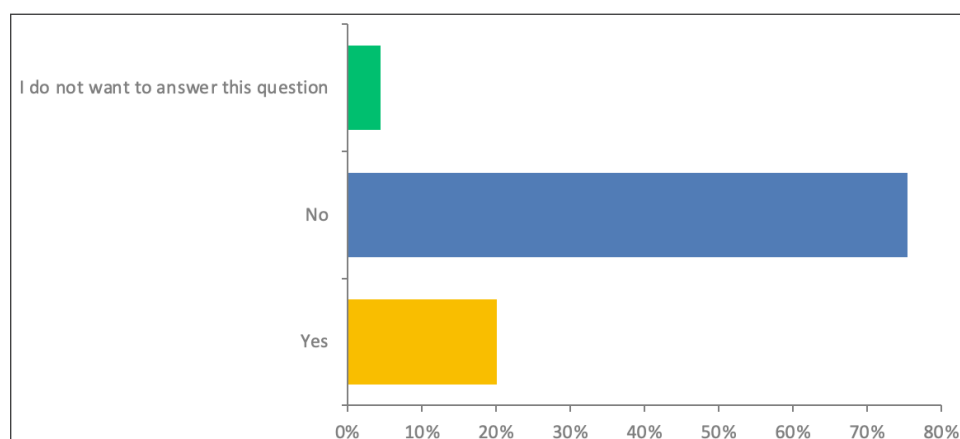
*This was a Yes/No question



Discrimination while receiving Health Care Services

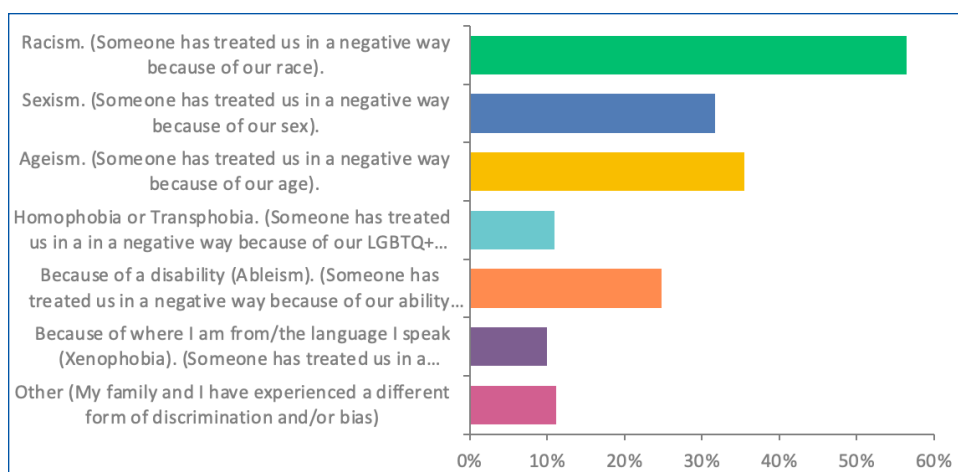
Respondents with Experiences of Discrimination Y/N	Percentage
I do not want to answer this question	4.42%
No	75.47%
Yes	20.11%

**This was a Yes/No question*



Experiences of Discrimination - Specific Experiences if Yes	Percentage
Racism. (Someone has treated us in a negative way because of our race).	56.43%
Sexism. (Someone has treated us in a negative way because of our sex).	31.67%
Ageism. (Someone has treated us in a negative way because of our age).	35.48%
Homophobia or Transphobia. (Someone has treated us in a negative way because of our LGBTQ+ identity).	10.95%
Because of a disability (Ableism). (Someone has treated us in a negative way because of our ability or dis/ability).	24.76%
Because of where I am from/the language I speak (Xenophobia). (Someone has treated us in a negative way because of our immigration status or our country of origin).	10.00%
Other (My family and I have experienced a different form of discrimination and/or bias)	11.19%

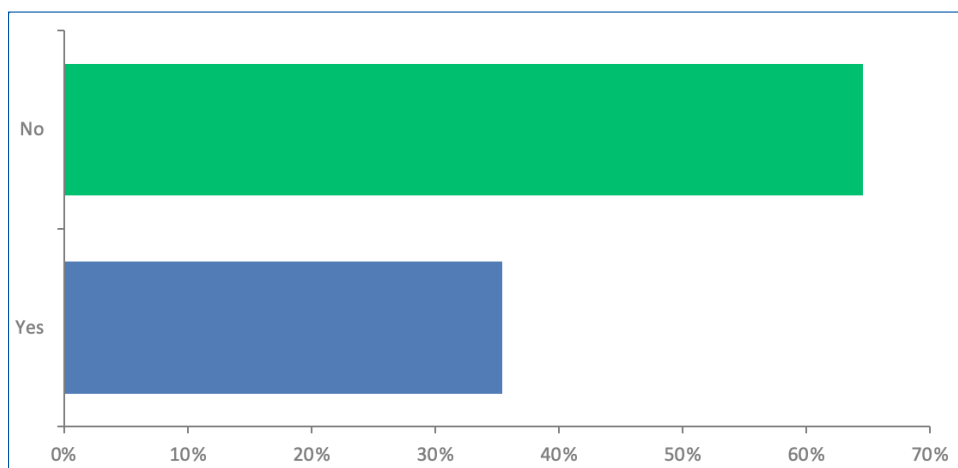
**Respondents could select all that applied*



Access to Health Care Services

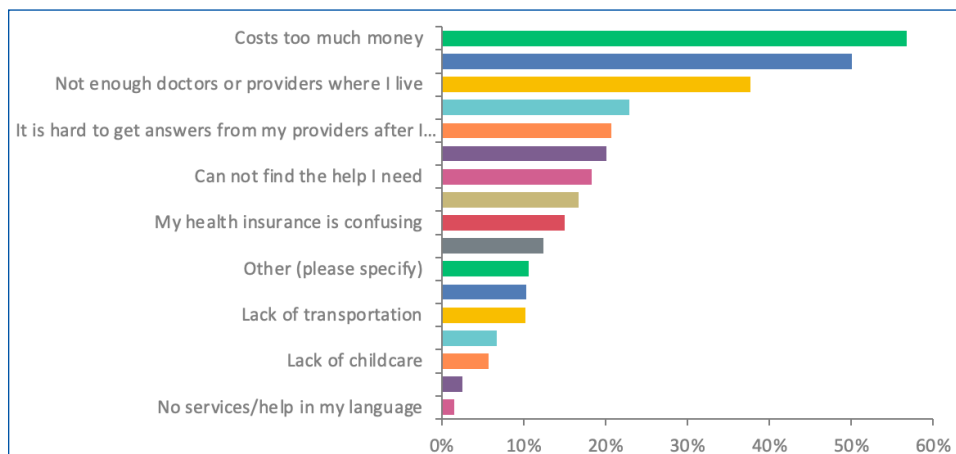
Difficulty in Health Care Access - Y/N	Percentage
No	64.56%
Yes	35.44%

*This was a Yes/No question



Difficulty in Health Care Access - Specific Barriers Faced by Respondents if Yes	Percentage
Costs too much money	56.78%
Long wait times to see a provider	50.07%
Not enough doctors or providers where I live	37.66%
Places I want to go do not accept my health insurance	22.82%
It is hard to get answers from my providers after I leave (prescriptions, referrals, consults)	20.68%
Help I need is not available after I leave work/Unable to get time off work	20.11%
Can not find the help I need	18.26%
I do not have health insurance	16.69%
My health insurance is confusing	14.98%
Not able to see the same provider each time	12.41%
Other (please specify)	10.56%
No vision or dental insurance	10.27%
Lack of transportation	10.13%
Do not have computer or internet for telehealth	6.70%
Lack of childcare	5.71%
No in-person interpreters	2.43%
No services/help in my language	1.43%

*Respondents could select all that applied



Significant need	How each need is currently serviced	Capacity and adequacy of current service level
Experiences of Violence	Bon Secours Violence Response Team provides forensic nursing and victim advocacy services, as well as community outreach through a variety of ways. These include participation in multiple sexual assault and child abuse response teams, as well as community lectures and presentations on sexual assault, human trafficking, strangulation, child abuse, elder abuse and interpersonal violence. Bon Secours also invests in community-building events and programs (including the Sarah Garland Jones Center for Healthy Living and the Petersburg Center for Healthy Living).	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Discrimination while receiving Health Care Services	Bon Secours trauma-informed care collaborative (including educational opportunities for Bon Secours associates), Age-Friendly initiatives across Bon Secours hospitals, Bon Secours leadership trainings focused on the dignity of all associates and patients, Bon Secours investment in partners focused on fostering unity through community-building activities	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Access to Health Care Services	Bon Secours emergency departments, acute hospital facilities, outpatient and Community Health medical resources address ongoing barriers to accessing needed health care. Bon Secours has a robust Community Health department that brings primary and specialty services into underserved communities. Bon Secours directly invests in other community-based organizations, such as safety net clinics, to support their clinical capacity in providing care for the most vulnerable and supporting patient care transitions across the continuum of care.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.

Significant Clinical Health Needs

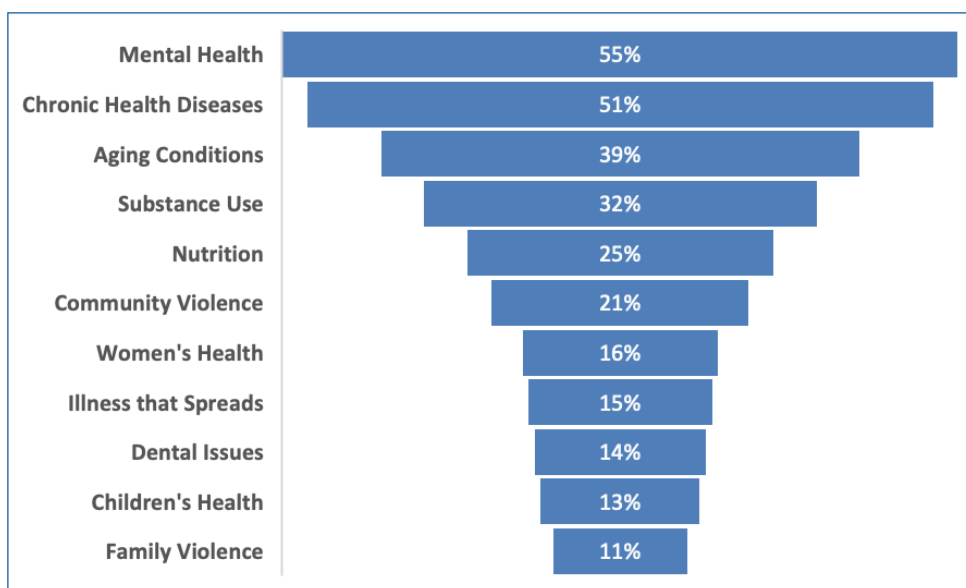
Clinical Health Needs — as identified by the community in the 2025 CHNA Survey*

Mental health, chronic disease and the need for increased prevention and education emerged as top concerns in both the survey and the focus groups/key informant interviews. Chronic diseases are a leading cause of death in our community, are multifaceted and require tremendous attention and resources to address. The community engaged in the CHNA process is passionate about building on the region's momentum to address these needs.

Mental health was identified as the number one need in the engagement survey. It was also a critical component of nearly every focus group and key informant interview, spanning both urban and rural communities.

Top 3 Biggest Health Needs	Percentage
Mental Health (Depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)	54.93%
Chronic Health Diseases (Cancer, Diabetes, High blood pressure, heart disease/heart attack, obesity, etc.)	50.55%
Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)	38.63%
Drug, alcohol and tobacco use, Substance Use (including overdose), Smoking and Vaping	31.77%
Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)	24.63%
Community Violence (Hate crimes/extreme group violence, gangs, assaults, homicides, firearm related injuries, human trafficking, death)	21.18%
Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)	16.11%
Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)	14.73%
Dental Issues	14.18%
Children's health concerns	13.08%
Family Violence (Child Abuse/Neglect, Elder Abuse, Domestic Violence, Intimate Partner Violence)	11.46%

*Respondents could select up to 3 clinical health needs facing their community. Needs selected by more than 10% of respondents have been included as significant for this question.



Significant need	How each need is currently serviced	Capacity and adequacy of current service level
Mental Health (Depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)	Bon Secours provides mental health care across the continuum of services, including outpatient and inpatient services such as partial hospitalization programs and psychiatric hospital beds, with crisis stabilization teams embedded into emergency services. Bon Secours invests in community-based partner organizations to support their clinical capacity for serving the most vulnerable and to address aspects of mental health care that are not traditionally provided in the acute or outpatient setting.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Chronic Health Diseases (Cancer, Diabetes, High blood pressure, heart disease/heart attack, obesity, etc.)	Bon Secours emergency departments, acute hospital facilities, outpatient and Community Health medical resources address ongoing chronic diseases and prevention efforts. Bon Secours has a robust Community Health department that brings primary and specialty services into underserved communities. Bon Secours directly invests in other community-based organizations, such as safety net clinics, to support their clinical capacity in providing care for the most vulnerable and supporting patient care transitions across the continuum of care.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.

Significant need	How each need is currently serviced	Capacity and adequacy of current service level
Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)	Bon Secours hospitals promote Age-Friendly initiatives at each acute facility. Bon Secours directly invests in organizations that support older adults, including supporting organizations that support older adults in aging in place and providing needed social support.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Drug, alcohol and tobacco use, Substance Use (including overdose), Smoking and Vaping	Bon Secours hospitals provide responsive care to substance users, seeking to prevent injury and mortality due to substance use. Bon Secours directly invests in organizations that support individuals with a history of substance use.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)	Bon Secours investment in organizations providing healthy food access and emergency food, Bon Secours investment in local community-based farms, Bon Secours investment in and programming on healthy cooking	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Community Violence (Hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)	Bon Secours Violence Response Team provides forensic nursing and victim advocacy services, as well as community outreach through a variety of ways. These include participation in multiple sexual assault and child abuse response teams, as well as community lectures and presentations on sexual assault, human trafficking, strangulation, child abuse, elder abuse, and interpersonal violence. Bon Secours also invests in community-building events and programs (including the Sarah Garland Jones Center for Healthy Living and the Petersburg Center for Healthy Living).	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.

Significant need	How each need is currently serviced	Capacity and adequacy of current service level
Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)	Bon Secours investment in women's medical care across the continuum for adolescents through older adults, including OB-GYN services, and Labor and Delivery and Neonatal Intensive Care Units at four hospitals across Bon Secours Richmond. Bon Secours investment in Every Woman's Life program, providing access to Preventive cancer screenings to women regardless of insurance status. Bon Secours provision of Prenatal Education to the community, regardless of ability to pay. Bon Secours directly invests in organizations that promote health and education for adolescents and teens, as well as organizations that support women in all stages of life.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Illness that spread (Flu, COVID-19, hepatitis, TB, etc.)	Bon Secours Preventive Services and Women's Health Services include the Instructive Visiting Nurse Association (IVNA), Every Woman's Life, and the Prenatal Education team. IVNA partners with businesses, faith-based organizations, schools, and community partners to provide vaccinations, biometric screenings, health education and homebound immunizations in the Greater Richmond area.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Dental Issues	Bon Secours Pediatric Dental Clinic provides dental care to children, regardless of their ability to pay.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Children's health concerns	Bon Secours offers a full suite of primary and specialty outpatient pediatric services, as well as inpatient pediatric services (including a pediatric intensive care unit) at St. Mary's Hospital.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.
Family Violence (Child Abuse/Neglect, Elder Abuse, Domestic Violence, Intimate Partner Violence)	Bon Secours Violence Response Team provides forensic nursing and victim advocacy services, as well as community outreach through a variety of ways. These include participation in multiple sexual assault and child abuse response teams, as well as community lectures and presentations on sexual assault, human trafficking, strangulation, child abuse, elder abuse, and interpersonal violence.	While Bon Secours and other organizations are addressing this health issue, significant needs remain to address this issue adequately across the Bon Secours Richmond footprint.

Resources Available

Bon Secours is committed to addressing the needs identified in our 2025 Community Health Needs Assessment and to making a measurable impact on community health across Bon Secours Richmond. True impact is achieved when strategic partnerships are formed and when collaborations are built that can achieve greater results collectively.

Bon Secours is dedicated to forming relationships that build a healthier community and to strengthening capacity in other nonprofits through investments, volunteerism and efforts that reduce barriers to coordinated patient care. The list below highlights key resources, though it is not exhaustive.

Health Care Facilities & Services:

- **Bon Secours Financial Assistance Team** – The Bon Secours Financial Assistance Program supports uninsured patients who do not qualify for government-sponsored health insurance and cannot afford their medical care. Insured patients may also qualify for assistance based on family income, family size and medical needs.
 - Financial hardship (e.g., finding a job that pays a living wage, being able to pay the bills)
 - Employment and unemployment (e.g., unsafe work conditions or inability to find a job)
- **Bon Secours Community Benefit Investments** – Between 2019 and 2022, Bon Secours provided over \$14 million through community benefit investments to community partners serving the uninsured and underinsured populations.
 - Financial hardship (finding a job that pays a living wage, being able to pay the bills, etc.)
 - Housing (homelessness, affordable housing, utility payments, etc.)
 - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
 - Discrimination (being treated unfairly because you are different in some way, like racism or ageism)
 - Education and literacy (being able to read, good schools)
 - Transportation (being able to get to work or to health care appointments)
 - Employment and unemployment (unsafe conditions at work or cannot find a job)
 - Problems related to food (finding healthy food, paying for food, etc.)
 - Families and communities (social isolation, violence between people that know each other, crime)
 - Experiences of violence
 - Discrimination while receiving health care services
 - Mental health (Depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)

- Chronic health diseases (Cancer, Diabetes, High blood pressure, heart disease/ heart attack, obesity, etc.)
 - Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)
 - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping
 - Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
 - Community Violence (Hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
 - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
 - Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
 - Children's health concerns
 - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)
- **Bon Secours Sarah Garland Jones Center for Healthy Living and Bon Secours Petersburg Center for Healthy Living** – These healthy living centers promote well-being and community engagement in Richmond's East End and in the Petersburg/ Crater region.
 - Problems related to food (finding healthy food, paying for food, etc.)
 - Families and communities (social isolation, violence between people that know each other, crime)
 - Access to health care services, mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
 - Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
 - **Bon Secours Violence Response Team** – This program provides care to patients 24/7 who have been victims of child abuse, sexual assault, community violence, domestic violence, elder abuse, human trafficking, and strangulation.
 - Families and communities (social isolation, violence between people that know each other, crime)
 - Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
 - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

- **Bon Secours Care-A-Van** – Mobile health clinics that provide free, primary, urgent, and Preventive health care to uninsured and vulnerable populations in a 60-mile radius of the City of Richmond.
 - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
 - Transportation (being able to get to work or to health care appointments)
 - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/ heart attack, obesity, etc.)
 - Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
- **Bon Secours Community Nutrition** – Improves community health, particularly in vulnerable communities, through nutrition counseling, healthy eating classes, and advocacy for food access.
 - Problems related to food (finding healthy food, paying for food, etc.)
 - Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
- **Bon Secours Every Woman's Life** – This program provides breast and cervical cancer screening and early detection, clinical breast exams, mammograms, pelvic exams, and Pap smears.
 - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
 - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
- **Bon Secours Instructive Visiting Nurse Association (IVNA)** – IVNA is an Immunization and Wellness Program that provides thousands of flu shots per year, in addition to other immunizations and wellness services, to the Greater Richmond community.
 - Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
 - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/ heart attack, obesity, etc.)
- **Bon Secours Medical Group** – Over four hundred and fifty physicians and advanced practice clinicians and associated staff providing primary and specialty medical care to the CHNA service area in over one hundred and fifty locations.
 - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
 - Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)

- Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
 - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
 - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
 - Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
 - Children's health concerns
- **Bon Secours Prenatal Education** – Team of Prenatal Educators providing community education about childbirth, breastfeeding, postpartum care, newborn care and safety, and more.
 - Families and communities (social isolation, violence between people that know each other, crime)
 - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
 - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
 - Children's health concerns
- **Bon Secours Hospital Emergency Departments** – Bon Secours Richmond includes seven acute facility hospitals with Emergency Departments that provide emergency care for acute physical and mental health needs.
 - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
 - Experiences of Violence
 - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
 - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
 - Drug, alcohol and tobacco use, Substance Use (including overdose), Smoking and Vaping
 - Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
 - Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
 - Children's health concerns
 - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

- **Federally Qualified Health Centers & Safety Net Clinics** – Capital Area Health Network (CAHN), Central Virginia Health Services, Crossover Health Ministry, Daily Planet, Free Clinic of Powhatan, Goochland Cares, Hanover Interfaith Clinics, Health Brigade, Northern Neck-Middlesex Free Health Clinic, and others.
 - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
 - Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
 - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
 - Dental issues
 - Drug, alcohol and tobacco use, Substance Use (including overdose), smoking and vaping
 - Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
 - Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
 - Children's health concerns
- **Central Virginia VA Health Care System, providing medical care to veterans across Virginia**
 - Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
 - Experiences of Violence
 - Mental Health (Depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
 - Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
 - Drug, alcohol and tobacco use, substance use (including overdose), smoking and vaping
 - Community Violence (Hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
 - Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
 - Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

- **HCA Virginia Health System and Virginia Commonwealth University (VCU) Health System**

- Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
- Experiences of Violence
- Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
- Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
- Dental Issues
- Drug, alcohol and tobacco use, substance Use (including overdose), smoking and vaping
- Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)
- Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
- Children's health concerns
- Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

Virginia Department of Health Local Health Districts:

- **Chesterfield County Health District, Chickahominy Health District, Crater Health District, Piedmont Health District, Richmond/Henrico Health District, Southside Health District, Three Rivers Health District**
- Health care services (access to hospitals and clinics, trust in providers like doctors and nurses)
- Families and Communities (social isolation, violence between people that know each other, crime)
- Environment (clean water, clean air, etc.)
- Mental health (depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
- Chronic health diseases (cancer, diabetes, high blood pressure, heart disease/heart attack, obesity, etc.)
- Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)
- Drug, alcohol and tobacco use, substance Use (including overdose), smoking and vaping
- Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
- Community violence (hate crimes/extreme group violence, gangs, assaults, homicides, firearm-related injuries, human trafficking, death)

- Women's health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)
- Illnesses that spread (Flu, COVID-19, hepatitis, TB, etc.)
- Children's health concerns
- Family violence (child abuse/neglect, elder abuse, domestic violence, intimate partner violence)

Other Local and National Resources

See **Appendix F** for additional local and national resources that address significant community health needs.



Prioritization of Health Needs

This CHNA used a robust prioritization process that included four meetings between February and April 2025. These meetings focused on selecting which needs to prioritize from the many identified by publicly available data, survey responses, focus groups and key informant interviews.

Community Health leadership compiled summaries of survey results from all respondents and selected key demographic groups, such as specific geographic areas, racial identity, age and insurance status. They also prepared summaries of key themes from focus groups and interviews.

Members of the CHNA Advisory Group completed a facilitated process to identify the key takeaways from the qualitative and quantitative CHNA data. The Advisory Group consolidated these into prioritized areas, which were then presented and reviewed by Bon Secours Community Health clinical and administrative leaders. Leaders considered alignment with available health system resources and local market priorities. The high priority areas were reframed as prioritized needs to reflect the most significant identified community health and social concerns.

The below prioritization of health issues and root causes is the culmination of the yearlong CHNA engagement process. While some service providers address each of these health needs, many are at capacity or require additional investment to sustain current operations to meet community needs. The three selected priority areas combine multiple health and social needs identified by community members and represent urgent opportunities for Bon Secours to respond. They also focus on prevention and address the root issues that drive health outcomes.

- Opportunity & Access (Clinical Needs)
- Systemic Solutions (Social Drivers of Health)
- Community Representation (Social Needs)

Prioritized Health Needs

Opportunity & Access (Clinical Needs)

- Insufficient opportunities for building wealth, which perpetuate generational cycles of poverty and contribute to poor health outcomes (e.g., affordable housing, financial literacy)
- Insufficient access to affordable primary and specialty care, resulting in health services that do not fully honor the dignity of every person we serve (e.g., chronic disease management, rural access)

Systemic Solutions (Social Drivers of Health)

- Traditional health care and community responses are often reactive “short term fixes,” but the root cause of health needs can also be recognized and addressed (e.g., housing, mental health, violence, discrimination, addiction, etc.)

Community Representation (Social Needs)

- Insufficient career pathways exist for low-income residents in the communities we serve (e.g., Community Health Workers, workforce pipelines)
- Unbalanced community representation in decision-making about proposed health solutions to address needs (e.g., staff that is not representative of the communities served, board service, community engagement processes)

Significant Health Needs Not Prioritized

Many of the significant needs addressed above are reflected in the overarching prioritized need categories. However, some significant community needs will not be addressed in this CHNA, due to limited resources or the presence of other partners already focused on these areas. These needs remain important to the community and are listed below.

Needs Not Prioritized

The following needs are important to the community, but we didn’t directly prioritize them in this CHNA due to limited resources and/or existing partners working to address these needs:

1. Dental Health

Several community partners provide affordable dental care:

- CrossOver Health Care Ministry: Preventive cleanings, education, screenings, fillings, extractions and dentures at low or no cost for uninsured patients.
- Capital Area Health Network and the Daily Planet: Comprehensive dental care on a sliding fee scale for uninsured patients.
- Virginia Commonwealth University: Dental care program for low-income, uninsured and underinsured individuals.

2. Sexually Transmitted Infections, including HIV/AIDS

Prevention and treatment are available through:

- Local and state health departments (STI/HIV prevention, PrEP and case management).
- Virginia Commonwealth University, Richmond Behavioral Health Authority, Health Brigade, the Minority Health Consortium and the Daily Planet (HIV/AIDS services across the region).

3. Infant & Maternal Mortality

Key programs include:

- Local health departments: reproductive health, family planning, WIC program and Centering Pregnancy group care.
- Urban Baby Beginnings: Community Cares program, birthing support, early childhood development, maternal mental health and workforce development services.

4. Alzheimer's and Dementia

Resources available include:

- Assisted living facilities across the region.
- Rick Sharp Alzheimer's Foundation and Greater Richmond Chapter of the Alzheimer's Association: education, family support and connections to resources.
- The Memory Center, adjacent to Bon Secours St. Francis Medical Center, dedicated resources for families facing these conditions.

5. Environmental Issues

Multiple nonprofits address environmental concerns that impact health outcomes:

- Alliance for the Chesapeake Bay, Nature Conservancy, Interfaith Alliance for Climate Justice, Capital Region Land Conservancy, James River Association and others.
- Their work advances environmental justice, which is closely tied to health equity.

Progress and Impact

Social and Economic Disparity

Strategies	Progress
Invest in community-based partnerships that address social determinants of health	Invested \$6,644,000 in 2023-2025 in community-based projects and programs that seek to reduce social and economic disparity, including affordable housing, education, workforce development and the built environment.
Expand community collaborations across the CHNA service areas with particular focus east and south of Richmond	Opened and now operate a new Bon Secours Community Health Hub at 3335 S. Crater Road, in Petersburg near Bon Secours Southside Regional Medical Center. Partnered with Goodr Mobile Grocery Store to provide Petersburg and Southern Virginia residents the opportunity to fill bags with a week's worth of groceries, combating food insecurity in underserved communities.
Explore opportunities to build community health worker models of care	Bon Secours maintained 20% growth of CHWs 2023-2025, continuing the focus on Southside Medical Center and Richmond Community Hospital service areas to address highest identified pockets of SDOH needs. Two CHWs were added to the Violence Response Team (focused on disrupting community violence in the Petersburg area). One CHW was added to the Neighborhood Engagement team as a community liaison. After adding additional grant funded Americorps CHWs, 5 CHWs are part of the Neighborhood Engagement team and have been supporting a Hypertension Management Program as well as supporting patients in the Richmond Community Hospital Emergency Department. From 2023-2025, CHWs provided SDOH screening/resources to 19 patients who were part of an intensive Hypertension Management Program. CHWs in the RCH ED assisted in patient connections to PCPs, patient connections to community resources and patient connections to specialty medical care.
Utilize evidence-based, community-focused models to screen for and address social drivers and determinants of health	The target was a 20% improvement, which was exceeded as of December 2023. January 2022 established a baseline of a 28.2% referral rate for BSR patients who have an SDOH need and received a referral to a community resource. As of EOY 2024, that target was achieved and the current screening rate is 73% and the resultant referral rate is 85%. This work remains a focus in 2025, and current estimates have Richmond on track to achieve screening and resource sharing goals in 2025.
Deploy technology solutions to connect individuals to the resources they need	Piloted Unite Us e-referral software across multiple new Bon Secours facilities and locations in 2023, leveraging technology to connect Bon Secours patients to the community resources they need, achieving Unite Us utilization goals. In 2024, 386 referrals were sent for 216 clients to 50 different organizations with an over 70% acceptance rate. The average Bon Secours Richmond Unite Us user sent 18.6 referrals in 2024. Between January 1 and June 3, 2025, 164 referrals impacting 102 clients were sent to 18 different organizations, with an 82% acceptance rate. The SPAN Center (formerly Senior Connections), the YMCA of Greater Richmond, FeedMore and La Casa de la Salud are some of the largest Unite Us referral-receiving organizations.

Engagement and Inclusion

Strategies	Progress
Host community engagement events and partner with trusted organizations to continue to identify real-time community needs and build social cohesion	Hosted 50+ events in 2023 – 2025, especially in the East End of Richmond through the Sarah Garland Jones Center for Healthy Living and the Center for Healthy Living in Petersburg. Events include mental health trainings, fitness activities like Chair Yoga or Cardio Fitness, holiday parties for lower income older adults, collaborative events with community partners and more.
Create opportunities for patients and community members to help inform our service delivery	Hosted multiple collaborative meetings to provide opportunities for community members to provide feedback and for Bon Secours leadership to engage with patients. Examples include hosting partner meetings in Petersburg to discuss healthy food access and collaboration opportunities, participating in discussions with Community Health Workers by collaborating with the Virginia Community Health Worker Association, meeting with community partners to explore opportunities to collaborate at the new Petersburg Center for Healthy Living, and meeting with community members and community partners to hear their feedback on issues, such as housing, transportation, mental health and community violence.
Enhance community advisory councils that reflect the voice of the community and inform the work of Bon Secours	Diverse Community Advisory Group comprised of community representatives and leaders from the entire Bon Secours Richmond service area that met six times from April 2024 through Spring 2025. This Advisory Group provided feedback on the CHNA process, including co-creating a community engagement plan, providing feedback on the CHNA survey and key informant/focus group questions, assisting with CHNA community engagement, and being a part of the need prioritization process.
Collaborate across the region to address existing and emerging needs as an anchor institution	Bon Secours associates participate in a wide variety of regional collaboratives that address identified and emerging community needs: Healthy East End Steering Committee (BS leader is co-chair of Government, Finances and Operations committee), Chesterfield Community Health Assessment Process, Chesterfield Community Health Improvement Plan “Access to Care” workgroup, Powhatan Community Health Assessment Process, Richmond Henrico Community Health Improvement Plan Process, the Help1RVA Steering Committee, the Unite Us Community of Practice (as a key organizer and co-founder), the VDH Heart Disease and Stroke Learning Collaborative, the VHHA Health Equity Learning Collaborative, the VHHA Unite VA Hospital Steering Committee, the VDH School Readiness Collaborative. The Violence Response Team collaborates across the state in several multidisciplinary teams to combat human trafficking and to coordinate resources for victims of violence, including providing guidance to the Governor’s Anti Human Trafficking initiatives and hosting and leading the BSR Tri-Cities Community Violence Collaborative.

Violence and Trauma

Strategies	Progress
Identify and participate in interventions focused on keeping neighborhoods safer, including new partnerships with schools, housing entities and other community-based organizations	Invested \$588,000 from 2023–2025 in community-based projects and programs that seek to prevent, reduce or respond to interpersonal or community violence.
Explore additional trauma-informed training opportunities for new Bon Secours associates and refresher trainings for existing associates	Bon Secours Trauma-Informed Care Committee hosted a Trauma-Informed Care Wellness Day with a rolling cart taking trauma-informed resources on site to each Bon Secours acute facility (hospital + free standing ED). Additionally, six in-person education events about the impact of trauma on health care professionals and open to all associates were scheduled in 2024 at MRM, SMH, SFMC, SMC and RCH, with over 75 attendees. Also, a Trauma-Informed Book Club program launched for Bon Secours associates, with four books read and discussed between 2023–2025.
Expand capacity to meet the growing case demand around community violence, particularly in market south	In 2023, 3410 calls for service were received across all BSR by the Violence Response Team. Of these patients, 1037 were enrolled to receive additional victim advocate support. The Violence Response Team expanded hours of coverage at Southside Medical Center, hiring two night nurses for the Petersburg team and expanded their onsite space at Southside Medical Center. In 2024, 3515 calls for service were received across all BSR by the Violence Response Team. Of these patients, 973 were enrolled to receive additional victim advocate support. In Q1 of 2025, 883 calls for service were received across all BSR by the Violence Response Team. Of these patients, 247 were enrolled to receive additional victim advocate support. Two CHWs were hired in 2023 to focus on preventing community violence in Petersburg, with 46 referrals of community members into this new program and 20 enrollees. In 2024, these two CHWs continued to focus on preventing community violence in Petersburg, with over 154 referrals of community members into this new program and 34 enrollees who received a variety of violence intervention support, including SDOH screenings and referrals, telephone calls, accompaniment to medical appointments and home visits. In 2025, these two CHWs continued to focus on preventing community violence in Petersburg, with 34 referrals of community members into this new program and 29 enrollees in Q1 2025. In the East End/RCH service area, established new partnership with RVA League for Safer Streets (supported primarily by RPD). It combines basketball with conflict resolution, job and skills training, and health education opportunities for young adult men from public housing. — A Community Health dietitian leads some of the health workshops. More than 120 men are impacted through program.
Promote safety of all associates and patients who work in or receive care from our facilities or partner organizations	Establishment of a workplace safety team and multiple workplace safety initiatives in 2023–2025 improved the health and well-being of Bon Secours associates.

Chronic Disease and Prevention

Strategies	Progress
Expand access to high-quality and disease-specific prevention and wellness services	Opened a new prevention suite inside Richmond Community Hospital's Medical Office Building with a ribbon cutting January 2023. This space is now the headquarters for the IVNA Community Health Preventive Health team.
Expand access to primary and specialty care services, especially for uninsured or underinsured patients	The ribbon cutting for the new Manchester Community Health Clinic was on March 23, 2023, with the new clinic opening to serve patients on April 3, 2023. In 2023, the Care-A-Van provided 13,873 patient visits for 5869 individual patients from across the BSR service area. Of these patients, 3287 individual patients were served at the Manchester Community Health Clinic between the April opening date and the end of December 2023. In 2024, the Care-A-Van provided 14983 patient visits for 11460 individual patients from across the BSR service area. Out of this total number, 7254 individual patients were served by 8585 patient visits at the new Manchester Clinic. The number of individual patients increased 8% from 2023 to 2024, representing the significant impact of the Manchester fixed site on the operations of the Care-A-Van. In January-May 2025, the Care-A-Van provided 5508 patient visits for 4228 individual patients from across the BSR service area. Of these patients, 2682 individual patients were served by 3129 patient visits at the new Manchester Clinic. In February 2025, weekly Care-A-Van clinics began at the new Petersburg Center for Healthy Living. Through July 2025, over 200 uninsured patients received care in the weekly Petersburg clinics.
Increase access to nutrition education, diabetes prevention and management execution, and healthy cooking and eating programs	We re-imagined our community nutrition outreach team and hired new staff in 2023. Across Bon Secours Richmond Community Health in 2024, 398 1:1 nutrition counseling sessions with patients were completed, and 53 sessions of group nutrition education were offered. Both nutrition counseling sessions and group nutrition education continue in 2025, with 7 sessions of group nutrition education and 72 1:1 nutrition counseling sessions with patients completed between January and May 2025. These offerings included Care-A-Van patients, events at the East End Sarah Garland Jones Center, and collaborations with community partners such as RVA C.O.O.K.S. and Girls for a Change.
Invest in nonprofit direct service providers who are caring for the most vulnerable uninsured and underinsured patients	We invested \$2,446,380 total in 2023-2025 to nonprofits that support uninsured and underinsured patients, including Virginia safety net clinics.

Strategies	Progress
Explore the reorganization of existing clinical services and the development of new clinical services to meet the needs of patients more adequately in underserved communities	We significantly reorganized and expanded to serve underserved communities, particularly in the East End of Richmond and in Market South (including Petersburg). Market South: Received the Hearst Foundation Grant for a new Care-A-Van vehicle for expansion to Market South. Opened the new Center for Healthy Living in Petersburg, with Community Health clinical services launched in Petersburg in February 2025. East End: Significant prioritization of East End Richmond Community Hospital (RCH) service area and residents' access to medical services. We reestablished East End OB/GYN outpatient services with both a doctor and a midwife. We expanded older adult services, including senior services and Primary Care at Home in 2023. We established a multispecialty clinic at RCH with Cardiology, Surgery, Oncology and Podiatry services on site. In 2024, RCH celebrated the delivery of a new state-of-the-art MRI, including building out a new \$4.3 million MRI Suite and Main Patient Registration Lobby. RCH began partnering with multiple local pediatric dentistry practices to provide surgical services to the Richmond area, with a focus on serving patients with autism. RCH was also recertified as a Primary Stroke Center for another two years.
Participate in collaboratives that drive scale toward addressing the prevalence of chronic diseases and root cause health needs	We regularly engage with Healthy East End Steering Committee as well as part of the Greater Richmond Health Care Safety Net Collaborative. See additional list of regional collaboratives under the Engagement and Inclusion section above.
Identify new partnership opportunities that seek to address root causes of chronic diseases across the CHNA service area	We focused on addressing root causes of food insecurity and supporting efforts to increase access to food. New partnerships include the following: Partnership with GoodR to bring mobile food access to those in Petersburg experiencing food insecurity, including hosting shopping experiences for 75+ families on the mobile GoodRmarket. Joined the Petersburg Healthy Opportunities Partnership Collaborative, a food access studies/collaborative effort to address food insecurity and nutrition education. Transferred former Bon Secours Class-A-Roll to Happily Natural to enable ongoing mobile teaching kitchen resource to the Petersburg community. Partnership with Shalom Farms to provide produce weekly to the East End community at discounted rates at the Sarah Garland Jones Center. We also collaborate with Shalom Farms to provide an ongoing market at the Ramsey UMC Care-A-Van site to provide uninsured patients with access to healthy food, including the Produce Rx program.

Mental Health

Strategies	Progress
Develop comprehensive strategy and deploy new emergency, inpatient and outpatient mental health services	Across Bon Secours Richmond, we launched three new Partial Hospitalization Programs (two adult, one adolescent) to serve behavioral health patients who need more support than outpatient services, but do not need a psychiatric bed in the hospital. Patient utilization data for 2023 and 2024 is included below, with programs continuing in 2025. 2023 Adult Partial Hospitalization Programs <i>Richmond Community Hospital Adult Partial Hospitalization Program</i> # Patient Days in 2023: 2,395 # Individual Patients Served in 2023: 143 # Crisis Interventions in 2023: 97 <i>Southside Medical Center Adult Partial Hospitalization Program</i> # Patient Days in 2023: 1,595 # Individual Patients Served in 2023: 113 # Crisis Interventions in 2023: 26 2024 Adult Partial Hospitalization Programs <i>Richmond Community Hospital Adult Partial Hospitalization Program</i> # Patient Days in 2024: 2615 # Individual Patients Served in 2024: 129 # Crisis Interventions in 2024: 41 <i>Southside Medical Center Adult Partial Hospitalization Program</i> # Patient Days in Q1-Q3 2024: 1425 # Individual Patients Served in Q1-Q3 2024: 102 # Crisis Interventions in Q1-Q3 2024: 23 2024 Adolescent Partial Hospitalization Program <i>Saint Mary's Hospital Adolescent Partial Hospitalization Program</i> # Patient Days in Q1-Q3 2024: 1114 # Individual Patients Served in Q1-Q3 2024: 78 # of Crisis Interventions in Q1-Q3 2024: 59 The Partial Hospitalization Program work continues in 2025.
Expand access to mental health services through increased community-based screenings	We achieved our target of >90% depression screening across Bon Secours Richmond (including on Community Health's Care-A-Van) in 2023-2025. 100% of patients seen by the BSMART Behavioral Health team in EDs across BSR receive resource information for mental health supports in the community.
Invest in nonprofit service providers addressing mental health needs throughout the CHNA service area, particularly school-based programs	We invested \$1,389,000 in 2023-2025 to nonprofits that address mental and behavioral health.



Appendix

Appendix A

Publicly Available Data Sources

- American Community Survey (ACS)
 - U.S. Census Bureau (ACS: Table B01001, Table B09020, Table B15002, Table B19013; Decennial Census: Table P012)
- Centers for Disease Control and Prevention (CDC)
 - National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project (USALEEP)
 - Population Level Analysis and Community Estimates (PLACES) Data
- Centers for Medicare & Medicaid Services (CMS), Mapping Medicare Disparities Data
- Eviction Lab at Princeton University, Estimating Eviction Prevalence across the United States
- Feeding America, Map the Meal Gap
- National Center for Health Statistics via County Health Rankings

Appendix B

CHNA Survey Questions in English

Community Health Needs Assessment 2025

Please pick what language you want to use for this survey:

- English
- Spanish

(Paper copies of survey available in English, Spanish, Portuguese, Arabic, Dari and Pashto.

Please e-mail Kerrissa_macpherson@bshsi.org to request a paper copy and return instructions.)

Please answer these questions for where you live.

Where do you live? *(Please choose your city/county)*

- | | | |
|--------------------|------------------|-------------------|
| ▪ Amelia | ▪ Henrico | ▪ Prince George |
| ▪ Brunswick | ▪ Hopewell | ▪ Powhatan |
| ▪ Chesterfield | ▪ King and Queen | ▪ Richmond (City) |
| ▪ Colonial Heights | ▪ King William | ▪ Southampton |
| ▪ Dinwiddie | ▪ Lancaster | ▪ Surry |
| ▪ Emporia | ▪ Middlesex | ▪ Sussex |
| ▪ Goochland | ▪ New Kent | ▪ Other _____ |
| ▪ Greenville | ▪ Northumberland | |
| ▪ Hanover | ▪ Petersburg | |

Where do you see **positive progress** in your community over the last three years?

(Pick as many as you want)

- | | |
|--|---|
| ▪ Access to Health Care (family doctor, dental, mental health, telehealth) | ▪ Low Crime/Safe Community |
| ▪ Access to Healthy and Affordable Food | ▪ Non-Profits that help people |
| ▪ Access to Internet | ▪ Parks and places to play |
| ▪ Affordable Housing | ▪ Public Transportation |
| ▪ Affordable quality childcare | ▪ Trusted relationships with family and friends |
| ▪ Available Good jobs | ▪ Trusted community/religious leaders |
| ▪ Bike Paths and Sidewalks | ▪ Trusted local government |
| ▪ Clean Environment (air, water, soil) | ▪ Other: _____ |
| ▪ Good Libraries | ▪ I do not see any positive progress |
| ▪ Good Schools | |

What are the biggest **health needs** in your community?

(Pick the 3 you think are most important)

- Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)
- Asthma and other breathing issues (COPD, emphysema)
- Children's health concerns
- Chronic Health Diseases (Cancer, Diabetes, High blood pressure, heart disease/heart attack, obesity, etc.)
- Community Violence (Hate crimes/ extreme group violence, gangs, assaults, homicides, firearm related injuries, human trafficking, death)
- Dental Issues
- Drug, alcohol and tobacco use, Substance Use (including overdose), Smoking and Vaping
- Family Violence (Child Abuse/ Neglect, Elder Abuse, Domestic Violence, Intimate Partner Violence)
- Hearing or Vision problems
- Illness that spreads (Flu, COVID-19, hepatitis, TB, etc.)
- Mental Health (Depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)
- Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)
- Sexually transmitted infections (HIV/AIDS, chlamydia, gonorrhea, syphilis, etc.)
- Women's health concerns (prenatal/ maternal health, reproductive health, menopause, teenage pregnancy)
- Worksite injuries (access to protective gear/equipment, safety at work)
- Other: _____

What **social needs** cause health problems in your community?

(Pick the 3 root causes you think are most impactful.)

- Discrimination (being treated unfairly because you are different in some way, like racism or ageism)
- Education and literacy (being able to read, good schools)
- Employment and unemployment (unsafe conditions at work or can not find a job)
- Environment (clean water, clean air, etc.)
- Families and Communities (social isolation, violence between people that know each other, crime)
- Financial Hardship (finding a job that pays a living wage, being able to pay the bills, etc.)
- Healthcare services (access to hospitals and clinics, trust in providers like doctors and nurses)
- Housing (homelessness, affordable housing, utility payments, etc.)
- Problems related to food (finding healthy food, paying for food, etc.)
- Transportation (being able to get to work or to healthcare appointments)
- Other: _____

Have you or someone in your family experienced **violence** or seen violence in your community? (*Examples of violence could be things like domestic /intimate partner violence, sexual violence, community assaults or gun violence*)

- Yes
- No
- I don't want to answer this question

Have you or your family experienced **discrimination or bias** while receiving healthcare? (*Examples of discrimination could be things like racism or sexism or ageism*)

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ No ▪ I don't want to answer this question. ▪ Yes, If yes, pick as many as you want <ul style="list-style-type: none"> – Racism. (Someone has treated us in a negative way because of our race). – Sexism. (Someone has treated us in a negative way because of our sex). – Ageism. (Someone has treated us in a negative way because of our age). – Homophobia or Transphobia. (Someone has treated us in a negative way because of our LGBTQ+ identity). | <ul style="list-style-type: none"> – Because of a disability (Ableism). (Someone has treated us in a negative way because of our ability or dis/ability). – Because of where I'm from/the language I speak (Xenophobia). (Someone has treated us in a negative way because of our immigration status or our country of origin). – Other (My family and I have experienced a different form of discrimination and/or bias: _____) |
|--|---|

Is it hard to get the **healthcare or help you or your family need**?

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ If yes, what makes it hard? (<i>Pick as many as you want</i>) <ul style="list-style-type: none"> ▪ Costs too much money ▪ Don't have computer or internet for telehealth ▪ Can't find the help I need ▪ Help I need isn't available after I leave work/Unable to get time off work ▪ I don't have health insurance ▪ My health insurance is confusing ▪ Lack of transportation ▪ Lack of childcare | <ul style="list-style-type: none"> ▪ Long wait times to see a provider ▪ No vision or dental insurance ▪ No in-person interpreters ▪ No services/help in my language ▪ Not able to see the same provider each time ▪ Not enough doctors or providers where I live ▪ Places I want to go don't accept my health insurance ▪ It's hard to get answers from my providers after I leave (prescriptions, referrals, consults) ▪ Other _____ |
|--|---|

To help the community, hospitals and providers should focus on:

(Pick **3** you think are most important)

- Programs to prevent people from getting sick
- Programs to help people that are already sick
- Programs to help people avoid mental health problems
- Programs to help people that have mental health problems
- Programs to help people avoid substance use disorders/addiction
- Programs to help people that have substance use disorders/addiction
- Programs that help people get the help they need for things like housing, food, transportation, financial hardship, etc.
- Partnering with other nonprofits and clinics in the community
- Financial donations to other nonprofits and clinics in the community
- Other _____

Is there anything you want to add about the health needs in your community? _____

How did you hear about this survey?

- At a community event
- Email from a personal friend
- Email from a professional friend (friend at work)
- Employee newsletter
- Faith based organization (church, mosque, synagogue, etc.)
- Family member
- Flyer or QR code
- Free Clinic
- Hospital, Medical Office, Clinic
- Radio
- Social media (Facebook, Instagram)
- TV
- Other _____

What is your zip code?

- _____
- I don't want to answer

Please choose your gender identity (Pick as many as you want):

- Female
- Gender Non-Conforming
- Male
- Transgender
- I don't want to say

Please choose your age:

- 17 and under
- 18-25
- 26-35
- 36-45
- 46-55
- 56-64
- 65-74
- 75 +

Please choose your race(s) + ethnicity: *(Pick as many as you want)*

- American Indian/Alaska Native
- Asian
- Black/African American
- Hispanic/Latino
- Middle Eastern
- Native Hawaiian/Pacific Islander
- White
- Unknown
- I don't want to say

Do you have health insurance?

- I don't want to say
- No
- Yes *(select all that apply)*
 - From a job
 - That you buy for yourself (private)
 - Medicare
 - Medicaid
 - Tricare
 - Other/I don't know

What is your highest level of education?

- Elementary School or Middle School
- High School Diploma or GED
- Associates Degree, Technical Degree, or Trade School
- Some college (but did not graduate)
- Bachelor's Degree
- Master's Degree or higher
- I don't want to say

What is your family income in \$?

- \$30,000 or below
- \$31,000 to \$50,000
- \$51,000 to \$80,000
- \$81,000 to \$115,000
- More than \$116,000
- I don't want to say

CHNA Survey Questions in Spanish

Evaluación de necesidades de salud de la comunidad 2025

Elija el idioma que desea utilizar para esta encuesta:

- Inglés
- Español

(Hay copias impresas de la encuesta disponibles en inglés, español, portugués, árabe, darí y pastún. Envíe un correo electrónico a Kerrissa_macpherson@bshsi.org para solicitar una copia impresa e instrucciones de devolución).

Responda las siguientes preguntas sobre su lugar de residencia.

¿Dónde vive? (Elija su ciudad/condado)

- | | | |
|--------------------|------------------|-------------------|
| ▪ Amelia | ▪ Henrico | ▪ Prince George |
| ▪ Brunswick | ▪ Hopewell | ▪ Powhatan |
| ▪ Chesterfield | ▪ King and Queen | ▪ Richmond (City) |
| ▪ Colonial Heights | ▪ King William | ▪ Southampton |
| ▪ Dinwiddie | ▪ Lancaster | ▪ Surry |
| ▪ Emporia | ▪ Middlesex | ▪ Sussex |
| ▪ Goochland | ▪ New Kent | ▪ Otro _____ |
| ▪ Greenville | ▪ Northumberland | |
| ▪ Hanover | ▪ Petersburg | |

¿Dónde ve un **progreso positivo** en su comunidad durante los últimos tres años?

(Elija todas las que desee)

- | | |
|---|---|
| ▪ Acceso a atención de la salud (médico de familia, atención dental, salud mental, telesalud) | ▪ Buenas escuelas |
| ▪ Acceso a alimentos saludables y asequibles | ▪ Comunidad segura/con bajo crimen |
| ▪ Acceso a internet | ▪ Organizaciones sin fines de lucro que ayudan a las personas |
| ▪ Vivienda asequible | ▪ Parques y lugares para jugar |
| ▪ Cuidado de niños de calidad y asequible | ▪ Transporte público |
| ▪ Empleos buenos disponibles | ▪ Relaciones de confianza con familiares y amigos |
| ▪ Carriles para bicicletas y aceras | ▪ Líderes comunitarios/religiosos de confianza |
| ▪ Medioambiente limpio (aire, agua, suelo) | ▪ Gobierno local de confianza |
| ▪ Buenas bibliotecas | ▪ Otros: _____ |
| | ▪ No veo ningún progreso positivo |

¿Cuáles son las mayores **necesidades de salud** en su comunidad? *(Elija las 3 que considere que son las más importantes)*

- Afecciones del envejecimiento (enfermedad de Alzheimer, osteoporosis, pérdida de la audición, etc.)
- Asma y otros problemas respiratorios (EPOC, enfisema)
- Problemas de salud de los niños
- Enfermedades crónicas de la salud (cáncer, diabetes, presión arterial alta, cardiopatía/ataque al corazón, obesidad, etc.)
- Violencia comunitaria (crímenes de odio/violencia grupal extrema, pandillas, agresiones, homicidios, lesiones relacionadas con armas de fuego, tráfico de personas, muerte)
- Problemas dentales
- Consumo de drogas, alcohol y tabaco, consumo de sustancias (incluida la sobredosis), tabaquismo y vapeo
- Violencia familiar (maltrato y abandono de niños, abuso de personas mayores, violencia doméstica, violencia de pareja)
- Problemas auditivos o visuales
- Enfermedad que se propaga (gripe, Covid-19, hepatitis, TB, etc.)
- Salud mental (depresión, ansiedad, estrés, aislamiento social/sensación de soledad, suicidio, etc.)
- Alimentación (encontrar alimentos saludables, tener buenos hábitos alimenticios, saber cómo cocinar alimentos saludables)
- Infecciones de transmisión sexual (VIH/sida, clamidia, gonorrea, sífilis, etc.)
- Problemas de salud de la mujer (salud prenatal/maternal, salud reproductiva, menopausia, embarazo en la adolescencia)
- Lesiones en el lugar de trabajo (acceso a vestimenta/equipo de protección, seguridad en el trabajo)
- Otros: _____

¿Qué **necesidades sociales** causan problemas de salud en su comunidad? *(Elija las 3 causas principales que considere que tienen más impacto)*

- Discriminación (ser tratado de manera injusta porque es diferente de alguna manera, como racismo o discriminación por edad)
- Educación y alfabetización (ser capaz de leer, buenas escuelas)
- Empleo y desempleo (condiciones inseguras en el trabajo o no poder encontrar un trabajo)
- Medioambiente (agua limpia, aire limpio, etc.)
- Familias y comunidades (aislamiento social, violencia entre personas que se conocen, delincuencia)
- Dificultad financiera (encontrar un trabajo que pague un salario mínimo, poder pagar las facturas, etc.)
- Servicios de atención de la salud (acceso a hospitales y clínicas, confianza en proveedores como médicos y personal de enfermería)
- Vivienda (personas sin hogar, vivienda asequible, pagos de servicios públicos, etc.)
- Problemas relacionados con los alimentos (encontrar alimentos saludables, pagar alimentos, etc.)
- Transporte (poder ir al trabajo o a las citas de atención de la salud)
- Otros: _____

¿Usted o alguien de su familia ha experimentado violencia o ha visto violencia en su comunidad? (*Ejemplos de violencia podrían ser cosas como violencia doméstica/de pareja, violencia sexual, agresiones en la comunidad o violencia armada*)

- Sí
- No
- No quiero responder esta pregunta

¿Usted o su familia ha experimentado **discriminación o sesgo** mientras recibían atención de la salud? (*Ejemplos de discriminación podrían ser cosas como racismo, sexismo o discriminación por edad*)

- No
- No quiero responder esta pregunta
- Sí, Si la respuesta es sí, elija todas las que desee
- Racismo. (*Alguien nos ha tratado de manera negativa debido a nuestra raza*).
- Sexismo. (*Alguien nos ha tratado de manera negativa debido a nuestro sexo*).
- Discriminación por edad. (*Alguien nos ha tratado de manera negativa debido a nuestra edad*).
- Homofobia o transfobia. (*Alguien nos ha tratado de manera negativa debido a nuestra identidad LGBTQ+*).
- Debido a una discapacidad (*ableísmo*). (*Alguien nos ha tratado de manera negativa debido a nuestra capacidad o discapacidad*).
- Debido a mi lugar de origen/al idioma que hablo (*xenofobia*) (*Alguien nos ha tratado de manera negativa debido a nuestra situación migratoria o a nuestro país de origen*).
- Otro (*mi familia y yo hemos experimentado una forma diferente de discriminación y/o sesgo: _____*)

¿Es difícil obtener la **atención de la salud o ayuda que usted o su familia necesita?**

- No
- Sí
- Si la respuesta es sí, ¿qué hace que sea difícil? (*Elija todas las que desee*)
- Cuesta demasiado dinero
- No tengo computadora ni internet para telesalud
- No puedo encontrar la ayuda que necesito
- La ayuda que necesito no está disponible cuando salgo del trabajo/ no puedo ausentarme del trabajo
- No tengo seguro de salud
- Mi seguro de salud es confuso
- Falta de transporte
- alta de cuidado de niños
- Tiempos de espera prolongados para ver a un proveedor
- No tengo seguro odontológico ni oftalmológico
- No hay intérpretes en persona
- No hay servicios/ayuda en mi idioma
- No puedo ver al mismo proveedor cada vez
- Cantidad insuficiente de médicos o proveedores donde vivo
- Los lugares a los que quiero ir no aceptan mi seguro de salud
- Es difícil obtener respuestas de mis proveedores después de irme (recetas, derivaciones, consultas)
- Otros _____

Para ayudar a la comunidad, los hospitales y proveedores deberían enfocarse en:

(Elija **3** que considere que son las más importantes)

- Programas para evitar que las personas se enfermen
- Programas para ayudar a las personas que ya están enfermas
- Programas para ayudar a las personas a evitar problemas de salud mental
- Programas para ayudar a las personas que tienen problemas de salud mental
- Programas para ayudar a las personas a evitar adicción/trastornos al consumo de sustancias
- Programas para ayudar a las personas con trastornos por consumo de sustancias/adicción
- Programas para ayudar a las personas a obtener la ayuda que necesitan para cosas como vivienda, alimentos, transporte, dificultades financieras, etc.
- Colaborar con otras organizaciones sin fines de lucro y clínicas de la comunidad
- Donaciones financieras a otras organizaciones sin fines de lucro y clínicas de la comunidad

¿Hay algo que desee agregar sobre las necesidades de salud de su comunidad? _____

¿Cómo se enteró de esta encuesta?

- En un evento comunitario
- Por un correo electrónico de un amigo personal
- Por un correo electrónico de un amigo profesional (amigo del trabajo)
- En un boletín informativo para empleados
- En una organización religiosa (iglesia, mezquita, sinagoga, etc.)
- Por un miembro de la familia
- Por un folleto o código QR
- En una clínica gratuita
- En un hospital, consultorio médico, o en una clínica
- En la radio
- En las redes sociales (Facebook, Instagram)
- En la televisión
- Otros _____

¿Cuál es su código postal?

- _____
- No quiero responder

Elija su identidad de género (elijá todas las que desee):

- Femenino
- Género no conforme
- Masculino
- Transgénero
- No quiero decirlo

Elija su edad:

- 17 años y menos
- 18 a 25 años
- 26 a 35 años
- 36 a 45 años
- 46 a 55 años
- 56 a 64 años
- 65 a 74 años
- 75 años o más

Elija su(s) raza(s) + origen étnico: *(Elija todas las que desee)*

- Indígena estadounidense/nativo de Alaska
- Asiática
- Negra/afroamericana
- Hispano/latino
- Medio Oriente
- Nativo de Hawái/de otra isla del Pacífico
- Blanco
- Desconocida
- No quiero decirlo

¿Tiene seguro de salud?

- No quiero decirlo
 - No
- Sí (seleccione todas las opciones que correspondan)
 - De un trabajo
 - Que usted paga (privado)
- Medicare
- Medicaid
- Tricare
- Otro/No sé

¿Cuál es el nivel educativo más alto que ha alcanzado?

- Escuela primaria o secundaria
- Título de escuela secundaria o GED
- Título de asociado, título técnico o escuela de oficios
- Asistió a la universidad (pero no se graduó)
- Licenciatura
- Maestría o superior
- No quiero decirlo

¿Cuál es su ingreso familiar en \$?

- \$30,000 o menos
- Entre \$31,000 y \$50,000
- Entre \$51,000 y \$80,000
- Entre \$81,000 y \$115,000
- Más de \$116,000
- No quiero decirlo

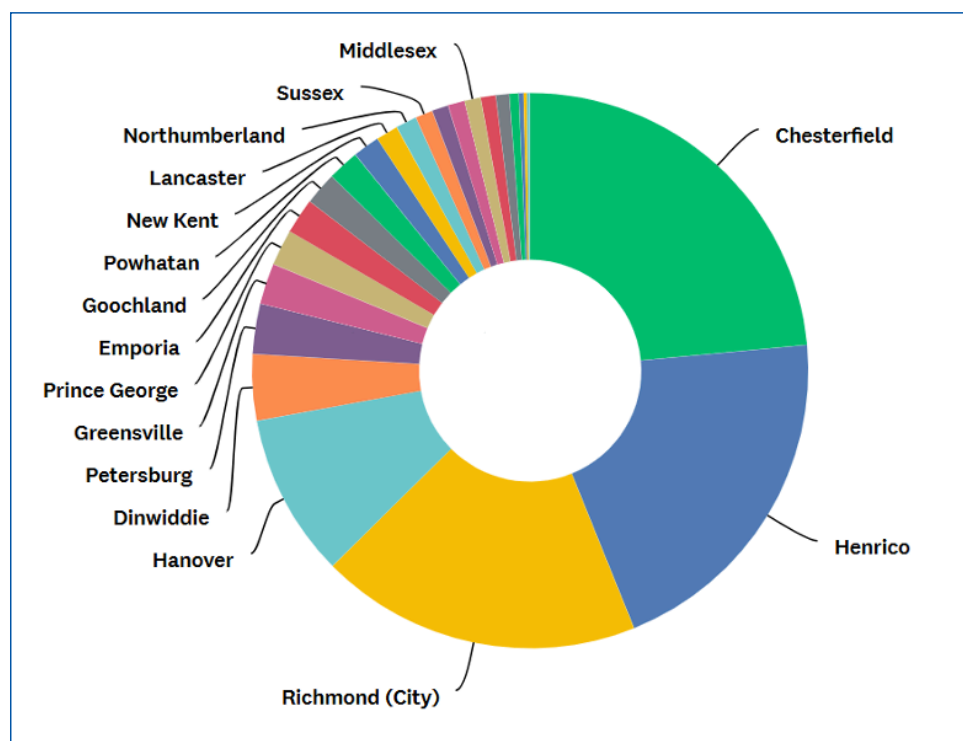
Appendix C

CHNA Results — Summary of all responses

CHNA Survey Results in English (Results are for All Respondents, n=2184)

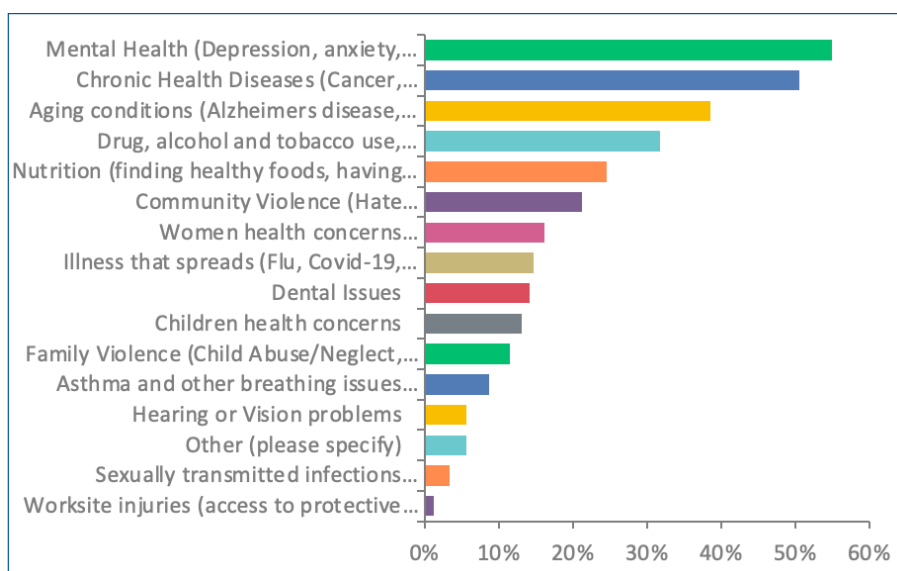
Note: Survey results can be subdivided by county/city, race, age, gender, language in which the survey was completed, socioeconomic level, and many other social drivers of health or demographics. If you're interested in receiving the raw data of survey results or would like to see the survey results for your specific geographic area or demographic, please email Kerrissa_macpherson@bshsi.org

Q1: Where do you live? (please choose your city/county)



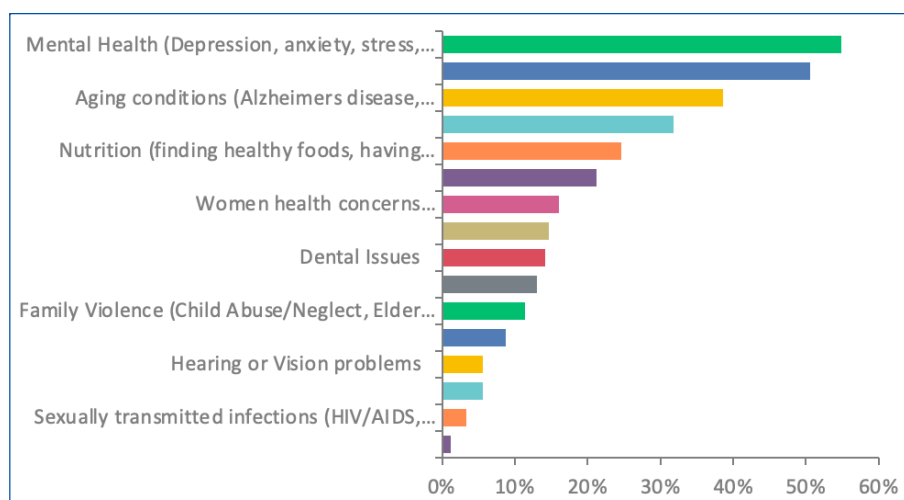
Survey Respondent County/City	Percentage	# of Respondents (n=2184)
Amelia	0.96%	21
Brunswick	0.55%	12
Chesterfield	23.53%	514
Colonial Heights	0.96%	21
Dinwiddie	3.85%	84
Emporia	2.06%	45
Goochland	1.92%	42
Greensville	2.38%	52
Hanover	9.52%	208
Henrico	20.38%	445
Hopewell	0.87%	19
King and Queen	0.18%	4
King William	0.78%	17
Lancaster	1.28%	28
Middlesex	0.96%	21
New Kent	1.56%	34
Northumberland	1.24%	27
Petersburg	2.93%	64
Prince George	2.11%	46
Powhatan	1.83%	40
Richmond (City)	18.68%	408
Southampton	0.27%	6
Surry	0.18%	4
Sussex	1.01%	22

Q2: Where do you see positive progress in your community over the last three years? (Pick as many as you want)



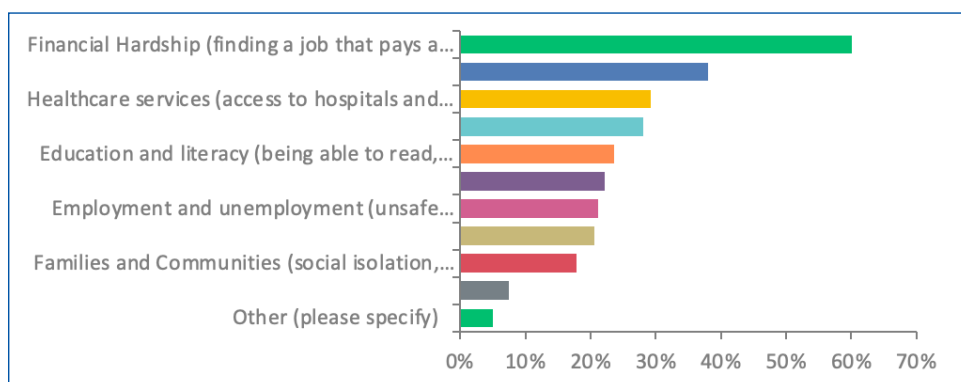
Positive Progress (Pick as many as you want)	Percentage	# of Respondents (n=2162)
Parks and places to play	36.08%	780
Good Libraries	35.66%	771
Access to Health Care (family doctor, dental, mental health, telehealth)	34.51%	746
Access to Internet	31.68%	685
Bike Paths and Sidewalks	28.77%	622
Trusted relationships with family and friends	28.68%	620
Good Schools	27.20%	588
Low Crime/Safe Community	25.67%	555
Non-Profits that help people	21.32%	461
Public Transportation	20.49%	443
Access to Healthy and Affordable Food	18.92%	409
Trusted community/religious leaders	16.33%	353
Clean Environment (air, water, soil)	13.74%	297
Available Good jobs	11.84%	256
I do not see any positive progress	11.70%	253
Trusted local government	8.79%	190
Affordable Housing	7.54%	163
Affordable quality childcare	3.47%	75
Other:	1.34%	29

Q3: What are the biggest health needs in your community? (Pick the 3 you think are most important)



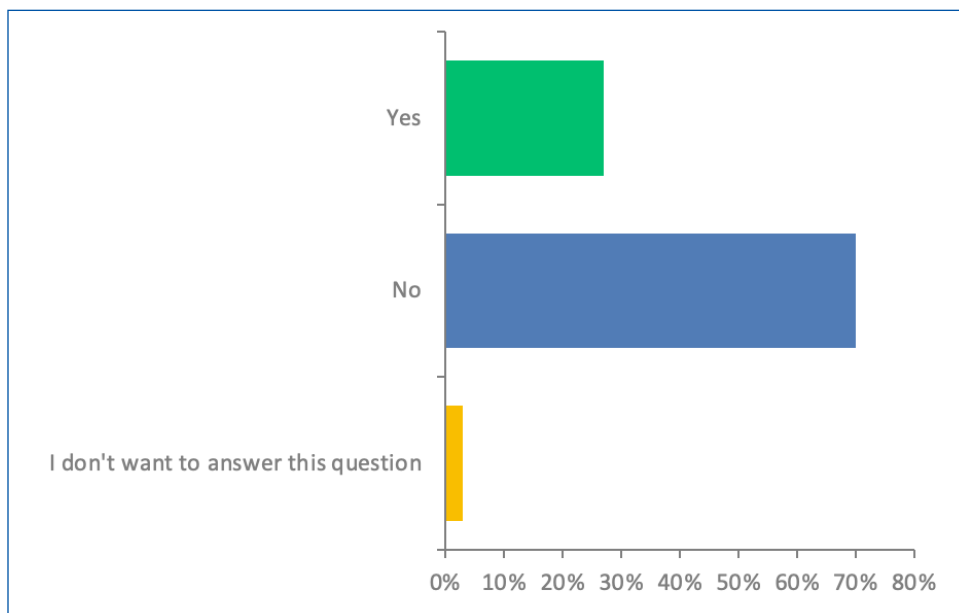
Top 3 Biggest Health Needs	Percentage	# of Respondents (n=2172)
Mental Health (Depression, anxiety, stress, social isolation/feeling lonely, suicide, etc.)	54.93%	1,193
Chronic Health Diseases (Cancer, Diabetes, High blood pressure, heart disease/heart attack, obesity, etc.)	50.55%	1,098
Aging conditions (Alzheimer's disease, osteoporosis, hearing loss, etc.)	38.63%	839
Drug, alcohol and tobacco use, Substance Use (including overdose), Smoking and Vaping	31.77%	690
Nutrition (finding healthy foods, having good eating habits, knowing how to cook healthy foods)	24.63%	535
Community Violence (Hate crimes/extreme group violence, gangs, assaults, homicides, firearm related injuries, human trafficking, death)	21.18%	460
Women health concerns (prenatal/maternal health, reproductive health, menopause, teenage pregnancy)	16.11%	350
Illness that spreads (Flu, COVID-19, hepatitis, TB, etc.)	14.73%	320
Dental Issues	14.18%	308
Children's health concerns	13.08%	284
Family Violence (Child Abuse/Neglect, Elder Abuse, Domestic Violence, Intimate Partner Violence)	11.46%	249
Asthma and other breathing issues (COPD, emphysema)	8.75%	190
Hearing or Vision problems	5.57%	121
Other (please specify)	5.57%	121
Sexually transmitted infections (HIV/AIDS, chlamydia, gonorrhea, syphilis, etc.)	3.36%	73
Worksite injuries (access to protective gear/equipment, safety at work)	1.20%	26

Q4: What social needs cause health problems in your community?
(Pick the 3 root causes you think are most impactful)



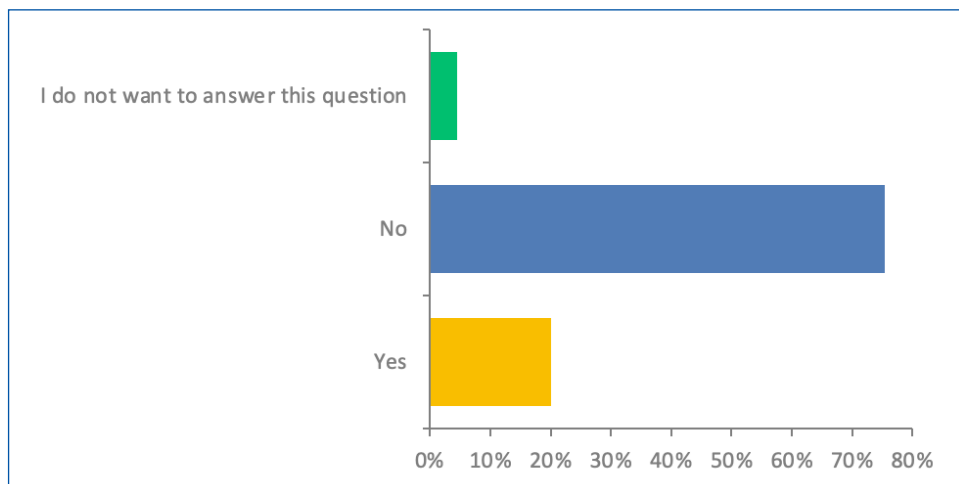
Top 3 Biggest Social Needs	Percentage	# of Respondents (n=2184)
Financial Hardship (finding a job that pays a living wage, being able to pay the bills, etc.)	60.03%	1,311
Housing (homelessness, affordable housing, utility payments, etc.)	38.05%	831
Healthcare services (access to hospitals and clinics, trust in providers like doctors and nurses)	29.21%	638
Discrimination (being treated unfairly because you are different in some way, like racism or ageism)	28.11%	614
Education and literacy (being able to read, good schools)	23.63%	516
Transportation (being able to get to work or to healthcare appointments)	22.12%	483
Employment and unemployment (unsafe conditions at work or can not find a job)	21.11%	461
Problems related to food (finding healthy food, paying for food, etc.)	20.51%	448
Families and Communities (social isolation, violence between people that know each other, crime)	17.90%	391
Environment (clean water, clean air, etc.)	7.51%	164
Other (please specify)	4.99%	109

Q5: Have you or someone in your family experienced violence or seen violence in your community? (Examples of violence could be things like domestic /intimate partner violence, sexual violence, community assaults or gun violence)



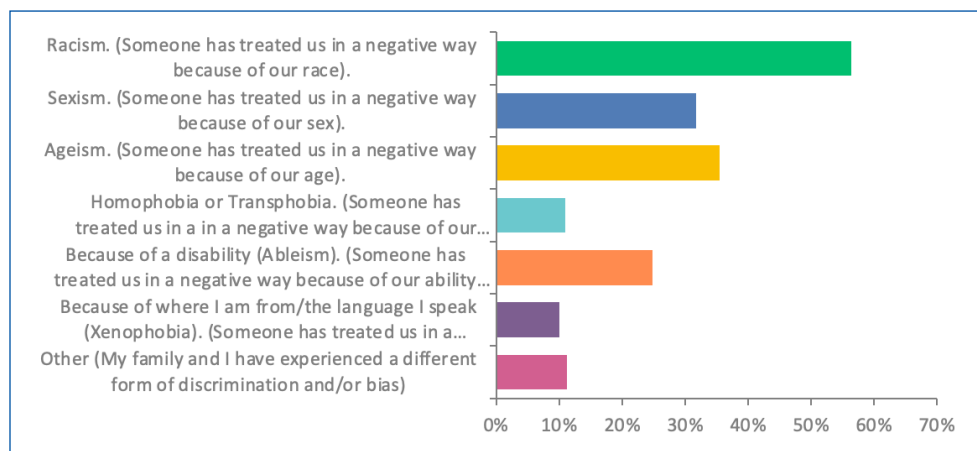
Experiences of Violence Y/N	Percentage	# of Respondents (n=2177)
Families and Communities (social isolation, violence between people that know each other, crime)	26.96%	587
Environment (clean water, clean air, etc.)	70.05%	1,525
Other (please specify)	2.99%	65

Q6: Have you or your family experienced discrimination or bias while receiving healthcare? (Examples of discrimination could be things like racism or sexism or ageism)

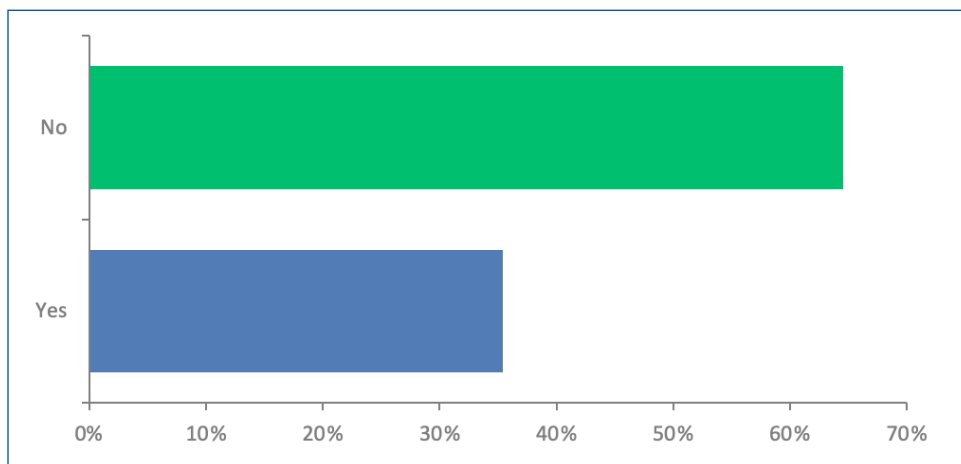


Experiences of Violence Y/N	Percentage	# of Respondents (n=2173)
I do not want to answer this question	4.42%	96
No	75.47%	1,640
Yes	20.11%	437

Q7: If you answered yes to the previous question, pick as many as you want:

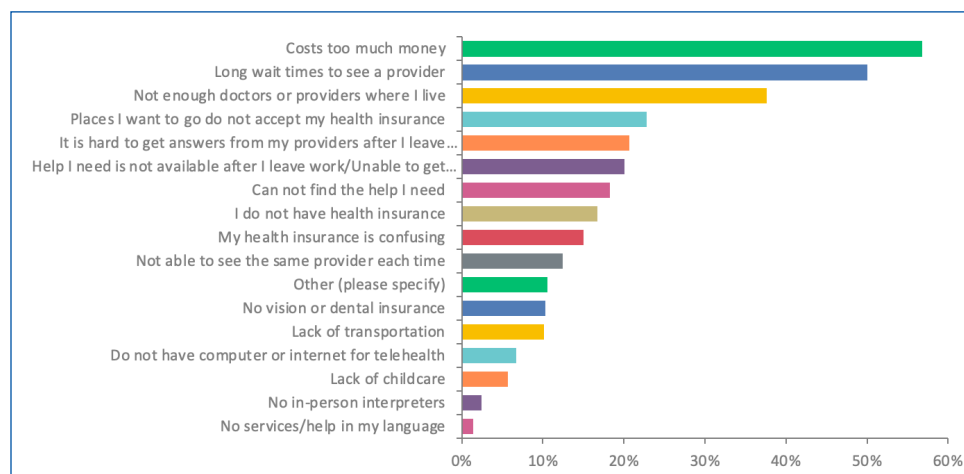


Experiences of Discrimination - Specifics if Y	Percentage	# of Respondents (n=420)
Racism. (Someone has treated us in a negative way because of our race).	56.43%	237
Sexism. (Someone has treated us in a negative way because of our sex).	31.67%	133
Ageism. (Someone has treated us in a negative way because of our age).	35.48%	149
Homophobia or Transphobia. (Someone has treated us in a in a negative way because of our LGBTQ+ identity).	10.95%	46
Because of a disability (Ableism). (Someone has treated us in a negative way because of our ability or disability).	24.76%	104
Because of where I am from/the language I speak (Xenophobia). (Someone has treated us in a negative way because of our immigration status or our country of origin).	10.00%	42
Other (My family and I have experienced a different form of discrimination and/or bias)	11.19%	47

Q8: Is it hard to get the healthcare or help you or your family need?

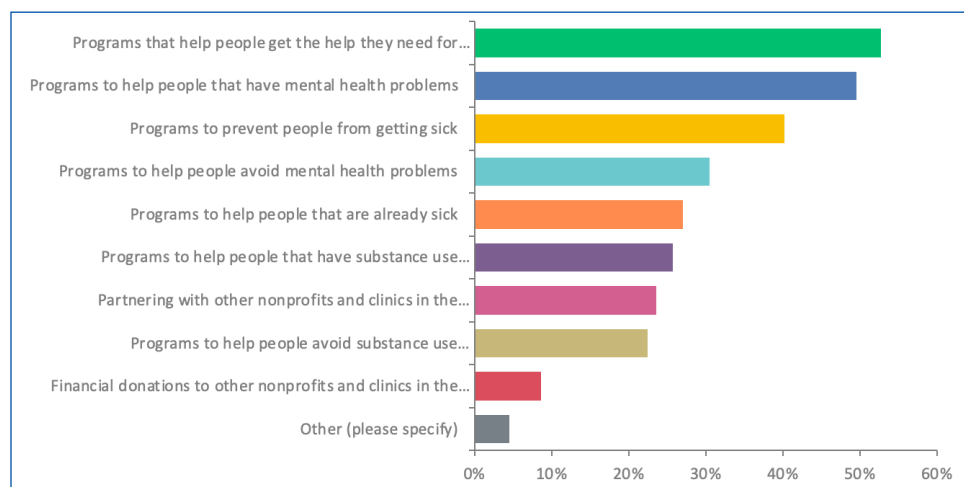
Difficulty in Health Care Access - Y/N	Percentage	# of Respondents (n=2133)
No	64.56%	1,377
Yes	35.44%	756

Q9: If yes, what makes it hard? (Pick as many as you want)



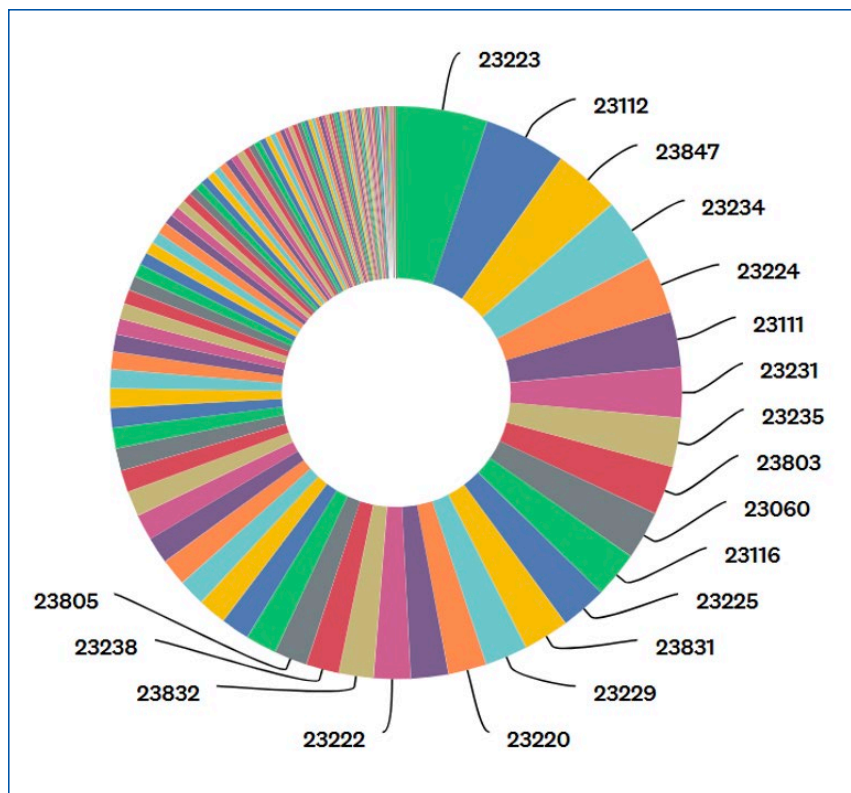
Difficulty in Health Care Access - Specifics if Y	Percentage	# of Respondents (n=701)
Costs too much money	56.78%	398
Long wait times to see a provider	50.07%	351
Not enough doctors or providers where I live	37.66%	264
Places I want to go do not accept my health insurance	22.82%	160
It is hard to get answers from my providers after I leave (prescriptions, referrals, consults)	20.68%	145
Help I need is not available after I leave work/Unable to get time off work	20.11%	141
Can not find the help I need	18.26%	128
I do not have health insurance	16.69%	117
My health insurance is confusing	14.98%	105
Not able to see the same provider each time	12.41%	87
Other (please specify)	10.56%	74
No vision or dental insurance	10.27%	72
Lack of transportation	10.13%	71
Do not have computer or internet for telehealth	6.70%	47
Lack of childcare	5.71%	40
No in-person interpreters	2.43%	17
No services/help in my language	1.43%	10

**Q10: To help the community, hospitals and providers should focus on:
(Pick 3 you think are most important)**



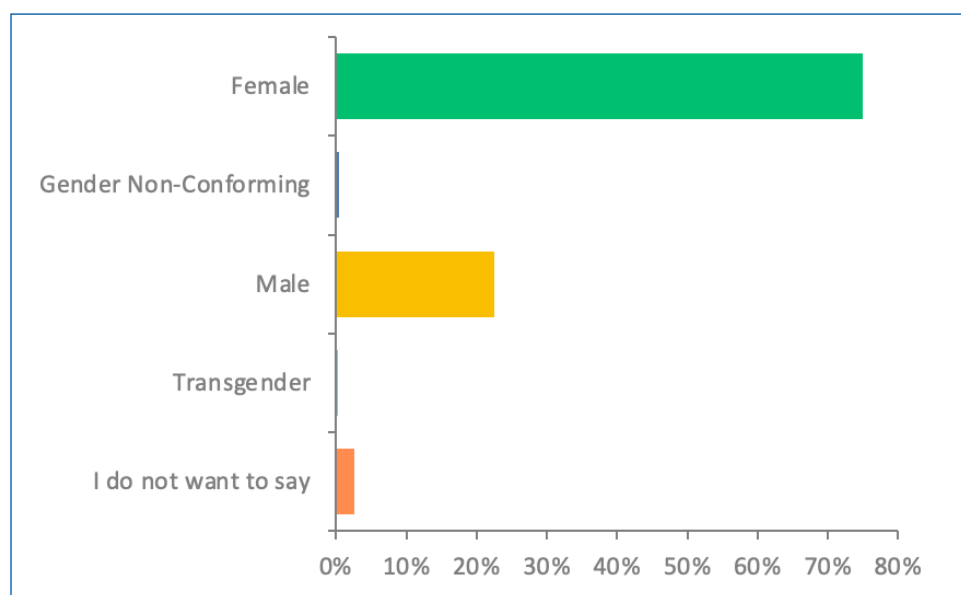
How Hospitals can help the community	Percentage	# of Respondents (n=2001)
Programs that help people get the help they need for things like housing, food, transportation, financial hardship, etc.	52.75%	1,066
Programs to help people that have mental health problems	49.53%	1,001
Programs to prevent people from getting sick	40.18%	812
Programs to help people avoid mental health problems	30.53%	617
Programs to help people that are already sick	27.07%	547
Programs to help people that have substance use disorders/addiction	25.68%	519
Partnering with other nonprofits and clinics in the community	23.60%	477
Programs to help people avoid substance use disorders/addiction	22.41%	453
Financial donations to other nonprofits and clinics in the community	8.61%	174
Other (please specify)	4.50%	91

Q13: What is your zip code?

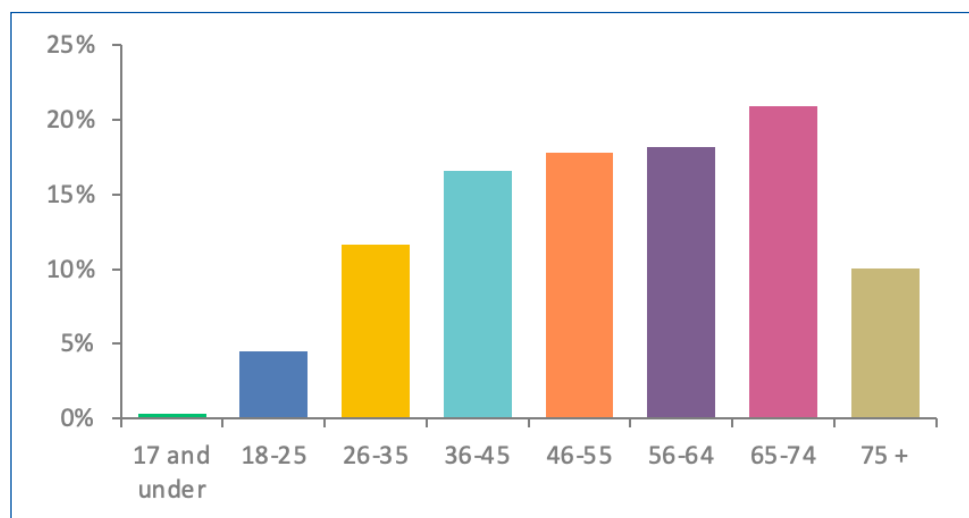


Top 10 Zip Codes	Percentage	# of Respondents
23223	5.19%	103
23112	4.59%	91
23847	3.83%	76
23234	3.63%	72
23224	3.23%	64
23111	3.13%	62
23231	2.82%	56
23235	2.77%	55
23803	2.77%	55
23060	2.72%	54

Q14: Please choose your gender identity (Pick as many as you want):

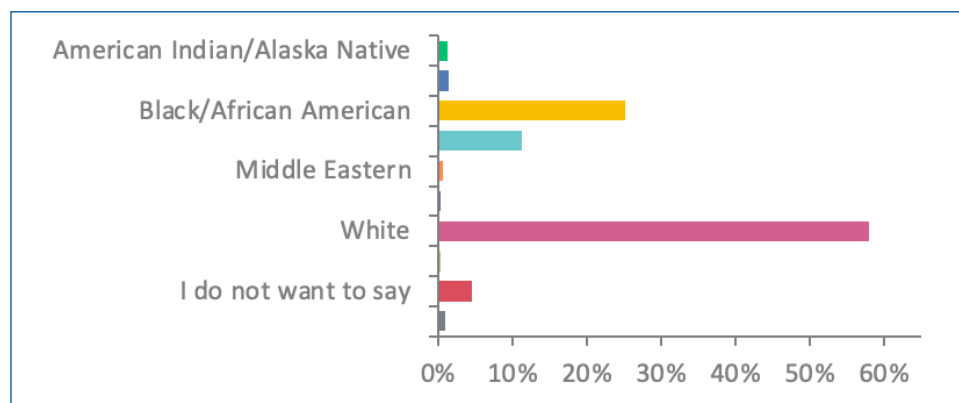


Gender Identity of Respondents	Percentage	# of Respondents (n=2017)
Female	74.91%	1,511
Gender Non-Conforming	0.35%	7
Male	22.46%	453
Transgender	0.30%	6
I do not want to say	2.53%	51

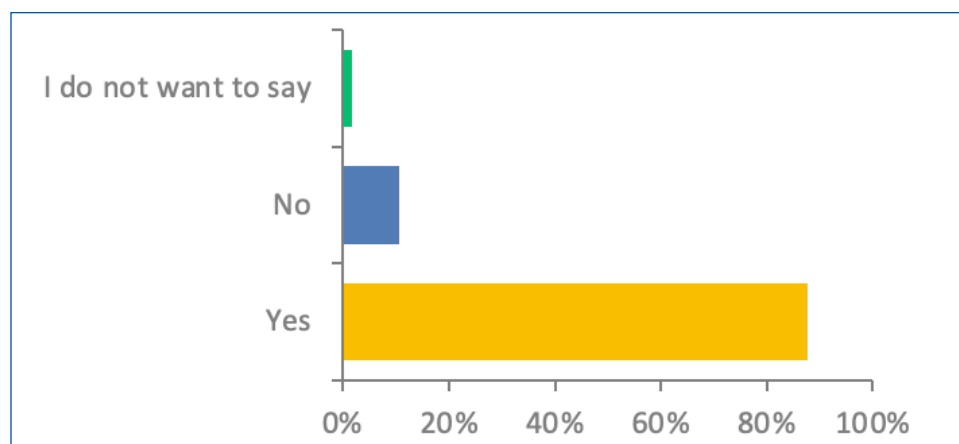
Q15: Please choose your age:

Age of Respondents	Percentage	# of Respondents (n=2006)
17 and under	0.35%	7
18-25	4.49%	90
26-35	11.67%	234
36-45	16.60%	333
46-55	17.80%	357
56-64	18.20%	365
65-74	20.89%	419
75 +	10.02%	201

Q16: Please choose your race(s) + ethnicity: (Pick as many as you want)

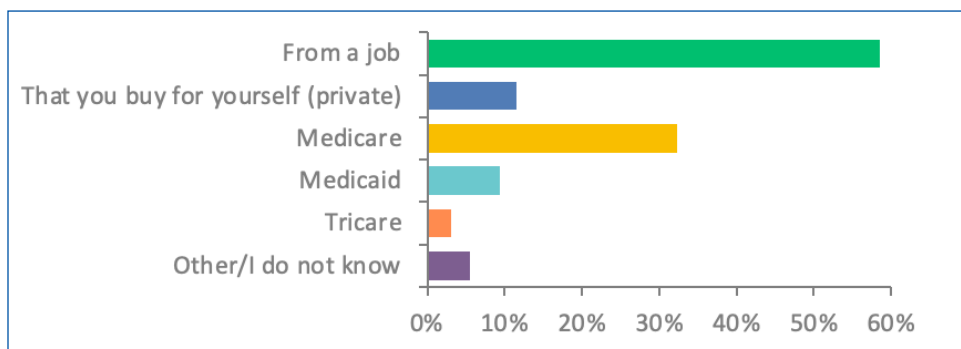


Q17: Do you have health insurance?



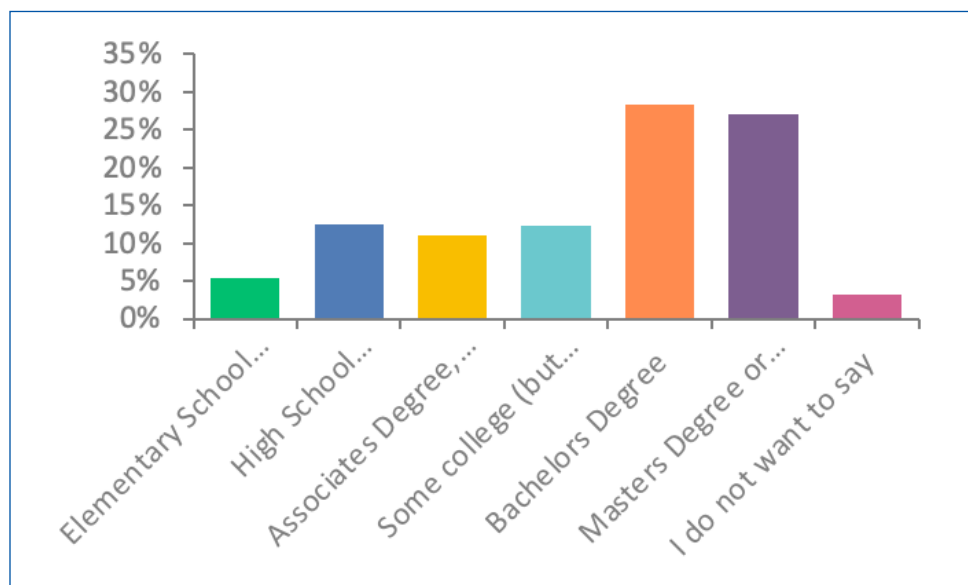
Insurance Status of Respondents	Percentage	# of Respondents (n=1702)
Yes	87.78%	1,774
No	10.59%	214
I do not want to say	1.63%	33

Q18: If yes, pick all that apply

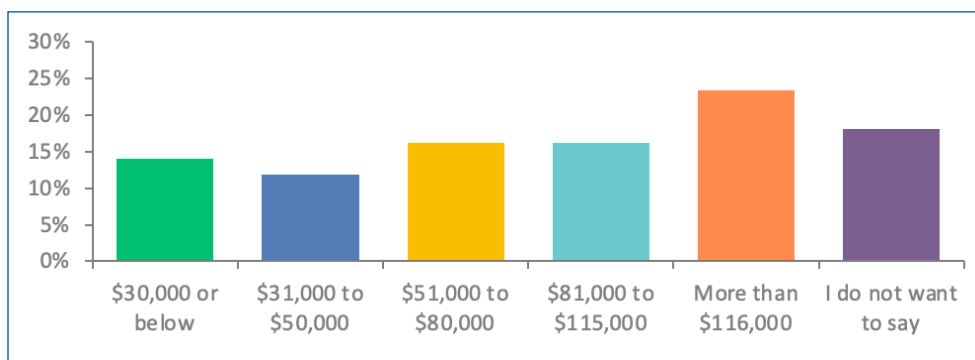


If Insured, Type of Insurance of Respondents	Percentage	# of Respondents (n=1702)
From a job	58.52%	996
Medicare	32.26%	549
That you buy for yourself (private)	11.57%	197
Medicaid	9.34%	159
Other/I do not know	5.58%	95
Tricare	3.11%	53

Q19: What is your highest level of education?



Education Level of Respondents	Percentage	# of Respondents (n=1986)
Elementary School or Middle School	5.34%	106
High School Diploma or GED	12.49%	248
Associates Degree, Technical Degree, or Trade School	11.08%	220
Some college (but did not graduate)	12.34%	245
Bachelors Degree	28.40%	564
Masters Degree or higher	27.09%	538
I do not want to say	3.27%	65

Q20: What is your family income in \$?

Income Level of Respondents	Percentage	# of Respondents (n=1989)
\$30,000 or below	14.08%	280
\$31,000 to \$50,000	11.92%	237
\$51,000 to \$80,000	16.24%	323
\$81,000 to \$115,000	16.24%	323
More than \$116,000	23.38%	465
I do not want to say	18.15%	361

Appendix D

Key Informant Interview Questions

1. Please tell us about yourself and your connections with your community – either where you live or where you work.
2. What are the strengths of your community?
3. What do you think are the biggest health needs facing your community? These can be needs such as mental health, chronic diseases, social issues like housing or food access, or something else that you see as a need.
4. What do you think are the root causes of these needs?
5. What would you implement if you “had a magic wand” to make one policy change? What are barriers/challenges you have run into related to this area, or what community resources are needed to address this need?
6. Thinking with a 3-year time frame (2025-2028), what is one measurable step that you think would help to address these root causes?
7. Is there anything we should be discussing today that we haven’t discussed?
8. Do you have any questions for us before we conclude this interview, and is there anyone you recommend that we engage with our CHNA process this year?

Focus Group Questions

Violence Focus Group Questions

- **Perceptions of Violence:** How do you perceive the levels of violence in your community compared to other communities? What factors do you think contribute to these perceptions? (What kind of violence are you talking about?)
- **What are things that have gotten better, what are things that have gotten worse, where are the gaps? What would you change?**
- **Community Resources:** If you or someone you know has experienced violence, did they try to reach out for resources? Were they available? Did they help? What would have helped?
- **If you “had a magic wand”** to change one thing about violence in the community, what would it be?

Women's Health Focus Group Questions

- **Perceptions of Women's Health:** How do you perceive women's health care across the communities that Bon Secours Richmond serves? What factors do you think are in play? What are top health needs or top SDOH issues women are facing?
- **What are things that have gotten better in the last few years, what are things that have gotten worse in the last few years, where are the gaps?**
- **Community Resources:** If you or someone you know is struggling with the needs we discussed in the last two questions, which community organizations do you think would be able to help them? How effective do you think they are? Are there additional resources (inside Bon Secours or outside) that could support the women you serve?
- **If you "had a magic wand"** to change one thing about women's health in the community, what would it be?

Mental Health Focus Group Questions

- **Perceptions of Mental Health:** How do you perceive the mental health in your community compared to other communities? What factors do you think contribute to these perceptions? (What kind of mental health needs are you talking about?)
- **What are things that have gotten better, what are things that have gotten worse, where are the gaps? What would you change?**
- **Community Resources:** If you or someone you know has a chronic or acute mental health need, did they try to reach out for resources? Were they available? Did they help? What would have helped?
- **If you "had a magic wand"** to change one thing about mental health in the community, what would it be?

Transportation Focus Group Questions

- **Perceptions of Transportation/Access:** How do you perceive transportation access across the communities that Bon Secours Richmond serves? What factors do you think are in play? What are top health needs or top Social Driver Of Health issues that are impacted by transportation needs?
- **What are things that have gotten better in the last few years, what are things that have gotten worse in the last few years, where are the gaps?**
- **Community Resources:** If you or someone you know is struggling with the needs we discussed in the last two questions, which community organizations do you think would be able to help them? How effective do you think they are? Are there additional resources (inside Bon Secours or outside) that could make a difference?
- **If you "had a magic wand"** to change one thing about transportation and transportation access in the community, what would it be?

Housing Focus Group Questions

- **Perceptions of Housing/Access:** How do you perceive housing access across the communities that Bon Secours Richmond serves? What factors do you think are in play? What are top health needs or top Social Driver Of Health issues that are impacted by housing needs?
- **What are things that have gotten better in the last few years, what are things that have gotten worse in the last few years, where are the gaps?**
- **Community Resources:** If you or someone you know is struggling with the needs we discussed in the last two questions, which community organizations do you think would be able to help them? How effective do you think they are? Are there additional resources (inside Bon Secours or outside) that could make a difference?
- **If you “had a magic wand”** to change one thing about housing and housing access in the community, what would it be?

Latinx Focus Group Questions (Note: These were translated into Spanish, and the discussion was led in Spanish by a Spanish speaking facilitator)

- What are the most important health issues affecting Latinx individuals in your community (e.g., chronic diseases, mental health, maternal health)?
- How do you usually find out about healthcare services available to you, and what challenges do you face when trying to access healthcare services?
- Have you or anyone you know faced discrimination or extra barriers when trying to access healthcare because of immigration status or because of being uninsured?
- In your experience, how welcoming and culturally sensitive are healthcare providers?
- Do you feel that mental health issues are treated with the same importance as physical health? Why or why not? Do cultural beliefs or traditions impact the way you and other Latinx individuals approach mental health and well-being?
- What would make it easier for you or others to engage in healthy behaviors (e.g., exercise, healthy eating)?
- Are there any specific challenges in understanding medical information (e.g., instructions, diagnoses) due to language barriers? How hard is it to get the help/healthcare you need in Spanish?
- Which community-based organizations or resources that have been helpful to you in managing health concerns?
- If you “had a magic wand” to improve one aspect of health in the Latinx community, what would it be?

Appendix E

Key Informant Interview and Focus Group Themes

Note on Theme Identification Process:

To minimize human bias from the theme identification process, the focus group and key informant interview transcripts and/or field notes were inputted into AI software, and the software was asked to identify key themes and to select relevant quotes directly from the transcripts and/or field notes.

Housing Focus Group

1. Barriers to Accessing Affordable Housing

- **Misinformation and Lack of Transparency:**
 - *"I commonly run into people that don't know where to go or where to look for lists, what organizations are running, what are the different affordable apartment buildings – they want a local or a central place where people can go for affordable housing options."*
- **Application and Screening Barriers:**
 - *"There are a lot more barriers than entry points: lease application fees, credit checks, background checks are barriers at the first step."*
 - *"Once approved since they have terrible credit they ask for double the rent and they reply I'm already paying rent where I am now. How do I find that money?"*

2. Challenges Faced by Vulnerable Populations (Older Adults, Families, and Disabled Individuals)

- **Older Adults and Families Reluctance to Move:**
 - *"Seniors stay in their houses even when it's not a good living situation (pest, mold, falling apart) because it's affordable."*
 - *"Seniors won't move because they like their doctor and he's close."*
 - *"If children are involved, they want to stay in the area where they are. Often, they want to stay in the area but when they get to the end of their rope they will go anywhere, they just want a roof over their head."*
- **Disability and Elderly Accessibility:**
 - *"Make housing vouchers more accessible for individuals with disabilities, and the elderly."*

3. Systemic Issues in Housing Policies and Practices

- **Unfair Evictions and Discriminatory Practices:**
 - *"If you file any type of complaint, you are putting a target on your back! I've executed my rights as a tenant and now they will not renew my lease and I have to move and come up with another downpayment and living paycheck to paycheck."*
 - *"It's an awful cycle. Paying for a hotel and cannot get ahead."*
 - *"Landlords are really trying to cover themselves and doing more strict screening. If you have an eviction on your record, it's like a scarlet letter."*
- **Lack of Support for Housing Arrears:**
 - *"Organizations that will support paying arrears, a balance from a previous situation because that is hanging out there they are not able to move forward."*
- **Housing that honors dignity:**
 - *"I would make our income-based housing stock a lot more dignified to break the stigma. They deserve a place that is clean, has a door, greenspace, not overlooking a jail."*

Transportation Focus Group Themes and Quotes –

1. Impact of Free Transit and Accessibility

- *"Thumbs up – making [GRTC] free was a huge change in the ridership of the system. We can't go back! It's game changing to have it free – I never rode it until it was free!"*
- *"Thumbs up – I'm physically unable to drive, so for me, the bus is a huge freedom. I can go to work, I can get to entertainment, and it frees up my budget for rent/groceries. The free fare is a huge factor."*
- *"I sold my car because the bus was free! As a senior, it helps me to be able to get around the city."*

2. Barriers to Access and Inefficiencies in the System

- *"Thumbs down – Henrico county...I have to walk 30 minutes without a sidewalk to get to a bus stop...I would like to ride the bus more, but because of those factors, I'm forced to drive."*
- *"You can add more than an hour to your transit time if you take the bus...We still have a ways to go."*
- *"I'd like to see the buses go further into the counties and down to Petersburg."*
- *"More routes so that you don't have to do the 30-40 minute walk after you get off at your stop."*
- *"Better sidewalks and better walkways."*

3. Healthcare Access and Transportation Barriers

- *"My father had a stroke a few years ago, and his transportation canceled on him, and so he missed his appointment and was charged a no-show fee."*
- *"I had to change providers due to transportation barriers."*
- *"I had to miss a doctor appt because where the bus dropped me off I had to walk a mile on an unsafe road (no sidewalk) pressed up against thorns in crazy heat, and I couldn't do it."*
- *"Even with the bus, I have to bring a bike or a skateboard along, and that's not a valid option if it's 113 degrees, or pouring rain, to make it the last mile."*
- *"GRTC has a disability transit option, but it's not very reliable...they also created a LINK transit option. It's a 'zone' door-to-door option."*

Violence Focus Group

1. Influence of Environmental and Socioeconomic Factors on Violence:

- Participants highlight how socioeconomic factors, such as financial hardship, trauma, and stress, contribute to violent behavior. The environment people grow up in is seen as a major factor in whether they turn to violence.
 - *"It usually happens when people don't have money to pay the bills. You don't have money, you start coming at me."*
 - *"What do you think most violence stems from? Drugs. Trauma. Multiple different places. Exposed as a child. Mental issues. Substances. Fear. Stress. Survival."*
 - *"Some areas have gotten better, but I don't think violence has gotten better. The violence just gets pushed to a different area."*

2. The Role of Media and Culture in Glorifying Violence:

- The influence of media, particularly music, is frequently mentioned as a source of violence glorification, especially among youth. Participants argue that rap music and other forms of media promote violence as a lifestyle, which can encourage young people to emulate it.
 - *"I blame rap music that tells you that goes out and catch as many bodies as you can."*
 - *"Kids are being glorified for catching a body, it's a lifestyle, and I'm like 'Dude, you don't realize, this isn't a life.'"*
 - *"This music is brainwashing youth...he did all these murders and now he's rich and famous, so maybe I need to do that too."*

3. Need for Community Support and Intervention Programs:

- There is a strong call for more community-based programs, mentorship opportunities, and youth outreach efforts to break the cycle of violence. Participants emphasize that children need positive influences and alternatives to violent behaviors, with several suggesting after-school programs, mentorship, and peer recovery support.
 - *"We need more groups like this, more Big Brother programs, something to teach the kids that it's not ok to be killing people."*
 - *"You have to go to prison sometimes to have someone sit down and talk with you about this stuff. What is it to be a man or a woman, not a gangster."*
 - *"I would tell them that there's more to life than the streets. You don't know what it's like being in that cell."*
 - *"Don't wait for kids to come to you – go to them. Find them in the projects playing basketball or in the park. Street outreach is needed."*
 - *"We need better, stricter gun laws. They need to strengthen the gun laws. People having guns – 3D printing guns. We need stricter laws on guns and knives."*

Women's Health Focus Group Themes and Quotes

1. Barriers to Access and Healthcare Deserts

This theme addresses the lack of accessibility to healthcare in certain areas, especially for women, and highlights the struggles women face in reaching providers or getting the care they need due to location, transportation, and financial barriers.

- *"Opening up the RCH office has opened my eyes to the importance of 'access to care' and healthcare deserts. It is amazing to meet the women in these areas that are so thankful that they can reach their doctor on the bus in their own backyard."*
- *"In the Latinx community, Providers are usually found through word of mouth/through a provider or friend. How can we make appointments more accessible? How can they make the appointment themselves? How can they pay for it?"*
- *"Transportation is a huge need. Sometimes they take a ride with someone that speaks their language but pay \$50 (that they may not have)."*

2. Social Drivers of Health (SDOH) and Mental Health Needs

This theme focuses on the social factors that influence women's health, such as social support, mental health, and the challenges of navigating the healthcare system. Mental health is highlighted as a critical area that needs more attention and resources.

- *"Women are always taking care of other people, and so many of our patients aren't taking care of themselves. We see a lot of gaps in care – not getting mammograms or Pap smears...not taking care of their mental health."*
- *"Social needs are a huge deal, and mental health is as well."*
- *"We need a social worker to help us with this."*
- *"Increasing mental health services. (Outpatient, inpatient, etc.) Including mental health access for uninsured patients."*

3. Need for Systemic Changes and More Coordinated Care

This theme emphasizes the desire for a more integrated and coordinated healthcare system, with an emphasis on improving access to services, including more flexible clinic hours, care coordination, and the development of one-stop-shop services for women.

- *"We are now offering Saturday clinics, which has helped working moms that can't get there on a M-F 9-4 regular clinic."*
- *"I'd love to see home visits in the future."*
- *"Care coordinators in practices...now that we do, it has been a huge impact to do the handoff from the provider to social work and to connect them with services right away."*
- *"Saturday clinic, evening clinic, it just makes sense. Yes, we need buildings/staff. It's easier said than done, but it's essential."*

Mental Health Focus Group Themes and Quotes

1. Perceptions of Mental Health and Access to Resources

- Mental health issues, including anxiety, depression, and serious mental illnesses, are on the rise across various age groups, with younger populations (middle school and up) particularly struggling with coping skills.
 - *"Anxiety and depression is very high amongst a lot of people (all ages), from pretty young (definitely middle school – even elementary school!) all the way to geriatric populations."*
- Chronic mental illnesses have worsened, leading to more aggression and difficulty in finding appropriate care and placements.
 - *"Our chronically mentally ill patients are significantly worse than they were a few years ago. There is a lot more violence/aggression."*

- Housing instability and financial insecurity are tightly linked to mental health struggles.
 - *"Anyone that is homeless is going to be depressed! Housing is a huge piece of it, as is financial instability."*

2. Improvements and Gaps in Mental Health Services

- Some resources, such as Crisis Stabilization Units and Partial Hospitalization Programs, have been beneficial, providing more timely access to care, especially for Medicaid/Medicare.
 - *"Having our 3 Partial Hospitalization Programs has been a Bon Secours gamechanger... It's very helpful that Bon Secours takes pretty much any insurance in our PHP."*
- However, homelessness, staffing shortages, and issues with telehealth (limited access to technology) have created barriers to care.
 - *"Homelessness has increased. ... There's a pro/con to this: because of COVID we now have virtual therapy/virtual provider appointments. But not all of our patients have phones/technology access."*
- The mental health system is perceived as broken, with people relying on emergency departments to meet basic needs, as well as confusion around available services.
 - *"The system is broken. People are utilizing the ER to get their basic needs met."*
 - *"A lot of people don't know about CSBs, for example. A lot better education could be done about what exists."*

3. The Need for Structural Change and Compassionate Care

- A major desire for change is more humanized care for mental health
 - *"I just wish that mental health was more humanized. Particularly in the hospital setting, we see people that are really sick. I wish people viewed mental health needs the same way we view physical health needs."*
- Barriers to care due to insurance status and geographic location create inequities in access.
 - *"If there was better care out there that everyone could access in the same way, then that would help the system... Depending on where you live, and your insurance, is going to determine whether you can access CSB programs."*

Latinx Community Health Focus Group Themes and Quotes –

Theme 1: Mental Health: Underprioritized and Stigmatized

- *"Mental health, if a mother is well with her mental health, then with her children, she will be okay, will be able give her children something better."*
- *"There is a fear of 'what others may say'... that's why we don't search for help. Hopewell has a very good clinic... It was hard but beautiful experience because I learned of two things: to let him speak, let him be himself, and know how to listen to him."*
- *"There are little things like 'if I tell mom she will hit me', 'if I tell dad he will not understand me'."*

Theme 2: Accessing Healthcare/Community Services, including Financial Strain & Food Deserts

- *"The clinics in my area, it is very rare to have Spanish speakers. They have never treated me badly, but I have referred people and they have told me they are not attended well."*
- *"If you get sick at night, and the next day you go to the clinic, without an appointment you will not be seen... even if you pay."*
- *"They told me if I needed economic help in order to get the surgery... But after I was operated, the big bills came... I tried calling and calling and they never picked up the phone again."*
- *"I went to the clinic with a strong pain, and they did not see me... if you don't have an appointment, they will not see you."*
- *"The bill was like that about \$2,500 and something... They send us to collections."*
- *"I go to the Care-A-Van Bon Secours. That is where I go and they have helped me a lot."*
- *"Thanks to God, I have always had an interpreter, especially because there are so many technical terms that you do not understand."*
- *"I went to the James House...they treated me very well...211 helps us get help for many things."*
- *"The junk food is the cheapest food there is."*
- *"There are times where Yes, I will admit that [I eat fast food] because of work, for something fast, anything...there is no time, when they get home after working 12 hours... they are tired."*

Theme 3: Discrimination, Cultural Sensitivity, Healthcare Providers' Attitudes

- *"I felt discriminated against because I do not have a social [security number] or insurance, it's like 'you figure out what you will do.'"*
- *"When I would take my daughter to the dentist... they would have me there for 20 minutes waiting just to tell me that they would not treat my daughter."*
- *"Sometimes if you are Latino, you have to wait before someone of their same race or is white, they will be attended first."*
- *"The people that work there are depressingly sarcastic. They treat you with ugly faces... I went to the other clinic... they attended me perfectly."*
- *"He began saying things, very ugly things... he would disconnect it very mad saying things."*
- *"In Petersburg, it is not only the Hispanic immigrants, there are also Africans, Haitians... there is no language available for them, if it is not in English there is no other."*
- *"No, no they do not treat them the same... for the immigrant there is not a clinic like that. They will not speak their native language."*

Key Informant Interview Themes/Quotes

Note: Individualized Key Informant Interview Themes/Quotes are not shared here to protect anonymity, but additional de-identified key informant interview information is available upon request by e-mailing Kerrissa_macpherson@bshsi.org. Key informant interviews were considered during the CHNA 2025 need prioritization process.

Overarching themes identified by key informant interviewees include the following. (Please note, some themes do not include quotes to protect the anonymity of the key informant interviewees).

- **Disability and Healthcare Accessibility**
 - *"Access and accessibility are very big challenges... from not having access to a gym to medical offices not having a wheelchair scale for disabled patients."*
- **Financial Barriers to Healthcare Access**
 - *"Healthcare is one of the only industries where you walk in and you don't know how much it is going to cost when you walk out."*
- **Healthcare Navigation and Access Challenges**
 - *"There are so many great resources and programs and things for patients – people are truly trying to make things better – but the work of connecting the people who need the services with the people offering the services seems to be harder and harder."*

- **Housing Affordability/Instability**

- *"Housing is at the top of the list. Housing IS healthcare."*
- *"Rent is really really expensive in Richmond, even for high income professionals, let alone those with lower socioeconomic status."*
- *"If I had a magic wand, I would make it so that every patient doesn't have constant low grade anxiety (or high grade anxiety) about where they're sleeping that night."*
- *"It costs a LOT less to pay for stable housing than it does to pay for ED utilization."*
- *Importance of Community Connection and Social Support*
- *"If we could get the patients the medications they need in a timely manner, it would reduce hospitalizations and potentially delay long term complications of the diseases. First - getting them seen sooner, second - being able to get them their medications without all the barriers (insurance companies, cost, etc.) If we had social workers...it would decrease the amount of times patients have to come to clinic, and prevent the wait time as well."*

- **Mental Health as a Primary Concern**

- *"Mental health is the big one. The resources are over-stressed. As a physician, I spend 80% of my visits addressing mental health issues, I find that I'm extremely frustrated when I don't have other resources (like psychologists or psychiatrists) to reach out to."*
- *"The first thing is that mental health doesn't pay very well...you're not going to fill the supply curve even if there is a ton of demand unless someone is altruistically going into this."*
- *"The needs for adolescents/children, it is even worse. If you have a child with Medicaid, the wait can be up to a year for seeing a psychiatrist depending on where you look."*
- *"Finding support for a child with significant mental health challenges is VERY difficult here in Richmond."*
- *"We are seeing people coming in sicker than we have ever seen them before. This has a lot to do with the fact that we were being more proactive in the past, but due to staffing challenges we are now being more reactive."*

- **Preventive Health and Education**

- *"Really trying to get all of Central Virginia into lifestyle modifications...preventative health education to all of the region would have a huge impact 5-10 years down the road."*

- **Rural Health**

- *"These [rural] communities are each very tight knit and close. They really work to serve each other." "In some of the rural areas, there can be less [opportunity], so it makes it difficult to secure what you need in order to afford a home, food, clothing, etc."*

- **Social and Structural Barriers to Health (SDOH/StDOH) and the Need for Policy Change**

- *"We saw awful things during the pandemic, but we also saw imagination...that resulted in increases to the child tax credit, supplemental income...We saw dramatic drops in poverty and stress."*
- *"What you see as a result of that lack of power is poverty, economic disinvestment, and that is a negative feedback loop (bi-directional) for these root causes."*
- *"The health needs are broadly connected to wildly inequitable access, whether that is access to healthy food, access to safe neighborhoods, access to quality teaching in a temperature regulated building that doesn't have mold and asbestos. What results from that is some people are on level ground and some people are in quicksand. When you're in quick sand and trying to figure out how you're going to find food for dinner tonight, you're not able to make decisions about preventative health care, or may not have the time and capacity for access to mental health providers, or transportation to get to appointments, or a job where you have the flexibility to get to an appointment at the time that a healthcare office is open. Everything is compounded by the broader structural issues."*

- **Support for Healthcare Providers and prevention of Moral Injury**

- *"Something more tangible: we need to make the system work better for our providers. The most valuable asset...is the people who work here. I have watched all the things we have talked about above (financial stressors for patients, increased demand on [provider] time, etc.) take a huge toll on the workforce. If I could suggest a change, it's not a yoga class or a neck massage, although those are helpful and matter. What I really want to see is systemic change."*

- **Systemic Inequities Facing the Latinx community**

- *"There is a true lack of Spanish-speaking mental health support in Richmond, which is surprising for a city this size."*

- **Transportation**

- *"Transportation...It really impacts patients being able to access...everything."*

- **Trauma and its Wide Ranging Impact on the Community**

- *"The population that we serve is traumatized. It seems like every patient I work with has trauma. It's not just that person that has trauma – their family, their community is also traumatized.*
- *"Crime of any magnitude has no name on it. A bullet has no name on it. When it sprays out, whoever is in the way gets hit."*
- *" Although the majority of the community is resilient, they also feel a sense of a hopelessness. They feel on their own. All of this contributes to their mental health, which is a major factor in the community that is traumatized and oppressed. That breeds violence, especially domestic violence. They are irritated/frustrated, they get aggressive because they can't deal with their emotions, and they feel like tearing up everything in sight. They feel like no one is working with them."*

- **Unconscious Bias and Attitudes toward People Receiving Healthcare**

- *"If we are hearing about bias that is being experienced by patients, there is certainly a need for quality professional development for employees (and that is not mandatory online slides). There is a level of depth needed to help people to have the self-reflection needed. There is an internal piece that is needed, but there is also an external focus in terms of "How do we comprehensively build trust?" Is that by supporting more community navigators, is that by supporting more local events. One of the challenges is that it takes years to build trust and it takes 5 seconds to break trust."*

Appendix F

Additional community resources

- **Access Now:** Volunteer Specialty network for free clinic patients.
- **Anna Julia Cooper School:** This faith-based middle school in Richmond's East End serves youth with limited resources.
- **Area Congregations Together in Service (ACTS):** ACTS provides funds, support and other resources to those living in the Greater Richmond area who are at risk of losing their housing, utilities or transportation. Those served by ACTS do not qualify for government prevention assistance due to eligibility requirements and often fall through the cracks.
- **Armstrong Priorities Freshman Academy:** Armstrong Priorities Freshman Academy will identify students entering ninth grade at Armstrong High School below grade level and will provide instruction in math and English to bring them up to grade level by the tenth grade.
- **Bay Aging:** Bay Aging is a premier provider of programs and services for people of all ages in the Northern Neck Region. Formed in 1978, Bay Aging is diverse in the programs it offers through three major divisions: Community Living, Bay Transit and Bay Family Housing.
- **Better Housing Coalition:** The Better Housing Coalition ensures every citizen in the Richmond region, regardless of their economic status, has good choices in where they live and opportunities to reach their fullest potential.
- **Boys and Girls Club:** The Club, which has an emphasis on Richmond's East End, provides life-skills training and serves more than 500 members with a daily participation of 150.
- **Boys To Men Mentoring:** This organization works within seven school districts in the greater Richmond and Tri-City area. It provides school- and community-based group mentoring circles, supporting young men in their efforts to become more mature, responsible and accountable.
- **CancerLINC (Legal Information Network for Cancer):** CancerLINC helps cancer patients and their families overcome legal and financial obstacles.
- **Center for Nonprofit Excellence:** This organization develops the capacity of nonprofits through education, information sharing and civic engagement.
- **Challenge Discovery Projects:** Challenge Discovery Projects provides direct services to over 1,600 at-risk youth in Richmond, with an emphasis on the East End. They are committed to improving the emotional health and well-being of children and their families through programs that promote self-worth and positive, healthy relationships.

- **Children’s Home Society of Virginia:** Children’s Home Society of Virginia is a full-service, private, nonprofit 501(c)(3), non-sectarian licensed child-placing agency, and one of Virginia’s oldest adoption agencies.
- **ChildSavers:** ChildSavers provides a fundamental commitment to the mental well-being of children and the positive bond between adult and child. ChildSavers supports this with clinical treatment, education and training services, with an emphasis on Richmond’s East End.
- **Circle Center Adult Day Services:** Circle Center provides comprehensive services dedicated to the well-being of older adults and their caregivers in RVA. They offer enriching programs of socialization, healthy aging and nutrition administered by a qualified team of health care professionals, recreational therapists, physical and speech therapists, and social workers.
- **Comfort Zone Camp:** Comfort Zone Camp is a nonprofit bereavement camp that transforms the lives of children who have experienced the death of a parent, sibling or primary caregiver.
- **Commonwealth Catholic Charities:** This organization provides quality, compassionate human services to all people, especially the most vulnerable, regardless of faith.
- **Commonwealth Parenting Center:** Commonwealth Parenting Center is a resource for parenting education.
- **Communities in Schools (Chesterfield, Henrico, Petersburg, Richmond):** Communities in Schools positions site coordinators inside schools to assess students’ needs and provide resources to help them succeed in the classroom and in life.
- **Community Coalition of Sussex Virginia:** This grassroots organization supports the needs of residents of Sussex County.
- **Creighton Family Resource Center:** Creighton Family Resource Center works in partnership with Richmond City Health Department and Richmond Redevelopment & Housing Authority. They deliver health screenings, checkups, health education, nutrition, parenting classes, budget management and community resource information to an underserved community.
- **Cristo Rey Richmond High School:** Cristo Rey Richmond is a Catholic learning community that educates young people of limited economic means to become men and women of faith, purpose and service. Through a rigorous college preparatory curriculum, integrated with relevant work-study experience, students graduate ready to succeed in college and in life.
- **Dignity Grows:** Dignity Grows is the national nonprofit leader in the fight against Period Poverty, a debilitating, often overlooked form of health inequity. In partnership with Petersburg Public Schools, Dignity Grows ensures hygiene support for students.

- **Downtown Churches United:** The Hope Center is a union of area faith communities, organizations and other charitable partners committed to filling the essential needs of Greater Petersburg's financially distressed citizens.
- **Eastern Virginia Care Transitions Partnership:** This organization coordinates and delivers quality care and prevention services to older adults living in the Northern Neck Region.
- **ExCELL:** ExCELL provides literacy efforts for children, with an emphasis on Richmond's East End.
- **Family Lifeline:** Family Lifeline is a partner to families and individuals that delivers intensive home and community-based services to achieve an equitable, resilient community where families and individuals are connected, safe and living a healthy, meaningful life. Family Lifeline provides in-home education, wellness and support services to Central Virginia's children, parents and older adults.
- **Feed More:** Feed More collects, prepares and distributes food and meals with the mission to fight hunger in Central Virginia and the vision that none shall go hungry. Feed More is the core hunger relief organization in Central Virginia.
- **FRIENDS Association for Children:** This organization provides quality childcare and development in an underserved part of Richmond, with an emphasis on Richmond's East End.
- **Full Circle Grief Center:** Full Circle Grief Center provides comprehensive professional bereavement support to children, adults, families and communities in the Greater Richmond area. Full Circle offers grief counseling groups, consulting services and bereavement educational programs.
- **Girls For A Change:** This organization prepares Black girls for the world by helping them visualize their potential through discovery, development and social change innovation within their communities.
- **Great Aspirations Scholarship Program (GRASP):** GRASP works to ensure that every student has an equal opportunity for continuing education after high school, regardless of financial or social circumstances.
- **Greater Richmond Fit4Kids:** This nonprofit organization is dedicated to improving children's health and reducing the prevalence of childhood obesity in the Richmond region. Greater Richmond Fit4Kids offers innovative programs that promote physical activity and healthy eating in schools, community organizations and beyond.
- **Greater Richmond SCAN:** SCAN works to prevent and treat child abuse and neglect throughout the Greater Richmond area by protecting children, promoting positive parenting, strengthening families, and creating a community that values and cares for its children.
- **GRTC (Greater Richmond Transit Company):** GRTC serves the City of Richmond, Chesterfield County and Henrico County with newly redesigned bus routes and the launch of PULSE BRT.

- **GRTC CARE:** GRTC Care provides curb-to-curb public transportation to disabled individuals who may not be reasonably able to use the GRTC fixed route bus.
- **Hanover & King William Habitat for Humanity:** This organization builds affordable homes for families and makes repairs to keep families, particularly older adults, in their homes.
- **Hanover Safe Place:** Hanover Safe Place provides services to victims of sexual or domestic violence and promotes violence prevention.
- **Healing Place/CARITAS:** Healing Place provides substance use rehab for homeless men and women.
- **Healthy Harvest Food Bank:** This food distribution organization offers comprehensive hunger solutions that target the region's most vulnerable neighbors. Serving six counties in Virginia's Northern Neck and Upper Middle Peninsula, it's the only organization of its kind in the region.
- **Henrico County Public Schools Career & Technical Education:** Students who complete CTE programs are prepared for successful transition into postsecondary education and work. Opportunities are available for students to earn college credit through selected courses and to prepare for licensure and/or industry certifications related to their programs of study.
- **Higher Achievement:** By leveraging the power of communities, Higher Achievement provides a rigorous year-round learning environment, caring role models, and a culture of high expectations. The program results in college-bound scholars with the character, confidence and skills to succeed.
- **HOME (Housing Opportunities Made Equal) of VA:** HOME advocates for fair housing by tackling systemically divisive housing practices through fair housing enforcement and research, advocacy and statewide policy work.
- **Homeward:** This planning and coordinating organization offers homeless services in the greater Richmond region. Homeward's mission is to prevent, reduce and end homelessness by facilitating creative solutions through the collaboration, coordination, and cooperation of regional resources and services.
- **Housing Families First:** This organization assists homeless women and their children to build their capacity to live productively within the community. It provides families experiencing homelessness with the tools to achieve housing stability. The goal is not only to assist families in finding permanent housing, but also to ensure that each family has access to the supportive services necessary to sustain housing long-term.
- **Jails and Juvenile Detention in Chesterfield County, Henrico County, and Richmond City, Northern Neck Regional Jail, Pamunkey Regional Jail, and Federal Correctional Complex in Petersburg:** These facilities partner with the Bon Secours Violence Response Team to promote the best possible outcomes for patients experiencing violence and/or trauma.

- **Justin K. Davis Heart Foundation:** The Justin J. Davis Heart Foundation identifies, shares and provides tools and resources which promote a healthy heart focus/lifestyle within communities of the Crater Health District.
- **La Casa de la Salud:** This organization provides community-based support and education to Spanish-speaking individuals across the Richmond area.
- **Latinos en Virginia Empowerment Center:** This organization provides education, advocacy and support to Spanish-speaking individuals affected by violence in Virginia and ensures they can access services that empower them to become happy, healthy and self-sufficient.
- **LISC Virginia:** LISC Virginia works with community organizations to revitalize underserved Richmond-area neighborhoods, leading to physical improvements, safer streets, increased property values and highly engaged residents. LISC Virginia supports community development organizations with grants, loans and expertise to help them construct businesses, community centers and affordable homes in low- and moderate-income neighborhoods.
- **Maggie Walker Community Land Trust:** The Maggie Walker CLT seeks to develop and maintain permanently affordable homeownership opportunities for low- and moderate-income households.
- **Medical Society of Virginia:** This physician-led organization provides medication assistance programs for uninsured patients.
- **Metropolitan Richmond Sports Backers:** This organization seeks to inspire people from all corners of the Greater Richmond community to live actively.
- **Middle Peninsula/Northern Neck Community Services Board:** Serving the ten counties of the Middle Peninsula and Northern Neck, this board provides services related to early intervention, intellectual disabilities, mental health, substance use prevention and treatment.
- **Multi-disciplinary/Sexual Assault/Domestic Violence Response Taskforces in Charles City County, Chesterfield County, Colonial Heights, Fort Lee/Kenner Army Hospital, Goochland County, Hanover County, Henrico County, Hopewell City, King William County, King & Queen County, Louisa County, New Kent County, Northumberland County, Petersburg County, Powhatan County, Richmond City, Richmond County, and Westmoreland County:** As partners of the Bon Secours Violence Response Team, these task forces promote the best possible outcomes for patients experiencing violence and/or trauma.
- **National Alliance on Mental Illness of Virginia:** The National Alliance on Mental Illness of Virginia (NAMI Virginia) was created in 1984 to provide support, education, and advocacy for individuals and families in Virginia affected by mental illness.

- **Neighborhood Resource Center (NRC):** NRC builds relationships, advocates for positive change, shares resources, and develops skills to enhance residents' lives through programs and partnerships in the Greater Fulton area of Richmond.
- **NextUp RVA:** NextUp provides a free, coordinated system of after-school programs for Richmond middle schools.
- **NextUp RVA:** NextUp provides RVA youth a strong system of accessible and equitable out-of-school time and expanded learning resources.
- **Northern Neck Family YMCA:** The YMCA offers youth development and physical activity programming.
- **Partnership for Housing Affordability:** The Richmond regional housing framework is for Chesterfield County, Hanover County, Henrico County, the City of Richmond and the Town of Ashland. The Partnership enables local officials and community representatives to implement solutions that will increase housing opportunities across the region.
- **Partnership for Smarter Growth:** This organization focuses on educating and engaging the communities in the Richmond region to work together to improve quality of life by guiding where and how we grow, including transportation services.
- **Peter Paul Development Center:** This community center in Richmond's East End offers child, youth and adult services, including a Senior Center Adult Day Care.
- **project:HOMES:** This organization improves the safety, accessibility and energy efficiency of existing houses and builds high-quality affordable housing throughout Central Virginia. project:HOMES serves low-income individuals and families by making critical home safety repairs and accessibility modifications and implements energy conservation measures in their homes.
- **Reach Out and Read:** Reach Out and Read prepares America's youngest children to succeed in school by partnering with doctors to prescribe books and encourage families to read together.
- **Real Life:** Real Life serves individuals impacted by incarceration, homelessness or a substance use disorder by giving them an opportunity to overcome their personal and community barriers that hinder their pathway to a thriving Life.
- **Richmond Behavioral Health Authority (RBHA):** RBHA provides services in four major behavioral health areas: mental health; intellectual disabilities; substance use disorders; and access, emergency and medical services.
- **Richmond Hill, Inc.- Armstrong Leadership Program:** Richmond Hill is an ecumenical Christian fellowship and residential community that serve as stewards of an urban retreat center within the setting of a historic monastery. The Armstrong Leadership Program provides students with leadership training, personal development, mentoring, service projects, career and college preparation, weekend retreats, and cultural enrichment.

- **Richmond Metropolitan Habitat for Humanity (RMHFH):** RMHFH is a nonprofit, non-proselytizing Christian housing ministry committed to making affordable and safe housing a reality for low-income families.
- **Richmond Metropolitan Transportation Authority:** The mission of the RMTA is to build and operate a variety of public facilities and offer public services, especially transportation-related, within the Richmond metropolitan area, each of which is operated and financed primarily by user fees.
- **Richmond Opportunities, Inc. (ROI):** ROI supports community transformation by creating pathways to self-sufficiency for people residing in Richmond's public housing communities.
- **RideFinders:** RideFinders offers real-time ride matching with interested commuters in your area that share similar work locations and hours.
- **River Street Education:** River Street Education's mission is to create a diverse and vibrant marketplace that connects local farmers, artisans, and artists with the Petersburg community. Through its year-round farmers market, events, and initiatives, River Street aims to support local farmers, promote healthier food options, and enhance the overall well-being and vibrancy of Petersburg and surrounding areas.
- **Robinson Theater Community Arts Center (RTCAC):** RTCAC is a multi-purpose facility that inspires, encourages and restores healthy community life to the residents of the North Church Hill area of Richmond.
- **RVA Rapid Transit:** RVA Rapid Transit's mission is to connect all people of the Richmond region as we educate, organize and advocate for the design, construction and operation of a first-class metro-area rapid transit system.
- **Rx Partnership:** Rx Partnership increases medication access for vulnerable Virginians and strengthens the health safety net.
- **Sacred Heart Center:** Sacred Heart Center offers many programs to the Latino community, including English as a Second Language, GED Prep in Spanish, Plaza Comunitaria - Spanish Literacy, Citizenship, Pasitos Exitosos: First Steps to Success (a bilingual school-readiness program), College & Career Bound, Cielito Lindo summer camp, Latino Leadership Institute and more.
- **Safe Harbor:** Safe Harbor offers comprehensive services and support for people who are experiencing or have experienced domestic violence, sexual violence or human trafficking. Working from a trauma-informed and empowerment-focused lens, Safe Harbor seeks to help clients understand and address; the impact of trauma and build resilience.
- **Salvation Army Red Shield Youth Center of Richmond:** Provides a safe, structured place where young people can laugh, learn, grow, and belong through enrichment, academic support, character development, arts, sports, and spiritual guidance.

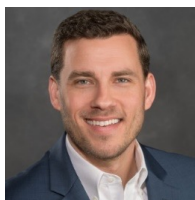
- **Science Museum of Virginia:** The Science Museum of Virginia promotes Science, Technology, Engineering, Math and Health Care (STEMH) career interests within the region.
- **Shalom Farms:** Shalom Farms grows healthy produce and distributes it to underserved communities. They provide learning opportunities for children and adults on growing food, overcoming barriers to cooking and eating nutritionally.
- **Shepherd's Center of Chesterfield:** This is an interfaith ministry of older adults volunteering to improve the lives of other older adults, including medical transportation services.
- **Side by Side VA:** Side by Side creates supportive communities where Virginia's LGBTQ+ youth can define themselves, belong and flourish.
- **SOAR365 (formerly Greater Richmond ARC):** In partnership with families, SOAR365 creates life-fulfilling opportunities for individuals with disabilities.
- **Stop Child Abuse Now (SCAN):** SCAN's mission is to prevent and treat child abuse and neglect throughout the Greater Richmond area by protecting children, promoting positive parenting, strengthening families and creating a community that values and cares for its children.
- **SupportWorks Housing (formerly Virginia Supportive Housing):** SupportWorks Housing seeks to end homelessness by providing permanent housing and supportive services.
- **SwimRVA:** SwimRVA works to build social bridges through aquatics that cross physical, racial and economic barriers. SwimRVA serves as a catalyst for water safety, health and fitness, sports tourism, competitive aquatics and possibility for all Richmonders.
- **The Faces of Hope of Virginia, Inc:** This organization strives to educate children and their families about healthy options and encourages personal empowerment to make significant strides toward preventing and fighting childhood and adult obesity.
- **The Faison Center:** This school addresses the unique learning needs of children with autism.
- **The Hanover Center for Trades and Technology:** This organization strives to create effective partnerships among students, parents, staff and the community. It enables students to become workplace-ready and develop into lifelong learners prepared to succeed in a competitive and ever-changing world.
- **The Positive Vibe Foundation:** Positive Vibe is a nonprofit dedicated to providing transformative training and coaching to help individuals with disabilities lead fulfilling and independent lives.
- **United Methodist Family Services (UMFS):** UMFS offers a network of flexible community-based services. Mentoring, community respite, visitation, community-based clinical support and parent coaching are just a few of the formal and informal offerings to support at-risk families.

- **United Way of Greater Richmond & Petersburg:** Through coalition building, regional leadership, program investments and fundraising, United Way mobilizes the caring power of our community to advance the common good. They focus on the building blocks of a good life, including education.
- **University of Richmond Bonner Center for Civic Engagement:** This center offers volunteering, community-based learning and research focused on community relationships and impacting the Richmond community. University of Richmond is home to one of the largest Bonner Scholars Programs in the country.
- **Virginia Asthma Coalition:** With an emphasis on Richmond's East End, these organizations and individuals are devoted to reducing the morbidity and mortality associated with asthma.
- **Virginia Center for Inclusive Communities:** Through workshops, retreats and customized programs that raise knowledge, motivation and skills, VCIC develops leaders who work together to achieve success throughout the Commonwealth.
- **Virginia Community Development Corporation (VCDC):** VCDC serves as a leader developing innovative affordable housing and revitalization of Virginia's communities by acting as a catalyst for creative and profitable private sector investments and by empowering nonprofit and other providers throughout the Commonwealth.
- **Virginia Health Care Foundation:** This foundation promotes and funds local public-private partnerships that increase access to primary health care services for medically underserved and uninsured Virginians.
- **Virginia Home for Boys and Girls (VHBG):** VHBG works to help children across Virginia with emotional and behavioral health concerns by facilitating the healing process using a relationship-based, cognitive behavioral approach.
- **Virginia Hospital & Healthcare Association (VHHA) Foundation:** The VHHA Foundation supports collaboration, research, and education in health care. It is on a mission to work with our hospital and health care partners to improve the overall health and well-being of the communities they serve and to be a guiding light on the road to a safer, more inclusive, and accessible health care system.
- **Virginia Interfaith Center for Public Policy:** The center engages people of faith and goodwill to advocate for economic, racial and social justice in Virginia's policies and practices through education, prayer and action.
- **Virginia Literacy Foundation:** Virginia Literacy Foundation provides funding and technical support to private volunteer literacy organizations throughout Virginia via challenge grants, training and **direct consultation**.
- **Virginia Poverty Law Center:** Virginia Poverty Law Center uses advocacy, education and litigation to break down systemic barriers that keep low-income Virginians in the cycle of poverty.

- **Voices for Virginia's Children:** Through championing public policies that improve the lives of Virginia's children, Voices for Virginia's Children identifies unmet needs and threats to child well-being, recommends sound policy solutions, provides objective input to policymakers, and educates and mobilizes leaders and concerned citizens to support policy initiatives.
- **YMCA of Greater Richmond:** The YMCA offers after school youth development and physical activity programming. YMCA out-of-school time (OST) programs benefit youth, families and schools by delivering accessible childcare, supporting learning recovery, fostering social-emotional development and promoting healthy daily activity. By offering safe and structured environments during high-risk hours — before- and after-school, on school holidays, and all summer long — these programs help prevent risky behaviors and reduce victimization.
- **YWCA Richmond:** YWCA Richmond helps women, children and families in the community of Richmond, VA through programs to eliminate racism and empower women.

Appendix G

Community Health Advisory Group



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Candace Benn

Executive Vice President, System Operations and Analytics
NextUp RVA

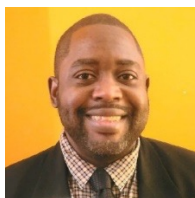
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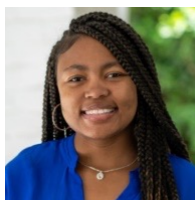


Jimmie Carter

Board Chair

Bay Aging

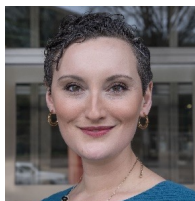
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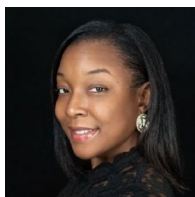


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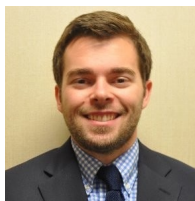


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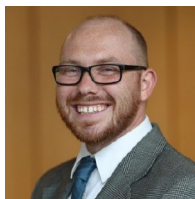
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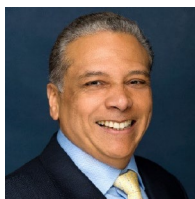
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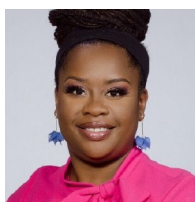
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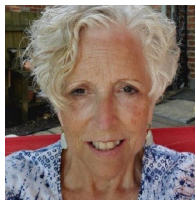
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Board Approval

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

Board Signature:

A handwritten signature in black ink, appearing to read "Lag R. Lubin", is written over a horizontal line.

Date: September 23, 2025

For further information or to obtain a hard copy of this Community Health Needs Assessment (CHNA) please contact:

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Bon Secours CHNA Website:

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



Bon Secours Richmond Market

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Bon Secours CHNAs