

Community Health Needs Assessment 2025

Sentara Obici Hospital, BelleHarbour Ambulatory Surgery Center, LLC, Sentara Obici Ambulatory Surgery, LLC, and the Obici Healthcare Foundation

This joint report was completed in collaboration between Sentara Obici Hospital, BelleHarbour Ambulatory Surgery Center, LLC, Sentara Obici Ambulatory Surgery, LLC, and the Obici Healthcare Foundation, which have the identical service areas of the cities of Franklin and Suffolk, and the counties of Isle of Wight, Southampton, Surry, Sussex, and Gates (North Carolina).



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Executive summary

Sentara Health is proud of our longstanding commitment to the communities served by Sentara Obici Hospital (SOH), BelleHarbour Ambulatory Surgery Center (BASC), Sentara Obici Ambulatory Surgery (SOAS), and the Obici Healthcare Foundation (OHF). We are committed to the cities of Franklin and Suffolk, and the counties of Isle of Wight, Southampton, Surry, Sussex, and surrounding communities, including Gates County, North Carolina.

In this exciting time, it is even more important that we listen to the voices of individuals in the community to better understand the health needs and priorities of those we serve. The Community Health Needs Assessment (CHNA) provides a view of the region's health through a combination of focus groups, a community survey, and data on health care utilization and trends.

Work on the 2025 CHNA for SOH, BASC, SOAS, and OHF began in 2024. The priorities identified by community members are consistent with previous assessments, as well as assessments conducted in other communities across the Commonwealth. Residents support continued work to improve access to behavioral health services, resources for chronic disease management, and a broad approach to health that includes initiatives addressing social determinants of health such as housing and food security.

Top priorities



Behavioral health



Chronic conditions



Social determinants of health

Sentara conducts a comprehensive Community Health Needs Assessment every three years for each of our inpatient hospitals and outpatient surgical centers across Virginia and Northeastern North Carolina. This important tool helps to determine community strengths and assets, including community partners, so that we can collectively address the challenges and opportunities identified in this report. These assessments are an essential element in realizing our mission to improve health every day. They help us to identify barriers to health access so we can more effectively address health disparities in our communities and provide the quality health care that residents deserve.

Looking at the data

Community demographics of the 185,034 persons living in the primary service area, which includes the cities of Franklin and Suffolk, and the counties of Isle of Wight, Southampton, Surry, and Sussex.

Racial profile

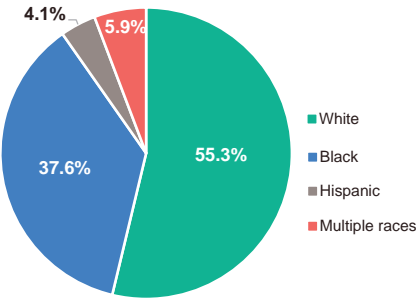


Figure 1

Source: United States Census Bureau

Population by age, 2019-2023

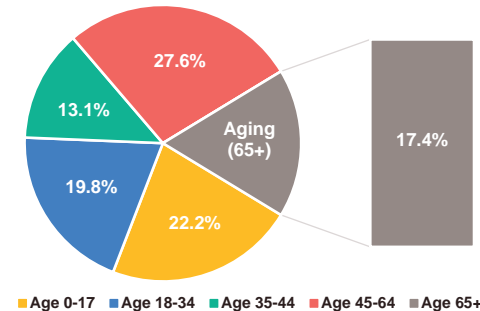


Figure 2

Population change from 2020-2023

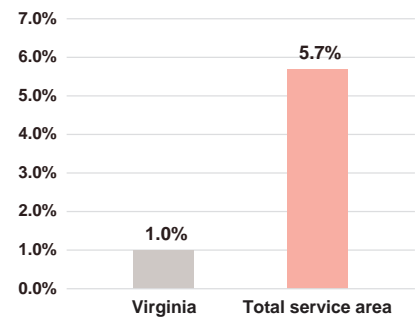


Figure 3

Determinants of health include:

Population with no high school diploma, percentage

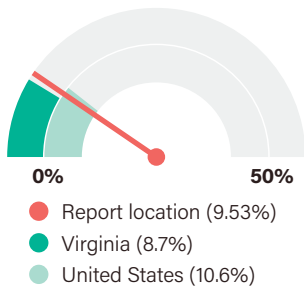


Figure 4

Population in poverty, less than age 18, percentage

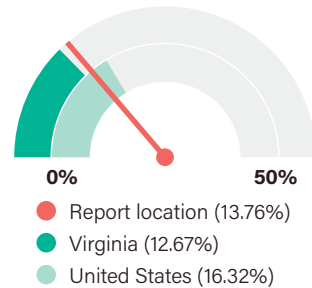


Figure 5

Households where housing costs exceed 30% of income, percentage

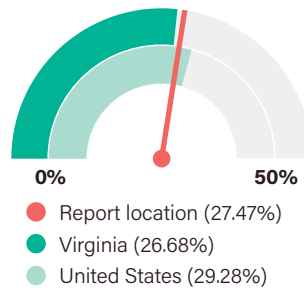


Figure 6

Population with a disability, percentage

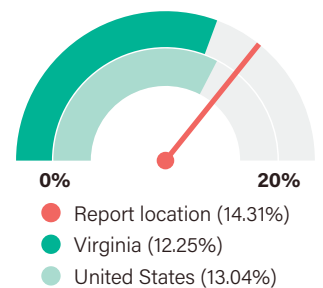


Figure 7

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

Top health concerns include:

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

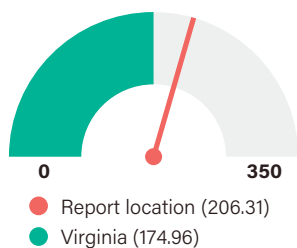


Figure 8

Hospitalizations with Diabetes, rate per 100,000, total population

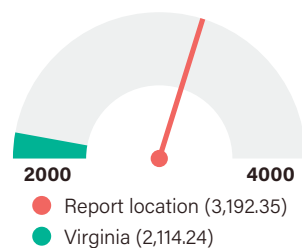


Figure 9

Hospitalizations with hypertension, rate per 100,000, total population

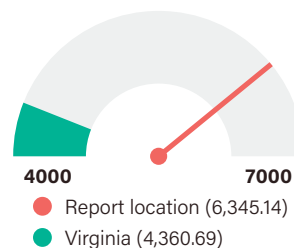


Figure 10

Hospitalizations with asthma, rate per 100,000, total population

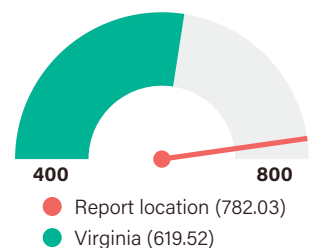


Figure 11

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

Key findings

This assessment incorporates community demographics and other factors influencing and contributing to the overall health of our communities. The report uses data on health factors, health outcomes, and health indicators from County Health Rankings.¹ These rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. Explore the model to learn more about these measures and how they fit together to provide a profile of community health.

- There are many factors that influence how well and how long people live.
- The County Health Rankings model is a population health model that uses data from a variety of sources to identify strengths and areas of concern to help communities achieve optimal health and wellness outcomes.

Demographics

Of the total population in the primary service area, 55.3% of residents are White, 37.6% are Black, 4.1% are Hispanic, and 6.0% are multiple races (total exceeds 100% due to rounding and multiple races selected in the census). The age profile for the population closely mirrors, yet slightly differs, from that of the Commonwealth of Virginia. Within the next 15 years, the total population in the service area is estimated to increase by almost 7.6% — an estimated addition of roughly 14,000 residents.³

Social and economic factors

Sentara and our partners recognize that a community's health outcomes are driven by a variety of factors beyond the clinical care provided in hospitals and other health care settings. Keeping this in mind, our CHNA includes information on education, employment, poverty, and public health insurance enrollment of residents in the service area.

County Health Rankings model

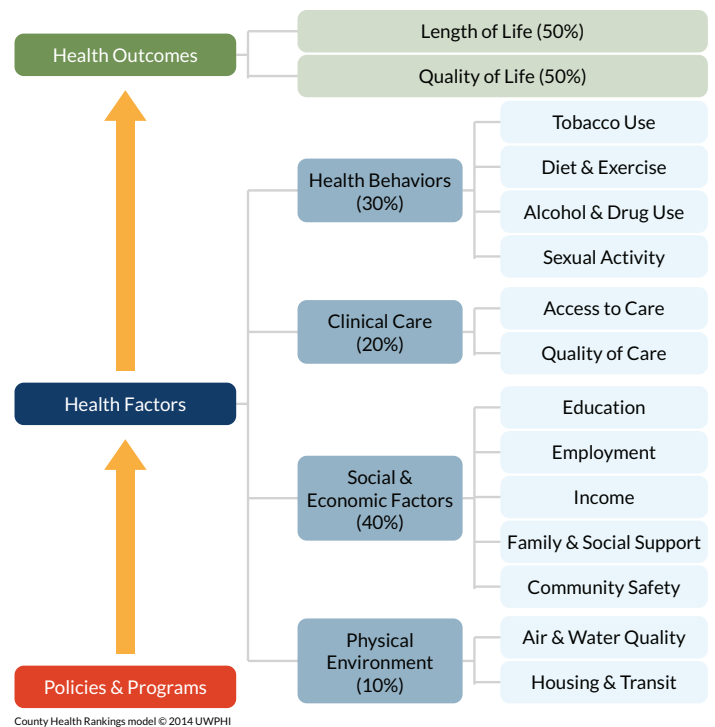


Figure 12

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

Education and employment

Education supports stable employment and financial stability for individuals and their families. As of the 2023 U.S. Census, 88.0% of the residents in the primary service area were high school graduates, compared to 90.6% of Virginia residents. According to the 2019-2023 American Community Survey, only 29.0% of residents in the primary service area hold advanced or professional degrees compared to 41.0% statewide.

As of the 2023 U.S. Census, 60.4% of residents in the service area participated in the labor force, slightly below the state average of 63.8%.

Poverty

Poverty creates barriers to accessing health care, healthy foods, and safe living environments, resulting in lower quality of life and negative health outcomes.

As of the 2023 U.S. Census, residents living in the primary service area were more likely to live

in poverty (11.4%) compared to the rest of Virginia (10.2%). The combination of socioeconomic factors and racial inequalities has a negative impact on health outcomes for individuals and families in this area.

Community insight

Community input is imperative, so we conducted a stakeholder and community member survey and held focus groups jointly with Bon Secours Hampton Roads, Children’s Hospital of The King’s Daughters, Riverside Health, and the Hampton and Peninsula Health Districts.

Community survey

From October 1, 2024, to February 28, 2025, we invited over 100 key community partners throughout Virginia to share and complete the survey, which resulted in 286 residents living in the service area participating. We appreciate the time and contributions those individuals made to help enhance health and well-being in our community.

Top concerns identified included:

- Neonatal and newborn health
- Asthma and allergies
- Mental health
- High blood pressure, cancer, and heart conditions

Barriers to health care services included:

- Limited or no insurance
- Did not know where to go or how to find a doctor
- No appointments available after 5 p.m. or on weekends
- Cost for health care services
- Responsibility as a caregiver for another person

Focus groups

Hospital leaders conducted community conversations from October 2024 through February 2025 to gain more in-depth insight from community stakeholders on their health concerns and health care barriers. Leaders

from the collaborative, SOH, BASC, SOAS, and OHF intentionally promoted these focus groups to diverse populations to obtain feedback from participants truly representative of the communities we serve.

Top concerns identified included:

- Mental health: Anxiety, depression, and postpartum depression
- Access to health care: Transportation, language barriers, and costs
- Chronic conditions: High blood pressure, diabetes, heart disease, cancer, and obesity

Health status

We viewed health status indicators from the 2024 County Health Rankings data and documentation to gain a better understanding of the clinical concerns community members face. When and where data was available, SOH, BASC, SOAS, and OHF paid particular attention to the disparities affecting historically marginalized populations.

Life expectancy for a person living in the Commonwealth of Virginia is 78.7 years. In the primary communities served by SOH, BASC, SOAS, and OHF, the average life expectancy is below the state average. It is important to note disparities affecting Black residents. The average life expectancy of Black residents in the communities served, with the exception of Sussex, is one to seven years less than

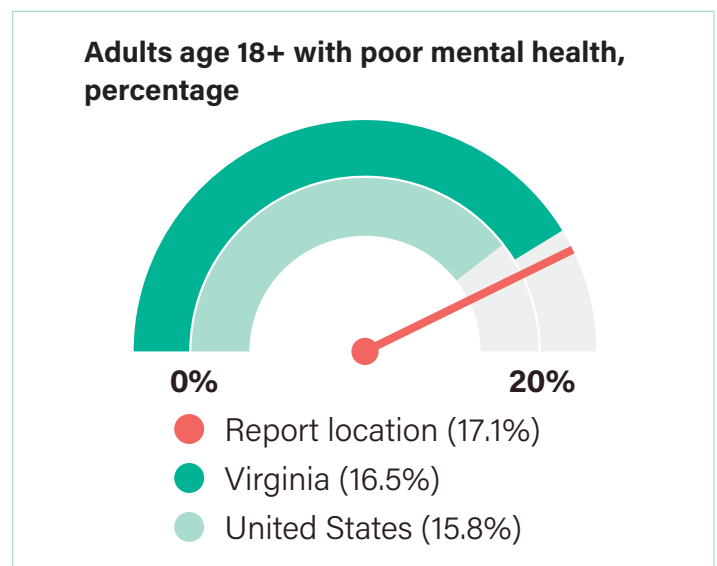


Figure 13 Source: Virginia’s Plan for Well-Being

White residents living in the service area.¹ Franklin has the lowest life expectancy (67.9 years) in the service area, with 64.6 years for Black residents and 71.6 years for White residents.

Access to health services is limited by the low numbers of primary care providers and mental health providers in this community. The need for access to mental health services continues to grow. In 2024, 1,823 adults and 243 youth visited the SOH and BASC emergency rooms for behavioral health concerns. Of those patients, 15.4% of the adults and 36.6% of the youth reported suicidal ideations.







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

Focus areas

Sentara Cares is the community engagement and impact arm of Sentara Health. Our goal is to advance health and ensure that all members of our communities have access to the resources they need to live their healthiest and most fulfilling lives. We are focusing our resources on the key issues listed below based on identified health disparities, the availability of effective interventions, community input, and alignment with our mission to “improve health every day.”

The remainder of this report provides more detail about the 2025 assessment, including social and economic data, demographic information, and health determinant data. Throughout this document, we have incorporated extensive information obtained through the community survey and stakeholder outreach.

Sentara Cares community benefit and building efforts enhance SOH, BASC, and SOAS health priorities for 2026-2028

Sentara priorities	Socioeconomic needs	Health needs	SOH, BASC, and SOAS priorities
	 Housing	 Behavioral and mental health	
	 Food security	 Chronic conditions	
	 Skilled careers	 Social determinants of health	




Table 1 Sentara cares priorities for grant opportunities and SOH, BASC, and SOAS implementation strategy priorities for 2026-2028.

Endnotes

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

²United States Census Bureau. QuickFacts. www.census.gov. Accessed March 10, 2025. <https://www.census.gov/quickfacts/fact/table/mecklenburgcountyvirginia,halifaxcountyvirginia,charlottetowncountyvirginia,VA/PST045221>.

³University of Virginia Weldon Cooper Center for Public Service. (2022). Virginia Population Projections. Accessed February 13, 2025. Retrieved from <https://coopercenter.org/virginia-population-projections>.

Introduction

Sentara Health

Sentara health care delivery system, celebrates more than 130 years in pursuit of its mission - "we improve health every day." Sentara is one of the largest health systems in the U.S. Mid-Atlantic and Southeast, and among the top 20 largest not-for-profit integrated health systems in the country, with 30,000 employees, 12 hospitals in Virginia and Northeastern North Carolina, and the Sentara Health Plans division which serves more than 1 million members in Virginia and Florida. Sentara is recognized nationally for clinical quality and safety and is strategically focused on innovation and creating an extraordinary health care experience for our patients and members. Sentara was named to IBM Watson Health's "Top 15 Health Systems" (2021, 2018), and was recognized by Forbes as a "Best Employer for New Grads" (2022), "Best Employer for Veterans" (2022, 2023), and "Best Employer for Women" (2020).¹

Sentara Obici Hospital (SOH)

Sentara Obici Hospital, a 175-bed state-of-the-art facility, is located in Suffolk, VA. Our full-service hospital continues a legacy of providing residents of Western Tidewater with high-quality, patient-centered care. As a recognized accredited Primary Stroke Center, and Magnet® hospital for nursing excellence, the hospital specializes in orthopedic and spine, heart and vascular, advanced imaging, gynecological and comprehensive breast services, behavioral health, maternity, weight loss surgery, and is a heartburn treatment center.²

BelleHarbour Ambulatory Surgery Center (BASC)

BelleHarbour Ambulatory Surgery Center, a modern outpatient medical center in North Suffolk, is here to provide families with convenient access to quality

Sentara at a glance

- **Headquartered in Hampton Roads**
- **Outpatient campuses**
- **135-year not-for-profit history**
- **Urgent care centers**
- **12 hospitals**
- **Advanced Imaging Centers**
- **One medical group**
- **Home health and hospice**
- **3,800+ provider medical staff**
- **Rehabilitation and therapy centers**
- **30,000+ team members**
- **Nightingale Regional Air Ambulance**
- **Sentara Health Plans**

medical care and services. From family medicine and specialty care, to physical therapy, outpatient surgery, lab and imaging services, and 24-hour emergency care, BelleHarbour Ambulatory Surgery Center is proud to serve the community.³

Sentara Obici Ambulatory Surgery (SOAS)

The Sentara Obici Ambulatory Surgery on the campus of Sentara Obici Hospital combines a caring atmosphere with new technologies in a full-service outpatient surgery center.

We are able to perform many complex surgeries in an outpatient center without the need for a hospital setting. The outpatient surgical setting offers many advantages, including lower surgical costs, as well as a convenient location and comfortable surgical

environment. Board-certified specialists will perform orthopedic, ENT, gynecologic, general, ophthalmologic, plastic, podiatry, and pain management surgeries and procedures in this convenient, outpatient setting.⁴

Obici Healthcare Foundation

The Obici Healthcare Foundation is a private, independent entity unrelated to any other health organization. Established in 2006 when the former Louise Obici Memorial Hospital was sold to Sentara, and coupled with assets of Mr. Obici's first foundation, the assets of the Obici Healthcare Foundation are over \$150 million.

The mission of the Obici Healthcare Foundation is to improve the health status of the people living in the service area by responding to the medical needs of the indigent and uninsured and by supporting programs which have the primary purpose of preventing illness and disease.⁵

Sentara Cares

Our purpose calls us to address health care issues every day, where people live — not just when patients are under our care. This broad vision is essential in our work to eliminate health disparities and promote access to nutritious foods, education, safe and affordable housing, and stable, rewarding job opportunities. We know that health disparities cannot be solved solely in the exam room, and they cannot be solved solely by Sentara. Through our partnerships, we continue to make both immediate impact and lasting change for our communities.⁶

Sentara Community Care

Sentara Community Care launched in 2022 to expand access to care and improve the health of communities across the Commonwealth. Leveraging data-driven strategies, we are rapidly expanding this model to meet the needs of Virginians, focusing on uninsured and Medicaid members. We have partnered with community and faith-based leaders to ensure that we can better understand and respond to the community's most pressing needs.

The goal is to reduce traditional barriers to health and wellness by maximizing convenience and providing consistent, embedded medical and wrap-around services in neighborhoods with the greatest needs. Services can include primary care for children and adults, behavioral health and social care services, health and wellness education, food and housing support, and health care navigation.

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

Now with six community care centers, six mobile care vehicles, school-based telehealth clinics, and numerous strategic partnerships, the Sentara Community Care program continues to extend its reach to provide holistic care in the communities that need it most.

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

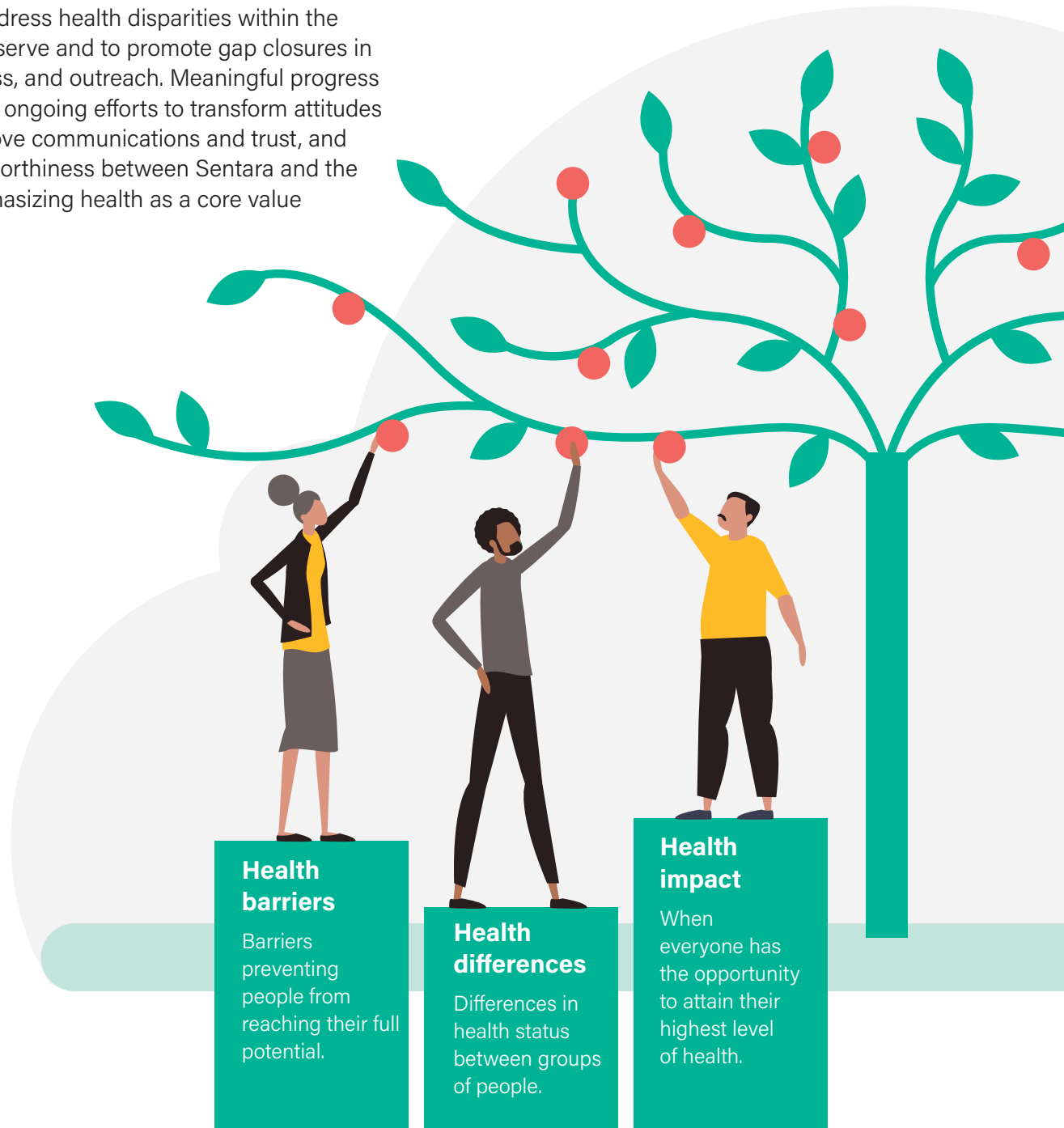
Sherry Norquist, MSN, RN-ACM,
Executive Director of Community Engagement & Impact



Health impact

By identifying the most pressing health concerns within a community, this assessment prioritizes health interventions and allocates resources to advance health based on community insight. Our efforts promote health impact, enhance awareness, education, and access to care across racial, ethnic, gender, age, language, geographic, and socioeconomic groups. Health impact involves not only examining the health and wellness of a population, it also addresses how hidden tendencies influencing decision-making among clinicians, caregivers, communities, and interested parties impact treatment decisions and outcomes. The shift toward value-based health care supports our mission to address health disparities within the communities we serve and to promote gap closures in knowledge, access, and outreach. Meaningful progress in health requires ongoing efforts to transform attitudes and beliefs, improve communications and trust, and strengthen trustworthiness between Sentara and the community, emphasizing health as a core value and priority.

Sentara collaborates with community organizations, faith leaders, academic institutions, government agencies, and clinicians to develop initiatives to address social drivers of health, reduce health disparities, and improve the health and well-being of the communities we serve. Our efforts focus on improving screening and diagnosis rates for health issues, such as hypertension, diabetes, and prostate cancer; increasing access to and utilization of treatment; and supporting health initiatives that benefit historically marginalized groups, including immigrant populations, individuals experiencing homelessness, sexual orientation and gender identity (SOGI) populations, and individuals with different [or diverse] abilities.



Health barriers

Barriers preventing people from reaching their full potential.

Health differences

Differences in health status between groups of people.

Health impact

When everyone has the opportunity to attain their highest level of health.

Assessment	Description
Qualitative data	We survey our community members and hold focus groups to discuss community conditions, health, and needs. We ask our community members about their personal circumstances—like having a safe place to live, healthy and accessible food, social connections, and other daily essentials—and connect them to community resources.
Quantitative data	We collect demographic and health indicator data to identify differences in community and health outcomes. We look at the data to better inform our community health improvement work.

Process overview

Mobilizing for action through planning and partnerships

City Health Officials (NACCHO) has implemented a community-driven strategic planning process for improving community health called Mobilizing for Action through Planning and Partnerships (MAPP). This framework includes engaging community partners in the collection and review of qualitative and quantitative data from trusted local and national sources. In doing so, participating partners can clearly define the conditions that support or obstruct wellness and identify resources to address obstacles.⁷

We began the MAPP process at SOH, BASC, and SOAS by engaging community partners, developing support teams, and creating a shared vision with common values. Community partners included OHF, Bon Secours Hampton Roads, Children’s Hospital of The King’s Daughters, Riverside Health, and the Hampton and Peninsula Health Districts. Sentara worked collaboratively with partners to engage community members through survey completion and focus groups, collecting responses to be used for prioritizing health needs. We then collected and analyzed data to identify strategic priorities and formulate goals and strategies to address health concerns.

Our process

Sentara conducts these comprehensive assessments to provide a snapshot of the health status of residents in our communities, including information about key

health and health-related challenges and opportunities. Each Community Health Needs Assessment incorporates information from a variety of primary and secondary quantitative data sources to help us to understand the disparities that affect vulnerable populations.

Sentara created a data profile that includes how people use emergency and preventive care, their ongoing health problems, and any cultural or language requirements they might have. A secondary statistical data profile uses advanced data sources to assess population characteristics such as household statistics, age, educational level, economic measures, mortality rates, prevalence rates of chronic illnesses, and racial and ethnic composition. Our assessment includes a review of risk factors, including obesity, smoking, and other health indicators.

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

- Centers for Medicare & Medicaid Services
- County Health Rankings (2024)
- National Cancer Institute
- United States Census Bureau
- Virginia Department of Health
- Virginia Medicaid, Virginia Department of Medical Assistance Services
- Virginia’s Plan for Well-Being: Virginia Community Health Assessment
- Weldon Cooper Center for Population Studies, University of Virginia
- CHNA survey and focus groups

Our next steps

Collectively, SOH, BASC, and SOAS work with a number of community partners, including OHF, to address health needs. Using the information from this assessment, SOH, BASC, and SOAS will develop an implementation strategy to address the identified health problems. The implementation strategy progress report for the 2022 CHNA is available at the end of this report.

Resource information is available from sources like 2-1-1 Virginia and Virginia's Plan for Well-Being. Together, we will work to improve the health of the communities we serve.

Your input is important to us so that we can incorporate your feedback into our future assessments. You may use our online feedback form available on [sentara.com](https://www.sentara.com).



Endnotes

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

² Sentara Health. Sentara Obici Hospital. Accessed March 12, 2025. <https://www.sentara.com/hospitalslocations/sentara-obici-hospital>.

³ Sentara Health. BelleHarbour Ambulatory Surgery Center, LLC. Accessed March 12, 2025. <https://www.sentara.com/hospitalslocations/sentara-belleharbour>.

⁴ Sentara Health. Sentara Obici Ambulatory Surgery, LLC. Accessed March 12, 2025. <https://www.sentara.com/hospitalslocations/obici-ambulatory-surgery-center>.

⁵ Obici Healthcare Foundation. Accessed March 12, 2025. <https://obicihcf.org/>.

⁶ Sentara Cares. Strengthening Communities. Accessed October 10, 2024. <https://sentaracares.com>.

⁷ National Association of County and City Health Officials. Accessed October 10, 2024. Mobilizing for Action through Planning and Partnerships (MAPP). <https://www.naccho.org/#:~:text=Mobilizing%20for%20Action%20through%20Planning%20and%20Partnerships%20%28MAPP%29,health%20issues%20%20and%20identify%20resources%20to%20address%20them>.

Community description

Locality demographics of our community

Sentara Obici Hospital, BelleHarbour Ambulatory Surgery Center, Sentara Obici Ambulatory Surgery, and the Obici Healthcare Foundation are all located in Suffolk, Virginia.

The primary service area includes a total population of 185,034 people who live in the 2,091.50 square mile report area.¹ The secondary service area includes a population of 10,343. The SOH, BASC, SOAS, and OHF primary community is comprised of two cities (Franklin and Suffolk) and four counties (Isle of Wight, Southampton, Surry, and Sussex) and surrounding communities with the secondary service area of Gates County, North Carolina.

Community-specific demographics

As of the 2023 U.S. Census, the Franklin population was 8,339, with 19.8% of residents living in poverty and 8.5% uninsured. Age demographics include 26.6% of residents between the ages of 0-17, 18.2% ages 18-34, 22.3% ages 35-54, and 33.0% ages 55 and older. The racial and ethnic profile for the city is 38.1% White, 51.7% Black, and 4.0% Hispanic.

For Suffolk, there is a population of 100,659, with 11.1% of residents living in poverty and 7.2% uninsured. Age demographics include 23.7% of residents between the ages of 0-17, 21.3% ages 18-34, 26.5% ages 35-54, and 28.6% ages 55 and older. The racial and ethnic profile for the city is 47.5% White, 42.0% Black, and 5.0% Hispanic.

For Isle of Wight, there is a population of 40,711, with 7.3% of residents living in poverty and 7.1% uninsured. Age demographics include 21.3% of residents between the ages of 0-17, 17.2% ages 18-34, 25.4% ages 35-54, and 36.1% ages 55 and older. The racial and ethnic profile for the city is 70.2% White, 22.1% Black, and 3.9% Hispanic.

For Southampton, there is a population of 17,975, with 13.3% of residents living in poverty and 7.6% uninsured. Age demographics include 19.1% of residents between the ages of 0-17, 16.6% ages 18-34, 26.2% ages 35-54, and 38.1% ages 55 and older. The racial and ethnic profile for the city is 61.3% White, 29.8% Black, and 2.3% Hispanic.

For Surry, there is a population of 6,593, with 12.4% of residents living in poverty and 7.2% uninsured. Age demographics include 17.0% of residents between the ages of 0-17, 16.2% ages 18-34, 22.8% ages 35-54, and 44.1% ages 55 and older. The racial and ethnic profile for the city is 55.8% White, 41.0% Black, and 2.9% Hispanic.

For Sussex, there is a population of 10,757, with 20.9% of residents living in poverty and 8.9% uninsured. Age demographics include 15.8% of residents between the ages of 0-17, 25.6% ages 18-34, 25.7% ages 35-54, and 33.0% ages 55 and older. The racial and ethnic profile for the city is 40.3% White, 55.0% Black, and 1.5% Hispanic.

For Gates, NC, there is a population of 10,343, with 14.0% of residents living in poverty and 9.2% uninsured. Age demographics include 19.6% of residents between the ages of 0-17, 17.8% ages 18-34, 23.5% ages 35-54, and 39.2% ages 55 and older. The racial and ethnic profile for the city is 63.5% White, 31.2% Black, and 2.1% Hispanic.

Looking at the data

Racial and ethnic profile, 2023

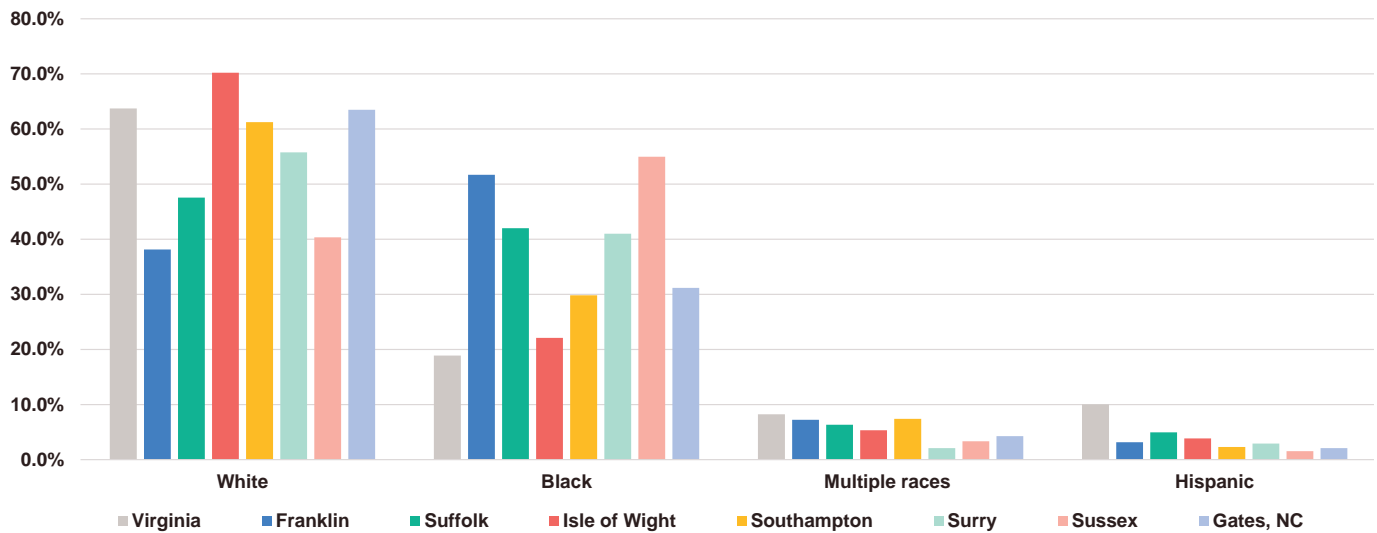


Figure 1 Source: U.S. Census Bureau

Population by age, 2019-2023

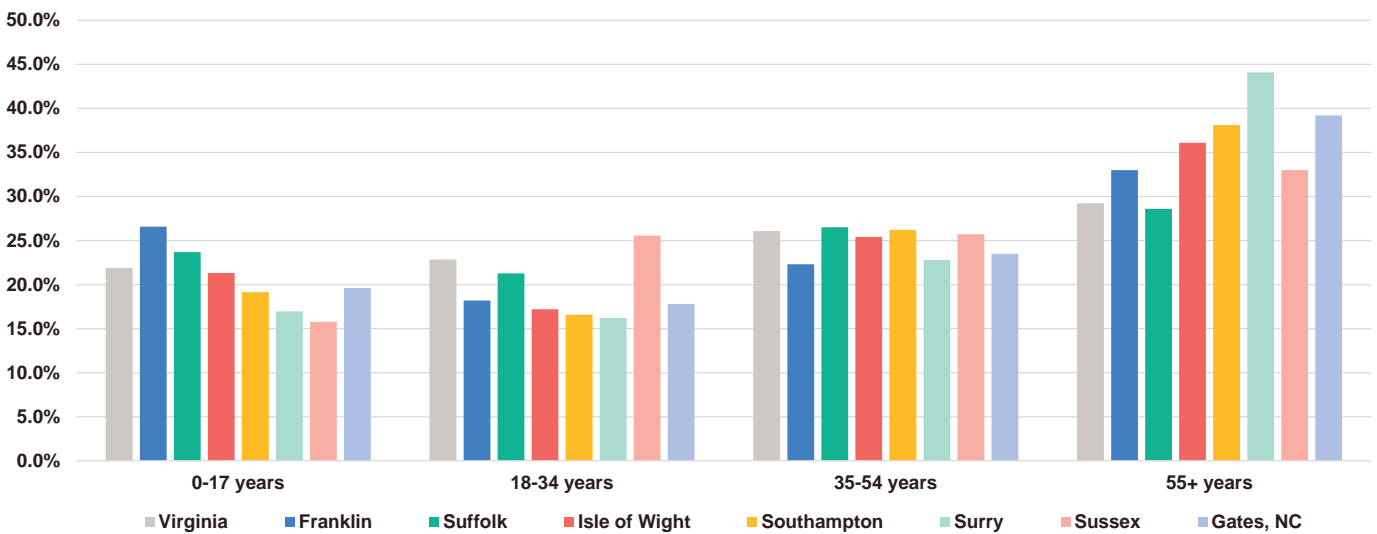


Figure 2 Source: U.S. Census Bureau

Median household income, 2023

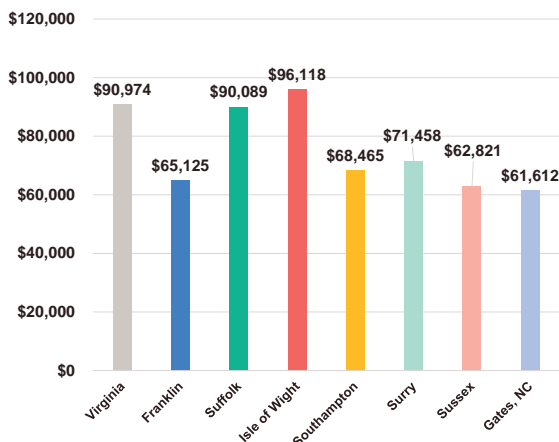


Figure 3 Source: U.S. Census Bureau

Poverty, 2023

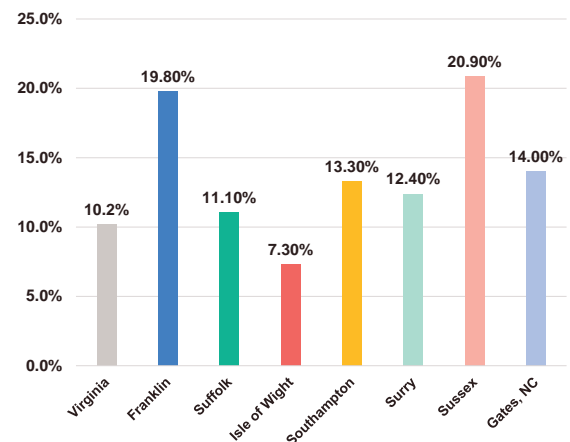


Figure 4 Source: U.S. Census Bureau

Population highlights

Population change

“Population projections provide an approximate idea of the expected future population size,” and, according to the University of Virginia’s Weldon Cooper Center for Public Service, the service area is expecting an increase of an estimated 19,000 people within the next five years.² These projections are based on “reliable and credible data.”² Gates shows a decline of -1.8% per the Office of State Budget and Management.³

Population change, 2020-2030

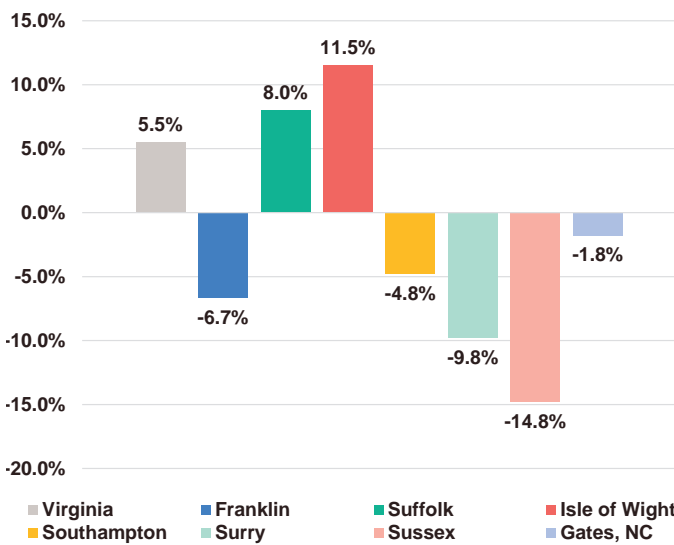


Figure 5 Source: Weldon Cooper and Office of State Budget and Management

Age and sex

Per the 2023 U.S. Census, of the total population of 185,034 people living in the primary service area, 10,478 in the secondary service area, most residents are over the age of 45. The percentage of primary service area residents who are children between the ages of 0-17 is 22.2%, which is slightly higher than the state level of 21.9%. Male (49.9%) and female (50.1%) resident percentages are similar to Virginia percentages (49.4% male, 50.6% female), based on sex assigned at birth.

Aging population

Research shows the highest utilization of medical services is among the aging population (ages 65 and older) and the elderly population (ages 85 and older).

In 2023, 17.4% of the residents living in the primary service area were ages 65 and older, compared to 16.3% in Virginia. Per the 2023 U.S. Census, Suffolk has the largest number of adults ages 65 and older in the service area, estimated at 14,496 residents. Estimates indicate the population of aging adults (ages 65 and older) living in the service area will increase to 25.8% by 2030.²

Other demographic features

According to the 2023 U.S. Census, Veterans represent 11.1% of the population in the service area, compared to 12.9% statewide. Slightly less households in the primary service area have computers (92.9%) and internet access (86.7%), decreasing access to remote learning, telehealth, and other resources. A slightly higher percentage of the population in the service area is living with a disability (14.3%) compared to the state overall (10.2%). The service area also has a higher percentage of persons living in poverty (12.0%) compared to Virginia overall (12.3%), and a lower percentage of residents with college degrees (37.8%) when compared to the state (49.3%).

Community diversity profile

Race and ethnicity

The population of the service area has a higher percentage of White (55.3%) and Black (37.6%) residents than other races and ethnicities.⁴ The service area is home to a small Hispanic (4.1%) population.⁴

Population with limited English proficiency, 2019-2023

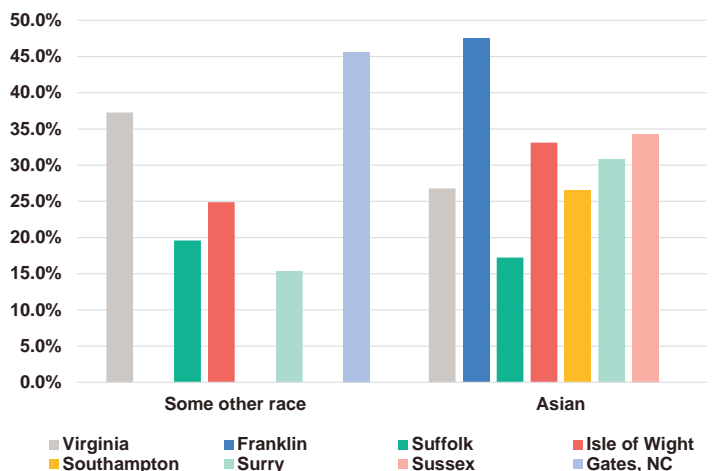


Figure 6 Source: U.S. Census Bureau

Cultural and linguistic needs

English is the primary language spoken in the service area. As of the 2023 U.S. Census, 98.6% of the population in the service area identified as English-speaking. Non-English-speaking populations are disproportionately represented in low socioeconomic groups, have poorer health outcomes, are more likely to have a disability, are often linguistically and culturally isolated, and have lower educational attainment compared to their English-speaking counterparts. Language barriers make it difficult for this population to understand, interpret, and benefit from information about their health.

2024 SOH language utilization

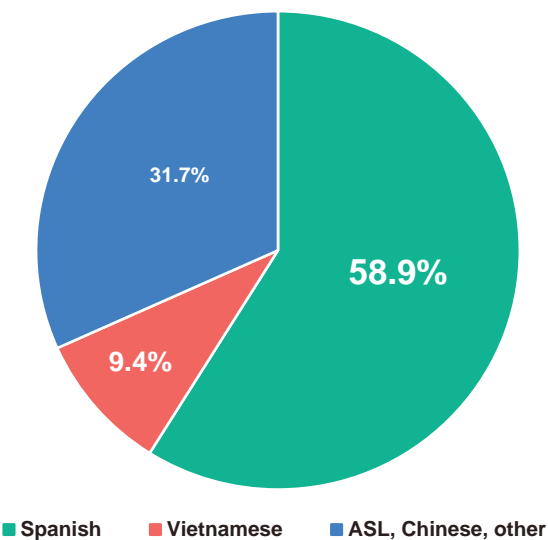


Figure 7 Source: SOH Language Line Usage Report

Sentara is committed to ensuring that all communication with our patients and health plan members is in their preferred language. Sentara provides its patients and their families with qualified interpreters for a variety of languages, including American Sign Language (ASL). In 2024, SOH had 2,192 requests for interpreter services. The highest percentage of interpreter services (58.9%) was for Spanish-speaking individuals, with the second highest percentage being Vietnamese (9.4%), ASL (7.1%), and Chinese (Mandarin) (6.0%).

Social determinants of health

Sentara recognizes that meaningful improvements in health outcomes requires strategies reaching beyond clinical settings to address the root causes of health inequities.

Sentara works to:

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

Social determinants of health



Figure 8 Source: U.S. Department of Health and Human Services. Healthy People 2030.

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

The cycle of poverty

- Poverty continues because it reproduces existing patterns of circumstances, opportunities, and effects.
- The causes of poverty lead to consequences that make it more likely that the individual — or their offspring — will experience poverty in the future.
- Generational poverty is a vicious cycle in which each generation is unable to escape poverty because of a lack of resources to put toward the effort.

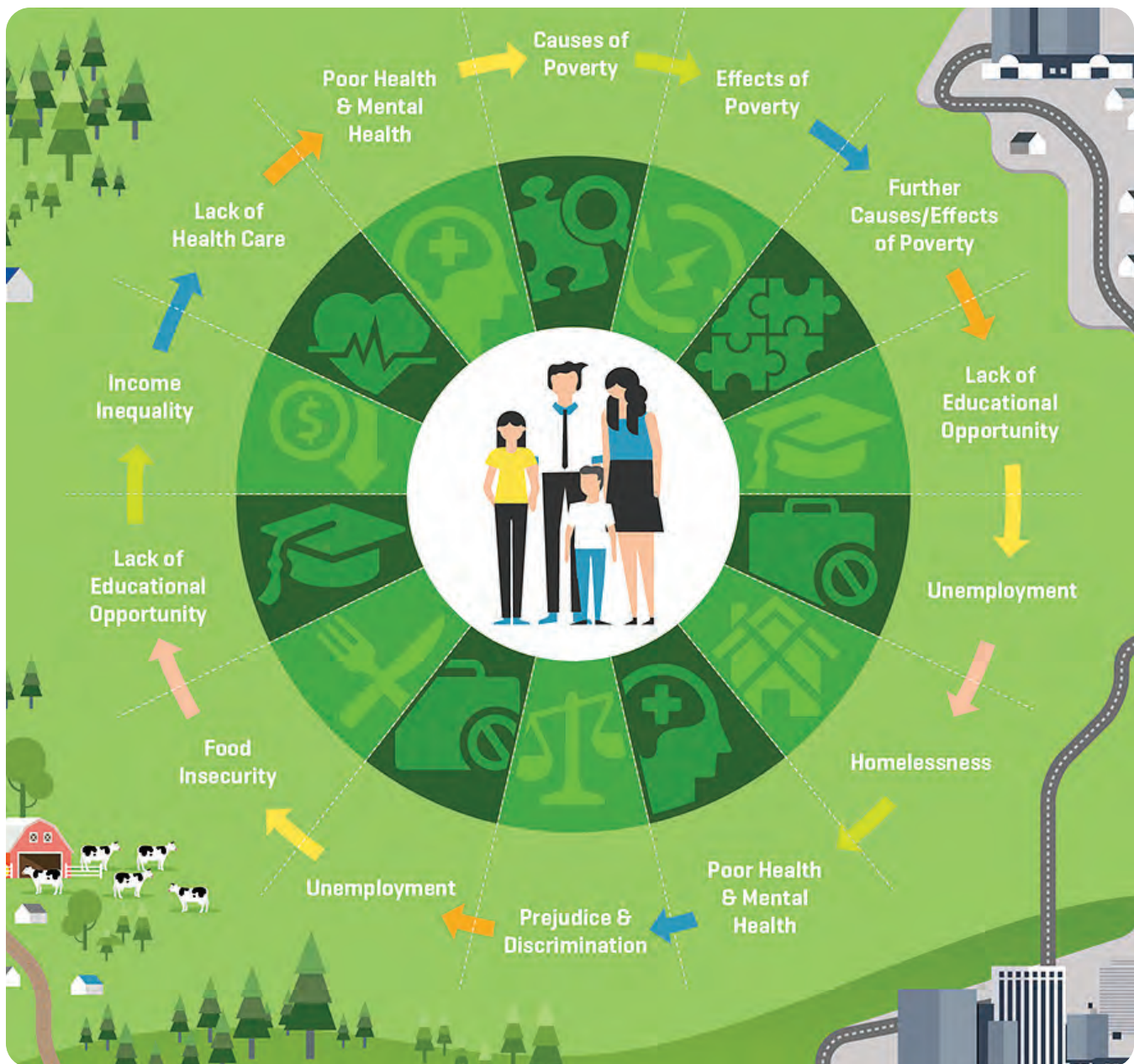


Figure 9 Source: Aurora University

Poverty

An examination of poverty rates and racial demographics underscores the racial disparities that impact economic and health outcomes for residents and their families. In Virginia, and the service area, Black and Hispanic residents are more likely to live in poverty compared to White residents. At 11.4%, the primary service area has a slightly higher percentage of residents living in poverty compared to the Commonwealth of Virginia (10.2%).⁴ Gates has a poverty percentage of 14.0%, with Black populations having a higher poverty percentage (8.3%) compared to White residents (7.4%).

Education

Education is the basis for stable employment and financial stability, which in turn supports access to quality health care and positive health outcomes. The primary service area has a lower percentage (90.6%) of high school graduates than the statewide percentage (91.3%). The service area also has a lower percentage of college graduates (29.0%) compared to the state overall (41.5%).⁴ Gates has a lower percentage than the primary service area of high school graduates (89.6%) and college graduates (10.8%).

Employment

Per the 2023 U.S. Census, the primary service area has a slightly higher percentage of unemployed residents (3.1%) compared to Virginia overall (2.7%). The labor force represents 62.8% of total residents living in the primary service area, with Gates having 56.2%. Within the labor force, 59.7% of female residents in the primary service area are employed, lower than the state (61.0%).⁴ In Gates, 55.6% of female residents participate in the labor force.

Medicaid and FAMIS, Medicare, Medicare and Medicaid

Public health insurance programs play an important role in providing coverage for individuals who qualify based on income, age, or disability. According to the 2023 U.S. Census, 7.3% of residents living in the primary service area, and Gates (9.2%), do not have health insurance. A total of 1,994,822 Virginians had health coverage through Medicaid and Family Access

Estimated poverty status by race, 2023

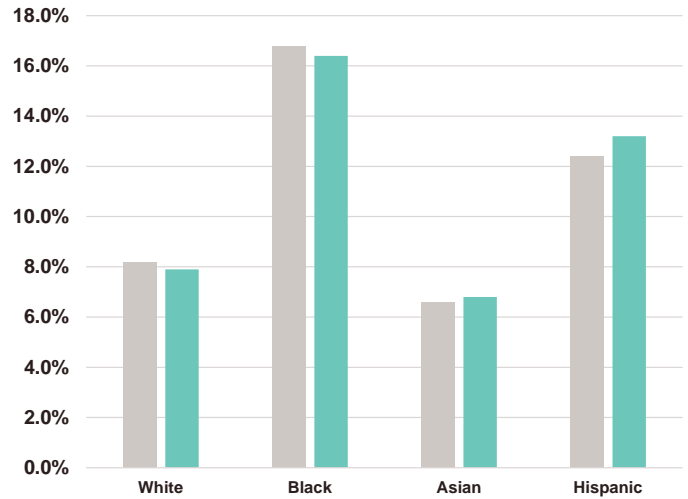


Figure 10 Source: U.S. Census Bureau

Education attainment, age 25+, 2019-2023

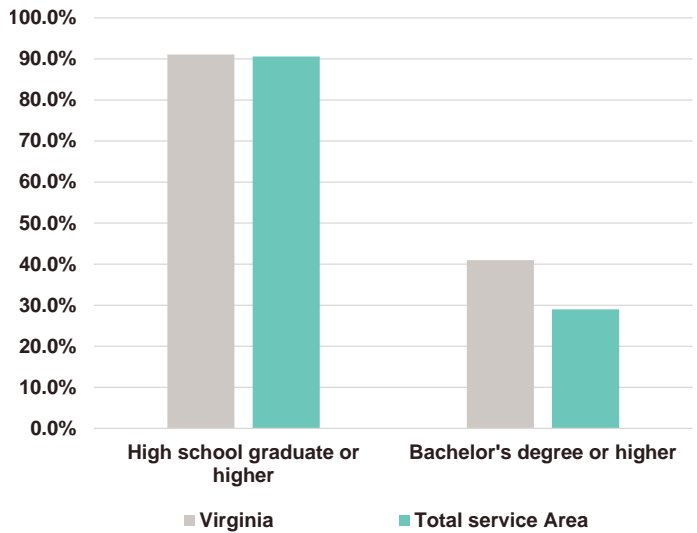


Figure 11 Source: U.S. Census Bureau

Civilian labor force, 2023

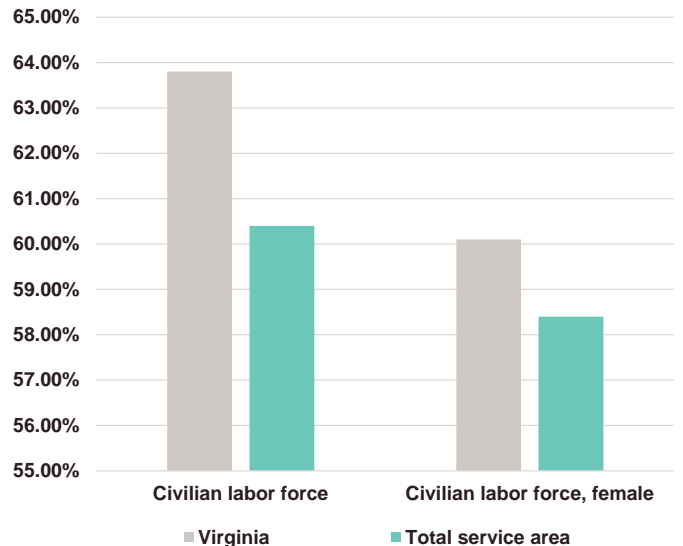


Figure 12 Source: U.S. Census Bureau

to Medical Insurance Security (FAMIS) as of January 1, 2025. This included 31,058 residents living in the service area served by SOH, BASC, and SOAS.⁸ Medicaid and FAMIS members represent 16.8% of the total population in the service area, lower than the 22.9% of all Virginians who have Medicaid or FAMIS health coverage.⁷ Community health workers and enrollment specialists are available to provide guidance and assistance for qualifying individuals and families with enrollment in these government programs.

Insurance coverage type, 2022

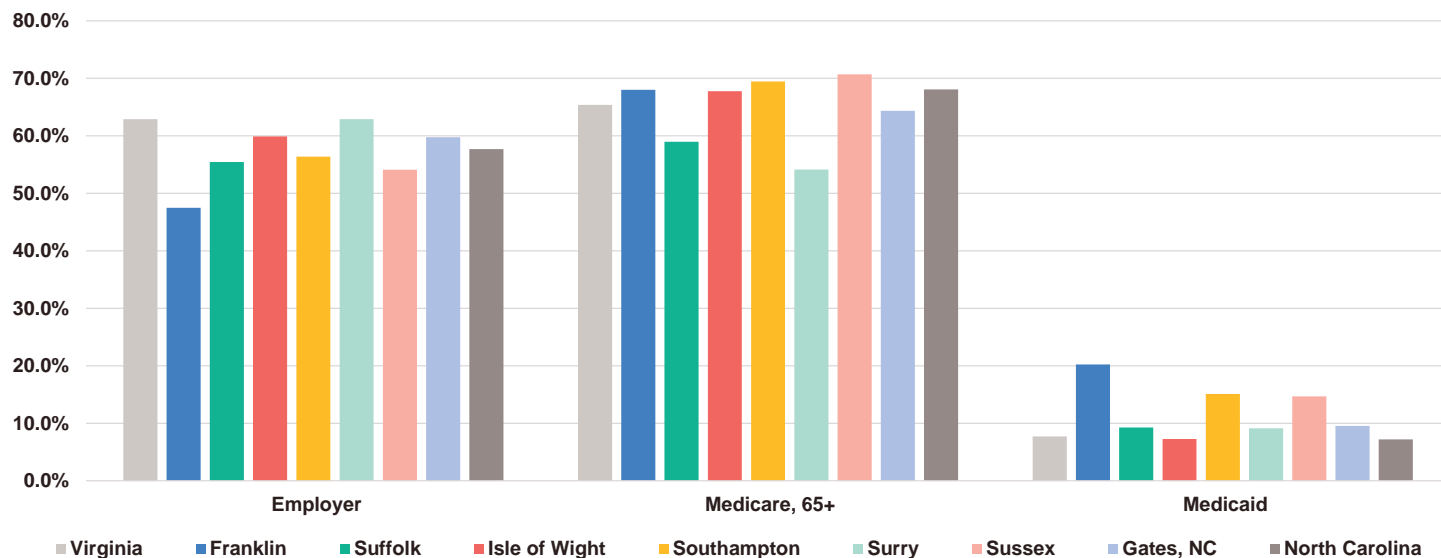


Figure 13 Source: Centers for Medicare & Medicaid Services Data

Endnotes

¹ United States Census Bureau. American Community Survey 5-Year Estimates, 2019-2023. Demographic and Housing Estimates. Accessed March 2, 2025. https://data.census.gov/table?q=United%20States&t=Age%20and%20Sex&g=040XX00US51_050XX00US51550,51710,51740,51800,51810.

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

³ Office of State Budget and Management. Population Growth. Accessed March 10, 2025. <https://www.osbm.nc.gov/facts-figures/population-demographics/state-demographer/countystate-population-projections>.

⁴ United States Census Bureau. QuickFacts. www.census.gov. Accessed March 3, 2025. <https://www.census.gov/quickfacts/fact/table/VA,chesapeakecityvirginia,norfolkcityvirginia,portsmouthcityvirginia,suffolkcityvirginia,virginiabeachcityvirginia/HSG445222#HSG445222>.

⁵ U.S. Department of Health and Human Services. Healthy People 2030. Accessed May 2, 2023. <https://health.gov/healthypeople/priorityareas/social-determinants-health>.

⁶ Aurora University. Social Work and Poverty: Rural vs. Urban Poverty. Access May 2, 2023. <https://online.aurora.edu/infographics/rural-poverty-vs-urban-poverty/>.

⁷ Department of Medical Assistance Services (DMAS) Data. Accessed February 10, 2025. <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>.

⁸ Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 10, 2025. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

Community input

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

Description

A broad range of diverse community members provided input through a community survey and focus groups. We consulted with individuals with firsthand knowledge of the health needs of the community. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations. In addition, we gathered input from community leaders, clients of local service providers, and other individuals representing people who are medically underserved, low income, or who face unique barriers to health (e.g., racial/ethnic minorities and individuals experiencing homelessness).

Methodology

To include a wide range of community perspectives, as well as the views of those who work with or represent underserved populations within the community, SOH, BASC, SOAS, and OHF staff used several methods to identify groups and collect qualitative data.

Working with the Peninsula Community Health Collaborative, and representatives from Bon Secours Hampton Roads, Children's Hospital of The King's Daughters (CHKD), Riverside Health, and the Hampton and Peninsula Health Districts, members reviewed the participant lists from previous CHNA reports in the same community. Importantly, the inclusion of service providers and community members (through surveys and focus groups) allowed

us to identify health needs from the perspectives of diverse populations.

Community survey

The community survey was conducted jointly with the Peninsula Community Health Collaborative and included a broad-based group of stakeholders and community members. Electronic surveys, and paper surveys in English and Spanish, were available to the public from October 1, 2024, to February 28, 2025.

The survey was distributed to stakeholders, including individuals representing public health, education, social services, businesses, local government, and local civic organizations. At the completion of the survey period, 286 survey responses were received from the SOH, BASC, SOAS, and OHF community.

After the initial survey period, the collaborative recognized that the majority of respondents were White. Most cities did not have an equally distributed response to surveys to represent the entire population. As a result, survey responses should be considered as only one component of information utilized to select health priorities. Feedback from the most underserved populations is not adequately reflected in most of the surveys. For the full list of questions and responses, see Appendix C.

Demographics of survey respondents

Of the 286 SOH, BASC, SOAS, and OHF community respondents, 67.1% identified as White, 30.1% as Black, 1.0% as Indigenous, 1.4% as Asian, and 2.4% as Hispanic.

Survey responses

For this CHNA, we will focus on the survey questions below. Survey respondents were asked to review a list of common community health issues for children (0-17) and adults, and select all that applied to their community. The tables below show the top three answers for the questions among community member respondents.

Top three most important health concerns in your community.

Rank	All responses (n=314)	Responses from Franklin City and Suffolk City (n=215)	Responses from the counties of Isle of Wight, Southampton, Surry, Sussex and Gates, NC (n=99)
Youth			
1	Mental health	Mental health	Mental health
2	Asthma and allergies	Asthma and allergies	Asthma and allergies
3	Obesity	Obesity	Obesity
Adults			
1	Mental health	Mental health	Mental health
2	Diabetes	Diabetes	Cancer
3	Cancer	Cancer and high blood pressure	Heart conditions

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

Rank	All responses (n=314)	Responses from Franklin City and Suffolk City (n=215)	Responses from the counties of Isle of Wight, Southampton, Surry, Sussex and Gates, NC (n=99)
Youth			
1	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment
2	Cost	Cost	Cost
3	Limited or no insurance	Limited or no insurance	No appointments available for new patients
Adults			
1	Cost	Cost	Cost
2	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment
3	Limited or no insurance	Limited or no insurance	Limited or no insurance

Top three social concerns impacting health in your community.

Rank	All responses (n=314)	Responses from Franklin City and Suffolk City (n=215)	Responses from the counties of Isle of Wight, Southampton, Surry, Sussex and Gates, NC (n=99)
Youth			
1	Lack of parenting support, education services	Lack of available healthy food	Lack of parenting support, education services
2	Lack of available healthy food	Lack of parenting support, education services	Lack of available healthy food
3	Lack of quality schools	Violence in the community (gun and/or gang)	Lack of quality schools
Adults			
1	Lack of affordable housing	Lack of affordable housing	Lack of affordable housing
2	Loneliness, isolation	Loneliness, isolation	Loneliness, isolation
3	Lack of available healthy food	Lack of available healthy food	Lack of available healthy food



Community focus groups

In addition to the online surveys for community insight, SOH, BASC, SOAS, and OHF carried out a series of more in-depth community focus groups to obtain greater insight from diverse stakeholders and community members. Focus groups were promoted electronically and by word of mouth to hospital patients and visitors, existing hospital and community groups, and partner organizations. Input was also sought from other populations in the community, including representatives of underserved communities and consumers of services. In collaboration with CHKD and Bon Secours, SOH, BASC, SOAS, and OHF held seven focus group sessions between October 2024 and February 2025. The number of participants in each group ranged from six to 14. Refer to Appendix C for complete notes.

2024 focus groups

- October 14: Filipino Focus, 9 participants
- November 14: HOPES Free Clinic, 7 participants
- November 14: Pruden Center, 17 participants
- November 21: Delta Sigma Theta, 7 participants
- December 12: Hampton Roads Parenting Network, 8 participants

2025 focus groups

- January 21: Iglesia de Dios de Adonai (group 1), 8 participants
- January 21: Iglesia de Dios de Adonai (group 2), 11 participants

Demographics

The 67 focus group participants ranged in age from 18 to 65 and older. Altogether, participants were 17.9% White, 28.4% Black, 13.4% Asian, and 40.3% Hispanic. The group identified as 70.1% female and 29.9% male.

Results

Topic	Key findings	
	Children	Adults
What serious health problems are in your community for children (0-17) and for adults (18+)?	<p>Mental health</p> <ul style="list-style-type: none"> Increasing rates of anxiety, depression, and developmental delays <p>Physical health</p> <ul style="list-style-type: none"> High obesity rates due to lack of physical activity and poor nutrition; chronic illnesses, such as diabetes and asthma, are prevalent <p>Nutrition and access to care</p> <ul style="list-style-type: none"> Families struggle to provide healthy meals due to fast-paced lifestyles <p>Substance use</p> <ul style="list-style-type: none"> Increase in vaping and drug use (including fentanyl overdoses in schools) 	<p>Chronic conditions</p> <ul style="list-style-type: none"> High blood pressure, diabetes, heart disease, kidney disease, cancer, and obesity are common <p>Mental health</p> <ul style="list-style-type: none"> Stress, anxiety, depression, and postpartum mental health issues, immigration-related stress, and lack of access to care <p>Caregiving challenges</p> <ul style="list-style-type: none"> Many adults are caring for aging parents with chronic illnesses <p>Substance use and addiction</p> <ul style="list-style-type: none"> Increase in vaping, marijuana, and alcohol-related health issues

Overall, both children and adults face significant challenges in health care access, economic stability, social support, and environmental conditions. Addressing these issues requires better transportation, affordable housing, health care reforms, and stronger community support systems.

Topic	Key findings	
	Children	Adults
What are some of the environmental and social conditions that affect quality of life for children and adults living in your community?	<p>Limited physical activity and safety concerns</p> <ul style="list-style-type: none"> Fear of violence prevents outdoor play Screen time replaces physical and social activities, affecting mental and physical health <p>Food insecurity and nutrition challenges</p> <ul style="list-style-type: none"> Food deserts limit access to fresh and affordable produce Families rely on fast food High cost of nutritious food prevents healthy eating habits <p>Health care and insurance barriers</p> <ul style="list-style-type: none"> Undocumented children struggle to access medical care Medicaid patients face discrimination from health care providers 	<p>Education and social development</p> <ul style="list-style-type: none"> Parents' literacy levels impact children's learning and school readiness Bullying is a major issue, sometimes forcing students to change schools Language barriers in schools prevent parents from fully engaging with their child's education <p>Community and social support</p> <ul style="list-style-type: none"> Grandparents often serve as primary caregivers due to financial hardship Economic struggles at home trickle down to affect children's well-being Lack of legal services for immigrant families seeking stability

Results (cont.)

There's a clear need for better communication, more accessible providers, increased affordability, and improved mental health support.

Topic	Key findings	
	Children	Adults
<p>What do you think about the health-related services that are available in your community, including medical care, dental care, and mental health care for children and adults?</p>	<p>Limited access to health care</p> <ul style="list-style-type: none"> Long wait times Many providers do not accept Medicaid, Medicare, or Tricare Insurance issues with people switching providers due to changes in coverage Cost of care being a major barrier <p>Dental care challenges</p> <ul style="list-style-type: none"> High out-of-pocket costs Lack of providers who accept certain insurances People opting out of necessary dental procedures due to cost 	<p>Transportation and system navigation issues</p> <ul style="list-style-type: none"> Lack of reliable medical transport Complicated insurance and health care navigation Language barriers <p>Economic factors impacting health</p> <ul style="list-style-type: none"> People prioritizing rent and food Parents unable to take time off from work Limited affordable childcare <p>Mental health stigma and accessibility</p> <ul style="list-style-type: none"> Stigma Limited mental health resources Long wait times Fear of repercussions

Community faces a mix of financial, logistical, and educational barriers to accessing and consuming fresh, healthy foods.

Topic	Key findings	
	Children	Adults
<p>Do you feel like it is hard to access healthy, fresh food in your community?</p> <p>What keeps you from trying new fresh fruits and/or vegetables?</p>	<p>Cost and affordability</p> <ul style="list-style-type: none"> Healthy food is perceived as more expensive, leading people to choose cheaper processed foods Families fear wasting money <p>Access and availability</p> <ul style="list-style-type: none"> Grocery stores with affordable, fresh produce are not always easily accessible Farmers markets have limited hours and locations Public transportation makes it difficult <p>Education and awareness</p> <ul style="list-style-type: none"> Lack of knowledge on how to store and prepare fresh foods, leading to waste Families stick to familiar foods and are hesitant to try new options Community gardens exist, but people are unsure how to use them effectively Restaurants could use better markers to highlight healthy options 	<p>Convenience and time constraints</p> <ul style="list-style-type: none"> Fast food is easier and often cheaper than preparing healthy meals Parents working long hours struggle to find time for meal prep Pre-packaged processed foods last longer and require less preparation <p>Cultural and taste preferences</p> <ul style="list-style-type: none"> Some people are not used to certain fruits and vegetables, making them less likely to buy them Produce in the U.S. is often frozen or picked before ripening, leading to lower-quality taste compared to fresh markets in other countries

Results (cont.)

Community has several strong programs and resources that support healthier living, including medical services, food access initiatives, exercise programs, and community partnerships.

Topic	Key findings	
	Children	Adults
<p>What is working in your community that can help residents live healthier lives?</p>	<p>Health care and medical support</p> <ul style="list-style-type: none"> ▪ Electronic health records ▪ Glennen Center for Geriatrics, VA Services: Providing care, supplies, and medication delivery for seniors and Veterans ▪ Mobile health clinics ▪ Doulas and home visiting programs ▪ Health fairs and insurance assistance <p>Food access and nutrition education</p> <ul style="list-style-type: none"> ▪ School and community food programs ▪ Food pantries and church support ▪ WIC and SNAP support ▪ Cooking classes and food storage education 	<p>Fitness and recreation opportunities</p> <ul style="list-style-type: none"> ▪ Recreation centers and YMCA partnerships ▪ 5K events and fun runs ▪ Therapeutic recreation and FACT programs <p>Community engagement and partnerships</p> <ul style="list-style-type: none"> ▪ Grandfamilies program ▪ Community gardens and farm-to-table events ▪ Social media and money-saving apps ▪ Interpretation services by Sentara: Helping non-English-speakers access health care

Community has identified key areas for improvement in health care access, affordability, education, and outreach.

Topic	Key findings	
	Children	Adults
<p>What do you think your local health systems (hospitals and primary care) and health departments can do to improve the health and wellness in your community?</p>	<p>Cost transparency and affordability</p> <ul style="list-style-type: none"> ▪ Clear itemized costs ▪ Lower health care costs ▪ Subsidized (not always free) care ▪ Shorter wait times for appointments <p>Access and care coordination</p> <ul style="list-style-type: none"> ▪ Easier medical records sharing ▪ Better parking and senior accessibility ▪ Mobile clinics in underserved areas ▪ More preventive services 	<p>Education and outreach</p> <ul style="list-style-type: none"> ▪ More community health fairs ▪ Early, preventive education ▪ Counter misinformation ▪ Workforce development in health care <p>Communication and awareness</p> <ul style="list-style-type: none"> ▪ Expand communication beyond social media ▪ Advocates in the community ▪ More virtual health options ▪ Promote free and low-cost resources

Health status and prioritization

Health indicators

To gain a deeper understanding of our community, we looked at the 2024 County Health Rankings data to view length of life, quality of life, health behaviors, clinical care, social and economic factors, and physical environment. Per the County Health Rankings, “many of the leading causes of death and disease are attributed to unhealthy behaviors.” Below are key health status indicators for the counties representing this community.

Access to health services

Access to quality and affordable health care is important to an individual’s health. Health insurance and local care resources can help to ensure access to care. If outpatient care in a community is poor, then people may be more likely to overuse the hospital as their main source of care, resulting in unnecessary hospital stays. Typically, areas with more primary care providers have lower rates of hospitalizations for preventable health issues.

Most of the primary service area has fewer doctors to community members compared to the state (1341:1), particularly in Isle of Wight (2455:1), Southampton (4502:1), Surry (6530:1), and Sussex (3588:1). Though, Franklin (913:1) and Suffolk (1300:1) have better access. Increasing access to primary care is a key solution to reducing unnecessary and costly hospital stays and improving the health of the community. It is important to note that Black populations living in Virginia and in the primary service area, including Gates, have higher rates of preventable hospital stays compared to White residents.¹

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

- Access to health services
- Life expectancy
- Diabetes
- Behavioral health
- Substance use
- Community violence
- Cancer
- Leading causes of death
- Women and infant health
- Older and aging adults

Preventable hospital stays by rate by race, 2021

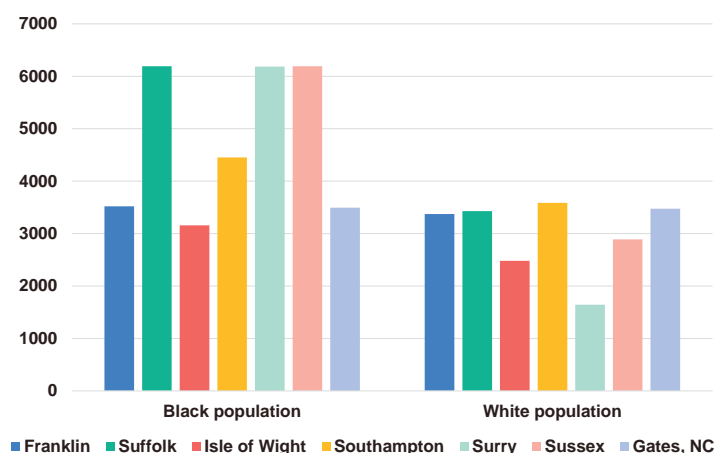
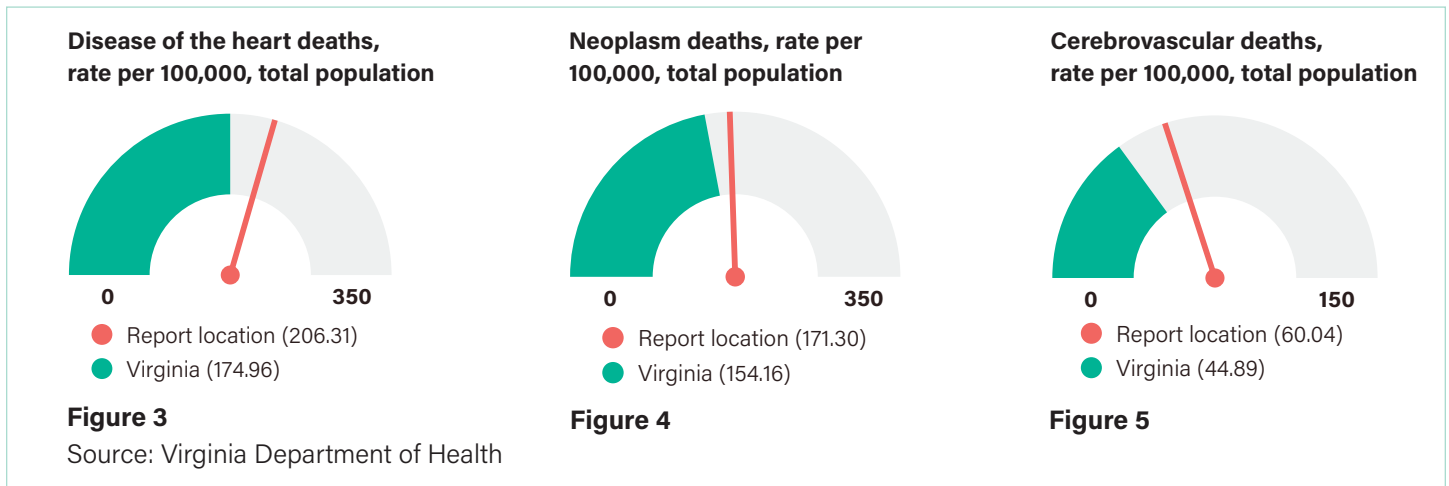
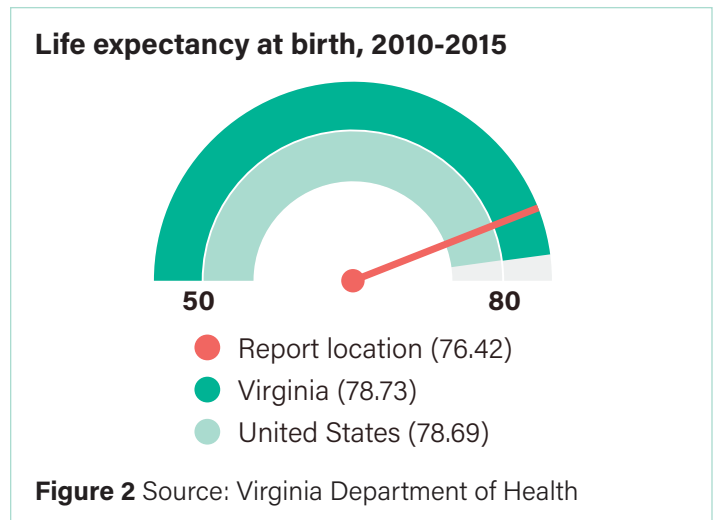


Figure 1 Source: County Health Rankings

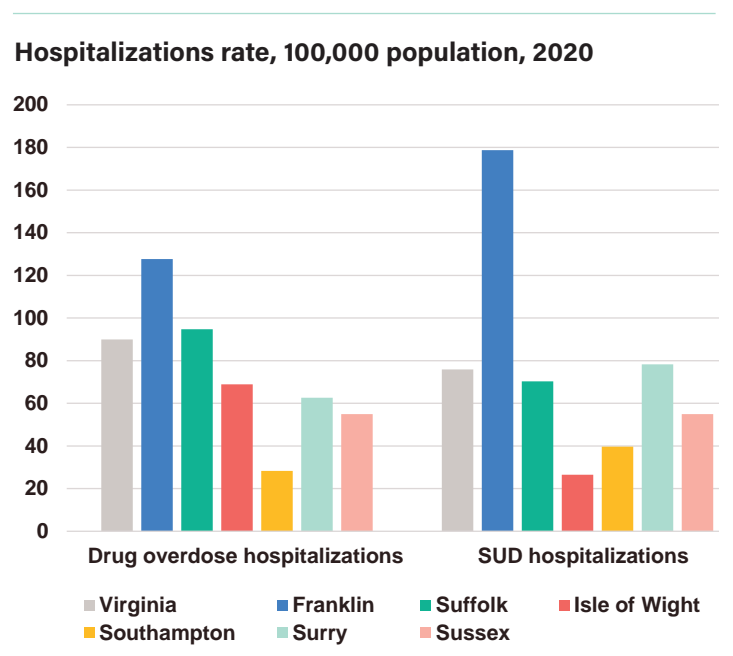
Life expectancy

Per the Virginia Department of Health, the life expectancy for a person living in the Commonwealth of Virginia is 78.7 years. At 76.4 years, residents in this community have a lower life expectancy than Virginians overall. It is important to note that there is a racial disparity related to life expectancy specific to Black populations. Per the 2024 County Health Rankings, the life expectancy for Black individuals is up to seven years shorter than White individuals in this service area.



Leading causes of death

The Virginia Department of Health examined leading causes of death in localities of this community. Between 2021 and 2023, heart disease, cancer, COVID-19, stroke, and accidents were the top five causes of death in the primary community.² Similarly for Gates, leading causes of death were heart disease, cancer, accidents, COVID-19, and chronic lower respiratory diseases.



Behavioral health, mental health, and substance use

Hospitalization rates due to substance use, drug overdose, mental health, suicide, and self-inflicted injury were examined. In the service area, there were higher hospitalization rates (per 100,000 population) due to drug overdose compared to Virginia rates.² This community also has a higher rate of alcohol-impaired driving deaths, liver disease, and cirrhosis compared to Virginia overall.

Mental health is becoming an increasing health concern for both adolescents and adults. Sentara examined emergency department visits in 2024 to gain a better understanding of the mental health crisis communities have been facing since the COVID-19 pandemic. In 2024, the SOH and BASC emergency departments treated 1,823 adults (age 19+) with behavioral health diagnoses. Of these visits, 15.4% of the patients presented with suicidal ideation, 5.2% with schizophrenia, 4.1% with major depressive disorder, 5.1 with schizophrenia, and 7.6% with mental disorder. Additionally, SOH and BASC saw 243 youth (age 0-18) present with behavioral health diagnoses. Of these visits, 36.6% presented with suicidal ideation and 7.6% with mental disorder. It is important to note that the mental health workforce is nearing retirement age, which will negatively impact provider capacity. There is also a need for greater racial and ethnic representation in the mental health workforce.³

Community violence

Violent crimes such as gun violence, robbery, or aggravated assault have a harmful socio-emotional impact. They can cause physical and emotional symptoms such as sleep disturbances, increased feelings of distress, anger, depression, inability to trust, and significant issues with family, friends, or coworkers. Chronic stress has been associated with violent crimes and increases the prevalence of certain illnesses such as upper respiratory illness and asthma. This can have a life-long impact on the health of the individual.

The firearm fatality rate for the primary service area (13.2 per 100,000) is higher than the state (10.7).

Substance use and mental health, age 18+

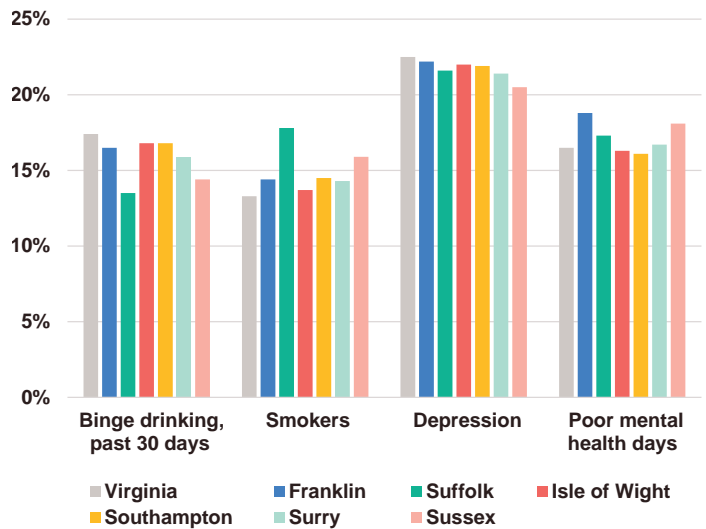


Figure 7 Source: Virginia’s Plan for Well-Being

Firearm fatality rate, 2022

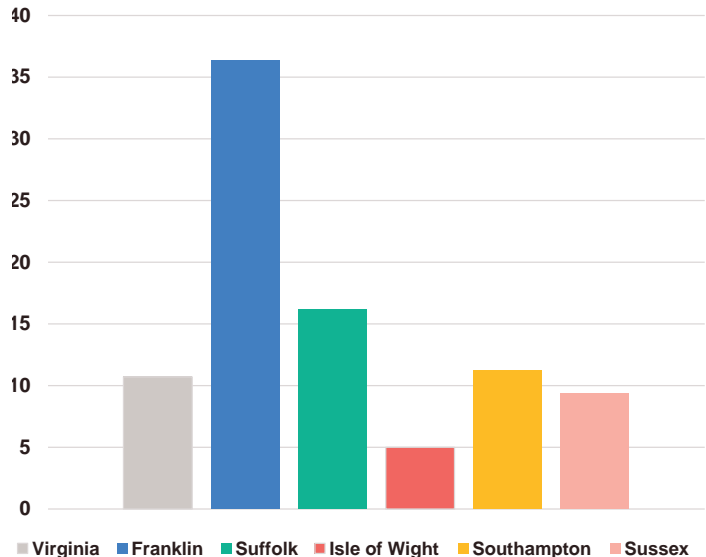


Figure 8 Source: Virginia’s Plan for Well-Being

Deaths due to firearms are considered largely preventable; as a result, gun violence has been identified as a key public health issue by national agencies. A 2022 study published by the American Academy of Pediatrics showed an increase in pediatric deaths due to firearms. The study also showed a disparity among Black youth, who are 14 times more likely to die of a firearm injury compared to their White peers.⁴

Cancer

Since cancer is a leading cause of death in this community, death and incidence rates for a variety of cancer types were examined. Compared to the previous three-year rates, 2017-2021, the number of cases and deaths from the most common types of cancer are decreasing in the Commonwealth of Virginia, as well as this community.⁵ It is important to note that the incidence rates of breast cancer are rising for the White and Asian populations living in Virginia. Mortality rates were highest among lung and breast cancers, though declining in this community. Prostate and lung cancers are the leading causes of cancer death for Black populations living in Virginia. Sussex has the greatest incidence rate for all cancers (525.4 per 100,000 population), which is trending to rise in the county.⁵ Medical advancements and community outreach programs providing cancer screenings and education are making strides but, to have the greatest impact, we will need to focus efforts on the populations at highest risk for various cancers.

Maternal and infant health

Unsupported and under-supported young families face many negative health outcomes and many long-term health challenges as time goes on, so looking at the way families begin can help us to understand the current and future health of the community. The percentage of mothers in the primary service area (5.1%) that had late or no prenatal care was the same as Virginia (5.1%). The primary service area had a higher percentage of preterm births (11.2%) and babies born with low birth weights (9.9%) compared to the Commonwealth (9.6%, 8.5%). In Gates, 8.6% of babies were born with low birth weights.¹¹ The infant mortality rate (7.2 per 1,000 births) was also greater compared to Virginia (6.0). While teen pregnancies (91 from 2020-2022) are a community concern, the low numbers do not permit meaningful standardization for comparison to state rates.²

Diabetes

According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase in the U.S. and is the seventh leading cause of death in the United States. Risk factors such as

Virginia cancer incidence rate race/ethnicity

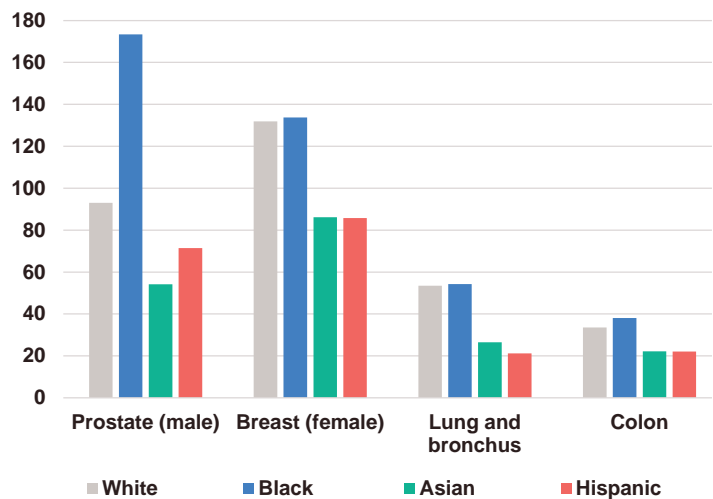


Figure 9 Source: Virginia's Plan for Well-Being

Maternal and infant health, 2020-2022

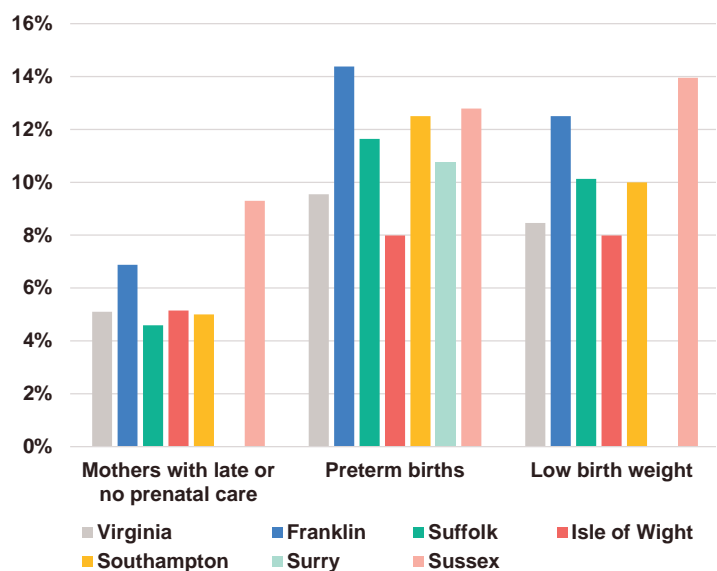


Figure 10 Source: Virginia's Plan for Well-Being

obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity are also key risk factors. The percentage of adults living with diabetes in this community (14.6%) is higher than the state percentage of 12.7%. The hospitalization rate at SOH, 3,192.35 (per 100,000), for diabetes was also above the state rate of 2,114.24.²

Older and aging adults

In many communities, older adults are the fastest growing segment of the population. Challenges come with an aging population, including health-related factors and other factors that ultimately impact health. The percentage of Medicare recipients seen for hypertension and diabetes, the top conditions for which patients received hospital treatment in this community, including Gates, was higher compared to Virginia overall. The percentage of Medicare beneficiaries treated for Alzheimer’s disease or dementia was also slightly higher in most of the communities served by SOH, BASC, SOAS, and OHF than Virginia overall (6%).⁸ These conditions are important to note as they will impact the aging population’s health, quality of life, health care demand, and costs.

Advance care planning

Sentara Obici Hospital is also working with the community to complete advance care plans. These plans are designed for adults to specify their medical wishes and/or designate someone as their medical decision-maker in the event they cannot communicate or advocate for themselves. While many team members working within the health care industry understand the importance and value of advance care plans, it is evident within the acute care setting that our community members may not have that same understanding until it is too late. Currently, within Virginia, there are approximately 48,271 active registrants with advance care plans filed within the U.S. Advance Care Planning Registry (formerly U.S. Living Will Registry).⁹ Sentara has approximately 78,520 active registrants with advance care plans on file within the U.S. Advance Care Plan Registry with 276 of those completed for residents of the SOH, BASC, SOAS, and OHF community, including Gates.

Surgical site infections

Surgical site infections (SSIs) occur after surgery and in the part of the body where the surgery took place. Surgical site infections can develop within days of the surgery or even months thereafter. Some patients may be at higher risk for developing an SSI due to

Medicare primary chronic conditions, 2022

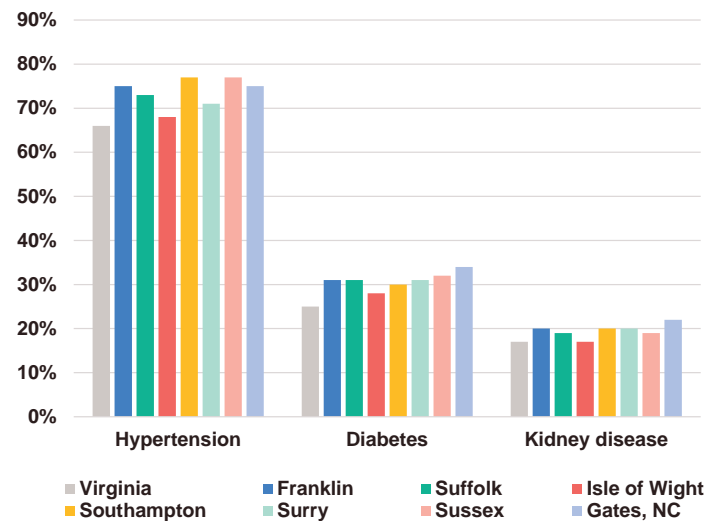


Figure 11 Source: Virginia’s Plan for Well-Being

their age and underlying medical conditions, such as diabetes and COVID-19 infections. “Data from AHRQ’s Partnership for Patients initiative indicates that the national rate of SSI decreased by 16% between 2010 and 2015, translating into significant benefits for patients (including many lives saved), as well as significant cost savings.”¹⁰ Advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical techniques, and the availability of antimicrobial prophylaxis, yet SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death in the inpatient setting.¹¹ Sentara tracks SSI rates and looks for opportunities to reduce the factors that lead to the development of SSIs.

SOH, BASC, and SOAS prioritization

The Forces of Change Assessment (FOCA) focuses on identifying all driving factors that can affect the public health system in a community. The assessment folds into the Mobilizing for Action through Planning and Partnerships model of community health improvement and was used to inform our new CHNA improvement strategy. Extensive secondary quantitative data from publicly available data, as well as primary qualitative data collected from surveys and focus groups, were synthesized and analyzed to identify the community’s health needs.

Recommendations

With the completion of the 2025 CHNA, Sentara, SOH, BASC, and SOAS developed goals to positively impact the community's identified health concerns and socioeconomic needs. We will leverage community partners and resources to identify ways to address these health concerns and create specific priority objectives for the implementation strategy. For 2026-2028, SOH, BASC, and SOAS will focus on the following:



Improve mental well-being



Improve chronic conditions and avoidable health outcomes



Address and invest in social determinants of health

Conclusion

The information presented in this CHNA reveals a community facing a number of health challenges based on the data collected, focus groups, and survey responses. The same challenges can be found in countless communities throughout the country. Beyond the scope of Sentara, SOH, BASC, and SOAS alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. We are committed to finding innovative, responsive, and successful strategies to address these challenges in order to fulfill our mission to improve health every day.

Endnotes

¹ County Health Rankings & Roadmaps: Rankings Data & Documentation. Accessed October 11, 2024. <https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation>.

² Virginia's Plan for Well-Being Community Health Improvement Data Portal. Accessed March 11, 2025. <https://virginiawellbeing.com/virginia-community-health-improvement-data-portal/>.

³ Virginia Health Care Foundation. (January 2022). Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce. Retrieved from <https://www.vhcf.org/wp-content/uploads/2022/01/BH-Assessment-Final-1.11.2022.pdf> on April 11, 2022.

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

⁵ National Cancer Institute, State Cancer Profiles. Incidence Rates Table. Accessed February 25, 2025. <https://statecancerprofiles.cancer.gov/incidencerates/index.php>.

⁶ National Cancer Institute, State Cancer Profiles. Death Rates Table. Accessed February 25, 2025. <https://statecancerprofiles.cancer.gov/deathrates/index.php>.

⁷ NCDHHS Division of Public Health. North Carolina Maternal and Infant Health Dashboard. Accessed April 3, 2025. <https://www.dph.ncdhhs.gov/programs/title-v-maternal-and-child-health-block-grant/nc-maternal-and-infant-health-data-dashboard>.

⁸ Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 12, 2025. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

⁹ The U.S. Will Registry. Accessed March 1, 2025. <https://www.theuswillregistry.org/>.

¹⁰ Agency for Healthcare Research and Quality (AHRQ). (September 7, 2019). Surgical Site Infections. Retrieved from <https://psnet.ahrq.gov/primer/surgical-site-infections> on August 10, 2022.

¹¹ Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP). Accessed January 1, 2025. <https://www.cdc.gov/nhsn/opc/ssi/index.html>.

Supplemental resources

2023-2025 Implementation strategy progress summary

The previous CHNA identified several health issues in the service area. The Sentara Obici Hospital (SOH), BelleHarbour Ambulatory Surgery Center (BASC), and Sentara Obici Ambulatory Surgery (SOAS) implementation strategy progress report was developed to document activities addressing health needs identified in the 2022 CHNA report through both primary and secondary data sources.

By identifying the most pressing health concerns within a community, the 2022 assessment assisted in setting priorities for health interventions and resource allocation to advance health based on patient demographic data and community insight.

This section of the CHNA report describes these activities and collaborative efforts. We are monitoring and evaluating progress to date in the 2023 implementation strategies to track implementation and document the impact of those strategies in addressing selected CHNA health needs. For reference, the list below includes the 2022 CHNA health needs that were prioritized to be addressed by SOH, BASC, and SOAS in the 2023 implementation strategy.

- Behavioral health
- Chronic diseases
- Social determinants of health

Behavioral health

Improving the mental and emotional well-being of all living in the SOH, BASC, and SOAS service area by increasing access to behavioral health services is an important priority. Sentara continues to improve access to behavioral health resources, knowing that one in five adults will have a mental illness severe enough to require treatment and many more will have emotional and mental health problems that prevent them from fully enjoying their lives.

At Sentara, we offer inpatient treatment services through telepsychiatry. Our adult and senior behavioral health inpatient programs provide diagnostic services and treatment for people 18 and older who are in crisis due to mental illness, emotional distress, or destructive behavior patterns. Because our treatment facilities are located within several of our hospitals, patients have access to the full range of both psychiatric and medical care. Sentara will continue to partner with community mental health programs to identify alternate placement options for Behavioral Health Emergency Department patients.

To increase community awareness and reduce stigma, Sentara partnered with the Virginia Stage Company to support an inspirational play about mental health. "Every Brilliant Thing" is an intimate, interactive performance which continues to be brought to communities throughout Virginia and North Carolina. Between 2024 and 2025, five events were held reaching 737 community members.

Sentara, SOH, BASC, and SOAS also partnered with Bon Secours, CHKD, Riverside Health, and the Hampton and Peninsula Health Districts to provide "Hiding in Plain Sight," a youth mental health

documentary with local panel discussion at a local middle school to begin the mental health discussion between teens and parents. Sixty participants attended this event.

Chronic diseases

Collectively, SOH, BASC, and SOAS are working to reduce the impact of chronic diseases on morbidity and mortality for the community living in the service area by increasing disease management resources and education. Sentara brings prevention, hope, inspiration, and support to our local community where SOH, BASC, and SOAS are working to reduce chronic disease impact by extending our reach into the community, where life happens. Both BASC and SOAS work with patients and their families to provide multiple resources and tools regarding mental health and chronic diseases. Our cancer educators implement programs focused on cancer prevention, detection, and provide community outreach by hosting and participating in screening and education events. Local cancer screening events for oral, head and neck cancers, FIT testing for colorectal cancer, breast cancer mammography screening, and skin cancer screening events are offered. We continue to remove barriers to mammography for the uninsured or underinsured, including supplementing traditional measures with a mobile mammography van and more

targeted efforts to reach underserved communities, such as connecting with faith leaders, providing transportation for those who need it, and building trust with patients.

Social determinants of health

Along with other Sentara hospitals, SOH has implemented the use of Unite Us, a cross-sector collaboration software establishing a new standard of care that identifies social needs in communities, manages enrollment of individuals in services, and leverages meaningful outcomes data and analytics to further drive community investment.

In partnership with the Western Tidewater Free Clinic, SOH provided an access navigation event for the community to educate community members on health care accessibility and financing their care. The hospital also hosted a week-long camp for middle school students to learn about medical careers. This camp provided an in-person, hands-on environment for kids to explore potential career opportunities in health care.

To further increase economic growth, job security, and educational opportunities, SOH, BASC, and SOAS continue to collaborate with various programs at multiple institutions of learning to provide training opportunities for health care professionals and students.

“The Community Health Needs Assessment offers a meaningful opportunity to listen closely, engage authentically, and give voice to the unique health concerns of the communities we serve—guiding us toward more responsive, equitable care.”

Tricia D Christoffer, MSN, RN, PCCN
Sentara Health Director of Ambulatory Services, Service Line Lead





Grantmaking and community benefit

In the 2023 implementation strategy process, Sentara and its hospital facilities planned for and drew on a broad array of resources and strategies to reach vulnerable populations, such as grant making, in-kind resources, collaborations, and partnerships.

Sentara is aware of the significant impact that our organization has on the economic vitality of our communities. As a system, Sentara will continue to invest in and support organizations and projects that address prominent social determinants of health. We will continue to promote health by working to eliminate traditional barriers to health and human services.

In 2023, Sentara invested more than \$294 million in the communities we serve — \$47 million in community giving, \$13 million in health and prevention programs, \$70 million in teaching and training of health care professionals, and \$164 million in uncompensated patient care. In 2024, Sentara invested more than \$329 million in the communities we serve — \$40 million in community giving, \$19 million in health and prevention programs, \$96 million in teaching and training of health care professionals, and \$174 million in uncompensated patient care.

Community health is defined by much more than medical care. As more is known about the role of social

determinants of health, more opportunities will arise to influence population health by engaging in community approaches to care. Beyond the scope of SOH, BASC, and SOAS alone, these opportunities will require active partnerships among local organizations and individuals to create lasting impact.

Sentara and its hospitals are committed to finding innovative, responsive, and successful strategies to address these challenges, to fulfill our mission to improve health every day. While we will consider proposals that fall outside of the following focus areas, we strongly encourage proposals that align with one or more of the following priorities:



Housing: Partner with agencies and organizations that can creatively address a variety of housing issues.



Food security: Improve food security in our communities through innovative programs.



Skilled careers: Educate people to gain higher paying jobs for more sustainable economic opportunities.

Serving the cities of Franklin and Suffolk, and the counties of Isle of Wight, Southampton, Surry, Sussex, and Gates (North Carolina)

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