

Sentara CarePlex Hospital,
CarePlex Orthopaedic Ambulatory Surgery Center,
and Port Warwick Surgery Center

Community Health Needs Assessment 2025

This joint Community Health Needs Assessment report was completed in collaboration between Sentara CarePlex Hospital, CarePlex Orthopaedic Ambulatory Surgery Center, and Port Warwick Surgery Center, which have the identical service areas of the cities of Hampton and Newport News.



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Executive summary

Sentara Health is proud of our longstanding commitment to the communities served by Sentara CarePlex Hospital (SCH), CarePlex Orthopaedic Ambulatory Surgery Center (COASC), and Port Warwick Surgery Center (PWSC). We are committed to the cities in our defined service area of Hampton, Newport News, and surrounding communities.

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, as well as data on health care utilization and trends.

Work on the 2025 CHNA for SCH, COASC, and PWSC 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 320,216 persons living in the service area, which includes the cities of Hampton and Newport News.

Racial profile

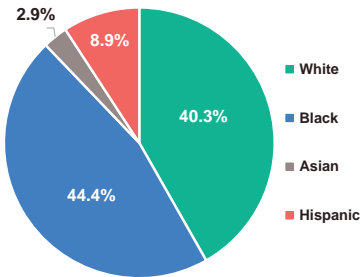


Figure 1

Source: United States Census Bureau

Population by age, 2019-2023

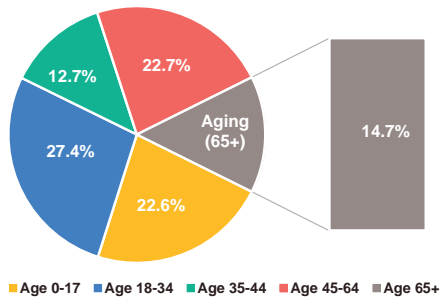


Figure 2

Population change from 2020-2023

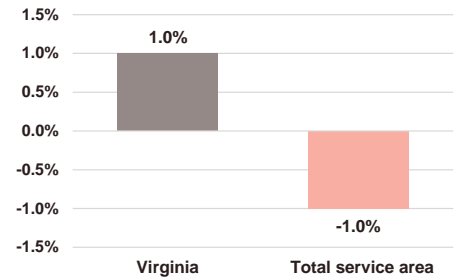


Figure 3

Determinants of health include:

Primary care providers, rate per 100,000 population

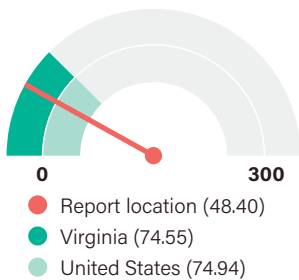


Figure 4

Population in poverty, percentage

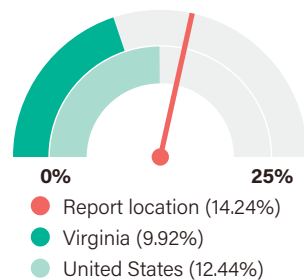


Figure 5

Households where housing costs exceed 30% of income, percentage

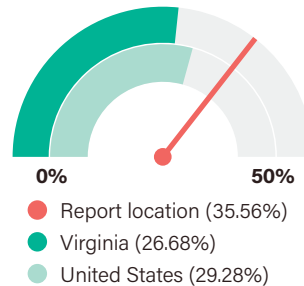


Figure 6

Population with a disability, percentage

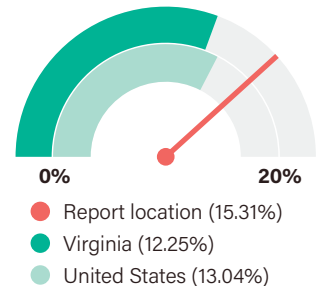


Figure 7

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

Top health concerns include:

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

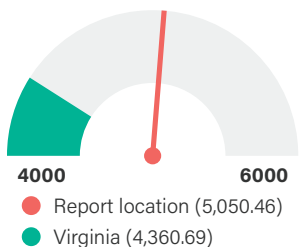


Figure 8

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

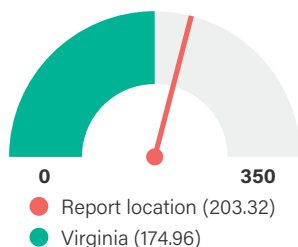


Figure 9

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

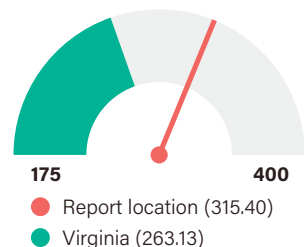


Figure 10

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

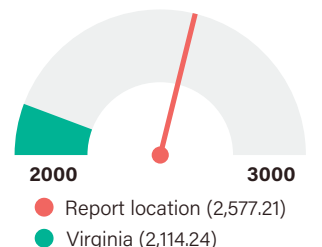


Figure 11

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 service area, 40.27% of residents are White, 44.43% are Black, 8.87% are Hispanic, 2.85% are Asian, and 9.65% are multiple races (total exceeds 100% due to rounding and multiple races selected in the census).² The age profile for the population closely mirrors, yet slightly differs, from that of the Commonwealth of Virginia. Within the next ten years, the total population in the service area is estimated to decrease by almost 1.0% — a loss of roughly 2,652 residents.³

Social and economic factors

Sentara recognizes 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, housing, poverty, and public health insurance enrollment of residents in the service area.

Education and employment

Education supports stable employment and financial stability for individuals and their families. As of the

County Health Rankings model

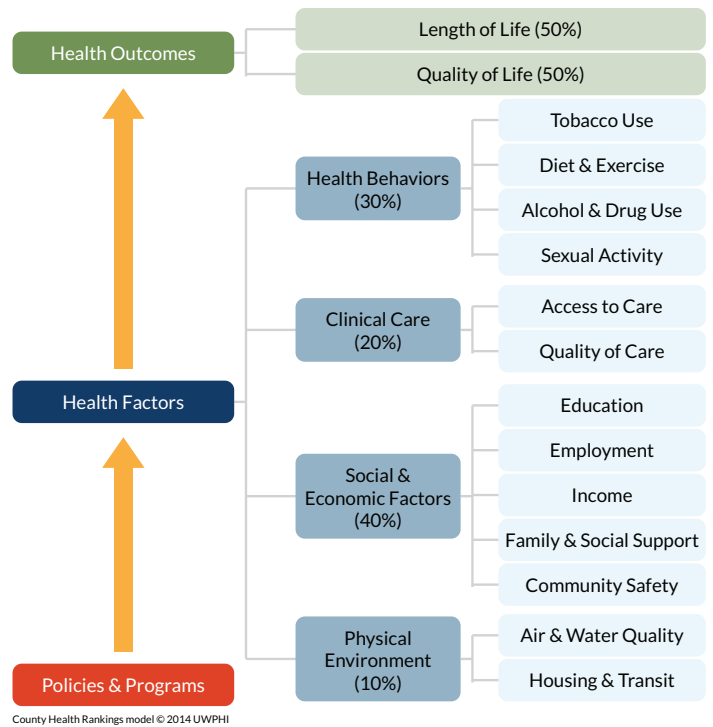


Figure 12

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

2023 U.S. Census, 92.2% of the residents in the service area were high school graduates, compared to 91.1% of Virginia residents. According to the 2019-2023 American Community Survey, just 38.8% of residents in the service area hold advanced or professional degrees compared to 43.8% statewide.

As of the 2023 U.S. Census, 67.8% of residents in the service area participated in the labor force, above the state average of 66.6%. Of total service area residents, the percentage of female residents in the civilian labor force (61%) is the same as the state average (61%).

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 service area are more likely to live in poverty (14.6%) 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. Similar to Virginia as a whole, People of Color living in the service area are more likely to live in poverty compared to White residents. In the service area, Black residents (17.6%) experience a higher rate of poverty compared to White residents (11.6%).

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 1,338 residents living in the service area participating. We appreciate the time and contributions these individuals made to help enhance health and well-being in our community.

Top concerns identified included:

- Mental health
- Asthma and allergies
- Obesity
- Diabetes and cancer

Top barriers identified included:

- Long wait for a scheduled appointment
- Cost of health care and services
- Appointments unavailable for new patients
- Limited or no insurance

Focus groups

Hospital leaders conducted community conversations from October 2024 through February 2025 to gain more in-depth insights from community stakeholders on their health concerns and health care barriers. Leaders from the collaborative, SCH, COASC, and

PWSC 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: PTSD, anxiety, depression, behavioral health, stress
- Access to health care: Cost, doctors, transportation, difficulty scheduling appointments
- Chronic conditions: Hypertension, diabetes, high cholesterol, cancer, kidney disease, 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, SCH, COASC, and PWSC 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 communities served by SCH, COASC, and PWSC, the average life expectancy is 76.4 — 2.3 years less than the state average. It is important to note disparities affecting Black residents. The average life expectancy

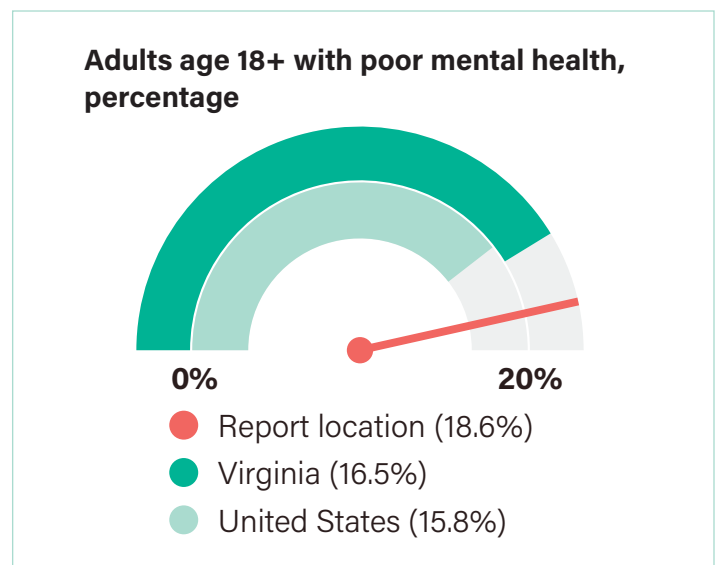


Figure 13 Source: Virginia’s Plan for Well-Being, Virginia Community Health Improvement Data Portal

of Black residents in the service area is 71.3 to 73.9 years — 3.8 to 2.4 years less than White residents (76.3, 75.1 years) living in the service area.¹

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, 1,680 adults and 196 youth visited the SCH emergency room for behavioral health concerns. Of those patients, 25.5% of the adults and 34.7% of the youth reported suicidal ideations.

Top health conditions driving hospitalizations, in order of highest rates, at SCH include asthma, hypertension, stroke, diseases of the heart, and mental health. Leading causes of death include heart disease, cancer, accidents, stroke, and COVID-19. 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 equity 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 SCH, COASC, PWSC health priorities for 2026-2028







Sentara priorities	Socioeconomic needs	Health needs	SCH, COASC, PWSC priorities	Increasing needs
	 Housing	 Behavioral and mental health		
	 Food security	 Chronic conditions		
	 Skilled careers	 Social determinants of health		

Table 1 Sentara cares priorities for grant opportunities and SSCH, COASC, and PWSC implementation strategy priorities for 2026-2028.

Endnotes

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

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

³ University 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, an integrated, not-for-profit 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 CarePlex Hospital (SCH)

Sentara CarePlex Hospital, located in Hampton, VA, is a 224-bed technologically advanced, acute care facility, and Certified Primary Stroke Center. At SCH, we offer eICU® to monitor patients even more closely with state-of-art equipment and computer software. Our outpatient pharmacy makes prescription pick-up more convenient for patients and family members upon discharge from the emergency department or inpatient stays. Other features include specialized services in heart and vascular, urologic care, along with advanced diagnostic and surgical capabilities, a hospitalist program, and one of the state’s busiest emergency departments. We are also home to the Orthopaedic Hospital at SCH, the area’s first dedicated orthopedic hospital.²

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**

CarePlex Orthopaedic Ambulatory Surgery Center (COASC)

The Orthopaedic Hospital at SCH is the area’s first dedicated orthopedic hospital, taking specialized orthopedic care to a new level. The 55,000-square-foot, two-story facility provides patients access to the full continuum of orthopedic services, from the pre-operative phase and surgery to rehabilitation and home care services. Located within the Orthopaedic Hospital is the Careplex Orthopaedic Ambulatory Surgery Center (COASC). The COASC is devoted to providing exceptional outpatient surgical care to patients. Our team of specialty-trained personnel is passionate about patient care and committed to continuously improving services for our patients.³

Port Warwick Surgery Center (PWSC)

Port Warwick Surgery Center's physicians and staff provide personalized experiences for every patient at a fraction of the cost of a hospital. We specialize in orthopedic and ENT services, and we take great pride in the care we provide. Our skilled orthopedic surgeons address common and complex orthopedic conditions, including total joint replacements in our technologically advanced surgical suites. Patients undergoing ear, nose, throat, or neck surgery receive advanced surgical care using the latest surgical techniques. Our specialists treat a full range of surgical needs for both adults and children.⁴

Sentara Cares

Our purpose calls us to address healthcare 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.⁵

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. ”

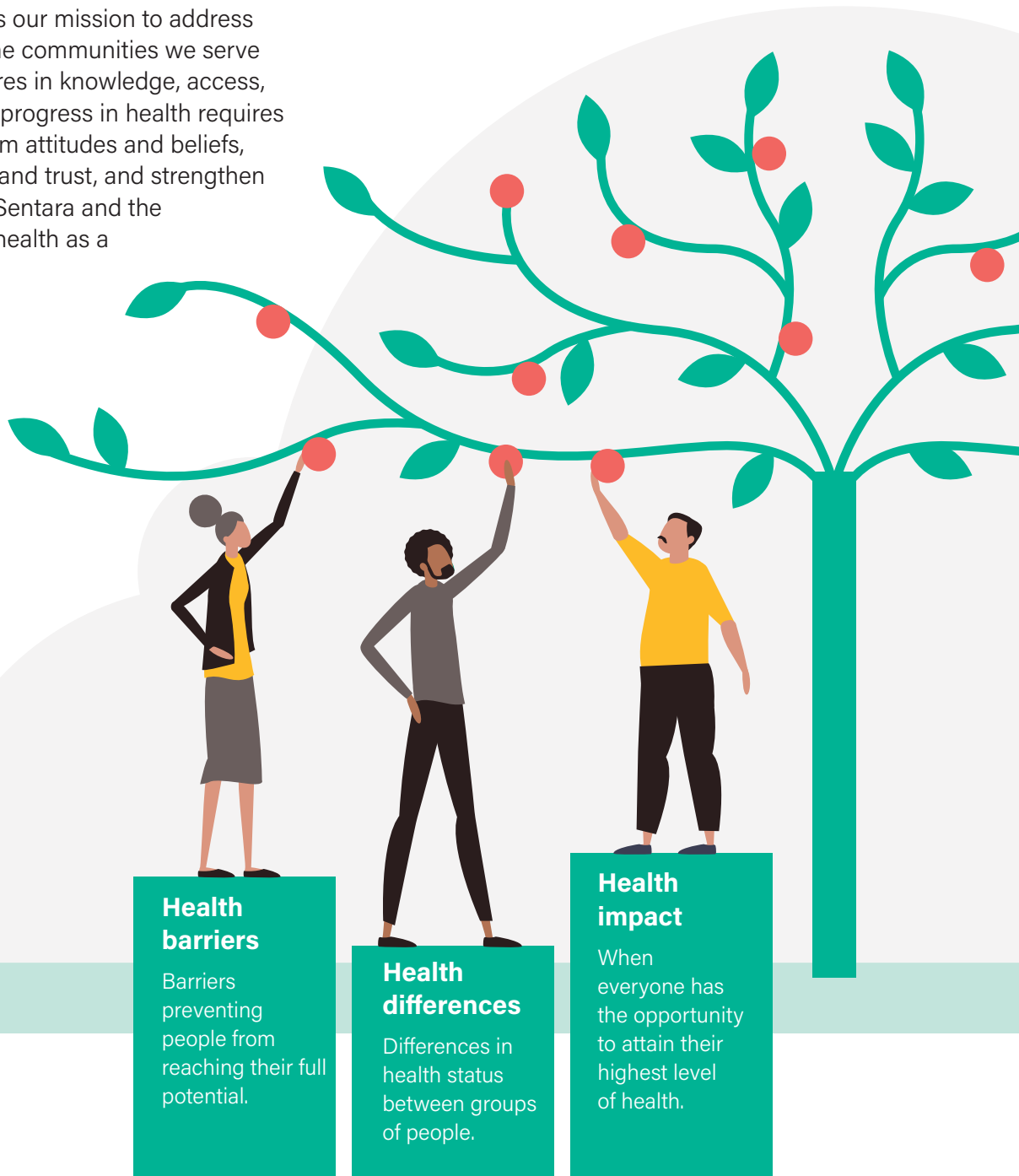
Sherry Norquist, MSN, RN-ACM, Executive Director of Community Engagement & Impact



Health impact

By identifying the most pressing health concerns within a community, this assessment prioritizes health interventions and allocates resources to advance health impact based on community insight. Our efforts promote health, enhance awareness, education, and access to care across racial, ethnic, gender, age, language, geographic, and socioeconomic groups. This 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 healthcare 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.



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

The National Association of County and 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.⁶

We began the MAPP process at SCH, COASC, and PWSC by engaging community partners, developing support teams, and creating a shared vision with common values. Community partners included 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 these 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

At SCH, COASC, and PWSC, we work with a number of community partners to address health needs. Using the information from this assessment, SCH, COASC, and PWSC 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.

Information on available resources 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.



Endnotes

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

² Sentara Health. Sentara CarePlex Hospital. Accessed February 20, 2025. <https://www.sentara.com/hospitalslocations/sentara-careplex-hospital>.

³ Careplex Orthopaedic Ambulatory Surgery Center. Accessed February 20, 2025. <https://www.careplexortho.com/>.

⁴ Port Warwick Surgery Center. Accessed February 20, 2025. <https://www.pwsurgerycenter.com/>.

⁵ Sentara Cares. Strengthening Communities. Accessed October 10, 2024. <https://sentaracares.com>.

⁶ 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

Both SCH and COASC are located in Hampton, with PWSC located in Newport News. The SCH, COASC, and PWSC community includes a total population of 320,216 people who live in the 2,674 square mile report area defined for this assessment according to U.S. Census Bureau's 2019-2023 American Community Survey 5-year estimates.¹ Newport News has the highest population in the service area.

Geography

The SCH, COASC, and PWSC community is comprised of two cities — Hampton and Newport News — and surrounding communities. This community is defined by cities because many health status indicators used in this report are only available at the city level, not at the zip code level, though much of the data incorporates the entire community that SCH, COASC, and PWSC serves.

Community-specific demographics

As of the 2023 U.S. Census, the Hampton population was 137,098, with 13.4% of residents living in poverty and 8.3% uninsured. Age demographics within Hampton include 24.5% of residents between the ages of 0-17, 26.4% ages 18-34, 22.9% ages 35-54, and 27.2% ages 55 and older. English is the primary

language for 92.8% of residents. The racial and ethnic profile for the city is 37.5% White, 49.0% Black, 6.6% Hispanic, and 2.2% Asian.

For Newport News, there is a population of 183,118, with 15.7% of residents living in poverty and 7.1% uninsured. Age demographics within Newport News include 23.3% of residents between the ages of 0-17, 28.1% ages 18-34, 23.1% ages 35-54, and 25.5% ages 55 and older. English is the primary language for 89.1% of residents. The racial and ethnic profile for the city is 42.3% White, 41.0% Black, 10.5% Hispanic, and 3.3% Asian.



Looking at the data

Racial and ethnic profile, 2023

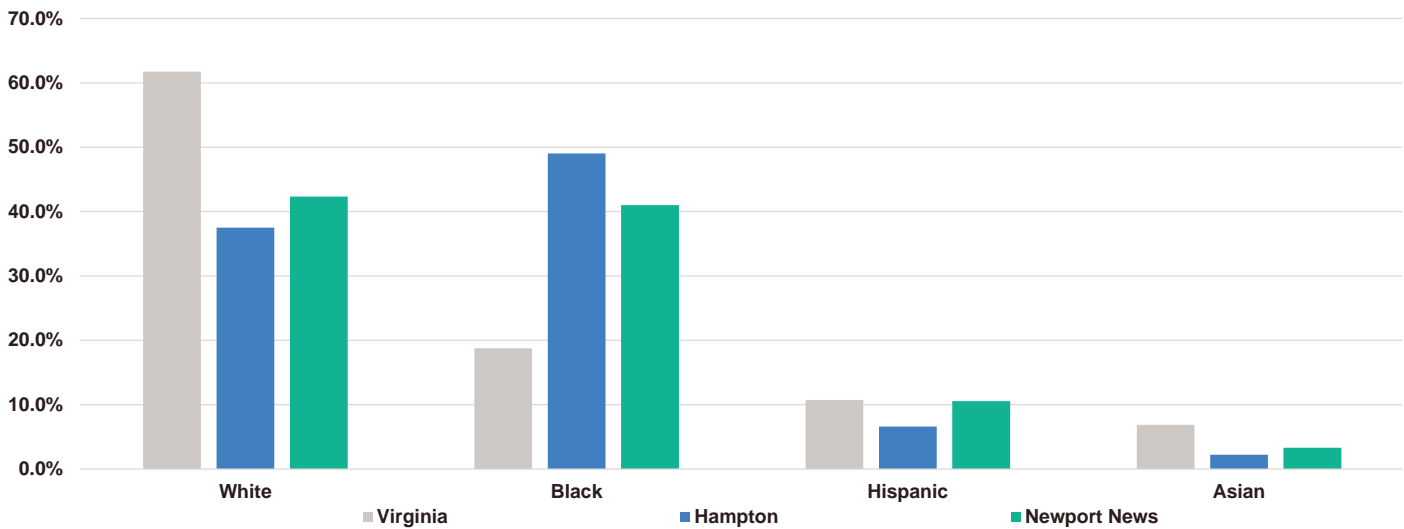


Figure 1 Source: Virginia's Plan for Well-Being

Population by age, 2019-2023

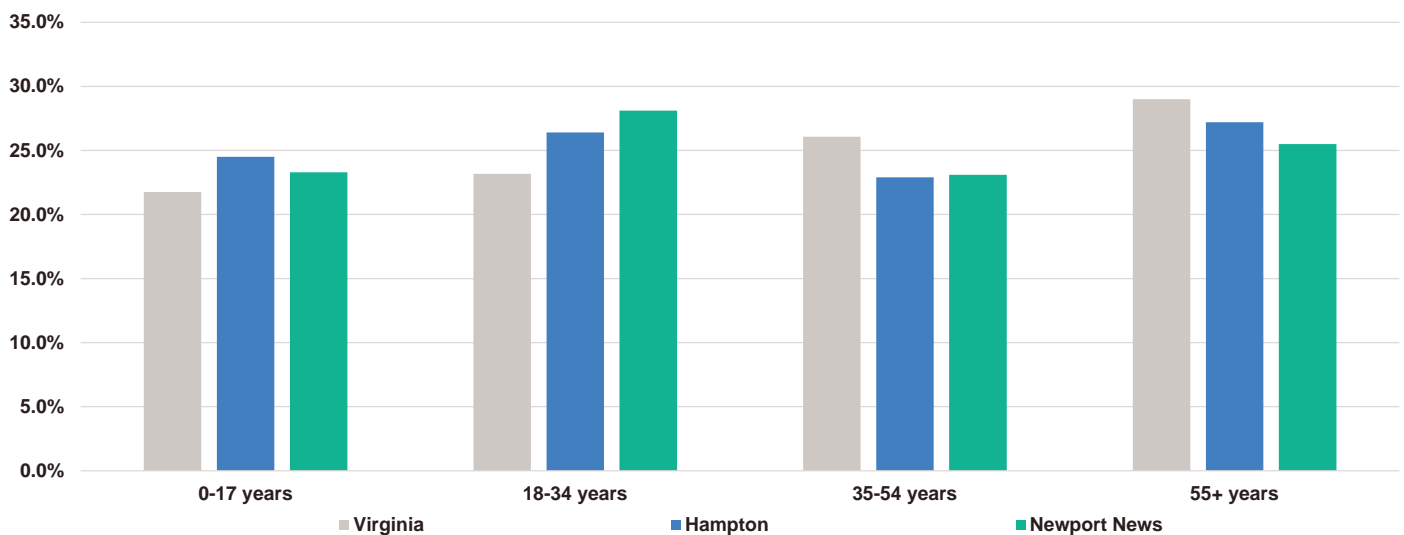


Figure 2 Source: Virginia's Plan for Well-Being

Median household income, 2023

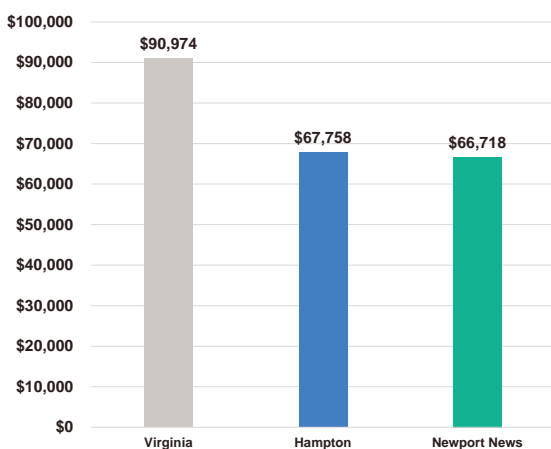


Figure 3 Source: U.S. Census Bureau

Poverty, 2023

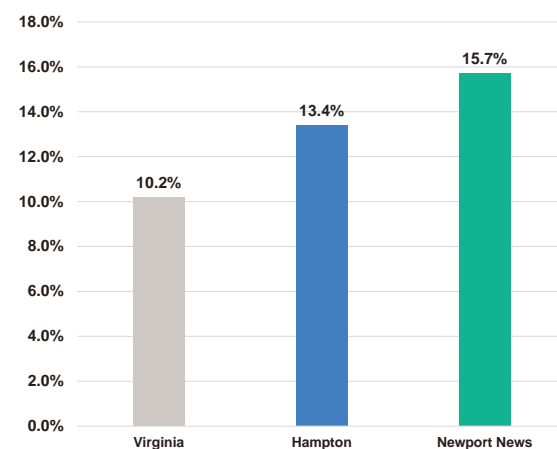


Figure 4 Source: U.S. Census Bureau

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, of the two cities, Newport News is expected to have an estimated increase of 6,000 people in the next 10 years. However, the service area as a whole is expected to see a decrease of an estimated 5,000 people over the next 20 years.² These projections are based on “reliable and credible data.”²

Population change, 2025-2035

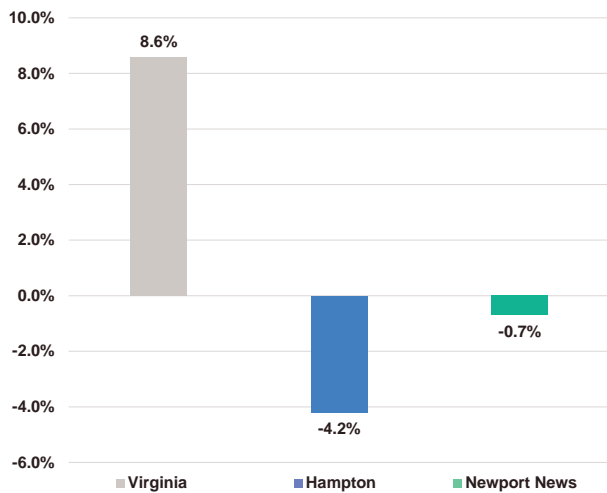


Figure 5 Source: U.S. Census Bureau

Age and sex

Per the 2023 U.S. Census, of the total population of 320,216 people living in the service area, most residents are between the ages of 18-54. The percentage of residents who are children between the ages of 0-17 is 22.6%, slightly higher than the state level of 21.9%. Male (48.4%) and female (54.6%) resident percentages are similar to Virginia percentages (49.5% male, 50.5% 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, 14.7% of the residents living in the service area were ages 65 and older, compared to 16.0% in Virginia. Per the 2023 U.S. Census, Hampton has the largest number of adults ages 65 and older in the service area,

estimated at 22,086 residents. Estimates indicate the population of aging adults (ages 65 and older) living in the service area will increase to 19.5% by 2030. Over the next 10 years, the number of aging adults will increase by an estimated 15,371 residents in the service area.²

Other demographic features

According to the 2023 U.S. Census, veterans represent 11.0% of the population in the service area, compared to 7.6% statewide. The service area has a lower percentage of owner-occupied homes (55.6%, 48.1%) compared to the state overall (67.2%). More households in the service area have computers (95.5%) and internet access (91.0%), increasing access to remote learning, telehealth, and other resources. A higher percentage of the population in the service area is living with a disability (15.3%) compared to the state overall (12.3%). The service area also has a higher percentage of persons living in poverty (14.6%) compared to Virginia overall (10.2%), and a lower percentage of residents with college degrees (28.4%) when compared to the state (41.0%).

Community diversity profile

Race and ethnicity

The population of the service area has a higher percentage of White (40.3%) and Black (44.4%) residents than other races and ethnicities.³ The service area is home to a small Hispanic (8.9%) and Asian (2.9%) population.³

Population with limited English proficiency, 2019-2023

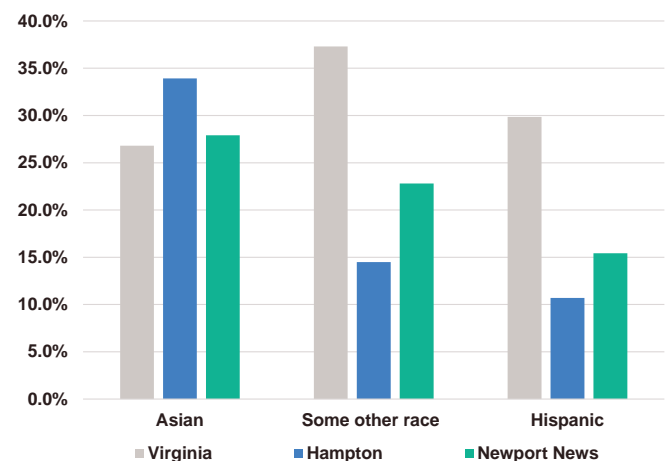
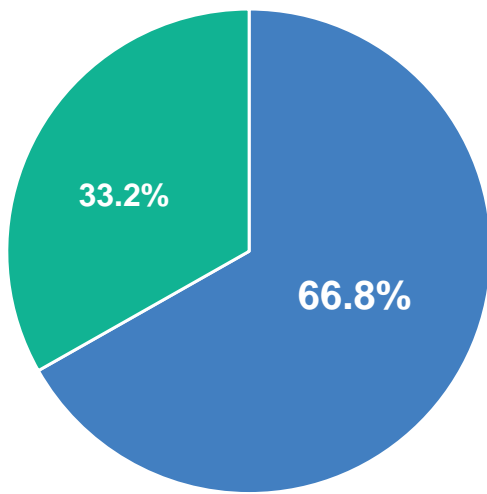


Figure 6 Source: U.S. Census Bureau

Cultural and linguistic needs

English is the primary language spoken in the service area. As of the 2023 U.S. Census, 90.7% 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 SCH language utilization



■ Spanish ■ Vietnamese, ASL, Arabic, Korean, other

Figure 7 Source: SCH 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, SCH had 5,925 requests for interpreter services. The highest percentage of interpreter services (66.8%) was for Spanish-speaking individuals, with the second highest percentage being Vietnamese (6.3%), and ASL (4.4%).

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 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. Accessed May 2, 2023. Source: [Healthy People 2030](#).⁴

To understand the population better, SCH, COASC, and PWSC 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.

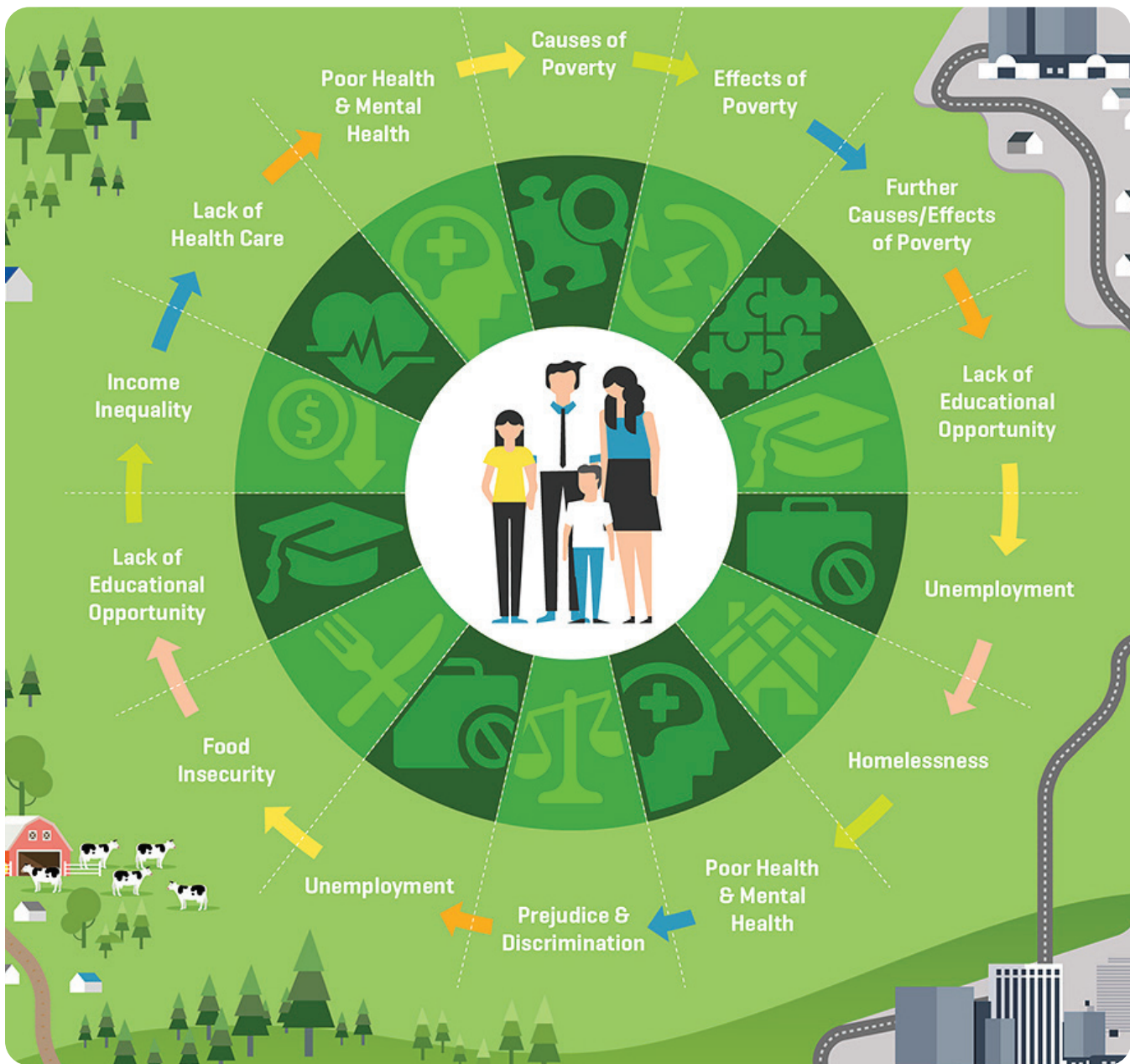


Figure 9 Source: Aurora University

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, Black and Hispanic residents in the service area are more likely to live in poverty compared to White residents. At 14.6%, the service area has a higher percentage of residents living in poverty compared to the Commonwealth of Virginia (10.2%).³

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 service area is slightly higher (92.2%) than the statewide percentage (91.1%) of residents who are high school graduates. However, the service area has a lower percentage of college graduates (28.4%) compared to the state overall (41.0%).³

Employment

Per the 2023 U.S. Census, the service area has a higher percentage of unemployed residents (3.5%) compared to Virginia overall (2.3%). The labor force represents 66.6% of total residents. Within the labor force, 61.3% of female residents in the service area are employed, aligned with the state (61.0%).³



Estimated poverty status by race, 2023

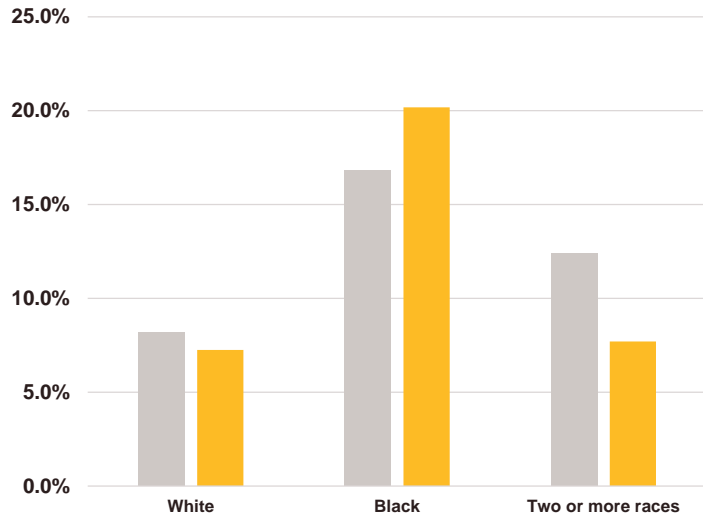


Figure 10 Source: U.S. Census Bureau

Education attainment, age 25+, 2019-2023

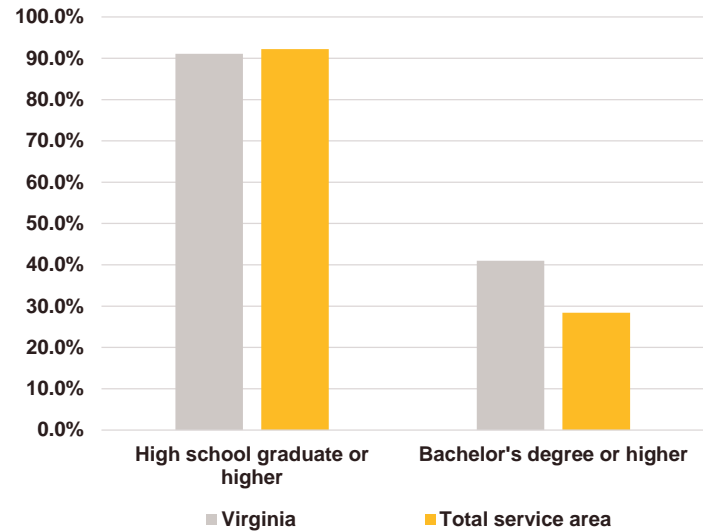


Figure 11 Source: U.S. Census Bureau

Civilian labor force, 2023

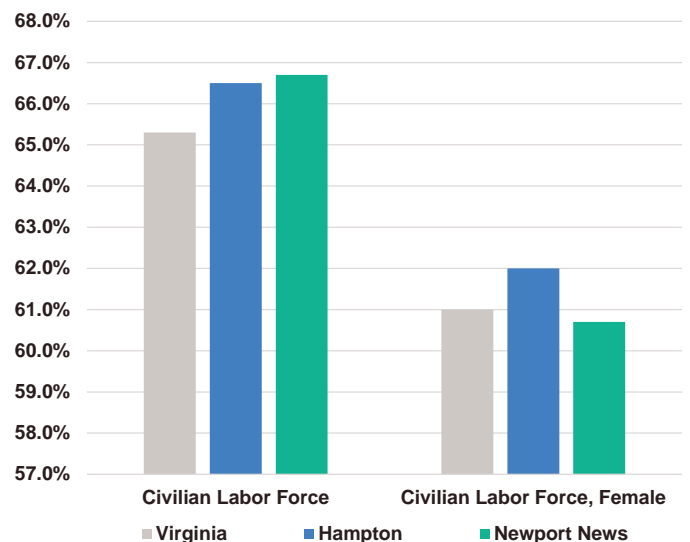


Figure 12 Source: U.S. Census Bureau

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, 7.6% of residents living in the service area do not have health insurance. A total of 1,994,822 Virginians had health coverage through Medicaid and Family Access to Medical Insurance Security (FAMIS) as of February 11, 2025. This included 108,681 residents living in the service area served by SCH, COASC, and PWSC.⁶ Medicaid and FAMIS members represent 33.9% of the total population in the service area. The city of Newport News has the highest rate of Medicaid and FAMIS membership at 35.9%. In comparison, 22.9% of all Virginians have Medicaid or FAMIS health coverage.⁶ Community health workers and enrollment specialists are available to provide guidance and assistance for qualifying individuals and families with enrollment in these government programs.

Medicaid and FAMIS (Below 138% FPL) Enrollment February 21, 2025				
	Virginia	Total service area	Hampton City	Newport News
Medicaid/FAMIS enrollment	1,994,822	108,681	42,855	65,826
Medicaid/FAMIS percentage	22.9%	33.9%	31.3%	35.9%
65+ enrolled in Medicaid/FAMIS enrollment	91,312	3,832	1,480	2,352
65+ enrolled in Medicaid/FAMIS percentage	1.0%	1.2%	1.1%	1.3%
Children enrolled in Medicaid/FAMIS	776,548	43,473	16,841	26,632
Children enrolled in Medicaid/FAMIS percentage	8.9%	13.6%	12.3%	14.5%
Medicare enrollment 2022				
65+ Medicare percentage	65.4%	-	50.9%	52.5%
65+ Medicare and Medicaid percentage	4.8%	-	6.3%	7.5%

Table 1 Sources: Virginia Medicaid, Department of Medical Assistance Services, and 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 November 12, 2024. https://data.census.gov/table?q=United%20States&t=Age%20and%20Sex&g=040XX00US51_050XX00US51550,51710,51740,51800,51810.

² University of Virginia Weldon Cooper Center for Public Service. (2022). Virginia Population Projections. Retrieved from <https://coopercenter.org/virginia-population-projections>.

³ United States Census Bureau. QuickFacts. www.census.gov. Accessed February 21, 2025. <https://www.census.gov/quickfacts/fact/table/VA,chesapeakecityvirginia,norfolkcityvirginia,portsmouthcityvirginia,suffolkcityvirginia,virginiabeachcityvirginia/HSG445222#HSG445222>.

⁴ U.S. Department of Health and Human Services. Healthy People 2030. Accessed May 2, 2023. <https://health.gov/healthypeople/priorityareas/social-determinants-health>.

⁵ Aurora University. Social Work and Poverty: Rural vs. Urban Poverty. Access May 2, 2023. <https://online.aurora.edu/infographics/rural-poverty-vs-urban-poverty/>.

⁶ Department of Medical Assistance Services (DMAS) Data. Accessed February 21, 2025. <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>.

⁷ Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 21, 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., race/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, SCH, COASC, and PWSC 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, 1,344 survey responses were received from SCH, COASC, and PWSC community members.

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 1,344 SCH, COASC, and PWSC community respondents, 62.1% identified as White, 29.1% as Black, 2.4% as Asian, 2.2% as Indigenous, and 6.1% 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	Overall responses (n=1,344)	Hampton City (n=624)	Newport News City (n=720)
Youth			
1	Mental health	Mental health	Mental health
2	Asthma, allergies	Asthma, allergies	Asthma, allergies
3	Obesity	Obesity	Obesity
Adults			
1	Mental health	Mental health	Mental health
2	Cancer	Cancer	Cancer
3	Diabetes	Diabetes	Diabetes

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

Rank	Overall responses (n=1,344)	Hampton City (n=624)	Newport News City (n=720)
Youth			
1	Cost	Cost	Cost
2	Limited or no insurance	Limited or no insurance	Limited or no insurance
3	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment
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	Overall responses (n=1,344)	Hampton City (n=624)	Newport News City (n=720)
Youth			
1	Violence in the community (gun and/or gang)	Violence in the community (gun and/or gang)	Lack of available healthy food
2	Lack of available healthy food	Lack of available healthy food	Violence in the community (gun and/or gang)
3	Lack of parenting support, education services	Lack of parenting support, education services	Lack of parenting support, education services
Adults			
1	Lack of affordable housing	Lack of affordable housing	Lack of affordable housing
2	Loneliness, isolation	Loneliness, isolation	Loneliness, isolation
3	Violence in the community (gun and/or gang)	Violence in the community (gun and/or gang)	Violence in the community (gun and/or gang)

Community focus groups

In addition to the online surveys for community insight, SCH, COASC, and PWSC 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, SCH, COASC, and PWSC held five focus group sessions between December 2024 and February of 2025. The number of participants in each group ranged from seven to 24. Refer to Appendix C for complete notes.

2024 focus groups

- November 25: Hampton Roads Community Action Program, 16 participants
- December 9: An Achievable Dream, 7 participants

2025 focus groups

- January 21: Peninsula Pastoral Counseling, 8 participants
- January 29: Hispanic Circle of Parents, 24 participants
- February 10: LINK of Hampton Roads & Newport News city officials, 12 participants

Demographics

The 67 focus group participants ranged in age from 18 to 65 and older. Altogether, participants were 26.9% White, 47.8% Black, 3.0% Indigenous, and 22.4% Hispanic. The group identified as 82% female and 18% male. Out of the 67 participants, seven preferred not to respond to the zip code questions.

Results

Topic	Key findings	
<p>What serious health problems are in your community for children (0-17) and for adults (18+)?</p>	Children	Adults
	<p>Mental health concerns</p> <ul style="list-style-type: none"> ▪ ADHD ▪ Anxiety and depression ▪ Increased behavioral problems ▪ Bullying and social/emotional struggles ▪ Trauma ▪ Self-harm and suicide <p>Access to care</p> <ul style="list-style-type: none"> ▪ Difficulty finding doctors ▪ Delayed diagnoses <p>Social issues</p> <ul style="list-style-type: none"> ▪ Lack of parenting skills ▪ Clothing and food insecurity ▪ Transportation barriers <p>Health-specific concerns</p> <ul style="list-style-type: none"> ▪ Respiratory and asthma ▪ Seasonal allergies ▪ Substance use, opioids, and marijuana 	<p>Chronic conditions</p> <ul style="list-style-type: none"> ▪ Hypertension, high cholesterol, and diabetes ▪ Prostate cancer ▪ Kidney disease/dialysis <p>Mental health concerns</p> <ul style="list-style-type: none"> ▪ Anxiety and depression ▪ PTSD ▪ Stress and college students <p>Health care access</p> <ul style="list-style-type: none"> ▪ Long wait times for specialists ▪ Accepting new patients ▪ High cost of health care and insurance <p>Caregiving and aging concerns</p> <ul style="list-style-type: none"> ▪ More seniors living alone, needing aging-in-place support ▪ Increasing caregiver burden, with need for respite care ▪ Isolation among elderly populations

Results (cont.)

Topic	Key findings	
Children and adults		
<p>What are some of the environmental and social conditions that affect quality of life for children and adults living in your community?</p>	<p>Food accessibility and nutrition</p> <ul style="list-style-type: none"> ▪ Food insecurity and limited access to fresh, healthy food ▪ Poor nutrition contributes to chronic conditions ▪ Fast food options are easier ▪ Limited knowledge of cooking <p>Health care access and coverage</p> <ul style="list-style-type: none"> ▪ Limited health care access ▪ Transportation barriers ▪ Disparities in health care coverage ▪ Mistrust of vaccines and medical institutions 	<p>Economic stability</p> <ul style="list-style-type: none"> ▪ Struggle with financial stability ▪ Childcare costs remain high ▪ Systemic economic disadvantages <p>Safety and community violence</p> <ul style="list-style-type: none"> ▪ Gun violence and gang activity ▪ Domestic violence ▪ School fights, bullying, and access to drugs <p>Mental health and social isolation</p> <ul style="list-style-type: none"> ▪ Struggle with mental health issues ▪ Social isolation among aging populations
Key strengths identified for children and adults		
<p>What is working in your community that can help residents live healthier lives?</p>	<p>Health care and community clinics</p> <ul style="list-style-type: none"> ▪ Partnership with Riverside: Provides vaccines and physicals for residents ▪ Community clinic: Led by Dr. Charlie Hill and his wife, offering medical services ▪ Awareness and education: Many community leaders and coaches educate families on available health resources ▪ Clearinghouse list: A resource to connect individuals with necessary services, ensuring they know where to go for assistance <p>Church and business partnerships</p> <ul style="list-style-type: none"> ▪ Coalition with churches: Partnerships with Ivy Baptist in the East End ▪ Church outreach: Several churches provide meal deliveries to seniors and low-income individuals ▪ Celebrate recovery program: Works to de-stigmatize counseling and mental health support <p>Challenges and barriers</p> <ul style="list-style-type: none"> ▪ Safety concerns: Gun violence and safety issues discourage outdoor activity ▪ Gentrification concerns ▪ Transportation barriers ▪ Medicaid/Medicare compensation issues 	<p>Physical activity and recreation</p> <ul style="list-style-type: none"> ▪ Sidewalks and bike paths: Increased access in the East End and downtown ▪ YMCA programs: Offers classes for exercise, fitness, and community engagement ▪ Boys and Girls Club: Serves children in need ▪ Athletic opportunities: Basketball camps, tennis club, swimming lessons, and the Girls on the Run program promote physical fitness ▪ Denbigh Community Center: Provides activities for seniors and space for indoor walking <p>Nutritional support and food accessibility</p> <ul style="list-style-type: none"> ▪ Farmers markets: Availability of fresh produce, though accessibility remains a challenge ▪ Community garden (pre-COVID): Previously provided shared vegetables and food support; efforts could be made to revive this initiative ▪ Sentara Medicare Plan: Offers a \$90 monthly food card, though awareness is a barrier ▪ Healthier fast food options: Some restaurants, like Panera, are offering healthier choices such as apples instead of potato chips

Results (cont.)

Topic	Key findings	
<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>	Children and adults	
	<p>Shortage of providers</p> <ul style="list-style-type: none"> ▪ Limited availability of medical, dental, and mental health professionals ▪ Long wait times for appointments ▪ Specialists often located in other cities, requiring travel <p>Access and transportation barriers</p> <ul style="list-style-type: none"> ▪ Difficulty in getting to health care facilities ▪ Limited transportation options for those without private vehicles <p>Insurance and financial challenges</p> <ul style="list-style-type: none"> ▪ High costs of health care services, medication, and insurance ▪ Limited coverage options and misinformation about Medicaid/Medicare ▪ Some providers do not accept certain insurance <p>Access to health care services</p> <ul style="list-style-type: none"> ▪ Clinic and provider shortages ▪ Urgent care reliance ▪ Insurance challenges <p>Mental health accessibility</p> <ul style="list-style-type: none"> ▪ Stigma and awareness ▪ Barriers to care ▪ Advocacy needs <p>Pediatric and preventive care</p> <ul style="list-style-type: none"> ▪ Immunization barriers ▪ Specialty care access ▪ Preventive care shortfalls <p>Transportation barriers</p> <ul style="list-style-type: none"> ▪ Getting to appointments ▪ Missed opportunities for care 	<p>Quality of care concerns</p> <ul style="list-style-type: none"> ▪ Patients feel rushed through appointments ▪ Disparities in treatment, including racial bias and lack of advocacy <p>Mental health care deficiencies</p> <ul style="list-style-type: none"> ▪ Lack of providers and long delays ▪ Many mental health facilities only offer medication management ▪ Stigma surrounding mental health care <p>Preventive care and education gaps</p> <ul style="list-style-type: none"> ▪ Many people lack knowledge about how to access health care resources ▪ Need for Medicaid education to help people apply for the right services ▪ Over-the-counter medications are expensive and inaccessible for some <p>Provider shortages</p> <ul style="list-style-type: none"> ▪ Mental health access ▪ High provider turnover <p>Transportation issues</p> <ul style="list-style-type: none"> ▪ Struggle with transportation to appointments ▪ Services are unreliable and limited <p>Dental and preventive care</p> <ul style="list-style-type: none"> ▪ Few dental providers accept Medicaid ▪ Lack of comprehensive preventive care <p>Health disparities</p> <ul style="list-style-type: none"> ▪ Black individuals dismissed or treated poorly ▪ Maternal health disparities, particularly for Black mothers

Results (cont.)

Topic	Key findings	
Children and 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>Affordability</p> <ul style="list-style-type: none"> Fresh fruits and vegetables are perceived as too expensive Organic and specialty foods are particularly costly Many individuals on financial assistance prioritize stretching their budget over purchasing fresh produce <p>Food deserts and store availability</p> <ul style="list-style-type: none"> Limited grocery stores offering fresh food Lower-income communities lack access to fresh, quality produce Certain grocery stores are avoided due to high costs and similar stores are avoided due to high costs 	<p>Transportation and accessibility</p> <ul style="list-style-type: none"> Many people lack reliable transportation Food distribution centers are not always conveniently located <p>Lack of knowledge and awareness</p> <ul style="list-style-type: none"> Many people are unsure which fruits and vegetables to eat for optimal health There is a lack of understanding of how to cook fresh produce Stereotypes exist around healthy eating <p>Cultural and social influences</p> <ul style="list-style-type: none"> Traditional diets and family habits influence food choices Families often rely on fast food
Key strengths identified for children and 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>Expanding access to preventive care</p> <ul style="list-style-type: none"> Offer community-wide physicals at multiple points throughout the year Provide mobile clinics and pop-up health screenings for uninsured and underinsured individuals Increase telehealth services <p>Addressing health care disparities</p> <ul style="list-style-type: none"> Ensure all health care providers accept a broad range of insurance plans, including Medicaid and Medicare Improve physician education on patient communication Enhance patient advocacy programs, particularly for seniors and those without family support, to help them navigate health care services <p>Enhancing health care accessibility</p> <ul style="list-style-type: none"> Increase appointment availability Improve transportation Expand hospital partnerships with local schools and clinics 	<p>Enhancing nutrition and wellness education</p> <ul style="list-style-type: none"> Provide recipe cards and food samples for unfamiliar nutritious foods Offer free virtual cooking classes through local social services Organize wellness expos with hands-on activities <p>Increasing mental health support</p> <ul style="list-style-type: none"> Expand telepsychiatry and mental health services Provide peer support groups Increase Spanish-language mental health resources <p>Improving elder care services</p> <ul style="list-style-type: none"> Develop peer support programs to connect seniors Advocate for policy changes in long-term care Create clear, accessible guides on elder care options

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.

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

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 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.

The service area has fewer doctors to community members compared to the state (1340:1), with Hampton having a ratio of 2700:1 and Newport News with a ratio of 1758:1. Increasing access to primary care is a key solution to reducing unnecessary, costly hospital stays and improving the health of the community. It is important to note that Black populations living in Virginia and in this community have higher rates of preventable hospital stays compared to White residents.¹

Preventable hospital stays by rate by race, 2021

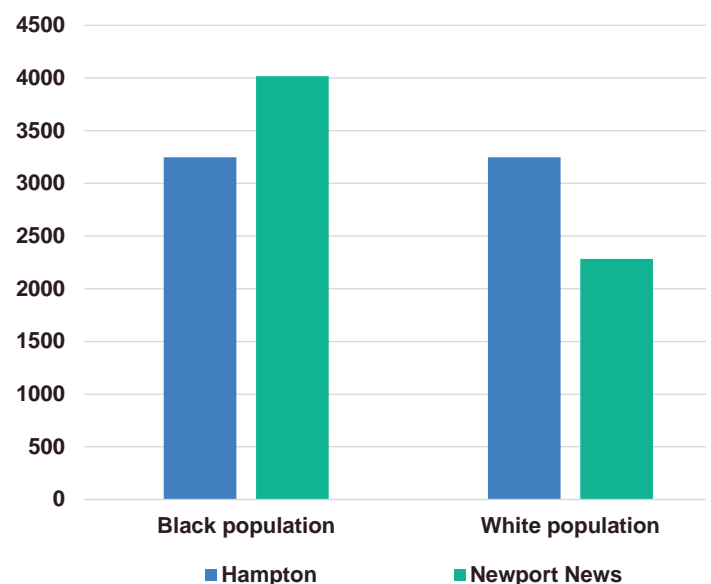


Figure 1 Source: County Health Rankings

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 one to five years shorter than White individuals in this service area.

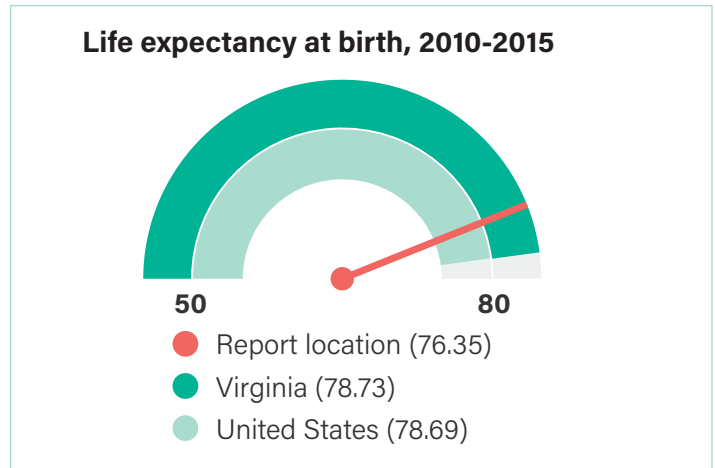


Figure 2 Source: Virginia Department of Health

The leading causes of death by race/ethnicity, 2021-2023

White	Black	Hispanic
Heart Disease	Heart Disease	Cancer
Cancer	Cancer	Heart Disease
Accidents	COVID-19	Accidents
COVID-19	Accidents	Stroke
Stroke	Stroke	COVID-19

Figure 3 Source: CDC Wonder

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, accidents, COVID-19, and stroke were the top five causes of death in this community.²

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.

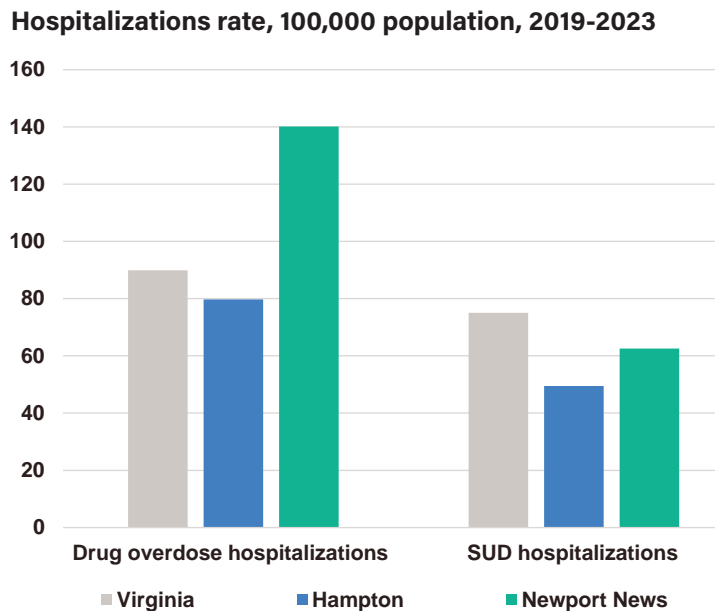


Figure 4 Source: Virginia's Plan for Well-Being



Mental health is becoming an increasing health concern for both adolescents and adults. Sentara examined emergency department visits for 2024 to gain a better understanding of the mental health crisis communities have been facing since the COVID-19 pandemic. In 2024, the SCH emergency department treated 1,680 adults (age 19+) with behavioral diagnoses. Of these visits, 25.5% of the patients presented with suicidal ideation, 4.5% with schizophrenia, 4.2% with generalized anxiety disorder, and 2.7% with bipolar disorder. Additionally, SCH saw 196 youth (age 0-18) present with behavioral health diagnoses. Of these visits, 34.7% presented with suicidal ideation and 2.0% with bipolar 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

Substance use and mental health, age 18+

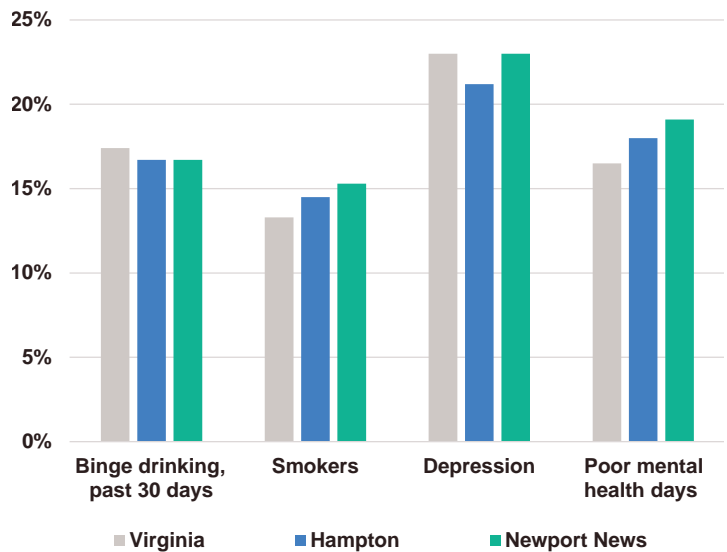


Figure 5 Source: Virginia's Plan for Well-Being

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 is higher than the state (13 per 100,000) in the cities of Hampton (21) and Newport News (21). 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 (Andrews et al., 2022).

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.⁷ 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. Newport News had the greatest incidence rates for all cancers (420.9 per 100,000).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.

Firearm fatality rate, 2022

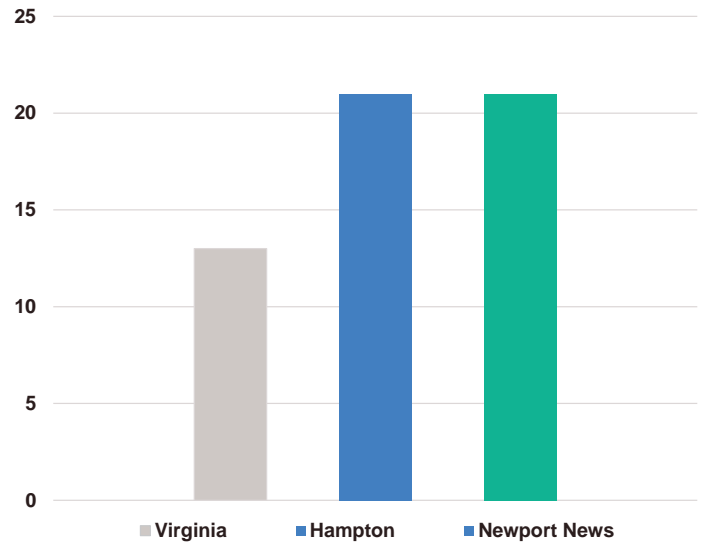


Figure 6 Source: Virginia’s Plan for Well-Being

Virginia cancer incidence rate race/ethnicity

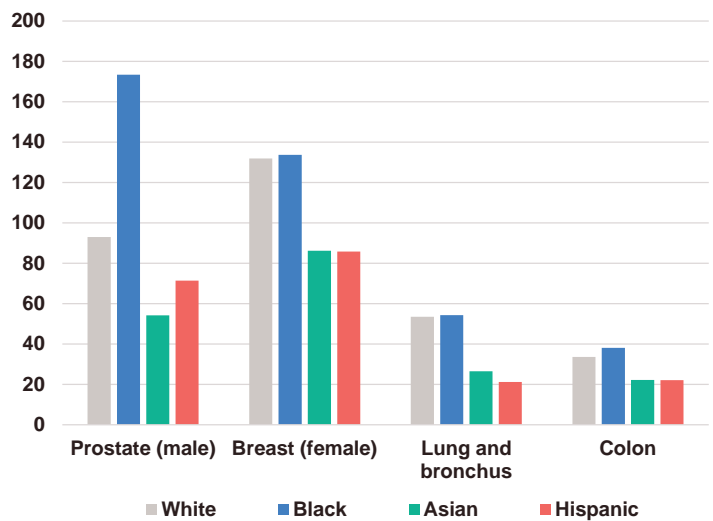


Figure 7 Source: Virginia’s Plan for Well-Being



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 understand the current and future health of the community. A greater number of mothers in the service area (7.5%) had late or no prenatal care compared to Virginia (5.1%). The service area had slightly higher percentages of preterm births (10.5%) and babies born with low birth weights (10.2%) compared to the Commonwealth (9.61%, 8.46%). The infant mortality rate was also greater in the localities (7.73 per 1,000) compared to Virginia (5.98). While teen pregnancies (263) are a community concern, the low numbers do not permit meaningful standardization for comparison to state rates.

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 obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity are

Maternal and infant health, 2020-2022

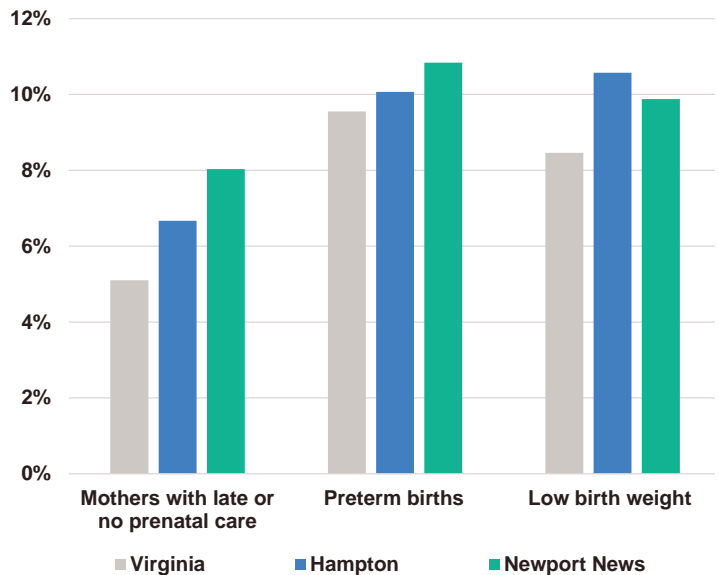


Figure 8 Source: Virginia’s Plan for Well-Being

also key risk factors. The percentage of adults living with diabetes in this community is higher than the state percentage of 12.0%. The SCH, COASC, and PWSC hospitalization rate, 2,577.21 (per 100,000), for diabetes was 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 being seen for hypertension and diabetes, the top conditions for which patients received hospital treatment in this community, was higher in this service area than in the state overall. The percentage of Medicare beneficiaries treated for Alzheimer's disease or dementia in this community (8%) is higher than Virginia overall (6%).⁶ 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 plans

Collectively, SCH, COASC, and PWSC are 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).⁷ Sentara has approximately 78,520 active registrants with advance care plans on file within the U.S. Advance Care Plan Registry with 425 of those completed for residents of the SCH, COASC, and PWSC community.

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 their age and underlying medical conditions, such as diabetes and COVID-19 infections. "Data from

Medicare primary chronic conditions, 2022

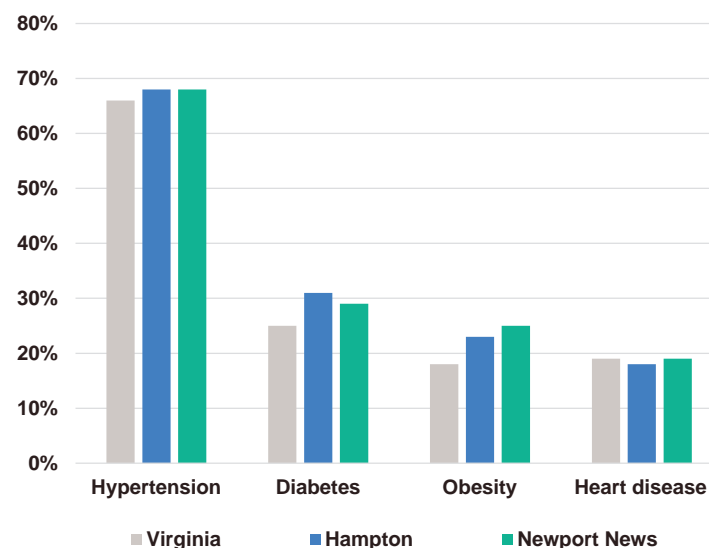


Figure 10 Source: Virginia's Plan for Well-Being

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.⁸ Advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical techniques, and availability of antimicrobial prophylaxis, yet SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death in the inpatient setting.⁹

SCH, COASC, and PWSC 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 health needs.

Recommendations

With the completion of the 2025 CHNA, Sentara, SCH, COASC, and PWSC developed goals to positively impact the community's identified health concerns and socioeconomic needs. Sentara, SCH, COASC, and PWSC 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, SCH, COASC, and PWSC 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, SCH, COASC, and PWSC alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. Sentara, SCH, COASC, and PWSC are committed to finding innovative, responsive, and successful strategies to address these challenges in order to fulfill our mission to improve health every day.

Endnotes

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

² Virginia's Plan for Well-Being Community Health Improvement Data Portal. Accessed February 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 National Cancer Institute, State Cancer Profiles. Incidence Rates Table. Accessed February 11, 2025. <https://statecancerprofiles.cancer.gov/incidencerates/index.php>.

⁵ National Cancer Institute, State Cancer Profiles. Death Rates Table. Accessed February 11, 2025. <https://statecancerprofiles.cancer.gov/deathrates/index.php>.

⁶ Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 11, 2025. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

⁷ The U.S. Will Registry. Accessed March 1, 2025. <https://www.theuswillregistry.org/>.

⁸ 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.

⁹ 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 CarePlex Hospital (SCH), CarePlex Outpatient Ambulatory Surgery Center (COASC) and Port Warwick Surgery Center (PWSC) 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 equity based on patient demographic data and community insight.

This section of the CHNA report describes these activities and collaborative efforts. Collectively, SCH, COASC, and PWSC 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 SCH, COASC, and PWSC 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 SCH, COASC, and PWSC 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, SCH, COASC, and PWSC partnered with 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 2023 and 2024, nine performances were held, reaching 910 community members living in the service area.

Sentara, SCH, COASC, and PWSC also partnered with Bon Secours, CHKD, Riverside Health, Hampton City Schools, and the Hampton and Peninsula Health District 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.

“Sentara CarePlex Hospital is proud to collaborate with partners across diverse sectors of our local communities—each doing vital work to enhance the well-being of those we serve. We deeply value these relationships which help our community thrive by improving health in conjunction with social and economic well-being.”

Loren Smith
Director, Patient Care Services, Sentara CarePlex Hospital



Chronic diseases

Together, SCH, COASC, and PWSC 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 support, resources, and education in the community, where life happens. Sentara brings prevention, hope, inspiration, and support to our local community where SCH, COASC, and PWSC are working to reduce chronic disease impact. Both COASC and PWSC work with patients and their families to provide multiple resources and tools regarding mental health and chronic diseases.

Cancer educators have implemented programs focused on cancer prevention and 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 wellness for uninsured or underinsured women for mammography, including supplementing traditional measures, such as utilizing mobile mammography, with more targeted efforts to reach underserved communities, including connecting with faith leaders, providing transportation for those who need it, and building trust with patients.

Social determinants of health

Collectively, SCH, COASC, and PWSC work with internal and external partners and organizations to identify and prioritize health disparities impacting our communities and consumers. This collaboration improves access to health care for low income and underinsured populations. When able, COASC and PWSC provide assistance for uninsured patients to enroll in health care insurance plans during the open enrollment period. Enrollment coaches are available to help enroll uninsured patients into the Federally Qualified Health Center primary care network.

Each hospital 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. To increase economic growth, job security, and educational opportunities, SCH, COASC, and PWSC continue to collaborate with multiple colleges and universities to provide fellowships, internships, and preceptorships for health care professionals and students.

Grantmaking and community benefit

In the 2023 implementation strategy process, Sentara and its hospital facilities supported vulnerable populations through efforts 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 equity by working to eliminate traditional barriers to health and human services.

To further our commitment to health equity, the Sentara Research Center received a \$3.4 million grant from the Patient Centered Outcomes Research Institute in partnership with Yale University, Massachusetts General Hospital, and Houston Methodist Hospital. This grant will be used by the Sentara Health Research Center and Health Equity teams to recruit participants from Sentara Community Care centers, mobile care services, and community-based partnerships with churches, homeless shelters, and food banks across South Hampton Roads, Newport News, and Hampton to study hypertension in underserved communities.

Sentara Health provided a grant of \$255,000 to help launch Peninsula C.A.R.E.S., which is focused on the Peninsula region's health inequities, maternal death, heart disease, diabetes, and hypertension among minorities, as well as food insecurity and economic opportunities for underserved communities in the Virginia cities of Newport News and Hampton. Sentara Health also invested \$11 million to support the Marshall-Ridley Choice Neighborhood Initiative in Newport News. These funds were to complete phase two of the project, focused on the overall rejuvenation of the former neighborhood and provide a variety of housing options to meet the needs of a diverse community by integrating affordable housing types in an equitable and indistinguishable manner with a goal to increase ownership rates and foster a sense of community.

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 SCH, COASC, and PWSC alone, these opportunities will require active partnerships among local organizations and individuals to create lasting impact.

Sentara and SCH, COASC, and PWSC are committed to finding innovative, responsive, and successful strategies to address these challenges and to fulfill our mission to improve health every day. While we 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 Hampton and Newport News

**Sentara CarePlex Hospital and
CarePlex Orthopaedic Ambulatory Surgery Center**

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Port Warwick Surgery Center

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