RIVERSIDE

Doctors' Hospital Williamsburg

2016 Community Health Needs Assessment and Implementation Plan

This Community Health Needs Assessment and Implementation Strategy for Riverside Doctors' Hospital of Williamsburg was conducted and developed between March 2016 and November 2016 to fulfill the requirements described in section 501(r)(3) of the Internal Revenue Code. It was formally adopted by the Riverside Doctors' Hospital of Williamsburg Board of Directors on November 21, 2016.

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Introduction

Riverside Doctors' Hospital of Williamsburg is part of Riverside Health System, with a mission to "care for others as we would care for those we love." While Riverside cares for its patients every day, it recognizes that caring for others can often mean those who are not in the hospital. Riverside Doctors' Hospital of Williamsburg understands it has a unique and important role in caring for the health of its community. Conducting a Community Health Needs Assessment allows Riverside to see the community as a broader population, and better understand the unique needs, concerns and priorities of the community it serves.

Community Health Needs Assessment Process

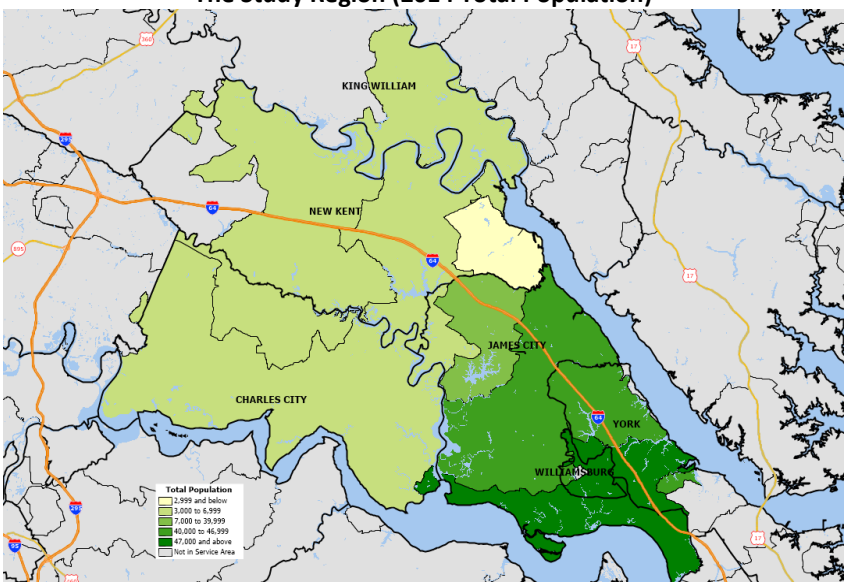
A Community Health Needs Assessment (CHNA) and Implementation Strategy for Riverside Doctors' Hospital of Williamsburg was conducted between March 2016 and November 2016 in fulfillment of the requirements described in section 501(r)(3) of the Internal Revenue Code. The CHNA was conducted with the assistance of Community Health Services, Inc. of Richmond, Virginia who collected the health indicator data and facilitated the community survey process.

The CHNA process consisted of four phases: data collection (quantitative), community input (qualitative), analysis and prioritization. The quantitative data is summarized in this report, and represents a broad assessment of demographic and health indicators. The data sources are noted within each section. The community input data was gathered through an electronic survey process from April 13 – May 13, 2016. The survey recipients and respondents of the survey are noted in the report. Riverside's Marketing, Strategy and Development team worked with Community Health Services, Inc. to analyze the data and present it in summary form for review. In October, the administrative leadership teams from Riverside Doctors' Hospital of Williamsburg and Sentara Williamsburg Regional Medical Center came together to review the data, ask questions, discuss area solutions and prioritize the needs to be addressed. The combined leadership teams from the two hospitals then created a proposed implementation strategy to present to the gathered community stakeholders at the Williamsburg Chronic Care Collaborative in November. The details of those meetings appear in the report.

Community Served by the Hospital

The community served by Riverside Doctors' Hospital of Williamsburg is a geographic region that covers 10 ZIP codes across the City of Williamsburg and the counties of Charles City, King William, New Kent, James City and York.

The Study Region (2014 Total Population)



Community Indicators

The community indicators present a wide array of quantitative community health indicators for the study region. To produce the profiles, Community Health Solutions analyzed data from multiple sources. By design, the analysis does not include every possible indicator of community health. The analysis is focused on a set of indicators that provide broad insight into community health, and for which there were readily available data sources. Detailed reviews follow below, but to summarize:

- **Demographic Profile:** As of 2014, the study region included an estimated 122,218 people. The population is expected to increase to 133,411 by 2019. Compared to Virginia as a whole, the study region is more rural, older, and less racially diverse. The study region also has higher income and education levels than Virginia as a whole.

- **Mortality Profile:** In 2013, the study region had 1,081 total deaths. The leading causes of death were malignant neoplasms (cancer) and heart disease by a wide margin; followed by cerebrovascular diseases, chronic lower respiratory diseases and unintentional injury. Death rates were higher than the statewide rates for all deaths combined, and for malignant neoplasms, heart disease, cerebrovascular diseases and Alzheimer's Disease.

- **Maternal & Infant Health Profile**: In 2013, the study region had 1,073 total live births. Compared to Virginia as a whole, the study region had a higher rate of births without early prenatal care. The teen pregnancy rate was higher than the statewide rate for the city of Williamsburg. The five-year infant mortality rate was higher than the statewide rate for the counties of Charles City and King William, and for the city of Williamsburg.

- **Preventable Hospitalization Discharge Profile:** The Agency for Healthcare Research and Quality (AHRQ) defines a set of conditions (called Prevention Quality Indicators, or 'PQIs') for which hospitalization should be avoidable with proper outpatient health care. High rates of

hospitalization for these conditions indicate potential gaps in access to quality outpatient services for community residents. In 2013, residents of the study region had 381 PQI hospital discharges. The leading diagnosis for these discharges was congestive heart failure by a wide margin; this is followed by bacterial pneumonia, diabetes, COPD or asthma in older adults, and urinary tract infection. Discharge rates for the study region were lower than the Virginia statewide rates for all PQI diagnoses.

- **Behavioral Health Hospitalization Discharge Profile:** Behavioral health hospitalizations provide another important indicator of community health status. In 2013, residents of the study region had 406 hospital discharges from Virginia community hospitals for behavioral health conditions. The leading diagnosis for these discharges by a large margin was affective psychoses; this is followed by schizophrenic disorders, depressive disorder, alcoholic psychoses, and senility without mention of psychoses. Discharge rates for the study region were lower than the Virginia statewide rates for all BH diagnoses.

- **Adult Health Risk Profile:** Local estimates indicate that substantial numbers of adults (age 18+) in the study region have health risks related to nutrition, weight, physical inactivity, tobacco and alcohol. In addition, substantial numbers of adults have chronic conditions such as high cholesterol, high blood pressure, arthritis, diabetes and asthma.

- **Youth Health Risk Profile:** Local estimates indicate that substantial numbers of youth (age 10-19) in the study region have health risks related to nutrition, weight, alcohol, mental health, tobacco, and physical inactivity.

- **Uninsured Profile:** At any given point in time in 2014, an estimated 14,644 nonelderly residents of the study region were uninsured. This included an estimated 1,836 children and 12,807 adults. The estimated uninsured rates were 7 percent for children age 0-18, 18 percent for adults age 19-64, and 15 percent for the population age 0-64.

- **Medically Underserved Profile:** Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are designated by the U.S. Health Resources and Services Administration as being at-risk for health care access problems. The designations are based on several factors including primary care provider supply, infant mortality, prevalence of poverty, and the prevalence of seniors age 65+. All six localities that overlap with the study region have been designated as partially or fully medically underserved areas.

Demographic Profile

Trends in health-related demographics are instructive for anticipating changes in community health status. Changes in the size, age and racial/ethnic mix of the population can have a significant impact on overall health status, health needs and demand for local services.

As shown in *Exhibit II-1*, as of 2014, the study region included an estimated 122,218 people. The total population is projected to increase to 133,411 by 2019. Focusing on age groups, a decline is

projected for all age groups except the 18-29 and 65+ age groups. Growth is projected for all age groups and all racial / ethnic groups.

Exhibit II-1
Health Demographic Trend Profile for the Study Region, 2010-2019

Indicator	2010 Census	2014 Estimate	2019 Projection	% Change 2014-2019
Total Population	116,768	122,218	133,411	14%
Population Density (per Sq. Mile)	172.8	180.9	197.5	14%
Total Households	44,939	47,191	51,905	16%
Population by Age				
Children Age 0-17	23,743	24,278	25,575	8%
Adults Age 18-29	19,240	20,334	22,059	15%
Adults Age 30-44	19,590	20,101	21,115	8%
Adults Age 45-64	33,244	34,274	35,915	8%
Seniors Age 65+	20,959	23,231	28,742	37%
Population by Race/Ethnicity				
Asian	2,886	3,044	3,540	23%
Black/African American	19,356	20,354	22,368	16%
White	88,546	92,191	99,414	12%
Other or Multi-Race	5,979	6,629	8,089	35%
Hispanic Ethnicity	4,999	6,004	7,308	46%

Note: Hispanic is a classification of ethnicity; therefore, Hispanic individuals are also included in the race categories.

Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Community health is driven in part by community demographics. The age, sex, race, ethnicity, income and education status of a population are strong predictors of community health status and community health needs.

Exhibit II-2 presents a snapshot of key health-related demographics of the study region. As of 2014, the study region included an estimated 122,218 people. Focusing on population rates as shown in the lower part of the Exhibit, compared to Virginia as a whole, the study region is more rural, older, and less racially diverse. The study region also has higher income and education levels than Virginia as a whole. *Note: Maps 1-13 in Appendix A (pages 34-40) show the geographic distribution of the population by ZIP code.*

Exhibit II-2 Health Demographic Snapshot Profile 2014			
Indicator		**Study Region**	**Virginia**
Population Counts			
Total Population	Population	122,218	8,282,921
Age	Children Age 0-17	24,278	1,889,338
	Adults Age 18-29	20,334	1,417,141
	Adults Age 30-44	20,101	1,678,713
	Adults Age 45-64	34,274	2,241,450
	Seniors Age 65+	23,231	1,056,279
Sex	Female	63,105	4,214,922
	Male	59,114	4,067,999
Race	Asian	3,044	486,905
	Black/African American	20,354	1,602,827
	White	92,191	5,616,313
	Other or Multi-Race	6,629	576,876
Ethnicity	Hispanic Ethnicity	6,004	705,701
Income	Low Income Households (Households with Income < $25,000)	7,295	594,210
Education	Population Age 25+ Without a High School Diploma	6,444	662,369
Population Rates			
Total Population	Population Density (pop. per sq. mile)	180.9	206.1
Age	Children Age 0-17 percent of Total Population	20%	23%
	Adults Age 18-29 percent of Total Population	17%	17%
	Adults Age 30-44 percent of Total Population	16%	20%
	Adults Age 45-64 percent of Total Population	28%	27%
	Seniors Age 65+ percent of Total Population	19%	13%
Sex	Female percent of Total Population	52%	51%
	Male percent of Total Population	48%	49%
Race	Asian percent of Total Population	2%	6%
	Black/African American percent of Total Population	17%	19%
	White percent of Total Population	75%	68%
	Other or Multi-Race percent of Total Population	5%	7%
Ethnicity	Hispanic Ethnicity percent of Total Population	5%	9%
Income	Low Income Households (Households with Income <$25,000) percent of Total Households	15%	19%
Education	Population Age 25+ Without a High School Diploma percent of Total Population Age 25+	8%	12%
Note: Hispanic is a classification of ethnicity; therefore, Hispanic individuals are also included in the race categories.			
Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.			

Mortality Profile

Mortality is one of the most commonly cited community health indicators. As shown in *Exhibit II-3*, in 2013, the study region had 1,081 total deaths. The leading causes of death were malignant neoplasms (cancer) and heart disease by a wide margin; this is followed by cerebrovascular diseases, chronic lower

respiratory diseases and unintentional injury. Death rates were higher than the statewide rates for all deaths combined, and for malignant neoplasms, heart disease, cerebrovascular diseases and Alzheimer's Disease. *Note: Maps 14-17 in Appendix A (pags 40-42) show the geographic distribution of deaths by ZIP code.*

Exhibit II-3
Mortality Profile 2013

Indicator	Study Region	Virginia
Total Deaths		
Deaths by All Causes	1,081	62,309
Deaths by Leading 14 Causes		
Malignant Neoplasms, Deaths	277	14,348
Heart Disease, Deaths	243	13,543
Cerebrovascular Diseases, Deaths	59	3,278
Chronic Lower Respiratory Diseases, Deaths	45	3,168
Unintentional Injury, Deaths	38	2,794
Alzheimer's Disease, Deaths	37	1,634
Diabetes Mellitus, Deaths	27	1,618
Influenza and Pneumonia, Deaths	22	1,430
Chronic Liver Disease, Deaths	17	836
Nephritis and Nephrosis, Deaths	15	1,547
Septicemia, Deaths	14	1,464
Parkinson's Disease, Deaths	14	549
Suicide, Deaths	8	1,047
Primary Hypertension and Renal Disease, Deaths	7	629
Crude Death Rates per 100,000 Population		
Total Deaths	890.3	755.5
Malignant Neoplasms, Deaths	228.1	174.0
Heart Disease, Deaths	200.1	164.2
Cerebrovascular Diseases, Deaths	48.6	39.7
Chronic Lower Respiratory Diseases, Deaths	37.1	38.4
Unintentional Injury, Deaths	31.3	33.9
Alzheimer's Disease, Deaths	30.5	19.8
Diabetes Mellitus, Deaths	--	19.6
Influenza and Pneumonia, Deaths	--	17.3
Chronic Liver Disease, Deaths	--	10.1
Nephritis and Nephrosis, Deaths	--	18.8
Septicemia, Deaths	--	17.8
Parkinson's Disease, Deaths	--	6.7
Suicide, Deaths	--	12.7
Primary Hypertension and Renal Disease, Deaths	--	7.6

Note: -- Rates are not calculated where n<30.

Source: Community Health Solutions analysis of mortality data from the Virginia Department of Health. See Appendix C. Data Sources for details.

Maternal and Infant Health Profile

Maternal and infant health indicators are another widely cited category of community health. As shown in *Exhibit II- 4A,* the study region had 1,073 total live births in 2013. Compared to Virginia as a whole, the study region had a higher rate of births without early prenatal care. *Note: Maps 18-19 in Appendix A (pages 42-43) show the geographic distribution of births by ZIP code.*

Exhibit II 4A.
Maternal and Infant Health Profile 2013

Indicators	Study Region	Virginia
Counts		
Total Live Births	1,073	101,977
Low Weight Births (under 2,500 grams / 5 lb. 8 oz.)	88	8,178
Births Without Early Prenatal Care (No Prenatal Care in First 13 Weeks)	181	13,435
Non-Marital Births	335	35,289
Live Births to Teens Age 10-19	58	5,316
Live Births to Teens Age 18-19	44	4,073
Live Births to Teens Age 15-17	14	1,208
Live Births to Teens Age <15	0	35
Rates		
Live Birth Rate per 1,000 Population	8.8	12.3
Low Weight Births percent of Total Live Births	8%	8%
Births Without Early Prenatal Care (No Prenatal Care in First 13 Weeks) percent of Total Live Births	17%	13%
Non-Marital Births percent of Total Live Births	31%	35%
Live Births to Teens Age 10-19 (per 1,000 Female Teens Age 10-19)	7.3	10.3
Live Births to Teens Age 18-19 (per 1,000 Female Teens Age 18-19)	19.4	36.4
Live Births to Teens Age 15-17 (per 1,000 Female Teens Age 15-17)	6.3	8.0
Live Births to Teens Age <15 (per 1,000 Female Teens Age <15)	0.0	0.1

Source: Community Health Solutions analysis of data from the Virginia Department of Health.

Exhibit II-4B below provides counts and rates of teen pregnancy and infant mortality for the six localities that overlap with the study region. These indicators are shown at the city/county level because teen pregnancy and five-year infant mortality data not readily available at the ZIP code level. As shown in the exhibit, the teen pregnancy rate was higher than the statewide rate for the city of Williamsburg. The five-year infant mortality rate was higher than the statewide rate for the counties of Charles City and King William, and for the city of Williamsburg.

Exhibit II-4B Teen Pregnancy and Infant Mortality 2013								
Indicators	**Charles City County**	**James City County**	**King William County**	**New Kent County**	**City of Williamsburg**	**York County**	**Study Region**	**Virginia**
Teen Pregnancy Counts and Rates								
Total Teenage (age 10-19) Pregnancies (2013)	4	33	14	15	29	23	118	7,447
Teenage (age 10-19) Pregnancy Rate per 1,000 Teenage Female Population (2013)	12.4	7.8	13.7	12.7	19.4	4.7	9.0	14.4
Infant Mortality Counts and Rates								
Total Infant Deaths (2009-2013)	3	17	9	5	8	14	56	3,402
Five-Year Infant Mortality Rate per 1,000 Live Births (2009-2013)	12.0	4.8	9.2	5.5	16.7	4.7	6.2	6.6
Note: Indicators are shown at the city and county level because teen pregnancy and five-year average infant mortality data are not readily available at the ZIP code level.								
Source: Community Health Solutions analysis of data from the Virginia Department of Health								

Preventable Hospitalization Discharge Profile

The Agency for Healthcare Research and Quality (AHRQ) identifies a defined set of conditions called Prevention Quality Indicators (PQIs) for which hospitalization should be avoidable with proper outpatient health care. High rates of hospitalization for these conditions indicate potential gaps in access to quality outpatient services for community residents.

As shown in *Exhibit II-5*, residents of the study region had 381 PQI hospital discharges in 2013. The leading diagnosis for these discharges was congestive heart failure by a wide margin; this is followed by bacterial pneumonia, diabetes, COPD or asthma in older adults, and urinary tract infection. Discharge rates for the study region were lower than the Virginia statewide rates for all PQI diagnoses. *Note: Map 20 in Appendix A (page 43) shows the geographic distribution of Total PQI Discharges by ZIP code.*

Exhibit II-5 Prevention Quality Indicator (PQI) Hospital Discharge Profile 2013		
Indicator	**Study Region**	**Virginia**
PQI Discharges		
Total PQI Discharges	381	76,860
PQI Discharges by Diagnosis		
Congestive Heart Failure, PQI Discharges	112	16,026
Bacterial Pneumonia, PQI Discharges	65	11,867
Diabetes, PQI Discharges	56	9,938
COPD or Asthma In Older Adults, PQI Discharges	51	18,239
Urinary Tract Infection, PQI Discharges	37	8,452
Dehydration, PQI Discharges	36	7,743
Hypertension, PQI Discharges	16	2,768
Perforated Appendix, PQI Discharges	7	1,189
Angina, PQI Discharges	6	941
Asthma in Younger Adults, PQI Discharges	0	444
Crude Rates per 100,000 Population		
Total Prevention Quality Indicator (PQI) Discharges	313.8	932
Congestive Heart Failure, PQI Discharges	92.2	221.2
Bacterial Pneumonia, PQI Discharges	53.5	143.9
Diabetes, PQI Discharges	46.1	120.5
COPD or Asthma In Older Adults, PQI Discharges	42.0	194.3
Urinary Tract Infection, PQI Discharges	30.5	102.5
Dehydration, PQI Discharges	29.6	93.9
Hypertension, PQI Discharges	--	33.6
Perforated Appendix, PQI Discharges	--	14.4
Angina, PQI Discharges	--	11.4
Asthma in Younger Adults, PQI Discharges	--	5.4
Note: -- Rates are not calculated where n<30. The sum of the individual diagnoses may differ slightly from the Total PQI Discharges figure for technical reasons. See Appendix C for details.		
Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information, Inc. and local demographic estimates from Alteryx, Inc. See Appendix C. Data Sources for details.		

Behavioral Health Hospitalization Discharge Profile

Behavioral health hospitalizations provide another important indicator of community health status. As shown in *Exhibit II-6,* residents of the study region had 406 hospital discharges from Virginia community hospitals for behavioral health conditions in 2013. The leading diagnoses for these discharges were affective psychoses, schizophrenic disorders, depressive disorders, alcoholic psychoses and senility without mention of psychoses. Discharge rates for the study region were lower than the Virginia statewide rates for all behavioral health discharges. *Note: Map 21 in Appendix A (page 44) shows the geographic distribution of behavioral health discharges by ZIP code.*

Exhibit II-6 Behavioral Health Hospital Discharge Profile, 2013		
Indicator	**Study Region**	**Virginia**
Behavioral Health Discharges		
Total Behavioral Health Discharges by All Diagnoses	406	60,600
Behavioral Health Discharges by Diagnosis by Leading 15 Diagnoses		
Affective Psychoses	127	26,709
Schizophrenic Disorders	49	8,136
Depressive Disorder, Not Elsewhere Classified	43	3,503
Alcoholic Psychoses	36	4,037
Senility Without Mention of Psychosis	20	1,688
Altered Mental Status	19	1,000
Adjustment Reaction	13	2,271
Symptoms Involving Head or Neck	12	933
Drug Psychoses	12	2,121
Neurotic Disorders	12	1,207
Other Organic Psychotic Conditions-Chronic	11	795
Other Nonorganic Psychoses	10	2,133
Alcohol Dependence Syndrome	7	2,391
Non Dependent Abuse of Drugs	3	600
Drug Dependence	3	816
Crude Rates per 100,000 Population		
Total Behavioral Health Discharges	334.4	734.8
Affective Psychoses	104.6	323.9
Schizophrenic Disorders	40.4	98.7
Depressive Disorder, Not Elsewhere Classified	35.4	42.5
Alcoholic Psychoses	29.6	49
Senility Without Mention of Psychosis	--	20.5
Altered Mental Status	--	12.1
Adjustment Reaction	--	27.5
Symptoms Involving Head or Neck	--	11.3
Drug Psychoses	--	25.7
Neurotic Disorders	--	14.6
Other Organic Psychotic Conditions-Chronic	--	9.6
Other Nonorganic Psychoses	--	25.9
Alcohol Dependence Syndrome	--	29
Non Dependent Abuse of Drugs	--	7.3
Drug Dependence	--	9.9
Note: Rates are not calculated where n<30.		
Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information and demographic data from Alteryx, Inc. See details on methods in Appendix C. Rates are not calculated where n<30.		

Adult Health Risk Profile

This profile examines health risks for adults age 18+. Prevalence estimates of health risks, chronic disease and health status can be useful in developing prevention and improvement efforts. As shown in *Exhibit II-7*, estimates from 2014 indicate that substantial numbers of adults in the study region have health risks related to nutrition, weight, physical inactivity, tobacco and alcohol. In addition, substantial numbers of adults have chronic conditions such as high cholesterol, high blood pressure, arthritis, diabetes and asthma. *Note: Maps 22-25 in Appendix A (page 44-46) show the geographic distribution of selected adult health risks by ZIP code.*

Exhibit II-7 Adult Health Risk Factor Profile (Estimates) 2014		
Indicator		**Study Region**
Count (Estimates)		
Estimated Adults age 18+		*97,940*
Risk Factors	Not Meeting Guidelines for Fruit and Vegetable Intake	78,154
	Overweight or Obese	61,123
	Not Meeting Recommendations for Physical Activity in the Past 30 Days	46,645
	Smoker	15,745
	At-risk for Binge Drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	17,844
Chronic Conditions	High Cholesterol (was checked, and told by a doctor or other health professional it was high)	35,375
	High Blood Pressure (told by a doctor or other health professional)	28,538
	Arthritis (told by a doctor or other health professional)	22,786
	Diabetes (told by a doctor or other health professional)	10,611
General Health Status	Limited in any Activities because of Physical, Mental or Emotional Problems	18,370
	Fair or Poor Health Status	16,407
Percent (Estimates)		
Risk Factors	Not Meeting Guidelines for Fruit and Vegetable Intake	80%
	Overweight or Obese	62%
	Not Meeting Recommendations for Physical Activity in the Past 30 Days	48%
	Smoker	16%
	At-risk for Binge Drinking (males having five or more drinks on one occasion, females having four or more drinks on one occasion)	18%
Chronic Conditions	High Cholesterol (was checked, and told by a doctor or other health professional it was high)	36%
	High Blood Pressure (told by a doctor or other health professional)	29%
	Arthritis (told by a doctor or other health professional)	23%
	Diabetes (told by a doctor or other health professional)	11%
General Health Status	Limited in any Activities because of Physical, Mental or Emotional Problems	19%
	Fair or Poor Health Status	17%
Source: Estimates produced by Community Health Solutions using Virginia Behavioral Risk Factor Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix C. Data Sources for details.		

Youth Health Risk Profile

This section examines selected health risks for youth age 10-19. These risks have received increasing attention as the population of American children has become more sedentary, more prone to unhealthy eating and more likely to develop unhealthy body weight. The long-term implications of these trends are serious, as these factors place children at higher risk for chronic disease both now and in adulthood.

As shown in *Exhibit II-8,* estimates from 2014 indicate that substantial numbers of youth in the study region have health risks related to nutrition, weight, alcohol, mental health, tobacco, and physical

activity. *Note: Map 26 in Appendix A (page 46) shows the geographic distribution of youth overweight or obese by ZIP code.*

Exhibit II-8
Youth Health Risk Factor Profile (Estimates) 2014

Indicator	Study Region
Counts (Estimates)	
High School Youth Age 14-19	
Total Estimated High School Youth Age 14-19	*10,413*
Not Meeting Guidelines for Fruit and Vegetable Intake	9,552
Overweight or Obese	2,774
Not Meeting Recommendations for Physical Activity in the Past Week	5,689
Used Tobacco in the Past 30 Days	1,904
Had at least One Drink of Alcohol At least One Day in the Past 30 Days	2,918
Felt Sad or Hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities)	2,640
Middle School Youth Age 10-14	
Total Estimated Middle School Youth Age 10-14	*3,513*
Not Meeting Guidelines for Fruit and Vegetable Intake	2,688
Not Meeting Recommendations for Physical Activity in the Past Week	2,283
Used Tobacco in the Past 30 Days	81
Percent (Estimates)	
High School Youth Age 14-19	
Not Meeting Guidelines for Fruit and Vegetable Intake	92%
Overweight or Obese	27%
Not Meeting Recommendations for Physical Activity in the Past Week	55%
Used Tobacco in the Past 30 Days	18%
Had at least One Drink of Alcohol At least One Day in the Past 30 Days	28%
Felt Sad or Hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities)	25%
Middle School Youth Age 10-14	
Not Meeting Guidelines for Fruit and Vegetable Intake	77%
Not Meeting Recommendations for Physical Activity in the Past Week	65%
Used Tobacco in the Past 30 Days	2%

Source: Estimates produced by Community Health Solutions using Virginia Youth Risk Behavioral Surveillance System data and local demographic estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Uninsured Profile

Decades of research show that health coverage matters when it comes to overall health status, access to health care, quality of life, school and work productivity, and even mortality. *Exhibit II-9* shows the estimated number of uninsured individuals by income in the study region as of 2014. At a given point in time in 2014, an estimated 14,644 nonelderly residents of the study region were uninsured, including 1,836 children and 12,807 adults. The estimated uninsured rates were 7 percent for children

age 0-18, 18 percent for adults age 19-64, and 15 percent for the population age 0-64. *Note: Maps 27-28 in Appendix A (page 47) show the geographic distribution of the uninsured population by ZIP code.*

Exhibit II-9
Uninsured Profile (Estimates) 2014

Indicator	Study Region
Estimated Uninsured Counts*	
Uninsured Nonelderly Age 0-64	14,644
Uninsured Children Age 0-18	1,836
Uninsured Children Age 0-18 <=138% FPL	596
Uninsured Children Age 0-18 <=200% FPL	922
Uninsured Children Age 0-18 <=250% FPL	1,132
Uninsured Children Age 0-18 <=400% FPL	1,505
Uninsured Children Age 0-18 138-400% FPL	909
Uninsured Adults Age 19-64	12,807
Uninsured Adults Age 19-64 <=138% FPL	4,690
Uninsured Adults Age 19-64 <=200% FPL	6,878
Uninsured Adults Age 19-64 <=250% FPL	8,290
Uninsured Adults Age 19-64 <=400% FPL	10,743
Uninsured Adults Age 19-64 138-400% FPL	6,053
Estimated Uninsured Percent	
Children Age 0-18	7%
Adults Age 19-64	18%
Population Age 0-64	15%

Note: Federal poverty level (FPL) categories are cumulative.

Source: Estimates produced by Community Health Solutions using U.S. Census Bureau Small Area Health Insurance Estimates (2014) and local demographic estimates from Alteryx, Inc. See Appendix C for details on methods.

Medically Underserved Profile

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are designations used by the U.S. Health Resources and Services Administration to identify populations at-risk for health care access problems. The designations are based on several factors including primary care provider supply, infant mortality, prevalence of poverty and the prevalence of seniors age 65+.

As shown in *Exhibit II-10*, all six localities that overlap with the ZIP code study region have been partially or fully designated as MUAs/MUPs. For a more detailed description, visit the U.S. Health Resources and Service Administration designation webpage at http://muafind.hrsa.gov/.

Exhibit II-10
Medically Underserved Areas Profile

Locality	MUA/MUP Designation	Census Tracts
Charles City County	Full	3 of 3 census tracts
James City County	Partial	6 of 11 census tracts
King William County	Full	4 of 4 census tracts
New Kent County	Full	3 of 3 census tracts
City of Williamsburg (see note)	Partial	3 of 3 census tracts
York County	Partial	3 of 14 census tracts

Note: The city of Williamsburg designation is an MUP (Medically Underserved Population) designation, indicating that the low income population of specific census tracts is designated as underserved.

Source: Community Health Solutions analysis of U.S. Health Resources and Services Administration data.

Community Input

In an effort to obtain community input for the study, a *Community Survey* was conducted with a broad-based group of community stakeholders identified by Riverside Doctors' Hospital of Williamsburg and Sentara Williamsburg Regional Medical Center. The survey participants were asked to provide their viewpoints on:

- Important health concerns in the community
- Significant service gaps in the community
- Vulnerable/at-risk populations in the community
- Vulnerable/at-risk geographic regions in the community
- Health assets within the community
- Health assets needed in the community
- Additional ideas or suggestions for improving community health

In an effort to broaden participation in the survey compared to the previous CHNA study in 2012/2013, the survey was sent to many more people for the 2016 CHNA. The survey was sent to a group of 922 community stakeholders. The community stakeholder list included representatives from public health, education, social services, business, local government and local civic organizations, among others. Riverside Doctors' Hospital of Williamsburg staff conducted outreach for community input via email, through personal phone calls, and in-person at local events and meetings. A total of 114 stakeholders (12.4 percent) submitted a response (although not every respondent answered every question).

- **Community Health Concerns.** Respondents identified many of specific health concerns, with the most commonly mentioned being mental health conditions, dementia/Alzheimer's Disease, obesity, high blood pressure/hypertension and heart disease

- **Community Service Gaps.** Respondents identified many of specific community service gaps, with the most commonly mentioned being aging services, mental health-behavioral health services, care coordination and transitions of care, health care insurance coverage, and services for vulnerable populations.

- **Vulnerable or At-Risk Populations.** Respondents identified a variety of vulnerable/at-risk populations in the community. Commonly mentioned examples (by category) included the chronically ill, children, individuals with disabilities, the elderly population, ethnic/racial minorities, homeless, the low income population, individuals with behavioral health conditions, individuals without access to healthcare services, individuals without transportation, the uninsured/underinsured, the unemployed, veterans and other populations with particular health concerns. Respondents also identified vulnerable/at-risk neighborhoods or geographic regions in the community, including low income neighborhoods and specific areas throughout the region.

- **Health Assets in the Community.** Respondents identified diverse health assets in the community. Examples included biking and walking trails, community organizations, faith-based organizations, hospitals and health systems, the natural environment, recreational

facilities, and safety net organizations.

- **Health Assets Needed in the Community.** Respondents identified health assets that could use enhancement. Examples included access to safe parks and recreational facilities, behavioral health services, community and health care services for seniors, primary and specialty medical care services, safe, affordable housing and transportation services.

- **Additional Ideas and Suggestions.** Respondents offered a variety of ideas and suggestions for improving community health. Examples included additional transportation resources, collaboration among local healthcare organizations, coordination of healthcare services, health education and prevention, improving access to healthcare services, and resources for the elderly population.

Survey Respondents

Exhibit I-1 below lists the organizational affiliations of the survey respondents.

Exhibit I-1 Survey Respondents by Organization	
What is the name of your organization?	
Note: A count is provided for organizations with multiple survey respondents.	
Angels of Mercy Medical Clinic	Retired (4)
Auxiliary of Sentara Williamsburg Regional Medical Center (7)	Riverside Doctor's Hospital Board (2)
Avalon Center	Riverside Health System
Bay Rivers Telehealth Alliance	Riverside Medical Group (29)
Beyond Boobs!	Sentara Healthcare
Catholic Charities of Eastern Virginia	Sentara Patient and Family Advisory Council (5)
Celebrate Healthcare LLC	Sentara Williamsburg Regional Medical Center (2)
Charles City County Sheriff's Office	Spring Arbor of Williamsburg
College of William and Mary	Tidewater Diagnostic Imaging
Colonial Behavioral Health (3)	United Way of Greater Williamsburg
Foundation for Rehabilitation and Endowment	United Way of the Virginia Peninsula
Gloucester County Community Education	VersAbility Resources
Gloucester-Mathews Care Clinic	Village Events, Ltd.
Grove Christian Outreach Center	Virginia Department of Health, Peninsula Health District
Hampton Roads Neurosurgical and Spine Specialists	Virginia Peninsula Chamber of Commerce
Healing Music	Virginia Peninsula Foodbank
Hospice House & Support Care of Williamsburg (2)	Volunteer (2)
Independent Consultant	West Point Town
International Black Women's Congress	West Point Police Department
James City County	Williamsburg City
Continued on the following page	

Exhibit I-1 Survey Respondents by Organization	
What is the name of your organization?	
Note: A count is provided for organizations with multiple survey respondents.	
James City County Board of Supervisors	Williamsburg Area Faith in Action
James City County Police Department	Williamsburg Community Foundation
James City County Social Services	Williamsburg Department of Human Services
King William County Sheriff's Office	Williamsburg Emergency Physicians
New Kent County Children's Services Act	Williamsburg Health Foundation (5)
Newport News Fire Department	Williamsburg James City County Public Schools
PBMares Wealth Management (2)	Williamsburg James City County Public Schools Board
Peninsula Agency on Aging (3)	Williamsburg Landing, Inc.
Peninsula Metropolitan YMCA	York County (2)
Respite Care of Williamsburg United Methodist Church	

Community Health Concerns

Survey respondents were asked to review a list of common community health issues. The list of issues draws from the topics in *Healthy People 2020* with some refinements. The survey asked respondents to identify from the list what they view as important health concerns in the community. Respondents were also invited to identify additional issues not already defined on the list. *Exhibit I-2* summarizes the results, including open-ended responses. As shown in *Exhibit I-2*, respondents identified dozens of specific health concerns, with the most commonly mentioned being mental health conditions, dementia/Alzheimer's Disease, obesity, high blood pressure/hypertension, and heart disease.

Exhibit I-2
Important Community Health Concerns Identified by Survey Respondents

Note: 110 of the 114 respondents answered this question. When interpreting the survey results, please note that although the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.

Answer Options	Response Percent	Response Count
Mental Health - Behavioral Health Conditions (e.g. depression, anxiety, etc.)	75%	83
Dementia / Alzheimer's Disease	69%	76
Obesity	65%	72
High Blood Pressure / Hypertension	63%	69
Heart Disease	62%	68
Substance Abuse (prescription or illegal drugs)	60%	66
Diabetes	56%	62
Cancer	54%	59
Alcohol Use	50%	55
Stroke	47%	52
Chronic Pain	45%	49
Accidents / Injuries	42%	46
Dental / Oral Health Care	36%	40
Respiratory Diseases (e.g. asthma, COPD, etc.)	36%	40
Tobacco Use	36%	40
Violence – Domestic Violence	35%	38
Arthritis	34%	37
Infant and Child Health	34%	37

Orthopedic Problems	33%	36
Prenatal and Pregnancy Care	29%	32
Hunger	25%	28
Neurological Conditions (e.g. seizures, multiple sclerosis, traumatic brain injury, etc.)	25%	28
Violence – Other than domestic violence	25%	28
Intellectual/Developmental Disabilities	25%	27
Renal (kidney) Disease	23%	25
Environmental Health (e.g. pollution, mosquito control, water quality, etc.)	20%	22
Physical Disabilities	20%	22
Bullying	19%	21
Drowning / Water Safety	18%	20
Infectious Diseases	17%	19
Sexually Transmitted Diseases	15%	17
Teen Pregnancy	15%	17
Autism	15%	16
HIV/AIDS	10%	11
Other Health Problems (see the following page)	19%	21

Exhibit I-2
Important Community Health Concerns Identified by Survey Respondents (continued)

Response #	Other Health Concerns (Open-Ended Reponses)
1	• Access to care and medications
2	• Access to low cost birth control and STD testing, (James City County) • Pregnancy care • Homelessness in our area
3	• Access to specialty care • Uninsured
4	• All are important to those who are facing them. Gaining Access to Services to address these needs is the challenge.
5	• Diseases of the aging are prevalent in this area due to everyday influx of retirees.
6	• Failing health education in primary and secondary public schools. • Availability of competent physicians in primary care • Inadequate government funding of preventative health care and excessive government funding of futile care at end of life
7	• Frailty
8	• Geriatric outpatient services, • Comprehensive pain management to include psych services
9	• Issues associated with aging-social isolation, unable to drive to doctor appointments
10	• Lack of adequate gerontology resources, including physicians. One third of the population in our geographic area will be seniors within the next 3 years. There are not adequate sources to help them at this time, particularly for low-income seniors. Families who are caretakers also need more support and help.
11	• Opiate and heroin addiction
12	• Other health problems-the growing danger of antibiotic resistant bacteria. • An aging population and growing numbers of obese individuals raises concerns and incidences of all the other health issues occurring.

13	• Sexual abuse is not listed; it is a serious health problem. • Homeless and those with no ID's have a serious problem getting help.
14	• Sexual assault both on college campus and off. We have seen a very big increase in clients in the last two years.

Community Service Gaps

Survey respondents were asked to review a list of community services that are typically important for addressing the health needs of a community. Respondents were asked to identify from the list any services they think need strengthening in terms of availability, access or quality. Respondents were also invited to identify additional service gaps not already defined on the list.

As shown in Exhibit I-3, respondents identified dozens of specific community service gaps, with the most commonly mentioned being aging services, mental health – behavioral health services, care coordination and transitions of care, health insurance coverage and services for vulnerable populations.

Exhibit I-3
Important Community Service Gaps Identified by Survey Respondents

Note: 111 of the 114 respondents answered this question. When interpreting the survey results, please note that although the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.

Answer Options	Response Percent	Response Count
Aging Services	65%	72
Mental Heath - Behavioral Health Services	56%	62
Care Coordination and Transitions of Care	55%	61
Health Care Insurance Coverage	50%	56
Services for Vulnerable Populations (e.g. uninsured/underinsured, migrant workers, homeless, etc.)	47%	52
Services for Caregivers	43%	48
Transportation Services	43%	48
Health Promotion and Prevention Services	42%	47
Substance Abuse Services	42%	47
Long Term Care Services	41%	45
Chronic Pain Management Services	40%	44
Chronic Disease Services (e.g. diabetes, high blood pressure, etc.)	39%	43
Self-Management Services (e.g. nutrition, exercise, taking medications)	36%	40
Home Health Services	33%	37
Dental / Oral Health Care Services	32%	36
Food Safety Net (e.g. food bank, community gardens, school lunches, etc.)	27%	30
Social Services	27%	30
Cancer Services (e.g. screening, diagnosis, treatment, etc.)	24%	27
Early Intervention Services for Children	22%	24
Veterans Services	21%	23
Domestic Violence Services	19%	21

Exhibit I-3
Important Community Service Gaps Identified by Survey Respondents

Note: 111 of the 114 respondents answered this question. When interpreting the survey results, please note that although the relative number of responses received for each item is instructive, it is not a definitive measure of the relative importance of one issue compared to another.

Answer Options	Response Percent	Response Count
Primary Care Medical Services	19%	21
Intellectual/Developmental Disabilities Services	17%	19
Specialty Care Medical Services (cardiologists, oncologists, etc.)	17%	19
Public Health Services	16%	18
Hospice Services	15%	17
School Health Services	14%	16
Maternal, Infant and Child Health Services	14%	15
Hospital Services (e.g. inpatient, outpatient, emergency care, etc.)	12%	13
Physical Rehabilitation	12%	13
Family Planning Services	10%	11
Public Safety Services	9%	10
Environmental Health Services	6%	7
Pharmacy Services	5%	6
Workplace Health and Safety Services	4%	4
Other Services (see responses below)	12%	14

Response #	Other Service Gaps (Open-Ended Reponses)
1	• Access to services through remote technology • Palliative Care and patient care navigation and advocacy
2	• Lab services that come to your home.
3	• Affordable, accessible adult day programs
4	• Co-factor of poverty, access to care and health disparities
5	• Companion care that is affordable for those who do not qualify for Medicaid but are still considered low income
6	• I see many families with inadequate resources and a great need for parent education for high risk families starting at birth. Lots of parents using drugs/alcohol, lack of knowledge about how to be a parent, having too many children to care for or support, unable to access services due to knowledge or ambition, children being raised with little supervision. Other parents trying hard to improve themselves and take care of their children but they are thwarted by insurance issues, transportation, etc. • Many children in need of behavioral/mental health services at all ages
7	• If one does not have an ID, getting the services I checked off is almost impossible.
8	• Insufficient coordination of care between the three hospitals and office based physicians
9	• Lack of adequate financial resources for the services listed directly impact availability and access.
10	• Long term services and supports • Palliative care education, training and workforce development
11	• Many of these are in place, concerns are with affordability and quality of services provided.
12	• MAT- medication assisted treatment for individuals who are chemically dependent particularly in the area of opioids and alcohol
13	• Obesity prevention and therapy
14	• Special need for mental health professionals for outpatient clinical care

Vulnerable and At-Risk Populations or Geographic Regions in the Community

Survey respondents were asked if there are particular populations within the community who are vulnerable/at-risk for health concerns or difficulties obtaining health services. Respondents were also asked if there are particular neighborhoods or geographic regions within the community where residents may be vulnerable/at-risk for health concerns or difficulties obtaining health services. Commonly mentioned examples include the following. Please see *Appendix B (page 41)* for a detailed listing.

- Chronically Ill
- Children
- Disabled
- Elderly
- Ethnic/Racial Minorities
- Homeless
- Low Income
- Residents with Behavioral Health Conditions (mental health and substance abuse)
- Residents of Particular Neighborhoods (see *Appendix B*)
- Residents without Transportation
- Residents who have been Victims of Violence
- Uninsured/Underinsured
- Unemployed
- Veterans

Health Assets in the Community

Survey respondents were asked to identify health assets within the community that promote a culture of health. *Exhibit I-4* summarizes the results. Respondents were also asked to identify health assets that the community needs, but may be lacking.

Exhibit I-4
Health Assets in the Community as Identified by Survey Respondents

Existing Assets that Promote a Culture of Health (by Category)	Assets the Community Needs, but May be Lacking (by Category)
• Biking and Walking Trails • Community Organizations • Faith-Based Organizations • Hospitals and Health Systems • Natural Environment • Recreational Facilities • Safety Net Organizations	• Access to Safe Parks and Recreation Facilities • Behavioral Health Services (Mental Health and Substance Abuse) • Community Services for Seniors • Health Care Services for Seniors • Primary Medical Care Services • Safe, affordable Housing • Specialty Medical Services • Transportation Services

Additional Ideas and Suggestions

Survey respondents offered open-ended responses with additional ideas and suggestions for improving community health. Common themes are listed below, and detailed responses are listed in *Appendix B (page 53)*.

- Additional Transportation Resources
- Collaboration among Local Healthcare Organizations
- Coordination of Healthcare Services
- Health Education and Prevention
- Improving Access to Healthcare Services
- Resources for the Elderly Population

Progress Made From the 2013 Implementation Plan

An important component of the 2016 CHNA is to review the work accomplished since the 2013 Implementation Plan. There were five key focus areas as a part of the 2013 Implementation Plan for the combined Peninsula and Williamsburg regions.

- ***Services for the Elderly:*** An identified issue was the need to increase awareness of, and access to, existing medical and community resources focused on the elderly. In response, Riverside worked to expand the senior navigation programs across the health system.

- ***Healthy Lifestyle, Nutrition and Wellness:*** Healthy lifestyle choices was another critcial issue identifed. Specifically, the focus was on how to improve community members' long term health through education of healthy lifestyle choices. To address this, Riverside offered regular public talks through "The Doc Is In" series. Topics inlcuded numerous health issues, including nutrition, preventative health care and important screening tests. Riverside also partenred with the Williamsburg Sports Complex to promote wellness issues in the community.

- ***Awareness and Navigation of Resources***: The need to increase awareness of existing health resources was also identified. Riverside worked to focus on care transitions across the system to ensure patients can access appropriate community resources at each stage in their health journey. Additionally, Riverside Nurse line directs people to appropriate community resources.

- ***Behavioral Health:*** Finally, the need to increase awareness of, and connection to, existing behavioral health resources was also identified. Riverside worked closely with community parners, including Colonial Behavioral Health to address the behavioral health needs in the community. Additionally, Riverside Behavioral Health Center in Hampton was aligned as part of Riverside Regional Medical Center to increase access to care for the community.

The hospital made every effort to solicit feedback from the community by providing a feedback mechanism on the hospital's website. However, at the time of this publication, no written feedback had been received on the 2013 CHNA and Implementation Plan.

Prioritization of the 2016 Significant Health Needs

In order to appropriately review the health indicator data and community survey input, the administrative leadership teams of Riverside Doctors' Hospital of Williamsburg and Sentara Williamsbirg Regional Medical Center came together in October to discuss the results. It was determined that a joint implementation plan between the hospitals would be appropriate, as both facilities serve the same region and work with the same community stakeholders. The group reviewed the demographic and

health indicator data as well as the community survey results. Additionally, there was a review and discussion of the 2013 CHNA Implementation Plans and the work that had been accomplished. There were multiple discussions about what the data reflected in the community, and which efforts had been working.

The goal of the prioritzation exercise was to identify a critical health issue for the region that could be impacted by the two hospitals working together, while avoiding program duplication or focusing on areas where existing progams and services were already addressing the issues.

In reviewing the health indiciator data and the survey results, the team of administraors from the two hospitals focused on four issues: mental health, opiate addiction, cancer and heart disease. For each issue, three questions were considered:

1. Is it a critical issue?
2. Is it a problem that the area hospitals can impact together?
3. Is it being addressed by other groups or programs?

	Is It A Critical Issue?	Is It A Problem the Area Hospitals Can Impact Together?	Is It Being Addressed By Other Groups / Programs?
Mental Health	Yes	Not a problem that can be significantly impacted by the two hospitals working together	Multiple area organizations, as well as state and national organizations are working to address
Opiate Epidemic	Yes	Potentially	Hampton Roads Working Group on Heroin is currently working to coordinate efforts across the broader region (coordinated initially by the joined health departments). Both systems are involved.
Cancer	Yes	Potentially	Multiple local, state and national organizations work to address prevention, screening, care, and research. Some cancer diagnoses have more community screening and funding than others.
Heart Disease	Yes	Potentially	Local, state and national organizations are working on prevention, screening, care and research.

Considering each of the identified issues, the group determined that heart disease was the issue to prioritize and focus on for the implementation plan. The group also agreed that if the heart diease collaboration is succesful that the second focus area would be cancer. Both hospitals indicated that they would continue to work on addressing behavioral health care and participating with the Hampton Roads Working Group on Heroin, but that it would not be under the auspices of the CHNA Implementation Plan.

IMPLEMENTATION STRATEGY

Strategy Process for Addressing Prioritized Health Needs

Following the prioritization of the health needs, the next step was to develop an implementation strategy to impact these concerns in the community. The conversation focused on what could be done to make Williamsburg a "Heart Safe Community." Representatives from both facilities felt this was an opportunity to work together to address education, prevention, screening and clincal care. Possible examples of what could be addressed included CPR classes, community lectures, community screenings based on a standard cardiovascular screening protocol and specialty cardiology care for at-risk patients idenitifed through screenings.

To ensure that this prioritization and implementation plan was an appropriate fit for the community, the plan was shared with the Williamsburg Chronic Care Collaborative on November 9, 2016. That group includes key community health groups such as the Williamsburg Health Foundation, Colonial Behavioral Health, Angels of Mercy Clinic, Gloucester-Mathews Free Clinic, Lackey Free Clinic, Olde Town Medical Center and Rx Partnership as well as Riverside and Sentara. Discussing the plan with these key public health groups and safety net clincs provided a great opportunity to refine the plan and receive feedback on how the concept can best meet the needs of the vulnerable and at risk populations in Williamsburg. The plan was well received overall, and the group confirmed that the chronic conditions surrounding heart disease were very prevalent in their patient populations. They affirmed the need for a consistent cardiovascular disease screening protocol. They were also very clear in the need to find pathways for their uninsured and underinsured patients to access specialty care once diagnosed as at-risk in the screenings.

Significant Health Need To Be Addressed

- Heart Disease

The focus area will be heart disease, including education, prevention, screening and clinical care.

Significant Health Needs Not Being Addressed

Not every need identified in the CHNA process can be addressed as a priority area for the 2016 CHNA Implementation Plan. The areas not selected may still be addressed through other programs or services offered by or supported by the hospital, but not as part of this plan.

Due to the limitation of resources, the size of the issue and the capacity of the existing organizations to impact the problem, the following issues were not identified as priorities:

- Cancer
- Mental Health
- Chronic Respiratory Conditions

- Stroke
- Reproductive health
- Infant mortality
- Hypertension
- Septicemia
- Nephritis
- Unintentional injury
- Domestic violence
- Chronic pain

Additionally, issues that did not rank as top health indicator problems in the quantitative analysis or noted as perceived community health issues in the survey are not going to be addressed as a part of the 2016 CHNA and Implementation Strategy. Examples of these areas include:

- Environmental Health
- Drowning / Water Safety
- Autism
- HIV / AIDS
- Dental / Oral Care
- Neurological Problems
- Arthritis
- Hunger
- Renal Disease
- Orthopedic Problems
- Sexually Transmitted Diseases
- Violence
- Physical Disabilities
- Bullying

Initial Implementation Strategy

Background information, action steps and anticipated resources are noted.

Creating a Heart Safe Community

Background:
As the health indicator data notes, the population across the Williamsburg region struggles with obesity and obesity-related conditions, such as hypertension and diabetes. Heart disease is listed as the primary cause of death for 22% of the deaths in the region.

Action Steps:
Working collaboratively, Riverside Doctors' Hospital and Sentara Williamsburg Regional Medical Center will create a detailed project plan to help make Williamsburg a "Heart Safe Community." The project plan will inlcude:

- Identifying individuals / roles on the Heart Safe Williamsburg Task Force
- Creating Deliverables for each area of focus:
    - ***Education and Prevention*** (CPR classes, education on the importance of calling 911, developing heart healthy habits, etc)
    - ***Screening*** (Developing standardized CVD screening protocol, identifying best avenues / locations for screenings to access at-risk populations)
    - ***Clincal Care*** (getting AEDs in schools and other public spaces, working with area cardiologists to creat pathways for uninsure / underinsured patients to access specialty care once identified through the screening process).
- Creating timelines
- Developing measurement and evaluation tools
- Identifying funding needs and sources.

Resources:
Riverside and Sentara will work together with other members of the Williamsburg Chronic Care Collabortive and other stakeholders in the community.

Questions, Comments and Copies

To view an electronic copy of this document, please visit www.riversideonline.com/community_benefit.

For questions or comments on this Community Health Needs Assessment and Implementation Plan, please contact Riverside's Marketing, Strategy and Development department at 757-534-7051 or via the comments section on www.riversideonline.com/community_benefit.

To obtain a paper copy, please visit the Riverside Doctors' Hospital of Williamsburg Administration Department or call 757-534-7051.

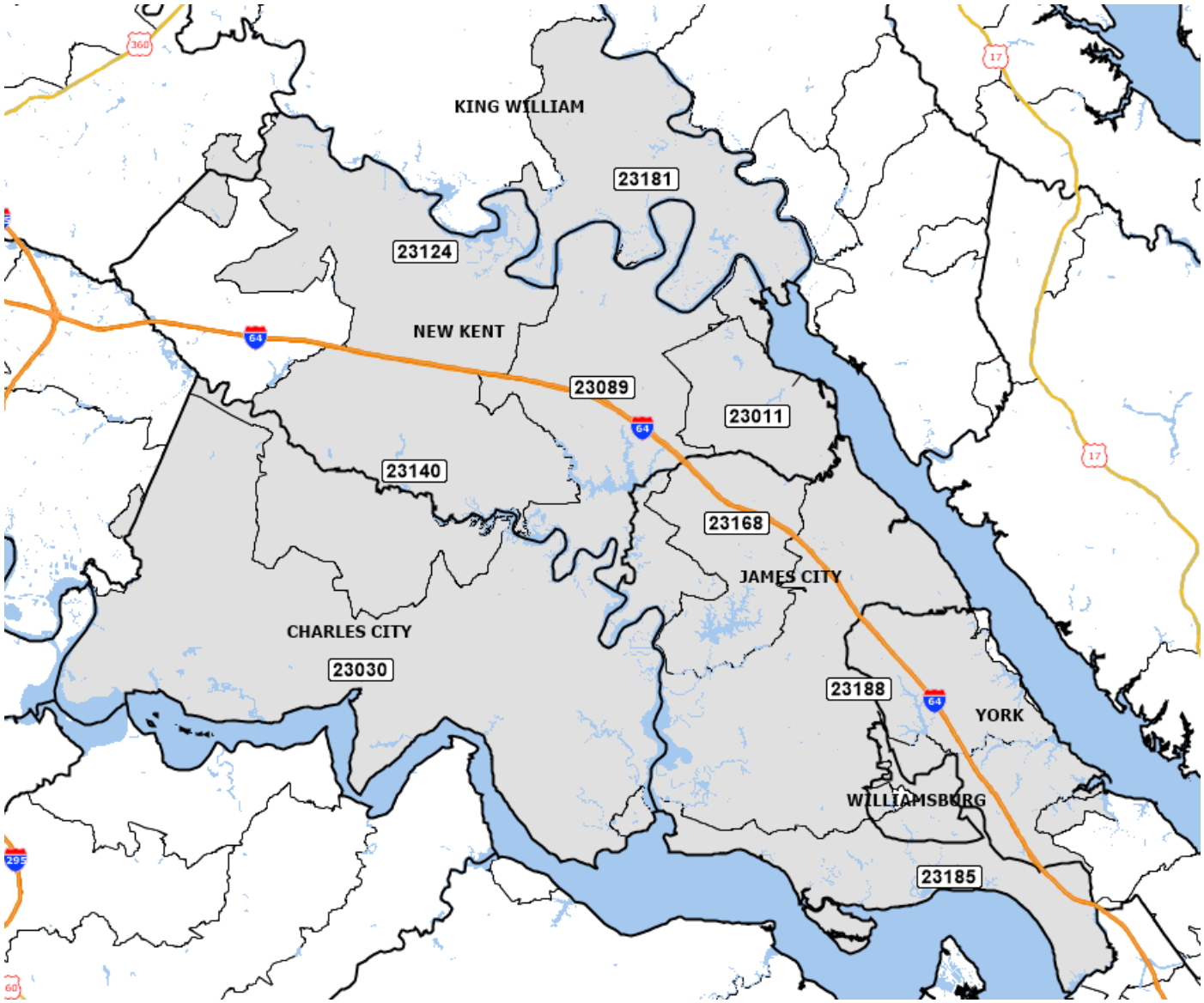
APPENDIX A. ZIP Code-Level Maps for the Study Region

The maps in this section illustrate the geographic distribution of the ZIP code-level study region population on key demographic and health indicators. The results can also be used alongside the Community Survey Results and the Community Indicators to help inform plans for community health initiatives. The exhibits in this section include the following.

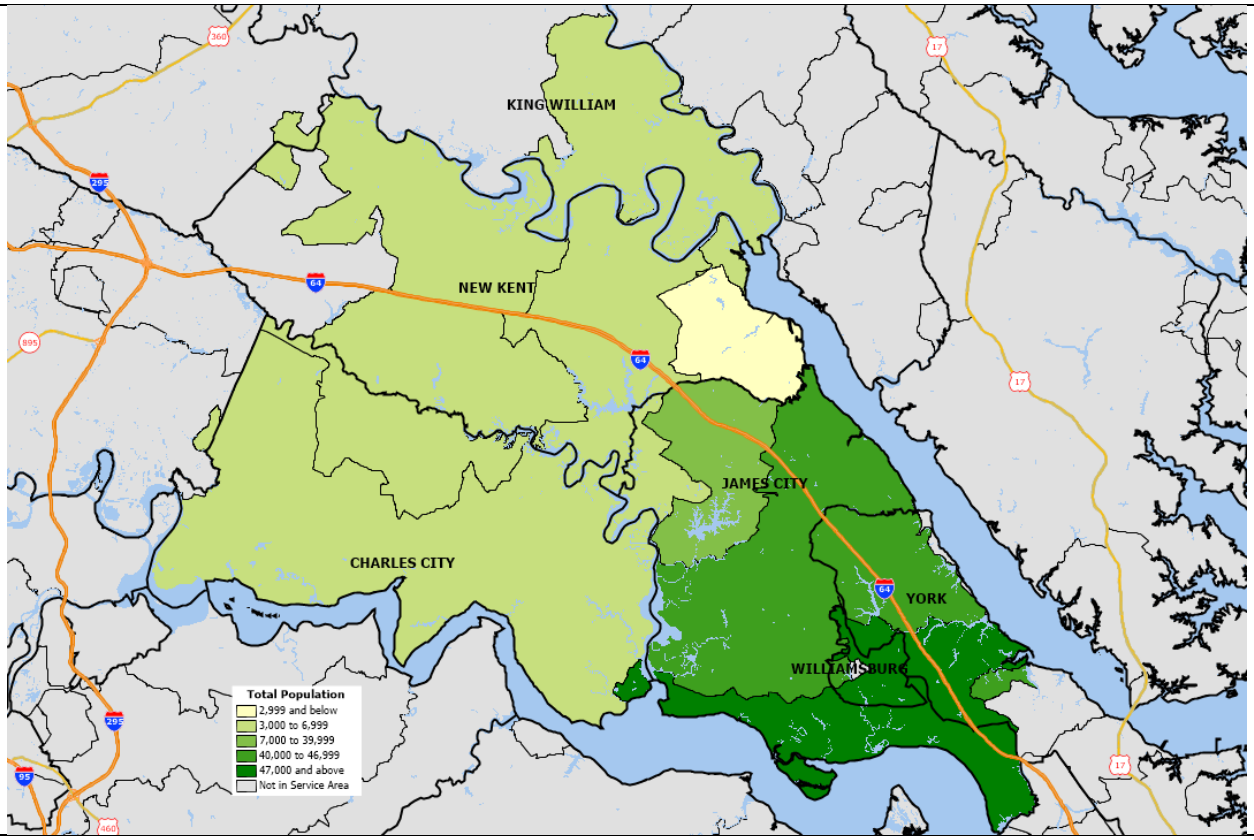
Technical Notes

1. The maps and data include 10 ZIP codes most of which fall within the counties of Charles City, King William, New Kent, James City and York; and Williamsburg City. Because ZIP code boundaries do not automatically align with city/county boundaries, there are some ZIP codes that extend beyond the county boundaries. Additionally, many residents of the service region use P.O. Boxes which are assigned to ZIP codes. Some of these ZIP codes can be mapped, but data are unavailable.
2. A reference map is provided first, to assist the ready in locating the ZIP codes of interest, as the data maps do not have ZIP codes labeled for readability.
3. The maps show counts rather than rates. Rates are not mapped at the ZIP code-level because in some ZIP codes the population is too small to support rate-based comparisons.
4. Data are presented in natural breaks.
5. ZIP Code-Level Study Region ZIP codes with zero values are noted.

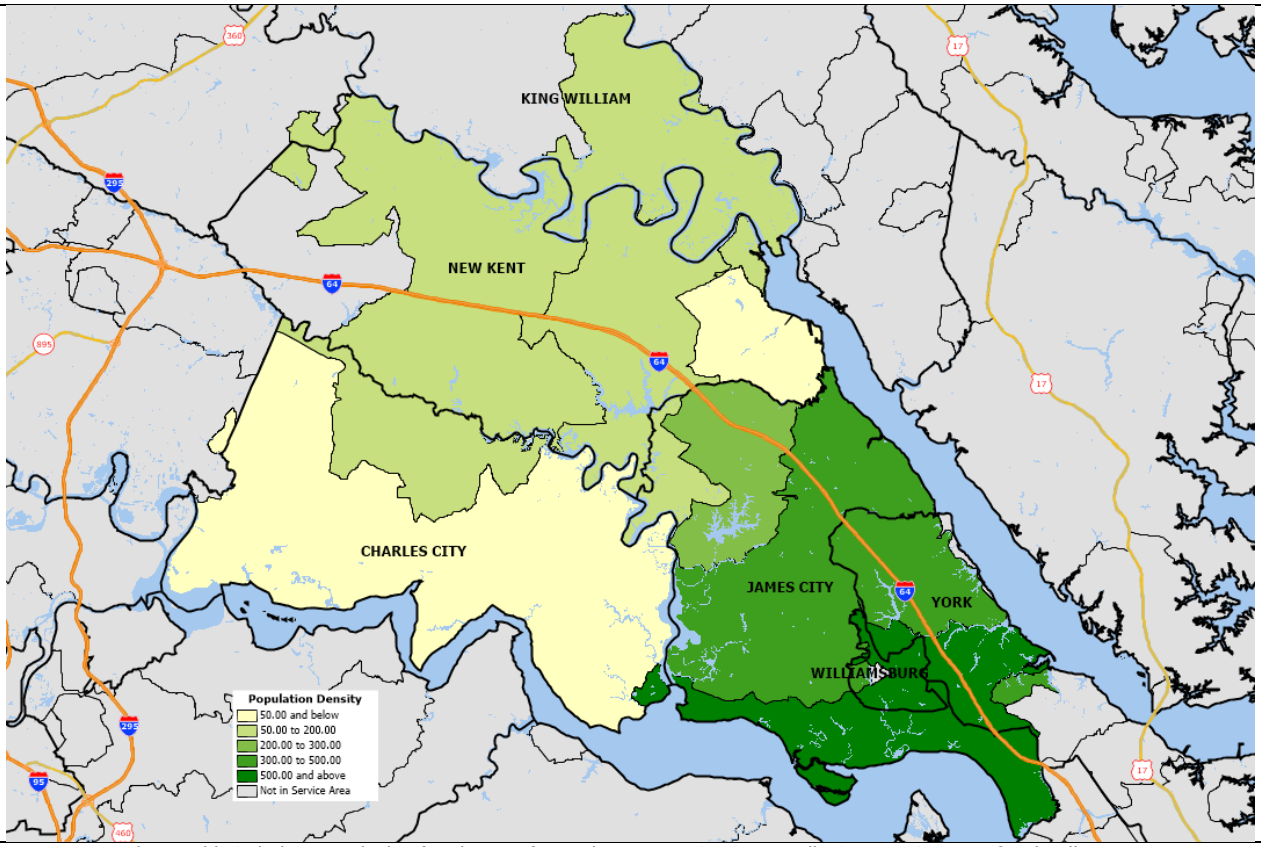
ZIP Code Reference Map



Map 1: Total Population, 2014

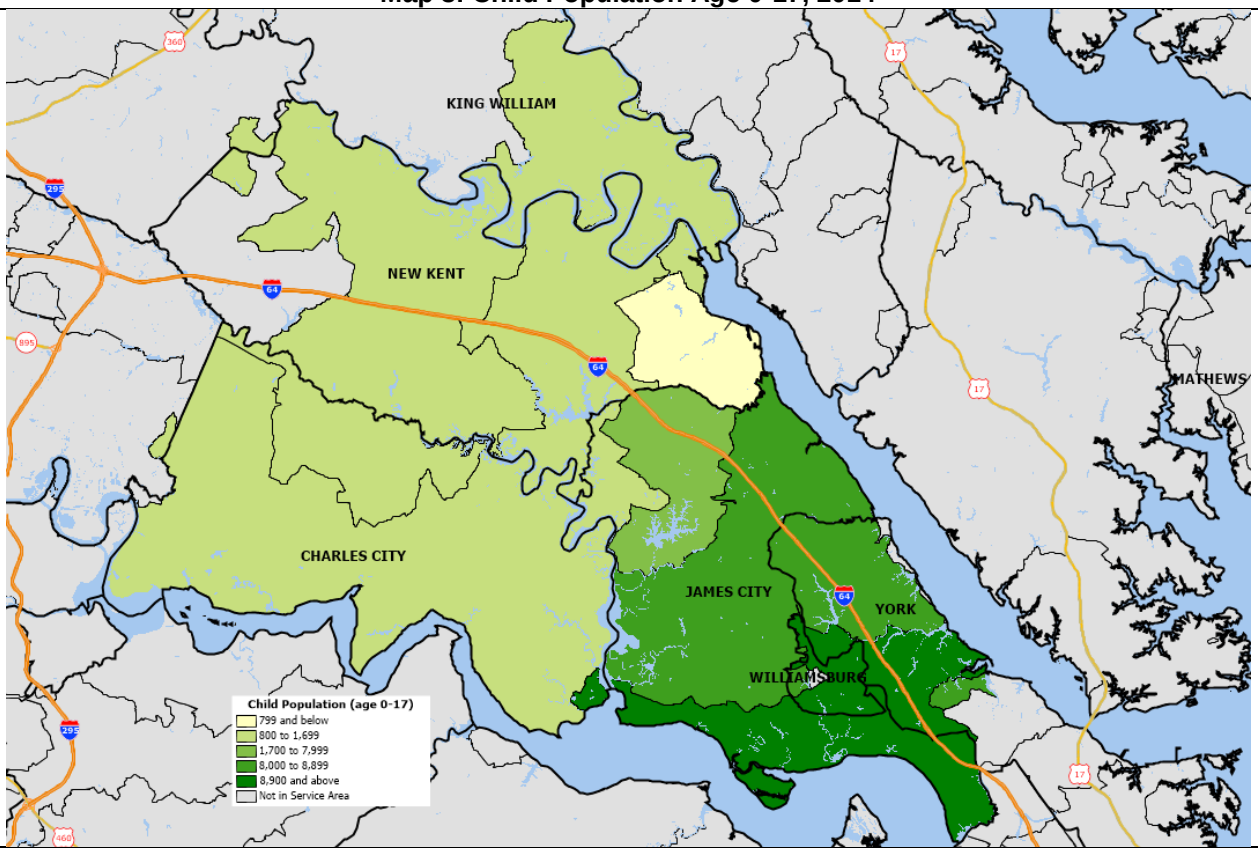


Map 2: Population Density (population per square mile), 2014

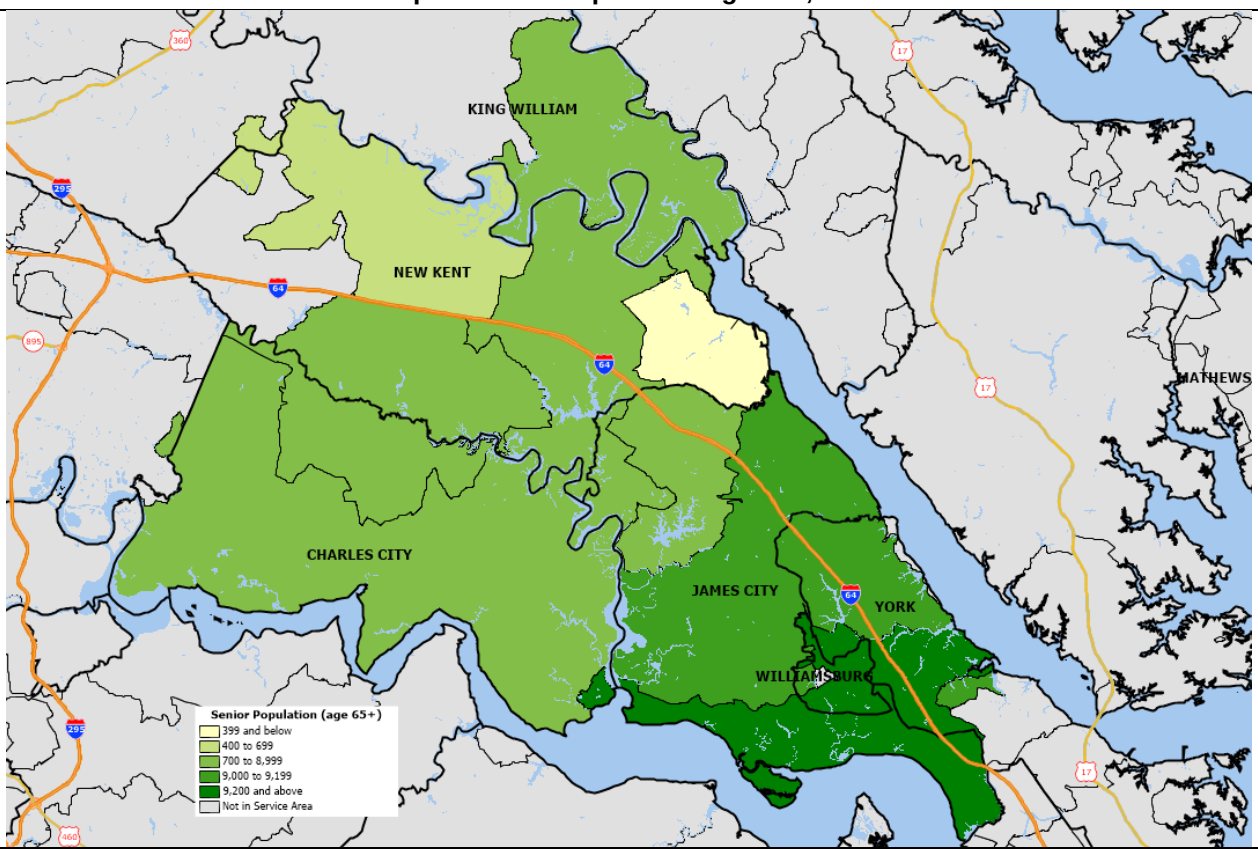


Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 3: Child Population Age 0-17, 2014

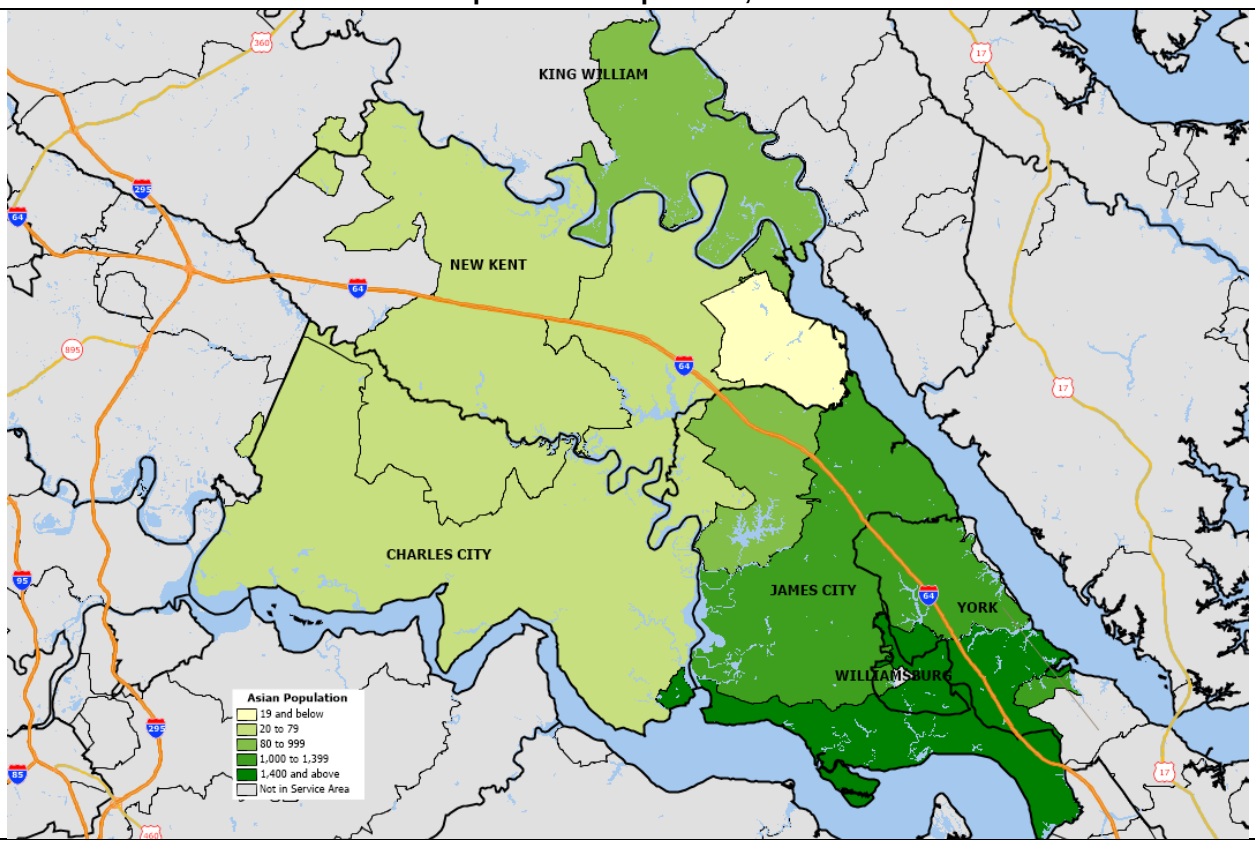


Map 4: Senior Population Age 65+, 2014

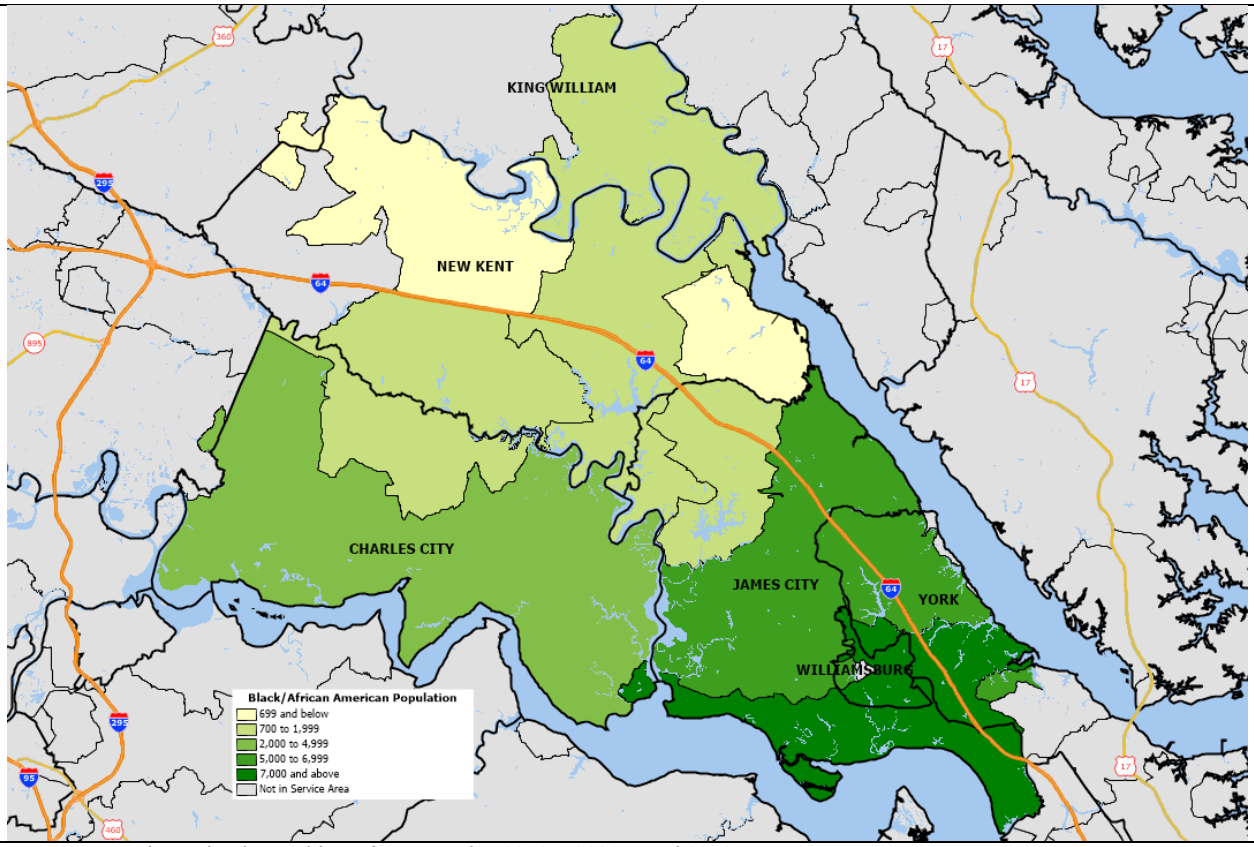


Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 5: Asian Population, 2014

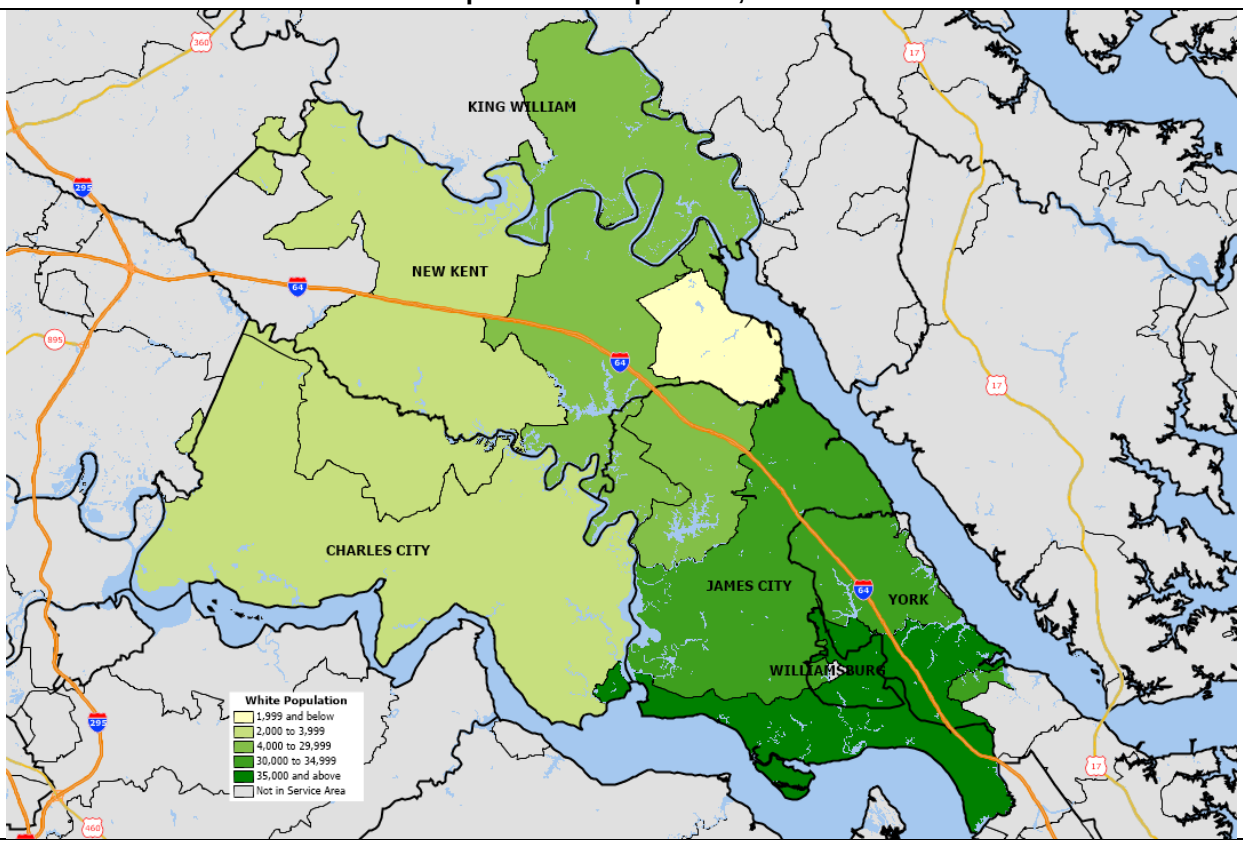


Map 6: Black/African American Population, 2014

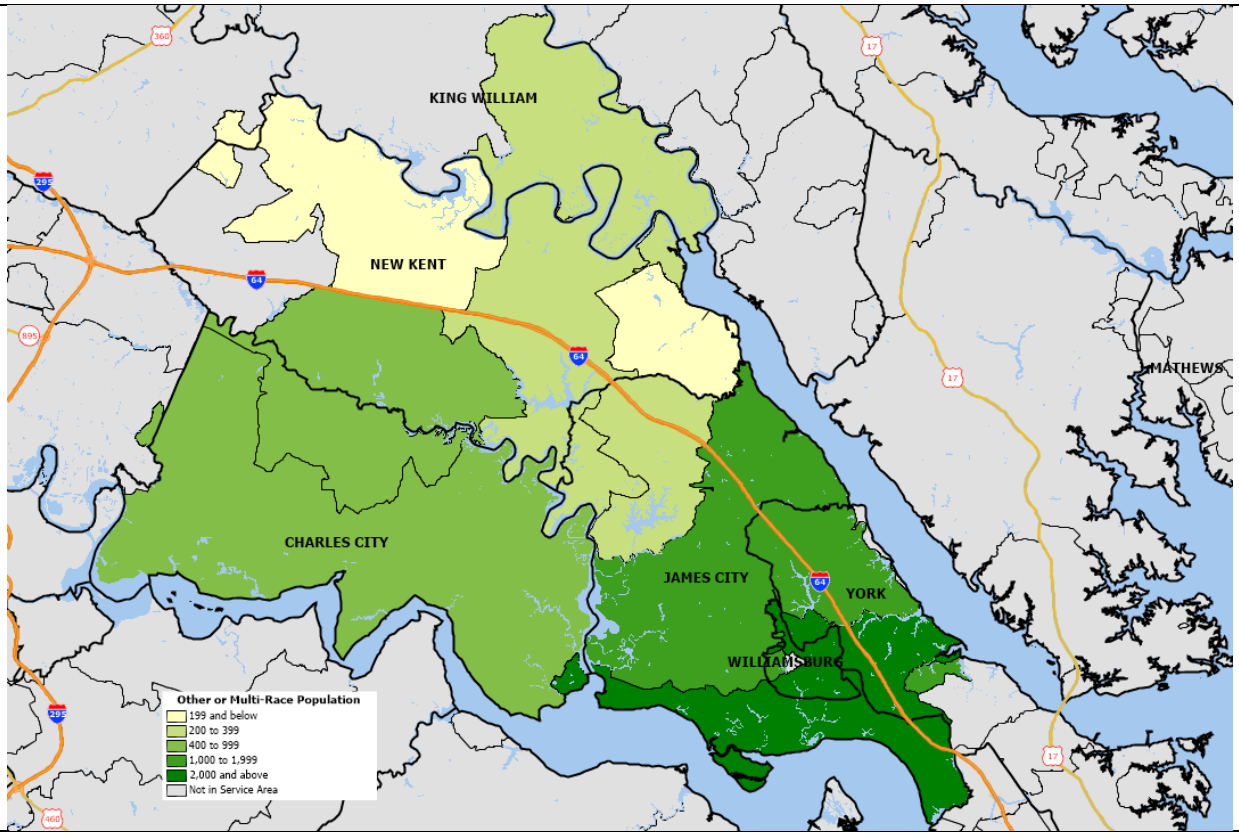


**There were no estimated Asian residents for ZIP codes 22509, 23805, and 23161.*
Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 7: White Population, 2014

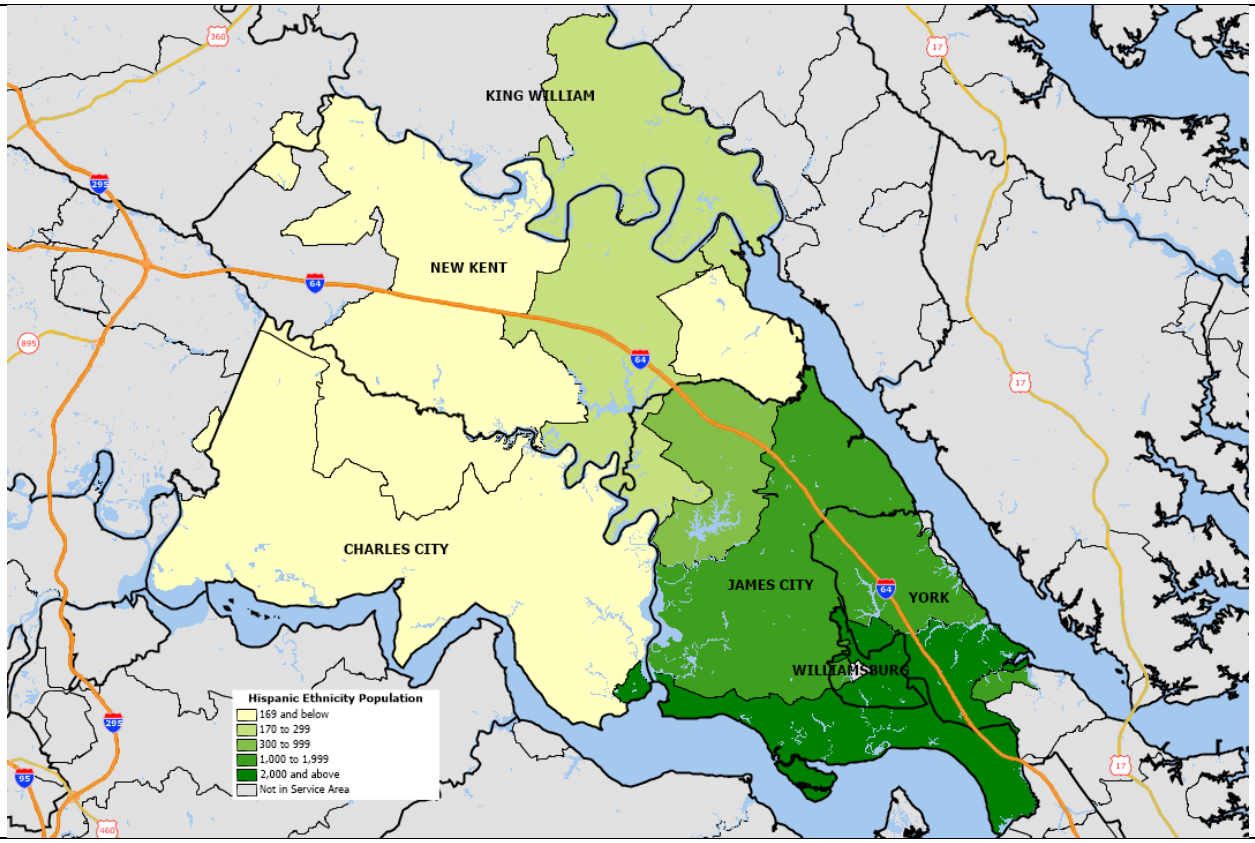


Map 8: Other or Multi-Race Population, 2014

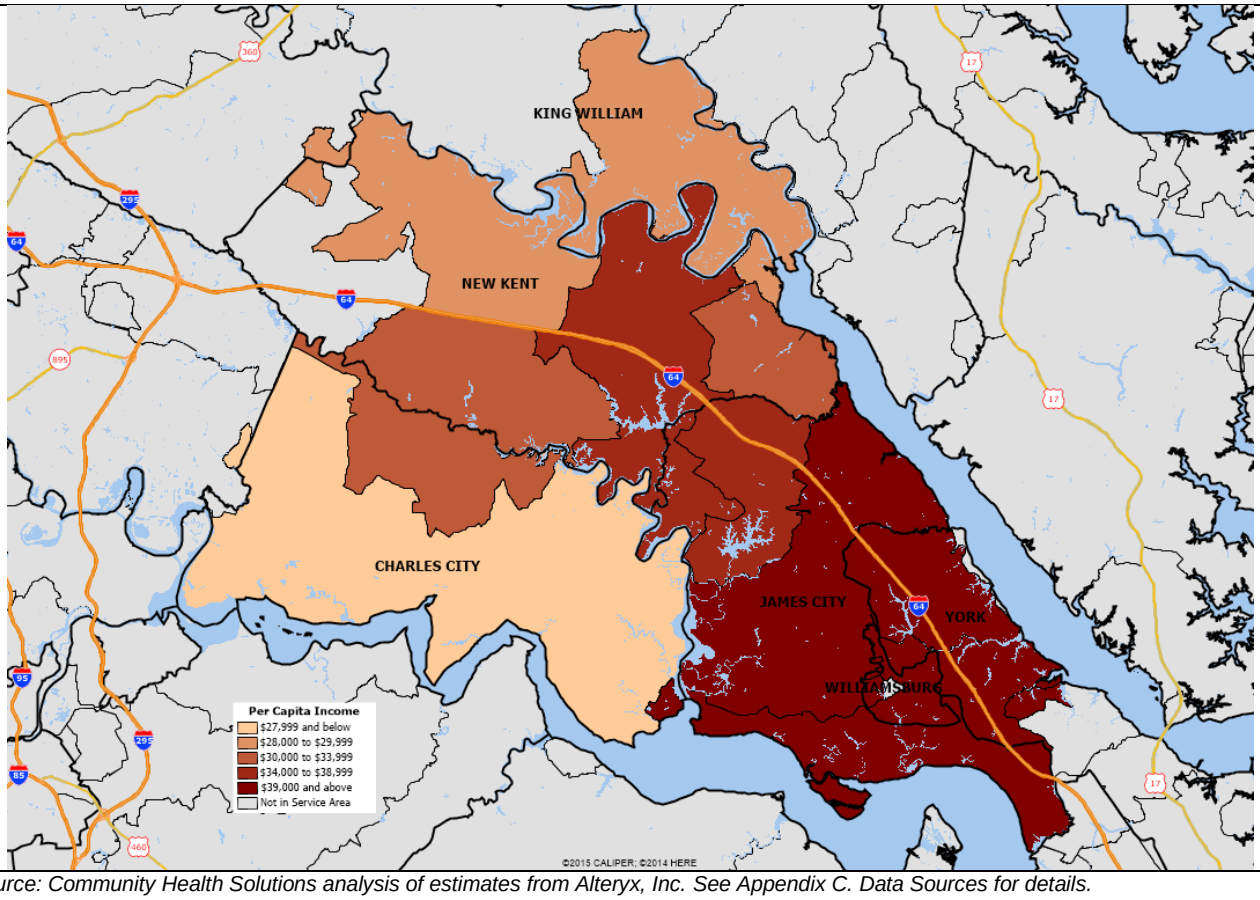


Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 9: Hispanic Ethnicity Population, 2014

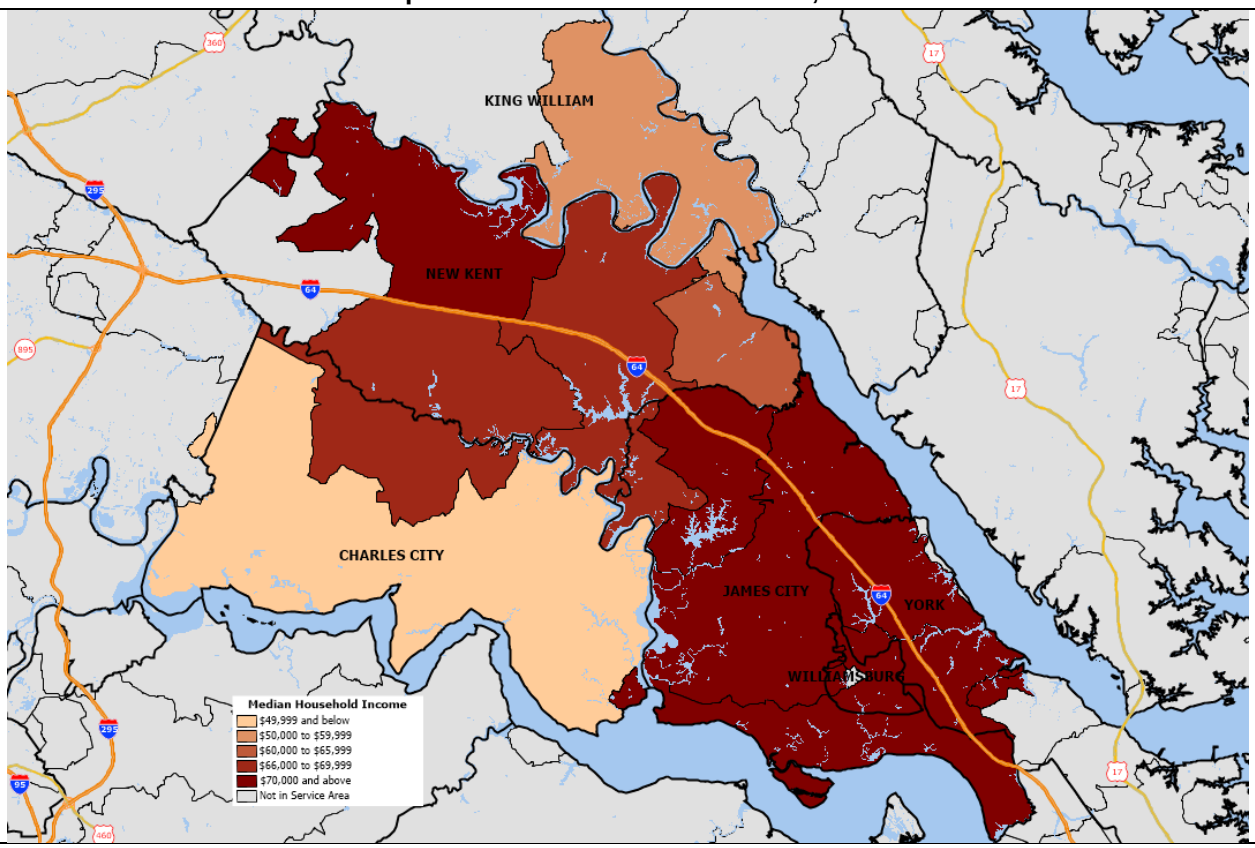


Map 10: Per Capita Income, 2014

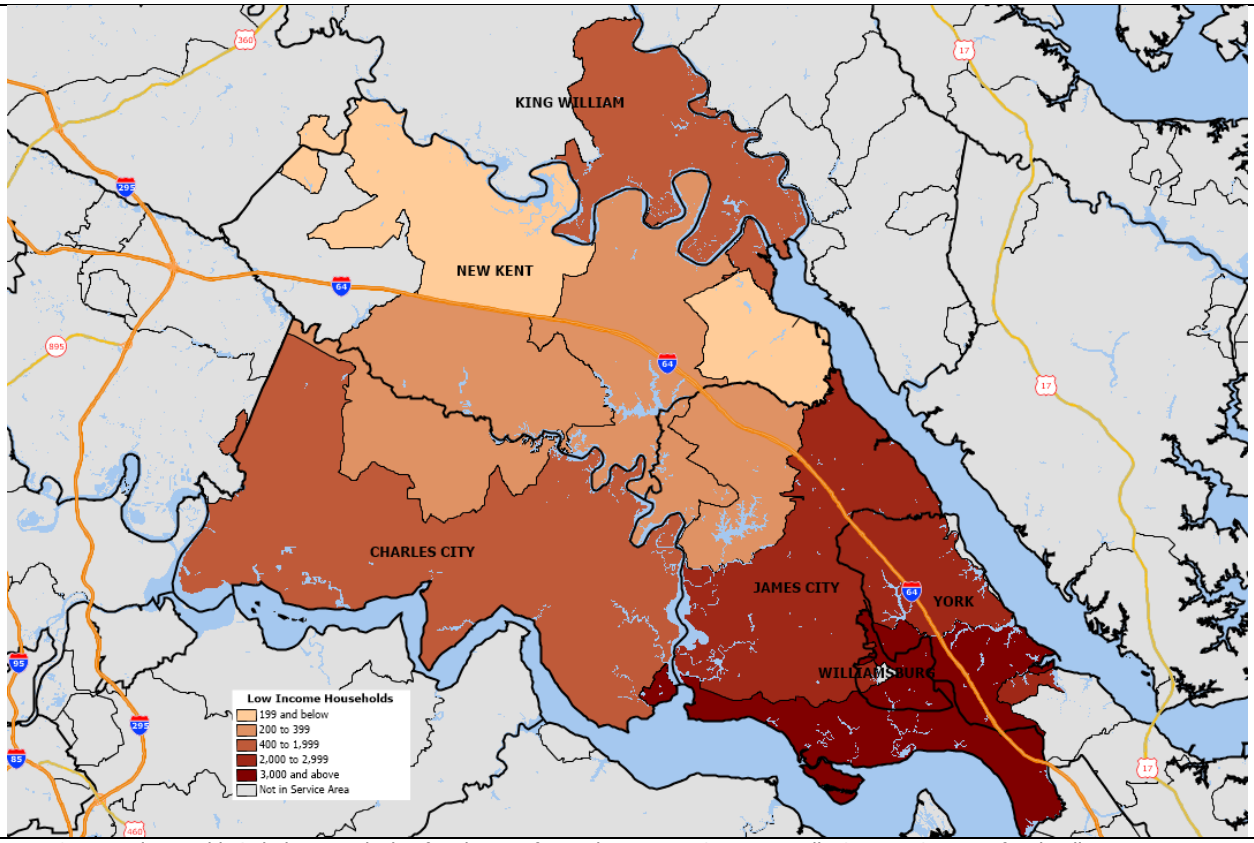


Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 11: Median Household Income, 2014

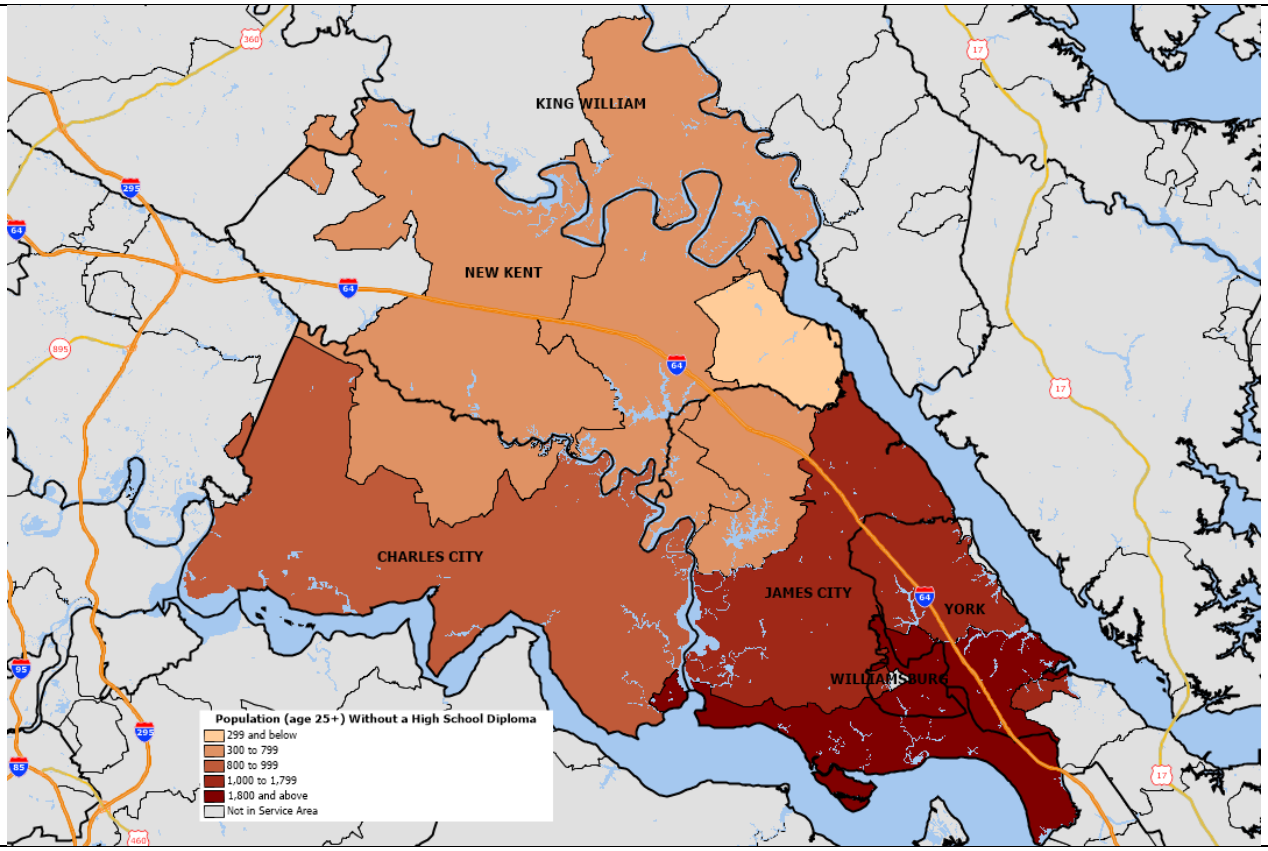


Map 12: Low Income Households (Households with Income<$25,000), 2014

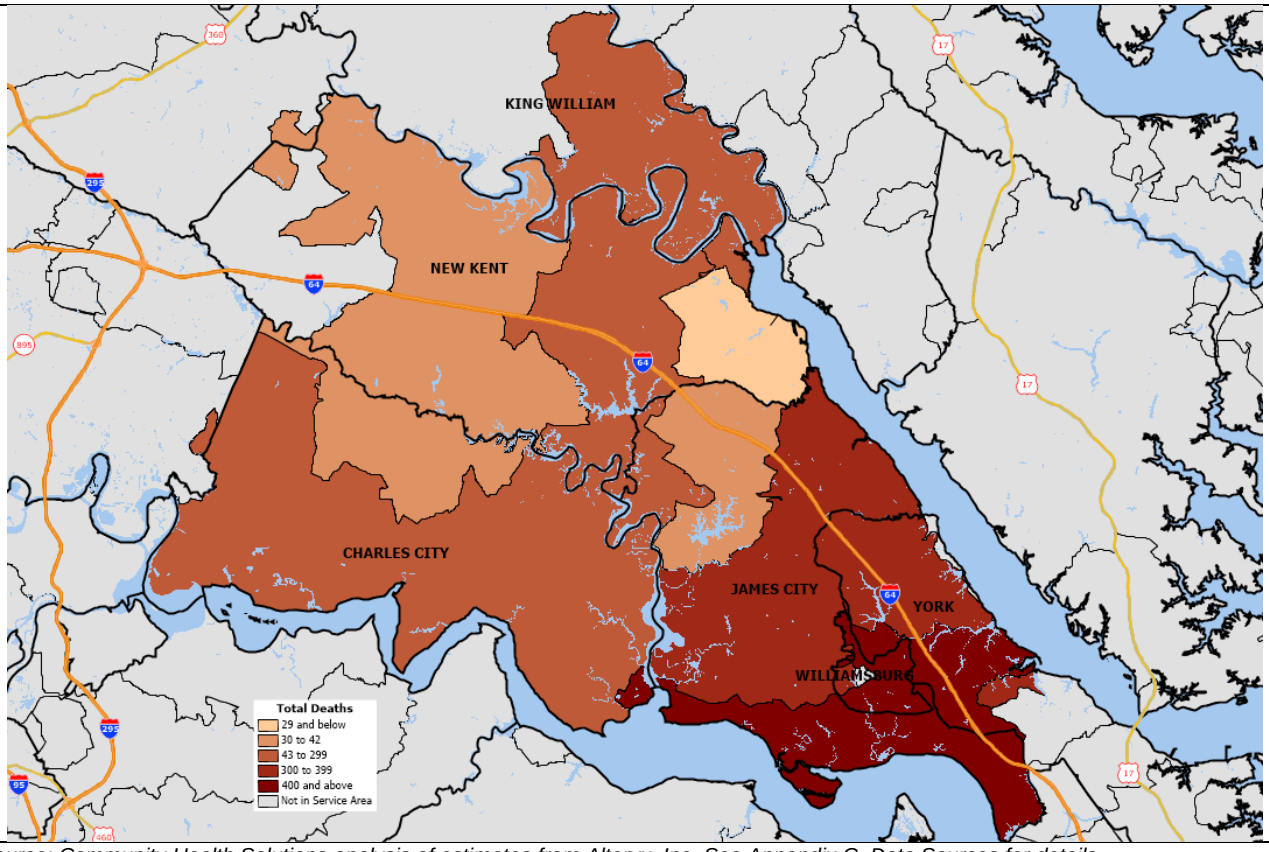


Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 13: Population Age 25+ Without a High School Diploma, 2014

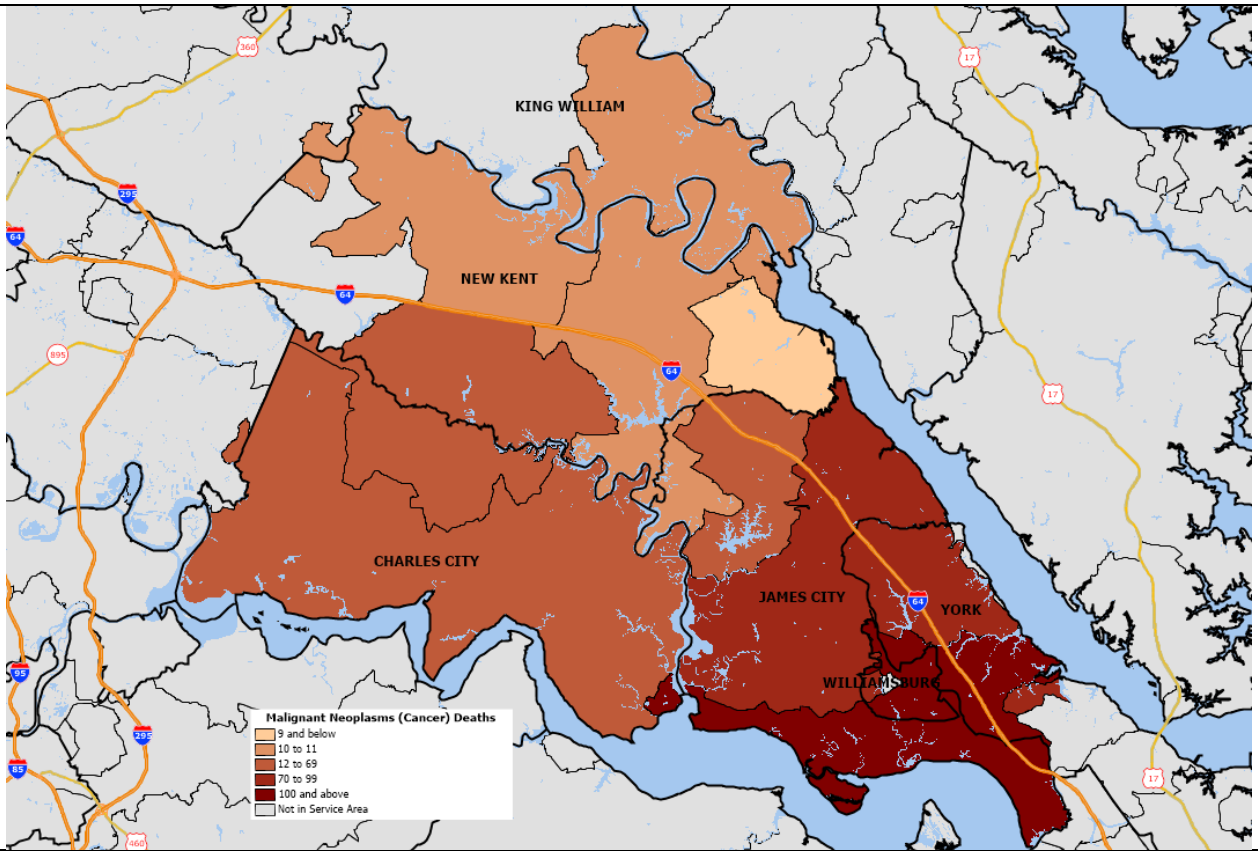


Map 14: Total Deaths, 2013*

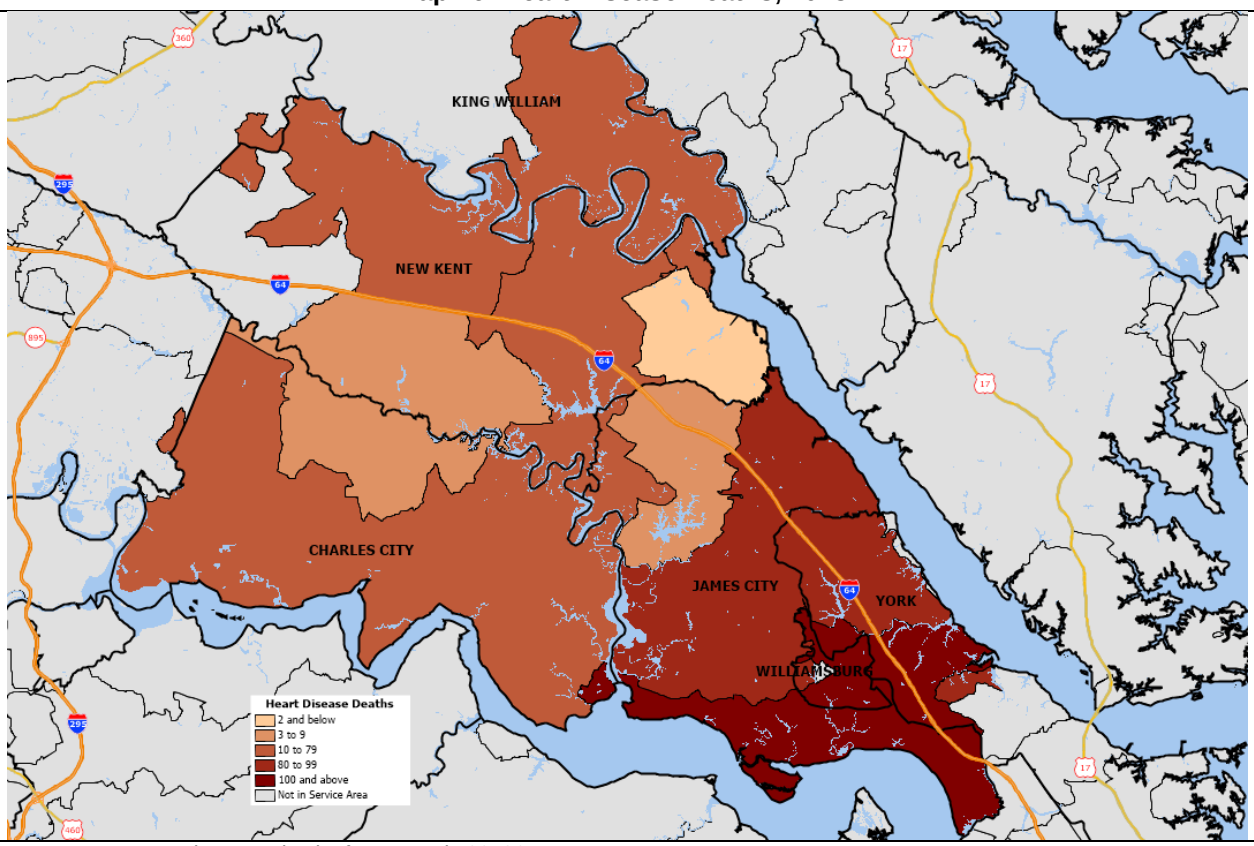


Source: Community Health Solutions analysis of estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 15: Malignant Neoplasm (Cancer) Deaths, 2013*

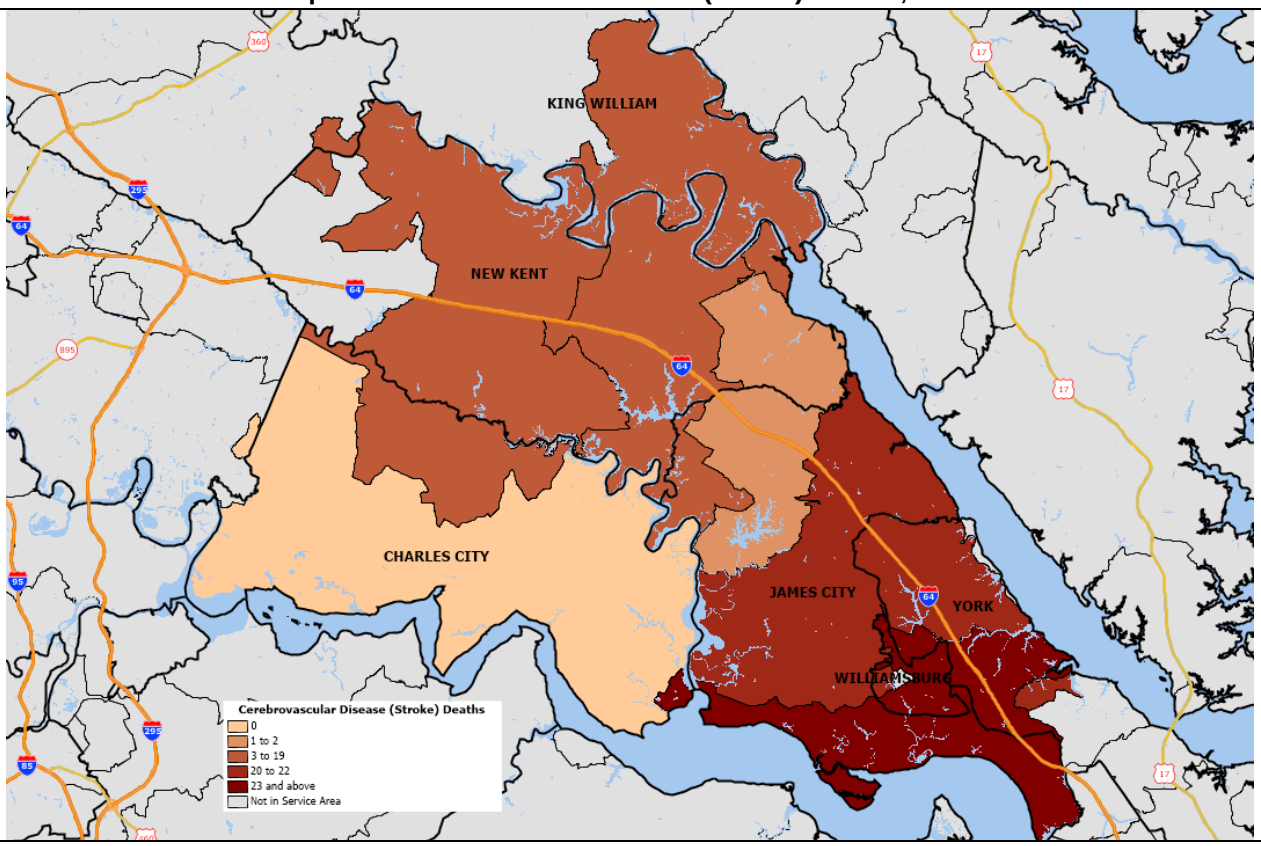


Map 16: Heart Disease Deaths, 2013*

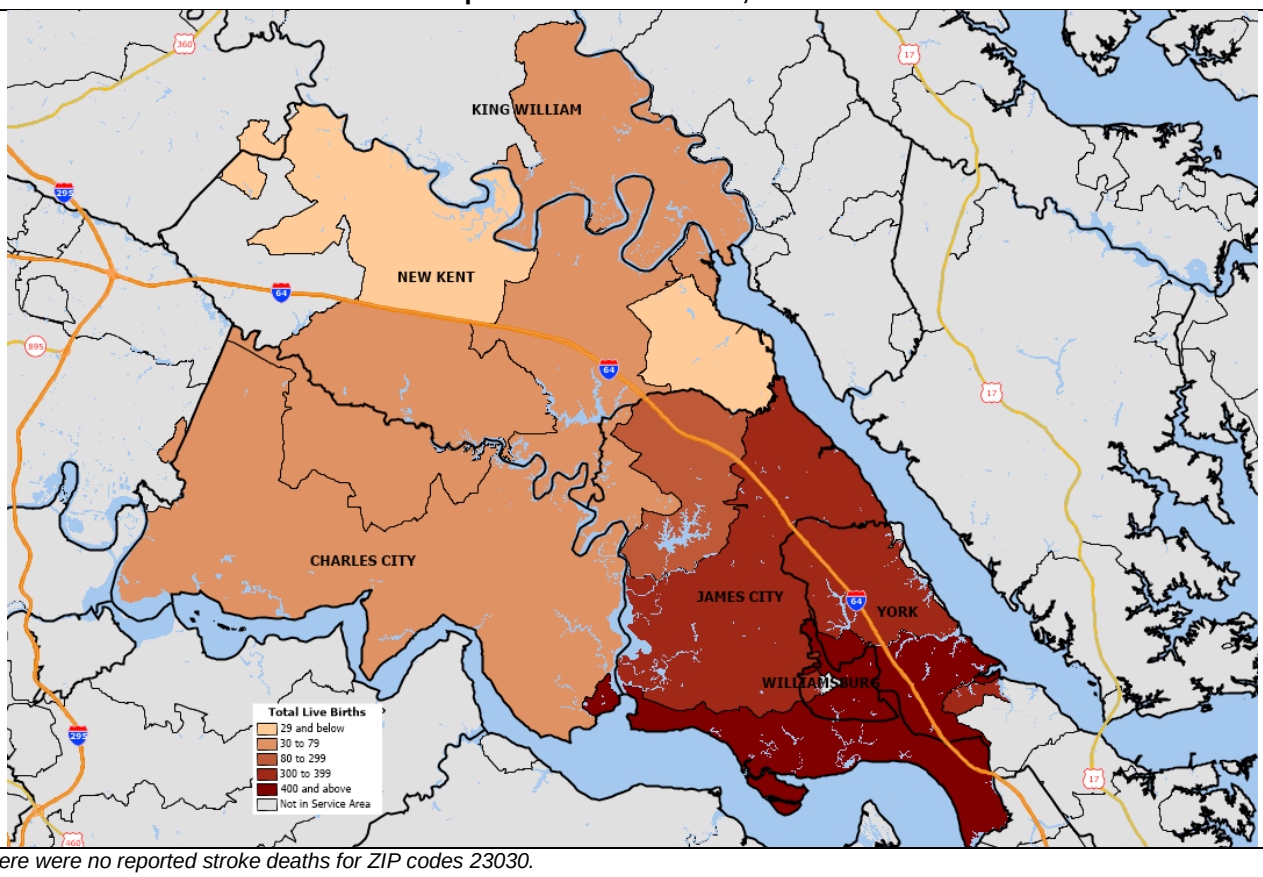


**There were no reported cancer deaths for ZIP code 23186.*
**There were no reported heart disease deaths for ZIP code 23186.*
Source: Community Health Solutions analysis of data from the Virginia Department of Health. See Appendix C. Data Sources for details.

Map 17: Cerebrovascular Disease (Stroke) Deaths, 2013*

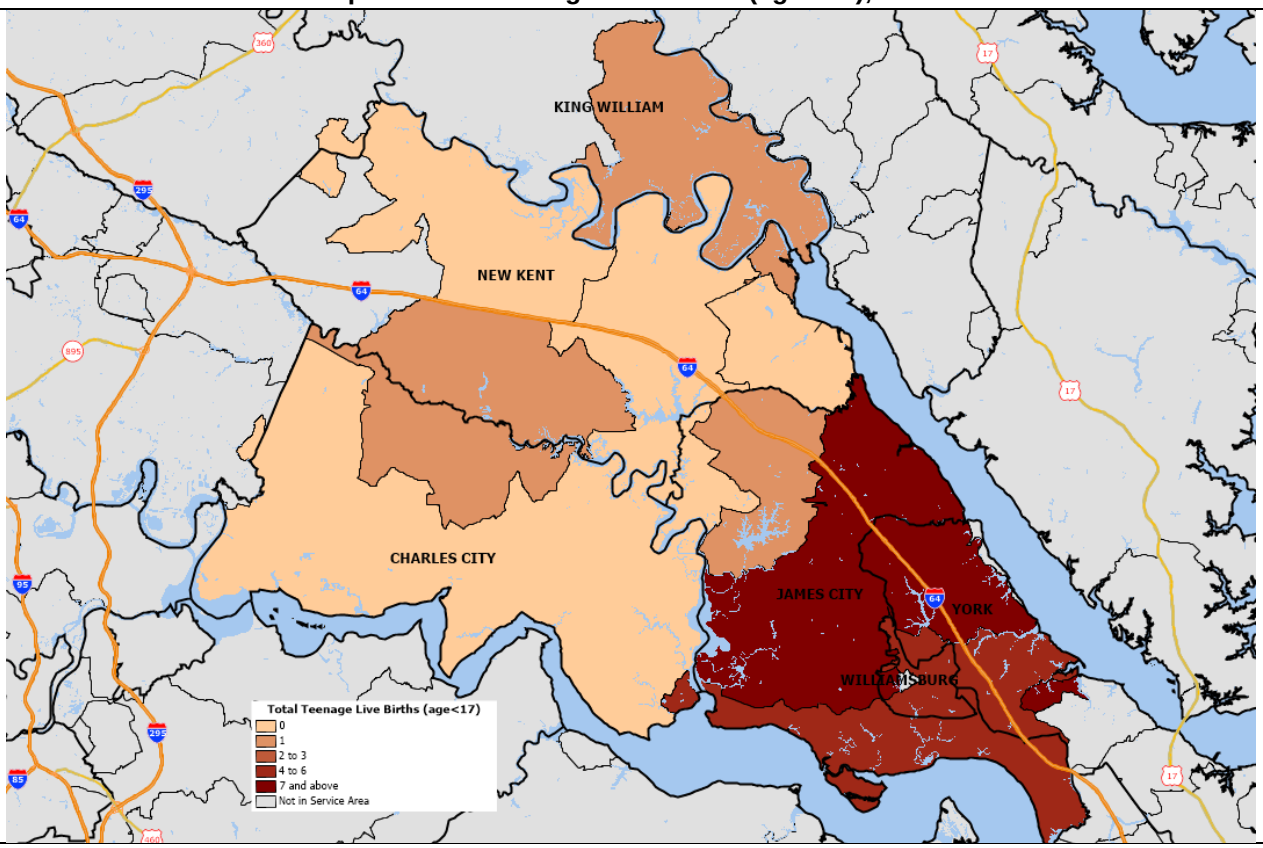


Map 18: Total Live Births, 2013*

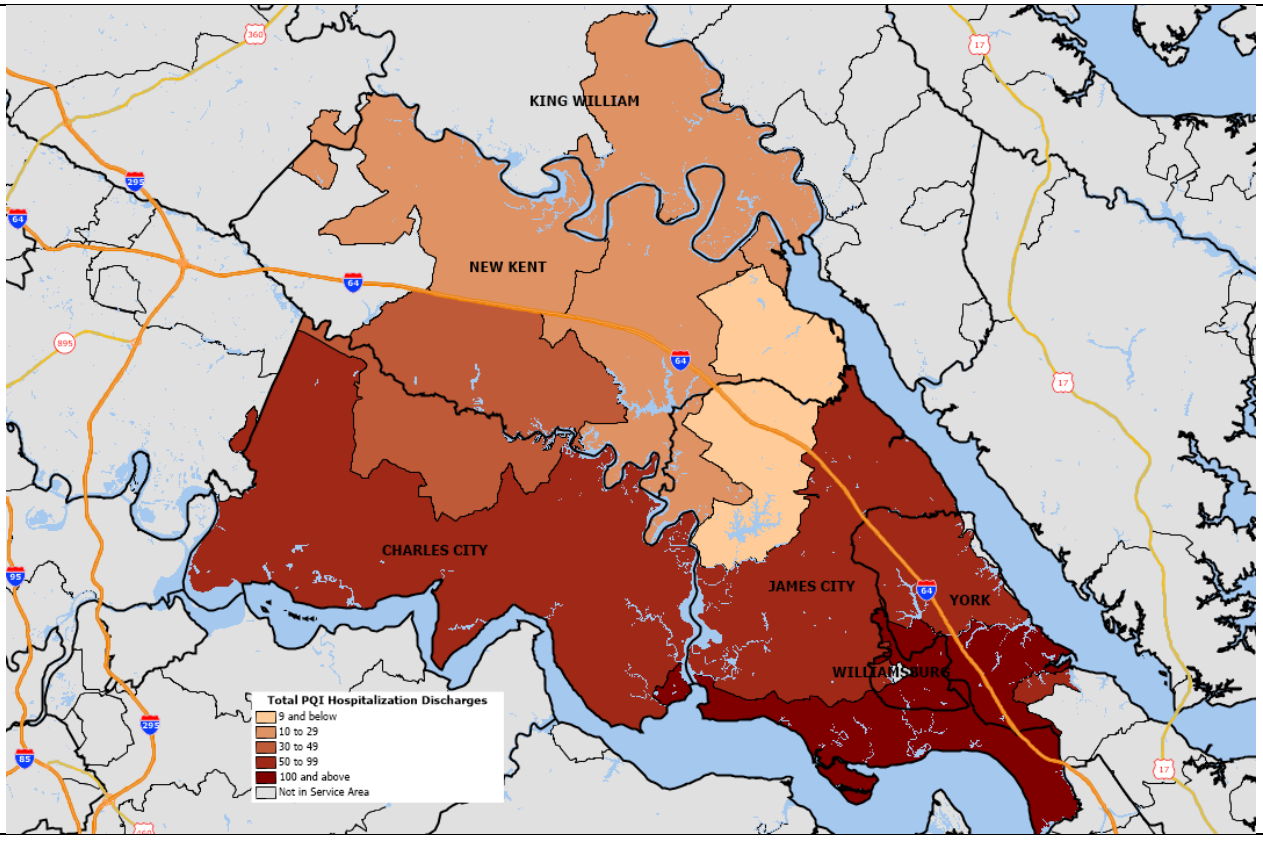


**There were no reported stroke deaths for ZIP codes 23030.*
Source: Community Health Solutions analysis of data from the Virginia Department of Health. See Appendix C. Data Sources for details.

Map 19: Total Teenage Live Births (age <18), 2013*

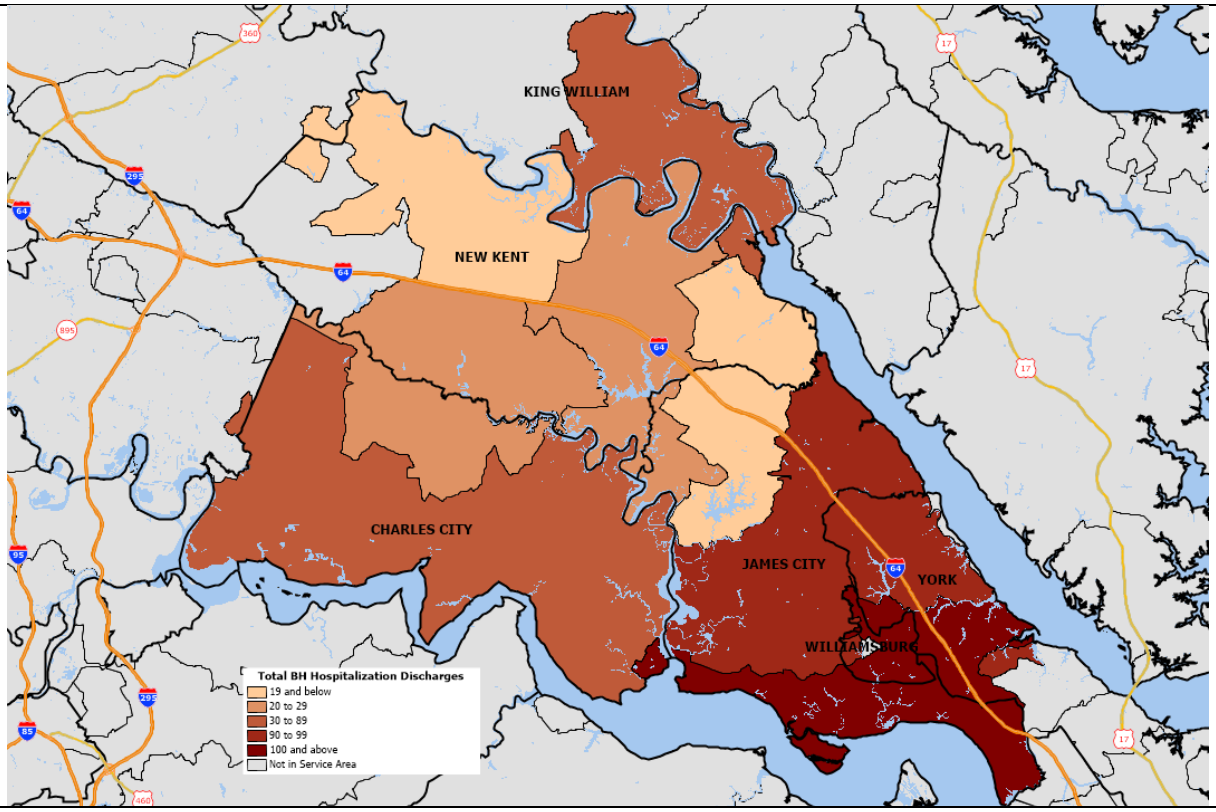


Map 20: Prevention Quality Indicator (PQI) Hospital Discharges, 2013*

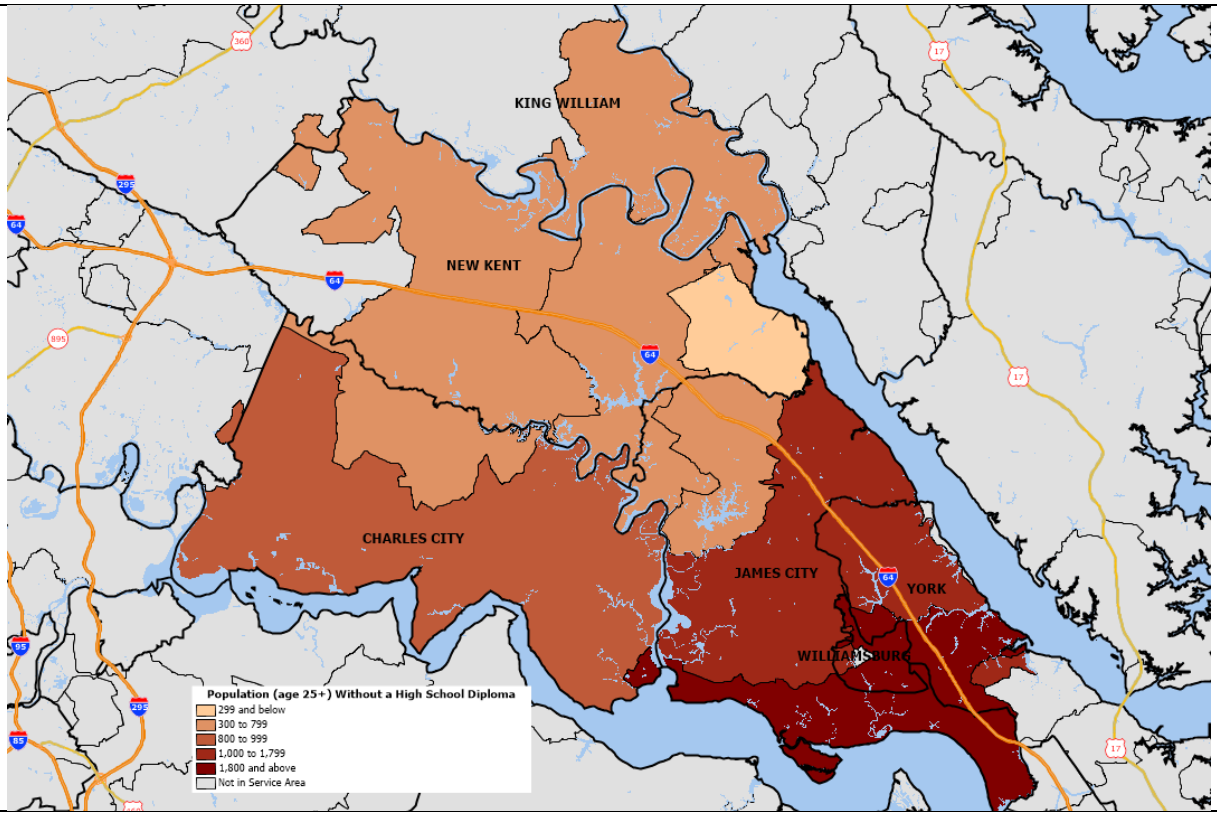


**There were no reported teenage live births (age <18) for ZIP codes 23011, 23030, 23089, 23124 and 23186.*
Source: Community Health Solutions analysis of data from the Virginia Department of Health. See Appendix C. Data Sources for details.

Map 21: Behavioral Health Hospital Discharges, 2013*

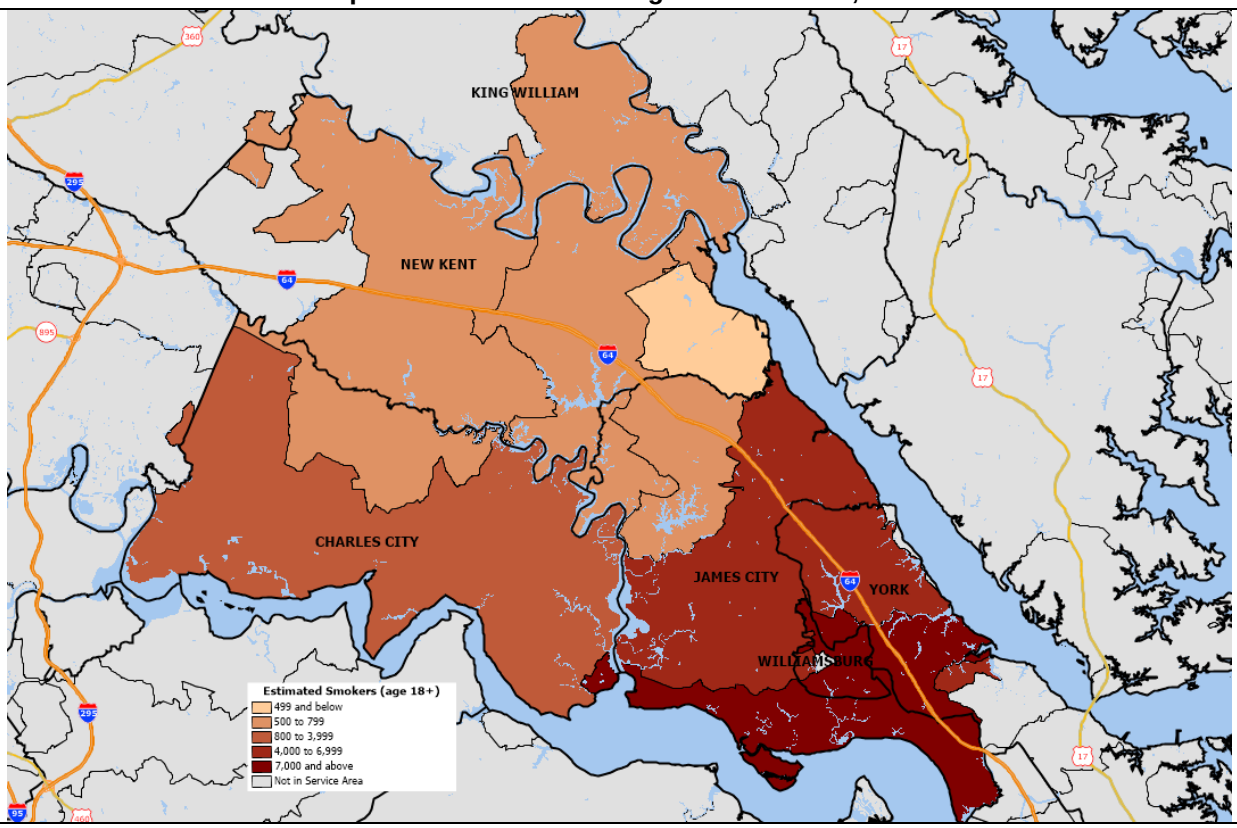


Map 22: Estimated Adults Age 18+ with No Dental Visit in the Last Year, 2014

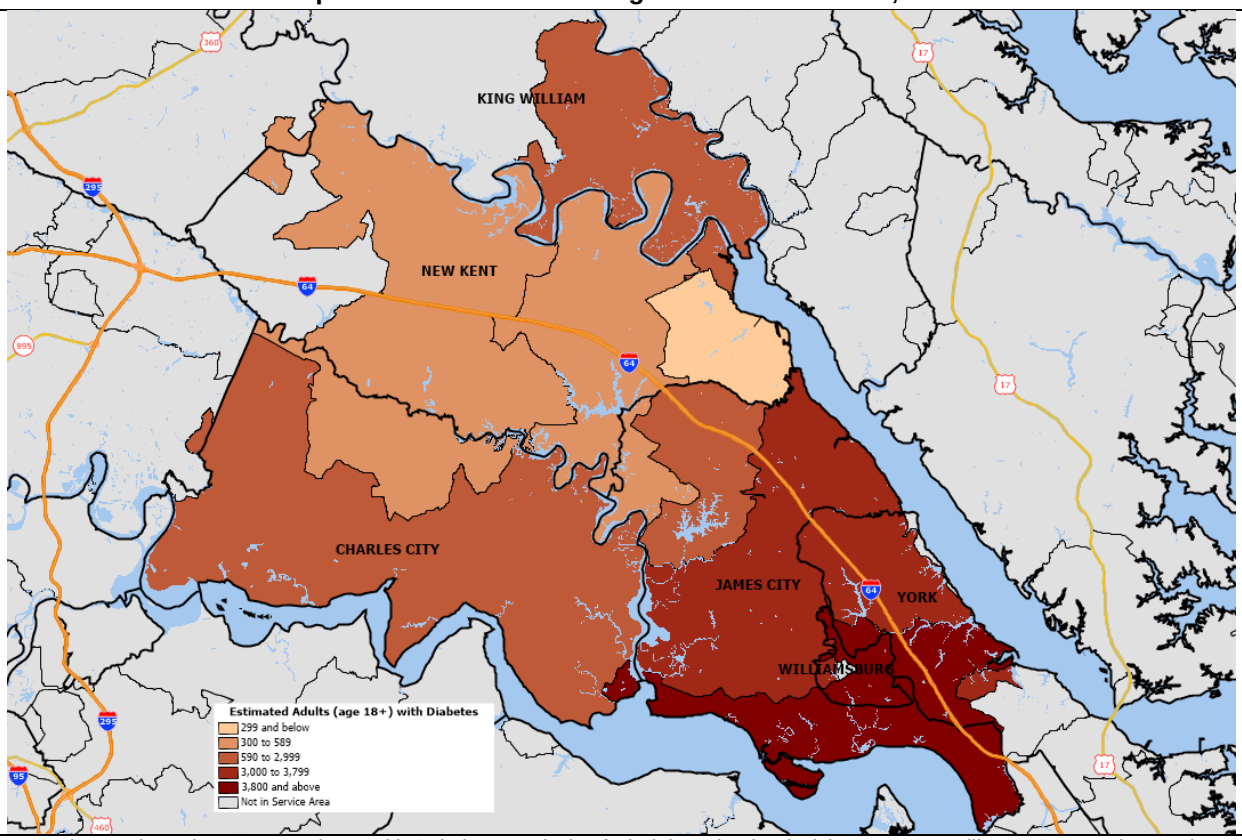


Source: Community Health Solutions analysis of hospital discharge data from Virginia Health Information, Inc. Estimates based on Community Health Solutions analysis of Virginia Behavioral Risk Factor Surveillance System data and estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 23: Estimated Adult Age 18+ Smokers, 2014

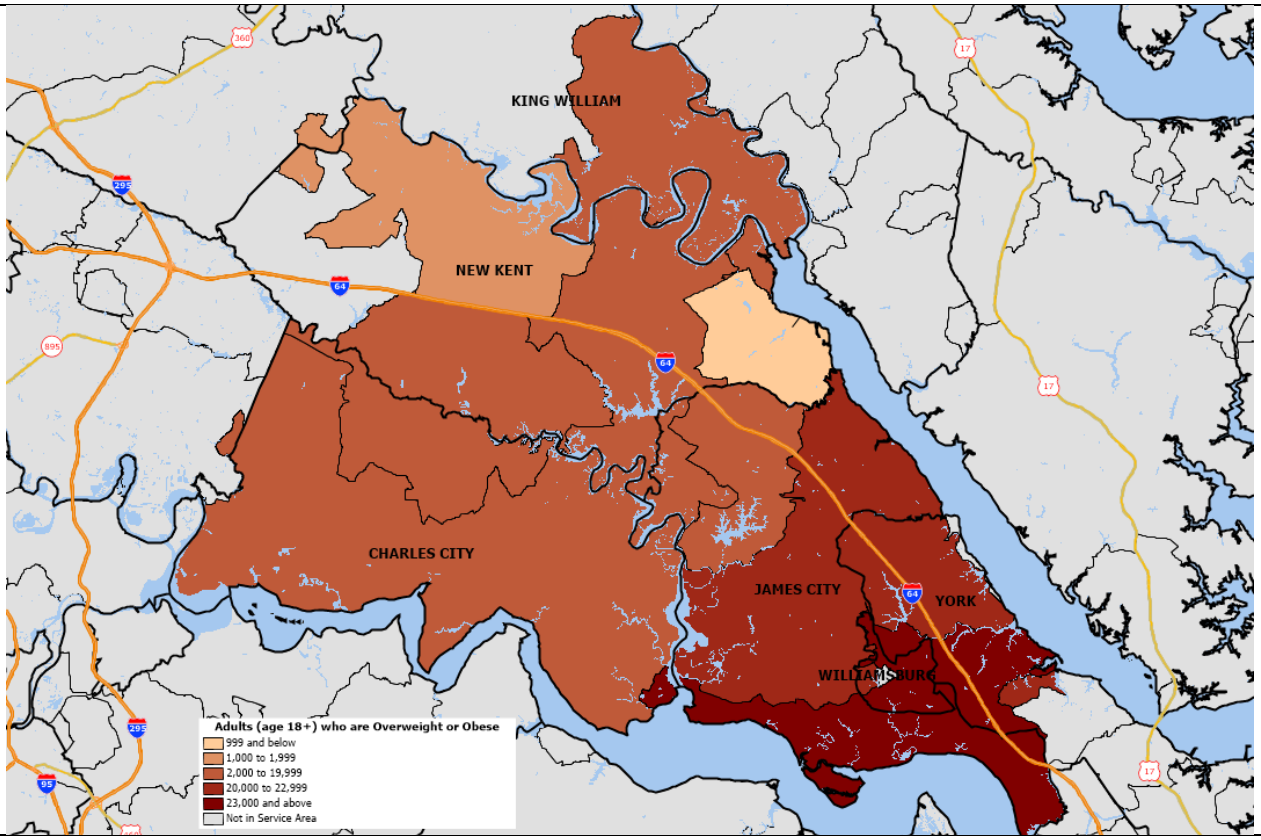


Map 24: Estimated Adults Age 18+ with Diabetes, 2014

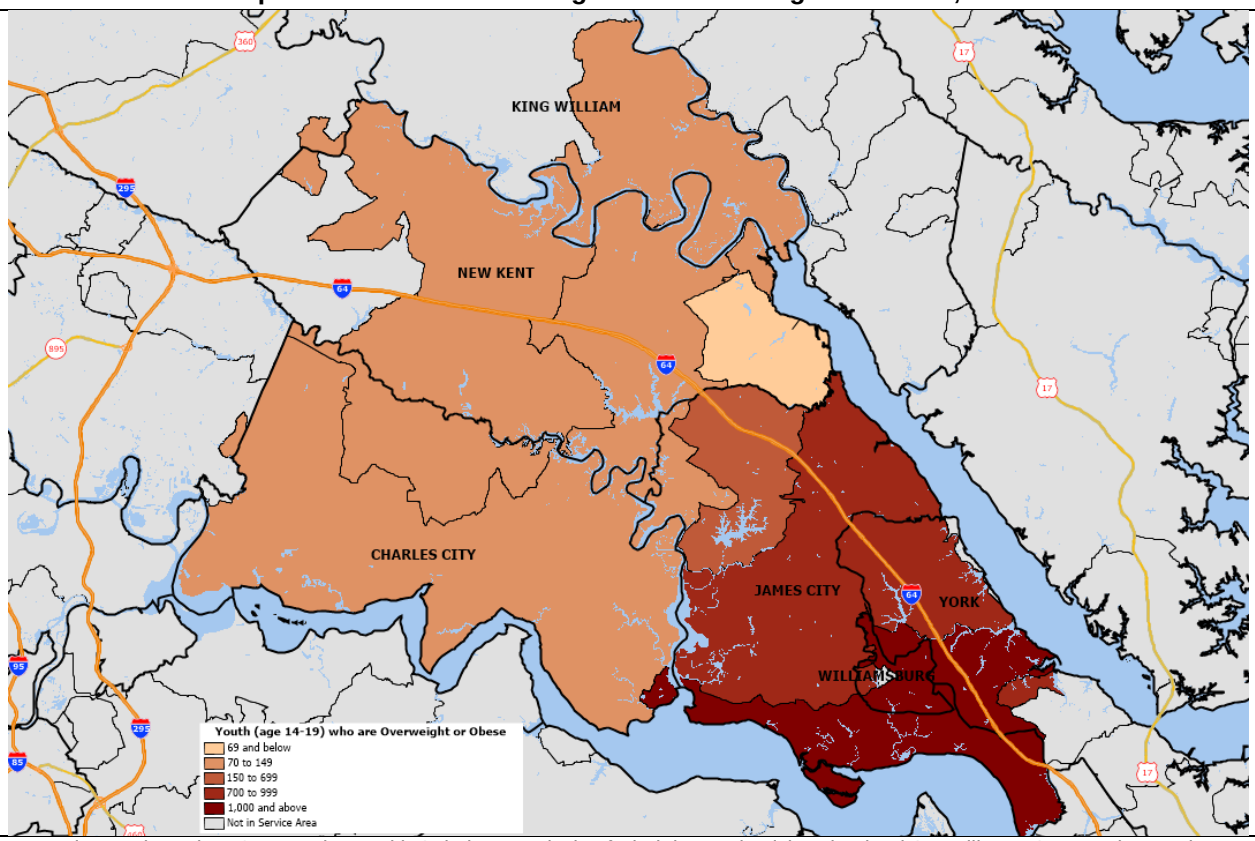


Source: Estimates based on Community Health Solutions analysis of Virginia Behavioral Risk Factor Surveillance System data and estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 25: Estimated Adults Age 18+ Overweight or Obese, 2014

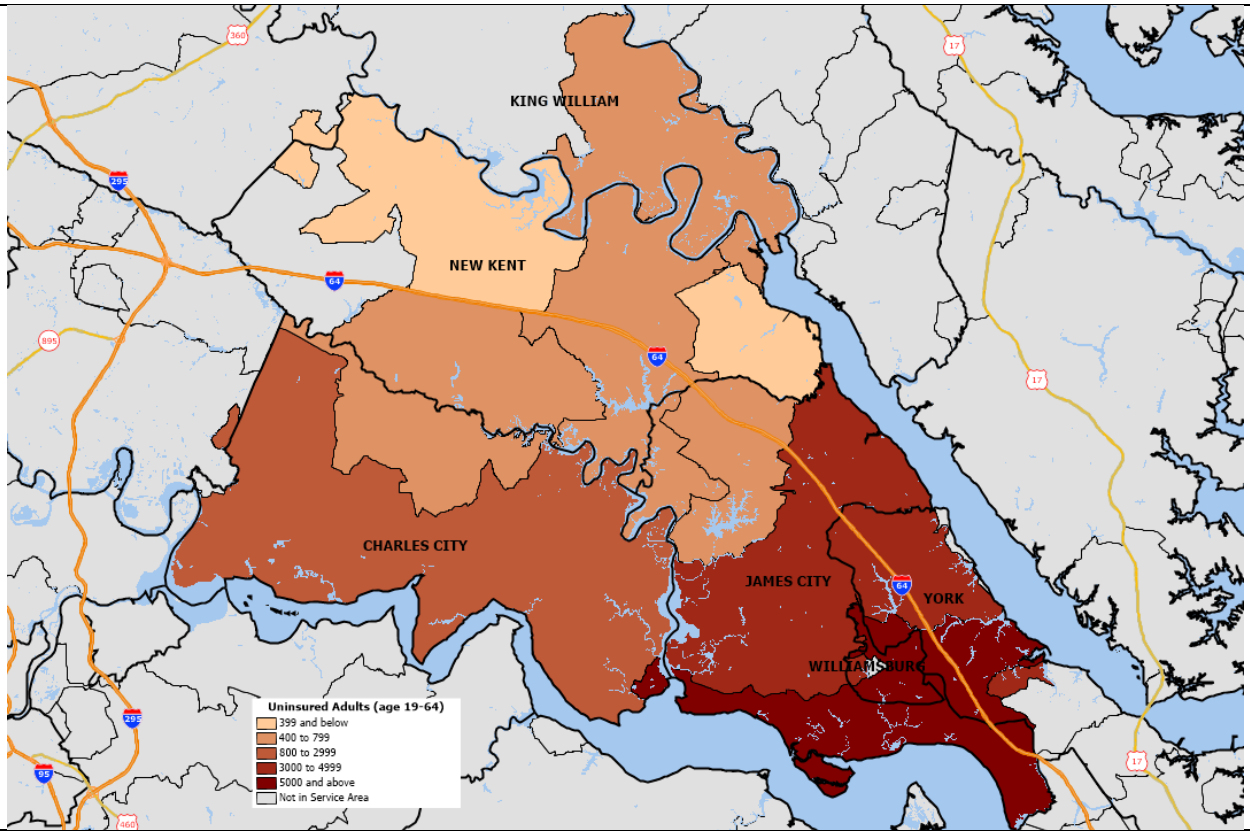


Map 26: Estimated Youth Age 14-19 Overweight or Obese, 2014

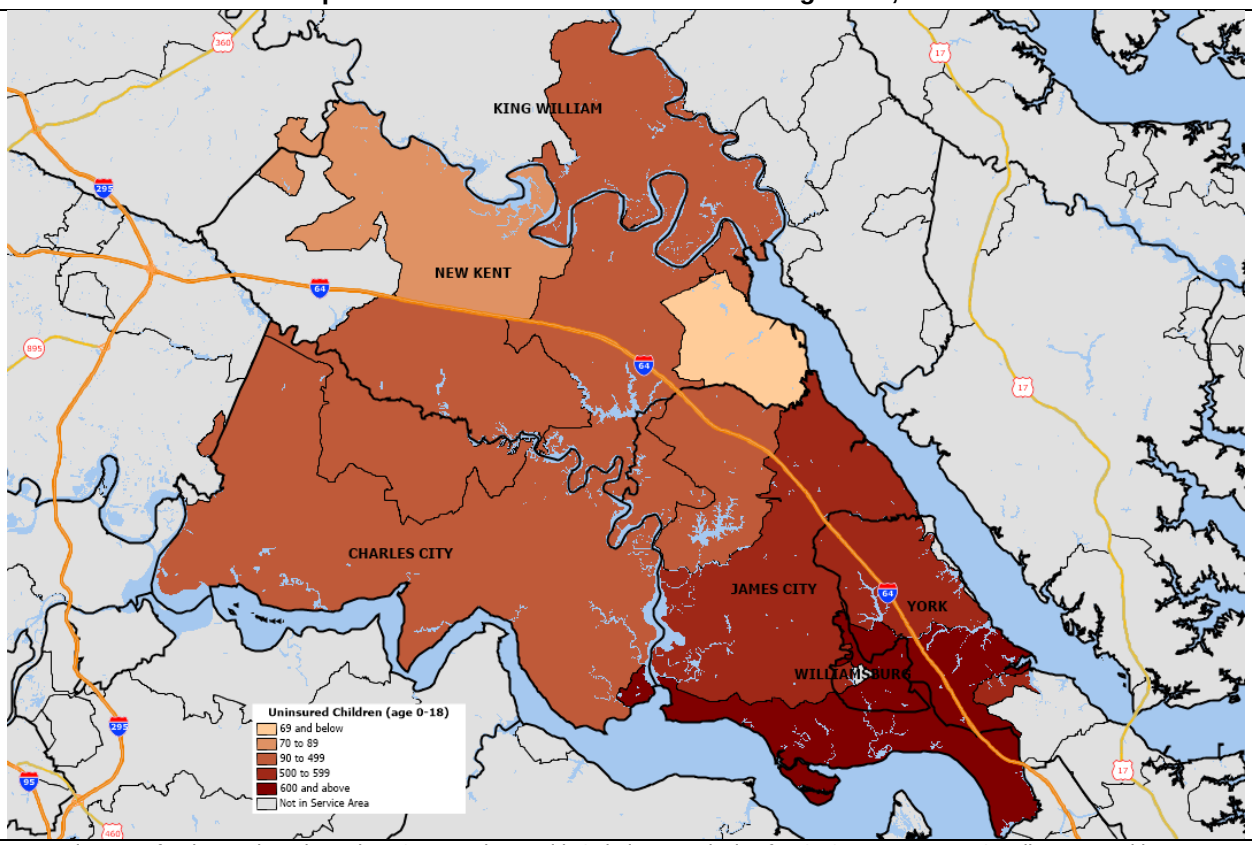


Source: Estimates based on Community Health Solutions analysis of Virginia Youth Risk Behavioral Surveillance System data and estimates from Alteryx, Inc. See Appendix C. Data Sources for details.

Map 27: Estimated Uninsured Adults Age 19-64, 2014



Map 28: Estimated Uninsured Children Age 0-18, 2014



Source: Estimates of uninsured are based on Community Health Solutions analysis of U.S. Census Bureau Small Area Health Insurance Estimates (2013) and demographic data from Alteryx, Inc. (2014). See Appendix C. Data Sources for details.

ZIP Code Map Table

ZIP Code	23011	23030	23089	23124	23140	23168	23181	23185	23186	23188
Total Population, 2014	838	5,316	5,358	3,507	4,955	7,129	5,608	47,113	2,198	40,196
Population Density, 2014	45.6	31.3	85.8	59.1	68.8	252.0	70.9	561.1	2,035.2	397.5
Child Population Age 0-17, 2014	134	895	1,122	815	1,043	1,768	1,303	8,944	78	8,176
Senior Population Age 65+, 2014	87	991	812	436	760	971	868	9,264	38	9,004
Asian Population, 2014	7	28	48	33	50	101	82	1,479	173	1,043
Black/African American Population, 2014	215	2,573	777	512	1,134	1,130	1,033	7,467	243	5,270
White Population, 2014	589	2,279	4,289	2,821	3,304	5,564	4,209	35,428	1,652	32,056
Other or Multi-Race Population, 2014	30	438	243	138	466	336	283	2,740	129	1,826
Hispanic Ethnicity Population, 2014	30	77	171	87	121	343	200	2,863	167	1,945
Per Capita Income, 2014	$32,513	$26,321	$34,315	$29,265	$33,244	$35,706	$28,539	$39,825	$ 1,232	$40,898
Median Household Income, 2014	$62,440	48,014	$68,519	$72,835	$66,370	$75,399	$57,863	$72,279	$50,394	$74,710
Low Income Households (Households with Income <$25,000), 2014	41	454	253	163	276	341	436	3,054	5	2,272
Population Age 25+ Without a High School Diploma, 2014	114	885	427	347	575	356	459	1,831	38	1,412
Total Deaths, 2013	7	47	43	31	38	40	53	473	1	348
Heart Disease Deaths, 2013	2	11	11	11	3	3	11	111	0	80
Cerebrovascular Disease (Stroke) Deaths, 2013	1	0	3	3	3	2	3	23	1	20
Malignant Neoplasms (Cancer) Deaths, 2013	2	14	10	10	12	13	11	126	0	79
Total Live Births, 2013	4	37	39	27	48	85	57	408	1	367
Total Teenage Live Births (age<17), 2013	0	0	0	0	1	1	1	4	0	7
Total Prevention Quality Indicator Hospitalization Discharges, 2013	1	59	18	23	34	9	26	145	1	65
Total Behavioral Health Hospitalization Discharges, 2013	5	40	22	6	29	13	33	162	3	93
Estimated Adult Age 18+ Smokers, 2014	131	819	653	559	635	706	686	7,135	321	4,101
Estimated Adults Age 18+ with No Dental Visit in the Last Year, 2014	176	1,088	768	783	683	1,097	906	8,781	485	6,815
Estimated Adults Age 18+ with Diabetes, 2014	100	608	494	361	508	625	590	3,870	168	3,287
Estimated Adults Age 18+ who are Overweight or Obese, 2014	442	2,866	2,677	1,657	2,432	3,242	2,693	23,642	1,253	20,218
Estimated High School-aged Youth (age 14-19) who are Overweight or Obese, 2014	16	102	110	77	90	158	121	1,099	208	793
Estimated Uninsured Children Age 0-18, 2014	13	105	107	77	99	112	96	681	25	522
Estimated Uninsured Adults, Age 19-64, 2014	91	809	504	332	465	601	572	5,906	378	3,149

Appendix B. Detailed Community Survey Responses

Exhibit B1. Vulnerable/At-Risk Populations in the Community

Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.

	Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?
1	• African American
2	• (I'm on the Bon Secours Community Health Needs Assessment Advisory Board, so I have information that I may have had otherwise.) • The low income population and those who do not speak English well are particularly vulnerable • The biggest issue seems to be transportation to any kind of health services. • The low income population is also particularly vulnerable because of poor eating habits, resulting in obesity, high blood pressure, and diabetes. It is difficult to afford nutritious food when you can barely afford food of any kind.
3	• Single, unattached adults with various health, mental health and/or substance abuse histories, with low incomes and poor work histories as a result are in a "catch 22" situation they cannot get out of.
4	• The uninsured and the under-insured who delay or avoid health care due to lack of funds • The homeless (there are probably more than we realize)
5	• Aging, low income residents
6	• Aging • People with substance/alcohol use disorders and behavioral health issues • Working poor • Rural families • Veterans
7	• Both the direct victim and the children who witness domestic violence are at risk for long term health issues. • Sexual assault victims should have access to an advocate and a specialized sexual assault nurse examiner when they are brought to the emergency room and should not be further traumatized by asking them to go to another city.
8	• Both the uninsured and underinsured as well as the elderly on fixed incomes
9	• Children in poverty with single parents • Children with behavioral/mental health problems • Children with developmental delays
10	• Children living in poverty, especially those who have parents working multiple jobs and/or with behavioral health problems. Child poverty is growing in this region.
11	• Co-occurring serious mental illness and mental health and/or substance use disorder; especially those who earn too much money to qualify for Medicaid but not enough to pay for their own insurance. • I am quite concerned what will happen to the individuals who are currently covered under GAP insurance when the pilot project ends.
12	• Dental services for nursing home residents is unobtainable due to lack of facilities that can accommodate wheelchairs and lack of payment. • Psych services for pain management has been lacking for years in this area. • Outpatient geriatric primary care; many primary care practices are not equipped to handle geriatric patients and geriatric syndromes. They don't have the time, training and expertise for this population.

Continued on the following page

Exhibit B1. Vulnerable/At-Risk Populations in the Community	
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Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?	
13	• Geriatrics in assisted living with mental health concerns
14	• Homeless
15	• Homeless families
16	• Homeless population and human sex trafficked females. The City of Williamsburg & James City County refuse to accept that they exist. • The uninsured/underinsured
17	• Homeless • Uninsured • Underinsured elderly
18	• Ignorant
19	• Indigents • Individuals with no insurance or poor plans • Geriatrics
20	• Individuals in a poverty situation
21	• Individuals that don't qualify for services but don't make enough money to afford quality care and services
22	• Low Income
23	• Low income and elderly
24	• Low income elderly • Immigrant service workers
25	• Low income populations, both elderly and transient • Uninsured residents
26	• Low income single parent families • Low income elderly
27	• Low income teenagers
28	• Low income older adults with frailty and ability to live at home independently • Minority populations
29	• Low income • Disabled • Homeless • Kinship (people caring for other people's children) providers
30	• Low income • Seniors with limited income • Single adults with no children • Mobile home dwellers • Families living in hotels
Continued on the following page	

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Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?	
31	• Low income • Smokers • Drug abusers • Obesity patients • Elderly
32	• Low income • Uneducated • Mentally disabled/ mentally ill population
33	• Lower income • Elderly populations • Those who speak a foreign language are most vulnerable to not getting services they need or understanding what they need to do to take care of their health needs at home
34	• Lower socioeconomic populations are at higher risk for developing obesity and the related comorbidities
35	• Low-income and seasonally employed persons face significant challenges to securing affordable health insurance and therefore preventive health care including mental health care.
36	• Many older individuals are in need of safe, affordable housing and lack transportation resources to enable them to access health care. • Health care providers also need to become more aware of the importance of social determinants in achieving successful health outcomes long term.
37	• Many patients that are Medicaid eligible fail to renew their services causing lapses in insurances. Others are unaware of Medicaid transportation services and miss appointments. Medicaid transportation requires that participants give 5 days' notice prior to appointment. This poses a problem if a patient is sick and needs a same day appointment. These patients tend to use Emergency Rooms or urgent care services, as they are unable to get transportation during normal business hours. • Medicaid adolescents are at increased risk for anxiety and depression. Much if this is linked to family social situations i.e. homelessness, poverty, lack of food and necessary resources.
38	• Medicaid/Medicare/dual eligibles • Behavioral Health • Frail and Elderly
39	• Most people - but especially the working poor - need affordable health care. • Everyone needs well-coordinated, prevention focused health care • I'm told we spend 17% of GDP on healthcare in the USA for mediocre outcomes. That is unacceptable.
40	• Mostly unemployed people. But even those with health insurance being unable to get their medications or tests completed.
41	• My closest geographic area is Williamsburg/James City County. Within that group I think we need more attentions to reasonably priced senior living quarters, medical help, exercise facilities and hospice care.
42	• Non-English speaking residents • Mental health patients • Substance abuse
Continued on the following page	

Exhibit B1. Vulnerable/At-Risk Populations in the Community	
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Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?	
43	• People living in poverty especially children • Seniors living alone
44	• People who are isolated and/or dealing with depression are more likely to have bad health outcomes, yet they are difficult to reach. • Services for managing depression, especially in the elderly, are difficult to find.
45	• People with disabilities face inadequate access to dental care and transportation challenges in accessing health care.
46	• People without access to regular health services including people who are: o Unemployed or under-employed; o Having few or no transportation resources; o Living in low-income environmentally unsafe housing; o Limited literacy (including English speakers). • A number of vulnerable people fall into more than one of these categories.
47	• Residents living at or below the poverty level
48	• Seniors, especially those who no longer drive, have no family nearby
49	• Seniors, particularly low-income
50	• The elderly • Patients with mental health issues.
51	• The homeless • The elderly
52	• The low income areas are particularly vulnerable
53	• The poor elderly
54	• The poor. Especially those without access to transportation.
55	• The under-employed, unemployed, homeless and minority immigrant population. • Dementia / Alzheimer patients without a family support group.
56	• The underinsured and uninsured
57	• The uninsured patients who I see as outpatients still have difficulty with access to diagnostic testing, as opposed to inpatients that generally can have any study done. As you know, this is not unique to our area.
58	• The very elderly • The very poor
59	• There are a number of homeless and transient patients that have very little social support
60	• There are homeless people who don't seem to get enough services. This could be because there are too many homeless.
61	• Transportation and access to services is a concern in our area due to lack of available providers.
62	• Un and under insured. - usually in the lower social-economic levels
Continued on the following page	

Exhibit B1. Vulnerable/At-Risk Populations in the Community	
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Are there particular populations within the community who are vulnerable or at risk for health problems or difficulties? obtaining health services?	
63	• Underinsured and uninsured
64	• Underinsured but employed & unable to obtain reasonably affordable insurance • Homeless individuals • Certain elderly populations
65	• Uninsured working poor • Elderly low mid income • Developmental delayed adults • Multiple handicap adults
66	• Uninsured, indigent and those with chronic conditions who are unable to obtain primary care
67	• Uninsured • Underinsured • Anyone with a 2K+ deductible • Homeless • Elderly with no family
68	• Urban areas that have residents that fall into the Medicaid gap
69	• Veterans • Behavioral health • Substance abuse
70	• Young women with cancer, especially breast cancer

Exhibit B2. Vulnerable/At-Risk Regions in the Community	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Are there particular neighborhoods or geographic regions within the community where the resident population may vulnerable or at risk for health problems or difficulties obtaining health services?	
1	• "Grove Area" within James City County seems to have large needs and several trailer parks which do not have access to public transportation.
2	• All of New Kent is rural. We need more services within the community and not have to travel to Williamsburg or Richmond
3	• All of the very low economic census tracts in Hampton, James City County, Williamsburg and Newport News.
4	• All the lower SES neighborhoods.
5	• Any of our woods have so many homeless, low budget hotels
6	• Any place where the population is impoverished.
7	• All of New Kent is rural. We need more services within the community and not have to travel to Williamsburg or Richmond
8	• As above- in particular PCPs from Brentwood and Mercury West describe this the most
9	• Assisted Living Communities
10	• Both Charles City and New Kent Counties served by Sentara.
11	• Census tracts: 502.4, 505, 506 Lackey area of York County • Census tract: 801.2 in Grove area of James City County • Census tracts: 3702 and 3703 in City of Williamsburg
12	• East End of Newport News, North End of Newport News, Hampton, The Grove area of James City County, and the Lackey area in York County
13	• Eastern part of James City County- Grove, western part of James City County-Toano, • Hotel dwellers throughout Williamsburg and James City County
14	• Grove
15	• Grove community
16	• Grove • Lackey • Centerville Road • Toano lanes
17	• Grove • Chickahominy Road • Other low income areas.
18	• Grove
19	• Grove • Lackey and other pockets in our community with concentrated poor
Continued on the following page	

Exhibit B2. Vulnerable/At-Risk Regions in the Community	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Are there particular neighborhoods or geographic regions within the community where the resident population may vulnerable or at risk for health problems or difficulties obtaining health services?	
20	• Grove • Lackey • Chickahominy Road • Centerville Road • Any place in the James City or York Counties that have limited access to public transportation
21	• It varies, but there are lower socio-economic areas that are more impacted with more serious and chronic health issues for a number of reasons.
22	• Lackey • Grove
23	• Low income seniors in any neighborhood throughout the region. Perception that in some neighborhoods all are wealthy, but that's not accurate. There are needy seniors in all areas. • Some areas definitely have concentrations of low income populations, e.g., Grove area, Chickahominy Haven.
24	• Low income, and those who are caught in between - making too much for Medicaid, but can't afford Obama care
25	• Lower income areas
26	• Maybe in the Grove community
27	• More rural ZIP codes in James City County and New Kent counties • Low-income neighborhoods including Grove and Lackey.
28	• Poverty is spread around greater Williamsburg, but it is concentrated in the multi-family complexes and depressed neighborhoods.
29	• Rural
30	• Grove area of James City County • Lackey area of York County • Williamsburg/James City County areas that must depend on public transportation. The buses stop too early and don't go far enough for them to obtain some needed health services.
31	• The areas that are underserved tend to be those with lower socioeconomic status
32	• The northeast area of the City of Williamsburg (Merrimac Trail) • Grove area of James City County
33	• The Grove in James City County
34	• North End in York
35	• Upper end of Williamsburg (Toano, Charles City, West Point, King William, King and Queen)

Exhibit B3. Health Assets in the Community	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?	
1	• Programs that provide useful information on health issues (diabetes, hypertension, dementia, etc. • Less expensive facilities for regular exercise activities.
2	• Three health networks.
3	• A very strong and supportive community of health care workers.
4	• AA and Al Anon • Capital Trail • Freedom Park
5	• Accessibility to resources
6	• Any walking or biking trail
7	• Bike lanes • CW • CSB • Parkway • Healthcare services: two hospitals, high quality medical staff
8	• Bike paths • Walking trails • Community centers, but they are over crowded
9	• Boo Williams • Noland Trail
10	• Built and Natural resources • Programs (obesity, diabetic management)
11	• CHKD for kids--but they cannot do it all. Children and families need more safe places to play, parents need places to learn about how to be a parent, we need more full service grocery stores in low income areas to improve access to healthy food.
12	• Church • People
13	• Clinics that serve the uninsured/underinsured for an affordable cost
14	• Community Health Foundation • Parks and Recreation facilities- parks, trails, facilities in James City County. Community pools • Jamestown Beach, VA • Cooperative Extension programs • Groups like Beyond Boobs, Erase the Need, nonprofit community organizations
15	• County and community parks • Nature trails • Public beaches and water access • Parks, Recreation & Tourism/YMCA/Wellness Centers, etc. • Adequately funded Health Department • Community Services Board for mental health
16	• Duke of Gloucester Street • Historic Jamestown for safe walking, nature trails, bike lanes, swimming pools and beaches
17	• For the low income population, the most needed/important health assets are the institutions and the people who work/volunteer there. • Our community has the highest level of food insecurity in the state of Virginia, which tells me that our poverty rate is very high. These individuals can't be concerned with walking trails and beaches when they have other

Exhibit B3. Health Assets in the Community	
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Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?	
	more important needs (health assets) not being met.
18	• Great hospitals, • Nonprofit health organizations (CDR, Beyond Boobs!, Bacon Street, the four free clinics) • Cancer medical professionals and facilities • YMCAs and Recreational centers
19	• Health departments
20	• Hospitals • Hospice Care • Walking Trails
21	• I think that the insured have great access to healthcare resources as well as healthy lifestyle resources.
22	• In general, we have good medical providers. • We also have access to many public parks and recreation activities that promote wellness
23	• James City County Parks and Recreation including their many parks, walking trails, and Rec Connect program. • Williamsburg Area Faith in Action is a wonderful health asset for our elderly population providing needed transportation services and respite care. • Williamsburg Health Foundation is a tremendous health asset for the Greater Williamsburg community providing more than $4 million a year in grants to agencies and programs like Olde Towne Medical Center and the School Health Initiative Program.
24	• Local hospitals and easy access to nearby medical centers, high quality physicians, • Community amenities such as Rec centers and parks, • Community support through local nonprofits of health care access (e.g., Olde Towne Medical, Williamsburg Health Foundation, etc.)
25	• Local hospitals, free clinics and human service programs that address and support health and mental health issues.
26	• Local medical offices, • Parks and recreation (programs that are administered for the elderly)
27	• Local Parks & Rec programs • Area health systems • AAA's • Local food bank.
28	• Medical specialists to serve a growing aging population • Walking and biking trails
29	• Network of Care website: wmbgcares.org • Strong network of safety-net healthcare clinics, but are only serving approximately one-third of people with no health insurance
30	• Newport News Park • Noland Trail • Sandy Bottom • Gosnold Park • Old Sentara Fitness trail • These are great resources within the community that can be utilized by residents to promote fitness and leisurely fun.

Exhibit B3. Health Assets in the Community	
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Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?	
31	• Noland • Sidewalks • Street lights • Green spaces
32	• Our Sentara Williamsburg Hospital cares for all the people in the hospital as well as in the community. Many programs promoted within the hospital are for the community and their health.
33	• Outdoor recreation opportunities • Public and private gyms • Community centers
34	• Parks
35	• Parks • Beaches
36	• Parks • Capital trail, Williamsburg • James City County Recreational Center
37	• Parks • Events • Fitness centers
38	• Parks • Wellness centers • Beaches • Libraries • Churches who house peer support groups or other community health activities
39	• Peer pressure • Community expectations/ word of mouth
40	• Peninsula Agency on Aging's programs, esp. Eastern Virginia Care Transitions Program, Chronic Disease Self-Management, Matter of Balance. • For youth- the SHIP programs • Easier access to safe biking routes, share the road enforcement
41	• People- the ones with the most impact on patients as far as prevention and treatment of obesity are PCPs and they don't have enough time to do obesity counseling and appropriate referrals
42	• People • Long term services and supports (underfunded) • Institutions • Pubic Health - underfunded
43	• People • Health education programs, support groups • Stronger push on health risks for smokers in the younger population and ETOH / drug abuse / addiction
44	• People • Programs
45	• Primary Care for all, and especially for those with chronic conditions, that is affordable, prevention focused and well-coordinated.
46	• Primary care, acute care, emergency care and specialty care readily available and accessible • Schools • Parks, trails and organizations that promote a culture of health and provide access to and motivational

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Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?	
	incentives for healthy lifestyles
47	• Professionals, hospitals, clinics • Natural environment
48	• Programs to help people stay in their homes when they are ill or disabled
49	• Quality hospital systems • Public parks/beaches • Foodbank • CINCH
50	• Riverside Health System • Riverside and Sentara Wellness Centers, • YMCA • Noland Trail • Newport News Park
51	• Riverview Park • Mariners Museum • Noland Trail • Yorktown beaches
52	• Shelters for the vulnerable; including domestic violence victims & homeless
53	• Sidewalks so people can walk, not the trails, they need nowhere!
54	• Strong competent physician and nursing staffs
55	• The elderly tend to be uninsured or not insured enough. They tend to not seek medical care because of out of the pocket expense until they are so sick that someone else has to make the decisions for them.
56	• The hospitals on the Peninsula are extremely important • Community Park Systems are of great value. • The YMA and various Fitness Centers also provide great service
57	• The people. We have many residents with time, talents and treasures that can come along side those with needs and provide a hand up.
58	• The two health systems • The senior living communities
59	• There are numerous organizations, both public and private, along with faith-based communities who are addressing these issues. • It would help to develop a better community health strategy that maximizes every entity's potential. I know that the Williamsburg Health Foundation is working on this.
60	• This area being strong in a senior population, I think we need more available places for assisted living that are affordable. • More educational programs for seniors.
61	• Trails for walking, bicycling, etc.
62	• Trails- James City County in particular has outstanding biking/walking trails. • There are many parks as well.
63	• Two hospitals • Olde Towne Medical Center • Health provider volunteers
64	• Two hospitals • Miles of bike trails

Exhibit B3. Health Assets in the Community	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Think of health assets as people, institutions, programs, built resources (e.g. walking trails), or natural resources (e.g. beaches) that promote a culture of health. In your view, what are the most important health assets within the community?	
	• Several good parks for those who can get there • Recent efforts to install sidewalks • Network of safety net clinics and a relatively strong group of non-profits focused on health and human services
65	• Variety of medical and specialty services • Two hospitals • Emergency mental health services • Child Development Resources • Social Services • Olde Towne Medical Center • Jamestown Beach • James City County Recreation Center • Walking trails
66	• Walking and biking trails • Organized activities that are close to neighborhoods that may help mitigate isolation among the elderly and those dealing with depression.
67	• Walking trail and cost effective programs at the James City County Recreational Center. • Walking trails all over town • Colonial Williamsburg is a lovely place to walk • Many senior programs at the library • Programs offered by Sentara Williamsburg Regional Medical Center.
68	• Walking trails • Affordable water aerobic facilities
69	• Walking trails • Senior centers
70	• Water access- boat ramp, canoe/kayak launch and trails
71	• Wellness Centers • Athletic programs associated with educational facilities at all levels • Chronic disease self-management programs
72	• YMCA and similar facilities
73	• YMCA • James City County recreation and parks • Olde Towne Medical Center • SHIP in schools

Exhibit B4. Health Assets Needed in the Community	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Are there any health assets that the community needs, but may be lacking?	
1	• A better system of walking, running, biking trails.
2	• Access to child psychiatrists, mental health and support groups for teens and caregivers
3	• Access to gyms and practice time for public school student athletes.
4	• Access to specialty care • Transportation is a barrier
5	• Adequate transportation to access resources listed above • Access to safe, affordable, housing
6	• Affordable fitness centers, especially low cost options for seniors at the rec centers that allow them access to all programs during less busy times
7	• Affordable public transportation with a set schedule and routes • Additional access to safety-net healthcare and the means to publicize this • Health insurance that would become available through the state expanding Medicaid
8	• All need a better job at getting their message out to the public
9	• Behavioral health is our most pressing need
10	• Better access to mental health care for children and low-income populations.
11	• Better transportation • More dental health availability • More specialty health services • More translators at health providers for those who do not speak English well.
12	• Boys and Girls clubs to provide afterschool homework assistance. These programs used to offer after school snacks and evening meals. These programs help to fill the gaps and helped to strengthen select children's' positive surroundings. Tutoring programs and programs that provide free internet access to children could help at risk children increase chances of school and lifetime success.
13	• Care related transportation • Even greater support of chronic conditions and preventive care
14	• Colonial Services Behavioral Health program is overwhelmed and insufficient
15	• Community center to include in-ground pool, outdoor/indoor playing fields and meeting/classroom facilities
16	• Efficient public transportation • Food access in the several food deserts • Safe and affordable housing
17	• Elderly resources centers
18	• Free or reasonable cost health clinics • More walking trails
19	• Homeless services are minimal
20	• Hospice inpatient facilities
21	• I don't like making broad statements, but a large part of the issue is lack of affordability and lack of access to the right kind of services
22	• I would like to see free smoking cessation classes offered by both Riverside and Sentara in every community.
23	• Lacking primary care access
24	• Lower cost to access the community rec centers. indigent people cannot afford to go to any type of gym.
25	• Maybe more walking trails
Continued on the following page	

Exhibit B4. Health Assets Needed in the Community	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Are there any health assets that the community needs, but may be lacking?	
26	• Mental health (improving)
27	• Mental health services and professionals are in too short supply.
28	• Mental Health services needs to be strengthened to include substance abuse aspects.
29	• More bike paths • Funding for all the nonprofits doing health related work, • Older citizens' health activities like Thai Chi classes, etc. in the parks
30	• More eye surgeons • Affordable facilities for indoor exercise and work out equipment
31	• More long term services and supports that allow aging in place • Dementia care resources • Chronic Disease Self-Management Programs • Geriatric and Palliative care medicine resources
32	• More Medicaid Waivers so people with disabilities have resources to access services • Handicapped Transportation to access health assets • Respite care • Dentists qualified and willing to treat people with disabilities and accept Medicaid • Autism-specific care and supports • More choices of insurance companies to ensure competition
33	• More neighborhood clinics
34	• Neighborhood parks and fields for playing
35	• A better system of walking, running, biking trails

Exhibit B5. Additional Ideas and Suggestions	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Optional: Please use the space below to share any additional ideas or suggestions for improving community health.	
1	• Access to specialty care • Transportation issues and congested traffic is a barrier to care.
2	• Additional crime prevention to lower the number of individuals who are killed or injured through gun violence. It seems to be getting worse.
3	• Affordable extracurricular activities for children especially in the summer • Increased educational opportunities • Affordable gym membership for needy families.
4	• As long as the population knows there is good quality care here, there should be good health here. • The competition between two health systems doesn't help make it easy for everyone to choose the best doctor and or facility. I expect better care at Sentara when it is larger and better equipped. • Keeping our healthcare local is the best thing we can do for our community.
5	• Bariatric surgery coverage for Riverside employees. It is hard to show the benefits of a program if we don't even offer it to our own employees. • We also need a Medical weight loss program.
6	• Better coordination of home health follow-up services • integrated medical records
7	• Community Health Workers
8	• Consider taking the resources to where the people are instead of the people having to come to the resources.
9	• Doctors and their staffs should work for their patients
10	• Engage the public sector, the educational community, and the business community at a higher level to encourage collaboration to address the social determinants.
11	• Find a way to end competition between two health systems and combine resources to provide better coverage for both facilities in this area.
12	• Form a coalition or task force on health and wellness for [the] region.
13	• Have free [membership] or people can volunteer their time in exchange for use of the rec centers.
14	• Having our community leaders filter health concerns/needs in all their policy making decisions because all decision have an impact on our health. Some more than others.
15	• I would encourage health systems to promote population health by striking a balance between clinical care and utilization of non-clinical supports and services.
16	• Innovative public transportation solutions to reduce current and future air pollution until electric cars are widespread • Local tax credits to encourage use of hybrid /electric vehicles
17	• It isn't until every part of the community, be they health organizations working together, business, government, employers, and community volunteer organizations, etc. come together with a defined strategy and coordinated role for everyone that we will see a major change in how we approach this subject.
18	• More accessible bike paths and walking trails in James City County to encourage people to bicycle or walk to their places of work, school, church, and play. • We live in a beautiful part of the country and should encourage residents to get out and walk instead of driving.
19	• More community outreach like the Caravan that Bon Secours does in their service areas. That would be great in our area of a more spread out population in James City Co, New Kent and the lower income population. Staff w/ NPs and volunteers. Educate Health Wellness Educators within this population. See / Visit Cross Over Clinic in Richmond - they have a great model. • The large Hispanic population (growing quickly) need care too!
20	• More health education resources
Continued on the following page	

Exhibit B5. Additional Ideas and Suggestions	
Note: The survey was conducted on a regional basis for multiple communities that fall within the study region for RDHW. Survey respondents were asked to provide their perspective based on where they live, work, or both. This Exhibit lists verbatim responses from those who reported that they live or work within the RDHW study region (although in some cases, respondents also identified communities beyond the study region within their comments). See Appendix C for details.	
Optional: Please use the space below to share any additional ideas or suggestions for improving community health.	
21	• More resources are needed to support residents that are economically marginalized, particularly around general health care and dental services.
22	• Need to be prepared for rapidly growing older senior population (those 75 and older)
23	• On the whole I think our community has plenty of facilities. The problem is getting the aging to use them, or to ask for help in finding them.
24	• Place greater resources (and advocate for reimbursement mechanisms) that support health education (nutrition & physical activity support), self-management support (particularly for the prevention and management of pre-diabetes, diabetes, obesity, and heart disease), disease prevention, and health promotion.
25	• Politicians need to invest more heavily in early childhood education services to make them available to all children regardless of ability to pay. • Parents that lack the ability to parent effectively should have parenting classes more readily available.
26	• Programs to assist low income members of the community

Appendix C: Data Sources

Section	Source
Part I. Community Survey Results	
1) Community Survey results as shown throughout Part 1.	Community Survey results are based on Community Health Solutions (CHS) analysis of Community Survey responses submitted by community stakeholders. The survey was conducted as follows: Riverside Health System and Sentara Healthcare worked collaboratively to conduct a joint community stakeholder survey for the following Peninsula region facilities: • Riverside Doctors' Hospital Williamsburg; • Sentara Careplex Hospital; • Sentara Williamsburg Regional Medical Center; and • Four Riverside Peninsula market facilities (Riverside Hampton Roads Specialty Center, Riverside Regional Medical Center, Riverside Behavioral Health Center, and Riverside Rehabilitation Institute). The two health systems collaborated on survey-related communications, and developed the survey instrument with technical support from CHS. Each system developed its own survey recipient list. The recipient lists were combined, and an email survey request was sent to 922 unduplicated community stakeholders on April 25, 2016. To enable assignment of responses to a particular facility's report, survey respondents were asked to identify the localities where they lived, worked, or both. A follow-up email request was sent on May 12, 2016. Additionally, Riverside Health System and Sentara Healthcare conducted outreach for community input via email, personal phone calls, and in-person at local events and meetings. The survey was closed on May 18, 2016, and a total of 163 survey responses were received.
Part II. Community Indicator Profile	
1) Health Demographic Trend Profile 2) Health Demographic Snapshot (also Appendix A. Maps 1-13)	Community Health Solutions analysis of demographic estimates from Alteryx, Inc. (2014 and 2019). Alteryx, Inc., is a commercial vendor of demographic data. Note that demographic estimates may vary from other sources of local demographic indicators.
3) Mortality Profile (also Appendix A. Maps 14-17)	Community Health Solutions analysis of Virginia Department of Health death record data (2013). Locality-Level counts and rates were obtained from the Virginia Department of Health. The combined study region counts and rates were produced by Community Health Solutions.
4) Maternal and Infant Health Profile (also Appendix A. Maps 18-19)	Community Health Solutions analysis of Virginia Department of Health death record data (2013). Locality-Level counts and rates were obtained from the Virginia Department of Health. The combined study region counts and rates were produced by Community Health Solutions.

Section	Source
5) Preventable Hospitalization Profile (also Appendix A. Map 20) 6) Behavioral Health Hospitalization Profile (also Appendix A. Map 21)	Community Health Solutions analysis of hospital discharge data from the Virginia Health Information (VHI) 2013 dataset and demographic estimates from Alteryx, Inc. (2013). Data include discharges for Virginia residents from Virginia hospitals reporting to Virginia Health Information, Inc.) The analysis includes records of discharges of Virginia residents from Virginia hospitals excluding state and federal facilities. Data reported are based on the patient's primary diagnosis. **Preventable Hospitalizations**. The prevention quality indicator (PQI) definitions are based on definitions published by the Agency for Healthcare Research and Quality (AHRQ). The definitions are detailed in their specification of ICD-9 diagnosis codes and procedure codes. Not every hospital admission for congestive heart failure, bacterial pneumonia, etc. is included in the PQI definition; only those meeting the detailed specifications. Low birth weight is one of the PQI indicators, but for the purpose of this report, low birth weight is included in the Maternal and Infant Health Profile. Also, there are four diabetes-related PQI indicators which have been combined into one for the report. Within the Exhibits, the *All PQI Discharges* figures are based on an AHRQ methodology that counts a hospital discharge with multiple PQI diagnoses as one discharge. By comparison, the figures for individual discharges do include a small number of cases in which a single hospital discharge with more than one PQI diagnosis would be counted more than once. Also, AHRQ refined their method to exclude the perforated appendix PQI from its list, but this diagnosis is included in the data used for this study. As a result of these methodological factors, the sum of the individual PQI discharges may be slightly different than the total for All PQI Discharges. These differences or on the order of less than one percent. For more information on the AHRQ methodology, visit the AHRQ website at www.qualityindicators.ahrq.gov/pqi_overview.htm *NOTE: Virginia Health Information (VHI) requires the following statement to be included in all reports utilizing its data: VHI has provided non-confidential patient level information used in this report which was compiled in accordance with Virginia law. VHI has no authority to independently verify this data. By accepting this report the requester agrees to assume all risks that may be associated with or arise from the use of inaccurately submitted data. VHI edits data received and is responsible for the accuracy of assembling this information, but does not represent that the subsequent use of this data was appropriate or endorse or support any conclusions or inferences that may be drawn from the use of this data.*
7) Adult Health Risk Factor Profile (also Appendix A. Maps 22-25)	Estimates of chronic disease and risk behaviors for adults 18+ were produced by Community Health Solutions using: • A multi-year dataset (2006-2010) from the Virginia Behavioral Risk Factor Surveillance System (BRFSS). For more information on BRFSS visit: http://www.cdc.gov/brfss/about/index.htm • Local demographic estimates from Alteryx, Inc. (2014) Estimates are used when there are no primary sources of data available at the local level. The estimates are for planning purposes only and are not guaranteed for accuracy. The statistical model to produce the local estimates was developed by Community Health Solutions. In this model, state-level data were used to predict local counts and rates, with adjustments for local demographics. Consequently, differences between local rates and state rates may reflect estimation error rather than valid differences. Therefore, state-level estimates are not provided in this report. Because of data limitations, it is not possible to assign specific margins of error or levels of significance to these statistical estimates.
8) Youth Health Risk Factor Profile (also Appendix A. Maps 26)	Estimates of risk behaviors for youth age 14-19 and 10-14 were produced by Community Health Solutions using: • Data from the Virginia Youth Risk Behavioral Surveillance System from the Centers for Disease Control (2013). For more information on YRBSS visit: http://www.cdc.gov/HealthyYouth/yrbs/index.htm • Local demographic estimates from Alteryx, Inc. (2014).

Section	Source
	Estimates are used when there are no primary sources of data available at the local level. The estimates are for planning purposes only and are not guaranteed for accuracy. The statistical model to produce the local estimates was developed by Community Health Solutions. In this model, state-level data were used to predict local counts and rates, with adjustments for local demographics. Consequently, differences between local rates and state rates may reflect estimation error rather than valid differences. Therefore, state-level estimates are not provided in this report. Because of data limitations, it is not possible to assign specific margins of error or levels of significance to these statistical estimates. Likewise, it is not possible to calculate the statistical significance of differences between local rates and state rates.
9) Uninsured Profile (also Appendix A. Maps 27-28)	Estimates of uninsured nonelderly age 0-64 were produced by Community Health Solutions using: • U.S. Census Bureau Small Area Health Insurance Estimates (2013). For more information, visit: http://www.census.gov/did/www/sahie/data/index.html. • Local demographic estimates from Alteryx, Inc. (2014) Estimates are used when there are no primary sources of data available at the local level. The estimates are for planning purposes only and are not guaranteed for accuracy. The statistical model to produce the local estimates was developed by Community Health Solutions. In this model, prior year locality-level rates were used to predict current year counts and rates, with adjustments for local demographics. Because of data limitations, it is not possible to assign specific margins of error or levels of significance to these statistical estimates. Likewise, it is not possible to calculate the statistical significance of differences between local rates and state rates. Additionally, populations in group living quarters (e.g. colleges) and undocumented populations may not be adequately addressed in this model.
10) Medically Underserved Profile	Community Health Solutions analysis of U.S. Health Resources and Services Administration data. For more information, visit: http://muafind.hrsa.gov/.

Appendix D: Community Survey Recipients

The following organizations were included in the initial survey distribution. The list of those who responded is on page 19. It is possible that not every group received the initial survey due to challenges collecting correct contact information for all of the individuals. In many cases, multiple individuals at an organization were sent the survey. For example, every member of the County Boards of Supervisors were sent the survey. Additionally, every physician, nurse practitioner and physician assistant at Riverside Medical Group was sent a survey.

Category	Organization	Notes
FAITH COMMUNITIES	• Hospital chaplains • Williamsburg United Methodist Church • BrutonParish Episcopal Church • First Baptist Church – Williamsburg • St. Beade's Catholic Church – Williamsburg • Williamsburg Community Chapel	These individuals can represent both the needs of the local government as well as representing the input of the broader community, and in some cases the minority populations who attend the place of worship.
CHAMBERS OF COMMERCE, LOCAL BUSINESSES AND CIVIC LEADERS	• West Point Chamber of Commerce • Williamsburg Chamber of Commerce • York County Chamber of Commerce • Ferguson Corporation • Governor's Land • Busch Gardens • Canon of Virginia • Colonial Williamsburg Foundation	
PUBLIC HEALTH EXPERTS	• Peninsula District of the Virginia Department of Health • Colonial Behavioral Health (Community Services Board)	
COUNTY / LOCAL GOVERNMENT	• County Administrator, York County • York County Social Services • York County Board of Supervisors • York County Sherrif • York County Fire Chief • County Administrator, New Kent County • New Kent County Fire Chief • New Kent County Board of Supervisors • New Kent County SHerrif • County Administrator, James City County • James City County Board of Supervisors • James City County Fire Chief • James City County Board of Supervisors • West Point Fire Dept. • Mayor& Vice Mayor, City of Williamsburg • Williamsburg / James City County Sherrif • City Manager, Williamsburg • Williamsburg Council Members • Mayor & Vice Mayor, Town of West Point • West Point Town Council • West Point Chief of Police	While sheriffs and first responders may represent public health issues, the intent is for the various representatives on the Boards of Supervisors to present their neighborhoods, including low income and minority members of their communities.

HEALTHCARE ORGANIZATIONS	• Peninsula Agency on Aging • Williamsburg Landing • Lackey Free Clinic • Old Towne Medical Center • Hospice House & Support Care of Williamsburg • Peninsula EMS Council • Gloucester-Mathews Free Clinic • Williamsburg Place • Riverside Doctors' Hospital of Williamsburg • Sentara Williamsburg Regional Medical Center • RMG Phsyicians & Advances Practice Providers- Williamsburg	These organizations work to represent the medically underserved, low income, minority and broad populations across Virginia's Middle Peninsula, as well as the health of the local environment on which the local economy is based.
SCHOOLS	• New Kent County Public Schools • New Kent County School Board • New Kenty County School Superintendent • York County Public Schools • York County School Board • York County School SUperintendent • Williamsburg – James City County Public Schools • Williamsburg James City County School Board • Williamsburg James City County Schools Superintendent • Walsingham Academy • College of William and Mary	