

Sentara Williamsburg Regional Medical Center
and Surgical Suites of Coastal Virginia

Community Health Needs Assessment 2025

This joint Community Health Needs Assessment report was completed in collaboration between Sentara Williamsburg Regional Medical Center and Surgical Suites of Coastal Virginia, which have the identical services areas of the city of Williamsburg, and the counties of Gloucester, James City, King and Queen, New Kent, and York.



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Executive summary

Sentara Health is proud of our longstanding commitment to the communities served by Sentara Williamsburg Regional Medical Center (SWRMC) and Surgical Suites of Coastal Virginia (SSCV). We are committed to the city of Williamsburg, and the counties of Gloucester, James City, King and Queen, New Kent, York, and surrounding communities.

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

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

Top priorities



Behavioral health



Chronic conditions



Social determinants of health

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

Looking at the data

Community demographics of the 242,364 persons living in the service area, which includes the city of Williamsburg, and the counties of Gloucester, James City, King and Queen, New Kent, and York.

Racial profile

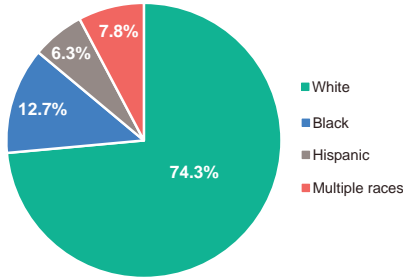


Figure 1

Source: United States Census Bureau

Population by age, 2019-2023

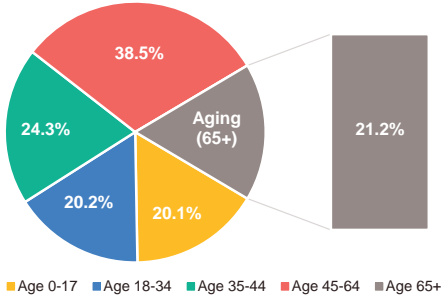


Figure 2

Population change from 2020-2023

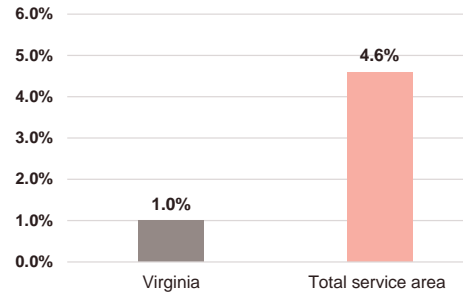


Figure 3

Determinants of health include:

Mental health care provider, rate per 100,000 population

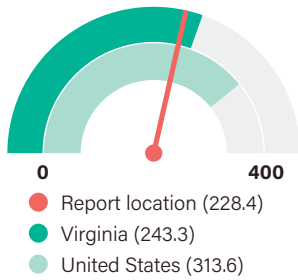


Figure 4

Source: Virginia's Plan for Well-Being

Dentists, rate per 100,000 population

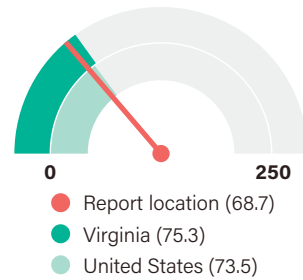


Figure 5

Population with a disability, percentage

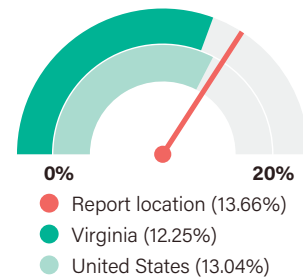


Figure 6

Top health concerns include:

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

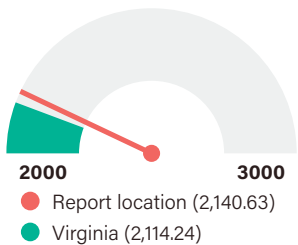


Figure 7

Source: Virginia's Plan for Well-Being

Alzheimer's disease deaths, rate per 100,000, total population

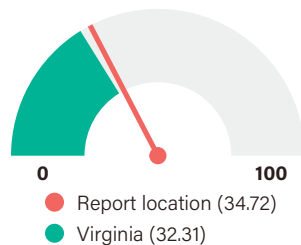


Figure 8

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

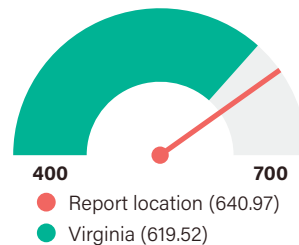


Figure 9

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

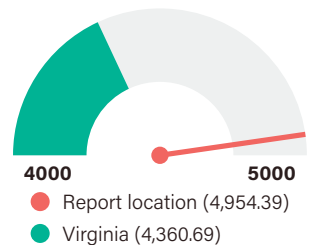


Figure 10

Key findings

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

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

Demographics

Of the total population in the service area, 74.3% of residents are White, 12.7% are Black, 6.3% are Hispanic, and 7.8% are multiple races (total exceeds 100% due to rounding and multiple races selected in the census).² The age profile for the population closely mirrors, yet slightly differs from, that of the Commonwealth of Virginia. Within the next ten years, the total population in the service area is estimated to increase by almost 8.4% — an estimated addition of roughly 22,000 residents.³

Social and economic factors

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

County Health Rankings model

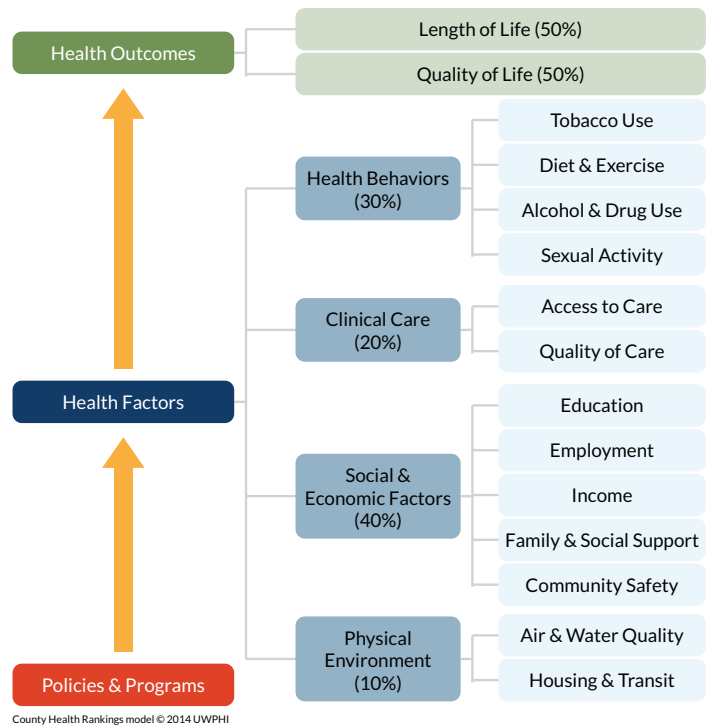


Figure 11

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

Education and employment

Education supports stable employment and financial stability for individuals and their families. As of the 2023 U.S. Census, 94.3% of the residents in the service area were high school graduates, compared to 91.3% of Virginia residents. According to the 2019-2023 American Community Survey, 43.6% of residents in the service area hold advanced or professional degrees, higher than the state at 41.5%.

As of the 2023 U.S. Census, 57.8% of residents in the service area participated in the civil labor force, lower than the state average of 63.7%. Of total service area residents, the percentage of female residents in the civilian labor force (53.8%) is also lower than the state average (61%).

Poverty

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

As of the 2023 U.S. Census, residents living in the service area are less likely to live in poverty (7.6%) compared to the rest of Virginia (10.2%). The combination of socioeconomic factors and racial inequalities has a negative impact on health outcomes for individuals and families in this area. Similar to Virginia as a whole, People of Color living in the service area are more likely to live in poverty compared to White residents. In the service area, Black (13.5%) and Hispanic (10.3%) residents experience a higher rate of poverty compared to White residents (5.2%).

Community insight

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

Community survey

From October 1, 2024, to February 28, 2025, we invited over 100 key community partners throughout Virginia to share and complete the survey, which resulted in 1,637 residents living in the service area participating. We appreciate the time and contributions these individuals made to help enhance health and well-being in our community.

Top concerns identified included:

- Neonatal and newborn health
- Asthma and allergies
- Mental health
- Cancer, heart conditions, and high blood pressure

Barriers to health care services included:

- Cost
- Limited or no insurance
- No appointments available after 5 p.m. or weekends
- Long wait for scheduled appointments
- No appointments for new patients

Focus groups

Hospital leaders conducted community conversations from October 2024 through April 2025 to gain more in-depth insights from community stakeholders on their health concerns and health care barriers. Leaders from the collaborative, SWRMC, and SSCV intentionally promoted these focus groups to diverse populations to obtain feedback from participants truly representative of the communities we serve.

Top concerns identified included:

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

Health status

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

Life expectancy for a person living in the Commonwealth of Virginia is 78.1 years. In the communities served by SWRMC and SSCV, the average life expectancy is 80.0 years—slightly higher than the state average. It is important to note disparities affecting Black residents. The average life expectancy of Black residents in the city of Williamsburg (67.3), and the counties of Gloucester (69.2), James City (76.8), King and Queen (66.89), New Kent (71.3), and York (79.2) is one to 10 years less than White residents living in the service area.¹

Access to health services is limited by the low numbers of primary care providers and mental health providers in this community. The need for access to mental health services continues to grow. In 2024, 429 adults and 59 youth visited the SWRMC emergency room for behavioral health concerns. Of those patients, 20.3% of the adults and 33.9% of the youth reported suicidal ideations.







Top health conditions driving hospitalizations at SWRMC and SSCV include hypertension, stroke, asthma, diseases of the heart, diabetes, and mental health. Leading causes of death include cancer, heart disease, stroke, accidents, and Alzheimer’s disease. Risk factors for chronic conditions include substance use, obesity, limited access to healthy foods, and physical inactivity.

Focus areas

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

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

Sentara Cares community benefit and building efforts enhance SWRMC and SSCV health priorities for 2026-2028

Sentara priorities	Socioeconomic needs	Health needs	SWRMC and SSCV priorities
	 Housing	 Behavioral and mental health	
	 Food security	 Chronic conditions	
	 Skilled careers	 Social determinants of health	




Table 1 Sentara cares priorities for grant opportunities and SWRMC and SSCV implementation strategy priorities for 2026-2028.

Endnotes

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

² United States Census Bureau. QuickFacts. www.census.gov. Accessed March 10, 2025. <https://www.census.gov/quickfacts/fact/table/williamsburgcityvirginia,gloucestercountyvirginia,jamescitycountyvirginia,kingandqueencountyvirginia,newkentcountyvirginia,yorkcountyvirginia/PST045223>.

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

Introduction

Sentara Health

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

Sentara Williamsburg Regional Medical Center (SWRMC)

Sentara Williamsburg Regional Medical Center is a 145-bed facility featuring the latest health care technologies, serving Williamsburg and its surrounding communities.

The hospital is a Certified Primary Stroke Center and STEMI Center that offers a full range of medical care including emergency heart catheterization, all-inclusive maternity care where patients may stay in one room, advanced imaging, "smart" operating rooms, as well as a Gold Level Geriatric Emergency Room.

With its Magnet® recognition, the hospital has achieved the nation's high honor for excellence in nursing.²

Sentara at a glance

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

Surgical Suites of Coastal Virginia (SSCV)

Our business is taking care of people and our treatment approach goes well beyond surgery. We provide care and support to make sure that our patients are successful, whether that means offering on-site classroom space to provide the tools to help patients successfully achieve their best health, or providing an atmosphere that is therapeutic from the moment patients step through the door. Our friendly, professional staff aims to make sure patients feel welcome. Our goal is to get patients back to the activities they love, free of pain.³

Sentara Cares

Our purpose calls us to address health care issues every day, where people live — not just when patients are under our care. This broad vision is essential in our work to eliminate health disparities and promote access to nutritious foods, education, safe and affordable housing, and stable, rewarding job opportunities. We know that health disparities cannot be solved solely in the exam room, and they cannot be solved solely by Sentara. Through our partnerships, we continue to make both immediate impact and lasting change for our communities.⁴

Sentara Community Care

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

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

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

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

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

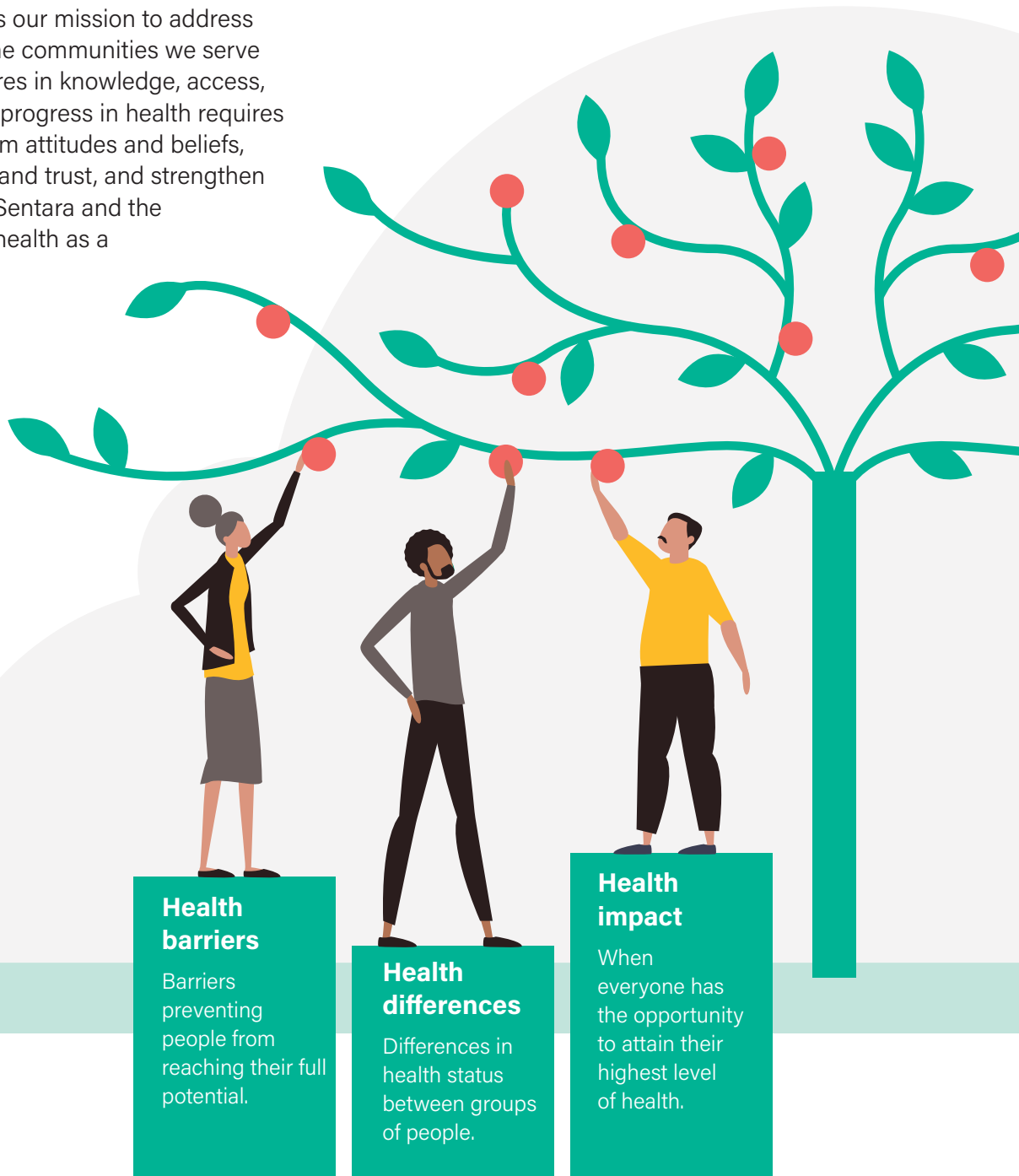
Sherry Norquist, MSN, RN-ACM,
Executive Director of Community
Engagement & Impact



Health impact

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

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



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

Process overview

Mobilizing for action through planning and partnerships

The National Association of County and City Health Officials (NACCHO) has implemented a community-driven strategic planning process for improving community health called Mobilizing for Action through Planning and Partnerships (MAPP). This framework includes engaging community partners in the collection and review of qualitative and quantitative data from trusted local and national sources. In doing so, participating partners can clearly define the conditions that support or obstruct wellness and identify resources to address obstacles.⁵

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

Our process

Sentara conducts these comprehensive assessments to provide a snapshot of the health status of residents in our communities, including information about key health and health-related challenges and opportunities. Each Community Health Needs Assessment incorporates information from a variety of primary and secondary quantitative data sources to help us to understand the disparities that affect vulnerable populations.

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

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

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

Our next steps

Both SWRMC and SSCV work with community partners to address health needs. Using the information from this assessment, SWRMC and SSCV will develop an implementation strategy to address the identified health problems. The implementation strategy progress report for the 2022 CHNA is available at the end of this report.

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

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



Endnotes

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

² Sentara Health. Sentara Williamsburg Regional Medical Center. Accessed March 14, 2025. <https://www.sentara.com/hospitalslocations/sentara-williamsburg-regional-medical-center>.

³ Surgical Suites of Coastal Virginia. Accessed March 14, 2025. <https://www.sscova.com/>.

⁴ Sentara Cares. Strengthening Communities. Accessed October 10, 2024. <https://sentaracares.com>.

⁵ National Association of County and City Health Officials. Accessed October 10, 2024. Mobilizing for Action through Planning and Partnerships (MAPP). <https://www.naccho.org/#:~:text=Mobilizing%20for%20Action%20through%20Planning%20and%20Partnerships%20%28MAPP%29,health%20issues%20%20and%20identify%20resources%20to%20address%20them>.

Community description

Locality demographics of our community

Both SWRMC and SSCV are located in Williamsburg, Virginia. The SWRMC and SSCV community includes a total population of 242,364 people who live in the 998.90 square mile report area.¹ The SWRMC and SSCV community is comprised of one city (Williamsburg) and five counties (Gloucester, James City, King and Queen, New Kent, and York) and their surrounding communities. This community is defined this way because many health status indicators used in this report are only available at the city or county level, not at the zip code level, though much of the data incorporates the entire community that SWRMC and SSCV serves.

Community-specific demographics

As of the 2023 U.S. Census, the Williamsburg population was 15,847, with 18.8% of residents living in poverty and 5.8% uninsured. Age demographics include 10.5% of residents between the ages of 0-17, 50.3% ages 18-34, 13.0% ages 35-54, and 26.2% ages 55 and older. English is the primary language for residents. The racial and ethnic profile for the city is 68.2% White, 15.2% Black, 7.0% Asian, and 6.3% Hispanic.

Gloucester County has a population of 40,057, with 7.9% of residents living in poverty and 8.0% uninsured. Age

demographics include 20.0% of residents between the ages of 0-17, 17.8% ages 18-34, 25.2% ages 35-54, and 36.9% ages 55 and older. English is the primary language for residents. The racial and ethnic profile for the county is 84.0% White, 8.1% Black, and 4.0% Hispanic.

James City County has a population of 82,654, with 7.2% of residents living in poverty and 6.0% uninsured. Age demographics include 19.7% of residents between the ages of 0-17, 16.4% ages 18-34, 23.3% ages 35-54, and 40.6% ages 55 and older. English is the primary language for residents. The racial and ethnic profile for the county is 74.9% White, 12.8% Black, 2.6% Asian, and 6.9% Hispanic.

King and Queen County has a population of 6,720, with 12.7% of residents living in poverty and 9.5% uninsured. Age demographics include 17.8% of residents between the ages of 0-17, 14.9% ages 18-34, 26.0% ages 35-54, and 41.3% ages 55 and older. English is the primary language for residents. The racial and ethnic profile for the county is 66.8% White, 23.8% Black, and 3.1% Hispanic.

New Kent County has a population of 26,134, with 5.6% of residents living in poverty and 7.5% uninsured. Age demographics include 19.5% of residents between the ages of 0-17, 19.5% ages 18-34, 27.3% ages 35-54, and 33.8% ages 55 and older. English is the primary language for residents. The racial and ethnic profile for the county is 78.0% White, 13.4% Black, and 3.6% Hispanic.

York County has a population of 70,952, with 6.5% of residents living in poverty and 6.0% uninsured. Age demographics include 23.3% of residents between the ages of 0-17, 20.0% ages 18-34, 26.1% ages 35-54, and 30.6% ages 55 and older. English is the primary language for residents. The racial and ethnic profile for the county is 69.1% White, 13.1% Black, 5.9% Asian, and 7.6% Hispanic.

Looking at the data

Racial and ethnic profile, 2023

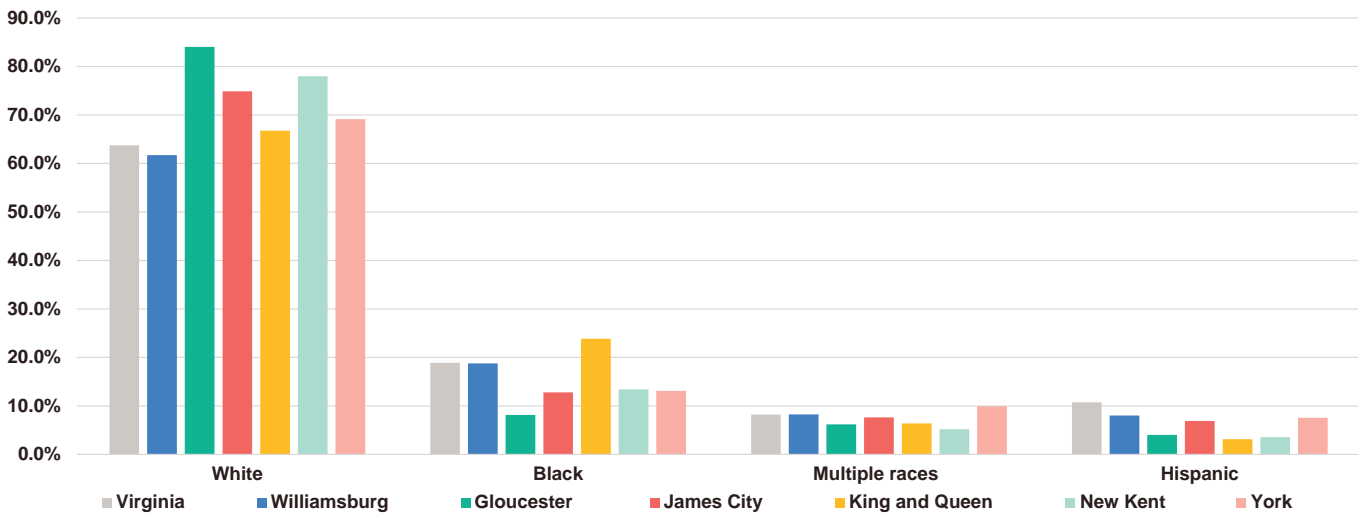


Figure 1 Source: Virginia's Plan for Well-Being

Population by age, 2019-2023

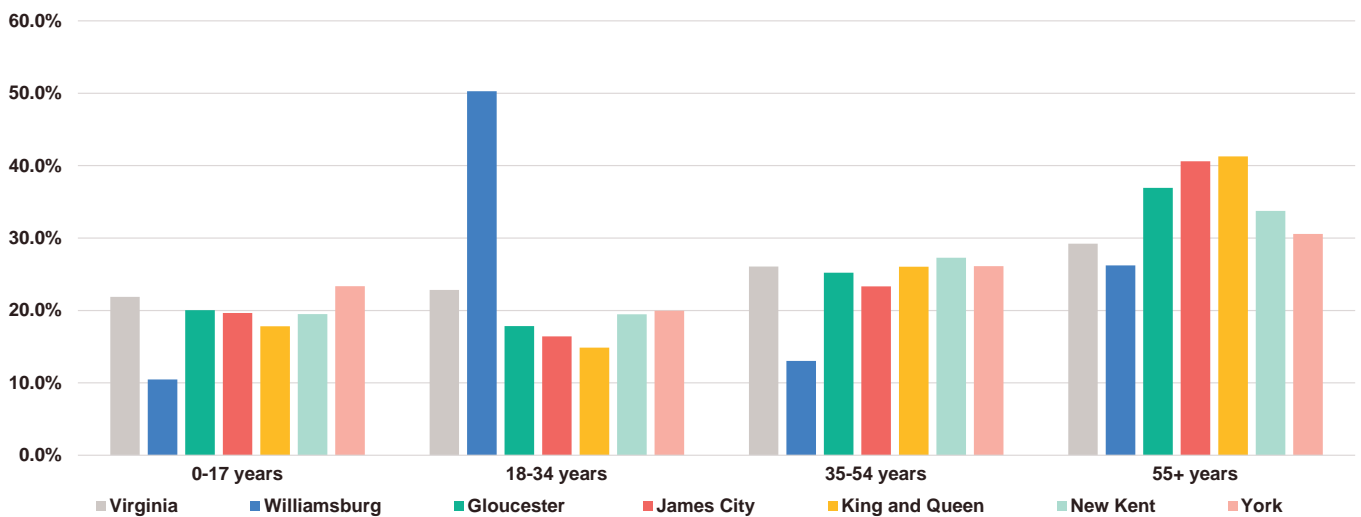


Figure 2 Source: Virginia's Plan for Well-Being

Median household income, 2023

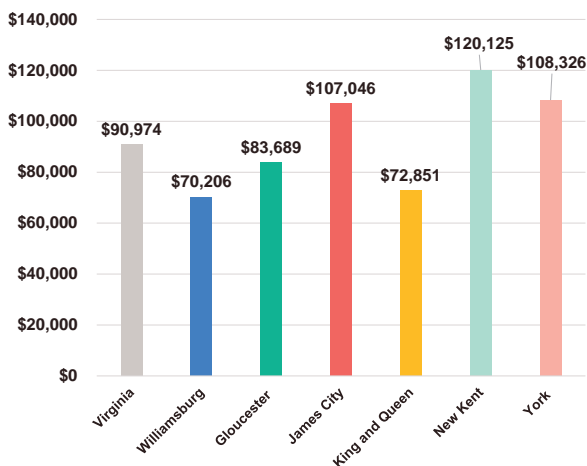


Figure 3 Source: U.S. Census Bureau

Poverty, 2023

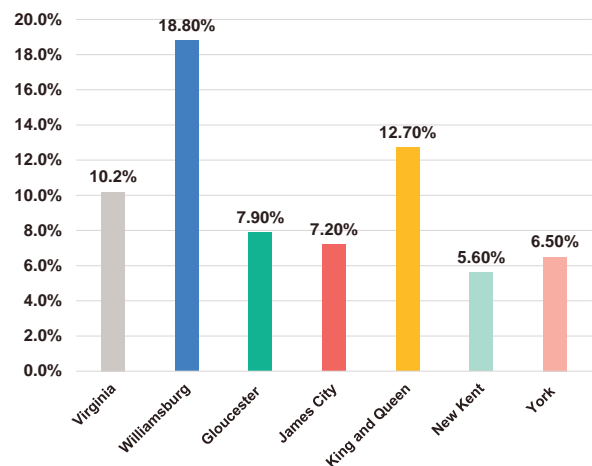


Figure 4 Source: U.S. Census Bureau

Population highlights

Population change

“Population projections provide an approximate idea of the expected future population size” and, according to the University of Virginia’s Weldon Cooper Center for Public Service, the service area is expecting an increase of an estimated 22,000 people within the next ten years.² These projections are based on “reliable and credible data.”²

Population change, 2020-2030

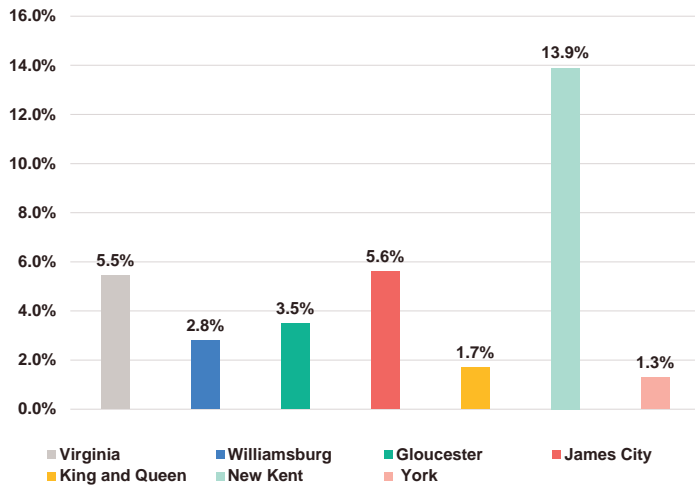


Figure 5 Source: U.S. Census Bureau

Age and sex

Per the 2023 U.S. Census, of the total population of 242,364 people living in the service area, most residents are over the age of 35. The percentage of residents who are children between the ages of 0-17 is 20.1%, slightly lower than the state level of 21.9%. Male (49.3%) and female (50.7%) resident percentages are similar to Virginia percentages (49.4% male, 50.6% female), based on sex assigned at birth.

Aging population

Research shows the highest utilization of medical services is among the aging population (ages 65 and older) and the elderly population (ages 85 and older). In 2023, 21.2% of the residents living in the service area were ages 65 and older, compared to 16.3% in Virginia. Per the 2023 U.S. Census, James City has the largest number of adults ages 65 and older in the service area, estimated at 21,103 residents. Estimates indicate the population of aging adults (ages 65 and older) living in the service area will increase to 27.7% by 2035.²

Other demographic features

According to the 2023 U.S. Census, veterans represent 10.7% of the population in the service area, compared to 7.3% statewide. Slightly more households in the service area have computers (95.8%) and internet access (91.7%), providing access to remote learning, telehealth, and other resources. A slightly higher percentage of the population in the service area is living with a disability (13.7%) compared to the state overall (12.3%). The service area has a lower percentage of persons living in poverty (7.6%) compared to Virginia overall (10.2%), and a higher percentage of residents with college degrees (52.7%) when compared to the state (49.3%).

Community diversity profile

Race and ethnicity

The population of the service area has a higher percentage of White (74.3%) residents than other races and ethnicities.³ The service area is home to a small Black (12.7%), Asian (3.4%), and Hispanic (6.3%) population.³

Cultural and linguistic needs

English is the primary language spoken in the service area. As of the 2023 U.S. Census, 97.9% of the population in the service area identified as English-speaking. Non-English-speaking populations are disproportionately represented in low socioeconomic

Population with limited English proficiency, 2019-2023

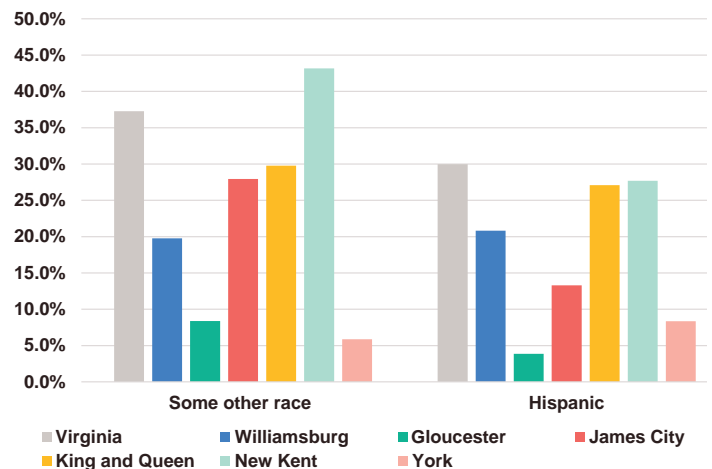


Figure 6 Source: U.S. Census Bureau

groups, have poorer health outcomes, are more likely to have a disability, are often linguistically and culturally isolated, and have lower educational attainment compared to their English-speaking counterparts. Language barriers make it difficult for this population to understand, interpret, and benefit from information about their health.

2024 SWRMC language utilization

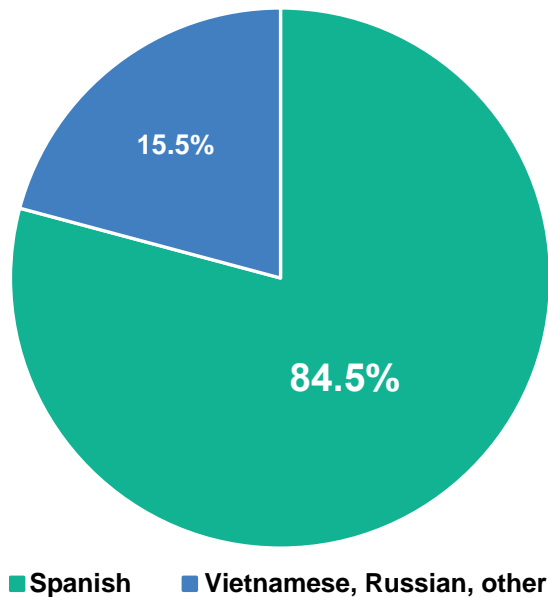


Figure 7 Source: SWRMC Language Line Usage Report

Sentara is committed to ensuring that all communication with our patients and health plan members is in their preferred language. Sentara provides its patients and their families with qualified interpreters for a variety of languages, including American Sign Language (ASL). In 2024, SWRMC had 5,231 requests for interpreter services. The highest percentage of interpreter services (84.5%) was for Spanish-speaking individuals, with the second highest percentage being Vietnamese (2.9%) and Russian (1.7%).

Social determinants of health

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

Sentara works to:

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

Social determinants of health



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

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

The cycle of poverty

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

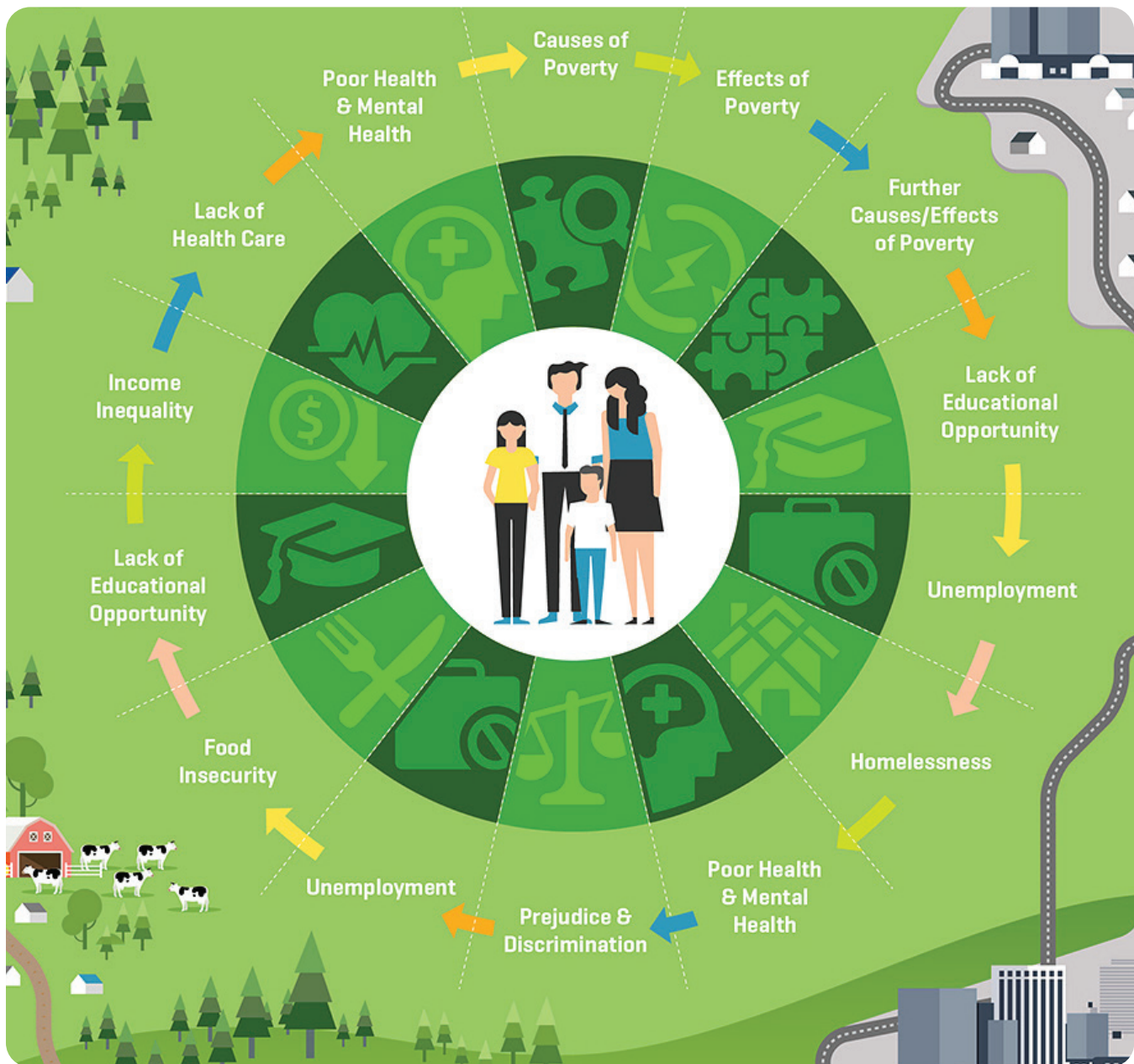


Figure 9 Source: Aurora University

Poverty

An examination of poverty rates and racial demographics underscores the racial disparities that impact economic and health outcomes for residents and their families. At 7.6%, the service area has a lower percentage of residents living in poverty compared to the Commonwealth of Virginia (10.2%). For this service area, Black, Asian, and Hispanic residents are more likely to live in poverty.³

Education

Education is the basis for stable employment and financial stability, which in turn supports access to quality health care and positive health outcomes. The service area has a higher percentage of residents who are high school graduates (94.3%) than the statewide percentage (91.3%). The service area also has a higher percentage of college graduates (43.6%) compared to the state overall (41.5%).³

Employment

Per the 2023 U.S. Census, the service area has a higher percentage of unemployed residents (4.0%) compared to Virginia overall (2.7%). The labor force represents 57.7% of total residents. Within the labor force, 54.7% of female residents in the service area are employed, lower than the state (61.0%).³

Medicaid and Medicare Programs

Public health insurance programs play an important role in providing coverage for individuals who qualify based on income, age, or disability. According to the 2023 U.S. Census, 9.2% of residents living in the service area do not have health insurance. A total of 1,994,822



Estimated poverty status by race/ethnicity, 2023

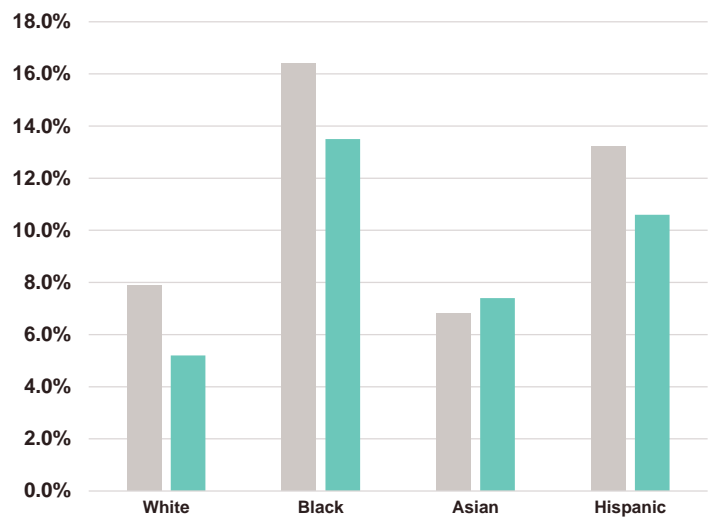


Figure 10 Source: U.S. Census Bureau

Education attainment, age 25+, 2019-2023

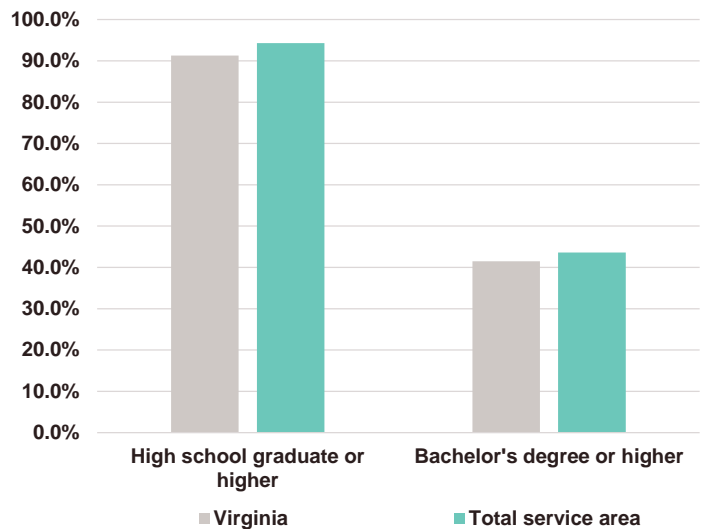


Figure 11 Source: U.S. Census Bureau

Civilian labor force, 2023

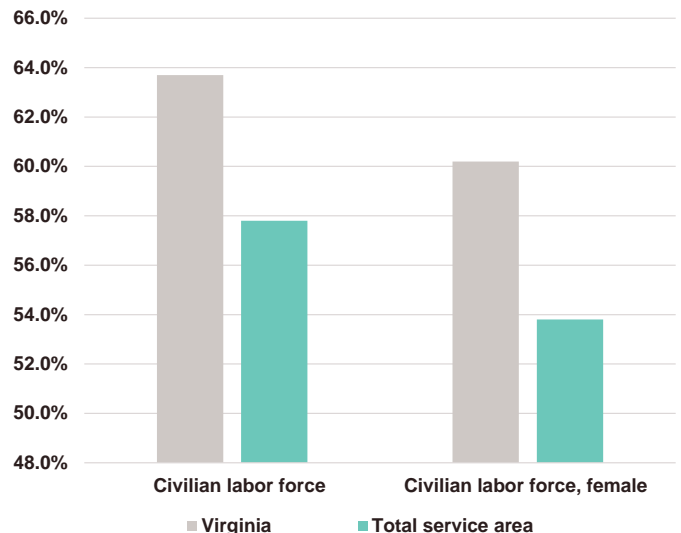


Figure 12 Source: U.S. Census Bureau

Virginians had health coverage through Medicaid and Family Access to Medical Insurance Security (FAMIS) as of February 11, 2025. This included 70,883 residents living in the service area served by SWRMC and SSCV.⁶ Medicaid and FAMIS members represent 22.8% of the total population in the service area, similar to the 22.9% of all Virginians who have Medicaid or FAMIS health coverage.⁶ Community health workers and enrollment specialists are available to provide guidance and assistance for qualifying individuals and families with enrollment in these government programs.

Medicaid and FAMIS (Below 138% FPL) Enrollment January 1, 2025						
	Virginia	Williamsburg	Gloucester	James City	York	
Medicaid/FAMIS enrollment	1,994,822	2,748	8,461	11,121	8,540	
Medicaid/FAMIS percentage	22.9%	17.3%	21.1%	13.5%	12.0%	
65+ enrolled in Medicaid/FAMIS enrollment	91,312	108	370	305	347	
65+ enrolled in Medicaid/FAMIS percentage	1.0%	0.7%	0.9%	0.4%	0.5%	
Children enrolled in Medicaid/FAMIS	776,548	1,040	3,005	4,567	3,437	
Children enrolled in Medicaid/FAMIS percentage	9.0%	6.6%	7.5%	5.5%	4.8%	

Medicare enrollment 2022							
	Virginia	Williamsburg City	Gloucester County	James City County	King and Queen County	New Kent County	York County
65+ Medicare percentage	65.4%	62.1%	61.5%	63.7%	72.4%	73.5%	52.7%
65+ Medicare and Medicaid percentage	4.8%	-	3.8%	2.2%	4.2%	2.4%	2.6%

Table 1 Sources: Virginia Medicaid, Department of Medical Assistance Services, and Centers for Medicare & Medicaid Services Data

Endnotes

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

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

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

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

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

⁶ Department of Medical Assistance Services (DMAS) Data. Accessed February 10, 2025. <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>.

⁷ Centers for Medicare & Medicaid Services. Data.CMS.gov. Mapping Medicare Disparities by Population. Accessed February 10, 2025. <https://data.cms.gov/tools/mapping-medicare-disparities-by-population>.

Community input

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

Description

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

Methodology

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

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

Community survey

The community survey was conducted jointly with the Peninsula Community Health Collaborative and included a broad-based group of stakeholders and community members. Electronic surveys, and paper surveys in English and Spanish, were available to the public from October 1, 2024, to February 28, 2025. The survey was distributed to stakeholders, including individuals representing public health, education, social services, businesses, local government, and local civic organizations. At the completion of the survey period, 1,642 community member survey responses were received from the SWRMC and SSCV community.

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

Demographics of survey respondents

Of the 1,642 SWRMC and SSCV community member respondents, 91.8% identified as White, 4.8% as Black, 0.8% as Indigenous, 2.3% as Asian, and 2.1% as Hispanic.

Survey responses

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

Top three most important health concerns in your community.

Rank	All responses (n=1,642)	Responses from Williamsburg City (n=186)	Responses from the counties of Gloucester, James City, King and Queen, New Kent and York (n=1,456)
Youth			
1	Mental health	Mental health	Mental health
2	Asthma and allergies	Asthma and allergies	Obesity
3	Obesity	Obesity	Asthma and allergies
Adults			
1	Cancer	Cancer	Cancer
2	Mental health	Heart conditions, mental health, neurological disorders	Mental health
3	Heart conditions	Obesity	Heart conditions

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

Rank	All responses (n=1,642)	Responses from Williamsburg City (n=186)	Responses from the counties of Gloucester, James City, King and Queen, New Kent and York (n=1,456)
Youth			
1	Cost	Cost	Cost
2	Limited or no insurance	Limited or no insurance	Limited or no insurance
3	Long wait for a scheduled appointment	Long wait for a scheduled appointment	Long wait for a scheduled appointment
Adults			
1	Long wait for a scheduled appointment	Cost	Long wait for a scheduled appointment
2	Cost	Long wait for a scheduled appointment	Cost
3	Limited or no insurance	Limited or no insurance	No appointments available for new patients

Top three social concerns impacting health in your community.

Rank	All responses (n=1,642)	Responses from Williamsburg City (n=186)	Responses from the counties of Gloucester, James City, King and Queen, New Kent and York (n=1,456)
Youth			
1	Lack of available healthy food	Lack of available healthy food	Lack of parenting support, education services
2	Lack of parenting support, education services	Lack of affordable housing	Lack of available healthy food
3	Lack of affordable housing	Lack of parenting support, education services	Lack of affordable housing
Adults			
1	Lack of affordable housing	Lack of affordable housing	Lack of affordable housing
2	Loneliness, isolation	Loneliness, isolation	Loneliness, isolation
3	Lack of available healthy food	Homelessness	Lack of available healthy food

Community focus groups

In addition to the online surveys for community insight, SWRMC and SSCV carried out a series of more in-depth community focus groups to obtain greater insight from diverse stakeholders and community members. Focus groups were promoted electronically and by word of mouth to hospital patients and visitors, existing hospital and community groups, and partner organizations. Input was also sought from other populations in the community, including representatives of underserved communities and consumers of services. In collaboration with CHKD and Bon Secours, SWRMC and SSCV held four focus group sessions between December 2024 and February 2025. Refer to Appendix C for additional notes.

2024 focus groups

- November 18: RF Wilkinson Family YMCA Williamsburg, 9 participants
- December 4: York Senior Center, 10 participants
- December 12: Gloucester Mathews Care Clinic, 10 participants

2025 focus groups

- February 5: SWRMC Patient & Family Advisory Council, 9 participants
- March 28: King and Queen County, 5 participants
- April 9: New Kent County (virtual), 4 participants

Demographics

The 47 focus group participants ranged in age from 26 to 65 and older. Altogether, participants were 72.3% White and 21.2% Black. The group identified as 61.7% female and 38.3% male.

Results

Topic	Key findings	
<p>What serious health problems are in your community for children (0-17) and for adults (18+)?</p>	Children	Adults
	<p>Mental health issues</p> <ul style="list-style-type: none"> ▪ Anxiety and depression, largely attributed to social media. Lack of mental health services for children. <p>Obesity & nutrition</p> <ul style="list-style-type: none"> ▪ Increase in BMI. Food deserts limit fresh food access. <p>Health literacy</p> <ul style="list-style-type: none"> ▪ Teens lack knowledge on obtaining health insurance and reading nutrition labels. <p>Social skills & adjustment Issues</p> <ul style="list-style-type: none"> ▪ Post-COVID effects — difficulty socializing, problem-solving, and adjusting to change. 	<p>Substance use & mental health</p> <ul style="list-style-type: none"> ▪ Need for detox services, mental health counselors, and same-day treatment. <p>Chronic diseases</p> <ul style="list-style-type: none"> ▪ Increasing diabetes rates. Need for diabetes education. ▪ Health care access issues ▪ Long wait times, lack of providers, and inadequate insurance. <p>Homelessness & food insecurity</p> <ul style="list-style-type: none"> ▪ Rise in food pantry use (30%). <p>Transportation</p> <ul style="list-style-type: none"> ▪ Limited access to health care and community centers. <p>Loneliness & aging in seniors</p> <ul style="list-style-type: none"> ▪ Isolation due to lack of mobility. Dementia. Lack of geriatric care managers.

Results (cont.)

Topic	Key findings	
Key strengths identified for children and adults		
<p>What is working in your community that can help residents live healthier lives?</p>	<p>Community resources & collaboration</p> <ul style="list-style-type: none"> ▪ Many Community-Based Organizations (CBOs) exist but are underrated and not well known. ▪ A resource guide will be developed in the spring to increase awareness. ▪ Schools offer resource books to families. ▪ Peer recovery specialists (42 in the Northern Neck/Middle Peninsula) are active in the community. ▪ Collaboration among community partners is growing to meet local needs. ▪ Health providers are transitioning to community-based roles rather than just clinical settings. <p>Children & youth programs</p> <ul style="list-style-type: none"> ▪ The YMCA provides a safe, healthy environment for kids. ▪ Sports opportunities exist through schools, recreation leagues, and the YMCA Leaders Club, emphasizing fitness and participation regardless of skill level. ▪ A strong arts community encourages creative activities like painting, singing, and poetry. <p>Adult & senior support</p> <ul style="list-style-type: none"> ▪ Collaborative efforts between organizations provide food drives, educational events (e.g., Alzheimer’s and Parkinson’s awareness), and public service announcements. ▪ Health systems are adapting to funding shortages by finding new ways to deliver services. ▪ Better medical communication is needed (e.g., TPMG, Sentara, and Riverside do not share records; military and civilian doctors struggle with data access). 	<p>Access to health & fitness</p> <ul style="list-style-type: none"> ▪ Public parks and open spaces encourage outdoor activity. ▪ Senior centers offer community engagement and wellness programs. ▪ Silver Sneakers allows seniors to access multiple gyms. ▪ James City County Recreation Center provides extensive fitness and recreational opportunities. ▪ Meals on Wheels delivers food and provides social interaction, also checking on those who don’t answer the door. <p>Technology & health information</p> <ul style="list-style-type: none"> ▪ Online health resources like WebMD and Google help people make informed health decisions. ▪ Sentara MyChart enables quick access to medical test results and direct messaging with doctors. ▪ AI tools (ChatGPT) and voice assistants (Alexa) help manage health, medication reminders, and daily schedules. ▪ Potential for tech-company partnerships to create tools for aging populations, such as TV-based reminders. <p>Transportation & accessibility</p> <ul style="list-style-type: none"> ▪ Transportation remains a major barrier, especially in York County. ▪ Shuttle service suggestions: Regular routes to grocery stores, Walmart, libraries, senior centers, and community hubs. ▪ Weekly trips to destinations like malls, Riverwalk, and Williamsburg could improve access. <p>Community support & neighborly care</p> <ul style="list-style-type: none"> ▪ Encouraging neighborly support.

Results (cont.)

Topic	Key findings	
<p>What do you think about the health-related services that are available in your community, including medical care, dental care, and mental health care for children and adults?</p>	<p>Children</p>	<p>Adults</p>
	<p>Limited dental access</p> <ul style="list-style-type: none"> Many children face difficulties accessing dental care due to paperwork barriers and lack of available appointments. Elementary and middle school students have some access through health department services, but additional outreach is needed. <p>Lack of general awareness</p> <ul style="list-style-type: none"> Many families are unaware of available services. Social media helps, but not all families have access or use it. More comprehensive community outreach is needed. <p>Need for a mobile clinic</p> <ul style="list-style-type: none"> A mobile health clinic could address gaps in medical, dental, and mental health services for children in underserved areas. <p>Emergency services overburdened</p> <ul style="list-style-type: none"> Non-emergency calls are clogging the system, leading to long wait times (up to three hours) for true emergencies. <p>Autism & specialized care barriers</p> <ul style="list-style-type: none"> Diagnosing autism and accessing therapy (such as speech therapy) is difficult, often requiring legal intervention due to insurance issues. There is also confusion about which specialists to see, and services vary greatly by locality. <p>Long wait times for dental care</p> <ul style="list-style-type: none"> Delays in routine cleanings, with some dentists dropping insurance due to low reimbursements. 	<p>Limited maternity care</p> <ul style="list-style-type: none"> No labor and delivery (L&D) services in the county or surrounding counties, so most women travel to Richmond. Lack of OB-GYN providers and licensed doulas in the health district. Lack of support services for young mothers, especially teenage mothers. <p>Limited support for specific conditions</p> <ul style="list-style-type: none"> No local support groups or specialized resources for Parkinson's disease or Huntington's disease. <p>Homelessness & dual diagnosis challenges</p> <ul style="list-style-type: none"> Growing tent encampments indicate a rising issue with homelessness, particularly among individuals with co-occurring mental health and substance abuse disorders. <p>Lack of general health care knowledge</p> <ul style="list-style-type: none"> Many adults struggle to navigate the health care system and are unaware of available resources such as free clinics. <p>Transportation barriers</p> <ul style="list-style-type: none"> Many patients struggle to reach medical appointments due to lack of reliable transportation. <p>Access to specialists</p> <ul style="list-style-type: none"> Long wait times for dermatologists, cardiologists, and other specialists. <p>Changing insurance coverage</p> <ul style="list-style-type: none"> Many patients lose access to their doctors due to insurance changes.
<p>Cross-cutting concerns for children and adults</p>		
<ul style="list-style-type: none"> Cost of care & insurance barriers: High costs of medications (e.g., Ozempic), expensive dental procedures, and insurance coverage gaps make care unaffordable. Urgent care challenges: Many urgent care centers require appointments, making walk-ins difficult. Some locations, like Williamsburg Urgent Care near Fresh Market, provide better service. Trust issues with health care providers: Patients feel some providers prioritize profit over care. Doctors recommend expensive procedures that may not be necessary. Lack of communication from doctors: Patients often receive inadequate explanations about diagnosis and treatment plans. Stronger advocacy and better doctor-patient communication are needed. Mental health crisis response needs improvement: Patients fear seeking help due to potential hospitalization. Alternative crisis intervention models, such as telehealth counseling, could help reduce unnecessary institutionalization. 		

Results (cont.)

Topic	Key findings	
<p>Do you feel like it is hard to access healthy, fresh food in your community?</p> <p>What keeps you from trying new fresh fruits and/or vegetables?</p>	Children and adults	
	<p>Lack of education & awareness</p> <ul style="list-style-type: none"> Many individuals, both children and adults, lack knowledge about healthy foods, nutritional value, and portion control. Limited understanding of food preparation, especially for fresh produce such as pomegranates or squash. Cultural differences influence food choices, leading to hesitancy in trying new foods. <p>Financial barriers</p> <ul style="list-style-type: none"> Healthy foods, especially fresh produce and organic options, are more expensive than processed alternatives. Individuals with lower incomes prioritize affordability over nutrition, often choosing processed and fast foods. Food pantry recipients may receive fresh produce but struggle to utilize it due to lack of knowledge and equipment. 	<p>Availability & accessibility</p> <ul style="list-style-type: none"> Fresh produce is not always available at convenience stores like Dollar General. Despite local farmland, much of the produce in stores is imported rather than locally sourced. School food programs provide processed rather than fresh. Limited fresh fruit and vegetable options in school cafeterias. Transportation barriers prevent some individuals from accessing grocery stores and farmers markets. <p>Convenience & lifestyle barriers</p> <ul style="list-style-type: none"> Processed foods are more convenient and require less preparation time compared to fresh foods. Working parents and busy lifestyles make it challenging to cook fresh meals. Some elderly individuals receiving Meals on Wheels do not take the time to reheat or prepare their meals.
<p>What are some of the environmental and social conditions that affect quality of life for children and adults living in your community?</p>	Children	Adults
	<p>Housing instability</p> <ul style="list-style-type: none"> Increase in homeless families, living in hotels, and couch surfing. <p>Education & health care barriers</p> <ul style="list-style-type: none"> Lack of knowledge on school systems, vaccine hesitancy, and conditional enrollments due to missing vaccinations/physicals. Parents prioritize food over health care. <p>Transportation issues</p> <ul style="list-style-type: none"> Difficulties accessing doctor appointments, leading to last-minute visits. <p>Mental health concerns</p> <ul style="list-style-type: none"> Lack of safe spaces for children and teens to discuss issues. Rising mental health challenges due to social media, misinformation, and self-image issues. <p>Nutrition & food security</p> <ul style="list-style-type: none"> Four hundred children visit food pantry monthly. Loss of programs supporting college readiness due to funding cuts. <p>Vaping epidemic</p> <ul style="list-style-type: none"> Educational efforts exist but are largely ineffective without addressing underlying stress factors. 	<p>Health care access barriers</p> <ul style="list-style-type: none"> Limited doctor availability, long appointment wait times, poor communication with providers, and stigma around mental health care. <p>Housing & economic struggles</p> <ul style="list-style-type: none"> Affordable housing shortage, rising homelessness, and minimum wage being too low while costs rise affects access to health care. <p>Transportation issues</p> <ul style="list-style-type: none"> Lack of reliable transport for doctor visits, daily needs, and senior mobility. <p>Mental health stigma</p> <ul style="list-style-type: none"> Social stigma prevents people from seeking professional help for mental health concerns. <p>Elderly care challenges</p> <ul style="list-style-type: none"> Limited assisted living options, high costs, and barriers to accessing care. <p>Food security & health literacy</p> <ul style="list-style-type: none"> Many struggle with navigating the health care system, reading nutrition labels, and making healthy food choices.

Results (cont.)

Topic	Key findings	
<p>What is working in your community that can help residents live healthier lives?</p>	<p>Key strengths identified for children and adults</p>	
	<p>Community resources & collaboration</p> <ul style="list-style-type: none"> ▪ Many Community-Based Organizations (CBOs) exist but are underrated and not well known. ▪ A resource guide will be developed in the spring to increase awareness. ▪ Schools offer resource books to families. ▪ Peer recovery specialists (42 in the Northern Neck/Middle Peninsula) are active in the community. ▪ Collaboration among community partners is growing to meet local needs. ▪ Health providers are transitioning to community-based roles rather than just clinical settings. <p>Children & youth programs</p> <ul style="list-style-type: none"> ▪ The YMCA provides a safe, healthy environment for kids. ▪ Sports opportunities exist through schools, recreation leagues, and the YMCA Leaders Club, emphasizing fitness and participation regardless of skill level. ▪ A strong arts community encourages creative activities like painting, singing, and poetry. <p>Adult & senior support</p> <ul style="list-style-type: none"> ▪ Collaborative efforts between organizations provide food drives, educational events (e.g., Alzheimer’s and Parkinson’s awareness), and public service announcements. ▪ Health systems are adapting to funding shortages by finding new ways to deliver services. ▪ Better medical communication is needed (e.g., TPMG, Sentara, and Riverside do not share records; military and civilian doctors struggle with data access). 	<p>Access to health & fitness</p> <ul style="list-style-type: none"> ▪ Public parks and open spaces encourage outdoor activity. ▪ Senior centers offer community engagement and wellness programs. ▪ Silver Sneakers allows seniors to access multiple gyms. ▪ James City County Recreation Center provides extensive fitness and recreational opportunities. ▪ Meals on Wheels delivers food and provides social interaction, also checking on those who don’t answer the door. <p>Technology & health information</p> <ul style="list-style-type: none"> ▪ Online health resources like WebMD and Google help people make informed health decisions. ▪ Sentara MyChart enables quick access to medical test results and direct messaging with doctors. ▪ AI tools (ChatGPT) and voice assistants (Alexa) help manage health, medication reminders, and daily schedules. ▪ Potential for tech-company partnerships to create tools for aging populations, such as TV-based reminders. <p>Transportation & accessibility</p> <ul style="list-style-type: none"> ▪ Transportation remains a major barrier, especially in York County. ▪ Shuttle service suggestions: Regular routes to grocery stores, Walmart, libraries, senior centers, and community hubs. ▪ Weekly trips to destinations like malls, Riverwalk, and Williamsburg could improve access. <p>Community support & neighborly care</p> <ul style="list-style-type: none"> ▪ Encouraging neighborly support.

Results (cont.)

Topic	Key findings	
<p>What do you think your local health systems (hospitals and primary care) and health departments can do to improve the health and wellness in your community?</p>	Key areas for improvement in local health systems	
	<p>Reducing long wait times for appointments</p> <ul style="list-style-type: none"> ▪ Wait times for new and existing patients are too long (4+ months). ▪ Need to fill open provider slots and increase staffing. ▪ Expand access to mobile clinics and telehealth hubs. <p>Expanding telehealth & internet access</p> <ul style="list-style-type: none"> ▪ Telehealth could improve access, but internet connectivity issues remain. ▪ Need telehealth hubs throughout the county (in collaboration with partners). ▪ Explore regional discussions and funding to improve telehealth accessibility. <p>Addressing basic needs (beyond health care)</p> <ul style="list-style-type: none"> ▪ Increase access to clean clothing and laundry services for homeless and underserved populations. ▪ Secure a full-time dentist for the community (current part-time providers are not sufficient). ▪ Address fear over loss of SNAP benefits and Medicaid restructuring, which may limit health care access. <p>Improving health literacy & conflict resolution</p> <ul style="list-style-type: none"> ▪ Children: Schools should focus on health literacy, conflict resolution, and emotional well-being post-COVID. ▪ Adults: Host community health fairs with screenings, resources, and education on navigating health care. 	<p>Increasing collaboration & resource sharing</p> <ul style="list-style-type: none"> ▪ Agencies should collaborate on a unified resource guide (currently, each has its own booklet). ▪ Better integration into the health system to help people understand where to go and what services are available. ▪ Improve communication between medical groups (e.g., TPMG, Sentara, Riverside, military doctors). <p>Enhancing transportation options</p> <ul style="list-style-type: none"> ▪ Lack of transportation is a barrier to health care, mental health, and even essential services like haircuts. ▪ Need homebound medical services (unsure who to call for in-home care). ▪ A shuttle service for doctor’s appointments, pharmacies, and health fairs would improve access. <p>Medication & pharmacy challenges</p> <ul style="list-style-type: none"> ▪ Refilling prescriptions while traveling is difficult due to insurance restrictions and doctor approvals. ▪ Elderly individuals often struggle with medication management and need additional support. <p>Leveraging technology for better health management</p> <ul style="list-style-type: none"> ▪ Partner with tech companies to create tools for aging populations (e.g., notifications on TVs for appointments, medication reminders). ▪ Teach people to use Alexa for reminders (appointments, medication schedules, and daily tasks).

Health status and prioritization

Health indicators

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

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

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

Access to health services

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

The service area has fewer doctors to community members in some of our communities compared to the state (1341:1), Williamsburg (7795:1), Gloucester (2171:1), King and Queen (3331:1), and New Kent (3414:1). Though, James City (898:1) and York (865:1) have better access. Increasing access to primary care is a key solution to reducing unnecessary, costly hospital stays and improving the health of the community. It is important to note that Black populations living in Virginia and in the service area have higher rates of preventable hospital stays compared to White residents.¹

Preventable hospital stays by rate by race, 2021

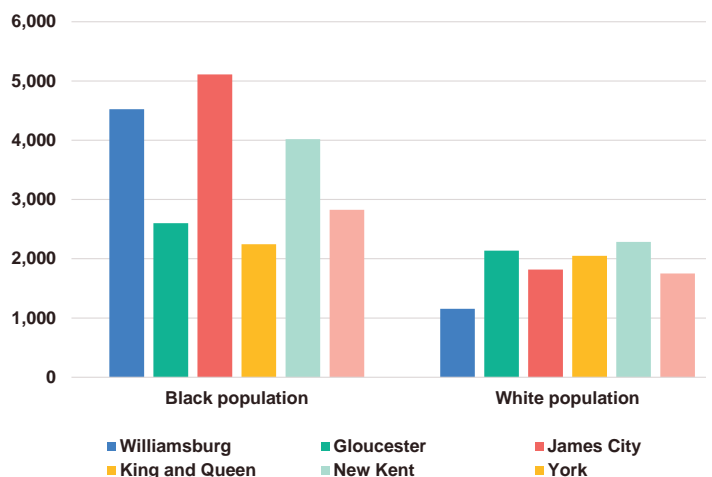


Figure 1 Source: County Health Rankings

Life expectancy

Per the Virginia Department of Health, the life expectancy for a person living in the Commonwealth of Virginia is 78.7 years. At 80.0 years, residents in this community have a higher life expectancy than Virginians overall. It is important to note that there is a racial disparity related to life expectancy specific to Black populations. Per the 2024 County Health Rankings, the life expectancy for Black individuals is up to eight years shorter than White individuals in this service area.

Life expectancy by race, 2019-2021

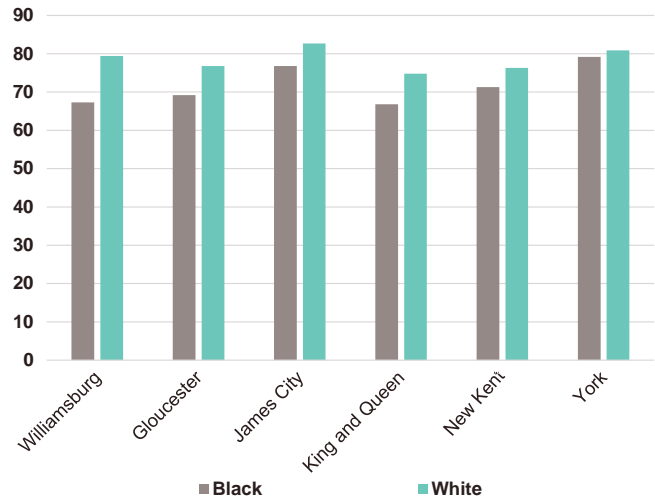


Figure 2 Source: 2024 County Health Rankings

The leading causes of death by race/ethnicity, 2018-2023

Virginia	Service Area	White	Black	Asian	Hispanic
Heart Disease	Cancer	Cancer	Heart Disease	Cancer	Cancer
Cancer	Heart Disease	Heart Disease	Cancer	Heart Disease	Heart Disease
Accidents	Stroke	Stroke	Stroke	Stroke	Accidents
Stroke	Accidents	Accidents	Accidents	COVID-19	-
COVID-19	Alzheimer's	Alzheimer's	Alzheimer's	-	-

Figure 3 Source: CDC Wonder

Leading causes of death

The Virginia Department of Health examined leading causes of death in localities of this community. Between 2021 and 2023, cancer, heart disease, stroke, accidents, and Alzheimer's disease were the top five causes of death in this community.²

Behavioral health, mental health, and substance use

Hospitalization rates due to substance use, drug overdose, mental health, suicide, and self-inflicted injury were examined. In the service area, there were higher death rates due to alcohol-impaired driving (2.0 per 100,000) and liver disease and cirrhosis (14.8) compared to Virginia rates (1.6, 13.5).²

Hospitalizations rate, 100,000 population, 2020

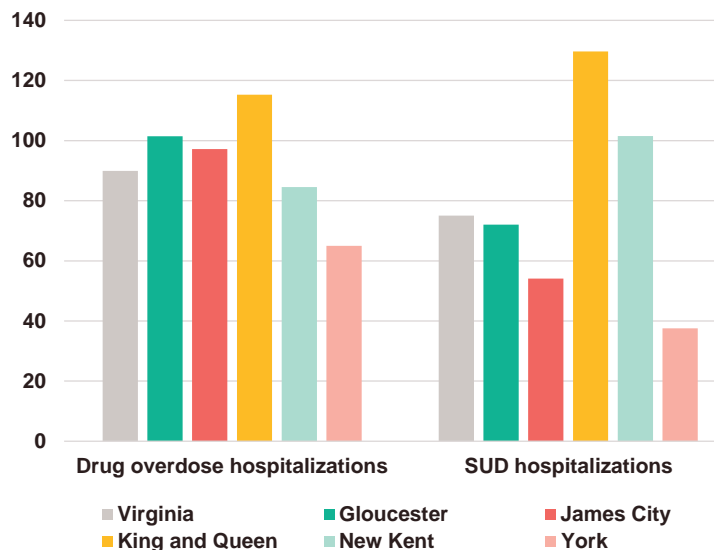


Figure 4 Source: Virginia's Plan for Well-Being

Mental health is becoming an increasing health concern for both adolescents and adults. Sentara examined emergency department visits for 2024 to gain a better understanding of the mental health crisis communities have been facing since the COVID-19 pandemic. In 2024, the SWRMC emergency department treated 429 adults (age 19+) with behavioral diagnoses. Of these visits, 20.3% of the patients presented with suicidal ideation, 5.6% with generalized anxiety disorder, 4.9% with major depressive disorder, and 2.6% with bipolar disorder.

Additionally, SWRMC saw 59 youth (age 0-18) present with behavioral health diagnoses. Of these visits, 33.9% presented suicidal ideation and 6.8% with generalized anxiety disorder. It is important to note that the mental health workforce is nearing retirement age, which will negatively impact provider capacity. There is also a need for greater racial and ethnic representation in the mental health workforce.³

Cancer

Since cancer is a leading cause of death in this community, death and incidence rates for a variety of cancer types were examined. Compared to the previous three-year rates, 2017-2021, the number of cases and deaths from the most common types of cancer are decreasing in the Commonwealth of Virginia, as well as this community.⁶ It is important to note that the incidence rates of breast cancer are rising for the White and Asian populations living in Virginia. Mortality rates were highest among lung and breast cancers, though declining in this community. Prostate and lung cancers are the leading causes of cancer death for Black populations living in Virginia. Staunton had the greatest incidence rates for all cancers (487.8 per 100,000).⁴ Medical advancements and community outreach programs providing cancer screenings and education are making strides but, to have the greatest impact, we will need to focus efforts on the populations at highest risk for various cancers.

Substance use and mental health, age 18+

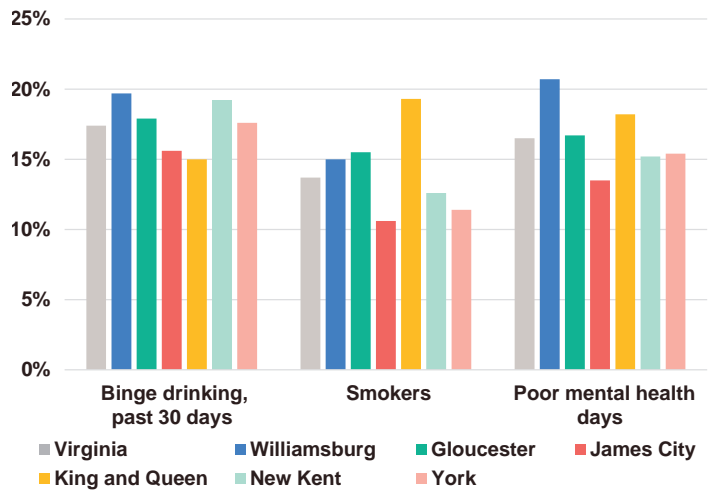


Figure 5 Source: Virginia’s Plan for Well-Being

Virginia cancer incidence rate, race/ethnicity

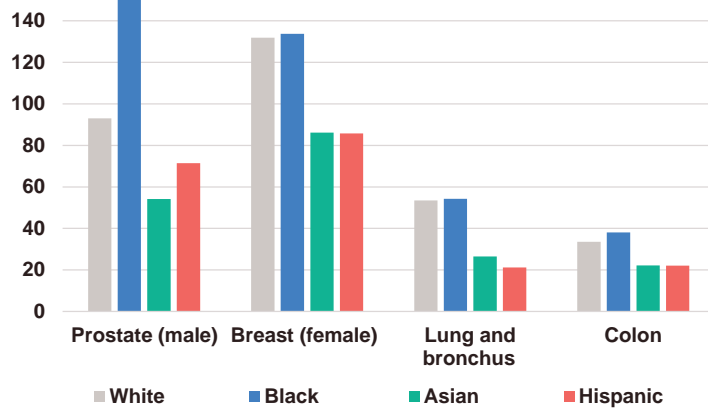


Figure 7 Source: Virginia’s Plan for Well-Being



Maternal and infant health

Unsupported and under-supported young families face many negative health outcomes and many long-term health challenges as time goes on, so looking at the way families begin can help us understand the current and future health of the community. A greater number of mothers in the service area (8.6%) had late or no prenatal care compared to Virginia (5.1%). The service area had slightly lower percentages of preterm births (8.7%) and babies born with low birth weights (6.8%) compared to the Commonwealth (9.6%, 8.5%). The infant mortality rate was greater in Gloucester (8.2 per 1,000) and New Kent (6.5) compared to Virginia (6.0). While teen pregnancies (65 from 2020-2022) are a community concern, the low numbers do not permit meaningful standardization for comparison to state rates.²

Maternal and infant health, 2020-2022

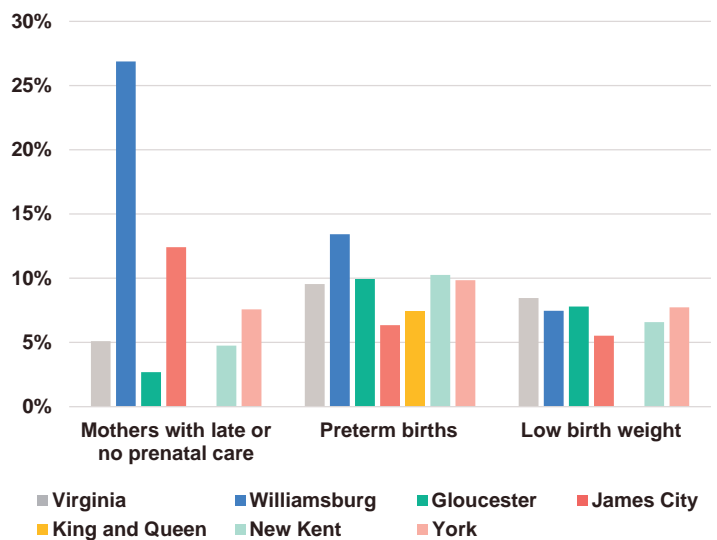


Figure 8 Source: Virginia's Plan for Well-Being

Diabetes

According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase and is the seventh leading cause of death in the United States. Risk factors such as obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity are also key risk factors. The percentage of adults living with diabetes in this community (12.6%) is slightly lower than the state percentage of 12.7%. Though, the SWRMC hospitalization rate, 2,140.63 (per 100,000), for diabetes was above the state rate of 2,114.24.²

Older and aging adults

In many communities, older adults are the fastest growing segment of the population. Challenges come with an aging population, including health-related factors and other factors that ultimately impact health. The percentage of Medicare recipients being seen for hypertension and diabetes, the top conditions for which patients received hospital treatment in this community, was higher in most communities in the service area compared to the state overall. The percentages of Medicare beneficiaries treated for Alzheimer’s disease or dementia in Williamsburg (7%) and James City (8%) are slightly higher than Virginia overall (6%).⁶ These conditions are important to note as they will impact the aging population’s health, quality of life, health care demand, and costs.

Collectively, SWRMC and SSCV are also working with the community to complete advance care plans. These plans are designed for adults to specify their medical wishes and/or designate someone as their medical decision-maker in the event they cannot communicate or advocate for themselves. While many team members working within the health care industry understand the importance and value of advance care plans, it is evident within the acute care setting that our community members may not have that same understanding until it is too late. Currently, within Virginia, there are approximately 48,271 active registrants with advance care plans filed within the U.S. Advance Care Planning Registry (formerly U.S. Living



Medicare primary chronic conditions, 2022

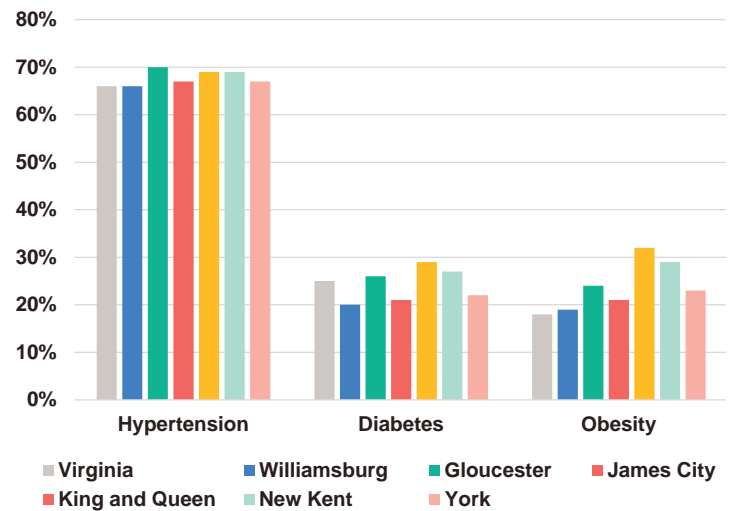


Figure 10 Source: Virginia’s Plan for Well-Being

Will Registry).⁷ Sentara has approximately 78,520 active registrants with advance care plans on file within the U.S. Advance Care Plan Registry, with 364 of those completed for residents of the SWRMC and SSCV community.

Surgical site infections

Surgical site infections (SSIs) occur after surgery and in the part of the body where the surgery took place. These infections can develop within days of the surgery or even months thereafter. Some patients may be at higher risk for developing an SSI due to their age and underlying medical conditions, such as diabetes and COVID-19 infections. "Data from AHRQ's Partnership for Patients" initiative indicates that the national rate of SSI decreased by 16% between 2010 and 2015, translating into significant benefits for patients (including many lives saved), as well as significant cost savings."⁸ Advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical techniques, and availability of

antimicrobial prophylaxis, yet SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death in the inpatient setting.⁹

SWRMC and SSCV prioritization

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

“Sentara Williamsburg Regional Medical Center aims to serve the unique needs of our diverse community. Being intentional about care delivery means gaining a deeper understanding of those needs, which this survey helps us achieve. In response to feedback and data analysis, we have made great strides in expanding access, designing spaces to meet the needs of our community, and gaining certifications that help us provide focused care. Sentara Williamsburg is the only hospital in Virginia with a Sensory Inclusive Certification, and offers the only Gold Level Geriatric ED. We have gained a deep understanding of the needs of our retirement population, as well as our growing pediatric population. People want to engage with us before they get sick, and focus on continued well-being and prevention. Because of that, we are prioritizing mental health access and support, classes, social isolation prevention, and wellness initiatives. We envision a future state where care comes to the patient, either virtually or in-person directly into their home, or through expanded mobile care.”

Amber Price
SVP, Chief Nursing Officer, Sentara Health

Recommendations

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



Improve mental well-being



Improve chronic conditions and avoidable health outcomes



Address and invest in social determinants of health

Conclusion

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

Endnotes

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Supplemental resources

2023-2025 Implementation strategy progress summary

The previous CHNA identified several health issues in the service area. The Sentara Williamsburg Regional Medical Center (SWRMC) and Surgical Suites of Coastal Virginia (SSCV) implementation strategy progress report was developed to document activities addressing health needs identified in the 2022 CHNA report through both primary and secondary data sources. By identifying the most pressing health concerns within a community, the 2022 assessment assisted in setting priorities for health interventions and resource allocation to advance health based on patient demographic data and community insight.

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

- Behavioral health
- Chronic diseases
- Social determinants of health

Behavioral health

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

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

To address maternal mental health, SWRMC and SSCV work to provide postpartum classes, providing information about baby blues and Perinatal Mood Anxiety Disorders, the number one complication of pregnancy and childbirth. The class discusses warning signs and resources to get help. A postpartum support group is also offered with a perinatal mental health certified nurse who facilitates the group for postpartum women with a baby under the age of one year. Evidence shows the importance of social support for mental wellness during the postpartum period.

To increase community awareness and reduce stigma, Sentara partnered with the Virginia Stage Company to support an inspirational play about mental health.

“Every Brilliant Thing” is an intimate, interactive performance which continues to be brought to communities throughout Virginia and North Carolina. Three events were held in this community, reaching 155 community members.

Sentara, SWRMC, and SSCV also partnered with Bon Secours, CHKD, Riverside Health, and the Hampton and Peninsula Health Districts to provide “Hiding in Plain Sight,” a youth mental health documentary with local panel discussion at a local middle school to begin the mental health discussion between teens and parents.

Chronic diseases

Together, SWRMC and SSCV are working to reduce the impact of chronic diseases on morbidity and mortality for the community living in the service area by increasing disease management support, resources, and education in the community, where life happens. Sentara brings prevention, hope, inspiration, and support to our local community where SWRMC and SSCV are working to reduce chronic disease impact. The SSCV team works with patients and their families to provide multiple resources and tools regarding mental health and chronic diseases.

Both SWRMC and SSCV participate in the Chronic Care Collaborative (CCC), which was founded by the Williamsburg Health Foundation in 2007 with the mission of strengthening the care of chronic diseases among the uninsured and under-insured in Greater Williamsburg.

The cancer educators implement programs focused on cancer prevention and detection and provide community outreach by hosting and participating in screening and education events. Local cancer screening events for oral, head, and neck cancers, FIT testing for colorectal cancer, breast cancer mammography screening, and skin cancer screening events are offered. We continue to remove barriers to wellness for uninsured or underinsured women for mammography, including supplementing traditional

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

Social determinants of health

Each hospital has implemented the use of Unite Us, a cross-sector collaboration software establishing a new standard of care that identifies social needs in communities, manages enrollment of individuals in services, and leverages meaningful outcomes data and analytics to further drive community investment. To increase economic growth, job security, and educational opportunities, SWRMC and SSCV continue to collaborate with multiple colleges and universities to provide fellowships, internships, and preceptorships for health care professionals and students.

Grantmaking and community benefit

In the 2024 implementation strategy process, Sentara and hospital facilities planned for and drew on a broad array of resources and strategies for vulnerable populations, such as grant making, in-kind resources, collaborations, and partnerships.

Grant allocations and awards are strategically awarded based on our plan. For example, the social determinants of health focus area is supported by grants to include the Community of Faith Mission Emergency Shelter Program, Williamsburg Area Meals on Wheels, Williamsburg House of Mercy Food Pantry, Habitat for Humanity, and the School Health Initiative Program. For behavioral health, a \$100,000 grant was made to Bacon Street Youth and Family Services to increase mental health services for low-income youth and their families, and a strategy of collaborating with NAMI Williamsburg, the Alzheimer’s Foundation, and Senior Advocates was launched.

In 2023, Sentara invested more than \$294 million in the communities we serve — \$47 million in community giving, \$13 million in health and prevention programs,

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

Community health is defined by much more than medical care. As more is known about the role of social determinants of health, more opportunities will arise to influence population health by engaging in community approaches to care. Beyond the scope of SWRMC and SSCV alone, these opportunities will require active partnerships among local organizations and individuals to create lasting impact.

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



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



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



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



Serving the city of Williamsburg, and the counties of Gloucester, James City, King and Queen, New Kent, and York.

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