Community Health Needs Assessment

Study Report 2024

VCUHealth™
Community Memorial Hospital

CHNA Study Report

VCU Health Community Memorial Hospital

June 27, 2024

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Executive Summary

This report presents the results of a Community Health Needs Assessment (CHNA) conducted by VCU Health Community Memorial Hospital for the six-county region served by the hospital.[1]. The CHNA study was guided by the team from VCU Health and a Community Advisory Group of community stakeholders. This executive summary describes the study approach and summary insights. Sections 1 through 4 provide additional details on the study results.

Executive Summary Outline	
A	Study Approach
B	Health-Related Social and Economic Factors
C	Access to Health Care Services
D	Access to Community Services and Supports
E	The Health Environment
F	Health Behaviors
G	Working Together as a Community
H	Organization of the Report

A. Study Approach

The CHNA study was focused on a six-county region which encompasses the primary zip codes served by the hospital. As shown in **Exhibit 1**, this region was home to an estimated 102,549 residents as of 2023.

Exhibit E-1
The Study Region

Estimated 2023 Population	
Total	102,549
Brunswick (VA)	15,623
Charlotte (VA)	11,271
Lunenburg (VA)	11,762
Mecklenburg (VA)	30,096
Nottoway (VA)	15,480
Warren (NC)	18,317

Source: CHS analysis of population estimates from ESRI, obtained through ArcGIS Business software.

The CHNA study was designed to provide insights about community health needs as well as ideas for how community partners can work together for community health improvement. Research activities for the study included a survey of community residents, a survey of community stakeholders (professionals working in organizations that service the community), and analysis of community health and demographic indicators. In addition, the hospital has engaged a Community Advisory Group and initiated a series of community interviews and events to continue obtaining community insight on an ongoing basis.

The remainder of this Executive Summary provides a synthesis of the study findings, focusing on health-related social and economic factors, access to services, the health environment, health behaviors, and ideas for how community partners can work together for community health improvement. The full report is organized into four sections as shown below. Data sources and methods are described in the four main sections of the report, and also in Appendix A.

- Section 1 describes health-related social and economic factors that can influence health status and access to health supports.
- Section 2 presents detailed results from the survey of community residents.
- Section 3 presents detailed results from the survey of community stakeholders.
- Section 4 provides a series of community health indicator profiles with measures of multiple health factors across the region.

[1] Community Health Solutions was retained to provide research and writing support for this report.

B. Health-Related Social and Economic Factors

Section 1 of the report reviews key social and economic factors that can influence health status and access to health services and supports for community residents. These factors are often called **social determinants of health**, or **social drivers of health**. **Exhibit E-2** shows summary insights from Section 1.

- □ Community health within the six-county region is shaped by health-related demographic factors including the rural setting, substantial numbers of people living with low income, an aging population, and a substantial population of Black / African American residents.

- □ When asked to identify people in their neighborhood or community who need help obtaining better health, community survey respondents identified older adults, children and families, low-income populations, minority populations, people with disabilities, and young adults.

- □ Research shows that social and economic factors can also influence health disparities, or differences in health status and access to health supports among different populations. Data on health disparities are limited at the local level, but an available set of statewide and regional measures indicate that health disparities affecting the Black / African American population include higher rates of poverty, early mortality (deaths before age 75), infant mortality, and selected types of cancer, and communicable disease. Additional populations may also be affected by health disparities based on their age, income, race, ethnicity, or other factors.

Exhibit E-2
Summary Insights about Health-Related Social and Economic Factors

Health-related demographic factors (estimates):
□ Six counties
□ Rural setting
□ Population of 102,249 in 2023
□ 18% living in poverty
□ 25% age 65 or older
□ 40% Black / African American
□ 4% Hispanic
□ Higher scores on the Social Vulnerability Index

People who need help as identified in the community resident survey:
□ Older adults
□ Children and families
□ Low income population
□ Minority populations
□ People with disabilities
□ Young Adults

Areas to explore for potential health disparities affecting Black / African American populations:
□ Higher poverty rate
□ Higher infant mortality rate
□ Higher early mortality rate
□ Higher incidence and mortality rates for some cancers
□ Higher rates for some communicable disease
□ Higher rates of ED visits for some mental health issues.

C. Access to Health Care Services

Access to health care services is a national, state, and local concern, especially in rural areas. **Exhibit E-3** shows summary insights on access to health care from the community resident survey, the community stakeholder survey, and the community health indicator profiles.

- The most frequently identified concerns identified by community residents included access to dental care, mental health care, services for weight control, affordable health insurance, and elder care services. Community residents also provided insights about particular obstacles to obtaining health care, and problems finding health care services within the community.
- The most frequently identified concerns identified by community stakeholders included access to mental health services, substance use services, dental services, affordable health insurance, and medical specialty services. Community stakeholders also identified particular health concerns in the community, all of which require access to health care services.
- Community indicators support community members' concerns about access, with all six counties being designated as health professional shortage areas for primary care, mental health care, and dental care.

Exhibit E-3
Summary Insights about Access to Health Care Services

From Section 2 Community Resident Survey (n=98 total)

Top five concerns about access identified by 95 respondents (n and % shown below):		
Dental health services	68	72%
Mental health services	57	60%
Services for weight control	50	53%
Affordable health insurance	48	51%
Medical specialty services	46	48%

Particular obstacles to obtaining health care services. Top five identified by 97 respondents (n and % shown below):		
Waiting time to get appointments	57	59%
High cost of out-of-pocket expenses	51	53%
Needed specialty care not available locally	50	52%
Long wait times in the emergency room	44	45%
Lack of provider follow-through	39	40%

Concerns about availability of local services identified by 94 respondents.		
Respondent or family member have had to travel outside the community to receive health services not available here	71	76%
Respondent or family member have needed services not available at VCU Health Community Memorial Hospital or elsewhere in the local community	55	59%

From Section 3 Community Stakeholder Survey (n=61 total)

Top five concerns about access identified by 60 respondents (n and % shown below):		
Mental health services	45	75%
Substance use services	38	63%
Dental services	37	62%
Affordable health insurance	36	60%
Elder care services	34	57%

Top five concerns about particular health conditions identified by 61 respondents (n and % shown below):		
Mental health conditions	50	82%
Adult obesity / overweight	49	80%
Substance use disorder - drugs	44	72%
Cancer	42	69%
Substance use disorder - alcohol	37	61%

From Section 4 Related Community Indicators

From community indicator profiles:

- All six counties designated as health professional shortage areas in primary care, mental health care, and dental care
- Population segments with substantial health care needs include at-risk mothers & infants, children with special health care needs, adults with chronic conditions, people with disabilities, and older adults.
- Compared to statewide rates, higher local rates of arthritis, asthma, chronic obstructive pulmonary disease, coronary heart disease, drug overdose death, diabetes, disability, high blood pressure, infant mortality, injury, premature death (before age 75), self-reported poor mental health, tooth loss, and substance use hospitalizations.
- Health disparities as noted in Section 1.

D. Access to Community Services and Supports

Community services and supports beyond clinical health care are also vitally important for helping community members attain and sustain good health and well-being. **Exhibit E-4** shows summary insights on access to community services and supports from the community resident survey, the community stakeholder survey, and the community health indicator profiles.

- ☐ The most frequently identified concerns identified by community residents and community stakeholders included various services for older adults and for children.

- ☐ Focusing on related community indicators, the study region has multiple population segments that need community services and supports beyond health care, including at-risk mothers and infants, children with special health care needs, adults with complex care needs, people with disabilities, and older adults. Community services and supports can be essential for helping these populations maintain healthy lifestyles and manage their conditions in the home and community setting.

Exhibit E-4
Concerns about Access to Community Services and Supports

Section 2 — Community Resident Survey (n=98 total)

Top five concerns identified by 98 respondents (n and % shown below):		
Eldercare services	64	65%
Services for older adults	60	61%
Long term care services	56	57%
Childcare services	56	57%
After school programs	49	50%
Assisted living services	49	50%

Section 3 — Community Stakeholder Survey (n=61 total)

Top five concerns identified by 61 respondents (n and % shown below):		
Services for older adults	39	65%
Elder care services	37	62%
Childcare services	36	60%
Services for children with special needs	36	60%
Services for adults with disabilities	35	58%

Section 4 — Related Community Indicators

From community indicator profiles:
☐ Population segments in need of community services and supports include at-risk mothers and infants, children with special health care needs, adults with chronic conditions, people with disabilities, and older adults.
☐ Estimated 25,181 residents (25%) age 65+
☐ Estimated 39,988 residents (41%) at or below 200% poverty
☐ Estimated 15,646 residents (19.6%) with a physical or intellectual disability

E. The Health Environment

The community health environment can have a powerful impact on the ability of community residents to adopt and sustain healthy lifestyles. **Exhibit E-5** shows summary insights about the health environment from the community resident survey, the community stakeholder survey, and the community health indicator profiles.

- The most frequently identified concerns identified by community residents and /or community stakeholders included access to healthy foods, public transportation, spaces for walking, community events and activities for health, school safety, and housing.

- In addition to being a rural region with associated transportation challenges, the study region has substantial numbers of low-income residents, older adult residents, and residents with disabilities. Accessibility to heathy lifestyle supports such as transportation and healthy food can be particularly challenging for these populations.

Exhibit E-5
Summary Insights about the Health Environment

From Section 2
Community Resident Survey
(n=98 total)

Top five concerns identified by 96 respondents (n and % shown below):		
Access to healthy foods	59	61%
Access to public transportation	50	52%
Spaces for walking	45	47%
Community events and activities for health	37	39%
School safety	35	36%

From Section 3
Community Stakeholder Survey
(n=61 total)

Top five concerns identified by 61 respondents:		
Access to healthy foods	42	70%
Access to public transportation	35	58%
Community events and activities for health	29	48%
School safety	25	42%
Housing safety	23	38%

From Section 4
Related Community Indicators

From community indicator profiles:
□ Rural region
□ Estimated 25,181 residents (25%) age 65+
□ Estimated 39,988 residents (41%) at or below 200% poverty
□ Estimated 15,646 residents (19.6%) with a physical or intellectual disability

F. Health Behaviors

Healthy behaviors are vitally important for preventing and managing adverse health conditions and events. **Exhibit E-6** shows summary insights about the health environment from the community resident survey, the community stakeholder survey, and the community health indicator profiles.

- ☐ The most frequently identified concerns identified by community residents and /or community stakeholders included substance use, unhealthy eating, sedentary lifestyle, bullying, vaping, and alcohol use.
- ☐ Focusing on related community indicators, there are concerns about youth and adults in relation to rates of drug use, alcohol use, tobacco use, vaping, bullying, and lack of physical activity.

Exhibit E-6
Concerns about Health Behaviors

From Section 2 – Community Resident Survey (n=98 total)

Top five concerns identified by 93 respondents (n and % shown below):		
Substance use (illegal drugs)	70	75%
Unhealthy eating habits	66	71%
Sedentary lifestyle	64	69%
Substance use (prescription drugs)	57	61%
Bullying (at school, online, in community)	56	60%

From Section 3 – Community Stakeholder Survey (n=61 total)

Top five concerns identified by 61 respondents (n and % shown below):		
Substance use (illegal drugs)	53	87%
Unhealthy eating habits	47	77%
Vaping	43	70%
Sedentary lifestyle	43	70%
Alcohol use	42	69%

From Section 4 – Related Community Indicators

From community indicator profiles:

- ☐ Drug overdose death rate higher in study region than statewide rate in 2016-2020 timeframe
- ☐ rates of death and hospitalization for injury higher than statewide rates.
- ☐ rates for some communicable diseases higher than statewide rates.
- ☐ Hospitalization rates for substance use higher than statewide rates in 2020
- ☐ Compared to statewide rates, higher rates of smoking, insufficient sleep, and no leisure-time physical activity
- ☐ Based on a statewide survey of high school youth, concerns about alcohol use, marijuana use, mental health, driving at risk, vaping, and bullying.

G. Summary Insights from Community Indicators

Section 1 of the report describes social and economic factors that can affect community heath, and Section 4 presents a series of community health indicator profiles. **Exhibit E-7** outlines summary insights based on differences between local rates and statewide rates, indicators of disparity, or both.

Exhibit E-7 **Summary Insights from Community Indicators**		
Section 1. Health-Related Social and Economic Factors		
Social and Economic Profile (Exhibits 1.1 – 1.10)	Higher local prevalence compared to state:	Rural population Low-income population Older adult population Black / African American population
Health Disparity Profile (Exhibit 1.11)	Based on available measures at the state and regional level, potential disparities affecting Black / African American populations:	Low-income status Infant mortality Premature death (years of potential life lost) Cancer incidence and mortality Communicable disease incidence Utilization of ED for mental heath
Section 4. Community Health Indicator Profiles		
Health Care Access Profile (Exhibit 4.2)	Differences as noted compared to state:	Primary care physicians (lower local supply) Dentists (lower local supply) Mental health care providers (lower local supply) Potentially avoidable hospitalizations (higher local rates)
Mortality Profile (Exhibit 4.3)	Higher local rates compared to state:	Premature death (years of potential life lost) Common causes of death
Maternal and Infant Health Profile (Exhibit 4.4)	Higher local rates compared to state:	Low weight births Preterm births Teen pregnancy Infant mortality
Youth Health Risk Profile (Exhibit 4.5)	Statewide concerns about:	Alcohol and marijuana use Depression and suicide Driving risk Vaping Violence and bullying
Adult Health Risk Profile (Exhibit 4.6)	Higher local rates compared to state:	Self-described poor health Smoking Insufficient sleep Lack of leisure-time physical activity
Adult Health Screening Profile (Exhibit 4.7)	Lower local rates compared to state:	Colorectal cancer screening Older adult screening
Chronic Condition Profile (Exhibit 4.8)	Higher local rates compared to state:	Arthritis Chronic Obstructive Pulmonary Disease Coronary Heart Disease Diabetes High Blood Pressure Overweight (BMI >30) Disability
Communicable Disease Profile (Exhibit 4.9)	Higher local rates compared to state:	Chlamydia Gonorrhea HIV/AIDS
Oral Health Profile (Exhibit 4.10)	Differences as noted compared to state:	Self-reported loss of natural teeth (higher local rates) Self-reported recent dental visit (lower local rates)
Mental Health Profile (Exhibit 4.11)	Higher local rates compared to state:	Self-reported poor mental health Self-reported depression Deaths by suicide
Substance Use Profile (Exhibit 4.12	Higher local rates compared to state:	Drug overdose deaths Hospitalizations for substance use Alcohol-involved crash deaths
Injury Profile (Exhibit 4.13)	Higher local rates compared to state:	Unintentional injury deaths Motor vehicle traffic crash deaths Hospitalization for injury

H. Working Together as a Community

Community health improvement requires collaboration among community organizations. With this vision in mind, the survey respondents were invited to share ideas for how community partners can work together to help community members obtain better health. The survey items were phrased in different ways across the two surveys, with the results summarized in **Exhibit E-8**.

Exhibit E-8
Ideas for Working Together as a Community

From Section 2
Community Resident Survey
(n=98 total)

Areas where community partners can help community members obtain better health. Top five themes identified in 35 write-in responses:	
Hospital services	n=12
Access to health care services**	n=11
Transportation	n=7
Access to health-related social supports	n=7
Mental health services	n=4

** Specific issues mentioned in the 'access to health care services" theme included primary care, specialty care, dental care, pulmonology, radiology, and lab services.

From Section 3
Community Stakeholder Survey
(n=61 total)

Community resources that could be leveraged to improve health and health care. Resources mentioned in 24 write-in responses (alphabetical order):

☐ After school programs	☐ Mental health services
☐ Biking spaces	☐ Parks & recreation
☐ Community support groups	☐ Transportation
☐ Home maintenance supports for seniors	☐ Urgent care
☐ Internet access for all	☐ Walking spaces
☐ Medical specialty care	☐ Water safety classes

Top three things we should do as a community to bridge healthcare access gaps and reduce health disparities in our community. Focus areas mentioned in 24 write-in responses (in alphabetical order):

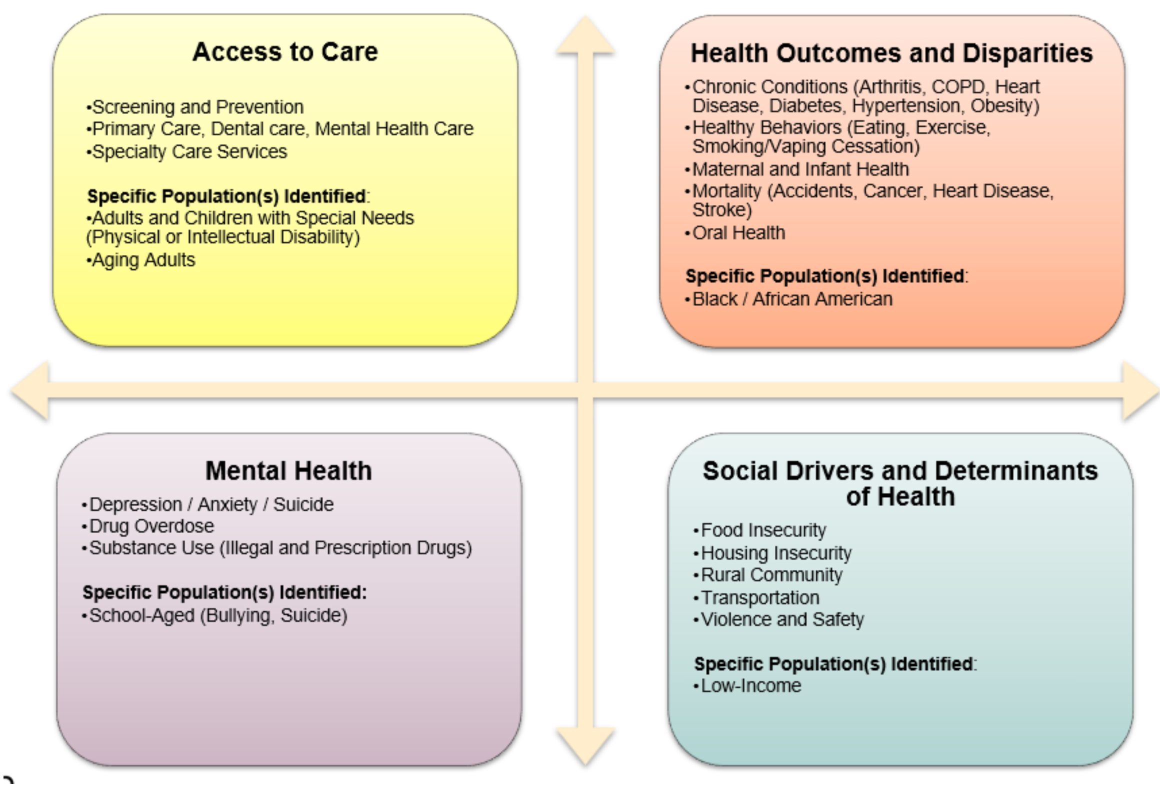
☐ Affordable health insurance	☐ Health equity
☐ Better communication & collaboration	☐ Health screening
☐ Community outreach to people in need	☐ Mental health awareness
☐ Community spaces & supports for healthy eating / active living	☐ Medical specialty care
☐ Community support groups	☐ More health care providers & resources
☐ Free clinics	☐ Transportation
	☐ Weekend clinics

H. Summary of Needs Emerging from the CHNA Study

Exhibit E-9 shows several themes emerging from the community insights and community data analyzed for this study.

- Needs to improve access to care are apparent in screening and prevention, primary care, dental care, mental health care, and specialty care services.
- Needs related to social drivers and determinants of health are also apparent, as food insecurity, housing insecurity, the rural setting, transportation gaps, personal safety risks, and low income can have a profound influence on health status and access to services and supports.
- Access to care and social supports are needed to improve health outcomes and address disparities related to chronic conditions, healthy behaviors, maternal and infant health, injury prevention, oral health. Access and social supports are also needed to address mental health concerns for adults and children in the region.

Exhibit E-9
Summary of Needs Emerging from the CHNA Study



Section 1. Health-Related Social and Economic Factors

The purpose of this community health needs assessment is to identify health needs within the six-county region served by VCU Health Community Memorial Hospital. As context for the assessment it is helpful to consider that health needs can be affected by social and economic factors that may influence health status and access to health services and supports. This section provides definitions of key concepts along with data and maps for exploring social and economic factors in community health.

Section 1 Outline	
A	Key Concepts
B	Community Indicator View
C	Exploring Health Disparities

A. Key Concepts

Research shows that social and economic factors can contribute to health inequities that in turn contribute to health disparities. With these dynamics in mind, this report uses the following definitions in exploring social and economic factors in community health.

- **Community health status** is defined as the health status of the community population, including differences in health status among community population segments.
- **Determinants of health**. Determinants of health are defined as factors that can influence health for individuals and populations, including the social and economic environment, the physical environment, and individual characteristics and behaviors.[2]
- **Social determinants of health** can be defined as non-medical factors in the social and economic environment that affect health outcomes. Commonly used categories of social determinants include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.[3]
- **Health disparities** can be defined as particular types of health differences that are closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[4]
- **Health equity** can be defined as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to address historical and contemporary injustices, overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities.[5]

The remainder of this section explores health-related social and economic factors as potential determinants or drivers of health and health disparities in the six-county region.

[2] World Health Organization. https://www.who.int/news-room/questions-and-answers/item/determinants-of-health
[3] CDC. https://health.gov/healthypeople/priority-areas/social-determinants-health
[4] CDC https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030
[5] CDC https://www.cdc.gov/healthequity/whatis/index.html

B. Community Indicator View

As a starting point for exploring social and economic factors, it is helpful to consider the characteristics and geographic distribution of the community population. The following ten exhibits provide a community indicator view of health-related social and economic factors in the region.

Exhibit	Title
1.1	Selected County-Level Indicators
1.2	Social Vulnerability Index, 2020
1.3	Estimated Median Household Income, 2023
1.4	Estimated Population in Poverty, 2021
1.5	Estimated Poverty-plus-ALICE Households, 2021
1.6	Estimated Senior Population Age 65+, 2023
1.7	Estimated Child Population Age 0-17, 2023
1.8	Estimated Households with 1 or more Persons with a Disability, 2021
1.9	Estimated Black / African American Population, 2023
1.10	Estimated Hispanic Population, 2023

Selected County-Level Indicators

Exhibit 1.1 shows selected indicators for which the study region differs from the statewide demographic profile for Virginia**.** As shown, the study region is more rural, has a higher proportion of low-income residents, is older, and has a higher proportion of Black / African American residents.

Exhibit 1.1
Selected County-Level Indicators

Indicators (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Warren, NC	Study Region	Virginia State
Total Population (2023)	15,623	11,271	11,762	30,096	15,480	18,317	102,549	8,787,063
Population Density (per sq mile)	27.6	23.7	27.2	48.1	49.2	42.8	36.1	222.5
Population at or below 100% of poverty (2021)	18%	19%	14%	18%	17%	19%	18%	10%
Population at or below 200% of poverty (2021)	41%	39%	38%	39%	42%	45%	41%	24%
Age 65 or older (2023)	22%	24%	23%	28%	20%	25%	25%	17%
Black or African American (2023)	54.8%	27.7%	32.3%	34.9%	37.6%	49.0%	39.8%	18.7%

Source: CHS analysis of data from ESRI obtained through ArcGIS Business software.

It is also helpful to explore population differences within county boundaries, at the census tract level. **Exhibits 1.2 through 1.10** provide tables and maps for this purpose, beginning with the Social Vulnerability Index.

The Social Vulnerability Index

The *Social Vulnerability Index* as published by the CDC is a single indicator of social and economic vulnerability for community populations. As shown in the box at right, the Social Vulnerability Index is based on multiple social and economic factors that can make community populations more vulnerable for health-related risks. The factors include measures of poverty, employment, education, age, disability family structure, minority status, language, and housing status. Given these factors, the Social Vulnerability Index can be helpful for identifying communities where people may be at higher risk for social and economic challenges that can affect health status and access to health services and supports.

Exhibit 1.2 shows the Social Vulnerability Index for the study region as of 2020. The index is on a scale from 0 to 1.00, with higher values indicating higher social and economic vulnerability for the local population. The county view within the exhibit shows the study region counties had Index values above the statewide value of .40 in 2020, indicating higher social and economic vulnerability. The map shows multiple census tracts with high levels of social and economic vulnerability, as indicated by darker blue shading.

Factors Included in the Social Vulnerability Index

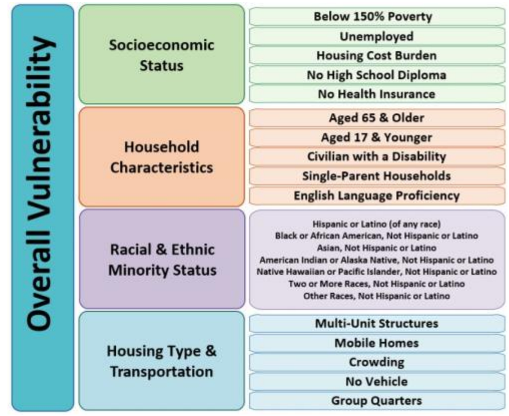
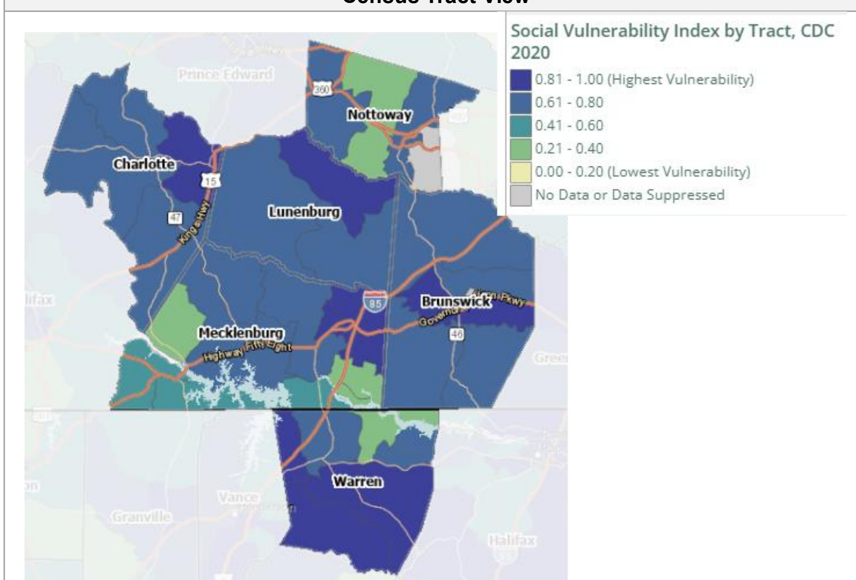


Exhibit 1.2
Social Vulnerability Index, 2020

County View	Index Score	
Brunswick, VA	.87	*
Charlotte, VA	.80	*
Lunenburg, VA	.82	*
Mecklenburg, VA	.65	*
Nottoway, VA	.83	*
Warren, NC	.97	*
Virginia	.40	

County Index > Virginia Index	*

Census Tract View



Source: Virginia Community Health Improvement Data Portal, May 2024, based on Social Vulnerability Index values from the CDC.

Low Income

Low income is a widely recognized risk factor for health disparities in health status and access to health supports at the community level. Income levels are explored in the following three exhibits, showing median household income, the population living in poverty, and 'poverty plus ALICE' households.

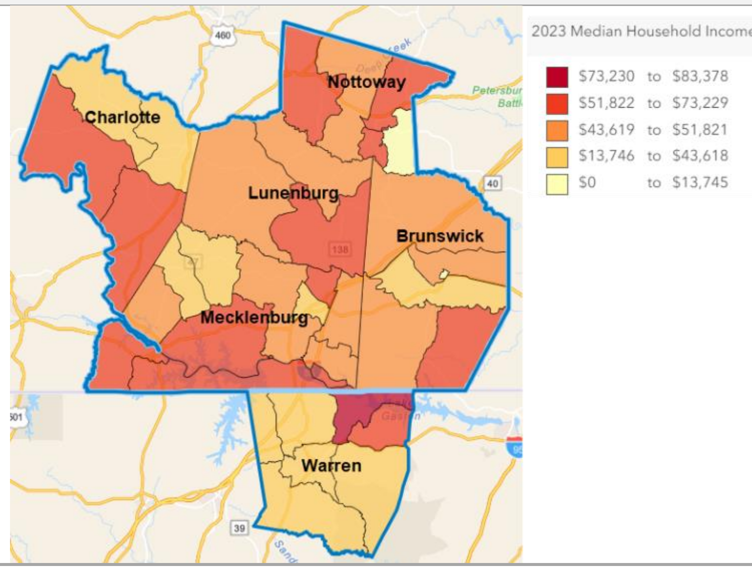
As shown in **Exhibit 1.3**, in 2023 all counties in the study region had estimated median household income below the Virginia statewide median of $83,550.

Exhibit 1.3
Estimated Median Household Income, 2023

County View	Total	
Brunswick, VA	$46,223	*
Charlotte, VA	$47,602	*
Lunenburg, VA	$48,564	*
Mecklenburg, VA	$46,552	*
Nottoway, VA	$54,533	*
Warren, NC	$43,449	*
Virginia	$83,550	

County median < Virginia median	*

Census Tract View



Source: CHS analysis of ESRI population estimates extracted using ArcGIS Business Software

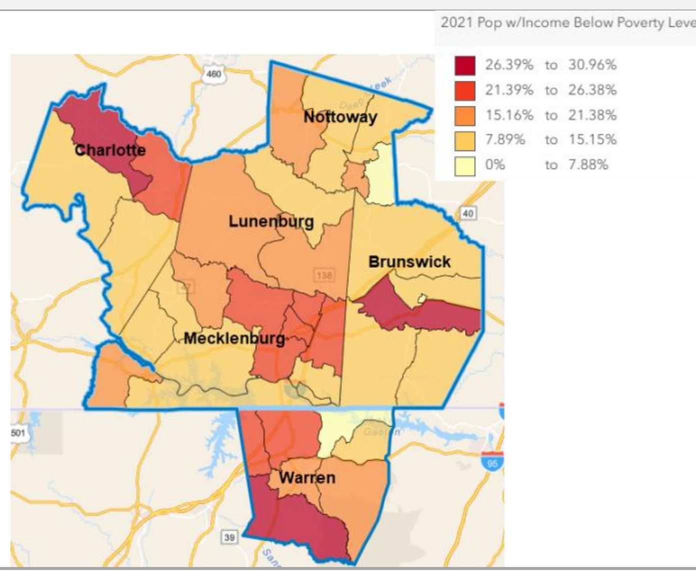
As shown in **Exhibit 1.4,** in 2021 there were an estimated 17,220 individuals living in poverty, and all study region counties had poverty rates above the statewide rate of 10%.

Exhibit 1.4
Estimated Population in Poverty, 2021

County View	Total	Percent	
Brunswick, VA	2,406	18%	*
Charlotte, VA	2,175	19%	*
Lunenburg, VA	1,550	14%	*
Mecklenburg, VA	5,272	18%	*
Nottoway, VA	2,306	17%	*
Warren, NC	3,511	19%	*
Study Region	17,220	18%	*
Virginia	828,664	10%	

County percent > Virginia percent	*

Census Tract View



Source: CHS analysis of ESRI population estimates extracted using ArcGIS Business Software

As shown in **Exhibit 1.5**, in 2021 there were an estimated 16,172 'poverty plus ALICE' households in the Virginia study region counties . ALICE is an acronym for households that have income above poverty, but are Asset Limited, Income Constrained, and Employed. These households earn above the Federal Poverty Level (FPL) but may still have difficulty affording the basic cost of living in their county. Despite struggling to make ends meet, ALICE households often do not qualify for public assistance. The figures shown in the exhibit represent the number of households in poverty plus the number of ALICE households in each county. All five Virginia counties had a percentage of poverty-plus-ALICE households above the statewide percentage as of 2021.

Exhibit 1.5
Poverty plus ALICE Households, 2021

County View	Total Households	Estimated Households: Poverty plus ALICE	Estimated Percent: Poverty plus ALICE	
Brunswick, VA	5,905	3,071	52%	*
Charlotte, VA	4,606	2,303	50%	*
Lunenburg, VA	4,304	2,367	55%	*
Mecklenburg, VA	12,655	6,201	49%	*
Nottoway, VA	5,309	2,230	42%	*
Virginia	3,288,768	1,249,732	38%	
Warren, NC	(nr)	(nr)	(nr)	

County percent > Virginia percent	*

Source: CHS analysis of data from United for ALICE, May 2024. https://www.unitedforalice.org/state-overview/Virginia

Older Adults

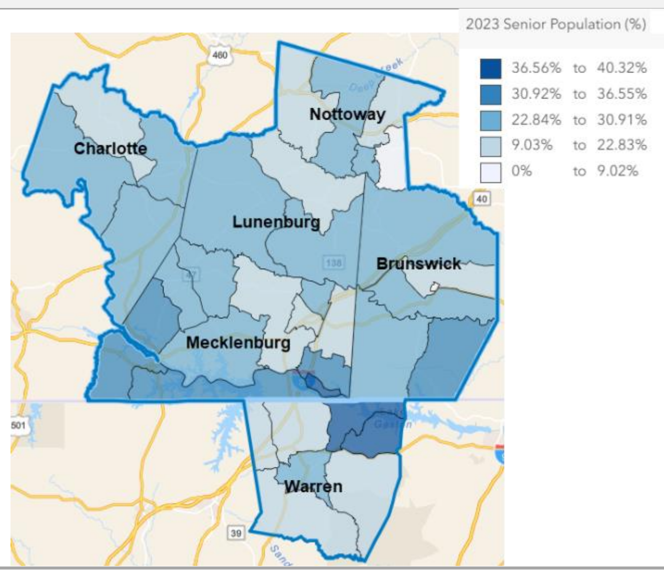
As shown in **Exhibit 1.6**, in 2023 there were an estimated 25,181 older adults in the study region, and all six counties had a higher percentage of seniors than the statewide rate of 17%.

Exhibit 1.6
Estimated Senior Population Age 65+, 2023

County View	Total	Percent	
Brunswick, VA	3,492	22%	*
Charlotte, VA	2,677	24%	*
Lunenburg, VA	2,732	23%	*
Mecklenburg, VA	8,449	28%	*
Nottoway, VA	3,168	20%	*
Warren, NC	4,663	25%	*
Study Region	25,181	25%	*
Virginia	1,518,249	17%	

County percent > Virginia percent	*

Census Tract View



Source: CHS analysis of ESRI population estimates extracted using ArcGIS Business Software

Children

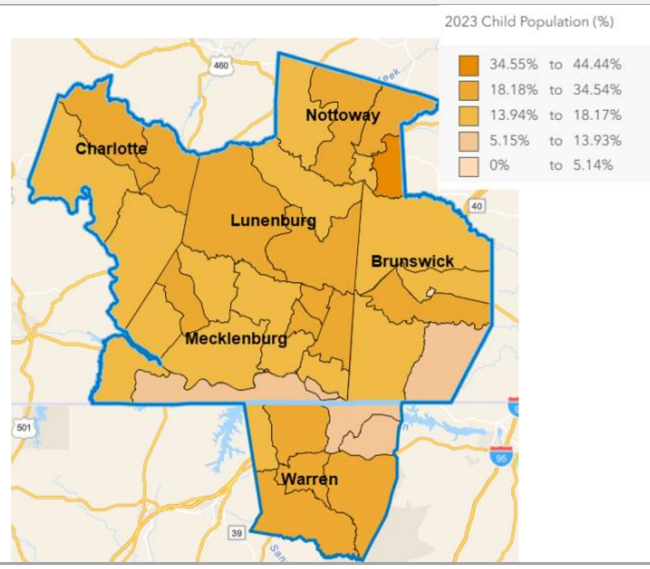
As shown in **Exhibit 1.7**, as of 2023 there were an estimated 17,917 children in the study region, and all six counties had a lower percentage of children than the statewide rate of 21%.

Exhibit 1.7
Estimated Child Population Age 0-17, 2023

County View	Total	Percent	
Brunswick, VA	2,442	16%	
Charlotte, VA	2,160	19%	
Lunenburg, VA	2,141	18%	
Mecklenburg, VA	5,098	17%	
Nottoway, VA	2,786	18%	
Warren, NC	3,290	18%	
Study Region	17,917	17%	
Virginia	1,859,754	21%	

Higher than Virginia percent	none

Census Tract View



Source: CHS analysis of ESRI population estimates extracted using ArcGIS Business Software

Households with Disabilities

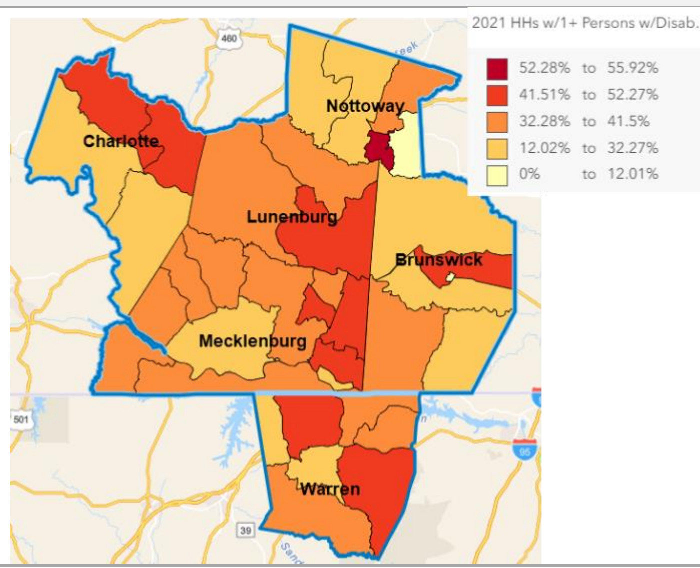
As shown in **Exhibit 1.8**, in 2021 there were an estimated 14,870 households where at least one member had a disability, and all six counties had a higher percentage of these households than the statewide rate of 24%. The scope of disability could be physical, intellectual, or both. The map within the exhibit illustrates variation in the percentage of households having a member with a disability at the census tract level.

Exhibit 1.8
Estimated Households with 1 or more Persons with a Disability, 2021

County View	Total	Percent	
Brunswick, VA	1,943	33%	*
Charlotte, VA	1,750	38%	*
Lunenburg, VA	1,687	39%	*
Mecklenburg, VA	4,662	37%	*
Nottoway, VA	1,902	36%	*
Warren, NA	2,926	38%	*
Study Region	14,870	37%	*
Virginia	776,691	24%	

County percent > Virginia percent	*

Census Tract View



Source: CHS analysis of ESRI population estimates extracted using ArcGIS Business Software

Black / African American Population

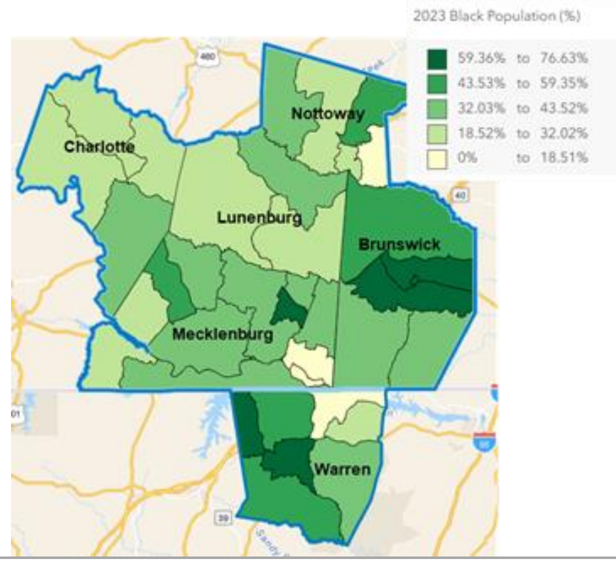
As shown in **Exhibit 1.9**, in 2023 the study region was home to an estimated 40.783 Black / African American residents. This population represented about 40% of the regional population, and all six counties had a higher percentage of Black / African American residents than the statewide rate of 19%. The map within the exhibit illustrates variation in the percentage of Black / African American residents at the census tract level.

Exhibit 1.9
Estimated Black or African American Population, 2023

County View	Total	Percent	
Brunswick, VA	8,565	55%	*
Charlotte, VA	3,121	28%	*
Lunenburg, VA	3,796	32%	*
Mecklenburg, VA	10,507	35%	*
Nottoway, VA	5,819	38%	*
Warren, NC	8,975	49%	*
Study Region	40,783	40%	*
Virginia	1,643,218	19%	

County percent > Virginia percent	*

Census Tract View



Source: CHS analysis of ESRI population estimates extracted using ArcGIS Business Software

Hispanic Population

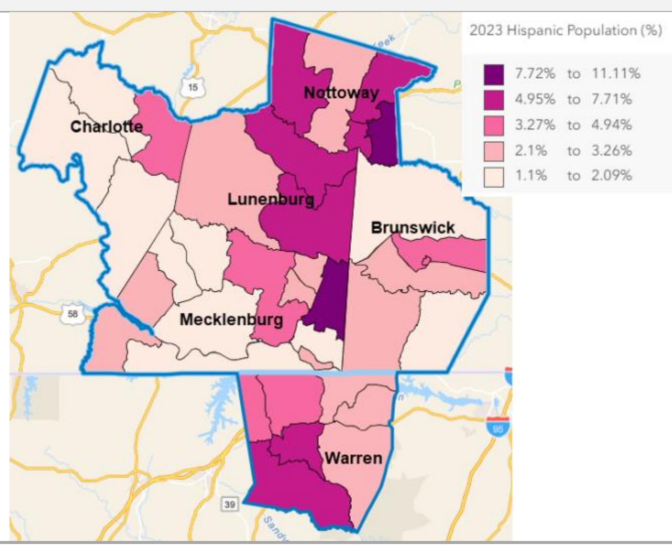
As shown in **Exhibit 1.10**, in 2023 the study region was home to an estimated 3,740 Hispanic residents. The Hispanic population represented about 4% of the regional population, compared to 11% for the state as a whole. The map within the exhibit illustrates variation in the percentage of Hispanic residents at the census tract level.

Exhibit 1.10
Estimated Hispanic Population, 2023

County View	Total	Percent	
Brunswick, VA	402	3%	
Charlotte, VA	263	2%	
Lunenburg, VA	618	5%	
Mecklenburg, VA	870	3%	
Nottoway, VA	813	5%	
Warren, NC	774	4%	
Study Region	3,740	4%	
Virginia	981,157	11%	

County percent > Virginia percent	None

Census Tract View



Source: CHS analysis of ESRI population estimates extracted using ArcGIS Business Software

C. Exploring Health Disparities

A growing body of published research indicates that social and economic factors can contribute to disparities in health status and access to health supports. However, limitations in available data make it difficult to conduct a comprehensive analysis of health disparities at the county level in Virginia. As an alternative approach, it can be instructive to explore health disparities at the regional or statewide level, and consider whether disparities apparent at these higher levels of geography may also be present in the local community.

With this approach in mind, **Exhibit 1.11** shows a list of disparity-related indicators available from the Virginia Community Health Improvement data portal at the regional or statewide level.

- The yellow-shaded areas within the exhibit indicate disparities between the non-Hispanic White population and the non-Hispanic Black / African American population in the listed health measures. The available indicators show adverse disparities in rates of poverty, infant mortality, early mortality (years of potential life lost), cancer, and communicable disease.

- When interpreting the data, please note that the exhibit includes only those indicators for which data are readily available, and therefore does not represent a comprehensive analysis of all possible disparities. Also, additional populations who may be experiencing disparities are not included in the exhibit because of data limitations.

Exhibit 1.11
Health Disparity Indicators from the Virginia Community Health Improvement Data Portal

Indicator	Geographic Level Available	Non-Hispanic White	Non-Hispanic Black / African American
Poverty rate			
Population in Poverty, 2018-2022.	Virginia	8%	16%
Children in Poverty, 2018-2022	Virginia	8%	25%
Infant and Child Mortality			
Infant Mortality per 1,000 live births 2022	Virginia	4.93	12.09
Early Mortality			
Years of Potential Life Lost before age 75 per 100,000 population. 2015-2021	Virginia Study Region	10,350.8	15,301.6
Cancer			
Cancer Incidence per 100,000 pop., 2016-2020	Virginia	407.8	428.0
Breast Cancer Incidence per 100,000 pop., 2016-2020	Virginia	125.7	129.8
Colon and Rectum Cancer Incidence per 100,000 pop, 2016-2020	Virginia	32.7	37.7
Cancer Mortality, Age-Adjusted rate per 100,000 pop. 2016-2020	Virginia Study Region	172.9	198.2
Communicable Disease			
Chlamydia Incidence rate per 100,000 pop. 2021	Virginia Study Region	143.3	592.6
Gonorrhea Incidence rate per 100,000 pop. 2021	Virginia Study Region	89.3	418.0
HIV Prevalence per 100,000 pop. 2021	Virginia Study Region	115.2	659.6
Mental Health			
Self-harm and suicide-related ED visit rate per 100,000 population age 5+ (2023)	Virginia	685.8	1088.3
Sources: Virginia Department of Health, Virginia Community Health Improvement Data Portal.			

Section 2. Insights from Community Residents

Insights from community residents are essential for understanding community health needs and generating ideas for community health improvement. To gather these insights, the study included a survey of community residents plus additional opportunities for community members to share insights at community events. This section provides an overview of survey methods, and a detailed summary of survey responses.

Section 2 Outline	
A	Survey Methods
B	Profile of Survey Respondents
C	Concerns about the Health Environment
D	Concerns about Health Behaviors
E	Concerns about Community Services and Supports
F	Concerns about Access to Health Care Services
G	Concerns about Obstacles to Obtaining Health Care Services
H	Availability of Services
I	Sources of Health Information
J	People Who Need Help Obtaining Better Health
K	Ideas for Community Partners

A. Survey Methods

The survey of community residents was conducted from March through May of 2024. The survey was fielded in collaboration with multiple community partners that helped raise awareness and encourage community members to complete the survey. Online surveys could be completed by community residents willing and able to do so. Paper surveys were also offered at several events.

It should also be noted that the surveys were conducted using convenience sampling. Convenience sampling is a practical approach for obtaining insights from as many people as possible, but without random selection. The results of a convenience sample are instructive for understanding the scope of issues and opportunities that may exist in a community; however, results might not be statistically representative of the entire population of the community.

As a technical note on the exhibits that follow, **'n'** refers to the number of survey respondents answering each item. Note that the **'n'** may vary because some respondents did not answer every survey item.

B. Profile of Survey Respondents

A total of 98 individuals submitted a response to the community resident survey. The respondents were invited to provide insights about community needs, community services, community members who need help, and ideas for how community organizations could work together for community health improvement. As shown in **Exhibit 2.1**:

- 93 of the 98 survey responses came from three counties, including Mecklenburg, Brunswick, and Lunenburg.
- The age distribution of survey respondents was fairly representative of all adult age groups.
- The distribution by sex or gender was heavily skewed toward female respondents, as is common in community health surveys.
- The distribution of responses by self-reported race and income levels was not fully representative of the Black / African American population or the low-income population for the region.

Given this profile of survey respondents, the survey results should be viewed as instructive but not definitive for community health assessment. In the context of this study, the suggested approach is to consider the community resident survey results alongside insights from community stakeholders (Section 3) and community health indicator profiles (Section 4).

As further context for interpreting the survey results, please note that VCU Health Community Memorial Hospital made a concerted effort to reach all segments of the community population in collaboration with multiple partners. The survey results presented here represent a snapshot in an ongoing effort by VCU Health Community Memorial Hospital to identify and address community needs in collaboration with multiple partners. The hospital has engaged a Community Advisory Group and initiated a series of community interviews and events to continue obtaining community insight on an ongoing basis. Insights gathered from these activities to date reinforce the findings from the community resident survey results that follow.

Exhibit 2.1
Community Resident Survey Respondents
(n=98)

County	Count	%
Mecklenburg, VA	57	58%
Brunswick, VA	22	22%
Lunenburg, VA	14	14%
Nottoway, VA	3	3%
Charlotte, VA	1	1%
Warren, NC	0	0%
Other or unnamed	1	1%
Total	98	100%

Age Group	Count	%
18-24	2	2%
25-34	13	13%
35-44	19	19%
45-54	23	23%
55-64	19	19%
65-74	17	17%
75-84	4	4%
85+	1	1%
Total	98	100%

Gender	Count	%
Female	79	86%
Male	12	13%
Unknown	1	1%
Total	92	100%

Race	Count	%
Asian	0	0%
American Indian or Alaska Native	0	0%
Black or African American	10	10%
Multiracial	2	2%
Pacific Islander	0	0%
White	86	88%
Total	98	100%

Household Size	Count	%
1	12	12%
2	32	33%
3	21	21%
4	22	22%
5	7	7%
More than 5	4	4%
Total	98	100%

School-Age Children	Count	%
Yes	38	39%
No	60	61%
Total	98	100%

Household Income (annual)	Count	%
Less than $25,000	5	5%
$25,000-$34,999	11	12%
$35,000-$49,999	10	11%
$50,000-$74,999	17	18%
$75,000+	45	47%
Don't know/not Sure	7	7%
Total	95	100%

Educational Attainment	Count	%
Less than high school	1	1%
High school diploma or GED	8	8%
Some college, but no degree	21	22%
Associate’s degree	10	10%
Bachelor’s degree	31	32%
Master's degree	20	21%
Professional degree	1	1%
Doctorate	5	5%
Total	97	100%

Source: CHS analysis of Community Resident Survey data.

C. Concerns about the Health Environment

Survey respondents were shown a list of factors in the **community environment**, and invited to identify any factors that need improvement in the neighborhood or community where they live. The responses are summarized in **Exhibit 2.2**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 2.2
Concerns about the Health Environment
(n=96)

Multiple Choice Responses	Count	%
Access to healthy foods	59	61%
Access to public transportation	50	52%
Spaces for walking	45	47%
Opportunities to participate in community events and activities for health	37	39%
School safety	35	36%
Housing safety	30	31%
Access to public parks or playgrounds	27	28%
Water quality	24	25%
Healthy messaging in media and public spaces	22	23%
Spaces for biking	22	23%
Food safety	16	17%
Workplace safety	13	14%
Traffic safety	13	14%
Air quality	8	8%

Additional Write-In Responses
□ Improve hospital services
□ Being able to afford housing
□ Health Education
□ Promote safe driving
□ Pesticides
□ Serious water problems, especially drinking water

Source: CHS analysis of Community Resident Survey Data

D. Concerns about Health Behaviors

Survey respondents were shown a list of **health behavior concerns**, and invited to identify any behaviors that are a significant concern in the neighborhood or community where they live. The responses are summarized in **Exhibit 2.3**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 2.3
Concerns about Health Behaviors
(n=93)

Multiple Choice Responses	Count	%
Substance use (illegal drugs)	70	75%
Unhealthy eating habits	66	71%
Sedentary lifestyle (not enough physical activity)	64	69%
Substance use (prescription drugs)	57	61%
Bullying (at school, online, or in the community)	56	60%
Vaping	49	53%
Alcohol use	43	46%
Tobacco use (smoking, snuff, or chewing)	42	45%
Violence in the community	40	43%
Violence in homes (sexual, domestic)	30	32%
Sexual risk behaviors	20	22%
Human trafficking	20	22%

Additional Write-In Responses
☐ Alcohol use is high and even people driving with alcohol in there system
☐ Assure quality of patient assessment for health behavior risks
☐ Marijuana use

Source: CHS analysis of Community Resident Survey Data

E. Concerns about Community Services and Supports

Survey respondents were shown a list of **community services and supports,** and invited to identify any for which access is a significant concern in the neighborhood or community where they live. Respondents were further instructed that access could be a concern because the service is not available at all, or because it is difficult to actually get a service. The responses are summarized in **Exhibit 2.4**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 2.4
Concerns about Access to Community Services and Supports
(n=98)

Multiple Choice Responses	Count	%
Eldercare services	64	65%
Services for older adults	60	61%
Long term care services	56	57%
Childcare services	56	57%
After school programs	49	50%
Assisted living services	49	50%
Services for children with special needs	43	44%
Services for people with disabilities (physical)	43	44%
Financial and legal counseling services	40	41%
Public transportation	38	39%
Services for people with disabilities (intellectual)	39	40%
Food supports	35	36%
Crime protection	26	27%

Additional Write-In Responses
□ Long term care for mental issues, this would be at the top of the list
□ More doctors and health care services
□ Mostly volunteer EMS, thus delaying treatment of emergencies and transport to local hospital.
□ Psychiatric services for all ages
□ There is no public transportation that is available for low income people. Getting to extra food supports due to lack of gas money.
□ Urgent care services or walk-in clinics

Source: CHS analysis of Community Resident Survey Data

F. Concerns about Access to Health Care Services

Survey respondents were shown a list of **health care services,** and invited to identify any for which access is a significant concern in the neighborhood or community where they live. Respondents were further instructed that access could be a concern because the service is not available at all, or because it is difficult to actually get a service. The responses are summarized in **Exhibit 2.5**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 2.5
Concerns about Access to Health Care Services
(n=95)

Multiple Choice Responses	Count	%
Dental services	68	72%
Mental health services	57	60%
Services for weight control	50	53%
Affordable health insurance	48	51%
Medical specialty services	46	48%
Elder care	44	46%
Primary care services	43	45%
Home health services	39	41%
Vision services	37	39%
Substance use services	33	35%
Hospital services	31	33%
Pharmacy services	25	26%
Hearing services	25	26%
Services for quitting smoking	16	17%

Additional Write-In Responses
□ Fragmented/uncoordinated health care
□ Long term mental care, there is nothing unless you are criminal.
□ MD
□ Often having to drive 1 hr. for health care services not available or not taking new clients.
□ There are no affordable dental services in this area. Way too high and can't get even a dental cleaning that is affordable or available for low income people. No available access for psychiatrists that are affordable as well. No access to specialty doctors (affordable GI, Neurology, Psychiatry, and Dentist)
□ Urgent Care
□ Urgent care
□ Urgent care services or walk in clinics

Source: CHS analysis of Community Resident Survey Data

G. Concerns about Obstacles to Obtaining Health Care Services

Survey respondents were shown a list of **obstacles or problems** that may prevent someone from obtaining the health care services they need, and invited to identify any obstacles or problems for themselves or their immediate family members. The responses are summarized in **Exhibit 2.6**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 2.6
Concerns about Obstacles to Obtaining Health Services
(n=97)

Multiple Choice Responses	Count	%
Waiting time to get appointments	57	59%
High cost of out of pocket expenses (example: co pays, medication or travel costs)	51	53%
Needed specialty care not available locally	50	52%
Long wait times in the emergency department	44	45%
Lack of provider/healthcare staff follow through (prescriptions, consults, referrals)	39	40%
Not able to get support after hours	35	36%
Not able to take time away from work for appointments	34	35%
Long wait times in urgent care centers	29	30%
Not able to get appointments at all	28	29%
Not able to see the same provider each time	27	28%
Preventative or alternative health services are not offered locally	27	28%
Limited or no insurance coverage	22	23%
Lack of transportation to get to appointments	19	20%
Don't know what services are available	9	9%
Language barriers in trying to obtain services	8	8%
Not Applicable - I do not experience any barriers in receiving healthcare	8	8%

Additional Write-In Responses
□ Available access for low income individuals to get the services above without affordable options. Sometimes not enough funds to get to and from appointments.
□ Improve ER wait times
□ Limited access to mental health services
□ No place to go in our town for non-urgent care , same or next day being seen
□ Pediatric specialist

Source: CHS analysis of Community Resident Survey Data

H. Availability of Services

Survey respondents were shown a list of statements about availability of local health services. They were then invited to indicate which statements were true for themselves or an immediate family member of theirs. The results are shown in **Exhibit 2.7**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 2.7
Availability of Services
(n=94)

Multiple Choice Responses	Count	%
On at least one occasion, I or a family member have received services from VCU Health Community Memorial Hospital.	87	93%
On at least one occasion, I or a family member needed to travel outside the local community to receive health services that were not available here.	71	76%
On at least one occasion, I or a family member have needed services that were not available at VCU Health Community Memorial Hospital or elsewhere in our local community.	55	59%

	Additional Write-In Responses
☐	Cardiac ablation
☐	Cardiac procedures, dermatology, orthopedic surgery
☐	Cardiologist surgery
☐	Dental, ophthalmology, dermatology, hand surgery
☐	GI cardiology
☐	Heart cath, neo natal care
☐	Long term mental health
☐	MRI, CT scan, eye exam, surgeries, urgent care (all available in CMH but wait times were too long). root canal, fertility specialist (was referred out due to needing a specialist),
☐	Neurological therapy; urgent care
☐	Neurologist, Cardiologist
☐	Neurology, dental care
☐	Orthodontist
☐	Pediatric specialist
☐	Pediatric specialists are not available locally, must drive at least an hour to two hours for a specialist
☐	Pediatric care urgent from ER, transportation for critical child on AMR unavailability for more than 6 hours. Having to travel with a child critical pov due to lack of services. Non Pediatric hospital care. Non stroke care
☐	Pediatric specialty care
☐	Surgery for compound fracture; and biopsy for cancer.
☐	The affordability of services and lack of local specialty providers.
☐	VCU in south hill is 45 minutes away at least

Source: CHS analysis of Community Resident Survey Data

I. Sources of Health Information

Survey respondents were shown a list of **sources** they might use if they had a question or needed information about improving their health, and invited to identify which sources they would use. The multiple choice results are shown in **Exhibit 2.8.**

Exhibit 2.8
Sources of Health Information
(n=97)

Multiple Choice Responses	Count	%
Health care provider (example: physician, nurse practitioner)	74	76%
Online resources (example: WebMD)	51	53%
Friends	19	20%
Family member	18	19%
Free clinic	1	1%
Urgent care	13	13%
Local health department	11	11%
Hospital emergency department	7	7%
Social media resources (example: Facebook)	7	7%
Faith based organization	6	6%
Other (describe)	5	5%

Source: CHS analysis of Community Resident Survey Data

J. People Who Need Help Obtaining Better Health

Survey respondents were invited to identify particular groups of people within their neighborhood or community who need help obtaining better health. This was an open question in which respondents were invited to write in their responses. A total of 35 responses were received. The detailed responses were analyzed using thematic analysis methods, resulting in six population groups being identified. The summary results are shown in **Exhibit 2.9.**

Exhibit 2.9
People within Your Neighborhood or Community Who Need Help Obtaining Better Health
(n=35)

Themes identified from 35 individual responses:	Number of responses involving this theme
Groups that may need help:	
Older Adults	14
Children and Families	6
Low Income Population	3
Minority Population/POC	2
People with Disabilities	1
Young Adults	1
Areas where help may be needed:	
Mental Health	8
Transportation	5
Health Related Social Supports	4
Food Security	3
Hospital	2
Health Equity	2
Health Coverage	2
Access to Services	2
Health Communication	1
Health Behaviors	1
Funding-Related	1
Faith-Based Communities	1
Education	1
Dental Care	1

Source: CHS analysis of Community Resident Survey Respondents

K. Ideas for Community Partners

Survey respondents were invited to share ideas on how VCU Health Community Memorial Hospital and its partners can help them and others in their neighborhood achieve better health. This was an open question in which respondents were invited to write in their responses. A total of 35 responses were received. The detailed responses were analyzed using thematic analysis methods. The summary results are shown in **Exhibit 2.10.**

Exhibit 2.10
Ideas for How Community Partners Can Help Community Members Achieve Better Health
(n=35)

Themes identified from 35 individual responses:	Number of responses involving this theme:
Services & supports mentioned:	
Hospital Services	12
Access to Services	11
Transportation	7
Health Related Social Supports	7
Mental Health	4
Dental Care	3
Other Health Services	2
Health Equity	2
Health Communication	2
Education	2
Health Environment (Built or Natural)	1
Health Behaviors	1
Funding-Related	1
Food Security	1
Faith-Based Communities	1
Employment	1
COVID-19	1
Populations mentioned:	
Older Adults	2
Children and Families	3
People with Disabilities	1
Low Income Population	1

Source: CHS analysis of Community Resident Survey Data

Section 3. Insights from Community Stakeholders

Section 2 describes the results of the survey of community residents, which was open to all community members. As an additional method for obtaining community insights, the study also included a survey of community stakeholders, defined as professionals who may have insights about community health needs from their particular professional perspective. The results from this survey of community stakeholders are described in this section.

Section 3 Outline	
A	Survey Methods
B	Profile of Survey Respondents
C	Concerns about the Health Environment
D	Concerns about Health Behaviors
E	Concerns about Community Services and Supports
F	Concerns about Access to Health Care Services
G	Concerns about Health Conditions in the Community
H	New or Emerging Health Issues in the Community
I	Community Resources that Could Be Leveraged
J	Ideas for Working Together
K	Additional Ideas or Suggestions

A. Survey Methods

The survey of community stakeholders conducted in March through May of 2024. The survey was conducted online with a group of community professionals working in organizations that serve the study region. Survey responses were invited by email and through community meetings with prospective survey respondents.

As a technical note on the exhibits that follow, **'n'** refers to the number of survey respondents answering each item. Note that the **'n'** may vary because some respondents did not answer every survey item.

B. Profile of Survey Respondents

A total of 61 individuals submitted a response to the community stakeholder survey. The respondents provided insights about community needs, community services, community members who need help, and ideas for how community organizations could work together for community health improvement. As shown in **Exhibit 3.1**, the respondents brought perspectives on all six counties in the study region. Also, the respondents' organizational homes included education, faith communities, health care, human services, local government, parks and recreation, public health and public safety.

Exhibit 3.1
Community Resident Survey Respondents
(n=61)

County Perspectives	Count
Brunswick County	38
Charlotte County	19
Mecklenburg County	58
Lunenburg County	30
Nottoway County	23
Warren County, North Carolina	21
Total	61

Exhibit 3.1
Community Resident Survey Respondents
(n=61)

Organizations Represented
Alberta Fire Department (2)
Capitol Financial Solutions
EVS (2)
General Dynamics
Kenbridge Construction Company
MCBOS
Mecklenburg County Public Schools (MCPS) (3)
Mecklenburg County
self
Southside Behavioral Health (4)
Southside Planning District Commission
Southside Rescue Squad Inc
Southside Virginia Community College (4)
The Hundley Center
Town of Kenbridge
VCU (5)
VCU Community Memorial Hospital (VCU CMH) (17)
VCU CMH Health
VCU CMH Hundley Center
VCU CMH Oncology (3)
VCU Health (3)
VCU Health Community Memorial Hospital (2)
VCU HEALTH- Dermatology
VCU-CMH Physicians
VCUHS
VCUHS CMH
Virginia Department of Health
White Rock AME Zion Church

Source: CHS analysis of Community Stakeholder Survey data.

C. Concerns about the Health Environment

Survey respondents were shown a list of factors in the **community environment**, and invited to identify any factors that need improvement in the communities their organization serves. The responses are summarized in **Exhibit 3.2**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 3.2
Concerns about the Health Environment
(n=61)

Multiple Choice Responses	Count	%
Access to healthy foods	42	70%
Access to public transportation	35	58%
Opportunities to participate in community events and activities for health	29	48%
School safety	25	42%
Housing safety	23	38%
Healthy messaging in media and public spaces	19	33%
Spaces for walking	20	32%
Spaces for biking	18	30%
Workplace safety	18	30%
Water quality	17	28%
Access to public parks or playgrounds	17	28%
Food safety	16	27%
Traffic safety	10	17%
Air quality	7	12%

Additional Write-In Responses
☐ Access to dental care is desperately needed for adults with dental Crisis and for Children whose family members have poor dental health.
☐ Affordable housing.
☐ Community does not have Uber or Lyft. Hospital is unable to transport discharged patients back to their residence.
☐ Community health. Urgent care facilities.
☐ I live close to the ever expanding Microsoft compound. They are cutting down the forest, destroying the roads, causing our taxes to rise, and exponentially increasing traffic. There's nothing we can do about it, but I am concerned.
☐ It goes along with School Safety but, Bullying is a HUGE concern that I have for those in the community, especially those in middle and high school. Once again, it can be at the Schools but Drug and Alcohol abuse is a massive problem as well.
☐ Indoor swimming facility, county parks and recreation.
☐ Lack of access to certain care in area.   Vascular specialist. Lack of mental Heath addiction care. More Home Heath needs
☐ Medication cost assistance | Wheelchair ramps for homes | Timely PCP and Specialist appointments | No Neurology services | No on-site dialysis | No pediatrician | No wheelchair vans for transportation | No cab services | Limited resources for illiterate patients | Limited food resources (not having FeedMore drives anymore) | No Psychiatrist | Limited mental health services | No Homeless Shelters
☐ Specialty physicians: neurologists, cardiologists, dentists, pulmonologists, wound care dr.
☐ Unlit roads in rural areas. Car accidents where tree collision result in death. Serve large prison population

Source: CHS analysis of Community Stakeholder Survey Data

D. Concerns about Health Behaviors

Survey respondents were shown a list of **health behavior concerns**, and invited to identify any behaviors that are a significant concern in the communities their organization serves. The responses are summarized in **Exhibit 3.3**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 3.3
Concerns about Health Behaviors
(n=61)

Multiple Choice Responses	Count	%
Substance use (illegal drugs)	53	87%
Unhealthy eating habits	47	77%
Vaping	43	70%
Sedentary lifestyle (not enough physical activity)	43	70%
Alcohol use	42	69%
Substance use (prescription drugs)	41	67%
Tobacco use (smoking, snuff, or chewing)	39	64%
Bullying (at school, online, or in the community)	34	56%
Violence in the community	27	44%
Violence in homes (sexual, domestic)	27	44%
Sexual risk behaviors	23	38%
Human trafficking	15	25%

	Additional Write-In Responses
☐	Additional Training on Impaired use of vehicles, due to ANY Kind of impairment (alcohol, Marijuana, rage, sleeplessness being upset)
☐	Community outreach. Better sex education in schools and better drug abuse prevention and counseling. More community support groups. Educated Professional personnel at each community health department to provide education in all these areas of need.
☐	I communicated most of these concerns in the first type box. I will add, vaping is a big problem in middle and high school, in Central Virginia. I've had more than one teen tell me there's a local convenience store that will sell vapes and "other stuff" to kids. I do not know what store or its location but, it's a male and he's either an owner or manager. Sedentary lifestyle - I see more teens with slumped shoulders and poor posture from staring at screens all day at home and school. Many teens don't participate in physical activities after school, they go home and play video games whether on computer or gaming console. Sexual Risk Behaviors - Many tweens and teens put themselves out on social media dressed risqué, giving contact info, and making sexual comments which puts them in severe danger.
☐	If addiction is noted and they ask for help- very limited resources for
☐	Inadequate health department services during off hours.
☐	Medication compliance Grief support/counseling Weight loss programs Healthy diet plans Outpatient exercise programs

Source: CHS analysis of Community Stakeholder Survey Data

E. Concerns about Community Services and Supports

Survey respondents were shown a list of **community services and supports,** and invited to identify any for which access is a significant concern in the communities their organization serves. Respondents were further instructed that access could be a concern because the service is not available at all, or because it is difficult to actually get a service. The responses are summarized in **Exhibit 3.4**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 3.4
Concerns about Access to Community Services and Supports
(n=61)

Multiple Choice Responses	Count	%
Services for older adults	39	65%
Elder care services	37	62%
Childcare services	36	60%
Services for children with special needs	36	60%
Services for people with disabilities (physical)	35	58%
After school programs	33	55%
Assisted living services	33	55%
Services for people with disabilities (intellectual)	31	52%
Financial and legal counseling services	29	48%
Food supports	21	35%
Crime protection	14	23%

Additional Write-In Responses

- ☐ ABA therapy is a HUGE need in our service area. Many parents that have tried to get in home ABA therapy for their child have been wait listed FOR YEARS. Virtual ABA is available but some do not have the means to offer that to their child.
- ☐ Retirement homes and nursing homes
- ☐ Some with significant disabilities are told can get care in Richmond- but- how are they able to easily get there- includes the elderly
- ☐ There seems to be an overwhelming need for all of the above community issues. We need more resources and facilities and educated personnel to assist in helping the needs of the surrounding communities.

Source: CHS analysis of Community Stakeholder Survey Data

F. Concerns about Access to Health Care Services

Survey respondents were shown a list of **health care services,** and invited to identify any that are significant concerns in the communities their organization serves. Respondents were further instructed that access could be a concern because the service is not available at all, or because it is difficult to actually get a service. The responses are summarized in **Exhibit 3.5**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 3.5
Concerns about Access to Health Care Services
(n=60)

Multiple Choice Responses	Count	%
Mental health services	45	75%
Substance use services	38	63%
Dental services	37	62%
Affordable health insurance	36	60%
Elder care services	34	57%
Medical specialty services	32	53%
Services for weight control	26	43%
Home health services	25	42%
Primary care services	25	42%
Hospital services	21	35%
Services for quitting smoking	18	30%
Pharmacy services	17	28%
Vision services	16	27%
Hearing services	13	22%

Additional Write-In Responses
□ 24 hour urgent care
□ Health Services for chronic issues for cerebral palsy adults and children
□ Psychiatric hospital
□ Virginia definitely needs more MH Crisis Care hospitals. I've seen past clients wait in hospital ER's for 3-9 days just so they could get a bed in a MH hospital.

Source: CHS analysis of Community Stakeholder Survey Data

G. Concerns about Particular Health Conditions in the Community

Survey respondents were shown a list of common **health conditions** that can affect community populations, and invited to identify any that are significant concerns in the communities their organization serves. The responses are summarized in **Exhibit 3.6**, with the multiple choice responses shown in the top part of the exhibit, followed by a list of additional write-in responses in the original words of the respondents.

Exhibit 3.6
Concerns about Particular Health Conditions in the Community
(n=61)

Multiple Choice Responses	Count	%
Mental health conditions (depression, anxiety, other)	50	82%
Adult obesity/overweight	49	80%
Substance use disorder - drugs	44	72%
Cancer	42	69%
Substance use disorder - alcohol	37	61%
Diabetes	36	59%
High blood pressure	36	59%
Childhood obesity/overweight	35	57%
Suicide	32	52%
Alzheimer's disease	31	51%
Aging concerns	30	49%
Stroke	27	44%
Autism	25	41%
Dental / oral health conditions for adults	25	41%
Intellectual/developmental disabilities	25	41%
Respiratory diseases (other than asthma)	23	38%
Neurological disorders (seizures, multiple sclerosis)	21	34%
Infant and child health concerns	20	33%
Maternal health concerns	20	33%
Renal (kidney) disease	20	33%
Chronic pain	19	31%
Dental / oral health conditions for children	18	30%
Arthritis	17	28%
Physical disabilities	16	26%
Infectious diseases that spread person to person	15	25%
Orthopedic problems	14	23%
Sexually transmitted diseases	14	23%
Asthma	11	18%
HIV/AIDS	10	16%
Preventable Injuries (care or bike crashes, falls)	9	15%

Additional Write-In Responses
□ Dental services for disabled adults and children i.e. cerebral palsy

Source: CHS analysis of Community Stakeholder Survey Data

H. New or Emerging Health Issues in the Community

Survey respondents were invited to identify in their own words any new or emerging health issues that may not be widely known yet, but could cause serious harm today or in the future within the communities their organization serves. The 12 responses provided are listed in **Exhibit 3.7**.

Exhibit 3.7
New or Emerging Health Issues in the Community
(n=12)

	Write-In Responses
☐	ATV Accidents
☐	Cell phone usage with young kids/teens and how it affects their mental health.
☐	Dependence on, or overuse of "screen time". Too much reliance by individuals of cell phone use/abuse - or tablets. This screen time overuse exacerbates obesity, non-exercise, and/or involvement with others in real time.
☐	Good nursing homes that invest back into the facility so the residents have a nice, clean, quality place to live.
☐	Increase in suicides - personal observation- do not have data
☐	Increased use of drug use in youth under the age of 18, especially within the school. Cyber bullying continues to be a concern.
☐	It's a known issue, but I believe vaping should be illegal.
☐	Lack of new primary care providers
☐	Large spike in illegal drug use in SBH's catchment area, in both public and private schools.
☐	Radon
☐	Substance abuse, illegal and legal. Unprotected sex in minors.
☐	Use of energy drinks and vaping in adolescents

Source: CHS analysis of Community Stakeholder Survey Data

I. Community Resources that Could Be Leveraged

Survey respondents were invited to identify in their own words any community resources that could be leveraged to improve community health and health care. For this item community resources were defined as the people, organizations, programs, services, supports, built resources (e.g., parks), or natural resources that exist across the community. The 24 responses provided are listed in **Exhibit 3.8**.

Exhibit 3.8
Community Resources that Could Be Leveraged to Improve Health and Health Care
(n=24)

	Write-In Responses
☐	After-school activities for children Access to internet in all homes
☐	Dance classes or other fun, engaging activities that will help with obesity concerns. Support groups to help community members deal with anxiety, depression and grief.
☐	Educational services to families about health and nutrition, reducing obesity, substance/alcohol/tobacco abuse in the home, etc.
☐	Expansion needed regarding elder services, including lake country area agency on aging.
☐	I believe more efforts and focus should be on offering services to those who are experiencing a mental health crisis.
☐	I understand that it is a massive and expensive undertaking, but I like the idea of more areas to ride bikes.
☐	Lack of transportation to take advantage of resources.
☐	Lake country area on aging partnership More interaction with the Mobile Health & Wellness Program Water safety program with all of the lakes here
☐	Mental health services
☐	More outdoor recreation.
☐	More specialty care within area
☐	More trails, particularly connecting South Hill to La Crosse by the Tobacco Heritage Trail.
☐	Nature trails-outdoor activities Supporting Youth sports Work out facilities for the elderly
☐	Need a YMCA for kids. More outside activities that caters to all races. Outings such as concerts and more events for adults and kids.
☐	Need urgent care access
☐	Our farmers...let's get healthy produce and livestock more available options other than food lion
☐	Parks and recreation. It serves the young and old
☐	Parks and Recreation. While the YMCA (Chase City and Clarksville) and the Yellow Jackets (aka: Park View Boosters) and a few private fitness clubs and organizations provide some youth, adult, and older adult offerings... these programs are limited in their resources and staff members to address the county as a whole. HOWEVER, even if these services were enhanced, or community and population have become very sedentary and/or apathetic toward organized activities.
☐	Paved walking trail in the community park. There is a paved section that could be made into a full loop. The Lacrosse to Lawrenceville trail is nice but feels very secluded due to many trees blocking anyone's view. It feels safer to walk in Centennial Park if walking alone as it is somewhat visible from two streets and also there are normally other families at the park.
☐	Significant need for transportation services for patients being discharged from the hospital. A significant part of our population is elderly and does not have local family or support systems or their support system is also elderly and unable to drive safely in the dark. Medicare does not cover transportation for ambulatory clients.
☐	Support for senior citizens who need maintenance done to their home both small and large jobs.
☐	Support groups for children with Autism, Trichotillomania, anxiety, and depression.
☐	There isn't enough time for providers to spend educating patients due to insurance and other one spent with each patient.
☐	TRANSPORTATION Mental health services for the geriatric population.

Source: CHS analysis of Community Resident Survey Data

J. Ideas for Working Together

Survey respondents were invited to identify in their own words the top three things we should do as a community to bridge healthcare access gaps and reduce health disparities in our community. The 24 responses provided are listed in **Exhibit 3.9**.

Exhibit 3.9
Ideas for Working Together
(n=24)

	Write-In Responses
☐	Make available resources known to the public/Communities. Provision of transportation to take advantage of available resources. Affordable health insurance More awareness of mental health issues and resources
☐	Better healthcare overall that accommodates all races. I've heard comments about healthcare caters more to whites versus any other race. Need better healthcare in the community.
☐	Increased access to screening such as promotion of screening opportunities and finding resources to cover uninsured or underinsured. Education on TVs in waiting room on top health issues. Smoking cessation resources and education.
☐	Have specialized services for the special needs community including ortho, physiatrist, dental, gi
☐	1 People need to eat less junk and get more exercise. 2 Everyone has to stop thinking alcohol/tobacco are the greatest things on earth. 3 Families need to spend more time doing activities together.
☐	Education on health and being active within schools. Opening places for the community to have access to a free gym or a scholarship for a free gym membership. More fresh/local foods produce within schools, workplaces, and within the community.
☐	Better hospital
☐	Monthly Community Stroke and Congestive heart failure support group
☐	Offer free or low cost transportation to appointments. Offer nutritional food/drink to those who have a need. Offer education on all the areas identified as problematic within Central Virginia.
☐	Community health fairs with the multidisciplinary team to answer questions and provide resources.
☐	- Free Clinics, - More free testing opportunities, - Increase dental care opportunities.
☐	More health fairs Community Events Awareness
☐	Healthcare Cost Transportation Timely and Doctor Availability and Access
☐	1. Improve transportation 2. Lower cost of medicine (Xarelto, Eliquis, Trelegy, etc.) 3. Nutrition classes with low impact exercises (is water aerobics, chair yoga, etc.)
☐	Screenings or assessments in school - sight, hearing, mental health, functional movement
☐	Pediatric and adult Weekend Clinics (and follow up), access to an interventionalist for family crisis related to drug abuse, Al-Non an NA-Non groups for families.
☐	1.Lack of communication across providers of different agencies. More intentional work should be done to develop improved interdisciplinary team work. 2. Education of what agencies provide what supports for appropriate referrals and networking 3. Collaborative team efforts at the administrative level of large stakeholders in the community to address problems that make impacts across all scopes of practice including homelessness, food accessibility, and transportation barriers.
☐	Possibly hold open meetings for providers in the community to meet and discuss services available in the area.
☐	Offer even education talks for the public. I believe these are very helpful

Exhibit 3.9
Ideas for Working Together
(n=24)

□	Work to bring more health care providers to the area. 24 hour urgent care to prevent overloading of the ER.
□	More physicians, specialists& APPs so that patients can get the appointments they need to prevent health decline by having to wait months. Reliable transportation to get patients to their appointments on time. Mental Health providers for the geriatric community.
□	Work with the schools, local governments
□	Transportation Focused Education Classes (parenting, medication safety, CHF) Go into the community schools, churches, etc. to educate and more importantly, find out their primary concerns first hand.
□	Work to bring resources to area- even if just a few days a month

Source: CHS analysis of Community Resident Survey Data

K. Additional Ideas or Suggestions

Survey respondents were invited to identify in their own words any additional ideas or suggestions. The 4 responses provided are listed in **Exhibit 3.10**.

Exhibit 3.10
Additional Ideas or Suggestions
(n=4)

	Write-In Responses
☐	I would love to offer my support and services in helping to resolve these challenges in our community. Please contact me and let me know how I can assist.
☐	Need a bus or van that goes into rural area so they can get to the stores or doctor
☐	Thanks for the opportunity to participate.
☐	You can lead a horse to water, but you can't make them drink. I suspect that the 30,000 + who reside in Mecklenburg County can find the opportunities, or make the opportunities to address their needs and desires. However, even if our resources and opportunities were limitless, only a percentage of community members would take advantage of them.

Source: CHS analysis of Community Stakeholder Survey Data

Section 4. Community Health Indicator Profiles

This section of the report provides a series of Community Health Indicator Profiles for the study region. The topics addressed in the profiles are listed in the Section 4 outline at right. Please review the following notes on data sources and methods before exploring the Community Health Indicator Profiles.

Section 4 Outline	
A	Data Sources and Methods
B	Community Demographic Profile
C	Health Care Access Profile
D	Mortality Profile
E	Maternal and Infant Health Profile
F	Youth Health Risk Profile
G	Adult Health Risk Profile
H	Adult Health Screening Profile
I	Adult Chronic Disease Profile
J	Communicable Disease Profile
K	Oral Health Profile
L	Mental Health Profile
M	Substance Use Profile
N	Injury Profile

Note: Also see Section 1 for a profile of social and economic factors and health disparity indicators.

A. Data Sources and Methods

Sources. The Community Health Indicator Profiles are based on data from multiple sources, as noted in the source notes for each profile exhibit.

- For the Virginia counties and Warren, NC, the primary source of health-related demographic indicators is ESRI, a commercial vendor of community demographic data.
- For health indicators, measures for Virginia counties were obtained primarily from the Virginia Department of Health via the Virginia Community Health Improvement Data Portal.
- Please note that in many cases, a comparable set of published indicators for Warren NC are not publicly available. Health indicators for Warren are included from available sources wherever possible.

Methods. The profiles are designed to provide a broad cross-section of indicators rather than all possible indicators of community health.

- In reviewing the community data profiles it is logical to compare indicators between counties and between the local region and the state. However, please note that such comparisons should be treated as *exploratory* rather than *definitive* because of the underlying structure of the data. For example:
  - The indicators within the profiles are in particular formats defined by the source organizations. The formats may limit the possibilities for making comparisons across counties.
  - In some situations, the underlying data are based on survey samples rather than complete health records, and the resulting indicators are not published in ways that support comparative statistical analysis.
  - In other situations, the underlying data are based on actual health records, but the relevant indicators are not reported for the smaller counties because of an insufficient number of cases.
  - A related consideration is that some indicators should be adjusted for age and/or population size, and the underlying data to support this analysis is not available.

Keeping these qualifiers in mind, the report does identify areas where local measures differ from statewide rates. These differences are noted as applicable and highlighted in yellow within the exhibits. The recommended approach is to use these comparisons as a starting point for further exploration of needs at the local level in collaboration with local stakeholders.

B. Community Demographic Profile

Exhibit 4.1 displays a community demographic profile of the region as of 2023. Insights for community health include:

- In 2023 the study region was home to an estimated 102,549 people.
- As shown by yellow shading within the exhibit, compared to Virginia as whole the region is more rural, and has higher proportions of low-income residents, older residents, and Black / African American residents.

Exhibit 4.1
Community Demographic Profile

Indicators (2022 estimates) — Areas to explore	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Warren, NC	Study Region	Virginia
Total Population (2023)								
Population (total)	15,623	11,271	11,762	30,096	15,480	18,317	102,549	8,787,063
Pop. Density (Per Square Mile)	27.6	23.7	27.2	48.1	49.2	42.8	36.1	222.5
Median Household Income (2023)								
Median Household Income	$46,223	$47,602	$48,564	$46,552	$54,533	$43,449	$47,580	$83,550
Poverty (2021 count)								
Population at or Below Poverty	2,406	2,175	1,550	5,272	2,306	3,511	17,220	828,664
Population at or Below 200% of Poverty	5,617	4,436	4,239	11,609	5,873	8,214	39,988	1,966,819
Poverty (2021 percent)								
Population at or Below Poverty	18%	19%	14%	18%	17%	19%	18%	10%
Population at or Below 200% of Poverty	41%	39%	38%	39%	42%	45%	41%	24%
Age (2023 count)								
Child Population (Age <18)	2,442	2,160	2,141	5,098	2,786	3,290	17,917	1,859,754
Adult Population (Age 18-64)	9,689	6,434	6,889	16,549	9,526	10,364	59,451	5,409,060
Senior Population (Age 65+)	3,492	2,677	2,732	8,449	3,168	4,663	25,181	1,518,249
Age (2023 percent)								
Child Population (Age <18)	16%	19%	18%	17%	18%	18%	17%	21%
Adult Population (Age 18-64)	62%	57%	59%	55%	62%	57%	58%	62%
Senior Population (Age 65+)	22%	24%	23%	28%	20%	25%	25%	17%
Race & Hispanic Ethnicity (2023 count)								
American Indian/Alaska Native Population	23	22	36	77	86	983	1,227	42,173
Asian Population	46	32	27	215	67	68	455	654,820
Black/African American Population	8,565	3,121	3,796	10,507	5,819	8,975	40,783	1,643,218
Pacific Islander Population	5	6	6	0	3	4	24	7,250
White Population	6,346	7,455	6,887	17,651	8,406	7,008	53,753	5,204,399
Other Race Population	223	175	364	520	358	530	2,170	480,201
Population of Two or More Races	415	460	646	1,126	741	749	4,137	755,002
Hispanic Population	402	263	618	870	813	774	3,740	981,157
Race & Hispanic Ethnicity (2023 percent)								
American Indian/Alaska Native Population	0.2%	0.2%	0.3%	0.3%	0.6%	5.4%	1.2%	0.5%
Asian Population	0.3%	0.3%	0.2%	0.7%	0.4%	0.4%	0.4%	7.5%
Black/African American Population	54.8%	27.7%	32.3%	34.9%	37.6%	49.0%	39.8%	18.7%
Pacific Islander Population	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%

Exhibit 4.1
Community Demographic Profile

Indicators (2022 estimates) — Areas to explore	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Warren, NC	Study Region	Virginia
White Population	40.6%	66.1%	58.6%	58.7%	54.3%	38.3%	52.4%	59.2%
Other Race Population	1.4%	1.6%	3.1%	1.7%	2.3%	2.9%	2.1%	5.5%
Population of Two or More Races	2.7%	4.1%	5.5%	3.7%	4.8%	4.1%	4.0%	8.6%
Hispanic Population	2.6%	2.3%	5.3%	2.9%	5.3%	4.2%	3.7%	11.2%
Limited English Proficiency (2022)								
Age5+ with Limited English Proficiency (count)	181	26	418	286	318	(nr)	**1,229	477,552
Age5+ with Limited English Proficiency (percent))	1.2%	0.2%	3.7%	1.0%	2.1%	(nr)	1.5%	5.9%
Sex / Gender (2023 count)								
Female	8,362	5,647	6,184	14,691	8,246	9,276	52,406	4,338,694
Male	7,261	5,624	5,578	15,405	7,234	9,041	50,143	4,448,369
Sex / Gender (2023 percent))								
Female	53.52%	50.10%	52.58%	48.81%	53.27%	50.64%	51.10%	49.38%
Male	46.48%	49.90%	47.42%	51.19%	46.73%	49.36%	48.90%	50.62%

Source: CHS analysis of ESRI data obtained from ArcGIS Business software, except Limited English Proficiency estimates from the Virginia Department of Health, Virginia Community Health Improvement Data Portal. **Note that Limited English Proficiency estimates are for the Virginia region only

C. Health Care Access Profile

Exhibit 4.2 displays a health care access profile for the study region. Areas to explore as indicated by yellow shading include:

- In 2021 uninsured rates in the study region were higher than rates for Virginia as a whole, although the rates are based on estimates and may not be statistically significant.
- As of 2021 the region had a lower supply of primary care physicians, dentists, and mental health providers than Virginia as a whole. All of the counties are designated as Health Professional Shortage Areas by the Virginia Department of Health and the U.S. Health Resources and Services Administration.
- In 2020 rates of preventable hospitalization were higher than the statewide rate in all five Virginia counties. Preventable hospitalizations include selected, specifically-defined cases involving asthma, chronic obstructive pulmonary disease, diabetes, heart disease, hypertension, pneumonia, and urinary tract infection. This measure is included here because hospitalization for these conditions indicates lack of access to ambulatory health care services. Please note that the rates are not age-adjusted, and may reflect the older population in the region.
- The differences outlined above are based on estimates, and might not be statistically significant in some cases.

Exhibit 4.2
Health Care Access Profile

Indicators (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Health Coverage (2021 count)								
Age 0-18 w/o Insurance	126	149	160	315	164	914	84,941	
Age 18-64 w/o Insurance	898	758	804	1,914	878	5,252	481,061	
Health Coverage (2021 percent)								
Age 0-18 w/o Insurance	4.9%	6.1%	6.7%	5.5%	5.5%	5.7%	4.4%	16% for age 0-64
Age 18-64 w/o Insurance	11.5%	11.9%	13.6%	12.0%	11.5%	12.0%	9.3%	
Primary Care Physicians (2021)								
Primary Care Physicians (count)	4	6	2	15	7	34	6,486	
Primary Care Physicians rate per 100,000 population	24.9	50.8	16.3	48.9	46.2	39.6	75.5	
Health Professional Shortage Area Designation	Yes	Yes	Yes	Yes	Yes			Yes
Dentists (2022)								
Dentists (count)	3	4	4	9	7	27	6,535	
Dentists rate per 100,000 population	19	35	33	30	45	32	75	
Health Professional Shortage Area Designation	Yes	Yes	Yes	Yes	Yes			Yes
Mental Health Providers (2023)								
Mental Health Providers (count)	14	7	9	34	18	82	21,124	
Mental Health Providers rate per 100,000 population	88	61	75	111	116	96	243	
Health Professional Shortage Area Designation	Yes	Yes	Yes	Yes	Yes			Yes
Potentially Avoidable Hospitalizations (2020)								
Potentially Avoidable Hospitalizations Age 18+ (count)	251	154	130	341	219	1,095	55,139	
Avoidable Hospitalizations (rate per 100,000 population 18+)	1,860	1,652	1,315	1,365	1,787	1,566	820	Yes

Source: Virginia Community Health Improvement Data Portal, May 2024. Estimates from U.S. Health Resources and Services Administration, Virginia Health Information, and U.S. Census Bureau American Community Survey Preventable hospitalizations are defined by a widely used methodology published by the U.S. Agency for Healthcare Research and Quality. https://qualityindicators.ahrq.gov/measures/PQI_TechSpec

D. Mortality Profile

Exhibit 4.3 displays a mortality profile for the study region. Areas to explore as indicated by yellow shading include:

- Years of potential life lost rates (due to deaths occurring before age 75) were higher in the study region than the statewide rate in 2019-2021.
- Among the five leading causes of death in the region, death rates were higher than the statewide rate for heart disease, malignant neoplasms, accidents, and cerebrovascular disease. The rates are not age-adjusted, and may reflect the older population in the region.

Exhibit 4.3
Mortality Profile

Indicators (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Premature Death (2019-2021)								
Premature Deaths (count)	370	262	266	660	313	1,871	110,096	
Years of Potential Life Lost (count)	4,545	4,440	4,091	9,660	4,303	27,039	1,757,476	
Years of Potential Life Lost (rate per 100,000 population)	10,371	14,007	12,374	11,868	10,189	11,644	7,297	13,300
Leading Causes of Death (2018-2021)								
Diseases of Heart (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	328.93	180.81	
Malignant Neoplasms (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	303.43	179.13	
Accidents (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	87.36	52.53	
Cerebrovascular Disease (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	77.40	46.12	
Alzheimer Disease (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	65.96	(not reported in top five)	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, and the US Census Bureau. Warren, NC data from County Health Rankings, University of Wisconsin Population Health Institute.

E. Maternal and Infant Health Profile

Exhibit 4.4 displays a maternal and infant health profile for the study region. Areas to explore as indicated by yellow shading include:

- Low weight births, preterm births, teen pregnancy, and infant mortality were higher in the study region than the state for the years reported.
- In 2020, 53% of babies born in the region were enrolled in Medicaid.

Note that infant mortality is reported at the bottom of the exhibit. Because complete data are not reported for each county, the data presented are for the Virginia study region. The infant mortality rate was higher than the statewide rate in the Virginia study region for the 2020-2022 timeframe.

Exhibit 4.4
Maternal and Infant Health Profile

Indicators (Areas to explore)	**Brunswick County**	**Charlotte County**	**Lunenburg County**	**Mecklenburg County**	**Nottoway County**	**Virginia Region**	**Virginia State**	**Warren, NC**
Total Live Births (2022 count)	116	122	107	272	145		95,615	
Low Weight Births (2022)								
Low Birth Weight (count)	18	13	6	38	11	86	8,088	
Low Birth Weight (percent of live births)	15.5%	10.7%	5.6%	14.0%	7.6%	11.3%	8.5%	
Pre-Term Births (2022)								
Preterm Births (count)	15	11	13	39	16	94	9,131	
Preterm Births (percent of live births)	13.2%	9.0%	12.3%	15.7%	11.0%	12.3%	9.6%	12%
Teen Pregnancy (2022)								
Female Population Ages 15-19 (count)	339	315	311	745	448	2,158	273,019	
Pregnancies of Females Ages 15-19 (count)	10	8	9	22	8	57	4,166	
Teen Pregnancies (rate per 1,000 Females Ages 15-19)	29.5	25.4	28.9	29.5	17.9	26.4	15.3	
Medicaid as Payment Source (2020)								
Babies Born (percent of live births)	65%	53%	48%	54%	46%	53%	32%	
Infant Mortality								
Live Births 2020-2022 Three Year (count)	(nr)	(nr)	(nr)	(nr)	(nr)	2,441	285,956	
Infant Death 2020-2022 (count)	(nr)	(nr)	(nr)	(nr)	(nr)	22	1,711	
Infant Deaths (2020-2022 rate per 1,000)	(nr)	(nr)	(nr)	(nr)	(nr)	9.01	5.98	10.8

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, and the US Census Bureau. Also Kids Count (for Medicaid as payment source in 2020). Warren, NC data from County Health Rankings, University of Wisconsin Population Health Institute and North Carolina State Center for Health Statistics, 2018-2022.

F. Youth Health Risk Profile

Exhibit 4.5 displays selected youth health risk indicators from the statewide Virginia Youth Survey. Although the survey was conducted in parts of the local region, local results are not publicly available. Because there are no comparisons made within the exhibit, there is no yellow shading. However the state-level indicators show that significant numbers of Virginia youth are engaging in health risk behaviors related to alcohol and marijuana, depression and suicide, driving at risk, smoking and vaping, and violence and bullying. Although local estimates are not available, it may be worth exploring the extent to which these risk indicators are present in the local youth population.

Exhibit 4.5
Youth Health Risk Profile
(Statewide)

Indicators	2021 Statewide Percent	Recent Trend (2015-2021)
Alcohol and Marijuana		
Had first drink of alcohol before age 13 (other than a few sips)	14.0%	Better
Currently drank alcohol (at least one drink of alcohol on at least one day in the 30 days before the survey)	19.4%	Better
Engaged in binge drinking (four or more drinks of alcohol in a row if female, five or more if male, within a couple of hours, on at least one day during the 30 days before the survey)	10.5%	No change
Currently used marijuana (one or more times during the 30 days before the survey)	13.3%	Better
Depression and Suicide		
Felt sad or hopeless (almost every day for >=2 weeks in a row so they stopped doing some usual activities, ever during the 12 months before the survey)	26.3%	Worse
Seriously considered attempting suicide (during 12 months before the survey)	13.3%	No change
Actually attempted suicide (one or more times during the 12 months before the survey)	5.9%	No change
Driving at Risk		
Rode with a driver who had been drinking alcohol	9.1%	Better
Drove when they had been drinking alcohol	3.4%	Better
Rode with someone who texted, called, e-mailed, or used the Internet or apps on a handheld cell phone while driving a car or other vehicle (such as YouTube, Instagram, or Facebook, on at least 1 day during the 30 days before the survey)	44.7%	Better
Smoking and Vaping		
Smoked cigarettes (at least once during 30 days before survey)	2.8%	Better
Used an electronic vapor product (on at least one day in the 30 days before the survey)	18.2%	Worse
Violence and Bullying		
Did not go to school because they felt unsafe at school or on their way to or from	10.5%	Worse
Threatened or injured with a weapon on school property	7.2%	No change
In a physical fight at school	14.7%	Better
Bullied on school property (during 12 months before the survey)	16.8%	Better
Bullied electronically (texting, Instagram, Facebook, other social media)	16.3%	No change
Experience sexual violence (being forced by anyone to do sexual things, counting such things as kissing, touching, or being physically forced to have sexual intercourse) that they did not want to do in the 12 months before the survey	8.6%	No change

Source: Virginia Department of Health, Virginia Youth Risk Behavior Survey, Trend Analysis Report, 2021. https://www.vdh.virginia.gov/virginia-youth-survey/data-tables/

G. Adult Health Risk Profile

Exhibit 4.6 displays selected adult health risk indicators from the statewide Virginia Behavioral Health Risk Survey. Note that the indicators shown are estimates based on survey data, and the measures are presented as crude rates and age-adjusted rates. Areas to explore as indicated by yellow shading include:

- Higher rates of self-reported poor or fair heath in the study region compared to statewide rates.
- Higher rates of smoking, insufficient sleep, and no leisure-time physical activity in the study region compared to statewide rates.
- The differences outlined above are based on estimates, and might not be statistically significant in some cases.

Exhibit 4.6
Adult Health Risk Profile

Indicators (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Self-Reported Health Status Age 18+ (2021)								
Poor or Fair General Health (Crude)	24.7%	22.9%	24.5%	21.9%	23.2%	23.2%	15.3%	22%
Poor or Fair General Health (Age-Adjusted)	22.8%	20.2%	22.0%	19.0%	21.7%	20.8%	14.6%	
Poor Physical Health (Crude)	14.6%	14.8%	15.2%	14.2%	14.1%	14.5%	10.4%	
Poor Physical Health (Age-Adjusted)	13.4%	13.1%	13.5%	12.3%	13.1%	12.9%	9.9%	
Current Smoking Age 18+ (2021)								
Current Smokers (crude rate)	20.6%	19.9%	21.3%	18.0%	20.9%	19.7%	13.7%	22%
Current Smokers (age-adjusted rate)	21.6%	21.2%	22.0%	19.5%	21.4%	20.8%	14.1%	
Binge Drinking Age 18+ (2021)								
In Past 30 Days (crude rate)	13.6%	13.5%	13.4%	12.4%	14.5%	13.3%	15.8%	13%
In Past 30 Days (age-adjusted rate)	15.3%	16.2%	15.9%	15.5%	15.9%	15.7%	16.8%	
Insufficient Sleep Age 18+ (2021)								
Less Than 7 Hours Average (crude rate)	39.5%	37.4%	37.4%	36.1%	39.9%	37.8%	34.1%	
Less Than 7 Hours Average (age-adjusted rate)	40.9%	38.9%	38.6%	38.2%	40.9%	39.3%	34.7%	
No Leisure-Time Physical Activity Age 18+ (2021)								
Within Past 30 Days (crude rate)	30.9%	30.1%	30.8%	30.0%	30.1%	30.3%	21.6%	29%
Within Past 30 Days (age-adjusted rate)	29.4%	27.9%	28.7%	27.5%	28.9%	28.3%	21.1%	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, and the US Census Bureau. Warren, NC data from County Health Rankings, University of Wisconsin Population Health Institute.

H. Adult Health Screening Profile

Exhibit 4.7 displays selected adult health screening indicators for the study region. Note that the indicators shown are estimates based on survey data, and the measures are presented as crude rates and age-adjusted rates. Areas to explore as indicated by yellow shading include:

- Rates of colorectal cancer were slightly lower in the study region compared to the state rate in 2020.
- The percent of older adult males and females up to date on core preventive services was lower in the study region compared to the statewide rate.
  - Core preventive services for men include: an influenza vaccination in the past year; a PPV ever; and either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the past 10 years.
  - Core preventive services for women include: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the previous 10 years; and a mammogram in the past 2 years.
- The differences outlined above are based on estimates, and might not be statistically significant in some cases.

Exhibit 4.7
Adult Health Screening Profile

Indicators (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Cervical Cancer Screening (2020)								
Females Age 21-65 with Cervical Cancer Screening Test (crude)	82.4%	81.7%	81.7%	83.7%	82.5%	82.7%	83.8%	
Females Age 21-65 with Cervical Cancer Screening Test (age-adjusted)	83.3%	82.4%	82.1%	84.4%	83.2%	83.4%	84.3%	
Colorectal Cancer Screening (2020)								
Adults Age 50-75 with Adequate Colorectal Cancer Screening (crude)	73.9%	70.6%	73.0%	74.9%	71.2%	73.2%	74.6%	
Adults Age 50-75 with Adequate Colorectal Cancer Screening (age-adjusted)	71.1%	67.8%	69.7%	71.3%	69.0%	70.1%	73.1%	
Older Adult Screening (2020)								
Males Age 65+ Up to Date on Core Preventative Services (crude)	35.8%	43.6%	41.6%	46.8%	43.5%	43.0%	48.1%	
Females Age 65+ Up to Date on Core Preventative Services (crude)	37.7%	33.9%	38.9%	41.0%	36.5%	38.3%	42.7%	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, and the US Census Bureau.

I. Adult Chronic Condition Profile

Exhibit 4.8 displays selected chronic disease indicators from the statewide Virginia Behavioral Health Risk Survey. Note that the indicators shown are estimates based on survey data, and the measures are presented as crude rates and age-adjusted rates. Areas to explore as indicated by yellow shading include:

- Higher prevalence of multiple chronic conditions within the study region compared to the state.
- Higher prevalence of chronic disease related risk factors including high blood pressure and obesity (based on Body Mass Index).
- Higher prevalence of disability, which may include physical or intellectual disability. (Note that disability figures include mostly adults, but children are included as well).
- The differences outlined above are based on estimates, and might not be statistically significant in some cases.

Exhibit 4.8
Adult Chronic Condition Profile

Indicators for Adults 18+ (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Arthritis (2021)								
Ever told have arthritis (crude)	32.6%	36.0%	34.5%	36.0%	31.3%	34.3%	26.7%	
Ever told have arthritis (age-adjusted)	27.5%	28.5%	27.5%	27.2%	27.1%	27.5%	24.3%	
Asthma (2021)								
With current Asthma (crude)	11.4%	11.3%	11.2%	11.1%	11.1%	11.2%	10.2%	
With current Asthma (age-adjusted)	11.5%	11.6%	11.3%	11.4%	11.2%	11.4%	10.2%	
Cancer (other than skin) (2021)								
Ever told have cancer (crude)	7.4%	8.5%	8.5%	8.0%	8.9%	8.1%	6.8%	
Ever told have cancer (age-adjusted)	5.8%	6.2%	6.0%	6.0%	6.0%	6.0%	6.1%	
Chronic Kidney Disease (2021)								
Ever told have CKD (crude)	4.2%	4.2%	4.3%	4.4%	3.9%	4.2%	3.0%	
Ever told have CKD (age-adjusted)	3.5%	3.2%	3.3%	3.1%	3.3%	3.3%	2.7%	
Chronic Obstructive Pulmonary Disease (COPD) (2021)								
Ever told have COPD (crude)	9.8%	10.5%	10.8%	10.0%	9.5%	10.1%	6.4%	
Ever told have COPD (age-adjusted)	8.2%	8.2%	8.6%	7.5%	8.2%	8.0%	5.7%	
Coronary Heart Disease (CHD) (2021)								
Ever told have angina or CHD (crude)	8.0%	8.6%	8.7%	8.7%	7.6%	8.4%	5.5%	
Ever told have angina or CHD (age-adjusted)	6.2%	6.0%	6.4%	5.7%	6.2%	6.0%	4.8%	
Diabetes (2021)								
Ever told have diabetes (crude)	16.9%	16.2%	17.0%	16.7%	15.5%	16.5%	11.1%	15%
Ever told have diabetes (age-adjusted)	14.0%	12.2%	13.2%	12.2%	13.2%	12.9%	9.9%	

Exhibit 4.8
Adult Chronic Condition Profile

Indicators for Adults 18+ (Yellow = Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
High Blood Pressure (2021)								
Ever told have HBP (crude)	45.3%	44.4%	46.0%	46.5%	43.0%	45.3%	34.3%	
Ever told have HBP (age-adjusted)	40.3%	36.5%	38.8%	37.5%	38.9%	38.3%	31.7%	
High Cholesterol (2021)								
Ever told have high cholesterol (crude)	41.6%	40.1%	42.2%	41.7%	42.9%	41.6%	37.6%	
Ever told have high cholesterol (age-adjusted)	33.5%	33.6%	33.7%	33.3%	34.1%	33.6%	33.4%	
Obesity (2021)								
BMI >=30 (crude)	43.9%	42.5%	42.9%	39.9%	39.6%	41.4%	34.5%	44%
BMI >=30 (age-adjusted)	44.3%	42.4%	42.5%	40.2%	39.6%	41.5%	34.5%	
Disability (2022)								
Population with a disability (all ages)	2495	2512	2357	5783	2499	15,646	1,017,014	
Population with a disability (percent of population)	18.0%	22.0%	21.2%	19.7%	18.0%	19.6%	12.1%	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, Behavioral Risk Factor Surveillance Survey, and the US Census Bureau American Community Survey.(Note that disability indicators include all ages). Warren, NC data from County Health Rankings, University of Wisconsin Population Health Institute

J. Communicable Disease Profile

Exhibit 4.9 displays selected communicable disease indicators for the study region. As illustrated in yellow shading, as of 2021, study region rates were higher than statewide rates for Chlamydia, Gonorrhea, and HIV/AIDS.

Exhibit 4.9
Communicable Disease Profile

Indicators (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Chlamydia (2021)								
Chlamydia Infections (count)	91	48	45	154	111	449	40,409	
Chlamydia Infections (rate per 100,000 population)	570.9	419.3	377.3	509.1	711.8	527.3	467.6	**591.6**
Gonorrhea (2021)								
Gonorrhea Infections (count)	45	16	38	89	20	208	14,323	
Gonorrhea Infections (rate per 100,000 population)	282.3	139.8	318.6	294.2	128.3	244.3	165.7	
HIV/AIDS (2021)								
Population with HIV/AIDS (count)	59	16	34	71	82	262	24,411	
Population with HIV/AIDS (rate per 100,000 population)	416.2	164.2	330.3	269.9	606.8	353.86	333.9	456

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, and the US Census Bureau. Warren, NC data from County Health Rankings, University of Wisconsin Population Health Institute

K. Oral Health Profile

Exhibit 4.10 displays selected indicators of oral health status for the study region. Note that the indicators shown are estimates based on survey data, and the measures are presented as crude rates and age-adjusted rates. Areas to explore as indicated by yellow shading include:

- Higher rates of self-reported poor dental health in the study region compared to statewide rates.
- Lower rates of recent dental visits (past year) compared to statewide rates.
- The differences outlined above are based on estimates, and might not be statistically significant in some cases.

Exhibit 4.10
Oral Health Profile

Indicators (yellow: Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Self-Reported Dental Health (2020)								
Adults Age 18+ Report Having Lost all of their Natural Teeth (crude)	15.9%	15.4%	14.9%	12.9%	13.7%	14.2%	8.6%	
Adults Age 18+ Report Having Lost all of their Natural Teeth (age-adjusted)	16.8%	16.3%	15.7%	13.6%	14.5%	15.0%	9.0%	
Self-Reported Dental Visits (2020)								
Adults Age 18+ with Dental Visit in Past Year (crude)	55.7%	57.1%	58.3%	62.1%	57.3%	58.8%	68.6%	
Adults Age 18+ with Dental Visit in Past Year (age-adjusted)	55.0%	56.2%	57.5%	60.8%	56.8%	57.9%	68.3%	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, and the US Census Bureau.

L. Mental Health Profile

Exhibit 4.11 displays selected indicators of mental health status for the study region. Note that the indicators shown are estimates based on survey data, and the measures are presented as crude rates and age-adjusted rates. Areas to explore as indicated by yellow shading include:

- Higher rates of self-reported poor mental health in the study region compared to statewide rates.
- Slightly higher rates of ever being diagnosed with depression in the study region compared to statewide rates.
- A higher death rate for suicide (unadjusted for age) compared to the statewide rate.
- The differences outlined above are based on estimates, and might not be statistically significant in some cases.

Exhibit 4.11
Mental Health Profile

Indicators (Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Self-Reported Mental Health (2021)								
Adults Age 18+ with Poor Mental Health in past 30 days (crude)	16.8%	16.7%	16.7%	15.5%	16.9%	16.3%	14.7%	18%
Adults Age 18+ with Poor Mental Health in past 30 days (age-adjusted)	18.0%	18.7%	18.5%	17.7%	17.9%	18.0%	15.3%	
Self-Reported Depression (2021)								
Adults Age 18+ Ever told have Depression (crude)	19.5%	22.1%	21.2%	20.1%	20.9%	20.6%	20.1%	
Adults Age 18+ Ever told have Depression (age-adjusted)	20.1%	23.6%	22.4%	21.7%	21.4%	21.7%	20.5%	
ED Visits for Self-Harm and Suicide (2021)								
Self-harm and Suicide-related ED Visit (count)	60	116	50	141	101	468	55,067	
Self-harm and Suicide-related ED Visit (per 100,000 population 5+)	390.6	1039.4	429.7	484	700.9	(nr)	680.9	
Deaths by Suicide (2016-2020)								
Suicide Deaths (count)	(nr)	(nr)	(nr)	(nr)	(nr)	67	5,930	
Death (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	18.8	13.9	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, and the US Census Bureau.

M. Substance Use Profile

Exhibit 4.12 displays selected indicators of substance use for the study region. Areas to explore as indicated by yellow shading include:

- Higher rate of drug overdose deaths in the study region compared to the statewide rate.
- Higher rates of hospitalization for drug overdose or other substance use in the study region compared to statewide rates.
- Higher rates of alcohol-involved crash deaths across the study region compared to the statewide rate.

Exhibit 4.12
Substance Use Profile

Indicators (yellow = Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Drug Overdose Deaths (2016-2020)								
Drug Overdose Deaths (count)	(nr)	(nr)	(nr)	(nr)	(nr)	82	8,147	
Crude Death (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	22.1	19.2	
Age-Adjusted Death (rate per 100,000 population)	(nr)	(nr)	(nr)	(nr)	(nr)	27.8	19.3	
Hospitalizations (2020)								
Hospitalizations with Drug Overdose (count)	11	11	11	35	21	89	7,725	
Hospitalizations with Drug Overdose (rate per 100,000 population)	68.6	93.1	89.7	114.1	138.5	103.5	89.9	
Hospitalizations with Substance Use Disorder (count)	7	11	7	26	18	69	6,447	
Hospitalizations with Substance Use Disorder (rate per 100,000 population)	43.7	93.1	57.1	84.8	118.7	80.3	75.1	
Alcohol-Impaired Driving Deaths (2016-2020)								
Alcohol-Involved Crash Deaths (count)	7	7	5	13	7	39	1,244	
Alcohol-Involved Crash Deaths (rate per 100,000 population)	8.8	12.1	8.4	8.6	9.0	9.1	2.3	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, the National Highway Traffic Safety Administration, and the U.S. Census Bureau.

N. Injury Profile

Exhibit 4.13 displays selected indicators of death and hospitalization due to injury within the study region. Areas to explore as indicated by yellow shading include:

- Higher rates of unintentional injury deaths and motor vehicle traffic crash deaths in the study region compared to statewide rates.
- Higher rates of hospitalization in the study region compared to statewide rates for all injuries, fall injuries, and motor vehicle traffic injuries.

Exhibit 4.13
Injury Profile

Indicators (yellow = Areas to explore)	Brunswick County	Charlotte County	Lunenburg County	Mecklenburg County	Nottoway County	Virginia Region	Virginia State	Warren, NC
Unintentional Injury Deaths (2016-2020)								
Total Deaths (count)	69	61	41	121	57	349	20,285	
Crude Death (rate per 100,000 population)	85.0	101.9	67.2	78.8	74.2	80.7	47.7	
Age-Adjusted Death (rate per 100,000 population)	73.1	89.3	54.6	73.8	65.2	71.6	45.3	
Motor Vehicle Traffic Crash Deaths (2016-2020)								
Total Deaths (count)	22	25	13	40	25	125	4,341	
Crude Death (rate per 100,000 population)	27.1	41.8	(nr)	26.1	32.5	28.9	10.2	
Age-Adjusted Death (rate per 100,000 population)	24.9	35.8	(nr)	26.4	31.2	28.6	9.8	
Hospitalization for Injury (2020)								
All Injuries (count)	90	88	58	171	115	522	33,241	
All Injuries (rate per 100,000 population)	561.2	744.5	472.8	557.4	758.6	607.2	387.0	
Fall Injury (count)	34	45	27	87	56	249	17,790	
Fall Injury (rate per 100,000 population)	212.0	380.7	220.1	283.6	369.4	289.7	207.1	
Motor Vehicle Traffic (MVT) Injury (count)	17	17	10	21	9	74	3,259	
MVT Injury (rate per 100,000 population)	106.0	143.8	81.5	68.5	59.4	86.1	37.9	

Source: Virginia Community Health Improvement Data Profile, based on data from the Virginia Department of Health, CDC, Virginia Health Information, and the U.S. Census Bureau.

Appendix A. Data Sources

The data sources used to produce the exhibits within the reports are listed below. Sources are also listed in the Source note within each report Exhibit. Community Health Solutions (CHS) used a combination of qualitative and quantitative analysis to develop the indicators presented in the Exhibits.	
Executive Summary	• All exhibits in the Executive Summary are drawn from subsequent exhibits presented in Sections 1-4.
Section 1. Health - Related Social and Economic Factors	CHS analysis of multiple data sources including: • Demographics estimates from ESRI obtained through ArcGIS Business Software • The survey of community residents • The survey of community stakeholders • The Virginia Community Health Improvement Data Portal published by the Virgnia Department of Health.**
Section 2. Insights from Community Residents	• CHS analysis of data from the survey of community residents. • The Exhibits show a summary analysis of results. • Detailed survey responses have been provided separately to VCU Health Community Memorial Hospital.
Section 3. Insights from Community Residents	• CHS analysis of data from the survey of community stakeholders. • The Exhibits show a summary analysis of results. • Detailed survey responses have been provided separately to VCU Health Community Memorial Hospital.

Section 4. Community Health Data Profiles	CHS analysis of multiple data sources including:
	• Demographic estimates from ESRI obtained through ArcGIS Business Software
	• The Virginia Community Health Improvement Data Portal published by the Virgnia Department of Health.
	• Selected additional indicators for Warren, NC were obtained from:
	  o County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute.
	  o The North Carolina State Center for Health Statistics, North Carolina Division of Public Health.

**** A Note on the Virginia Community Health Improvement Data Portal**	• Primary data sources within the portal include the Virginia Department of Health, the U.S. Centers for Disease Control, the U.S. Census Bureau, and the U.S. Health Resources and Services Administration. • The data portal is available to the public at: https://virginiawellbeing.com/virginia-community-health-improvement-data-portal/
Technical Questions	Technical questions about the data sources and methods can be forward to: • Stephen Horan • Community Health Solutions • 804.673.0166 • shoran@chsresults.com

Appendix B. Actions Taken in Response to the 2021 CHNA Study

Introduction

VCU Health Community Memorial conducted a comprehensive community health needs assessment (CHNA) study in 2021.

- In response to the findings from that study, the hospital worked with community partners identified a set of priority issues for action. Many of these initiatives will provide a starting point for continued action in response to the 2024 CHNA study.
- The following sections describe actions taken in response to the priority themes identified in the 2021 CHNA study.

Priority Themes from the 2021 CHNA Study
A. Health Care Disparities and Inequities B. New Service Offerings C. Workforce Development D. Heart Disease E. Malignant Neoplasms F. Cerebrovascular Disease G. Chronic Lower Respiratory Disease H. Infant Mortality I. Mental Health J. Injury and Violence

A. Health Care Disparities and Inequities

Actions Steps

a. Health Related Social Needs (HRSN) screening, data analytics, and action planning is in place to identify and address social needs of patients
b. Partnered with Feed More to provide food to patients who identified as having a food need
c. Launched VCU School of Nursing Mobile Health and Wellness Program (MHWP) van in Lawrenceville to provide health screenings and resource connections
d. Launched front end process change to decrease patients who leave without being seen in the ED to ensure timely access to care

B. New Service Offerings

Action Steps

a. Employed a GI physician with clinic, outpatient infusion, inpatient, and procedural offerings
b. Employed a Rheumatologist with clinic and outpatient infusion therapy offerings
c. Ongoing participation in clinical trials and physician research/publications across orthopedics, oncology, ICU Red Heart, Heart Failure, and COVID-19

C. Workforce Development

Action Steps

a. Launched VCU Health Rural Track Family Medicine Residency Program
b. Ongoing participation in medical and clinical education and training thought VCU (medical students, nursing students)
c. Provide a clinical site for Southern Virginia Community College nursing students and serve as clinical site for radiation oncology, imaging, physical/occupational/speech therapy
d. Continuing summer nurse extern program

D. Heart Disease

Action Steps

a. Hired additional 2 FT Advanced Practice Providers for Cardiology Program
b. Moved EKG interpretation to cardiologists/pediatric cardiologist
c. Implemented EPIC Electronic Medical Record to all sites to standardize care platforms.

E. Malignant Neoplasms

Action Steps

a. Launch of telemedicine appointments at cancer care clinic and addition of 2nd Advanced Practice Provider
b. Increased low dose lung cancer screenings by 10%
c. Increased participant enrollment in clinical trials by 6%
d. Implemented tobacco cessation education and resources
e. Provided education on prostate cancer
f. Implemented community screenings and education for prostate cancer
g. Continue to offer free mammograms to women in need through partnership with Susan Komen Foundation
h. Identifying and addressing barriers to radiation treatment appointments to ensure access to care and decrease no shows

F. Cerebrovascular Disease

Action Steps

a. Joint Commission Primary Stroke Center Accredited
b. Hired one community neurologist

G. Chronic Lower Respiratory Disease

Action Steps

i. Hired two community Pulmonologist and one part time Advanced Practice Provider

H. Infant Mortality

Action Steps

a. Aligned CMH with VCU Medical Center's High-Risk OB for care and treatment protocols
b. Aligned CMH with VCU Medical Center's NICU for care and treatment protocols
c. Hired an additional Obstetrician

I. Mental Health

Action Steps

a. Opened outpatient mental health clinic with one Psychiatrist and one licensed social worker
b. Partnering with local Community Service Board to support patients in crisis

J. Injury and Violence

Action Steps

a. Completed gap analysis to purse Level 3 Trauma designation and now in planning and recruitment phase
b. Ongoing collaboration with VCU Health System to assess and reduce workplace violence
c. Launched weapons screening initiative to support a safe workplace for staff and patients

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