CENTRA

2021–2024

City of Lynchburg and Amherst, Appomattox, Campbell and Pittsylvania Counties

Lynchburg Area Community Health Needs Assessment

Centra Lynchburg General Hospital | Centra Virginia Baptist Hospital | Centra Specialty Hospital

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Executive Summary

Centra Health is pleased to provide the triennial 2021 Community Health Needs Assessment (CHNA) for Centra Hospitals (Centra Lynchburg General, Virginia Baptist, and Centra Specialty Hospitals) located in Lynchburg, Virginia. For the purposes of this report, the service area is referred to as the Lynchburg Area and includes the city of Lynchburg and the counties of Amherst, Appomattox, Campbell and Pittsylvania. The CHNA provides an overview of the health status of the communities served by the health system. It is the intent of this report to provide readers with a deeper understanding of the needs of the Lynchburg Area as well as to guide Centra Health, and its community partners and stakeholders, in developing Implementation Plans to address the prioritized needs identified because of the assessment process. The Community Health Needs Assessment and Prioritization of Needs was approved by the Centra Community Benefit Committee on November 19, 2021 and the Centra Board of Directors on December 6, 2021.

The Partnership for Healthy Communities is a planning initiative led by Centra, the Community Access Network, the Central Virginia, Piedmont, and Pittsylvania/Danville Health Districts, the Bedford Community Health Foundation, Greater Lynchburg Community Foundation, Johnson Health Center and United Way of Central Virginia. The partners are committed to regional alignment of a collaborative and rigorous needs assessment process that will result in action-oriented solutions to improve the health of the communities they serve. A Community Health Assessment Team composed of over 70 individuals with a broad representation of community leaders and cross-sector stakeholders acted to oversee, advise, and support the CHNA activities.

The 2021 Lynchburg Area Community Health Needs Assessment focused on lifting the voice of the community through the collection of 4,450 Community Health Surveys as well as conducting a stakeholder focus group/survey. In addition, over 65 sources of publicly available secondary data were collected.

KEY FINDINGS

The data for the Community Health Needs Assessment is reported using the framework for the County Health Rankings from the University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation. These rankings, released annually, measure the health of a community, and rank them against all other counties within a state. In Virginia, there are 133 localities that are ranked annually. The County Health Rankings for the Lynchburg service area for 2019-2021 are in the 2nd to 3rd quartile for "Health Outcomes", which is a measure of morbidity and mortality and how healthy a locality is today. "Health Factors," represents factors that influence health of a community in the future.

County Health Rankings

Locality	2019		2020		2021	
	Health Outcomes	Health Factors	Health Outcomes	Health Factors	Health Outcomes	Health Factors
Amherst	47	65	52	72	55	70
Appomattox	74	74	77	83	75	86
Campbell	53	78	46	78	44	74
Lynchburg City	81	82	86	81	72	60
Pittsylvania	68	92	87	97	90	98

Note: "1" equals best; "133" equals worst. In Virginia, Health Outcome and Health Factor Ranks are by quartiles as follows 1st quartile (1 to 33); 2nd quartile (34 to 66); 3rd quartile (67 to 100); 4th quartile (101 to 133).

Locality	3 Year Change	
	Health Outcomes	Health Factors
Amherst	8	5
Appomattox	1	12
Campbell	-9	-4
Lynchburg City	-9	-22
Pittsylvania	22	6

Change: 'minus (-)' equals improving;
'plus (+)' equals worsening

HEALTH FACTORS

Four major categories contribute to the Health Factors rankings for a community. Forty percent (40%) of these factors are impacted by social and economic factors; 30% by health behaviors; 20% by clinical care; and 10% by physical environment.

Demographics, Social and Economic Status

According to the U.S. Census, the total population for the service area is 244,432 where 48.0% of the population is male and 51.97% is female. The median age for the service area is 41.8 years and ranges from 28.3 years in Lynchburg to 47.2 years in Pittsylvania County. The median age in Virginia is 38.2. Approximately 18.5% of the population is 65 years of age or older which is slightly higher than those 65 years of age or older living in Virginia (15.1%). Approximately 75.3% of those living in the service area are White, 20.1% are Black, and 2.7% are Hispanic or Latino.

The median household income in the service area is $51,069 as compared to $74,222 in Virginia with whites and Hispanic populations having higher median household incomes than blacks. Approximately 34.88% of the population lives at or below 200% of the Federal Poverty Level as compared to 24.8% in Virginia. In Lynchburg, 40.9% of the population lives at or below 200% of the Federal Poverty Level. Additionally, approximately 41% of the 95,926 households in the service area are classified as ALICE (Asset Limited, Income Constrained, Employed) as compared to 29% of households in Virginia. ALICE is a way of defining and understanding the struggles of households that earn above the Federal Poverty Level, but not enough to afford basic household needs (i.e., cost of living outpaces what they earn).

Of the public school-aged children in the service area, 62% (19,405) are eligible for free and reduced lunches as compared to 45.64% of children in the Commonwealth. This is even more pronounced for children attending Lynchburg City Schools where 82.04% are eligible for free and reduced lunches. Almost half of children (46%) living in the Lynchburg service area live at or below 200% the Federal Poverty Level as compared to 33% in Virginia and that is estimated to be 23,506 children. The greatest concentration of these children live in the city of Lynchburg and Pittsylvania County.

Although unemployment rates were decreasing in 2018 and 2019 across the Commonwealth, there was an almost doubling of these rates in 2020 as a result of the COVID-19 pandemic. The unemployment rate for the service area and Virginia was 6.2% in 2020 with the highest unemployment rate in the city of Lynchburg (7.2%). In the service area, of the population age 25 and over, educational attainment is 14.0% for less than high school graduate; 32.5% for high school graduate or equivalency; 27.7% for some college or Associate's Degree; and 22.5% for Bachelor's Degree or Higher.

Most Community Health Survey respondents (90.2%) lived in the Lynchburg Area with a median age of 35 years (47 years in 2018). In 2021, we saw a significant increase in the number of male respondents (42.4%) while 54.8% were female, and 2.6% identified as non-binary. Fewer survey respondents were White (58.4%) or Black/African American (12.8%) as compared to 2018 respondents. However, there was a significant increase in the number who reported being Hispanic/Latino (5.3%) or either Asian, American Indian/Alaska Native or Native Hawaiian/ Pacific Islander (21.6% collectively).

Fewer survey respondents in 2021 reported an annual income of $20,000 or less per year as compared to 2018 (17.6% versus 31.4% respectively). However, a significant number of respondents (28.8%) reported incomes of $20,001 to $40,000. This may reflect an increase in the number who are ALICE (Asset Limited, Income Constrained, Employed). There was a slight decrease in the number of those reporting household incomes of over $70,000 per year in 2021. An estimated 46.3% of respondents lived no greater than 200% of the Federal Poverty Level (FPL) of which an estimated 19.9% lived below 100% of FPL. Survey respondents had higher education attainment rates than the population as a whole. Over half were employed full-time with 7% reporting being unemployed which is slightly higher than the unemployment rates for the service area (6.2%). Approximately 37% of respondents reported not having enough money in the past 12 months to pay for rent or mortgage while 45.3% reported not having enough money in the past 12 months to buy food. Approximately 20% could not afford to pay for their medications.

Over 25% of respondents reported being a victim of domestic violence or abuse in the past 12 months a significant increase from 3.6% in 2018 while 10% of respondents did not feel safe where they lived. When asked which social/support resources are hard to get in the community, the top 5 responses included (1) childcare; (2) affordable/safe housing; (3) employment/job assistance; (4) domestic violence assistance; and (5) healthy food.

Health Behaviors

The obesity rate for the service area is 36.5% with the highest rates in Appomattox (40.7%), Campbell (38.4%) and Pittsylvania County (38.9%). Approximately 23% of Community Health Survey respondents self-reported being overweight while 39% reported being obese. According to data from County Health Rankings, a greater proportion of the population report no-leisure time physical activity especially in the more rural communities of Appomattox (30%), Campbell (31%) and Pittsylvania (33%) as compared to 22% of adults in the Commonwealth. Only 29% of Lynchburg Area Community Health Survey respondents met physical activity guidelines of 150 minutes of aerobic activity weekly in 2021.

Approximately 20% of Community Health Survey respondents reported that their neighborhoods don't support physical activity and that it is not easy to get affordable fresh fruits and vegetables in their neighborhoods. There was a significant reduction in the number of respondents who reported that they get their food from grocery stores (and an increase in those who reported using corner stores, Meals on Wheels and Back-pack or summer food programs). Additionally, the majority of respondents did not meet the minimum requirements for daily fruit and vegetable consumption.

Data for the service area reveals that 17.6% of adults binge or drink heavily (17.7% in Virginia) while 21.6% are current tobacco smokers (15% in Virginia). Thirty-three percent (33%) of Community Health Survey respondents reported using tobacco products and 28% reported binge drinking during one occasion in the past month. There was a significant increase in the number who reported taking prescription drugs to get high (13.6% in 2021 compared to 1.6% in 2018) while 9.8% used marijuana and 2.9% used other illicit drugs in the past month.

In 2019, the Lynchburg region had 34 fatal opioid overdoses of which 65% were attributed to Fentanyl/Analog and 35% to Heroin or Prescription Drugs. The per capita death rate in the region was 13.91 per 100,000 as compared to 15.52 per 100,000 for Virginia with 75.1% of overdoses involving fentanyl or analogs. In 2020, overdose deaths in the United States reached a record 93,000 eclipsing the high of 72,000 deaths the year before (29% increase). The pandemic exacerbated this "overdose pandemic" which is being driven by fentanyl contaminated opioids and amphetamines. Service area opioid overdose data for 2020 was unavailable for this assessment.

Clinical Care

All of the localities in the service area, with the exception of Campbell County, are federally designated as Medically Underserved Areas and all localities are designated as Health Professional Shortage Areas for Primary Care, Mental Health, and Dental. There are three Federally Qualified Health Centers (FQHCs), one FQHC Look-a-like, one Free Clinic and two Community Services Boards that serve the area.

Over 85% of Community Health Survey respondents reported using medical services. Of those who use medical services, 35% reported "doctor's office" as their top choice for care while there was an increase in the use of Urgent Care (34%), Emergency Rooms (27%), and Federally Qualified Health Centers (FQHC) (24%) in 2021. Almost 12% reported using online/telehealth/virtual visits and 4% reported not seeing, postponing, or cancelling visits with their healthcare providers due to COVID-19.

Twenty percent (20%) of respondents do not use dental services and of those who do, 40% reported having a dental exam within the past 12 months a drop from 63% in 2018. More used the Free Clinic (22%) and FQHC's (26%) for dental care, four times the response rates in 2018. In 2021, respondents who used an Urgent Care or the Emergency Room for dental care (11% and 4.7% respectively) increased significantly from 2018 (1% and 2% respectively).

The number of respondents indicating that they use mental health, alcohol or drug abuse services increased dramatically from 17.6% in 2018 to 46.5% in 2021. More than 1 out of 5 used online, telehealth, or virtual visits for their care and the use of FQHC's (36.4%), Free Clinics (27.5%), and the Emergency Room (ER) (24.4%) increased significantly from 2018 (15%; 4.1%; 9.4% respectively). The use of the area Community Services Board decreased from 57% in 2018 to 11% in 2021.

Almost 5% of respondents reported not seeing, postponing, or cancelling dental and mental health/substance abuse visits with their providers due to COVID-19.

The number of respondents indicating that they had no insurance fell from 9% in 2018 to 4.1% in 2021. Respondents with Medicare coverage increased to 38.7% while slightly fewer respondents reported they had Medicaid (15.6%). With Medicaid Expansion in Virginia beginning in 2019, an estimated 400,000 people were expected to become eligible for coverage under the expanded guidelines, but that number is higher now that the COVID pandemic has caused widespread job losses. By early 2020, about

375,000 people had gained coverage under the expanded eligibility guidelines. By December 2020, however, that number had grown to more than 494,000 people. When the job market rebounds after the pandemic recedes, some of those individuals will transition away from Medicaid.

When asked which healthcare services are hard to get in the community, survey respondents reported (1) alternative therapies; (2) mental health/counseling; (3) eldercare; (4) cancer care and (5) domestic violence services. When asked what prevents them from being healthy, survey respondents reported (1) cost; (2) high co-pays; (3) long waits for appointments; (4) lack of evening and weekend services; and (5) don't know what types of services are available.

Physical Environment

The physical environment can impact a wide range of health and quality-of-life outcomes and include such factors as the natural environment, transportation, the built environment, housing, exposure to toxic substances, and physical barriers especially for those living with disabilities. Data for the service area reveals that 12.5% of households have severe housing problems with the largest number in the city of Lynchburg (17%). Housing problems include overcrowding, high housing costs, or lack of kitchen or plumbing facilities. Additionally, residential segregation (the degree to which two or more groups live separately from one another in a geographic area) is highest in Lynchburg at a segregation index of 35 as compared to 41 in Virginia.

Community Health Survey respondents were asked where they sleep most often. In 2021, 63% of respondents slept most often in their own homes. The additional respondents who reported either sleeping at a friend's or family's home, in a shelter or transitional housing, or in a group home, hospital, or treatment program was 35.4%.

Approximately 89% of respondents indicated that they had access to reliable transportation. When asked what type of transportation they use most often, in 2021, 51% indicated that they drove, biked/walked (14.6%), relied on others to drive them (16.4%) or used public transit (8.4%).

During the pandemic shutdown, the lack of broadband access especially in the more rural areas, made it difficult for adults to work remotely, prevented children from attending school virtually, and decreased access to telehealth services. In the service area, the percentage of households with Broadband Internet access is 73% as compared to 84% in Virginia as a whole.

HEALTH OUTCOMES

Health Outcomes rankings are determined by length of life and quality of life measures and reflect the physical and mental well-being of residents within a community.

Length of Life

In the service area, the life expectancy by average number of years lived is 77.5 years as compared to 79.5 in Virginia. The lowest life expectancy rates are in Lynchburg (76.3 years) and Pittsylvania County (76.7 years). The premature death rate for the service area is 391.4 as compared to 320.0 in Virginia with the highest rates in Lynchburg (430.6) and Pittsylvania County (404.8). In the service area, death rates are higher for overall deaths; deaths due to injury; and hypertension. Service area death rates for heart disease and stroke were higher especially in blacks compared to whites. Cancer incidence rates are higher for all cancer types especially lung, colon and rectal cancers as compared to rates in Virginia.

Suicide rates in the service area (18.36) are higher than the overall state rate (13.20) with the highest rates in Appomattox (23.85) and Pittsylvania County (21.63).

Quality of Life

Low birth weights per total live births on average were slightly lower in the service area as compared to the Commonwealth. Racial disparities exist however for black and "other" races where low birth weight percentages are higher than percentages for whites . These disparities are also evident for teen birth rates where rates for all localities (except the city of Lynchburg) are higher than the rates for Virginia and rates for black teens are higher than whites (except in Appomattox County).

In 2021, when thinking about their health in the past month, 57% of survey respondents reported that their physical health was not good for 1 to 15 days and 36.7% of persons felt their mental health was not good for 6 to 15 days (13.9% in 2018). The impact of COVID-19 should be considered as a contributor to this increase. Secondary data for the service area revealed that persons reporting physically unhealthy days in the past month and reporting average number of poor mental health days in the past 12 months was higher for the service area as compared to Virginia.

Survey respondents diagnosed with a chronic condition had depression or anxiety, high blood pressure, obesity/ overweight, high cholesterol, mental health problems and drug or alcohol problems most frequently.

COVID-19

The COVID-19 pandemic has changed how we work, learn, and interact with each other leading to a more remote, virtual life for many both personally and professionally. It has resulted in increases in depression and anxiety, domestic violence and child abuse, joblessness, and food insecurity. Its impact has been especially hard on communities of color, the young and the elderly, and those suffering from chronic disease. Locally, current COVID-19 cases and death rates in the Lynchburg service are higher than the rates in Virginia as a whole and our vaccination rates are lower. Although we are seeing a downward turn in our cases and positivity rates, we can expect to feel the impact of this global pandemic for years to come.

COMMUNITY NEED

2021 Community Health Survey respondents were asked what are the most important issues that affect health in our community by ranking both health factors and health conditions/ outcomes. The top 10 responses were as follows:

Health Factors		
1	**Alcohol and illegal drug use**	42.5%
2	**Access to healthy foods**	37.9%
3	**Poor eating habits**	32.6%
4	**Aging problems**	29.8%
5	**Lack of exercise**	28.0%
6	**Cell phone use / texting and driving / distracted driving**	26.9%
7	**Access to affordable housing**	26.9%
8	**Child abuse / neglect**	25.8%
9	**Domestic Violence**	24.8%
10	**Tobacco use / smoking / vaping**	23.8%

Health Conditions or Outcomes		
1	**COVID-19 / coronavirus**	44.4%
2	**Diabetes**	42.1%
3	**Mental health problems**	40.2%
4	**Overweight / obesity**	39.6%
5	**High blood pressure**	37.6%
6	**Heart disease and stroke**	36.1%
7	**Cancers**	34.3%
8	**Stress**	31.6%
9	**Dental problems**	24.7%
10	**Disability**	24.6%

A Focus Group meeting was held with 75 cross-sector stakeholders, non-profit organizations, service providers, business leaders, and local government officials. Keeping the impact of the COVID-19 pandemic in mind, they were asked questions regarding the needs of those they serve, resources available in the community to address those needs (including any gaps in resources), and how we can work together to create healthier communities. In the Lynchburg Area, the top 5 needs identified by these stakeholders were (1) access to mental health services; (2) transportation; (3) childcare; (4) food insecurity and nutrition; and (5) housing.

PRIORITIZATION OF NEEDS

Upon completion of primary and secondary data collection, the Lynchburg Area Community Health Assessment Team (CHAT) was charged with prioritizing the needs of the community.

Using the data collected for the 2021 Community Health Needs Assessment, a detailed "Prioritization of Needs Worksheet" was developed based on the importance placed on areas of need identified through two methods:

1. Responses from the Community Health Survey

a. Q2A: What do you think are the most important issues that affect health in our community? (Health Factors) (n= 4403 survey responses)

b. Q2B: What do you think are the most important issues that affect health in our community? (Health Conditions or Outcomes) (n= 4374 survey responses)

c. Q3: Which health care services are hard to get in our community? (n= 4325 responses)

d. Q4. Which social/support resources are hard to get in our community? (n= 4227 responses)

2. Responses from the Stakeholders' Focus Group/Survey

a. Q1. What are the top 5 greatest needs in the community(s) you serve? (n= 253 responses)

CHAT members were asked to rank the top five priority areas of need (out of the 37 identified) with 1 being the greatest need and 5 being the 5th greatest need.

The 2021 Prioritization of Needs Top 10 Rankings for the Lynchburg Area includes:

1. Access to Healthcare Services
2. Mental Health and Substance use Disorders & Access to Services
3. Issues Impacting Children and their Families
   a. Childcare
   b. Child Abuse/Neglect
4. Poverty
5. Aging and Eldercare
6. Housing
7. Financial Stability
8. Chronic Disease
9. Food Insecurity and Nutrition
10. Equity, Inclusion and Diversity

PROJECT BACKGROUND

This section highlights Centra's services and programs, a project overview, and description of the service area, target population and methodology for the 2021 Lynchburg Area Community Health Needs Assessment.

Project Background

ORGANIZATIONAL OVERVIEW

Centra Health (Centra) is a regional nonprofit healthcare system based in Lynchburg, Virginia. With more than 8,100 employees, 500 employed providers and physicians, and a medical staff of nearly 800 providing care in 50 locations, Centra serves over 500,000 people as the dominant provider of critical medical services in central and southern Virginia. Over the last five years, the system's net revenues grew from $930 million in 2015 to $1.2 billion in 2020.

Centra was created in 1987 through the merger of the Lynchburg General (LGH) and Virginia Baptist (VBH) Hospitals. In 2006, Southside Community Hospital (CSCH) in Farmville became a Centra affiliate. In 2014, Centra acquired full ownership of Bedford Memorial Hospital (BMH), in the town of Bedford, which is its fourth hospital. In addition to these flagship facilities, the system includes Centra Specialty Hospital, a long-term acute care hospital, a regional standalone emergency department, health and rehabilitation centers, a cancer center, a nursing school, sites and providers serving a geography of approximately 9,000 square miles, and a health plan. Centra's services also include residential and outpatient mental health facilities, home health and hospice programs, mammography centers, a sleep disorders center, and a center for wound care and hyperbaric medicine. Centra is home to the Central Virginia Center for Simulation and Virtual Learning, the only center in Virginia that offers a full range of simulation experiences. In September of 2021, Centra welcomed Amy Carrier to the role of president and Chief Executive Officer, the first female to hold that position since the founding of the health system.

Centra Lynchburg General Hospital (LGH), with 358 beds, is home to the Centra Stroobants Heart Center and Stroobants Cardiovascular Pavilion, a national benchmark facility for cardiac care. Centra Heart Center specialists perform more than 6,000 major cardiac procedures each year. LGH is also a Level II Trauma Center, providing emergency and critical care services to more than 85,000 patients per year (LGH's emergency department ranks as one of the busiest in the state). LGH has a pediatric center and an outpatient surgery center and provides orthopedic, neurology, neurosurgery, diabetes, oncology and pulmonary services. The five-story East Tower at LGH has 144 private patient rooms for orthopedic, oncology, pulmonary and surgery patients.

Centra Virginia Baptist Hospital (VBH), a 161-bed facility located three miles from LGH, includes The Birth Center, Women's and Children's Health, and the region's neonatal intensive care unit. VBH also serves as the primary regional provider of children and adult mental health services. VBH operates an outpatient surgery center and provides acute rehabilitation, physical therapy and ambulatory surgery. VBH is home to a variety of specialty services, including the Breast Imaging Center, Heartburn Treatment Center, Sleep Disorders Center, and the Center for Pain Management.

At the ***Alan B. Pearson Regional Cancer Center*** that opened in 2008, Centra caregivers treat a broad range of cancers, including lung, prostate, breast, brain, kidney, bladder, ovarian, lymphoma, leukemia, colon, uterine and rectal. The Cancer Center brings radiation and medical oncology together in one facility for patient convenience. Centra's comprehensive cancer services and treatments range from the newest minimally invasive robotic surgery and Trilogy linear accelerator to chemotherapy, biological and targeted drug therapies; genetic testing; and clinical trials.

Centra College offers four nursing programs: Registered Nurse to Bachelor of Science in Nursing (RN-BSN), Associate Degree in Nursing (ADN), Practical Nursing Program (PN) and Nurse Aide Education Program. The College incorporates the various aspects of the Professional Practice Model developed and implemented by Centra for the purpose of educating nursing students to provide safe, quality, patient-centered care based on best practices.

Centra Heart and Vascular Institute (HVI) is home to many heart and vascular services. In addition to providing general cardiology care, the Institute offers specialty care for patients with a wide range of heart and blood vessel disorders like arrythmias, peripheral artery disease, heart failure, aortic stenosis and varicose veins. They offer advanced cardiac imaging and other diagnostic tests. HVI has locations throughout the Centra footprint including Lynchburg, Farmville, Danville, Gretna, Moneta, and Bedford.

Centra Medical Group (CMG) is a network of local family practices, primary care physicians, and medical and surgical specialists. With over 260 employed physicians, specialists and surgeons covering the greater Lynchburg area and spanning from Danville to Farmville, and Moneta to Big Island and Bedford, CMG provides the community with primary care physicians, cardiologists, cardiothoracic surgeons, gerontologists, neurosurgeons, physiatrists, psychiatrists, therapists and urologists. CMG- Lynchburg Family Medicine Residency is a training ground for future Family Physicians. Many of the physicians at the site hold academic appointments with the University of Virginia, Virginia Commonwealth University, Edward Via College of Osteopathic Medicine, and Liberty University.

The ***Centra Foundation*** was established in 1993 to develop and direct resources for the support of Centra. Over the past five years, on average the Centra Foundation provided $5.7 million annually in support of Centra programs. The Centra Foundation currently manages $30 million in endowed assets with a total net asset portfolio of $85 million. Gifts in 2020 totaled $2.3 million.

Centra's Department of Community Health, formed in 2020, is responsible for the development and management of system-wide triennial Community Health Needs Assessments and Implementation Plans, community-based grants and sponsorships, and Community Benefit Reporting. In 2020, community grants totaled $175,000 and in 2021, we anticipate awarding $1.5 million in grants and sponsorships.

Centra is the parent of ***Piedmont Community Health Plan, Inc.,*** a for profit network and administrative services company, which itself is the parent of an insurer (Piedmont Community Healthcare, Inc.) and a health maintenance organization (Piedmont Community Healthcare HMO, Inc.), which together cover over 21,000 individuals. In addition to Administrative Services Only (ASO) services for self-funded employers, Piedmont offers fully insured products, including individual Exchange plans and large and small group products. Piedmont's primary service area is largely aligned with Centra's, with expansion plans for its network underway. In 2021 Piedmont will implement a new claims platform and technology infrastructure to support its current membership and growth plans. Piedmont recently exited the Medicare Advantage (MA) business but intends to return to MA.

Through Piedmont and another affiliate, ***Archetype Health,*** which is an accountable care organization (ACO) and clinically integrated network (CIN), Centra will develop the expertise to manage risk as it transitions from a "volume to value" orientation and focuses on population health. Together Piedmont and Archetype will further the adoption of new models of reimbursement, care management, electronic patient-member record integration, data analytics, and physician alignment to support high-quality, affordable care.

SCOPE AND PURPOSE OF COMMUNITY HEALTH NEEDS ASSESSMENT

The scope of this Community Health Needs Assessment pertains to Centra Lynchburg General, Virginia Baptist, and Centra Specialty Hospitals.

Centra defines its triennial Community Health Needs Assessment (CHNA) as a continuous process for evaluating the health needs of the communities served. Most importantly it is to support the system's "Just Cause" which is "Partnering with you to live your best life". In 2021-2022, Centra is undergoing a strategic planning process and the CHNA will help inform the design and implementation of new services, programs, and partnerships in response to identified unmet community health needs. In addition, the CHNA and Implementation Plan is used to guide the actions of the Centra's Board of Directors' Community Benefit Committee, which provides community-based grant and sponsorship funding to area non-profit organizations addressing prioritized needs identified through the triennial CHNA. Lastly, the completion of both the triennial Community Health Needs Assessment and successful execution of the associated Implementation Plan ensures compliance with the Patient Protection and Affordable Care Act of 2010 which is promulgated in regulation by the Internal Revenue Service as documented annually in Centra's Form 990- Schedule H.

PROJECT OVERVIEW

"Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments."

Source: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Social Determinants of Health. Accessed at https://health.gov/healthypeople/objectives-and-data/social-determinants-health. Retrieved November 8, 2021.

"Hospitals and health systems have a tradition of serving their communities—of not only improving community health by providing health care services, but of bolstering the local economy and quality of life by hiring local workers and contractors, buying locally through their procurement strategies, and building new clinical facilities in neighboring communities. These activities often lead these hospitals to be called 'anchor institutions.' These increasingly frequent forms of community investment by health care organizations typically flow either from their charitable purpose or from their long-term mission of providing community benefit. In places with relatively high-functioning systems, stakeholders from community organizations, government agencies, foundations, banks, and nonprofits collaborate to articulate clear community priorities, develop a pipeline of investable opportunities that advance those priorities, and shape the context of policies and processes so that investments can move forward."

Source: Center for Community Investment, Initiative for Responsible Investment, & Robert Wood Johnson Foundation. Improving Community Health by Strengthening Community Investment. Accessed at https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf435716. Retrieved November 8, 2021.

In Virginia, a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are a Virginia Department of Health (VDH) requirement for all health districts every 5 years. Oversight of this process is provided by the Public Health Accreditation Board. In April of 2018, "the VDH and Virginia Hospital and Healthcare Association (VHHA) formed a new partnership to improve the population health in the Commonwealth. Partnering for a Healthy Virginia coordinates efforts between VHHA and its member hospitals and health systems, and VDH, local health departments, local jurisdictions, the medical community, and other stakeholders to address population health. This work will be informed by the findings of current and future community health needs assessments (CHNA)." A Memorandum of Agreement establishing this effort was signed by both the VDH and VHHA. (Virginia Hospital & Healthcare Association, Communications- Virginia Hospitals, Virginia Department of Health Partner on New Population Health Effort. (***http://www.vhha.com/communications/virginia-hospitals-virginia-department-of-health-partner-on-new-population-health-effort/***) Current efforts are focused on developing a statewide shared database that can be used by all hospitals and health districts for the CHNA's and CHA's, technical support and sharing of best practices through monthly meetings and "office hour" appointments.

To ensure we all have the opportunity to live in vibrant healthy communities, it is important to assess the strengths, weaknesses and unique resources across all sectors of each community and to listen to those who live, work and play there. A community-driven assessment provides the data and information that allows us to act and develop goals and strategies that can contribute to long-lasting social changes and positive health outcomes. Recognizing the importance of these collaborative efforts, Centra and the Partnership for Healthy Communities again partnered in 2021 to conduct Community Health Needs Assessments across Centra's service region.

The "Partnership for Healthy Communities" (PHC) is a planning initiative led by Centra, the Community Access Network, the Central Virginia, Piedmont, and Pittsylvania/Danville Health Districts, the Bedford Community Health Foundation, Greater Lynchburg Community Foundation, Johnson Health Center and United Way of Central Virginia. The partners are committed to regional alignment of a collaborative and rigorous needs assessment process that will result in action-oriented solutions to improve the health of the communities they serve.

The ***Community Access Network (CAN)*** serves as the backbone organization for PHC. CAN was founded in 2015 as a 501(c)3 public benefit corporation and is the result of Centra's previous Lynchburg Area Community Health Needs Assessment. CAN began as a workgroup of primary care providers who came together in early 2014 to address the lack of access to primary care in the Lynchburg metropolitan area and the resultant inappropriate utilization of Centra's Lynchburg General Hospital Emergency Department (ED). CAN is the outgrowth of collaborative efforts between Centra, Centra Medical Group, the Free Clinic of Central Virginia, and other community leaders to address the needs of patients with complex medical, behavioral health and social needs. From these conversations, the "5th Street Community Health Center" was born and CAN gained designation as a Federally Qualified Health Center Look-a-Like. In January 2018, the Community Health Center, which includes CAN, Hill City Pharmacy, the Free Clinic of Central Virginia, CARES (formerly Ryan White) and Horizon Behavioral Health opened, in large part due to Centra and Centra Foundation support and exists to provide comprehensive and holistic solutions to those who lack access to healthcare.

In the Lynchburg Area, the ***Central Virginia Health District (CVHD)*** is one of the 35 districts that comprise the Virginia Department of Health (VDH). The district serves the residents of the City of Lynchburg and the counties of Amherst, Appomattox, Bedford and Campbell. ***The Pittsylvania/Danville Health District*** comprises a total area of 1,045 square miles and serves Pittsylvania County and the City of Danville. Prior to the COVID-19 pandemic, the health districts had been aligning their CHA/CHIP with Centra's previous CHNA and Implementation Plan however their focus since March of 2020 has been on the public health crisis caused by the pandemic.

For more than 30 years the ***Bedford Community Health Foundation (BCHF)*** has been supporting area organizations that provide health related services to the citizens of Bedford County. The foundation works to identify and address community health issues by leading initiatives and providing funding. In that time, BCHF has provided more than $6 million in grants and scholarships to Bedford residents. The ***Greater Lynchburg Community Foundation*** is committed to enhancing the lives of central Virginians through the provision of grants and scholarships to nonprofits and students in the city and the four surrounding counties. These totaled over $1.9 million in this fiscal year and benefitted 175 different nonprofits and thousands of people. The ***United Way of Central Virginia's (UWCV)*** mission is to mobilize the

compassionate power of our community to improve the quality of lives in Central Virginia. In the past year, UWCV funded 38 programs through its partner agencies, investing $1.5 million in the community impacting over 60,500 people living in the counties of Amherst, Appomattox, Bedford, and Campbell and the city of Lynchburg.

Johnson Health Center (JHC) is a Federally Qualified Health Center (FQHC) serving Lynchburg and the counties of Amherst, Bedford and Campbell. The Health Center was founded by Centra in 1998 and became a FQHC in 2003. It offers comprehensive primary care, pediatric, OB/GYN, behavioral health, dental, pharmacy, transportation, and mobile services throughout the Lynchburg region. In addition, in partnership with Centra Virginia Community College's Workforce Development Certified Clinical Medical Assistant Program, JHC prepares graduates to sit for the NHA Medical Assistant Certification Exam.

Each of these organizations is represented on the ***PHC Steering Committee*** which met monthly during the 2021 CHNA to review the activities of the assessment process.

Centra contracted with Care Journey in Arlington, Virginia for the collection of Secondary Data; with Health Access Strategies in Stuarts Draft, Virginia for the analysis of the Primary Data (Community Health Survey and Stakeholder Focus Group/Survey); and with Community Health Solutions in Richmond, Virginia for polling and data collection for Stakeholder Focus Group meetings and the Community Health Assessment Team meeting focused on data presentation.

A ***Community Health Assessment Team (CHAT)*** with over 70 individuals and a broad representation of community leaders and cross-sector stakeholders in the service area was developed. The role of the CHAT is to oversee, advise and assist in CHNA data collection activities, prioritize needs, and participate in the development of the Implementation Plan as appropriate. A list of these individuals is presented in the "Acknowledgements" section of this report.

CHNA activities began in March 2021 and concluded in early September with the Prioritization of Needs. A timeline and work plan were created for the 2021-2022 CHNA and Implementation Planning (IP) process for all Centra catchment areas. As in 2018, the work plan included primary data collection (Community Health Survey, Stakeholders' Focus Group) as well as secondary data collection. We did not host target population focus group meetings for this CHNA due to COVID-19 restrictions for meeting in public.

2021-2022 Lynchburg Area CHNA & IP Activities	*Date*
Data Collection: Primary & Secondary Data	March- August 2021
CHAT: Launch of CHNA activities	April 12, 2021
Stakeholder Focus Group Meeting	May 10, 2021
CHAT: Presentation of Primary & Secondary Data	August 23, 2021
CHAT: Prioritization of Needs	September 13, 2021
Presentation to Centra Executive Leadership	November 17, 2021
Approval by Community Benefit Committee	November 19, 2021
Approval by Centra Board of Directors	December 6, 2021
Implementation Planning	December 2021 – April 2022
Centra Board Approval of Implementation Plan	By May 15, 2022

Centra Boards of Directors, Community Benefit Committee, and Executive Leadership have been kept informed of the 2021 CHNA process through updates from the Community Benefit Chair, Chief Transformation Officer, and Director of Community Health.

The 2021 Lynchburg Area Community Health Needs Assessment (CHNA) and Prioritization of Needs (PON) was approved by the Centra Community Benefit Committee on November 19, 2021. This committee includes members of both the Centra Board of Directors and the Centra Foundation Board of Directors and provides oversight of the health system's community benefit activities. Final approval of the 2021 CHNA and PON by the Centra Board of Directors occurred on December 6, 2021. The Community Health Needs Assessment was made publicly available on the Centra website the week of December 6, 2021 and was widely shared with the Community Health Assessment Team and other key community stakeholders and leaders.

SERVICE AREA

The service area for the 2021 Lynchburg Area Community Health Needs Assessment includes the city of Lynchburg and the counties of Amherst, Appomattox, and Campbell (localities served by the Central Virginia Health District) and Pittsylvania County (served by the Pittsylvania/Danville Health District). The service area was determined by assessing 80% of the hospital discharges for Centra Hospital (Lynchburg General, Virginia Baptist and Centra Specialty Hospitals) by zip code and locality for the 2019 calendar year (Source: Cerner, January 2021).

The findings revealed:

Discharge Summary By Zip Codes Representing 80% Of Discharges

County	*# of Discharges*	*% of Total Discharges*
LYNCHBURG (CITY)	45973	41.51
CAMPBELL	14637	13.22
AMHERST	12479	11.27
***BEDFORD**	6241	5.63
APPOMATTOX	4246	3.83
PITTSYLVANIA	3302	2.98
***BEDFORD (CITY)**	3129	2.83
	90007	***81.26***
Other Zip Codes	***20748***	***18.73***

*Bedford and the town of Bedford will be included in the 2021 Centra Bedford Area Community Health Needs Assessment.

The Lynchburg Region (Metropolitan Statistical Area) is one of the loveliest parts of Virginia. Encompassing 2,122 square miles, the region includes the City of Lynchburg; the counties of Amherst, Appomattox, Bedford, and Campbell; and the towns of Altavista, Amherst, Appomattox, Bedford, and Brookneal. The diverse region possesses an abundance of natural beauty, history, culture, arts, and outdoor recreation including the Blue Ridge Mountains, Appalachian Trail, James River, Smith Mountain Lake (the largest man-made lake in the state), the Appomattox Court House National Historical Park and the D-Day Memorial. ***(www.insidelynchburgregion.com)*** The region is primarily rural in nature and Lynchburg serves as the urban hub boasting a vibrant economy, nationally-ranked public schools, five colleges, a community college and trade schools. The city of 50 square miles is located near the geographic center of the state and is approximately 180 miles southwest of the nation's capital, Washington, D.C. and two hours from Richmond, the state capital. Lynchburg is the site of Centra's flagship hospital Lynchburg General and Virginia Baptist Hospital. ***(www.Lynchburgva.gov)***

The largest county in Virginia, Pittsylvania County consists of 982 square miles. Situated in the south-central Piedmont plateau region, the rural land is rolling to hilly, borders the state of North Carolina and is adjacent to the City of Danville. Chatham, the county seat, is 140 miles from Richmond and 50 miles from Lynchburg. Like the Lynchburg Region, it is rich in outdoor recreation, with numerous trail systems, rivers and lakes and is steeped in history. ***(www.pittsylvaniacountyva.gov)***

TARGET POPULATION

The target population is defined as (1) the medically underserved, low-income, or minority populations and those suffering from chronic disease; (2) the geographic area served by the hospital(s); and (3) targeted populations served by the hospital(s) (i.e., children, women, seniors, cancer patients).

METHODOLOGY

The 2021 Lynchburg Area Community Health Needs Assessment (CHNA) "lifted the voice of the community" (primary data) and included a collection of over 65 sources of publicly available secondary data. In addition, information about existing community resources was gathered. Primary data included findings from a Community Health Survey and Stakeholders' Focus Group and Survey. Details on the specific methodology and findings of the primary and secondary data components are included in following sections of this assessment.

The data collected for the CHNA is reported using the framework for County Health Rankings and Roadmaps, a collaboration between the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. The work is rooted in a deep belief in health equity, the idea that everyone has a fair and just opportunity to be as healthy as possible, regardless of race, ethnicity, gender, income, location or any other factor. Released annually, the rankings are based on a model of population health that emphasizes the many factors, that if improved, can help make communities healthier places to live, learn, work and play. ***(http://www.countyhealthrankings.org/)***

The County Health Rankings Model measures health outcomes and health factors for each community. Health outcomes represent how healthy a county is today through:

- **Length of Life** (Mortality)
- **Quality of Life** (Morbidity)

Health factors represent what influences the health of a county in the future and includes four types of factors:

- **Social and Economic Factors**
  (accounts for 40% of what influences health)
- **Health Behaviors**
  (accounts for 30% of what influences health)
- **Clinical Care**
  (accounts for 20% of what influences health)
- **Physical Environment**
  (accounts for 10% of what influences health)

All of the data collected for the Community Health Needs Assessment was used to prioritize needs for the Lynchburg service area and will be used to develop a 3-year Implementation Plan for the hospital system, community partners, and stakeholders in the Lynchburg service area.

PRIMARY DATA

Collection of primary data allows us to "lift the voice of the community" and is a key driver in the development of prioritized needs for each of Centra's service regions. In 2021, a Community Health Survey and Stakeholder Focus Group meeting provided primary data that was used for identification and prioritization of needs.

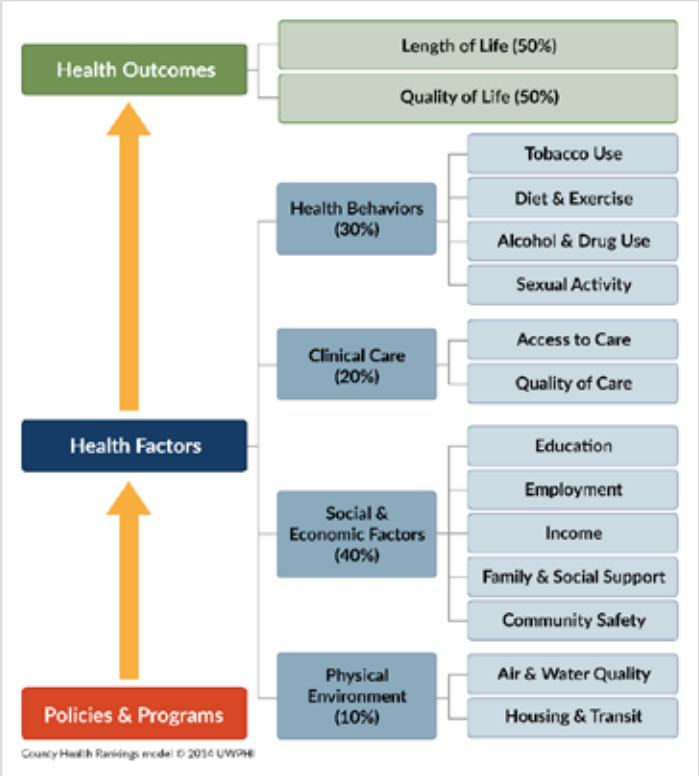
Community Health Survey

A Community Health Survey was administered to Lynchburg Area residents, 18 years of age and older, from April 12, 2021 to June 15, 2021. The survey tool was developed by Carilion Clinic and Healthy Roanoke Valley headquartered in Roanoke, Virginia and adopted by Centra and the Partnership for Healthy Communities in both 2018 and 2021. The survey includes standardized questions that address the County Health Rankings' four health factors that influence health (Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment) and health outcomes (Length of Life and Quality of Life). Many of the questions were developed from national survey tools from the Centers for Disease Control and Prevention, Healthy People 2020, and the Behavior Risk Factor Surveillance System so that local data can be compared to state and national data, benchmarks and targets. The survey tool and the full report of the 2021 Lynchburg Community Health Survey can be found in the Appendix.

The Community Health Survey was administered both electronically through a publicly available link via Survey Monkey and through paper surveys (which were in turn entered into Survey Monkey). Paper surveys were available in both English and Spanish. A total of 4,450 surveys were collected. All survey respondents were offered the opportunity to enter a raffle to win a $25 gift card if they completed the survey.

The survey link was advertised in local newspapers, on social media, on Centra's website and through a mass email to all Centra staff. In addition to marketing the survey to the general population, attempts were made to oversample the target population in the service area. Members of the Community Health Assessment Team (CHAT) who serve and represent the target population, were asked to assist in advertising and distributing the survey (both electronically and paper) to their client base. However, engaging these target populations was more difficult in 2021 due to the COVID-19 pandemic and the virtual nature of the services provided during this time as well as possible technology barriers that impact our target populations (i.e., lack of internet access, lack of access to smart phones, computers, etc.).

The County Health Rankings Model was used as the framework to summarize the findings of the 2021 Lynchburg Community Health Survey that follow. This framework is based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).



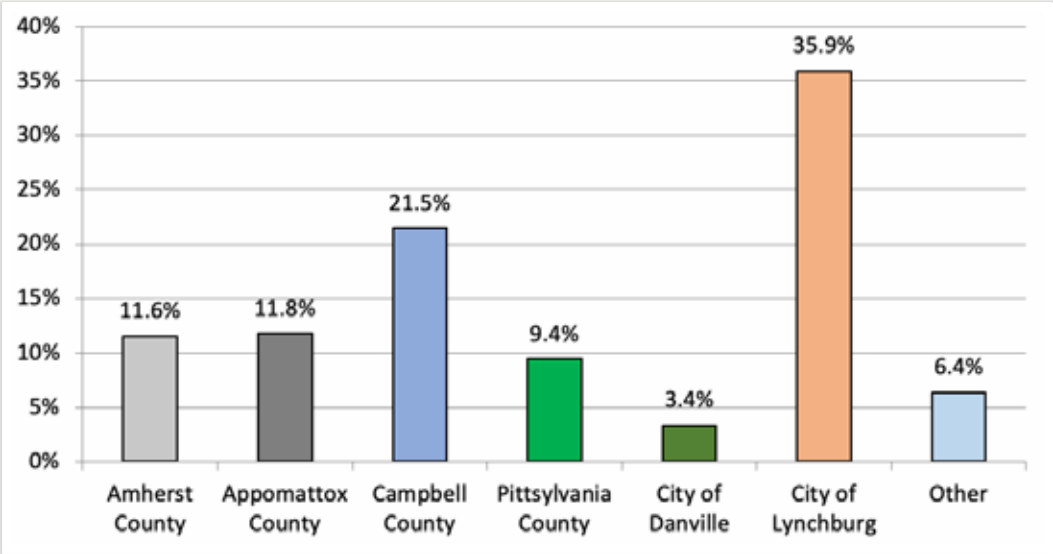
Source: County Health Rankings & Roadmaps. Accessed November 2, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model.

It is important to note that the 2021 Centra Community Health Survey did not have Health Factor questions addressing sexual activity (Health Behavior) and air and water quality (Physical Environment) or Health Outcome questions addressing length of life measures. However, there is data in the "Secondary Data" section of this Community Health Needs Assessment for these topic areas. In addition, where applicable, findings from the 2021 survey are compared to the findings from the Community Health Survey conducted in 2018.

DEMOGRAPHIC PROFILE OF RESPONDENTS

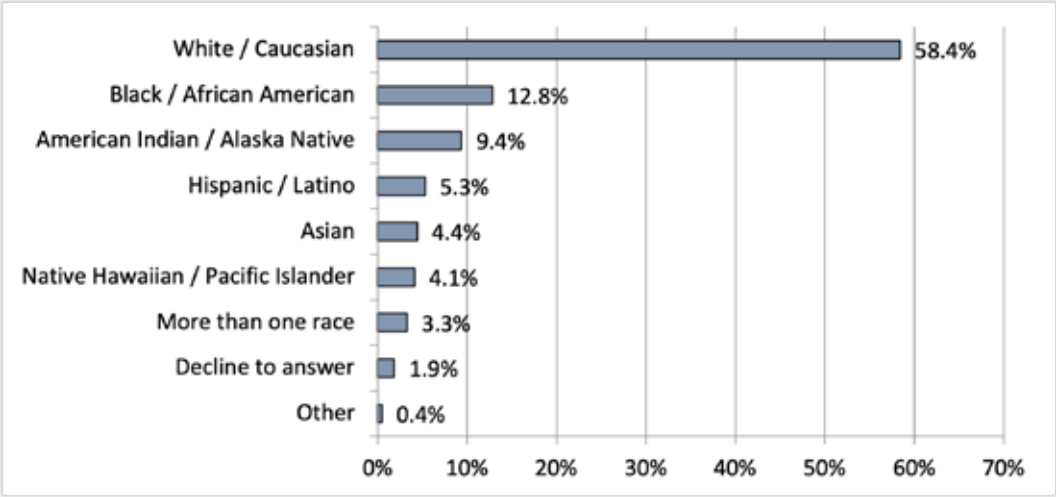
The majority of respondents lived in the service area.

Where do you live?



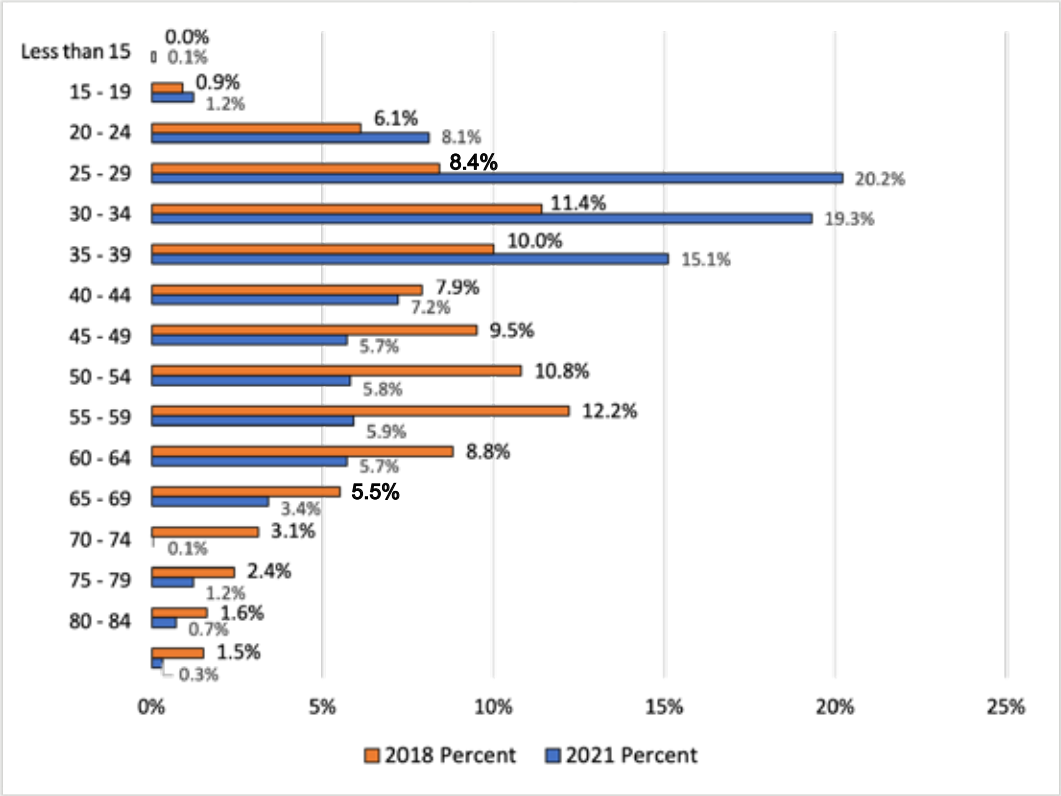
The number of White respondents decreased from 69% in 2018 to 58% in 2021. This number is lower than the overall percentage of the White population in the service area – 75.3% (U.S. Census). The number of respondents indicating they are Black or African-American fell from 2018 (25.5%) to 2021 (13%) compared to 20% in the service area (U.S. Census). The service area percentage of Hispanics or Latino is 2.7% (U.S. Census). The number of Hispanic or Latino respondents in 2021 was 5.3%, increasing from just 0.8% in 2018. There was a significant increase in those reporting to be Asian (4.4%), American Indian/Alaska Native (9.4%) and Native Hawaiian/Pacific Islander (4.1%) in 2021 as compared to 2018 (0.81%; 0.81%; and 0.2% respectively). Service area population numbers for these groups were 0.9% Asian, 0.3% American Indian/Alaskan Native, and 0.0% for Native Hawaiian/Pacific Islander.

What race/ethnicity do you identify with? (Please check one)



The percentage of respondents age 25 to 39 in 2021 nearly doubled to 54.6% from 28.8% in 2018. The number of respondents in 2018 age 40 to 64 was 49.2%. The number of respondents in this age group fell to 30.3% in 2021. The rate of respondents age 65 and older decreased to 5.6% in 2021 from 14.1% in 2018. The average median and mean ages in 2021 (35 and 39.3 respectively) were lower than in 2018 (47 and 47.3 respectively) with minimal differences in the age range for the two assessment years.

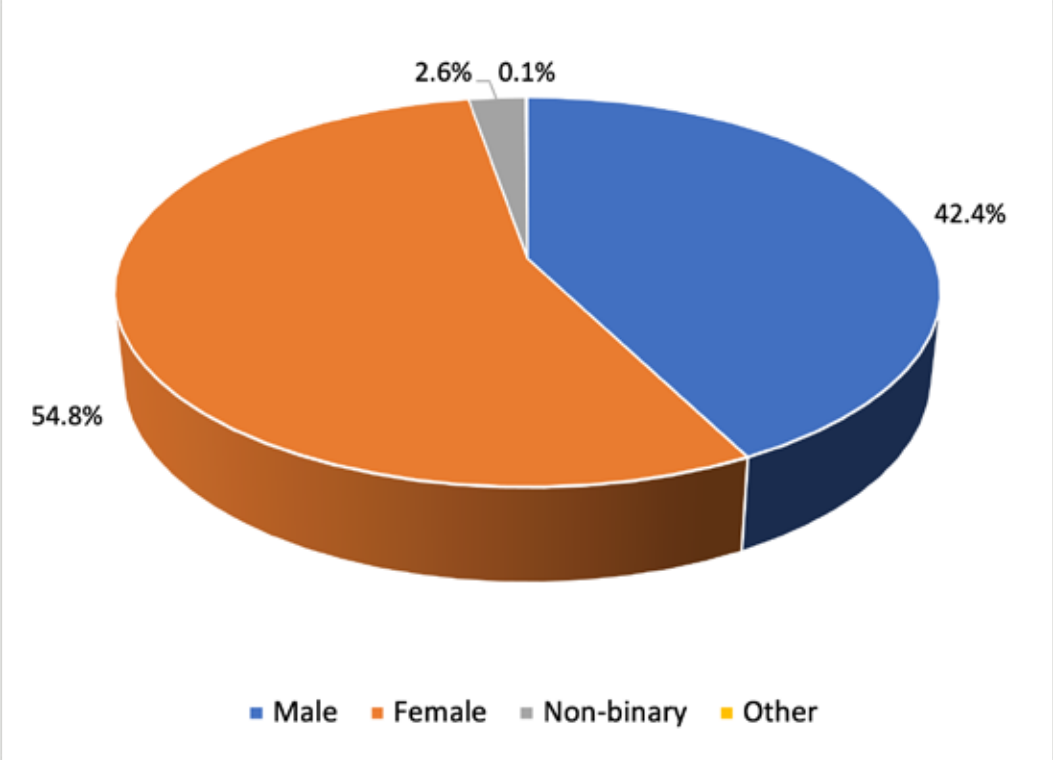
What is your age?



Median Age	35
Mean Age	39.3
Age Range	12–96

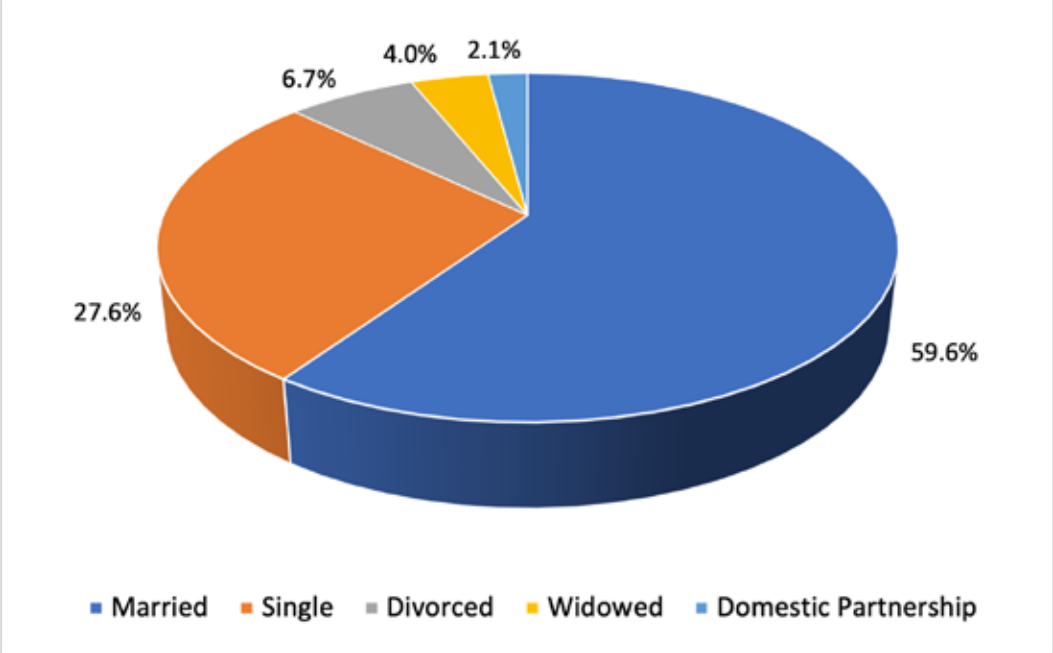
The number of male respondents increased from 20% in 2018 to 42% in 2021. Males represent 48% of the service area's population (U.S. Census). "Non-binary" was added as a response to this question in 2021.

What is your gender identity?



The percentage of persons responding that they were married in the 2021 assessment increased 9.2% over the 2018 response (50.4%). The percentage of widowed respondents decreased from 5.8% in 2018 to 4% in 2021. The number of divorced respondents fell to 6.7% of 2021 respondents from 11.7% of 2018 respondents.

What is your marital status?

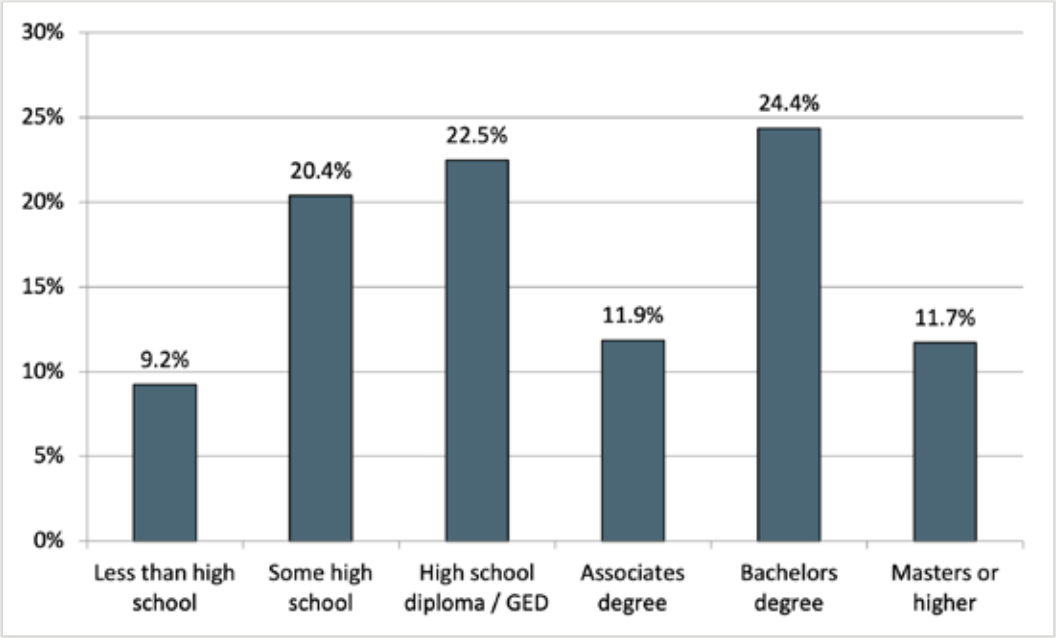


SOCIAL AND ECONOMIC FACTORS

Education

The number of respondents indicating that they had a degree (Associates – Masters or higher) remained the same from 2018 to 2021 (48%). The percent of 2021 respondents indicating that they had less than a high school diploma or GED was 9.2% compared to 29.6% in 2018. For persons age 25 and over residing in the Lynchburg Area, 14% had less than a high school education or equivalence (U.S. Census). Those who had graduated from high school or equivalency was 32.5% (U.S. Census), higher than the 2021 respondent rate 22.5%. The percentage of persons in the service area with a Bachelor's Degree or higher was 15.5% (U.S. Census), significantly lower than the 2021 respondent percentage of 36.1%. Respondents with an Associate's degree were not compared to area statistics as the U.S. Census includes Associate's Degree attainment in a category with "Some College" (U.S. Census, Table S1501).

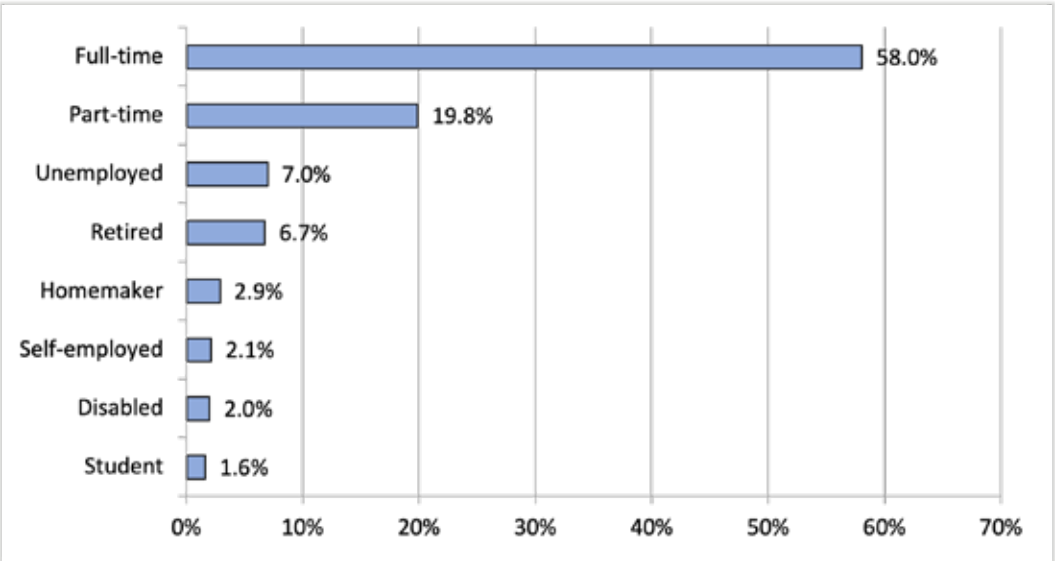
What is your highest education level completed?



Employment

The rate of 2021 respondents employed full-time was consistent with 2018 respondents for this status (58% compared to 55%). The number of unemployed was more than double the rate for the 2018 respondents than 2021 respondents (14.7% compared to 7%). The number of part-time employed respondents was 20% in 2021 compared to 12.3% in 2018. The 2018 assessment reflected more retired respondents (12%) than 2021 respondents (6.7%).

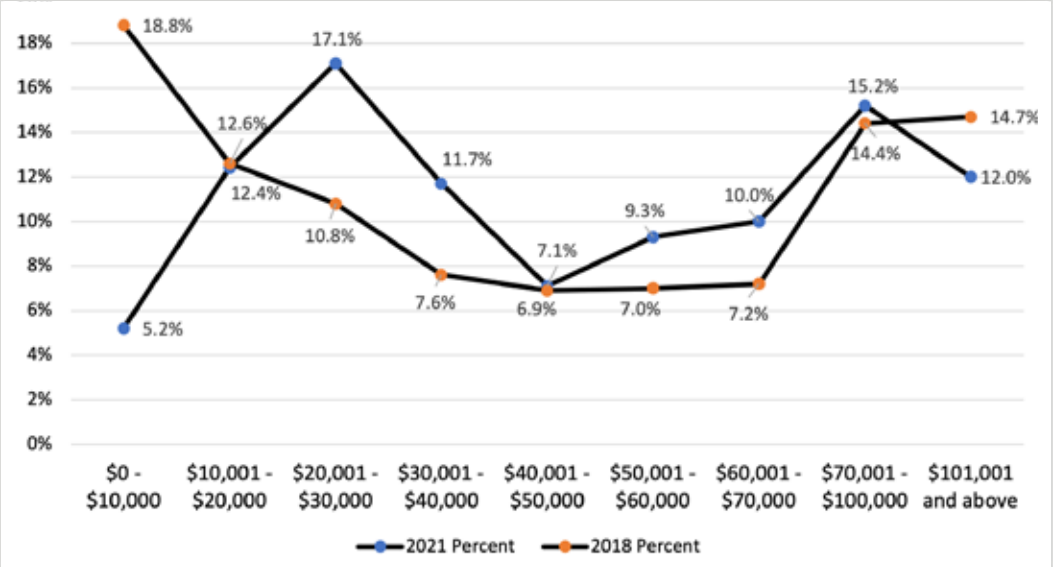
What is your current employment status?



Income

Respondents in 2021 reflected a large variance from the lowest household income categories (at or below $20,000) from 2018 respondents (17.6% of 2021 respondents compared to 31.4% of 2018 respondents). The 2021 respondents comprised a higher percentage of households from $20,001 to $40,000 (28.8%) than in 2018 (18.4%). The number of respondents with a household income of over $100,000 was slightly higher in 2018 (14.7%%) than that of 2021 respondents (12%).

What is your yearly household income?



Analysis of Poverty Status Among Survey Respondents

House-hold Size	Number	Self-Reported Household Income Category							<100% FPL	<200% FPL
		0-10,000	10,001-20,000	20,001-30,000	30,001-40,000	40,001-50,000	50,001-60,000	60,001-70,000		
1	375	47	37						12.5%	22.4%
2	782	36	50	103					4.6%	24.2%
3	779	15	91	122	96				13.6%	41.6%
4	739	18	98	113	83	51			15.7%	49.1%
5	620	16	92	119	63	43	47		36.6%	61.3%
6	328	12	50	69	51	19	23	43	39.9%	81.4%
7	126	12	13	20	16	6	20	17	48.4%	82.5%
8	71	10	7	13	8	4	3	11	53.5%	78.9%
Total	*3,820*	*166*	*438*	*559*	*317*	*123*	*93*	*71*	*19.9%*	*46.3%*

Although survey income categories do not align with the Federal Poverty Level guidelines (FPL), respondent poverty status can still be estimated at levels below 100% and 200% of the FPL. Based on the FPL, the number of respondents in each household size noted above in yellow would fall below 100% of the FPL. The number of responses in blue would fall below 200% of the FPL. Combining these values represent respondents whose household income falls below 200% of the FPL. A respondent's household income will often fall between FPL category minimum and maximum limits. For example, a respondent's household income that is $11,500 would still be below 100% of the federal poverty level but would be placed in the survey's $10,001 to $20,000 income category because it cannot be determined that the respondent's household income is, in fact, below 100% of the poverty level, between 100% and 150% of the FPL, or at some point over 150% FPL. However, it can be determined that this income is still below 200% of the FPL. In 2021, a minimum of 20% of respondents represented in the table above had incomes below 100% of the FPL and 46.3% had incomes below 200% FPL. The total number of households in the table above represent 90.6% of all income respondents.

Federal Poverty Level Guideline Table

Household Size	100% FPL	150% FPL	200% FPL	300% FPL
1	$12,760	$18,140	$25,520	$38,320
2	$17,240	$25,860	$34,480	$51,720
3	$21,720	$32,580	$43,440	$65,160
4	$26,200	$39,300	$52,400	$78,600
5	$30,680	$46,020	$61,360	$92,040
6	$35,160	$52,740	$70,320	$105,480
7	$39,640	$59,460	$79,280	$158,560
8	$44,120	$66,180	$88,240	$176,480

FPL table reproduced from table listed by Medicare Plan Finder accessed July 29, 2021 at https://www.medicareplanfinder.com/medicare/federal-poverty-level/

Affordability and Safety

Survey respondents were asked a series of questions regarding affordability of medications, rent/mortgage, and food. Additional questions focused on both personal and community safety and social connectedness.

Regarding affordability, the number of respondents indicating that they can afford the medicine needed for their health conditions increased 9% from 57.5% in 2018 to 66.5% in 2021 while those reporting "no" remained about the same as reported in 2018 (21%). The percentage of respondents who did not have enough money in the past 12 months to pay rent or mortgage rose from 2018 (24.8%) to 2021 (37.1%). The number of respondents who indicated that there had been times when they did not have enough money to buy the food they or their family eat increased from 2018 (30.3%) to 2021 (45.3%).

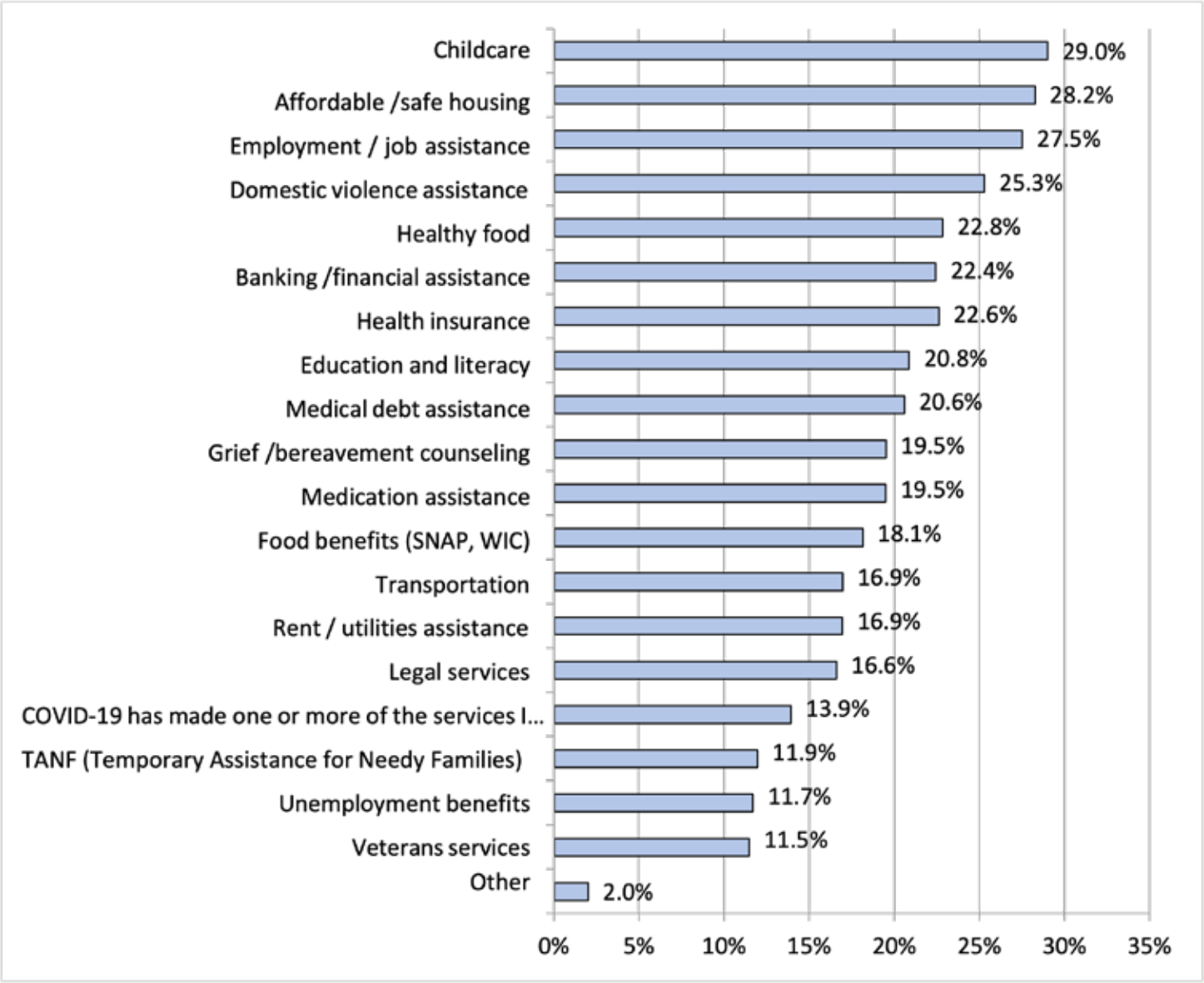
Regarding safety, the number of respondents who reported that they had been victims of domestic violence in the last 12 months was seven times the number from 2018 (3.6%) to 2021 (25.75%). The number of respondents who felt safe where they live remained essentially the same from 2018 (90.2%) to 2021 (89.4%). The percentage of respondents who felt somewhat connected to the community and those around them increased from 2018 (54%) to almost 60% in 2021. The number of respondents who felt very connected remained steady from 30% in 2018 to 29% in 2021. The number of respondents who felt not connected decreased to 11% in 2021 from 16% in 2018.

I cannot afford my medications (%)	19.7	
In the past 12 months- I could not afford rent/mortgage (%)	37.1	
In the past 12 months- I could not afford food (%)	45.3	
I have been a victim of domestic violence or abuse in the past 12 months (%)	25.7	
Do not feel safe where you live (%)	10.6	
Feel connected with the community and those around you (%)	*Very*	29.0
	Somewhat	59.8
	Not connected	11.2

Social/Support Resources in the Community

Respondents were asked which social/support resources are hard to get in our community and could check more than one response. Childcare and affordable and safe housing were cited by 2021 respondents as the most difficult services to get in the community. Affordable and safe housing also ranked high in the 2018 assessment at 38% (ranked first among 2018 services that were hard to get in the community). While childcare was not an option in 2018, the 2018 Lynchburg Region stakeholder survey respondents cited "childcare" as the fourth greatest need. Domestic violence services increased significantly from the 2018 assessment (11.9%) to 25.3% for the 2021 assessment.

Which social / support resources are hard to get in our community? (Respondents could check more than one)



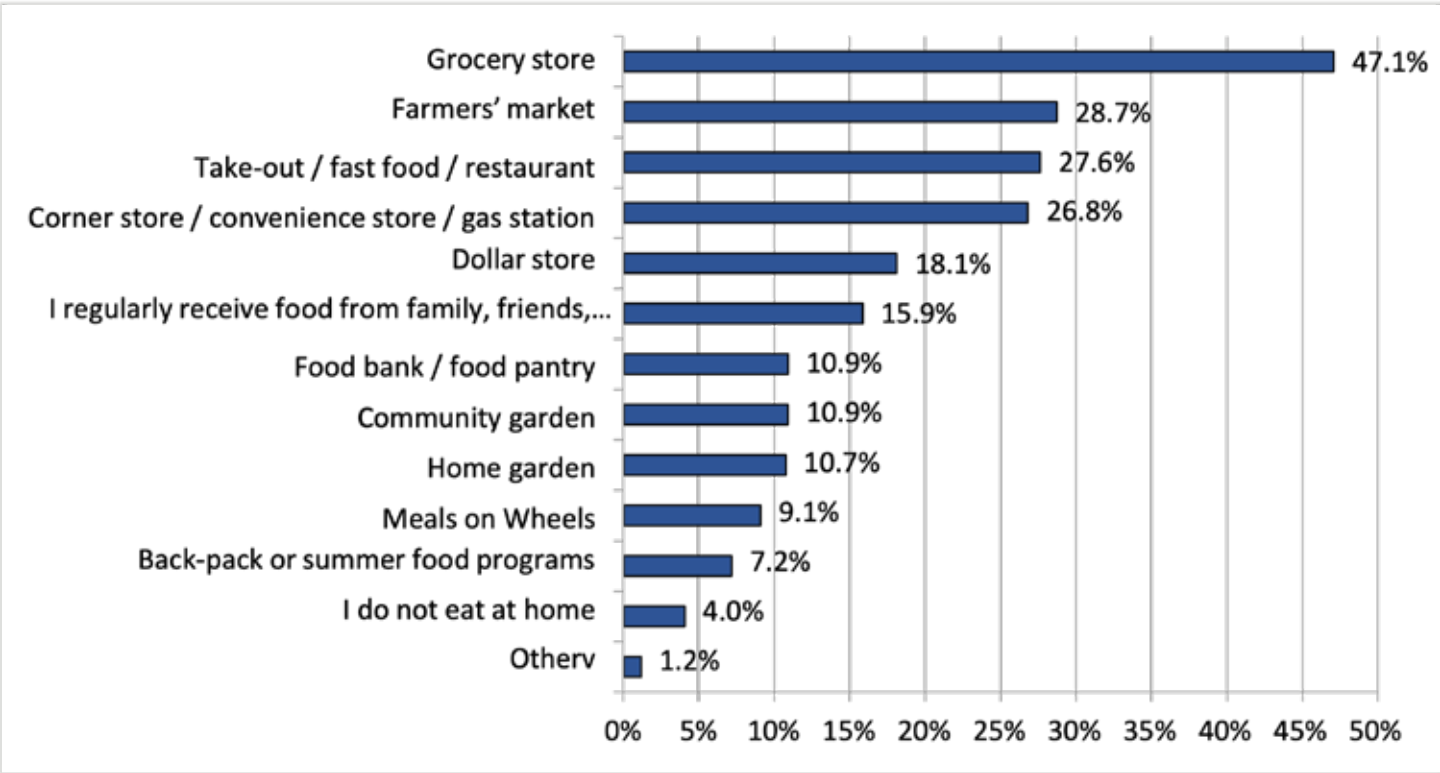
HEALTH BEHAVIORS

Diet and Exercise

Respondents were asked a series of questions regarding food availability, fruit and vegetable consumption, family meal patterns and physical activity.

In 2021 respondents appear to be getting their food from sources other than the grocery store. In 2018, the number of respondents indicating that they got food from the grocery store was 97.6% and in 2021 that number was less than half at 47%. The percent of respondents getting food from dollar stores decreased from 2018 (21%) to 18% in 2021 however more respondents in 2021 reported getting food from a corner store, etc. (26.8%) compared to 2018 (10.6%). Fewer respondents in 2021 got their food from home gardens than in 2018 (10.7% compared to 19.7%) while a larger number used community gardens in 2021 (10.9%) as in 2018 (2.7%). The number of respondents getting take-out/fast food/or restaurant food fell from 47% in 2018 to 27.6% in 2021. More respondents in 2021 reported receiving food from family, friends, neighbors, or their church (15.9%) than in 2018 (11.7%) while those relying on Meals on Wheels (9.1%) and Back-pack or summer food programs (7.2%) increased exponentially in 2021 compared to 2018 (2.7% and 1.4% respectively). Additionally in 2021, 4% of respondents reported they do not eat at home compared to 0.5% in 2018.

Where do you get the food that you eat at home? (Please check all that apply)



The number of respondents indicating that it was easy to get affordable fresh fruits and vegetables increased from 68.3% in 2018 to 79.2% in 2021. Approximately 36% of respondents ate fruit and vegetables on a daily basis but is less than the rate in 2018 (45.1%). In the Lynchburg Area, 35% of respondents had meals with their families between three and six times a week. Those eating meals together seven or more times per week in 2021 was 29.2% compared to 18.3% in 2018. Frequent family meals are associated with decreased risk factors in youth.

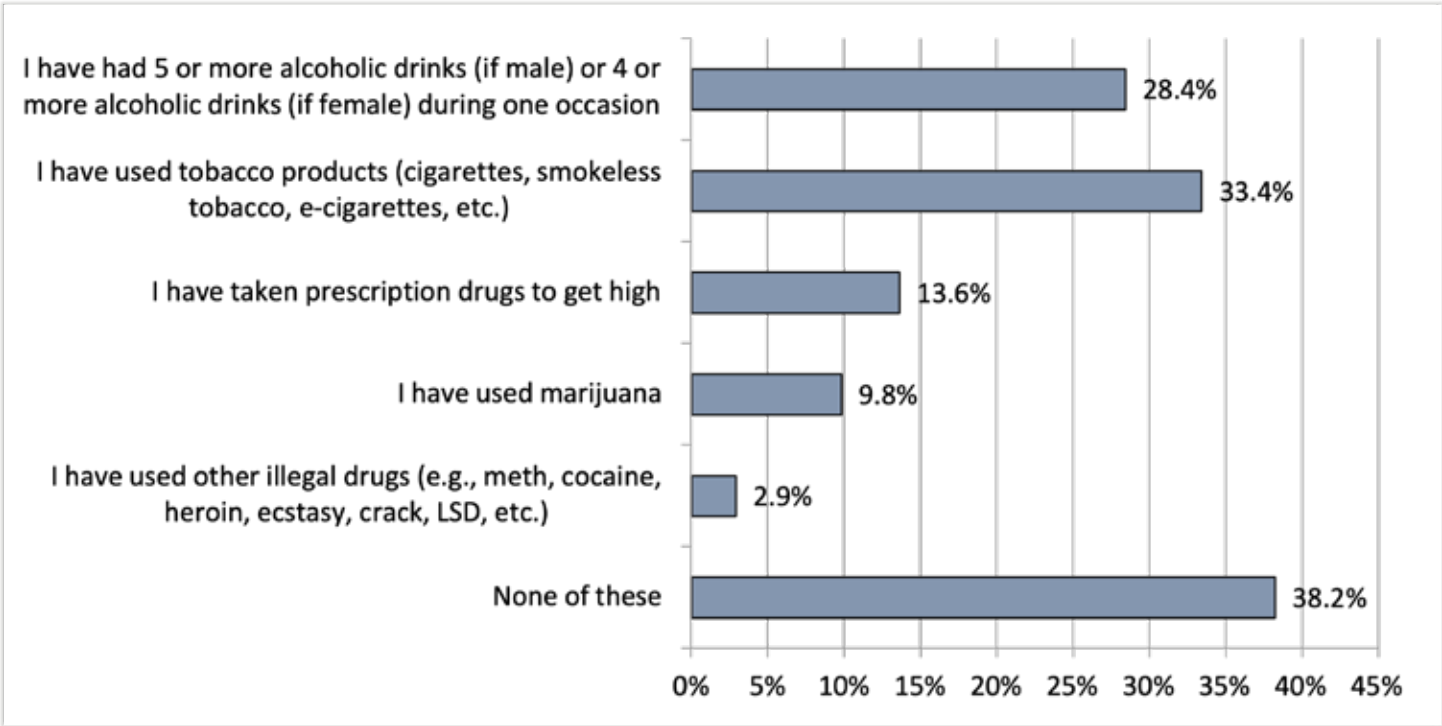
Regarding physical activity, there was a significant increase in the number of respondents who indicated that their community supported physical activity in 2021 (80.8%) compared to 53% of respondents in 2018. Access to physical activity "spaces" is important as regular exercise reduces the number of risk factors (such as obesity) associated with many health conditions. The number of respondents who were physically active five or more days per week decreased from 32.2% in 2018 to 29.3% in 2021. The number of respondents who were active three to four days per week fell from 28.3% in 2018 to 23.4% in 2021. The number of respondents who were active one or two days per week increased from 27% in 2018 to 36% in 2021.

In the area that you live, it is easy to get affordable fresh fruits and vegetables? (%)	79.2
During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice. (Please check one) Respondents who ate fruits and vegetables one time per day or greater (%)	36.3
In the past 7 days, how many times did all or most of your family living in your house eat a meal together? (%) Respondents who ate with their families 7 or more times per week (%)	29.2
The community supports physical activity? (e.g., parks, sidewalks, bike lanes, etc.) (%)	80.8
In the past 7 days, how many days were you physically active for a total of at least 30 minutes? Respondents who met physical activity guidelines of 150 minutes of aerobic activity weekly(%)	29.3

Alcohol, Tobacco, and Other Substance Use

Respondents were asked about their alcohol, tobacco, and substance use over the past 30 days. There was a decrease in the number of respondents who indicated that they used tobacco products from 2018 (53%) to 2021 (33.4%). There was also a decrease in the number of persons who reported binge drinking (i.e., having five or more alcoholic drinks for males or four or more for females) in the past 30 days (42% for 2018 respondents and 28.4% for 2021 respondents). More 2021 respondents indicated that they have taken prescription drugs to get high – approximately 13.6% in 2021 compared to just 1.6% in 2018. Those who used other illegal drugs (including marijuana) was 7.7% in 2018. In 2021, illegal drug use excluded marijuana with 2.9% of respondents reporting illegal drug use and 9.8% reporting having used marijuana. On July 1, 2021, recreational use of marijuana became legal in Virginia although retail sales will not begin until 2024.

During the past 30 days: (Please check all that apply)



CLINICAL CARE

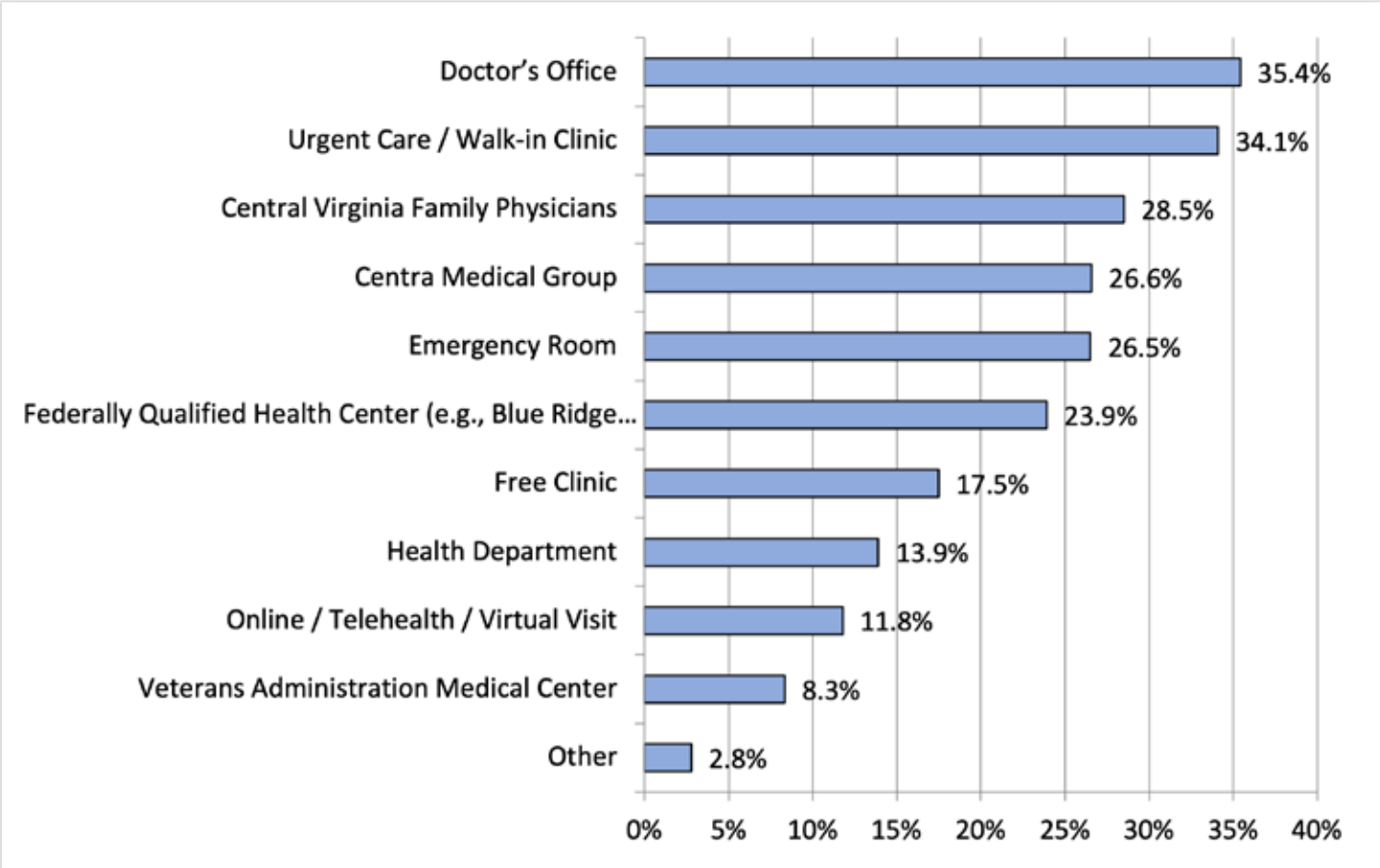
Access and Utilization of Services

Survey respondents were asked about their use of medical, dental, and mental health, alcohol use, or drug use services.

The number of respondents who indicated that they use medical services increased slightly from 2018 (84.5%) to 86.4% in 2021. The number of respondents who indicated that they had been to the Emergency Room in the past 12 months increased from 28% in 2018 to 40.4% in 2021 while the number of respondents indicating that they had used the emergency room for an injury in the last 12 months was close to four times that in 2018 (8.6%) than in 2021 (32.4%).

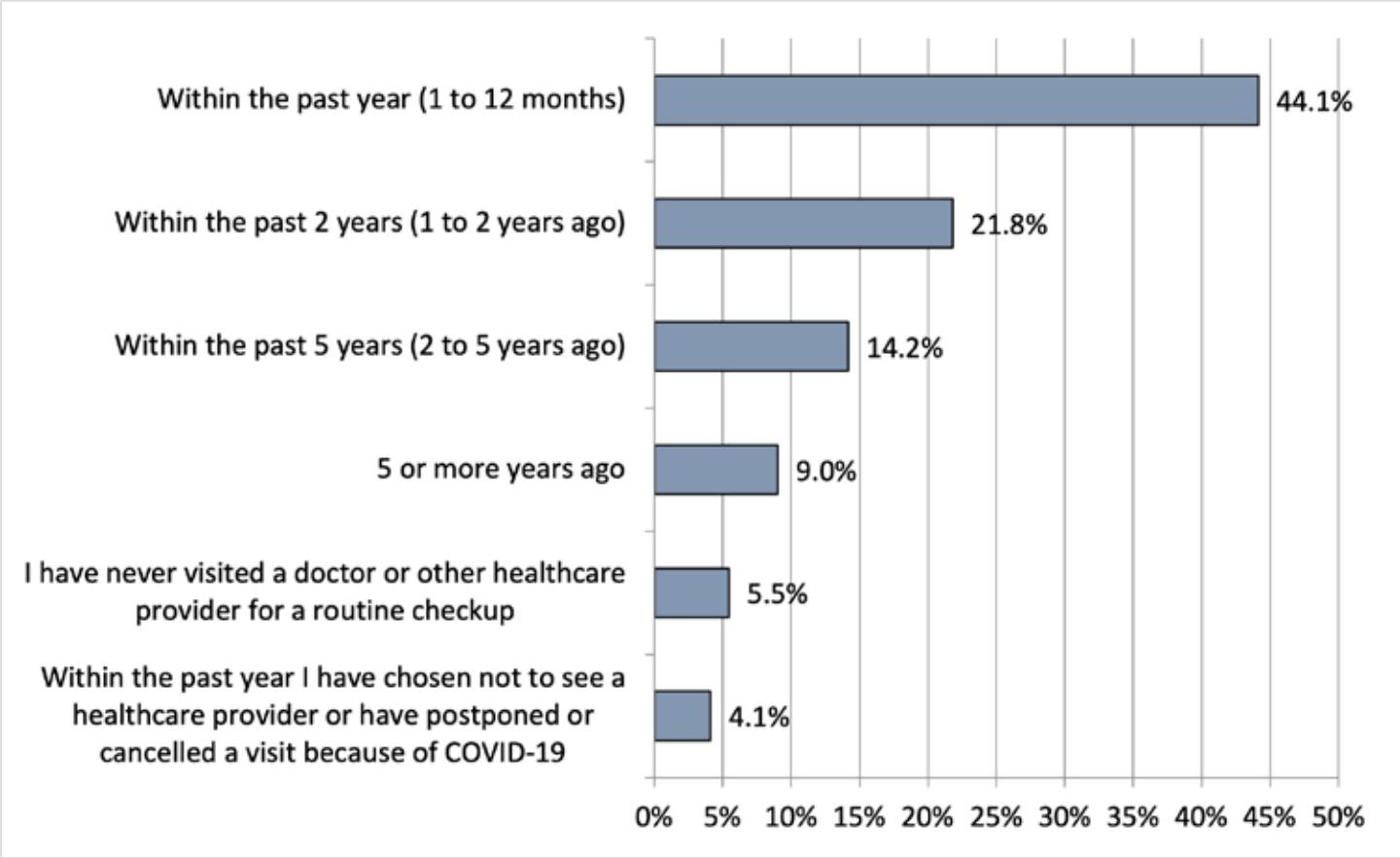
When asked what type of medical services they use, the generic "Doctor's Office" was the top response in 2018 and 2021 but dropped from 57% in 2018 to 35% in 2021. Respondents selecting Centra Medical Group increased slightly to 28.5%% in 2021 from 25% in 2018. Respondents indicating that they used the Emergency Room rose from 24.7% in 2018 to 26.5% in 2021. Urgent Care or Walk-in Clinic showed a large increase from 23% in 2018 to 34% in 2021. The use of the region's Federally Qualified Health Center increased from 15.8% in 2018 to 24% in 2021. Those who used online/telehealth/virtual visits in 2021 was 11.8%. There was not an option for this answer in the 2018 assessment however, 1.8% of respondents answered "Centra 24/7 virtual visit" that year.

Please check all the medical care services you use:



The number of respondents indicating that they last visited a healthcare provider for a routine check-up within the past year dropped dramatically from 77% in 2018 to 44% in 2021. The number of respondents who had not visited a healthcare provider for a routine check-up within the past five years increased from 5% in 2018 to 9% in 2021. Additionally, 4.1% reported not seeing, postponing, or cancelling visits with their healthcare providers due to COVID-19.

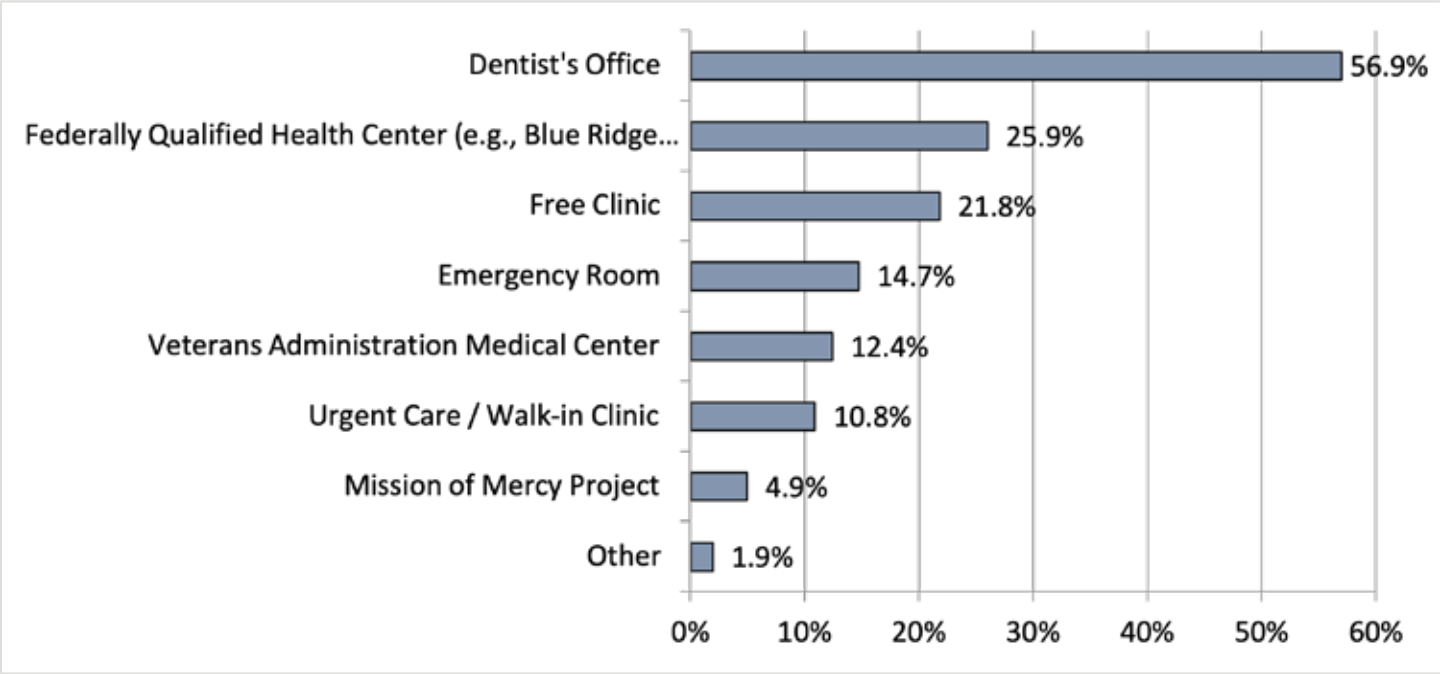
How long has it been since you last visited a doctor or other healthcare provider for a routine checkup?



The number of respondents indicating that they use dental care services increased 6.4% from 2018 (74.3%) to 80.7% in 2021.

Respondents were asked what type of dental services they use. The number of respondents selecting the generic response "Dentist's Office" decreased from 84% in 2018 to 57% in 2021. The use of "Free Clinic" for dental services increased in 2021 to 22% from just 6% in 2018. Respondents using "Urgent Care or Walk-in Clinic" increased dramatically to almost 11% in 2021 from 1% in 2018. Respondents using Federally Qualified Health Center (Johnson Health Center or Community Access Network) more than quadrupled from 2018 (6%) to 26% in 2021. Respondents using "Mission of Mercy Project" for dental services was almost 0% in 2018 to 5% in 2021. Use of the Emergency Room for dental services increased significantly from 2% in 2018 to 14.7% in 2021. The number of respondents who reported having dental insurance in 2021 (24.9%) decreased as compared to 2018 (30.2%).

Please check all the dental care services you use:



The number of respondents who have visited a dentist or dental clinic in the last 12 months fell from 63% in 2018 to 40% in 2021. More people reported having not visited the dentist or dental clinic within the past two years in 2021 (22%) than in 2018 (12%) as well as within the past 5 years (15.9% in 2021 compared to 10.6% in 2018). The number of respondents who had not visited a dentist or dental clinic in the past five or more years decreased from 14.4% in 2018 to 10.7% in 2021. Finally, almost 5% of respondents reported not seeing, postponing, or cancelling visits with their healthcare providers due to COVID-19.

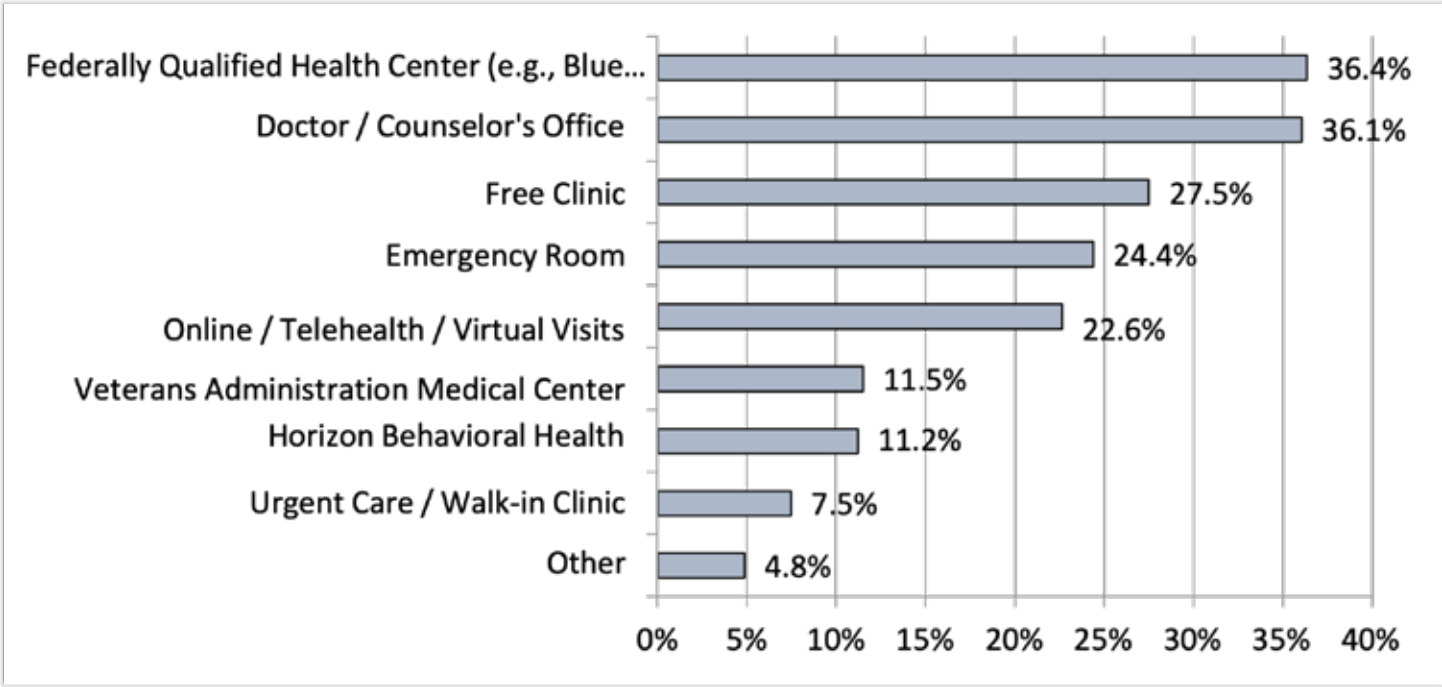
How long has it been since you last visited a dentist or dental clinic for any reason?

Within the past year (1 to 12 months)	40.3%
Within the past 2 years (1 to 2 years ago)	22.1%
Within the past 5 years (2 to 5 years ago)	15.9%
5 or more years ago	10.7%
I have never visited a dentist or dental clinic for any reason	6.2%
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	4.7%

The number of respondents indicating that they use mental health, alcohol or drug use services increased dramatically from 17.6% in 2018 to 46.5% in 2021.

Respondents were asked what type of mental health, alcohol or drug use services they use. The number of respondents who used Horizon Behavioral Health for services fell from 57% in 2018 to 11% in 2021. Online, telehealth, or virtual visits were not an option for respondents in 2018. More than 1 out of 5 respondents using mental health, alcohol use, or drug use services indicated such a visit. The number of respondents using the Free Clinic or a Federally Qualified Health Center (FQHC) both increased significantly from 2018 (4.1% Free Clinic; 15% FQHC) to 2021 (Free Clinic 27.5%; FQHC 36.4%). The generic response, "Doctor or Counselor's Office," was combined from two separate responses from 2018 – "Doctor's Office" and "Counselor's Office." These two responses in 2018 were approximately 13.5% and 23.4%, respectively, while combined for 2021, the percentage of responses was 36% - relatively unchanged between assessment years. The use of the Emergency Room increased significantly from 9.4% in 2018 to 24.4% in 2021.

Please check all the mental health, alcohol use, or drug use services you use:



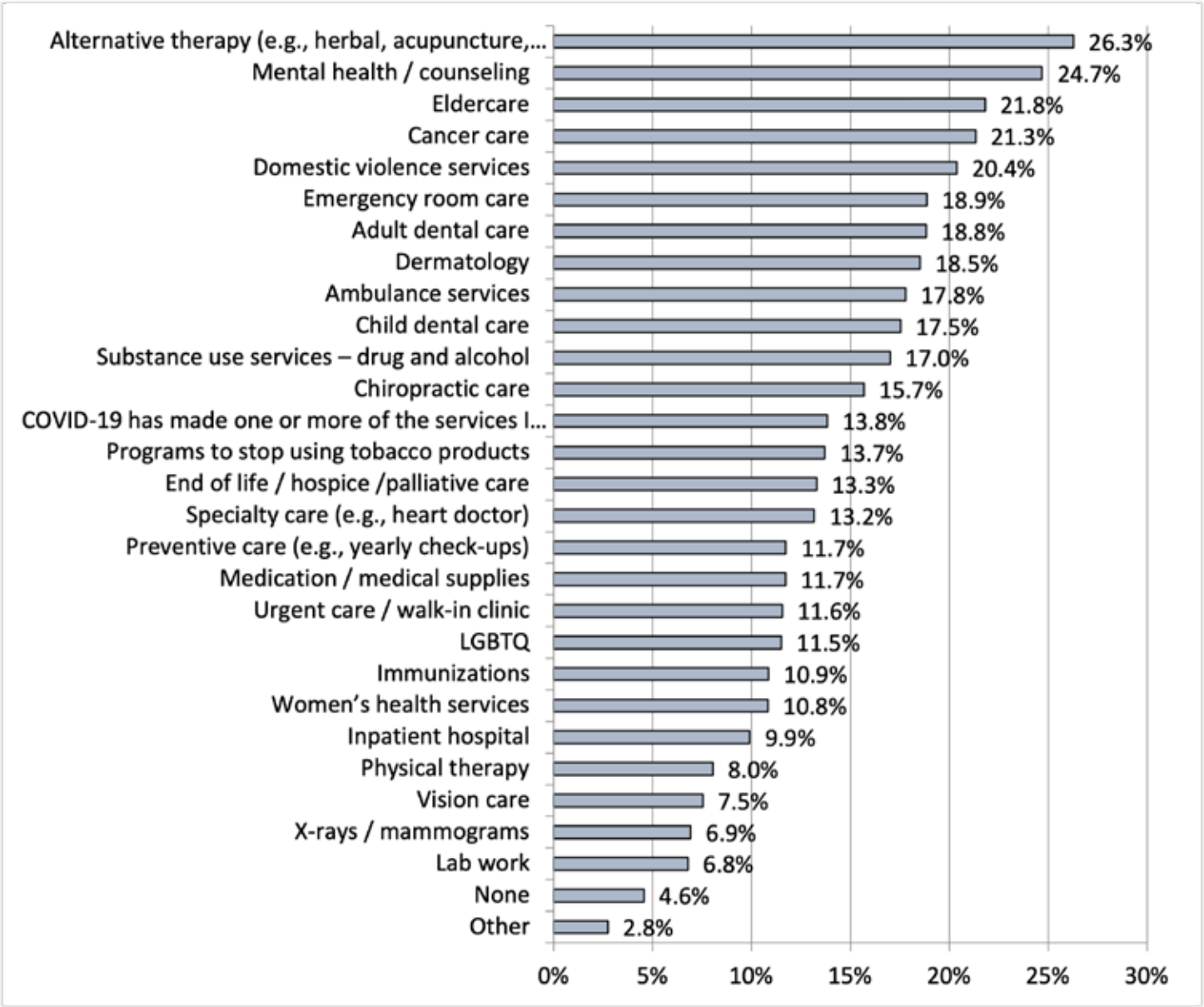
Within the past year, 19% or about one out of five of respondents used mental health, alcohol use, or drug use services. An additional 3.4% of respondents did not seek services due to COVID-19.

How long has it been since you last used mental health, alcohol use, or drug use services for any reason?

Within the past year (1 to 12 months)	18.9%
Within the past 2 years (1 to 2 years ago)	18.3%
Within the past 5 years (2 to 5 years ago)	15.8%
5 or more years ago	11.5%
I have never used mental health, alcohol use, or drug use services for any reason	32.1%
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	3.4%

Survey respondents were asked what health care services are hard to get in the community. In 2021, the respondents indicated that Alternative therapies were the hardest service to get in the community (compared to 22.2% and a ranking of six among 2018 respondents). Mental health and counseling services were cited by almost 25% of 2021 respondents, down slightly from 28% in 2018. Eldercare was consistent from 2018 (20.4%) to 2021 (22%). Cancer care was broken out from the category of "Specialty care" in 2018. Adult dental care ranked high in both assessments (28% in 2018 and 19% in 2021). It is important to note that beginning July 1, 2021, Virginia Medicaid started providing adult dental service to Medicaid beneficiaries for the first time.

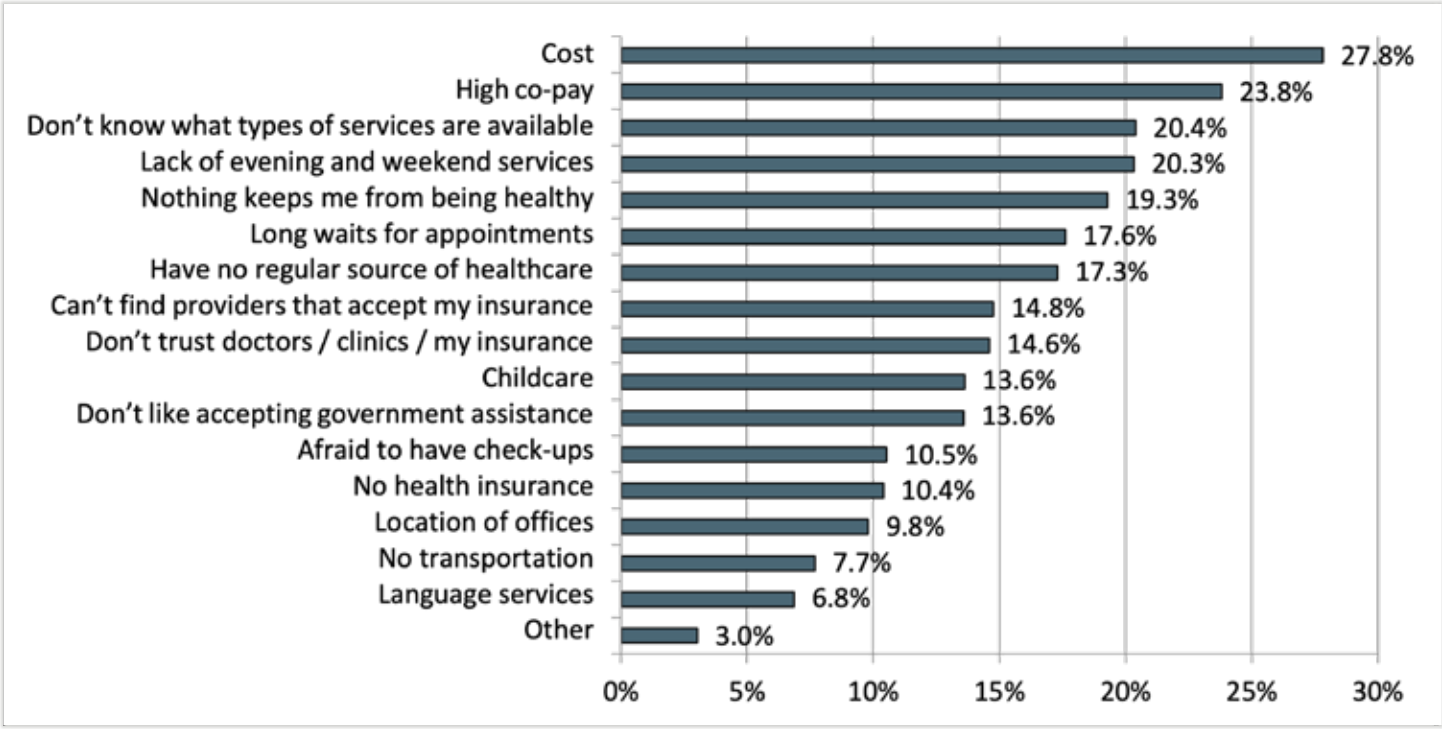
Which health care services are hard to get in our community? (Respondents could check more than one)



Health Status

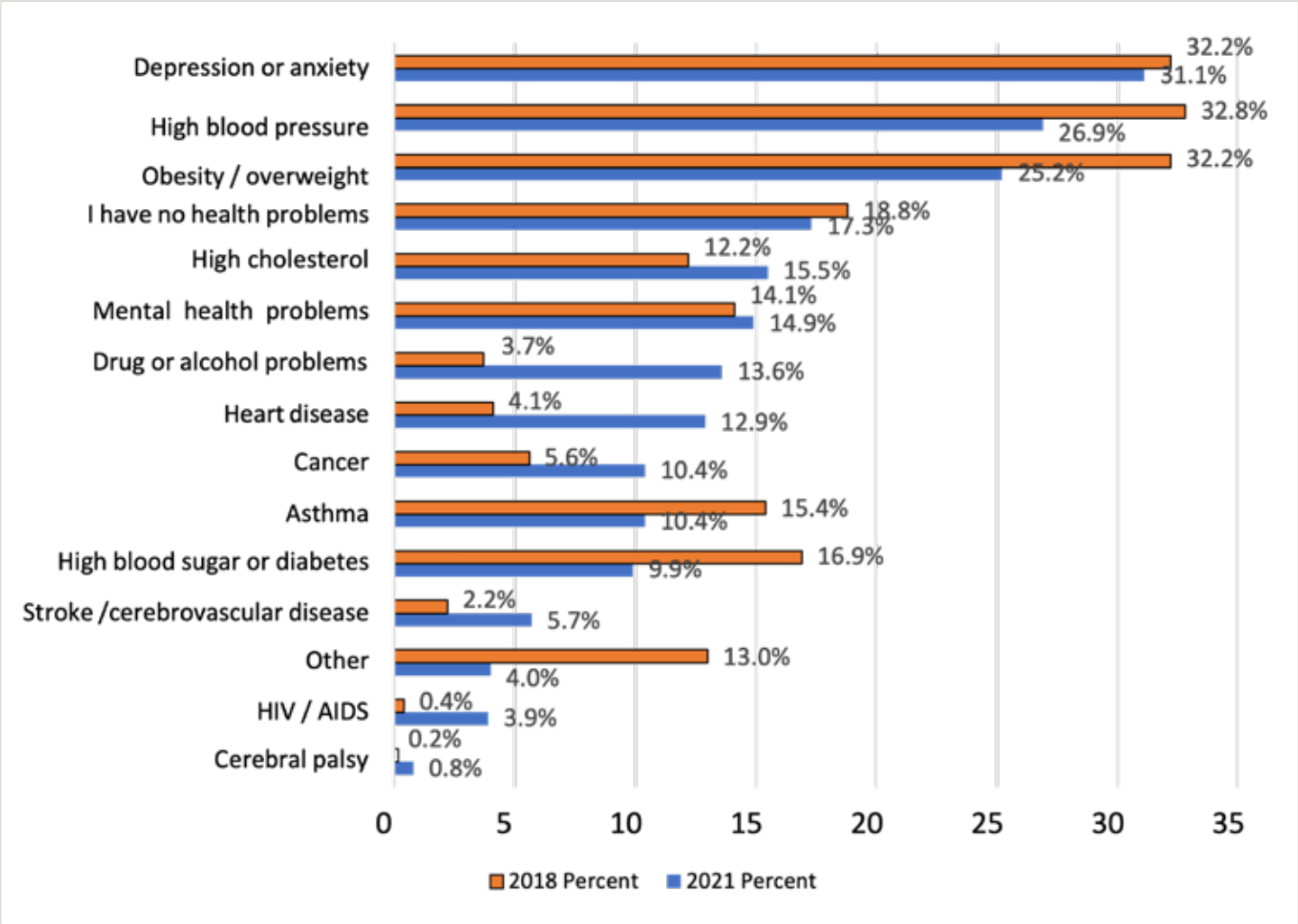
Respondents were asked, "What Keeps you from being healthy?". In 2018, the response "Nothing keeps me from being healthy" was not an option. The 2018 assessment had a similar question, "What do you feel prevents you from getting the services you need?" In 2021, the top two reasons respondents felt kept them from being healthy were identical to the top two reasons respondents felt were obstacles to getting the services they needed in 2018. Cost was 28% in 2021 and 48% in 2018. High co-pays were 28% in 2018 and 24% in 2021. "Don't know what types of services are available" increased to 20.4% in 2021 from 16.7% in 2018. Lack of evening and weekend services decreased slightly in 2021 to 20% from 22% in 2018. Long waits for appointments decreased to 17.6% in 2021 compared to 25.7% in 2018. No health insurance dropped as a reason from 13% in 2018 to 10% in 2021.

What keeps you from being healthy? (Respondents could check more than one)



Respondents were asked if they had been told by a doctor if they have a certain medical condition. The trend among disorders is largely consistent between 2018 and 2021. Again, depression or anxiety was one of the top conditions, followed by high blood pressure, and overweight/obesity. Less respondents in 2021 have been told that they have high cholesterol (15% in 2021 compared to 21% in 2018). The largest disparities were among respondents who have been told they have a drug or alcohol problem (up almost 10% in 2021) and heart disease (up approximately 9%).

Have you been told by a doctor that you have... (Respondents could check more than one)

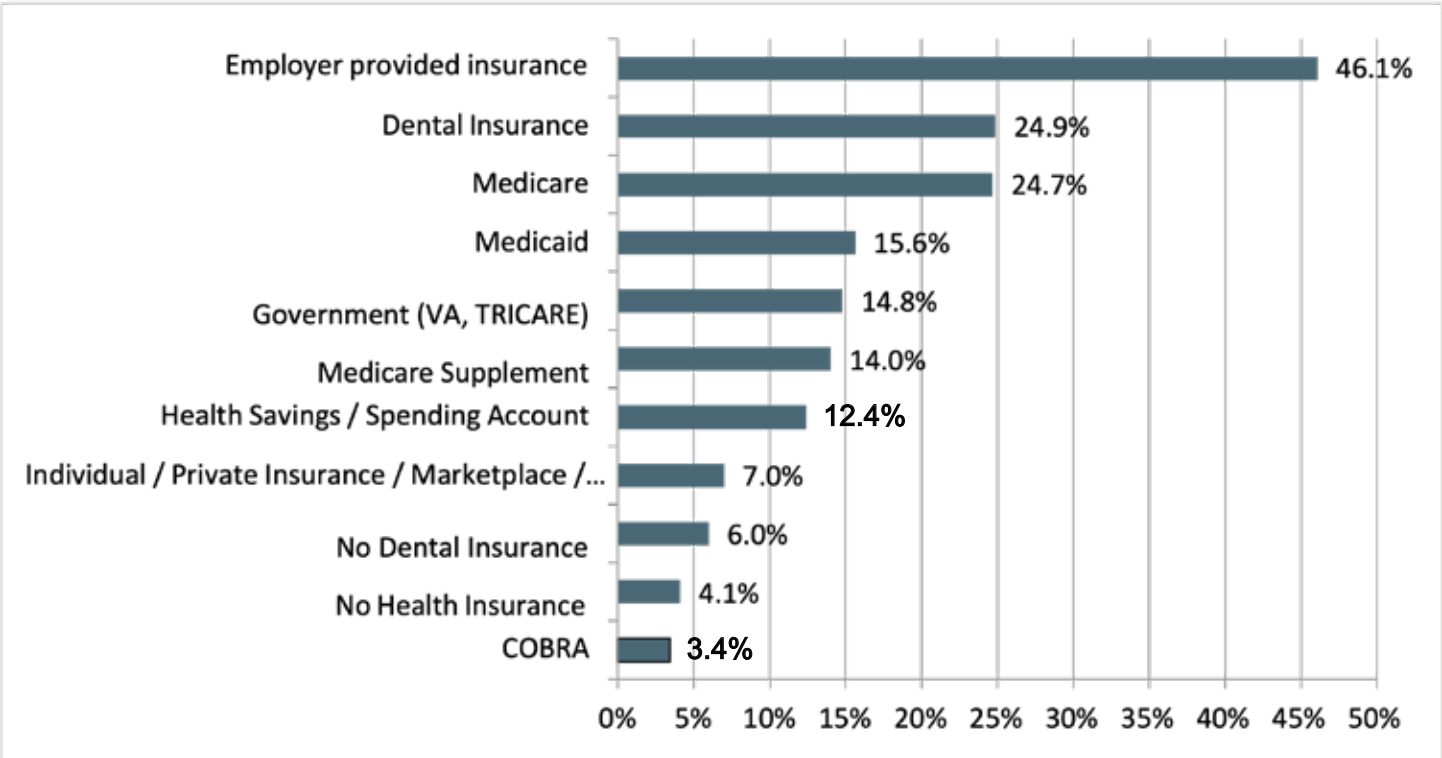


Health Insurance Status

When asked about their health insurance status, more respondents in 2018 indicated that they had employer provided insurance than in 2021 (55% in 2018 compared to 46% in 2021). The number of respondents indicating that they had no insurance fell significantly from 9% in 2018 to 4.1% in 2021. The number of respondents indicating that they had dental insurance decreased to 25% in 2021 from 30% in 2018. Respondents indicating that they had either Medicare, or a Medicare supplement, increased to 38.7% from 24.4% in 2018 while slightly fewer respondents reported they had Medicaid (15.6%) in 2021 compared to 16.6% in 2018. The 2021 respondents who indicated that they were currently on a COBRA plan increased from 0.4% in 2018 to 3.4% in 2021.

For those who did not have health insurance, the number of respondents indicating that health insurance was too expensive in 2018 was consistent to the percentage choosing this answer in 2021 (14% compared to 15% in 2021). There were more responses to unemployed/no job respondents in 2021 (10.3%) as compared to 2018 (7.1%). More 2021 respondents indicated that health insurance was not available at their job (8.2%) than 2018 respondents (4%). A significantly larger percent of respondents in 2021 (28.8%) reported they don't understand the Marketplace/ Obamacare as compared to 2018 (1.7%).

Which of the following describes your current type of health insurance? (Please check all that apply)

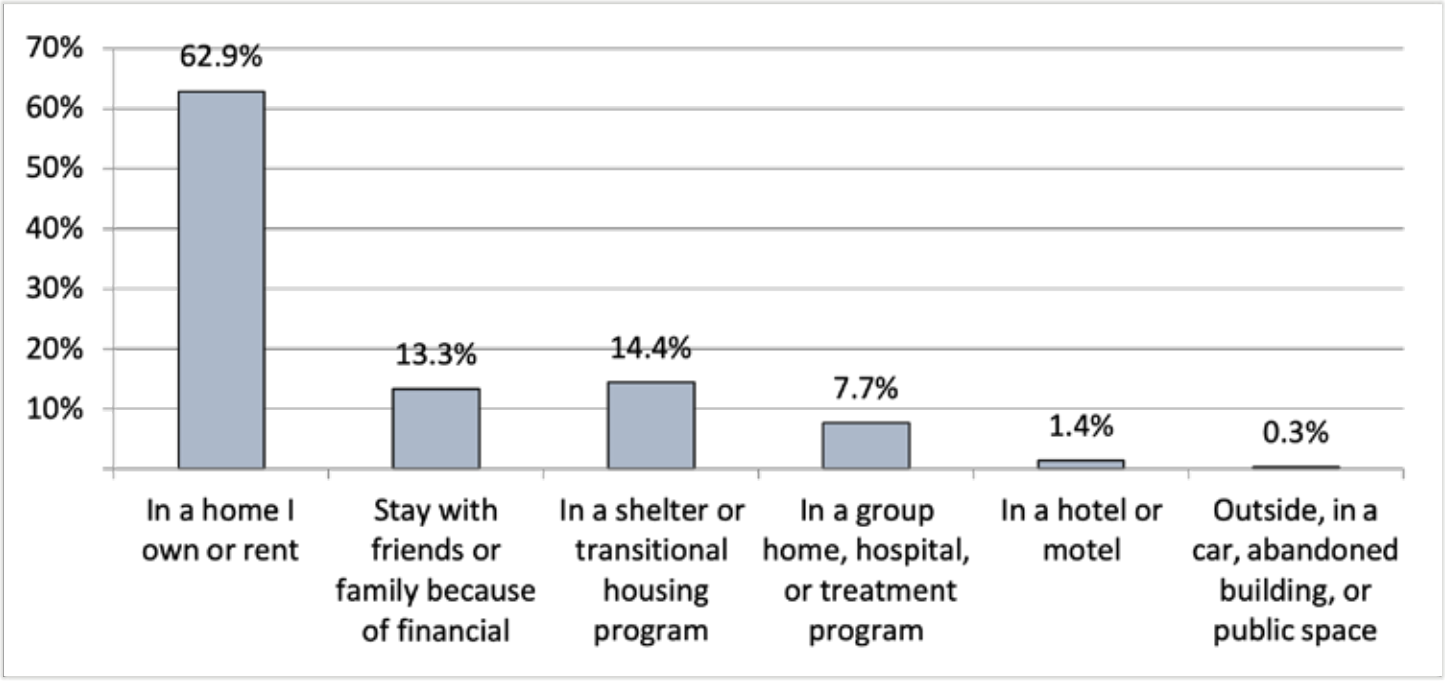


PHYSICAL ENVIRONMENT

Housing

To determine housing insecurity, respondents were asked where they sleep most often. In 2021, 63% of respondents slept most often in their own homes. The additional respondents who reported either sleeping at a friend's or family's home, in a shelter or transitional housing, or in a group home, hospital, or treatment program was 35.4%.

Where do you sleep most often? (Please check one)

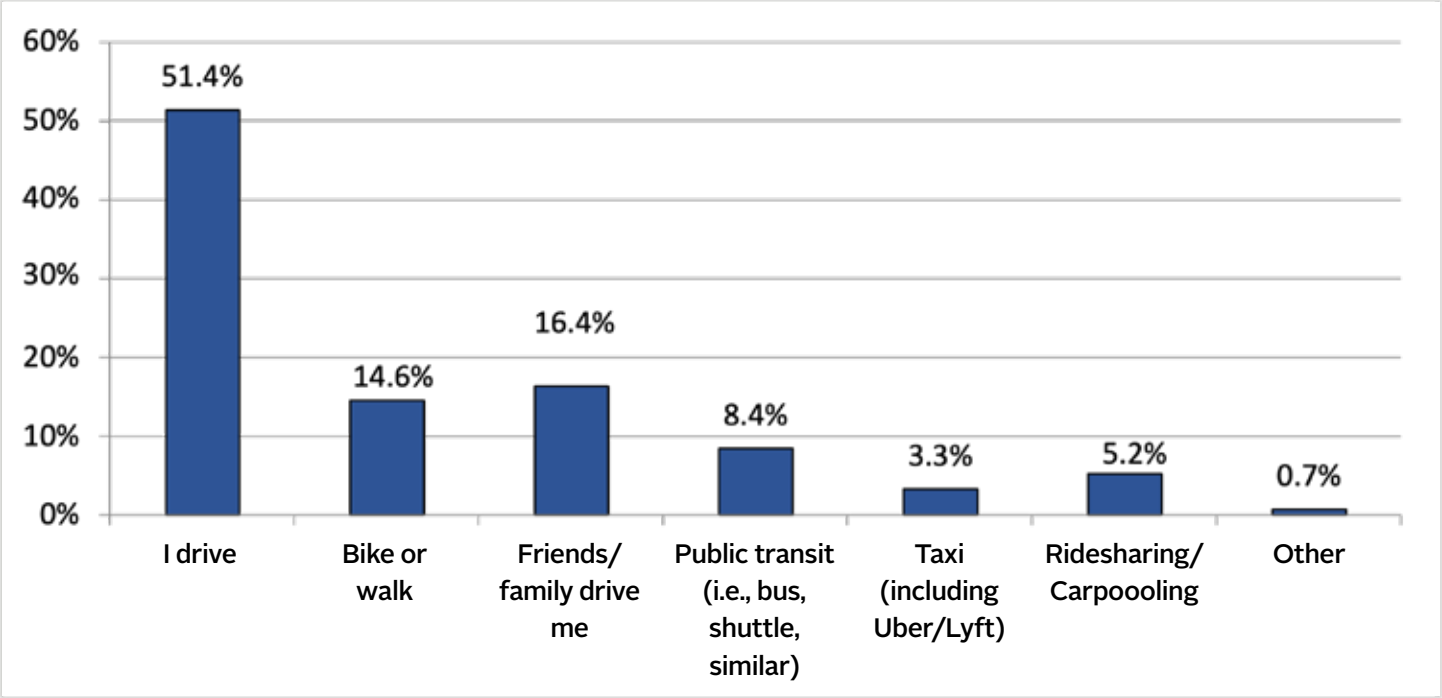


Transportation

Survey respondents were asked if they had reliable transportation. Approximately 89% of respondents indicated that they had access to reliable transportation. This question was not a question on the 2018 assessment. However, the 2018 assessment included how many vehicles were owned, leased, or available for regular use by the respondent and those in their household. The percentage indicating zero (0) was 11.3%.

When asked what type of transportation they use most often, in 2021, 51% indicated that they drove. In 2018, 86% indicated that the mode of transportation that they "typically used" was a car. In 2018 respondents were able to select multiple answers. This makes comparisons between the assessment years difficult. However, the number of 2021 respondents who indicated that they use public transportation increased slightly from 7.3% in 2018 to 8.4% in 2021.

What type of transportation do you use most often?



QUALITY OF LIFE

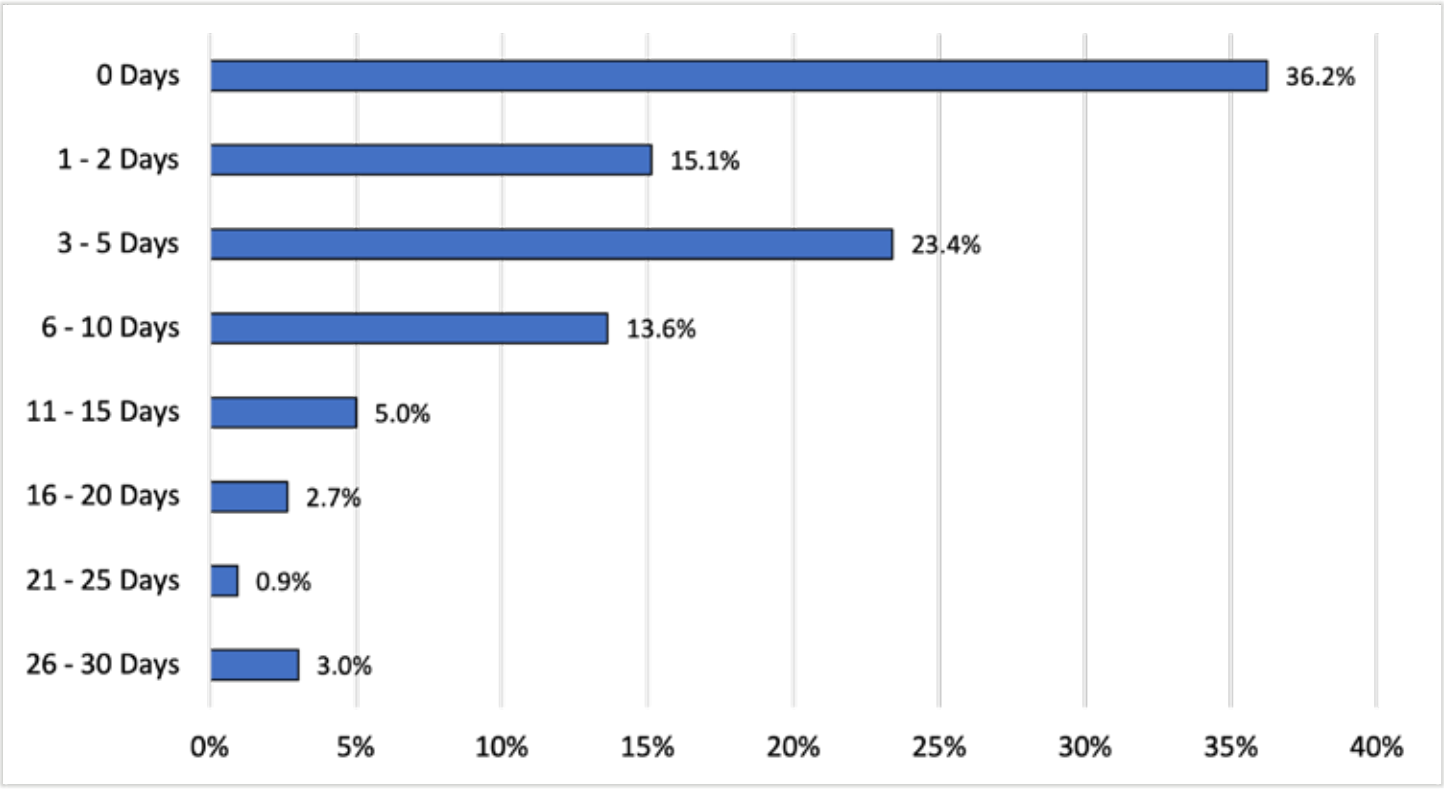
Physically and Mentally Unhealthy Days

Respondents were asked whether their physical and mental health was not good over the past 30 days.

The 2021 assessment breaks out 2018's assessment from 0-5 days to 0 days, 1 to 2 days, and 3 to 5 days. Combined the number of persons who reported that their health was not good from 0 to 5 days was 78% in 2018 compared to 74.5% in 2021. There was an increase in the number of respondents who said their health was not good for 6 to 15 days in 2021 (18.6% in 2021, 11.9% in 2018). There was only a small change from the 2018 assessment to the 2021 assessment among respondents answering 16 to 20 days (2.7% in 2021 compared to 2.4% in 2018) as well as those answering 21 to 25 days (0.9% in 2021 compared to 1.3% in 2018).

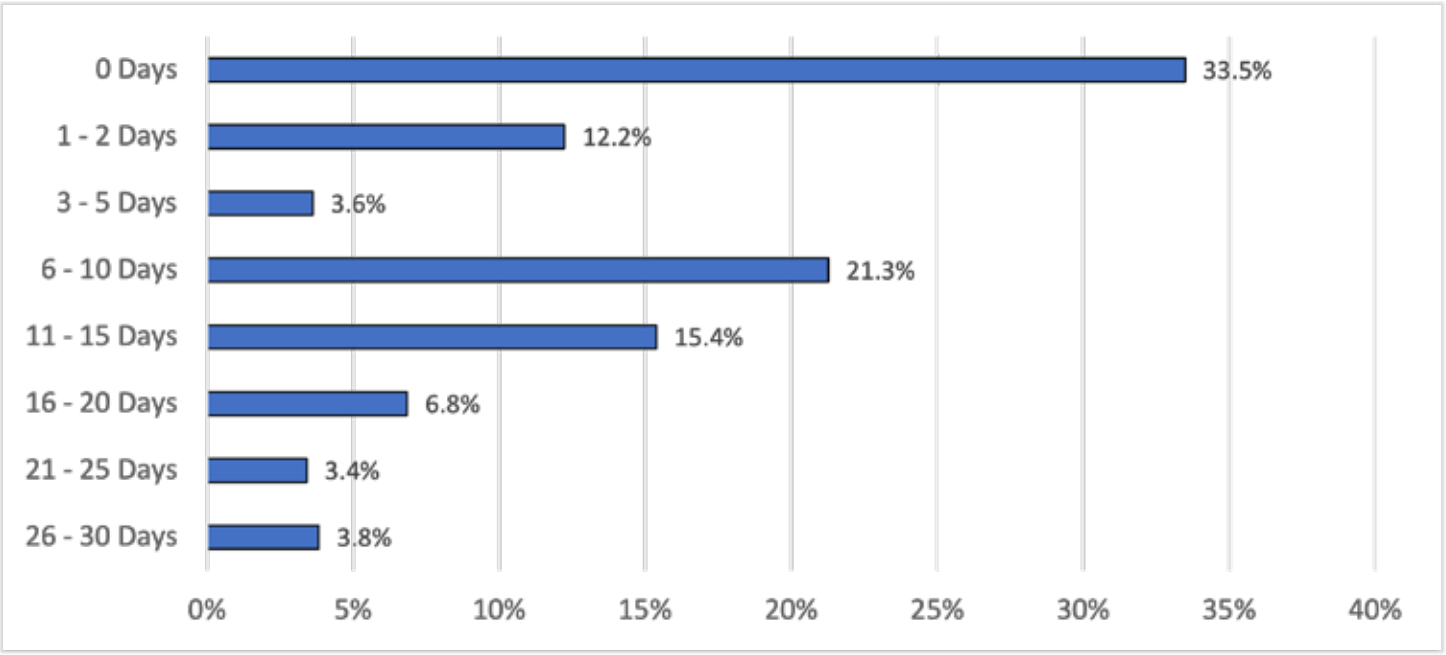
The percentage of respondents indicating that their physical health was not good for 26 to 30 days decreased from 6.2% in 2018 to 3% in 2021.

Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?



The percentage of 2021 respondents who felt their mental health was not good for more than 15 days in the last 30 days decreased from 15.2% in 2018 to 14%. The percentage of persons who felt their mental health was not good between 6 and 15 days increased significantly between assessments (13.9% in 2018 compared to 36.7% in 2021). Fewer reported that their mental health was not good for 0-5 days in 2021 (49.3%) as compared to 2018 (70.9%). The impact of COVID-19 should be considered as a contributor to this increase.

Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

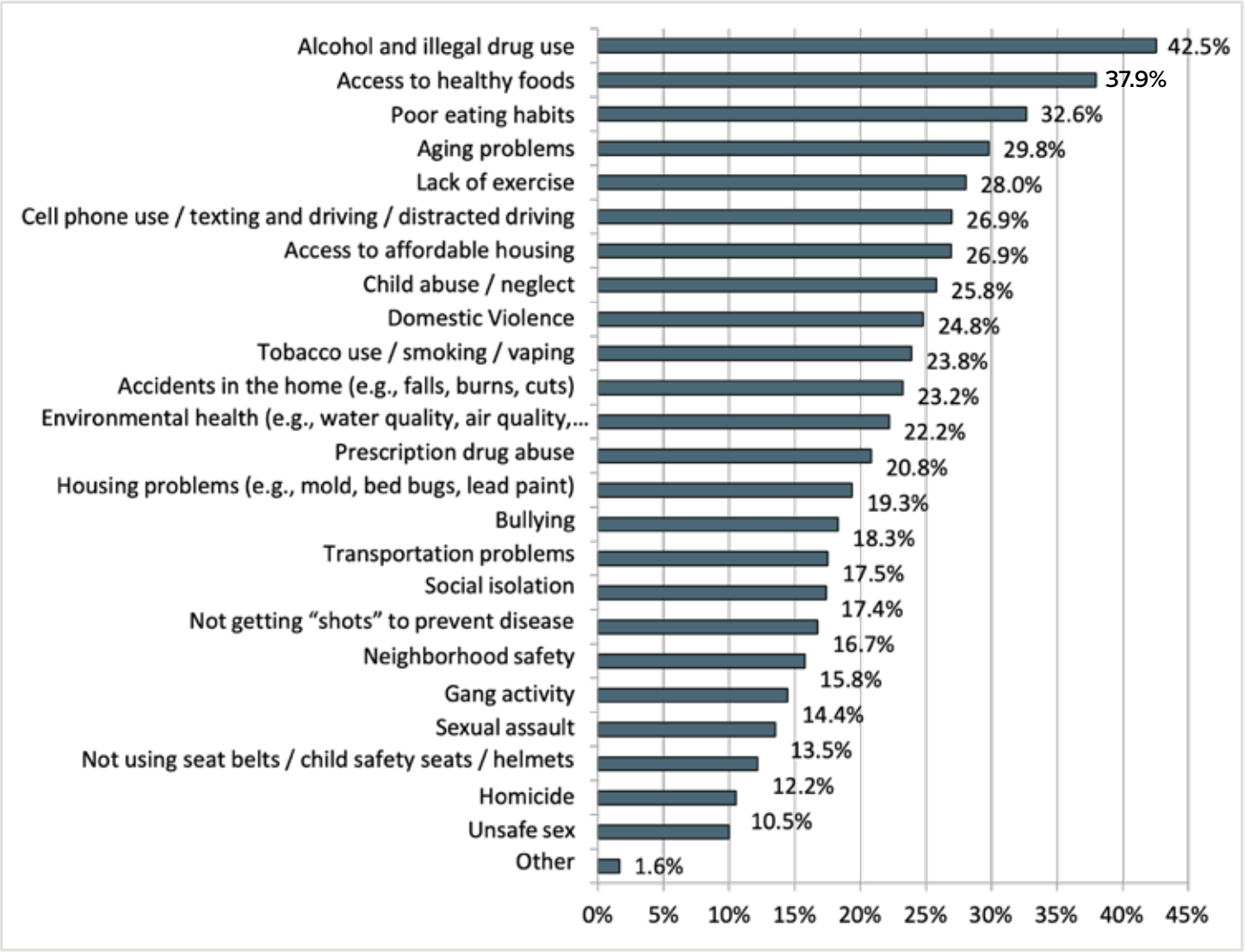


COMMUNITY NEED

Respondents were asked which health factors and health conditions/outcomes have the greatest impact on the health of the community.

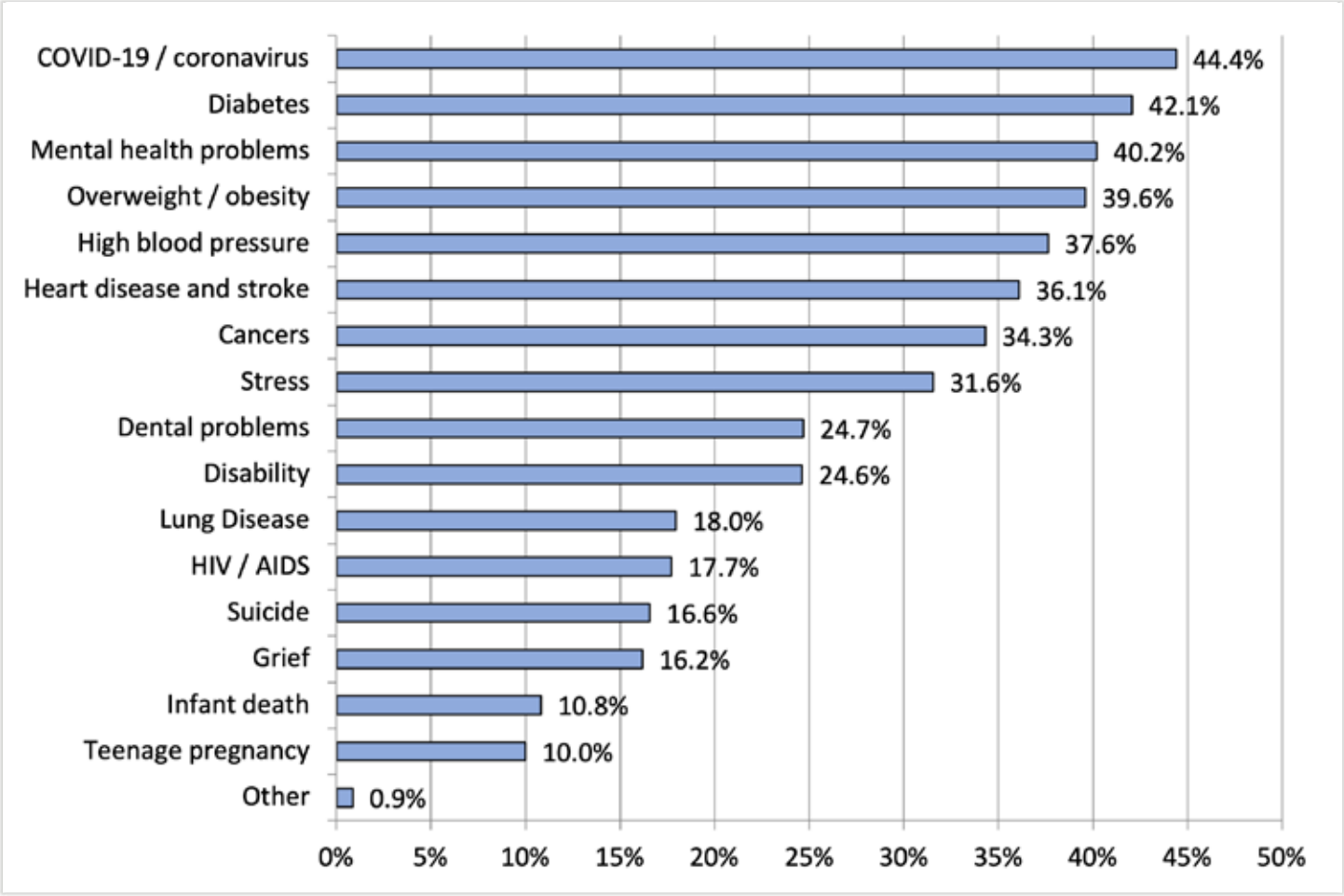
In the Lynchburg region, 2021 respondents ranked alcohol and illegal drug use as the most important health factor. Alcohol and illegal drug use were ranked in the top five of 2018 responses with 30.1% of respondents selecting this factor. Access to healthy foods was also highly ranked in 2018 with 26.9% of all responses. Poor eating habits increased significantly from the 2018 assessment (15.8%) to 32.6% in 2021. Aging problems doubled in the percentage of responses from 2018 (14.3%) to 2021 (29.8%). Lack of exercise increased approximately 12% from 2018 (16.3%) to 28% in 2021.

What do you think are the most important health factor issues that affect health in our community? (Respondents could check more than one)



COVID-19 was ranked most frequently among health conditions or outcomes cited by 2021 respondents. Of course, this was not an option in the 2018 assessment. Ranked health conditions or outcome issues that directly address diabetes or are significant risk factors for other chronic diseases included obesity and high blood pressure. Of particular note, in 2018, respondents indicated that mental health problems were 29% of their five selections, and in 2021 that number increased to 40%. This increase may be impacted by COVID-19 and the fact that health care "factors" and health care "issues" were broken into separate questions in 2021.

What do you think are the most important health condition or outcome issues that affect health in our community? (Respondents could check more than one)



STAKEHOLDERS SUMMARY

Stakeholder Focus Group and Survey

To further understand the needs of the target populations in the Lynchburg Area and the factors that impact the health of these residents, a Stakeholder Focus Group meeting was held on May 10, 2021 via Microsoft Teams. A total of 75 individuals attended the meeting including members of the Community Health Assessment Team and other identified cross-sector stakeholders, non-profit organizations, service providers, business leaders, and local government officials. A directory of participants can be found in the Appendix.

The focus group meeting was a 90-minute session. An overview of the Lynchburg Area 2021 Community Health Needs Assessment and the 2018 top ten prioritized needs were presented to participants. The participants were then asked to answer a series of questions regarding the needs of those they serve. When answering the questions, participants were asked to keep in mind the impact that the COVID-19 pandemic has had on these needs. Responses were available in real time using the "Poll Everywhere" application which was administered by Community Health Solutions in Richmond, Virginia.

After the Focus Group meeting, a Stakeholder Survey was administered and included the same questions that were asked in the Focus Group meeting. An additional question asking about the impact of the COVID-19 pandemic on the needs in the community was included in the survey. The survey was available via Survey Monkey from May 10 to May 26, 2021 for individuals and/or organizations who were unable to attend the Focus Group meeting. All total, 4 surveys were completed for the Lynchburg Area. An example of the survey can be found in the Appendix.

Stakeholder Focus Group questions included:

1. **What are the greatest issues/needs in the community(s) you serve? (List up to 5)**
2. **Of the needs listed, what is one issue/need we can work on together, to create a healthier community?**
3. **What are one or two ways we can work together on this issue/need?**
4. **Are there particular populations that are especially vulnerable to this issue/need? If yes, please describe.**
5. **What resources are available in the community to address this issue/need?**
6. **Are there gaps in these resources that we need to address?**

Responses for the Focus Group meeting and the Stakeholder Survey were sorted using Excel workbooks generated by Poll Everywhere and Survey Monkey. Similar responses for each question were grouped together and coded by topic area so that the frequency of responses could be quantified by total number and percentage of responses for each question. In addition, when applicable, pertinent comments depicting community need were noted. The analysis of this data was conducted by Health Access Strategies of Stuart's Draft, Virginia. Stakeholder Focus Group and Survey responses reflected many of the needs identified in the Community Health Survey and are delineated by question as follows.

Lynchburg Area Stakeholder Summary Tables

1. What are the top 5 greatest needs in the community(s) you serve?

Area of Need	*Number of Responses*	*% of Responses*	*Comments*
Access to mental health services	**37**	**14.6**	Trauma; Loneliness and isolation; Lack of reliable supports; Understanding impact of and treating trauma; Lack of mental health resources; Access to mental health; Suicide; Connection to meaningful activities and relationships; Lack of motivation
Transportation	**32**	**12.6**	Public transportation; Transportation to specialty offices
Childcare	**23**	**9.1**	Access to affordable childcare; Accessible childcare; Access to pre-K programs; Childcare – universal and affordable
Food Insecurity and Nutrition	**22**	**8.7**	Food insecurity; Access to healthy food & knowledge of healthy diet; Food desert; Nutrition education; Food disparities
Housing	**22**	**8.7**	Lack of affordable housing; Overcoming redlining from the past; Ending of the eviction moratorium
Access to care	**22**	**8.7**	Access to medical care including dental and mental health; Access to primary care; Extended hours – late evenings and weekends; Access to medical equipment; Emergency Department capacity; Cost of medicine and healthcare for those without health insurance; Would love to see a nurse visiting program
Poverty	**19**	**7.5**	Generational poverty; Lack of adequate income; Low-income disparities
Workforce	**14**	**5.5**	Living wage jobs; Skilled workforce training; Available workforce; Job help; Job readiness; Quality employment; Vocational education
Education	**11**	**4.3**	Access to pre-K programs; Out-of-school support; School failure; Adult training and education; Early childhood education
Physical Activity	**7**	**2.8**	Park infrastructure in all neighborhoods; Walkability; Physical inactivity; Low-cost exercise access
Substance use	**6**	**2.4**	Substance abuse treatment, for adults & teens too! Treatment that can be pursued while in the home, that doesn't have to lead to family separation! Education of stakeholders of best practice substance abuse treatment (e.g., lots of stigma remaining around medication-assisted treatment, etc.); Substance use detox
Health Education	**4**	**1.6**	Chronic disease prevention; Prevention before intervention; Healthcare education for families; Prevention programs
Healthcare Workforce	**4**	**1.6**	Apathy from health care providers; Lack of Asian providers; Public health expert; Quality treatment from health providers
Technology	**4**	**1.6**	Access to affordable internet; Cost of technology; No internet access
Racism	**4**	**1.6**	Institutionalized racism; Racial justice
Economic Disparities	**3**	**1.2**	Income inequality: big gap between the “haves” and “have nots”; inequity
Elderly	**3**	**1.2**	Fall risks; Independence – aging in place; Senior resources
Equity, Inclusion & Diversity	**3**	**1.2**	Equity and inclusion and diversity; Health equity access to meet individual needs due to poor health

1. What are the top 5 greatest needs in the community(s) you serve? *continued...*

Area of Need	*Number of Responses*	*% of Responses*	*Comments*
Health Literacy	**3**	**1.2**	Understanding the reports/information provided by health care providers
Families	**2**	**0.8**	Family Education/Child 0-4 help; Parenting
Outreach	**2**	**0.8**	Understanding and how to obtain and utilize the available resources in the community; Develop a relationship with the community to address needs & interest
Access to Dental Care	**1**	**0.4**	
Obesity	**1**	**0.4**	
Collaboration	**1**	**0.4**	Not duplicating resources
Political divide	**1**	**0.4**	
Domestic Violence	**1**	**0.4**	
Teen Pregnancy	**1**	**0.4**	
Total	**253**	**100%**	

2. How has the COVID-19 pandemic impacted these needs? (Survey respondents only)

Needs Impacted by COVID-19	*Number of Responses*	*Comments*
Mental Health & Substance Use Disorder	**4**	• Mental health and substance use disorder needs have gone up considerably. • Serious added stressor • We have had to limit much of our work to being socially distanced or virtual, which makes relationships more difficult. • Isolation and fear
Access to care	**2**	• Made access worse and consumers/patients left on their own to "figure it out". • The covid pandemic has placed restrictions on the ability to access resources in the community effectively. Having to wait for appointments and the covid policies in place can and have deterred clients from seeking resources
Affordable Housing	**2**	• The end of eviction moratorium will be significant. • Houses cost more than ever
Food Insecurity	**2**	• Food insecurity has greatly increased. • The community is helping families who need food.
Parenting	**2**	• The restrictions of COVID have made early single motherhood very isolating and challenging. • Limiting much of our work to being socially distanced or virtual, which makes relationships more difficult. Four of the girls in our independent living program have had babies since the pandemic hit.
Civic Infrastructure	**1**	• Stores are closed, public transport, and even private transport such as Uber or Lyft, have been sparse. Government offices have been closed.
Workforce	**1**	• Low wage jobs are available

3. Of the needs listed, what is one issue/need we can work on together, to create a healthier community?

One Issue	Number of Responses	% of Responses	Comments
Mental Health	**12**	**16.7**	TRAUMA - -there needs to education of all stakeholders, but especially of our medical community, of impact of trauma, & how we can urgently treat it in the moment. Trauma leads to almost everything else--substance use, cardiac disease, autoimmune disease, high-risk sexual behavior, respiratory disease, types of cancer. It also offers language & means to unpack & heal racism. We need de-identified screening of Adverse Childhood Events in primary care; Access to mental health services once MHSS services are no longer approved. There is no longer a psychosocial rehabilitation center in Lynchburg; Sufficient, quality, and QUICKER mental health resources that are equitable; Healthy relationships bring about holistic health. We'd love to have people invested in the lives of our youth who can be great mentors and simultaneously help them to learn how to be healthy individuals- mentally, emotionally, and physically.
Access	**9**	**12.5**	More providers of services; Reducing barriers to accessing services - primary care, mental health; Access to affordable medical care with convenient hours; Affordable total health care – includes mental health
Housing	**7**	**9.7**	Affordable housing
Childcare	**5**	**6.9**	
Food Insecurity and Nutrition	**5**	**6.9**	Making sure everyone eats a healthy diet - there will be ripple effects from solving that which will affect the other problems we listed; Food insecurity; How to prepare healthy meals
Transportation	**5**	**6.9**	Transportation is key to many of the other issues; Reliable transportation
Equity	**3**	**4.2**	Break down the hierarchy in the community; Equitable investments in community infrastructure; Contribute to a healthier community (offering services to everyone)
Health Education	**3**	**4.2**	Lack of knowledge about health; chronic disease prevention; generational poor health choices
Poverty	**3**	**4.2**	
Substance use	**3**	**4.2**	Substance use disorder because it is the root cause of many of the other problems in our community
Collaboration	**2**	**2.8**	Better community collaboration to avoid duplication; A united safety net of community collaborations
Education	**2**	**2.8**	Youth education; Access to early childhood education for families
Racism	**2**	**2.8**	Systemic racism
Outreach	**2**	**2.8**	We need to listen to the people we serve
Basic Needs	**1**	**1.4**	Food and Housing
Communication	**1**	**1.4**	Effective communication
Mentorships	**1**	**1.4**	
Health Equity	**1**	**1.4**	Disparities in socio-economic status that is inextricably tied to racism, sexism, less-adequate healthcare, substance abuse, trauma and other local issues

3. Of the needs listed, what is one issue/need we can work on together, to create a healthier community? *continued...*

Area of Need	*Number of Responses*	*% of Responses*	*Comments*
Health Literacy	**1**	**1.4**	Community education for improved health literacy
Healthcare Workforce	**1**	**1.4**	Recruit primary care doctors with diverse backgrounds
Physical Activity	**1**	**1.4**	Public spaces with free physical fitness infrastructure for all
Wellness	**1**	**1.4**	Overall wellness--physical & emotional
Workforce	**1**	**1.4**	Living wages
Total	**72**	**100%**	

4. What are one or two ways we can work together on this issue/need?

One Issue	Number of Responses	% of Responses	Comments
Collaboration	**26**	**33.8**	Collaborative work specifically that pools resources and has agencies working together intentionally on core missions and visions that serve the WHOLE community; Awareness of what other organizations are doing; Creating better relationships with each other and community members, access and referrals need to be easier; Create an area resource council as in Bedford (i.e., Bedford Area Resource Council)
Mental Health	**7**	**9.1**	Mental Health collaboration in care, have a universal communication platform, like Unite VA & VMAP; Healthy relationships bring about holistic health. We'd love to have people invested in the lives of our youth who can be great mentors and simultaneously help them to learn how to be healthy individuals; Education on how to become trauma-informed in all of our organizations for all of our clients
Communication	**6**	**7.8**	Improve communication and awareness of resources
Workforce	**5**	**6.5**	Advocacy for living wages; Partnership with employers to provide necessary resources/subsidies for their employees in need; Bring in more employers
Food Insecurity and Nutrition	**4**	**5.2**	Make Lynchburg area a model local food system - including support for individuals to grow their own food, community gardens, local farmers; boost institutional demand for healthy food; widespread nutrition and cooking programs for everyone, including doctors and medical providers, and more; Food insecurity
Health Education	**3**	**3.9**	Community supported chronic disease prevention programs; Teach wellness
Transportation	**3**	**3.9**	If we can improve access to public transportation and expand public school bus transportation, we can help get people where they need to go to access the other resource available
Access to care	**2**	**2.6**	Define "Access" for healthcare (i.e., appointments, someone answering phone, to specialists, in neighborhood, type of provider)
Best Practice & Quality Improvement	**2**	**2.6**	Pick a cohort group to run through a system and continually improve; Review of policies and practices from publicly funded organizations
Community Outreach	**2**	**2.6**	Create Community Wellness Hubs using the existing community locations. Bring the resources to the people; Implement the target outreach approach
Internet	**2**	**2.6**	Increase services by internet to cut down on transportation and wait time; Better internet
Poverty	**2**	**2.6**	Basic income for persons living below poverty line; Implement Bridges out of Poverty training not just have the training;
Basic Needs	**1**	**1.3**	
Cancer	**1**	**1.3**	Funding allocated for cancer survivorship
Childcare	**1**	**1.3**	Provide incentives and regional training for those nonprofits that create and maintain early childcare facilities

4. What are one or two ways we can work together on this issue/need? *continued...*

One Issue	Number of Responses	% of Responses	Comments
Domestic Violence	**1**	**1.3**	We also need a men's group for domestic violence. Right now, as far as I know, only way to access these services for men who have perpetrated domestic violence, is a criminal conviction
Education	**1**	**1.3**	Education equity
Funding	**1**	**1.3**	Bring stakeholders relevant to problem together to solve. Many issues aren't resolved because of lack of funding.
Healthcare Workforce	**1**	**1.3**	Recruit primary care doctors with diverse backgrounds
Housing	**1**	**1.3**	Housing - bring together community housing partners to develop an integrated process to meet the needs
Policy	**1**	**1.3**	Bring in legislators
Racism	**1**	**1.3**	Those with privilege must actively lead the charge for change through community intervention and being openly anti-racist, etc.
Resiliency	**1**	**1.3**	Efforts that focus specifically on building resiliency
Substance use	**1**	**1.3**	Substance use disorders because it is the root cause of many of the other problems in our community
Unite Us	**1**	**1.3**	Community implementation of "Unite Us Virginia" referral network
Total	**77**	**100%**	

5. Are there particular localities/populations that are especially vulnerable to this issue/need? If yes, please describe.

Vulnerable Populations or Localities	*Number of Responses*	*% of Responses*	*Comments*
Low income	**17**	**14.8**	Low-income neighborhoods; Those living in generational poverty; Persons receiving social services; Low income rural and urban neighborhoods; Low-income and underserved; low-income families with children; Low-income families face difficulty finding safe affordable housing
Elderly	**14**	**12.2**	Seniors without a car or do not drive; The homebound; elderly and disabled; elderly minorities; low-income elderly
People of Color	**12**	**10.4**	African American women; Historically redlined neighborhoods; Traditionally marginalized populations
Children and Youth	**12**	**10.4**	Young children and their families; Youth aging out of foster care are extremely vulnerable; Children that are "in the system"; Children in rural communities; Children 0-4 years of age; Childcare - the population that is in most dire need of childcare are the working poor and college bound students with children; At-risk youth
Mental Health	**12**	**10.4**	Resources to address early childhood mental health are scarce! But also, we need more outreach-type services (e.g., nurse home visiting programs). For children at risk, we need to wrap around the whole family! Those affected by covid 19 isolation; Mental health access, teens, young children, trauma; Covid changes with school; Increased suicidal ideas; There are many who are vulnerable to mental health issues in our community; Especially vulnerable are those with lower access, trauma history, mental health comorbidities, lack of access to health insurance, low SES, lack of parental supervision, at-risk youth, those with addiction struggles, foster families, dysfunctional family units, those without outside support systems; Persons whose mental health and substance abuse issues have not been sufficiently addressed.
Disabled	**7**	**6.1**	Persons with disabilities - difficulties in finding affordable accessible housing; People with limited ability to work who are yet to be approved for disability; Disabled/homebound people under the age of 60; Persons living with intellectual disabilities.
Lynchburg	**7**	**6.1**	Big pockets of poverty and little to no investment in former redlined areas affecting largely black population; Downtown, away from main street; Into Florida Ave, Floyd Ave, in Greenbrier, and the College Hill apartments; 12th Street
Rural Communities	**6**	**5.2**	Rural areas (Callands, Long Island, Sutherlin); More rural populations such as Amherst & Bedford Country; Access to resources is more limited and transportation is an issue especially for those on the outskirts.
Civic Infrastructure	**4**	**3.5**	Homes along non-state-maintained roads; Areas without paving; housing and safety; Areas without internet.
Substance use	**4**	**3.5**	Adult & teen substance treatment is scarcer in the rural localities; Those with addiction struggles.

5. Are there particular localities/populations that are especially vulnerable to this issue/need? If yes, please describe. *continued...*

Vulnerable Populations or Localities	*Number of Responses*	*% of Responses*	*Comments*
Families/Parents	**3**	**2.6**	Right now, there are more barriers to accessing robust services to help the parents (beyond just what's funded for Medicaid), or families as a whole unless they are in foster care. That will change in July when Families First legislation hits, but it should never have been that way to start with! Foster families; Lack of parental supervision.
Transportation (Persons lacking)	**3**	**2.6**	Rural and urban communities are both impacted by lack of adequate public transportation - they cannot access already available resources; Areas without public transportation; Heavily used public transportation routes.
Education/Literacy	**2**	**1.7**	Those with limited education; illiteracy
Food Insecurity and Nutrition	**2**	**1.7**	Food insecurities; Food deserts
Single mothers	**2**	**1.7**	
Asians	**1**	**0.9**	
Brookneal	**1**	**0.9**	
English as a Second Language (ESL)	**1**	**0.9**	ESL populations - navigation of resources can be difficult
Formerly incarcerated	**1**	**0.9**	
Isolation	**1**	**0.9**	Those who are socially isolated
Lack of Health Insurance	**1**	**0.9**	
LGBTQX	**1**	**0.9**	
Pregnant Women	**1**	**0.9**	
Unemployed	**1**	**0.9**	
Total	**115**	**100%**	

6. What resources are available in the community to address this issue/need?

Resources	Number of Responses	% of Responses	Comments
Faith Community	**9**	**6.2**	Interfaith outreach; Red Truck Ministries
Community Access Network (CAN)	**8**	**5.5**	CAN was supposed to be Centra's response to many of these needs
Centra	**5**	**3.4**	Centra community outreach programs
Community based organizations	**5**	**3.4**	Private purpose driven organizations have everything we need to solve the problem. We lack communication and a way to coordinate our efforts; Lots of great non-profits; NGOs and community action groups that don't require new funds -- people are willing to work on good, specific proposals
Central Virginia Continuum of Care	**5**	**3.4**	
Meals on Wheels	**4**	**2.7**	
Community Centers	**4**	**2.7**	
Community Health Workers (CHW)	**4**	**2.7**	Find champions or lay leaders within communities to reach their neighbors (Community Health Workers)
Funding	**4**	**2.7**	Any COVID funds? National grants we could collaboratively apply for? Our (existing) lines of communication and organizations that might have funds or grants available to already meet these needs
Health Department	**4**	**2.7**	Needs expansion; WIC
Horizon Behavioral Health	**4**	**2.7**	
United Way	**4**	**2.7**	And their partner agencies
Schools	**4**	**2.7**	
Collaboration	**3**	**2.1**	Need to remove silos so organizations work together; Synergy from local communities; We may need a community resources mapping
Education	**3**	**2.1**	Pre-K initiatives ; Libraries ; Universities
Food Bank	**3**	**2.1**	The Food Bank; Food banks and free meals by many churches; Blue Ridge Food Bank
Johnson Health Center	**3**	**2.1**	
Lynchburg Regional Housing Collaborative	**3**	**2.1**	
Parkview Community Mission	**3**	**2.1**	
University of Lynchburg	**3**	**2.1**	Partnerships with University of Lynchburg; University of Lynchburg has a new collaborative leadership imitative with academic resources available
Support Groups	**3**	**2.1**	Alcoholics Anonymous, Narcotics Anonymous
YMCA	**3**	**2.1**	Childcare: power scholars, beyond the bell - chronic disease prevention programs and support groups
Central Virginia Alliance for Community Living	**2**	**1.4**	
Central Virginia Community College	**2**	**1.4**	CVCC Educational Foundation

6. What resources are available in the community to address this issue/need? *continued...*

Resources	Number of Responses	% of Responses	Comments
Dept. of Social Services	**2**	**1.4**	
Free Clinic	**2**	**1.4**	
Healthy Families	**2**	**1.4**	Broaden when a child can be enrolled for Healthy Families. Consider pairing with nurse home visiting program.
HumanKind	**2**	**1.4**	
Lynchburg Grows	**2**	**1.4**	
Lynchburg Redevelopment and Housing Authority	**2**	**1.4**	
Mental health	**2**	**1.4**	Crisis intervention services; Mental health skill building – out-patient, case management, psychiatric services
Miriam's House	**2**	**1.4**	
MoveUp	**2**	**1.4**	Transportation service
Virginia Cooperative Extension	**2**	**1.4**	
American Heart Association	**1**	**0.7**	
Big Brothers & Big Sisters	**1**	**0.7**	
Boys and Girls Club	**1**	**0.7**	
City of Lynchburg	**1**	**0.7**	Hire Lynchburg program
Department for the Aging	**1**	**0.7**	
Employers/Businesses	**1**	**0.7**	
Family Assessment and Planning Team	**1**	**0.7**	
FREE Foundation	**1**	**0.7**	
Habitat for Humanity	**1**	**0.7**	
Impact Living Services	**1**	**0.7**	Serve at-risk children and youth aging out of foster care... happy to collaborate with other organizations in order to provide the best services to the youth through our programs.
CASA	**1**	**0.7**	
Girls on the Run	**1**	**0.7**	
Greater Lynchburg Community Foundation	**1**	**0.7**	
Independent service providers	**1**	**0.7**	Community leaders and pillars (need resources)
Jubilee Family Center	**1**	**0.7**	
Kids First Collaborative	**1**	**0.7**	
Lighthouse Community	**1**	**0.7**	
Lynchburg Area Center for Independent Living	**1**	**0.7**	
Oxford House	**1**	**0.7**	
Pathways	**1**	**0.7**	
Roads to Recovery	**1**	**0.7**	
Rush Homes	**1**	**0.7**	

6. What resources are available in the community to address this issue/need? *continued...*

Resources	*Number of Responses*	*% of Responses*	*Comments*
SHARE	**1**	**0.7**	
The Gateway	**1**	**0.7**	Homeless males
The Health Collaborative	**1**	**0.7**	Danville and Pittsylvania County
The Motherhood Collective	**1**	**0.7**	
Virginia Career Works	**1**	**0.7**	
Wellness Program	**1**	**0.7**	Free dietician & wellness program & steps tracker
Total	**146**	**100%**	

7. Are there gaps in these resources that we need to address?

Gaps	Number of Responses	% of Responses	Comments
Care Coordination	**13**	**14.9**	Discouraged end user gives up before a total plan for person is put together; Navigation of all (services); Connecting people to resources; The resources are there, the gap comes from a lack of knowledge & understanding; Connecting people with needs with the resources because of the lack of centralized administration; Creating opportunities for neighbors helping neighbors; Making the connections easier; Lack of awareness of resources; Improving knowledge of resources; Empathy and understanding of those unlike the administrators and providers
Funding	**13**	**14.9**	Local funding that can leverage state/federal/other private resources; Braiding the funding across agencies to make a bigger impact (remove silos); Investments in community infrastructure; Need further funding (e.g., Medicaid funding) for robust in-home parent coaching/family counseling; Funding for staffing capacity for non-profits
Housing	**8**	**9.2**	Funding for housing allocated to those who may not meet eligibility requirements under current State and Fed guidelines and are working; Expanded housing vouchers /subsidies; Eviction prevention services; resources to address critical housing needs for owner-occupied "blighted" housing
Mental Health	**7**	**8.0**	Responsive mental health agency; Gaps in mental health services for isolated seniors; Gaps in mental health care for the young; The step down from mental health skill building to a less intensive service; Trauma informed care
Assessment & Planning	**6**	**6.9**	Evaluation of the resources we are using; We need to understand what the individual people need and develop a program/s that addresses their needs; Follow through on plan with action items. Do something - enough talk; Systems thinking; Knowledge on how to address complex issues like poverty and the vast amount of resources it takes to improve walkability and develop healthier, planned communities
Collaboration	**6**	**6.9**	Develop partnerships to address the whole problem; Overlap and lack of collaboration; Silos of organizations letting territorial control get in the way; Buddy system -individuals willing to partner/sponsor with those in need; Duplication of efforts
Substance Use	**4**	**4.6**	There is no facility for homeless women who are substance users but are not with children. The Gateway is under-funded; Need coordination amongst providers as to best practices in treating parental substance abuse, rather than relying on more outmoded attitudes (e.g., stigma towards medication-assisted treatment; bringing a child into foster care because a parent tests positive for marijuana, etc.)
Communication	**3**	**3.4**	Communication gaps; Communication about what resources are available
Transportation	**3**	**3.4**	Transportation to these resources, ease of accessing services, wraparound services for entire family - not just one issue; Affordable and accessible transportation
Childcare	**2**	**2.3**	Quality childcare; Inadequate childcare facilities, education about resources

7. Are there gaps in these resources that we need to address? *continued...*

Gaps	Number of Responses	% of Responses	Comments
Workforce	**2**	**2.3**	Opportunities for job mentorships or internships; Clear path from high school to local jobs/workforce. Specific job training
Children and Youth	**1**	**1.1**	Need to broaden window of when children/families can be enrolled in Healthy Families
COVID	**1**	**1.1**	COVID has created many barriers that we have never seen before
Domestic Violence	**1**	**1.1**	We need more resources & easier access to robust, evidence-based services for men who perpetrate domestic violence
Family/Faith	**1**	**1.1**	Institutions can do so much, but can never replace the efficacy of family and faith communities
Food Insecurity and Nutrition	**1**	**1.1**	Food deserts
Poverty	**1**	**1.1**	Generational poverty - get people skilled and trained and then we don't have to rely on systems.
Healthcare Workforce	**1**	**1.1**	Huge gap - for example, Central VA Family Physicians has no Asian providers. Very few Asian providers in the hospital
Homelessness	**1**	**1.1**	Support for those "at risk" of homelessness but not yet meeting homeless definition
Outreach	**1**	**1.1**	Neighborhood centric services
Technology	**1**	**1.1**	Make our systems (databases) accessible to others
Total	**87**	**100%**	

SECONDARY DATA

Secondary data in this assessment includes population data for the Centra Lynchburg Service Area. The service area includes the following counties: Amherst, Appomattox, Campbell, and Pittsylvania — as well as the city of Lynchburg.

Lynchburg Population by Age Group by Locality

Age Group	Amherst		Appomattox		Campbell	
	Number	Percent	Number	Percent	Number	Percent
Under 5 years	1,724	5.40%	894	5.70%	2,829	5.10%
5 to 9 years	1,507	4.70%	907	5.80%	3,117	5.60%
10 to 14 years	2,003	6.30%	923	5.90%	2,994	5.40%
15 to 19 years	1,816	5.70%	1,080	6.90%	3,304	6.00%
20 to 24 years	2,002	6.30%	789	5.00%	3,137	5.70%
25 to 34 years	3,417	10.80%	1,775	11.30%	7,377	13.40%
35 to 44 years	3,500	11.00%	1,740	11.10%	6,260	11.30%
45 to 54 years	4,399	13.80%	2,101	13.40%	7,392	13.40%
55 to 59 years	2,566	8.10%	1,116	7.10%	4,218	7.60%
60 to 64 years	2,309	7.30%	1,199	7.60%	3,788	6.90%
65 to 74 years	3,739	11.80%	1,845	11.70%	6,200	11.20%
75 to 84 years	2,056	6.50%	992	6.30%	3,101	5.60%
85 years and over	737	2.30%	346	2.20%	1,508	2.70%
Median Age	**44.8**		**42.6**		**43**	
Total	**31,775**	**100%**	**15,707**	**100%**	**55,225**	**100%**

Age Group	Lynchburg		Pittsylvania		Service Area		Virginia	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under 5 years	4,885	6.10%	2,560	4.20%	12,892	5.3%	508,399	6.0%
5 to 9 years	3,871	4.80%	3,339	5.50%	12,741	5.2%	515,885	6.1%
10 to 14 years	4,282	5.30%	3,413	5.60%	13,615	5.6%	525,704	6.2%
15 to 19 years	8,954	11.10%	3,588	5.90%	18,742	7.7%	551,262	6.5%
20 to 24 years	13,653	16.90%	3,127	5.10%	22,708	9.3%	576,327	6.8%
25 to 34 years	11,139	13.80%	6,280	10.30%	29,988	12.3%	1,174,091	13.9%
35 to 44 years	7,125	8.80%	6,726	11.00%	25,351	10.4%	1,100,460	13.0%
45 to 54 years	7,299	9.10%	8,962	14.60%	30,153	12.3%	1,139,236	13.5%
55 to 59 years	3,836	4.80%	4,711	7.70%	16,447	6.7%	571,821	6.8%
60 to 64 years	4,157	5.20%	5,178	8.50%	16,631	6.8%	519,332	6.1%
65 to 74 years	5,945	7.40%	7,876	12.90%	25,605	10.5%	756,712	9.0%
75 to 84 years	3,577	4.40%	4,326	7.10%	14,052	5.7%	368,997	4.4%
85 years and over	1,846	2.30%	1,170	1.90%	5,607	2.3%	146,237	1.7%
Median Age	**28.3**		**47.2**				**38.2**	
Total	**80,569**	**100%**	**61,256**	**100%**	**244,532**	**100%**	**8,454,463**	**100%**

Table Source: U.S. Census, ACS Demographic and Housing Estimates. Table DP05. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Population by Sex

Locality	Male		Female	
	Number	Percent	Number	Percent
Amherst County	15,290	48.10%	16,485	51.90%
Appomattox County	7,599	48.40%	8,108	51.60%
Campbell County	26,711	48.40%	28,514	51.60%
Lynchburg City	37,729	46.80%	42,840	53.20%
Pittsylvania County	30,113	49.20%	31,143	50.80%
Service Area	117,442	48.03%	127,090	51.97%
Virginia	4,159,173	49.20%	4,295,290	50.80%

Table Source: U.S. Census, ACS Demographic and Housing Estimates. Table DP05. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Lynchburg Population by Race

Locality	White	Black	American Indian / Alaskan Native	Asian	Native Hawaiian or Pacific Isl	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino
Amherst County	24,381	5,709	212	162	19	286	1,006	766	31,009
Appomattox County	12,263	3,105	5	12	0	31	291	260	15,447
Campbell County	44,982	7,735	106	506	15	323	1,558	1,394	53,831
Lynchburg City	46,202	12,307	37	275	22	593	1,820	1,612	59,644
Pittsylvania County	52,348	23,069	206	1973	8	920	2045	3361	77,208
Service Area	180,176	51,925	566	2,928	64	2,153	6,720	7,393	237,139

Lynchburg Population by Race by Percent of Total Population

Locality	White	Black	American Indian / Alaskan Native	Asian	Native Hawaiian or Pacific Isl	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino
Amherst County	76.7%	18.0%	0.7%	0.5%	0.1%	0.9%	3.2%	2.4%	97.6%
Appomattox County	78.1%	19.8%	0.0%	0.1%	0.0%	0.2%	1.9%	1.7%	98.3%
Campbell County	81.5%	14.0%	0.2%	0.9%	0.0%	0.6%	2.8%	2.5%	97.5%
Lynchburg City	75.4%	20.1%	0.1%	0.4%	0.0%	1.0%	3.0%	2.6%	97.4%
Pittsylvania County	65.0%	28.6%	0.3%	2.4%	0.0%	1.1%	2.5%	4.2%	95.8%
Service Area	75.3%	20.1%	0.3%	0.9%	0.0%	0.8%	2.7%	2.7%	97.3%
Virginia	67.6%	19.2%	0.3%	6.4%	0.1%	2.6%	3.8%	9.4%	90.6%
United States	72.5%	12.7%	0.8%	5.5%	0.2%	4.9%	3.3%	18.0%	82.0%

Table Source: U.S. Census, ACS Demographic and Housing Estimates. Table DP05. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Limited English-Speaking Households

Locality	Total			Limited English Speaking by Language	
	Total Population	Limited English	Percent Limited English	Spanish	Asian Pacific Isl.
Amherst County	12,160	25	0.20%	5	8
Appomattox County	6091	19	0.30%	19	0
Campbell County	23071	234	1.00%	162	42
Lynchburg City	26267	222	0.80%	135	15
Pittsylvania County	28273	372	1.30%	155	116
Service Area	**95,862**	**872**	**0.72%**	**476**	**181**
Virginia	**3,151,045**	**84,373**	**2.70%**	**41,500**	**24,490**

Table Source: U.S. Census, Limited English Speaking Households. Table S1602. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

A "limited English-speaking household" is one in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English "very well." In other words, all members 14 years old and over have at least some difficulty with English.

Source: U.S. Census Frequently Asked Questions. Accessed August 16, 2021. Retrieved from https://www.census.gov/topics/population/language-use/about/faqs.html.

Population Projections

"Population projections provide a lens to look into the future to anticipate what the decades ahead may hold. While projections are inherently uncertain, as the future is largely unknown, accuracy at larger geographic levels—and for the near future—can be highly valuable and useful. They provide us with a baseline for planning, and guide the needs and priorities for decision-making across the Commonwealth.

The Weldon Cooper Center at the University of Virginia recently released the updated 2019 population projections for all counties, cities, and large towns across Virginia. These updated projections show that while Virginia continues to grow in population size, the pace of growth may be a little slower than what was earlier projected, with a 2020 population of 8.65 million. The 13% statewide growth rate of the last decade (2000-2010) has decelerated to 8% for the current decade and is anticipated to hold steady through 2020-2030 assuming that current trends will continue, specifically lower births, higher deaths (result of aging), and fewer people moving into the state."

Source: Weldon Cooper Center for Public Service. Population Projections show that Virginia is aging and growing more slowly. Published July1st, 2019. Accessed July 8th, 2021. Retrieved from http://statchatva.org/2019/07/01/population-projections-show-that-virginia-is-aging-and-growing-more-slowly/

Population Projections by Locality, 1990 - 2010

Locality	1990	2000	2010	+/-
Amherst County	28,578	31,894	32,353	13.2%
Appomattox County	12,298	13,705	14,973	21.8%
Campbell County	47,572	51,078	54,842	15.3%
Lynchburg City	66,049	65,269	75,568	14.4%
Pittsylvania County	55,655	61,745	63,506	14.1%
Service Area	**42,030**	**44,738**	**48,248**	**14.8%**
Virginia	**6,187,358**	**7,078,515**	**8,001,024**	**29.3%**

Table Source: Virginia Department of Health, Division of Health Statistics. Year(s) Measured: 1990 - 2010. Retrieved from https://www.vdh.virginia.gov/data/

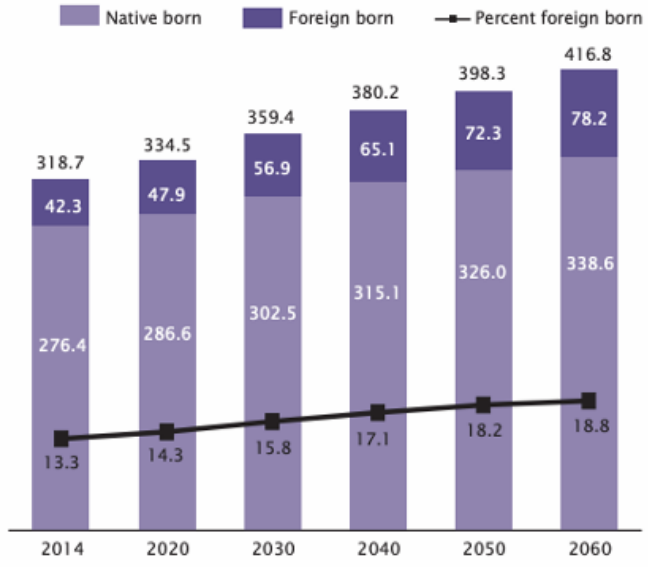
Population Projections by Locality, 2020-2040

Locality	2020	2030	2040	+/-
Amherst County	31,831	31,402	30,599	-3.9%
Appomattox County	15,866	16,742	17,391	9.6%
Campbell County	55,665	57,325	58,240	4.6%
Lynchburg City	82,791	90,526	96,956	17.1%
Pittsylvania County	61,379	60,523	58,946	-4.0%
Service Area	**49,506**	**51,304**	**52,426**	**5.9%**
Virginia	**8,655,021**	**9,331,666**	**9,876,728**	**14.1%**

Table Source: Weldon Cooper Center for Public Service. Date of Table: 2019. Year(s) Measured: 2020 - 2040. Retrieved from http://demographics.coopercenter.org

"The year 2030 marks a demographic turning point for the United States. Beginning that year, all baby boomers will be older than 65. This will expand the size of the older population so that one in every five Americans is projected to be retirement age (Figure 1). Later that decade, by 2034, we project that older adults will outnumber children for the first time in U.S. history. The year 2030 marks another demographic first for the United States. Beginning that year, because of population aging, immigration is projected to overtake natural increase (the excess of births over deaths) as the primary driver of population growth for the country. As the population ages, the number of deaths is projected to rise substantially, which will slow the country's natural growth. As a result, net international migration is projected to overtake natural increase, even as levels of migration are projected to remain relatively flat. These three demographic milestones are expected to make the 2030s a transformative decade for the U.S. population."

Figure 1.
U.S. Population by Nativity: 2014 to 2060
(Population in millions)



Content & Table Source: U.S. Census. Demographic Turning Points for the United States: Population Projections for 2020 to 2060. Issued March 2018, Revised Feb 2020. Accessed July 9th, 2021. Retrieved from: https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf

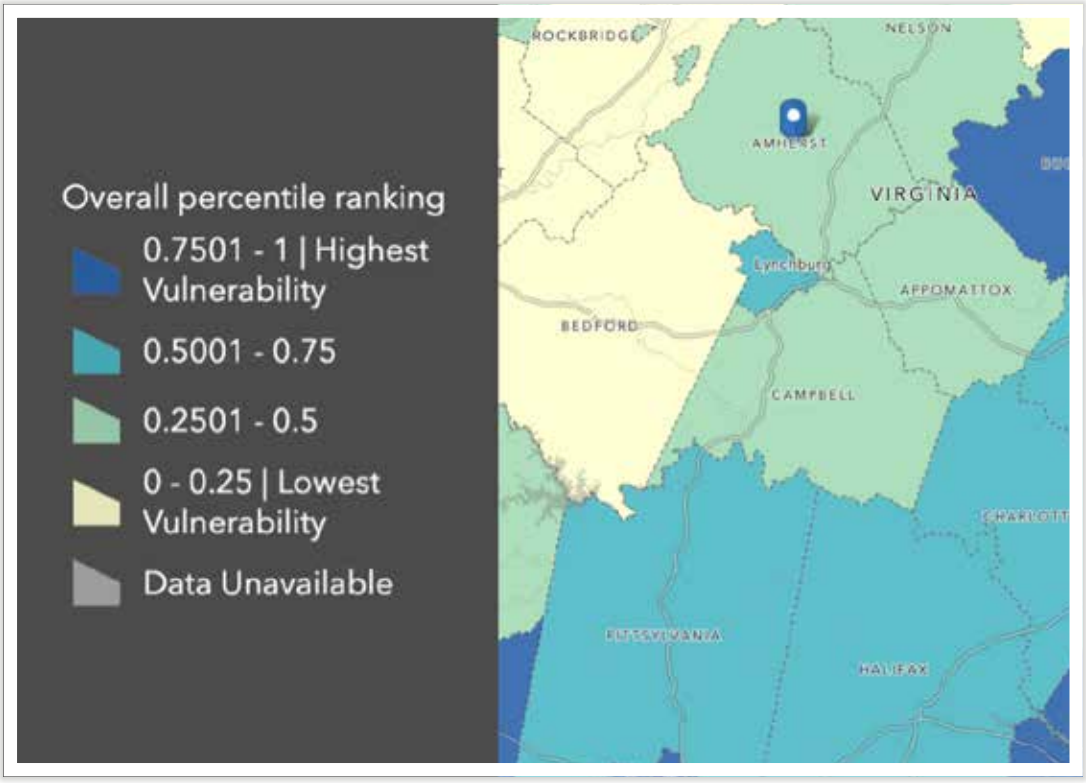
SOCIAL VULNERABILITY INDEX

"What is social vulnerability?

Every community must prepare for and respond to hazardous events, whether a natural disaster like a tornado or disease outbreak, or a human-made event such as a harmful chemical spill. A number of factors, including poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss in a disaster. These factors are known as social vulnerability.

What is CDC Social Vulnerability Index?

The Agency for Toxic Substances & Disease Registry's (ATSDR) Geospatial Research, Analysis & Services Program (GRASP) created databases to help emergency response planners and public health officials identify and map communities that will most likely need support before, during, and after a hazardous event. CDC SVI uses U.S. Census data to determine the social vulnerability of every census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. CDC SVI ranks each tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes. Maps of the four themes are shown in the figure below. Each tract receives a separate ranking for each of the four themes as well as an overall ranking."



Content & Image Source: Agency for Toxic Substances & Disease Registry. Social Vulnerability Index (SVI) Mapping Dashboard. Page Last Reviewed April 28th, 2021. Accessed July 9th, 2021. Retrieved from https://www.atsdr.cdc.gov/placeandhealth/svi/fact_sheet/fact_sheet.html

Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).

***Amherst*:** A score of **0.4682** indicates a low to moderate level of vulnerability.

***Appomattox*:** A score of **0.3637** indicates a low to moderate level of vulnerability.

***Campbell*:** A score of **0.2615** indicates a low to moderate level of vulnerability.

***Lynchburg*:** A score of **0.7369** indicates a moderate to high level of vulnerability.

***Pittsylvania*:** A score of **0.6427** indicates a moderate to high level of vulnerability.

EDUCATION

The Link Between Education and Health

"Of the various social determinants of health that explain health disparities by geography or demographic characteristics (e.g., age, gender, race-ethnicity), the literature has always pointed prominently to education. Research based on decades of experience in the developing world has identified educational status (especially of the mother) as a major predictor of health outcomes, and economic trends in the industrialized world have intensified the relationship between education and health. In the United States, the gradient in health outcomes by educational attainment has steepened over the last four decades in all regions of the United States, producing a larger gap in health status between Americans with high and low education. Among white Americans without a high school diploma, especially women, life expectancy has decreased since the 1990s, whereas it has increased for others. Death rates are declining among the most educated Americans, accompanied by steady or increasing death rates among the least educated. The statistics comparing the health of Americans based on education are striking:

- At age 25, U.S. adults without a high school diploma can expect to die 9 years sooner than college graduates.
- According to one study, college graduates with only a Bachelor's degree were 26 percent more likely to die during a 5-year study follow-up period than those with a professional degree. Americans with less than a high school education were almost twice as likely to die in the next 5 years compared to those with a professional degree.
- Among whites with less than 12 years of education, life expectancy at age 25 fell by more than 3 years for men and by more than 5 years for women between 1990 and 2008.
- By 2011, the prevalence of diabetes had reached 15 percent for adults without a high school education, compared with 7 percent for college graduates.

Source: Zimmerman, E. B., Woolf, S.H., Haley, A. Agency for Healthcare Research and Quality. Population Health: Behavioral and Social Science Insights. Understanding the Relationship Between Education and Health. Page Last Reviewed November 2015. Accessed July 9th, 2021. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/ref12/index.html

Poverty Status and Educational Attainment

Poverty Rate for the Population Age 25+ and for Whom Poverty Status is Determined by Educational Attainment

Locality	*Less than high school graduate*	*High school graduate*	*Some college, associate's degree*	*Bachelor's degree or higher*
Amherst County	22.9%	10.0%	7.9%	4.3%
Appomattox County	16.0%	12.7%	9.3%	3.2%
Campbell County	26.0%	10.2%	6.7%	3.3%
Lynchburg City	23.4%	13.7%	11.1%	5.0%
Pittsylvania County	27.7%	14.1%	12.9%	8.3%
Service Area	**23.2%**	**12.1%**	**9.6%**	**4.8%**
Virginia	**21.6%**	**11.8%**	**7.8%**	**3.2%**

Table Source: Weldon Cooper Center for Public Service. Date of Table: 2019. Year(s) Measured: 2020 - 2040. Retrieved from http://demographics.coopercenter.org

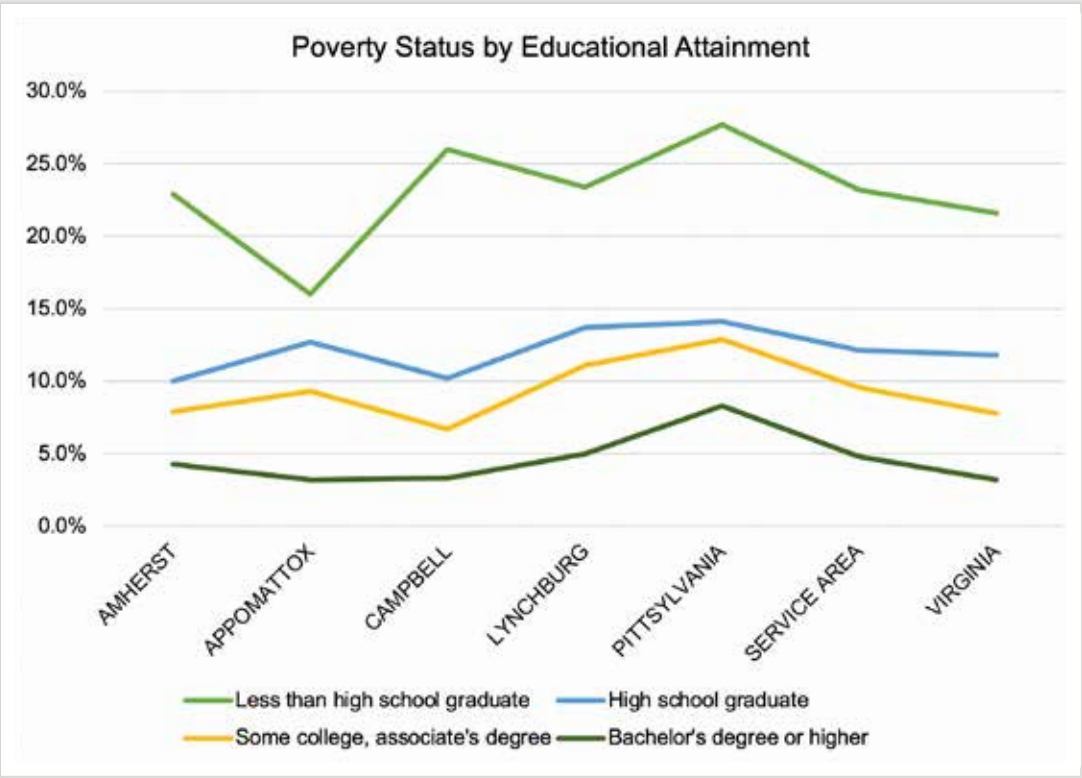


Table Source: U.S. Census, Poverty Status in the past 12 months. Table S1701. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Among the service area localities, roughly 1 in 5 Lynchburg and Amherst residents living in poverty have less than a high school education. Campbell and Pittsylvania were higher than the service area at 26% and 27.7% respectively. Poverty rates by academic attainment were higher for the service area as compared to the same rates for Virginia. The chart above provides a visual representation of the difference in poverty status based on educational attainment with a clear indication of the gap between less than a high school education and those with a high school education.

Educational Attainment by Locality for the Population Age 25 and Over

Locality	*Population 25 Years and Over*	*Less than High School Graduate*	*High School Grad or Equivalent*	*Some College of Associate's Degree*	*Bachelor's Degree or Higher*
Amherst County	22,723	14.36%	36.00%	30.56%	19.10%
Appomattox County	11,114	14.10%	33.90%	26.96%	20.90%
Campbell County	39,844	12.85%	32.20%	26.96%	22.50%
Lynchburg City	44,924	11.30%	25.20%	26.96%	35.60%
Pittsylvania County	45,229	17.34%	35.00%	26.96%	14.50%
Service Area	**163,834**	**14.0%**	**32.5%**	**27.7%**	**22.5%**
Virginia	**5,776,886**	**10.3%**	**24.0%**	**26.9%**	**38.8%**

Table Source: Census_ACS_Table S1501. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

On Time Graduation and Drop-Out Rates by Locality by Race by Gender

Division Name	Race	Gender	Economically Disadvantaged	2018		2019		2020	
				Graduation	Dropout	Graduation	Dropout	Graduation	Dropout
Amherst County	Black	F	N	<	<	100.00%	0.00%	100.00%	0.00%
	Black	M	N	100.00%	0.00%	92.86%	7.14%	93.33%	0.00%
	White	F	N	97.30%	1.35%	97.78%	0.00%	100.00%	0.00%
	White	M	N	95.71%	4.29%	94.83%	3.45%	97.33%	1.33%
	Black	F	Y	94.74%	5.26%	69.23%	15.38%	94.44%	5.56%
	Black	M	Y	90.00%	6.67%	76.92%	11.54%	100.00%	0.00%
	White	F	Y	88.37%	4.65%	89.19%	2.70%	90.00%	3.33%
	White	M	Y	87.10%	9.68%	74.42%	13.95%	87.88%	9.09%
Appomattox County	Black	F	N	<	<	<	<	<	<
	Black	M	N	90.91%	9.09%	<	<	<	<
	White	F	N	98.00%	0.00%	97.22%	0.00%	100.00%	0.00%
	White	M	N	89.47%	5.26%	100.00%	0.00%	93.75%	6.25%
	Black	F	Y	100.00%	0.00%	100.00%	0.00%	84.62%	7.69%
	Black	M	Y	100.00%	0.00%	100.00%	0.00%	<	<
	White	F	Y	88.46%	11.54%	82.61%	8.70%	95.24%	0.00%
	White	M	Y	85.71%	7.14%	80.95%	14.29%	66.67%	4.76%
Campbell County	Black	F	N	92.59%	3.70%	93.33%	6.67%	100.00%	0.00%
	Black	M	N	90.00%	10.00%	85.71%	10.71%	100.00%	0.00%
	White	F	N	95.45%	0.65%	94.74%	2.63%	98.59%	0.00%
	White	M	N	93.59%	2.56%	97.33%	1.07%	94.66%	1.53%
	Black	F	Y	92.50%	2.50%	84.00%	4.00%	91.18%	5.88%
	Black	M	Y	96.97%	3.03%	93.10%	3.45%	94.12%	2.94%
	White	F	Y	88.73%	5.63%	89.89%	2.25%	92.86%	4.29%
	White	M	Y	83.82%	4.41%	79.41%	5.88%	89.72%	1.87%
Lynchburg City	Black	F	N	86.11%	8.33%	84.38%	12.50%	93.33%	3.33%
	Black	M	N	75.68%	18.92%	73.91%	15.22%	69.05%	16.67%
	White	F	N	89.58%	8.33%	91.95%	4.60%	92.96%	7.04%
	White	M	N	89.80%	7.14%	92.78%	6.19%	95.45%	3.41%
	Black	F	Y	85.83%	3.33%	82.46%	7.02%	92.92%	6.19%
	Black	M	Y	87.36%	9.20%	77.17%	9.78%	77.88%	14.42%
	White	F	Y	89.29%	10.71%	87.50%	12.50%	84.21%	10.53%
	White	M	Y	83.72%	9.30%	75.86%	13.79%	78.13%	9.38%
Pittsylvania County	Black	F	N	96.55%	0.00%	100.00%	0.00%	100.00%	0.00%
	Black	M	N	92.31%	3.85%	90.00%	5.00%	92.31%	7.69%
	White	F	N	97.83%	2.17%	98.51%	1.49%	97.50%	2.50%
	White	M	N	94.61%	5.39%	96.43%	2.98%	93.46%	6.54%
	Black	F	Y	95.08%	3.28%	95.08%	4.92%	91.43%	8.57%
	Black	M	Y	85.45%	10.91%	83.33%	15.00%	90.00%	8.33%
	White	F	Y	89.81%	8.33%	87.18%	11.97%	84.80%	15.20%
	White	M	Y	78.35%	11.34%	78.07%	15.79%	77.50%	19.17%

Note: '<' indicates insufficient data from VDOE

Table Source: Virginia Department of Education, GRADUATION, COMPLETION, DROPOUT & POSTSECONDARY DATA. Date of Table: 2020. Year(s) Measured: 2018 - 2020. Retrieved from https://www.doe.virginia.gov/statistics_reports/graduation_completion/index.shtml

Amherst County

Amherst County High	Total	Male	Female	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	95.22%	95.03%	95.45%	95.24%	96.97%	100.00%	91.87%	97.56%
Drop-out Rate	3.07%	3.11%	3.03%	2.65%	1.52%	0.00%	5.69%	2.44%

Appomattox County

Appomattox County High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	91.36%	96.39%	86.80%	90.83%	89.47%	<	85.33%	100.00%
Drop-out Rate	2.47%	1.20%	3.80%	2.75%	2.63%	<	2.67%	0.00%

Campbell County

Altavista High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	87.64%	87.80%	87.50%	87.27%	90.48%	<	85.71%	<
Drop-out Rate	2.25%	4.88%	0.00%	0.00%	4.76%	<	2.04%	<

Brookville High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	94.17%	95.61%	92.86%	94.57%	92.86%	<	92.22%	100.00%
Drop-out Rate	3.33%	2.63%	3.97%	2.17%	7.14%	<	4.44%	<

Rustburg High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	96.80%	97.12%	96.52%	97.04%	97.14%	<	95.10%	<
Drop-out Rate	0.46%	0.96%	0.00%	0.59%	0.00%	<	98.00%	<

William Campbell High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	95.31%	100.00%	90.91%	92.86%	100.00%	<	92.11%	<
Drop-out Rate	3.13%	0.00%	6.06%	4.76%	0.00%	<	5.26%	<

Lynchburg City

E.C. Glass High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	84.31%	89.94%	79.26%	91.84%	82.61%	58.33%	82.16%	60.47%
Drop-out Rate	11.48%	8.28%	14.36%	5.44%	12.42%	41.67%	12.43%	34.88%

Heritage High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	85.93%	87.02%	84.85%	87.80%	85.94%	65.22%	83.75%	93.55%
Drop-out Rate	9.13%	9.16%	9.09%	8.54%	7.81%	30.43%	10.00%	6.45%

Pittsylvania County

Chatham High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	91.19%	94.81%	87.80%	90.99%	91.18%	90.00%	88.51%	89.29%
Drop-out Rate	7.55%	5.19%	9.76%	8.11%	5.88%	10.00%	9.20%	10.71%

Dan River	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	88.89%	91.49%	86.05%	89.83%	88.68%	<	83.18%	79.31%
Drop-out Rate	11.11%	8.51%	13.95%	10.17%	11.32%	<	16.82%	20.69%

Gretna High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	89.15%	90.67%	87.91%	85.44%	98.04%	<	87.74%	83.33%
Drop-out Rate	10.24%	9.33%	10.99%	13.59%	1.95%	<	11.32%	16.67%

Tunstall High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	88.31%	88.46%	88.19%	88.17%	87.50%	90.00%	80.53%	71.88%
Drop-out Rate	10.82%	11.54%	10.24%	10.75%	12.50%	10.00%	17.70%	28.13%

Note: '<' indicates insufficient data from VDOE

Table Source: Virginia Department of Education, GRADUATION, COMPLETION, DROPOUT & POSTSECONDARY DATA. Date of Table: 2020. Year(s) Measured: 2020 Cohort. Retrieved from https://www.doe.virginia.gov/statistics_reports/graduation_completion/index.shtml

Chronic Absenteeism

"More than 6.5 million children in the United States, approximately 13% of all students, miss 15 or more days of school each year. The rates of chronic absenteeism vary between states, communities, and schools, with significant disparities based on income, race, and ethnicity. Chronic school absenteeism, starting as early as preschool and kindergarten, puts students at risk for poor school performance and school dropout, which in turn, put them at risk for unhealthy behaviors as adolescents and young adults as well as poor long-term health outcomes.

Common health conditions that have been associated with school absenteeism include influenza infection, group A streptococcal pharyngitis, gastroenteritis, fractures, poorly controlled asthma, type 1 diabetes mellitus, chronic fatigue, chronic pain (including headaches and abdominal pain), seizures, poor oral health, dental pain, and obesity.

Furthermore, the literature reveals that poor school performance is associated with poor adult health outcomes. Compared with adults with higher educational attainment, those with low educational attainment are more likely to be unemployed or work at a part-time or lower-paying job, less likely to report having a fulfilling job, feeling that they have control over their lives, and feeling that they have high levels of social support. Adults with lower educational attainment are also more likely to smoke and less likely to exercise, which are directly linked to poor health outcomes. Not earning a high school diploma is associated with increased mortality risk or lower life expectancy. Conversely, obtaining advanced degrees and additional years of education are associated with a reduced mortality risk. Over the past 20 years, disparities in mortality rates based on educational attainment are worsening for preventable causes of death."

Source: American Academy of Pediatrics, The Link Between School Attendance and Good Health. Mandy A. Allison, Elliott Attisha and COUNCIL ON SCHOOL HEALTH. Published Feb 2019. Accessed July 9th, 2021. Retrieved from: https://pediatrics.aappublications.org/content/143/2/e20183648

Chronic Absenteeism by Percent

Locality	2014 - 2015	2015 - 2016	2016 - 2017	2018 - 2019
Amherst County	14.0	21.2	14.2	13.2
Appomattox County	10.9	8.9	10.7	9.1
Campbell County	8.5	8.4	8.3	9.1
Lynchburg City	12.0	12.0	12.7	14.6
Pittsylvania County	11.8	11.8	11.9	14.0
Service Area	**11.3**	**12.0**	**11.4**	**12.0**
Virginia	**10.1**	**10.4**	**10.6**	**10.7**

Table Source: Kids Count Data Center - VA Kids . Date of Table: 2019. Year(s) Measured: 2018-2019. Retrieved from https://datacenter.kidscount.org/

The chronic absenteeism rate in the service area is slightly higher than the overall state rate. Absenteeism rates for the state, service area, or the localities that comprise the service area have generally remained steady over the four-year period (2014-2019). Amherst County has the highest absenteeism rate overall and Lynchburg has the second-highest absenteeism rate overall.

Free and Reduced Lunch Data

"The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or no-cost lunches to children each school day. The program was established under the Richard B. Russell National School Lunch Act, signed into law by President Harry Truman in 1946. About 7.1 million children participated in the NSLP in its first year. Since then, the Program has reached millions of children nationwide: 1970: 22.4 million children; 1980: 26.6 million children; 1990: 21.1 million children; 2000: 27.3 million children; 2010: 31.8 million children; and 2016: 30.4 million children.

Participating school districts and independent schools receive cash subsidies and USDA Foods for each reimbursable meal they serve. In exchange, NSLP institutions must serve lunches that meet Federal meal pattern requirements and offer the lunches at a free or reduced price to eligible children. School food authorities can also be reimbursed for snacks served to children who participate in an approved afterschool program including an educational or enrichment activity.

Children may be determined 'categorically eligible' for free meals through participation in certain Federal Assistance Programs, such as the Supplemental Nutrition Assistance Program, or based on their status as a homeless, migrant, runaway, or foster child. Children enrolled in a federally funded Head Start Program, or a comparable State-funded pre-kindergarten program, are also categorically eligible for free meals. Children can also qualify for free or reduced-price school meals based on household income and family size. Children from families with incomes at or below 130 percent of the Federal poverty level are eligible for free meals. Those with incomes between 130 and 185 percent of the Federal poverty level are eligible for reduced price meals. Schools may not charge children more than 40 cents for a reduced-price lunch."

Source: USDA Food and Nutrition Service, National School Lunch Program (NSLP) Fact Sheet. Last Updated: March 20th, 2019. Accessed July 9th, 2021. Retrieved from: https://www.fns.usda.gov/nslp/nslp-fact-sheet

Amherst County: Free and Reduced Lunch by Locality & School

School Name	School Type	SNAP Member	FREE Eligible	FREE Percent	Reduced Eligible	Reduced Percent	TOTAL Eligible	TOTAL Percent
ELON ELEM	Elementary	345	114	33.04%	28	8.12%	142	41.16%
CENTRAL ELEM	Elementary	382	344	90.05%	0	0.00%	344	90.05%
AMELON ELEM	Elementary	432	195	45.14%	34	7.87%	229	53.01%
AMHERST ELEM	Elementary	272	111	40.81%	14	5.15%	125	45.96%
TEMPERANCE ELEM	Elementary	102	40	39.22%	8	7.84%	48	47.06%
MADISON HTS ELEM	Elementary	396	356	89.90%	0	0.00%	356	89.90%
MONELISON MIDDLE	Middle	610	293	48.03%	51	8.36%	344	56.39%
AMHERST ED CTR	Combined	38	34	89.47%	0	0.00%	34	89.47%
AMHERST MIDDLE	Middle	407	167	41.03%	27	6.63%	194	47.67%
AMHERST COUNTY HIGH	High	1,143	405	35.43%	68	5.95%	473	41.38%
TOTALS		**4,127**	**2,059**	**49.89%**	**230**	**5.57%**	**2,289**	**55.46%**

Appomattox County: Free and Reduced Lunch by Locality & School

School Name	School Type	SNAP Member	FREE Eligible	FREE Percent	Reduced Eligible	Reduced Percent	TOTAL Eligible	TOTAL Percent
APPOMATTOX ELEM	Elementary	503	229	45.53%	26	5.17%	255	50.70%
APPOMATTOX PRIMARY	Elementary	587	277	47.19%	26	4.43%	303	51.62%
APPOMATTOX MIDDLE	Middle	509	241	47.35%	28	5.50%	269	52.85%
APPOMATTOX COUNTY HIGH	High	665	246	36.99%	29	4.36%	275	41.35%
TOTALS		**2,264**	**993**	**43.86%**	**109**	**4.81%**	**1,102**	**48.67%**

Campbell County: Free and Reduced Lunch by Locality & School

School Name	School Type	SNAP Member	FREE Eligible	FREE Percent	Reduced Eligible	Reduced Percent	TOTAL Eligible	TOTAL Percent
TOMAHAWK ELEM	Elementary	709	248	34.98%	56	7.90%	304	42.88%
CONCORD ELEM	Elementary	406	154	37.93%	40	9.85%	194	47.78%
ALTAVISTA ELEM	Elementary	497	269	54.12%	41	8.25%	310	62.37%
BROOKNEAL ELEM	Elementary	367	237	64.58%	31	8.45%	268	73.02%
LEESVILLE ROAD ELEM	Elementary	662	233	35.20%	53	8.01%	286	43.20%
YELLOW BRANCH ELEM	Elementary	594	282	47.47%	32	5.39%	314	52.86%
RUSTBURG ELEM	Elementary	452	239	52.88%	56	12.39%	295	65.27%
BROOKVILLE MIDDLE	Middle	735	241	32.79%	51	6.94%	292	39.73%
CAMPBELL CO TECH CTR		232	88	37.93%	17	7.33%	105	45.26%
ALTAVISTA HIGH	Combined	622	278	44.69%	33	5.31%	311	50.00%
WILLIAM CAMPBELL HIGH	Combined	388	226	58.25%	19	4.90%	245	63.14%
RUSTBURG MIDDLE	Middle	626	268	42.81%	55	8.79%	323	51.60%
RUSTBURG HIGH	High	728	264	36.26%	65	8.93%	329	45.19%
BROOKVILLE HIGH	High	854	231	27.05%	47	5.50%	278	32.55%
TOTALS		**7,872**	**3,258**	**41.39%**	**596**	**7.57%**	**3,854**	**48.96%**

Lynchburg City:
Free and Reduced Lunch by Locality & School

School Name	School Type	SNAP Member	FREE Eligible	FREE Percent	Reduced Eligible	Reduced Percent	TOTAL Eligible	TOTAL Percent
DEARINGTON ELEM	Elementary	158	147	93.04%	0	0.00%	147	93.04%
T.C. MILLER ELEM	Elementary	219	203	92.69%	0	0.00%	203	92.69%
ROBERT S. PAYNE ELEM	Elementary	512	475	92.77%	0	0.00%	475	92.77%
WILLIAM M. BASS ELEM	Elementary	194	180	92.78%	0	0.00%	180	92.78%
PERRYMONT ELEM	Elementary	314	291	92.68%	0	0.00%	291	92.68%
BEDFORD HILLS ELEM	Elementary	436	404	92.66%	0	0.00%	404	92.66%
SHEFFIELD ELEM	Elementary	422	391	92.65%	0	0.00%	391	92.65%
PAUL MUNRO ELEM	Elementary	360	334	92.78%	0	0.00%	334	92.78%
LINKHORNE ELEM	Elementary	417	387	92.81%	0	0.00%	387	92.81%
SANDUSKY ELEM	Elementary	323	300	92.88%	0	0.00%	300	92.88%
HERITAGE ELEM	Elementary	454	421	92.73%	0	0.00%	421	92.73%
P L DUNBAR MID	Middle	642	596	92.83%	0	0.00%	596	92.83%
SANDUSKY MID	Middle	512	475	92.77%	0	0.00%	475	92.77%
LINKHORNE MID	Middle	578	536	92.73%	0	0.00%	536	92.73%
HERITAGE HIGH	High	1,010	532	52.67%	90	8.91%	622	61.58%
E.C. GLASS HIGH	High	1,351	600	44.41%	79	5.85%	679	50.26%
CARL B. HUTCHERSON		195	181	92.82%	0	0.00%	181	92.82%
EMPOWERMENT ACAD		38	35	92.11%	0	0.00%	35	92.11%
FORT HILL COMM		112	104	92.86%	0	0.00%	104	92.86%
LAUREL REG SPEC ED		43	40	93.02%	0	0.00%	40	93.02%
TOTALS		**8,290**	**6,632**	**80.00%**	**169**	**2.04%**	**6,801**	**82.04%**

Pittsylvania County:
Free and Reduced Lunch by Locality & School

School Name	School Type	SNAP Member	FREE Eligible	FREE Percent	Reduced Eligible	Reduced Percent	TOTAL Eligible	TOTAL Percent
JOHN L. HURT ELEM	Elementary	272	234	86.03%	0	0.00%	234	86.03%
GRETNA ELEM	Elementary	536	461	86.01%	0	0.00%	461	86.01%
UNION HALL ELEM	Elementary	210	173	82.38%	0	0.00%	173	82.38%
MT. AIRY ELEM	Elementary	162	134	82.72%	0	0.00%	134	82.72%
TWIN SPRINGS ELEM	Elementary	764	349	45.68%	37	4.84%	386	50.52%
BROSVILLE ELEM	Elementary	239	144	60.25%	14	5.86%	158	66.11%
STONY MILL ELEM	Elementary	420	217	51.67%	31	7.38%	248	59.05%
KENTUCK ELEM	Elementary	571	302	52.89%	49	8.58%	351	61.47%
SOUTHSIDE ELEM	Elementary	444	241	54.28%	38	8.56%	279	62.84%
CHATHAM ELEM	Elementary	247	212	85.83%	0	0.00%	212	85.83%
GRETNA MIDDLE	Middle	449	371	82.63%	0	0.00%	371	82.63%
DAN RIVER MIDDLE	Middle	498	264	53.01%	38	7.63%	302	60.64%
TUNSTALL MIDDLE	Middle	650	290	44.62%	53	8.15%	343	52.77%
CHATHAM MIDDLE	Middle	497	241	48.49%	40	8.05%	281	56.54%
DAN RIVER HIGH	High	673	317	47.10%	63	9.36%	380	56.46%
GRETNA HIGH	High	575	325	56.52%	28	4.87%	353	61.39%
CHATHAM HIGH	High	646	274	42.41%	44	6.81%	318	49.23%
TUNSTALL HIGH	High	853	324	37.98%	51	5.98%	375	43.96%
TOTALS		**8,706**	**4,873**	**55.97%**	**486**	**5.58%**	**5,359**	**61.56%**

Virginia Total:
Free and Reduced Lunch by Locality & School

Locality	SNAP Member	FREE Eligible	FREE Percent	Reduced Eligible	Reduced Percent	TOTAL Eligible	TOTAL Percent
Virginia	**1,300,263**	**528,632**	**40.66%**	**64,779**	**4.98%**	**593,411**	**45.64%**

Table Source: Virginia Department of Education. Date of Table: 2019. Year(s) Measured: 2019 - 2020 school year . Retrieved from https://www.doe.virginia.gov/support/nutrition/statistics/index.shtml

These tables compare Free and Reduced Program rates among localities and individual schools. This data is valuable in identifying school districts and their geographic boundaries that have higher rates of low income families and children.

EMPLOYMENT

Unemployment and Wages

Every day, many Americans are either working or looking for work. Multiple aspects of employment—including job security, the work environment, financial compensation, and job demands—may affect health. As of October 2017, approximately 254 million people in the United States were eligible for the labor force. Of those, 63% participated (i.e., were employed or unemployed); the remaining 37% were out of the labor force (e.g., retired).

Job benefits such as health insurance, paid sick leave, and parental leave can affect the health of employed individuals. In 2017, 70% of civilian workers and 67% of private industry workers had access to health insurance, while 89% of state and local government employees had access. Two key functions of health insurance are access to affordable medical care and financial protection from unexpected health care costs. In addition, highly demanding jobs and lack of control over day-to-day work activities are sources of psychosocial stress at work. Other sources of workplace stress include high levels of interpersonal conflict, working evening shifts, working more than 8 hours a day, and having multiple jobs. These stressors put people at risk for mortality and depression, and they may be correlated with increased parent-child conflict and parental withdrawal. People in highly stressful jobs may also exhibit unhealthy coping skills such as smoking or alcohol abuse.

Furthermore, those who are unemployed report feelings of depression, anxiety, low self-esteem, demoralization, worry, and physical pain. Unemployed individuals tend to suffer more from stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease, and arthritis. In addition, experiences such as perceived job insecurity, downsizing or workplace closure, and underemployment also have implications for physical and mental health.

Source: Office of Disease Prevention and Health Promotion, The Healthy People 2030 Social Determinants of Health. Accessed July 9th, 2021. Retrieved from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment

Unemployment Rates by Locality

Locality	*2018*	*2019*	*2020*
Amherst County	3.3	3.1	5.6
Appomattox County	3.6	3.3	5.8
Campbell County	3.3	3	5.9
Lynchburg City	4	3.6	7.2
Pittsylvania County	3.5	3.2	6.5
Service Area	**3.5**	**3.2**	**6.2**
Virginia	**2.9**	**2.7**	**6.2**
United States	**3.9**	**3.7**	**8.1**

Table Source: Employment Commission. Date of Table: 2020. Year(s) Measured: 2018 - 2020. Retrieved from https://virginiaworks.com/

Annual Employment and Wage Statistics by Locality in 2020

Locality	Annual Establishments	Annual Average Employment	Annual Average Weekly Wage	Annual Wages per Employee
Amherst County	773	7,618	$780	$40,565
Appomattox County	491	3,228	$630	$32,767
Campbell County	1,492	16,844	$965	$50,178
Lynchburg City	1,388	11,674	$747	$38,856
Pittsylvania County	2,699	48,668	$937	$48,708
Service Area	**6,843**	**17,606**	**$812**	**$42,215**
Virginia	**283,780**	**3,744,370**	**$1,253**	**$65,146**
United States	**10,494,952**	**139,106,969**	**$1,231**	**$64,013**

Table Source: U.S. Bureau of Labor Statistics, Quarterly Census of Employment and Wages. Date of Table: 2020. Year(s) Measured: Annual 2020. Retrieved from https://data.bls.gov/cew/apps/table_maker/v4/table_maker.htm#type=2&st=51&year=2020&qtr=A&own=0&ind=10&supp=0

It is important to understand these unemployment rates in the context of the COVID-19 Pandemic, where many U.S. Citizens found themselves unable to or out of work. Given rates doubled in 2020, we can expect this number to decrease in the future as businesses open back up, re-hire and the community heals from the health and non-health related effects of the pandemic.

Largest Employers

Amherst: Top 10 Largest Employers in Q4 2020

Employer Name	Size
Amherst County School Board	500 to 999 employees
Glad Manufacturing Company	250 to 499 employees
County of Amherst	250 to 499 employees
Greif Packaging LLC	250 to 499 employees
Wal Mart	250 to 499 employees
Sweet Briar College	100 to 249 employees
Food Lion	100 to 249 employees
Johnson Health Center	100 to 249 employees
Centra Health	100 to 249 employees
Lowes' Home Centers, Inc.	100 to 249 employees

Appomattox: Top 10 Largest Employers in Q4 2020

Employer Name	Size
Appomattox County Schools	250 to 499 employees
Wal Mart	100 to 249 employees
Appomattox County Board of Supervisors	100 to 249 employees
Delta Response Team, LLC	100 to 249 employees
Kroger	50 to 99 employees
Petrochem Recovery Svc	50 to 99 employees
Virginia Department of State Police	50 to 99 employees
Gretna Health Care Center	50 to 99 employees
Farmers Bank of Appomattox	50 to 99 employees
Bull Daddys Restaurant	50 to 99 employees

Campbell: Top 10 Largest Employers in Q4 2020

Employer Name	Size
Babcock & Wilcox Nuclear	1000 and over employees
Campbell County Schools	1000 and over employees
Abbott Laboratories	500 to 999 employees
Wal Mart	250 to 499 employees
Campbell County	250 to 499 employees
BGF Industries Inc.	250 to 499 employees
Moore's Electrical and Mechanical	250 to 499 employees
Food Lion	250 to 499 employees
Schrader-Bridgeport Intl Inc.	100 to 249 employees
The Babcock & Wilcox Co	100 to 249 employees

Lynchburg: Top 10 Largest Employers in Q4 2020

Employer Name	Size
Centra Health	1000 and over employees
Lynchburg City Schools	1000 and over employees
City of Lynchburg	1000 and over employees
Areva NP Inc.	1000 and over employees
J. Crew Outfitters	1000 and over employees
University of Lynchburg	1000 and over employees
Wal Mart	500 to 999 employees
GNA Corporation	500 to 999 employees
Kdc Lynchburg	500 to 999 employees
Sodexho	500 to 999 employees

Pittsylvania: Top 10 Largest Employers in Q4 2020

Employer Name	Size
Pittsylvania County School Board	1000 and over employees
Pittsylvania County Board	250 to 499 employees
Unique Industries	250 to 499 employees
Morgan Olson Llc	250 to 499 employees
Intertape Polymer Corp	250 to 499 employees
Green Rock Correctional Center	250 to 499 employees
Food Lion	100 to 249 employees
Haynes Brothers	100 to 249 employees
Whittle Plywood	100 to 249 employees
Centra Health	100 to 249 employees

Table Source: Employment Commission. Date of Table: 2020. Year(s) Measured: Q4 2020. Retrieved from https://virginiaworks.com/

According to Virginia Career Works, Liberty University (located in Lynchburg and Campbell County) is not required to report data to the Department of Labor regarding their overall employment. Their status as a tax-exempt, religious organization allows them to opt out of this requirement. An Economic Impact report prepared by Mangum Analytics, commissioned by Liberty University and released in 2020, listed Liberty's employment within the Lynchburg MSA as 7,987 during FY 2018-19 which would make them the largest employer in the region.

(Accessed at https://www.liberty.edu/news/wp-content/uploads/sites/137/2020/11/Libery_U_EIA_2020_102320_1430_final.pdf August 16, 2021)

INCOME

Poverty

"Poverty has long been recognized as a contributor to death and disease, but several recent trends have generated an increased focus on the link between income and health. First, income inequality in the United States has increased dramatically in recent decades, while health indicators have plateaued, and life expectancy differences by income have grown. Second, there is growing scholarly and public recognition that many nonclinical factors—education, employment, race, ethnicity, and geography—influence health outcomes. Third, health care payment and delivery system reforms have encouraged an emphasis on addressing social determinants of health, including income.

- Income is strongly associated with morbidity and mortality across the income distribution, and income-related health disparities appear to be growing over time.
- Income influences health and longevity through various clinical, behavioral, social, and environmental mechanisms. Isolating the unique contribution of income to health can be difficult because this relationship intersects with many other social risk factors.
- Poor health also contributes to reduced income, creating a negative feedback loop sometimes referred to as the health-poverty trap.
- Income inequality has grown substantially in recent decades, which may perpetuate or exacerbate health disparities.
- Policy initiatives that supplement income and improve educational opportunities, housing prospects, and social mobility—particularly in childhood—can reduce poverty and lead to downstream health effects not only for low-income people but also for those in the middle class."

Source: Health Affairs, Health, Income, & Poverty: Where We Are & What Could Help. Dhruv Khullar Dave A. Chokshi. OCTOBER 4, 2018. Accessed July 9th, 2021. Retrieved from: https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/

2021 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family/ Household	*Poverty Guideline*
1	$12,880
2	$17,420
3	$21,960
4	$26,500
5	$31,040
6	$35,580
7	$40,120
8	$44,660

For families/households with more than 8 persons, add $4,540 for each additional person.

Source: https://aspe.hhs.gov/poverty-guidelines

Number of Population at or below 50%, 125% and 200% of Poverty Level

Locality	50 percent of poverty level	125 percent of poverty level	200 percent of poverty level
Amherst County	2,137	5,235	9,549
Appomattox County	992	2,996	4,915
Campbell County	2,699	9,545	17,960
Lynchburg City	6,341	12,420	22,963
Pittsylvania County	3,245	17,682	28,659
Service Area Total	**15,414**	**47,878**	**28,659**
Virginia	**414,408**	**1,143,890**	**2,030,587**

Table Source: Census_ACS_Table S1701. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Percent of Population for whom Poverty Status is Determined at or below 50%, 125% and 200% of Poverty Level

Locality	50 percent of poverty level	125 percent of poverty level	200 percent of poverty level
Amherst County	6.9%	16.9%	30.8%
Appomattox County	6.3%	19.2%	31.5%
Campbell County	5.0%	17.5%	32.9%
Lynchburg City	9.0%	25.2%	40.9%
Pittsylvania County	5.4%	20.7%	38.3%
Service Area Total	**6.52%**	**19.90%**	**34.88%**
Virginia	**5.1%**	**13.9%**	**24.8%**

Table Source: Census_ACS_Table S1701. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Persons in the service area living at 125% of the poverty level is almost 1.5 times higher than the state as a whole (19.9% as compared to 13.9% respectively). In Lynchburg, 1 in 4 residents live near or below poverty. The large majority of localities in the service area exceeds the state rate for all three poverty groupings (50%, 125% and 200%).

Median Household Income ($) by Locality, by Race 2019

Locality	Households	White	Black	Hispanic
Amherst County	52,888	54,519	39,286	23,850
Appomattox County	58,696	66,088	30,354	62,886
Campbell County	49,664	51,453	44,082	34,886
Pittsylvania County	47,690	49,679	39,927	36,518
Lynchburg City	46,409	54,197	33,953	62,358
Service Area	**51,069**	**55,187**	**37,520**	**44,100**
Virginia	**74,222**	**79,578**	**51,654**	**68,772**

Table Source: Census_ACS_TableS1903. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Most striking is the difference between Household Income between Black and White households for each locality. This difference is a significant factor when considering the impact of race on health outcomes and behaviors.

ALICE Households

"With the cost of living higher than what most people earn, ALICE families – an acronym for Asset Limited, Income Constrained, Employed – have incomes above the Federal Poverty Level, but not high enough to afford a basic household budget that includes housing, child care, food, transportation, and health care. ALICE households live in every county and independent city in Virginia – urban, suburban, and rural – and they include women and men, young and old, and all races and ethnicities.

In 2018, of the 121 million households in the U.S., 42% (51 million) could not afford basic necessities of housing, childcare, food, transportation, health care, a smartphone plan, and taxes:

16 million households (13%) were in poverty, meaning they earned below the Federal Poverty Level (FPL)

35 million households (29%) – more than double the number in poverty – were ALICE, meaning they earned above the FPL but less than the cost of living in their county."

In Virginia, of the 3,169,804 households, 10% lived in poverty (316,980 households), 29% (919,243 households) were ALICE, and 61% (1,933,580 households) lived above the ALICE threshold.

ALICE Households by Locality by Percent, 2018

Locality	*Household*	*Poverty Household*	*ALICE Household*	*Above ALICE Household*	*Percent ALICE Households*
Amherst County	12044	1519	5236	5289	43%
Appomattox County	6095	776	2284	3035	37%
Campbell County	22957	2902	9790	10265	43%
Lynchburg City	28500	4798	14287	9415	50%
Pittsylvania County	26330	4024	7783	14523	30%
Service Area	**95926**	**14019**	**39380**	**42527**	**41%**

Table & Content Source: ALICE United Way. Date of Table: 2018. Year(s) Measured: 2018. Website last updated 2021. Accessed July 9th, 2021. Retrieved from http://unitedwayalice.org/Virginia

All localities in the Lynchburg Area had higher percentages of ALICE households as compared to Virginia as a whole.

Impact of Poverty on Physical Health of Children

"Poverty is an important social determinant of health and contributes to child health disparities. Children who experience poverty, particularly during early life or for an extended period, are at risk of a host of adverse health and developmental outcomes through their life course. Poverty has a profound effect on specific circumstances, such as birth weight, infant mortality, language development, chronic illness, environmental exposure, nutrition, and injury. Child poverty also influences genomic function and brain development by exposure to toxic stress, a condition characterized by 'excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships.' Children living in poverty are at increased risk of difficulties with self-regulation and executive function, such as inattention, impulsivity, defiance, and poor peer relationships. Poverty can make parenting difficult, especially in the context of concerns about inadequate food, energy, transportation, and housing."

Source: The American Academy of Pediatrics. Poverty and Child Health in the United States. COUNCIL ON COMMUNITY PEDIATRICS. April 2016, 137 (4) e20160339; DOI: https://doi.org/10.1542/peds.2016-0339. Published Online May 12th, 2016. Accessed July 9th, 2021. Retrieved from: https://pediatrics.aappublications.org/content/137/4/e20160339/tab-article-info

Children that are Economically Disadvantaged (Below 200% FPL)

Locality	*Number Below 200% FPL*	*Percent below 200% FPL*
Amherst County	2,882	45%
Appomattox County	1,361	41%
Campbell County	4,773	42%
Lynchburg City	8,068	53%
Pittsylvania County	6,422	51%
Service Area	**23,506**	**46%**
Virginia	**620,201**	**33%**

Table Source: Kids Count Data Center - VA Kids . Date of Table: 2018. Year(s) Measured: 2016 - 2017. Retrieved from https://datacenter.kidscount.org/

Approximately one-half of children in the service area live at or below 200% of poverty. The highest rates are found among children residing in Pittsylvania county and the City of Lynchburg. Children and adults between 200% and 300% of poverty are often economically vulnerable and may live 'pay check-to-pay check'. This reality suggests that approximately 50% of the children residing in the Service Area are subject to the impact of living in or near poverty as described in the American Association of Pediatrics brief cited above and are at risk for poor health and issues associated with poverty.

Poverty and Seniors

"Over 15 million Americans aged 65+ are economically insecure—living at or below 200% of the federal poverty level (FPL) ($25,760 per year for a single person in 2021). These older adults struggle with rising housing and health care bills, inadequate nutrition, lack of access to transportation, diminished savings, and job loss. For older adults who are above the poverty level, one major adverse life event can change today's realities into tomorrow's troubles.

- In 2018, 7.3 million older Americans faced the threat of hunger, representing 10% of adults aged 60+ in the U.S. (Feeding America, 2020)
- Only 48% of older adults aged 60+ who are eligible for the Supplemental Nutrition Assistance Program (SNAP) are enrolled and receiving benefits. (USDA Food and Nutrition Service, 2020)
- Older women are more likely to live in poverty than men as a result of wage discrimination and having to take time out of the workforce for caregiving. (Justice in Aging, 2020)
- Over half of Black and Hispanic seniors aged 65+ have incomes below 200% of the Federal poverty line. (Kaiser Family Foundation, 2018)
- Over 14.8 million, or 4 in 10, older adults are lifted out of poverty by obtaining Social Security benefits. (Center on Budget and Policy Priorities, 2020)
- The 2.3 million older adults on Supplemental Security Income (SSI) receive, on average, just $475 each month. (Social Security Administration, 2021)

Source: National Council on Aging. Get the Facts on Economic Security for Seniors. Published March 1st, 2021. Accessed July 9th, 2021. Retrieved from: https://www.ncoa.org/article/get-the-facts-on-economic-security-for-seniors

Person Age 65+ Years: Below Poverty

Locality	Persons	Percent
Amherst County	590	9.20%
Appomattox County	192	6.10%
Campbell County	1,155	10.90%
Lynchburg City	1,125	8.50%
Pittsylvania County	915	8.60%
Service Area	**3,977**	**8.66%**
Virginia	**84,788**	**7.6%**

Table Source: Census_ACS_Table S1701. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Percentage of Families and People Whose Income in the Past 12 Months is Below the Poverty Level

Locality	All families	Married couple families	Families with female householder, no spouse present
Amherst County	7.60%	4.30%	18.50%
Appomattox County	11.30%	4.60%	32.60%
Campbell County	8.20%	4.60%	22.30%
Lynchburg City	11.90%	4.90%	26.80%
Pittsylvania County	12.40%	6.00%	32.80%
Service Area	**10.28%**	**4.88%**	**26.60%**
Virginia	**7.10%**	**3.20%**	**22.70%**

Table Source: Census_ACS_Table DP03. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Across all localities in the service area as well as in Virginia, significantly more families with a female head of household live below the poverty level as compared to all families and married couple families.

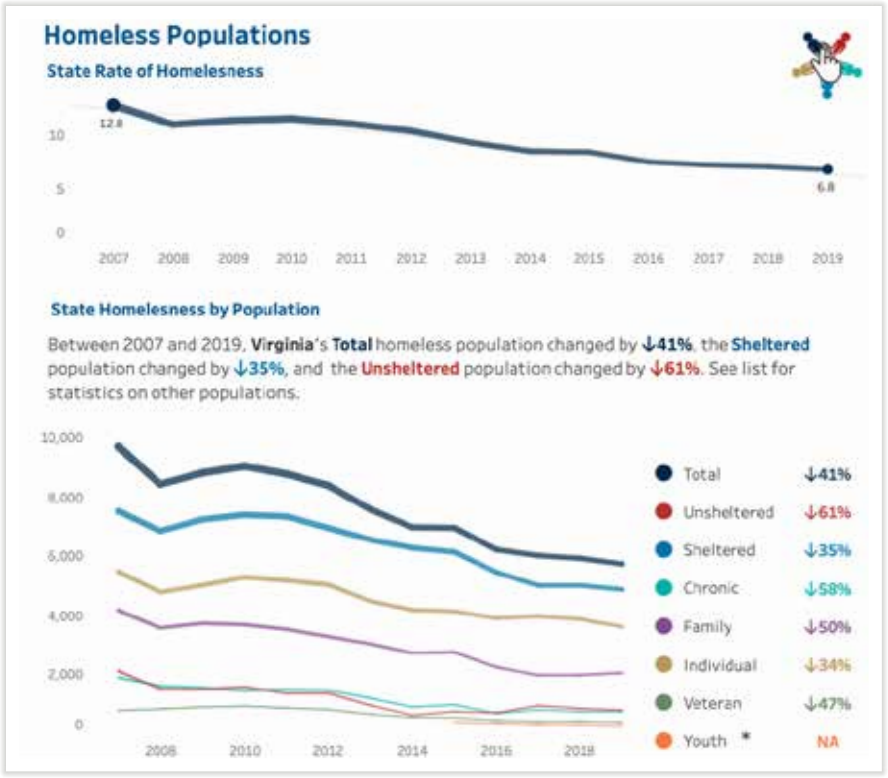
HOMELESSNESS

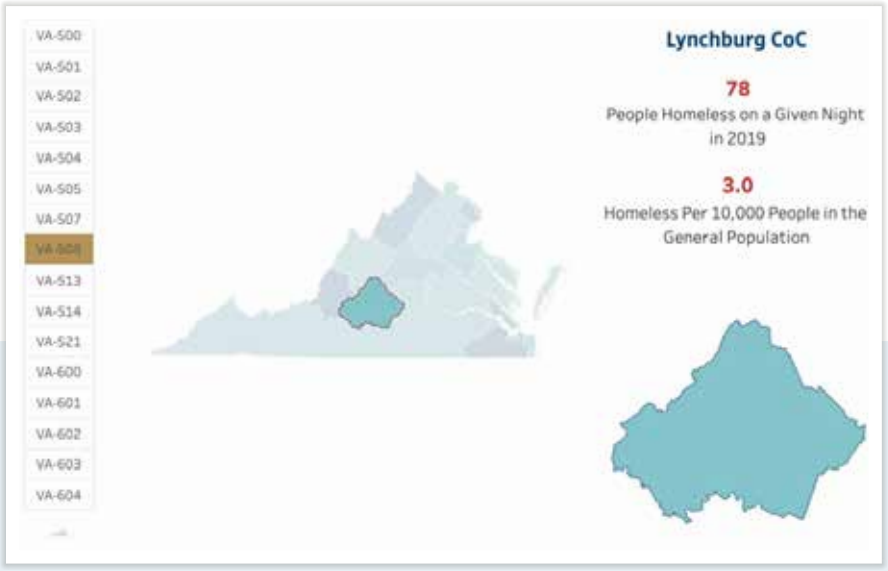
"According to the U.S. Department of Housing and Urban Development, people living in shelters are more than twice as likely to have a disability compared to the general population. On a given night in 2017, 20 percent of the homeless population reported having a serious mental illness, 16 percent conditions related to chronic substance abuse, and more than 10,000 people had HIV/AIDS.

Treatment and preventive care can be difficult to access for people who are experiencing homelessness. This is often because they lack insurance or have difficulty engaging health care providers in the community.

For chronically homeless people, the intervention of permanent supportive housing provides stable housing coupled with supportive services as needed – a cost-effective solution to homelessness for those with the most severe health, mental health and substance abuse challenges."

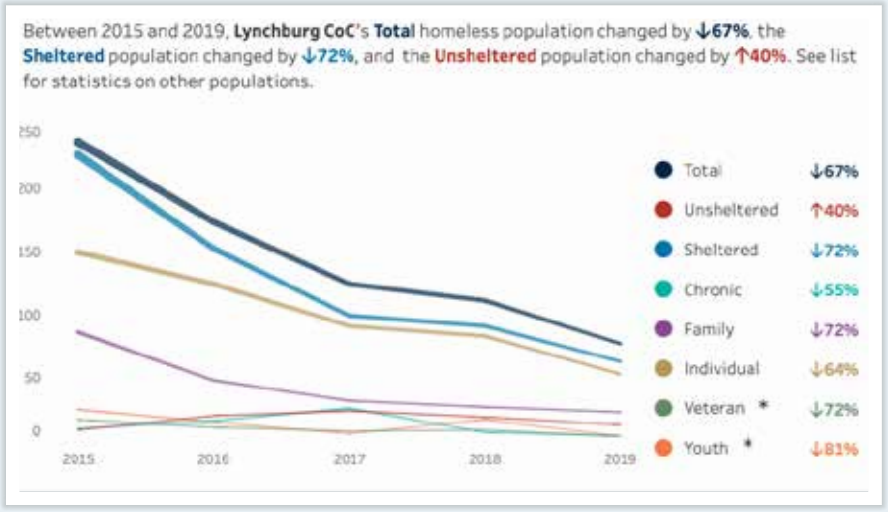
Source: National Alliance to End Homelessness. Health and Homelessness. Website Last Updated 2020. Accessed July 9th, 2021. Retrieved from: https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/

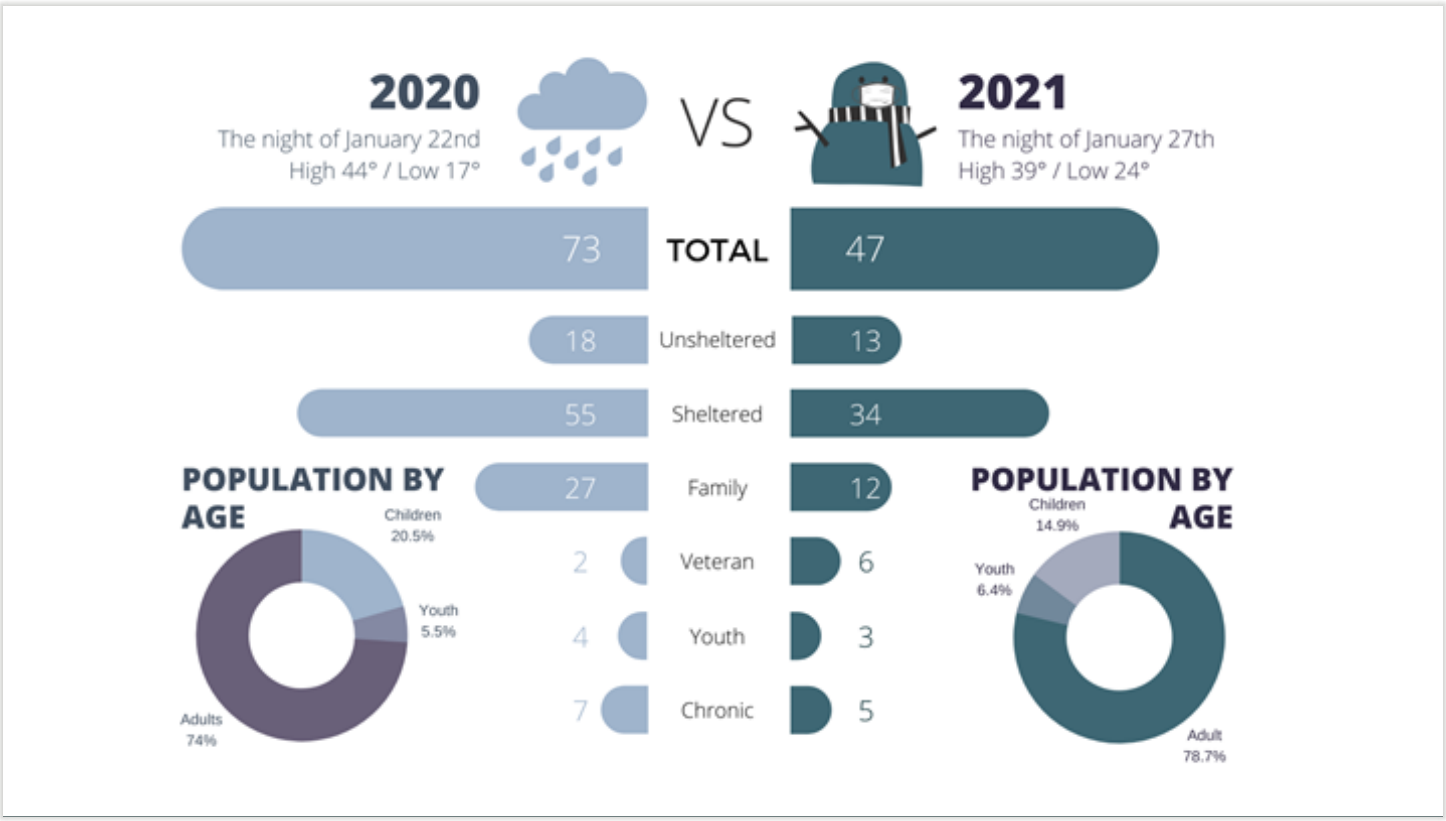




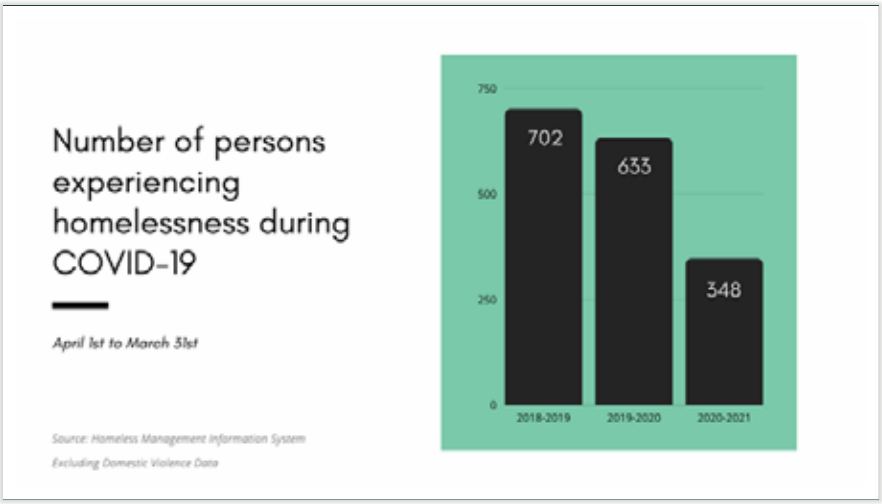
The Central Virginia Continuum of Care (CVCoC) is a coalition of agencies, nonprofits, congregations and individuals working to end homelessness in central Virginia. The CVCoC is responsible for the homeless response system that meets the needs of persons experiencing homelessness in the City of Lynchburg and the Counties of Amherst, Appomattox, Bedford and Campbell.

Findings from the CVCoC "Point in Time" studies in January 2020 and January 2021 are as follows. On January 22, 2020, there were 73 total persons experiencing homelessness in the City of Lynchburg and the counties of Amherst, Appomattox, Bedford, and Campbell. There was a 36% decrease in overall homelessness with 47 total persons experiencing homelessness on January 27, 2021.





From April 1, 2020 to March 31, 2021, there were 348 persons experiencing homelessness during the whole year representing a 45% decrease from the same timeframe last year (April 1, 2019 to March 31, 2020) due to the eviction moratorium and increased resources to help households remain in housing such as the Virginia Rent and Mortgage Relief Program.



Each year, the Central Virginia Continuum of Care submits System Performance Measures to the U.S. Department of Housing and Urban Development. The most recent year measured is from October 1, 2019 to September 30, 2020. During that time, the CVCoC's average length of time households remain homeless was 32 days. This is 136 days less than the national average. The CVCoC's returns to homelessness rate was 18% which is a less than the national average of 19.8%.

FAMILY SUPPORT

Local Departments of Social Services work to promote self-sufficiency while providing support to residents throughout the service area. Services include financial assistance programs including aid to families with dependent children-foster care; emergency assistance and energy assistance; state and local hospitalization benefits; Medicaid and FAMIS (Family Access to Medical Insurance Security). Both Medicaid and FAMIS are health insurance programs for low-income individuals. In Virginia, the Supplemental Nutrition Assistance Program (SNAP) (food incentive programs for eligible families) and the Temporary Assistance for Needy Families (TANF) (cash assistance program for very low-income families) help families address their basic needs. Other support programs include adult and child protective services; prevention services for families; foster care and adoption services; and childcare development.

Food Insecurity

SNAP Participation Report

Locality	2018	2019	2020	2021	4 YR Change
Amherst County	10.9%	12.9%	10.9%	11.0%	0.1%
Appomattox County	12.6%	12.2%	11.5%	11.4%	-1.2%
Campbell County	12.3%	12.0%	11.1%	11.3%	-1.0%
Lynchburg City	16.6%	11.4%	13.9%	13.9%	-2.7%
Pittsylvania County	11.2%	15.6%	11.2%	10.7%	-0.5%
Service Area	**12.7%**	**12.8%**	**11.7%**	**11.7%**	**-1.0%**
Virginia	**13.9%**	**14.0%**	**13.2%**	**13.1%**	**-0.8%**

Table Source: Virginia Department of Education. Date of Table: 2020. Year(s) Measured: May 2018 - May 2021. Retrieved from https://www.dss.virginia.gov/geninfo/reports/financial_assistance/fs.cgi

Other than Amherst County, there has been a slight decrease in SNAP participation in the service region with the greatest participation occurring in the city of Lynchburg. "The far-reaching health and economic effects of COVID-19 and widespread business closures to limit its spread have made it even more difficult for many low-income households to afford food and other needs. Data have shown a sharp increase in the number of families reporting difficulties affording adequate food and other basic needs, which have remained high throughout the pandemic compared to pre-pandemic levels, despite recent declines. SNAP is essential to helping these families put food on the table."

Source: Center on Budget and Policy Priorities. States Are Using Much-Needed Temporary Flexibility in SNAP to Respond to COVID-19 Challenges. Last Updated: June 3rd, 2021. Accessed July 9th, 2021. Retrieved from: Retrieved from: https://www.cbpp.org/research/food-assistance/states-are-using-much-needed-temporary-flexibility-in-snap-to-respond-to

Food Insecurity Among Child Population under 18

Locality	2017	2018	2019	3 YR Change
Amherst County	16.1%	15.7%	16.3%	0.2%
Appomattox County	17.0%	16.0%	16.9%	-0.1%
Campbell County	14.8%	14.1%	14.6%	-0.2%
Lynchburg City	19.7%	18.6%	18.3%	-1.4%
Pittsylvania County	16.9%	16.5%	18.9%	2.0%
Service Area	**16.9%**	**16.2%**	**17.0%**	**0.1%**
Virginia	**13.3%**	**13.2%**	**12.5%**	**-0.8%**

Table Source: Kids Count Data Center - VA Kids. Date of Table: 2020. Year(s) Measured: 2016 - 2018 . Retrieved from https://datacenter.kidscount.org/

Food insecurity in children and youth under 18 years of age is higher in the service area as compared to Virginia as a whole.

TANF Participation Report - Total Persons

Locality	2019	2020	2021	3 YR Change
Amherst County	116	115	112	-3.4%
Appomattox County	80	68	85	6.3%
Campbell County	256	294	304	18.8%
Lynchburg City	468	527	687	46.8%
Pittsylvania County	262	280	250	-4.6%
Service Area	**236**	**257**	**288**	**21.7%**
Virginia	**36336**	**36723**	**37229**	**2.5%**

Table Source: Virginia Department of Education. Date of Table: 2020. Year(s) Measured: April 2019 - April 2021. Retrieved from https://www.dss.virginia.gov/geninfo/reports/financial_assistance/tanf.cgi

"Families experiencing poverty should have access to cash assistance to help them afford their basic needs and maintain stability, an especially urgent need during the COVID-19 pandemic. Since the creation of the Temporary Assistance for Needy Families (TANF) program more than two decades ago, families have used it to pay for rent, utilities, diapers, food, transportation, and other necessities. Yet too few families struggling to make ends meet have access to the program, and TANF's history of racism means that it disproportionately fails to reach families in states where Black children are likelier to live. In 2019, for every 100 families in poverty, only 23 received cash assistance from TANF — down from 68 families in 1996. This 'TANF-to-poverty ratio' (TPR) is nearly the lowest in the program's history."

Source: Center on Budget and Policy Priorities. Cash Assistance Should Reach Millions More Families to Lessen Hardship. By Laura Meyer and Ife Floyd. Updated November 30th, 2020. Accessed July 9th, 2021. Retrieved from: https://www.cbpp.org/research/family-income-support/cash-assistance-should-reach-millions-more-families-to-lessen

Foster Care

Rate of Children Entering Foster Care per 1,000 Population

Locality	3-Yr. Avg.	2017	2016	2015
Amherst County	1.7	1.9	2	1.1
Appomattox County	3.0	4.7	1.8	2.4
Campbell County	1.7	1.2	1.5	2.5
Lynchburg County	4.2	3.7	4.4	4.4
Pittsylvania County	1.1	1.7	0.9	0.6
Service Area	**2.3**	**2.6**	**2.1**	**2.2**
Virginia	**2.5**	**1.5**	**1.5**	**1.5**

Table Source: Kids Count Data Center - VA Kids . Date of Table: 2018. Year(s) Measured: 2015 - 2017 . Retrieved from https://datacenter.kidscount.org/

In the "Foster Care Children Demographic" report for August 2021 (as of September 1, 2021) for the service area, 339 children were in foster care representing 6.3% of the total children in foster care across the state (5359). The largest number of children in foster care (3.3%) lived in the city of Lynchburg.

Source: Virginia Department of Social Services. Foster Care Demographic Report. Accessed October 8, 2021. Retrieved from https://www.dss.virginia.gov/geninfo/reports/children/fc.cgi

Child Abuse and Neglect

Child abuse and neglect is one cause of children entering the foster care system. Nationally, the rising abuse of opioids has led to more children entering foster care. Lynchburg's rate is close to twice the state rate average, with rates in Appomattox the second highest. "While most people in financial need do not maltreat their children, poverty can increase the likelihood of maltreatment, particularly when poverty is combined with other risk factors, such as depression, substance use, and social isolation."

Source: US Department of Health & Human Services. Administration for Children & Families. Children's Bureau. Child Welfare Information Gateway. Poverty and Economic Conditions. Accessed July 9th, 2021. Retrieved from https://www.childwelfare.gov/topics/can/factors/contribute/environmental/poverty/

"Children are specifically vulnerable to abuse during COVID-19. Research shows that increased stress levels among parents is often a major predictor of physical abuse and neglect of children. Stressed parents may be more likely to respond to their children's anxious behaviors or demands in aggressive or abusive ways. The support systems that many at-risk parents rely on, such as extended family, child care and schools, religious groups and other community organizations, are no longer available in many areas due to the stay-at-home orders. Child protection agencies are experiencing strained resources with fewer workers available, making them unable to conduct home visits in areas with stay-at-home orders. Since children are not going to school, teachers and school counselors are unable to witness the signs of abuse and report to the proper authorities. Also, many at-risk families may not have access to the technology children needed to stay connected with friends and extended family."

Source: US Department of Health & Human Services. Substance Abuse and Mental Health Services Administration. Intimate Partner Violence and Child Abuse Considerations during COVID-19. Accessed October 11, 2021. Retrieved from https://www.samhsa.gov/sites/default/files/social-distancing-domestic-violence.pdf

The Virginia Department of Social Services reports child abuse case responses by locality each fiscal year (July – June) including the number of cases received, the number of cases accepted, and the number of cases investigated. From 2018 to 2020 in the Lynchburg Service Area, the greatest number of child abuse case responses occurred in the city of Lynchburg and Campbell and Pittsylvania Counties. However, all case and investigation numbers decreased during the height of the pandemic in 2020 (July 2020 to June 2021). According to the Virginia Department of Social Services, and as referenced above, schools are the highest reporters of abuse cases in the state. Schools were shuttered during this time due to the State of Emergency declared in Virginia and most likely led to under-reporting in 2020.

Child Abuse Case Responses by Localities | 2018-2020

Locality	Cases Received			Cases Accepted			Investigations		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Amherst County	498	379	368	221	190	199	99	65	65
Appomattox County	152	176	135	90	102	77	11	20	22
Campbell County	1,014	1,005	839	393	351	323	88	87	64
Lynchburg City	1,110	1,164	869	746	812	566	132	182	132
Pittsylvania County	729	705	615	408	442	355	167	137	109
Total	**3503**	**3429**	**2826**	**1858**	**1897**	**1520**	**497**	**491**	**392**
Virginia	**88,124**	**90,492**	**75,758**	**39,404**	**39,970**	**35,704**	**11,102**	**11,201**	**9,423**

Table Source: Virginia Department of Social Services, Virginia Social Services CPA Reports- Abuse Cases by Localities/FIPS. Years Measured: 2018- 2020. Retrieved from https://cpsaccountability.dss.virginia.gov/index-social-services.html

Childcare

The Center for American Progress (CAP) defines childcare deserts as a ratio of more than three young children for every licensed childcare slot. Families in rural areas face the greatest challenges in finding childcare, with 3 in 5 rural communities lacking adequate childcare supply. In addition, low-income urban areas have roughly the same rate of childcare deserts as the average rural area. For too long, federal and state governments have underfunded childcare, leaving many communities without licensed childcare options. And such options are a necessity for working families: Two-thirds of U.S. children who have not started school have all parents in the workforce. At the same time, the cost of child care is out of reach for the average family; in most areas of the country, it exceeds the costs of rent or in-state college tuition." In a 2018 study, CAP data showed that most localities in the Lynchburg region are classified as childcare deserts.

Source: Center for American Progress. America's Child Care Deserts in 2018. Published December 6, 2018. Accessed October 24, 2021. Retrieved from https://www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/.

As the COVID-19 pandemic set in across the nation, the impact on childcare has undoubtedly been tremendous. Early in the pandemic, childcare centers and schools shuttered their doors and parents were faced with caring for their children at home while teleworking or scrambling to find care for their children so that they could keep their jobs outside the home. This was even more pronounced for families living in poverty. This lack of structured programming will no doubt have long range effects on children's (and their families) psychosocial relationships. "Research tells us that 90% of brain development occurs in the first five years of life, and what children experience in these early years (see, hear, smell, taste and feel) shapes their brains. High quality childcare programs feature enriched experiences that are linked to greater achievement and success in school and in life."

Source: Virginia Department Of Education. Child Care VA. Why Quality Matters. Accessed October 13,2021. Retrieved from: https://www.doe.virginia.gov/cc/parents/index.html?pageID=0

In August of 2021, Virginia's Governor Ralph Northam announced increased investments in Virginia's two largest state-funded preschool programs, the Virginia Department of Education's Virginia (VA) Preschool Initiative (https://www.doe.virginia.gov/early-childhood/preschool/vpi/index.shtml) and the Virginia Early Childhood Foundation's Mixed Delivery Preschool Grant Program (https://vecf.org/mixed-delivery-grantees/). In fiscal year 2022 (July 1, 2021 to June 30, 2022), the Commonwealth has authorized $151.6 million to these two programs, a $60.9 million increase from fiscal year 2021 and twice the investment made in fiscal year 2018. In Centra's Bedford and Lynchburg service regions, United Way of Central Virginia's Smart Beginnings Initiative is a mixed delivery grantee.

With "the expansion of the Virginia Preschool Initiative, 23,600 students across 126 school divisions were able to be served. Prior to the COVID-19 Pandemic only 18,000 students were served across 124 school divisions, so the impact of this expansion has proven to be great. In addition to this, 1,600 three-year-old children across 37 school divisions will be served via the VA Preschool initiative. Because of the efforts towards the Virginia Early Childhood Foundations Mixed Delivery Preschool Grant approximately 1,500 preschool-age children across 45 localities will be served this fall, whereas pre-pandemic only 239 children were able to be served in 9 localities during the 2020-2021 school year. Due to the temporary expansion of eligibility requirements, the Virginia Child Care Subsidy Program was able to allow for families earning up to 85% of state median income to be eligible for the Program. Because of this expansion, the Federal Head Start & Early Head Start were also both funded to serve approximately 14,463 children this school year and in August 2021, over 20,000 children were enrolled in the Subsidy Program, a 51% increase or an additional 7,325 children from March 2021.

Governor Northam also announced that $316.3 million from 2020 federal relief dollars were invested in Virginia early childhood system. As a result, 95% of childcare & Early Education programs (licensed & regulated) are now open and running, allowing for more enrollment and childcare support. As of August 2021, The General Assembly has approved for The Child Care and Development Block Grant to receive an additional $793 million of the American Rescue Plan dollars, further aiding in the state's efforts to eradicate barriers to accessible, affordable, and quality childcare."

Source: Commonwealth of Virginia. Virginia Governor Ralph S. Northam. Governor Announces Historic Enrollment in Early Childhood Education Programs. Accessed October 13, 2021. Retrieved from: https://www.governor.virginia.gov/newsroom/all-releases/2021/august/headline-905593-en.html

"Head Start programs promote the school readiness of infants, toddlers, and preschool-aged children from low-income families. Services are provided in a variety of settings including centers, family childcare, and children's own home. Head Start programs also engage parents or other key family members in positive relationships, with a focus on family wellbeing. Parents participate in leadership roles, including having a say in program operations.

Head Start programs are available at no cost to children ages birth to 5 from low-income families. Programs may provide transportation to the centers so enrolled children can participate regularly. Families and children experiencing homelessness, and children in the foster care system are also eligible. Additionally, Head Start services are available to children with disabilities and other special needs.

Head Start programs deliver services through 1,600 agencies in local communities. Most Head Start programs are run by non-profit organizations, schools, and community action agencies. They provide services to more than a million children every year, in every U.S. state and territory.

Head Start programs promote the school readiness of children ages 3 to 5. Most of these programs are based in centers. In other programs, children and families may receive services from educators and family service staff who regularly make home visits.

Infants, toddlers, and pregnant women are served through Early Head Start programs. Early Head Start programs are available to the family until the child turns 3 years old and is ready to transition into Head Start or another pre-K program. Services to pregnant mothers and families, including prenatal support and follow-up, are also provided by Early Head Start. Many Early Head Start programs are provided in a child's own home through weekly home visits that support the child's development and family's own goals. Other Early Head Start programs are located in centers which provide part day or full day programming for children. Early Head Start-Child Care Partnerships are programs that are dedicated to offering Early Head Start services to eligible families within the childcare system."

Source: US Department of Health & Human Services. Office of Head Start. An Office of the Administration for Children & Families. Head Start Programs. Accessed October 24, 2021. Retrieved from https://www.acf.hhs.gov/ohs/about/head-start.

Early Head Start (EHS) in the City of Lynchburg and in Amherst County is administered by HumanKind headquartered In Lynchburg, Virginia. They have one location in Lynchburg with 3 classrooms serving 24 children in total. They are currently renovating a new facility in the city which will have 6 classrooms serving 48 children doubling their capacity. The existing location will close when these renovations are complete. There is currently a waiting list at this EHS site. Since the COVID-19 pandemic, the Center's hours have been shortened temporarily and finding qualified staffing has been a challenge. EHS is in the process of selecting a location for a site in Amherst which will have 2 classrooms serving 16 children.

At the completion of the future location renovations and openings in Lynchburg and Amherst, the Early Head Start serving Lynchburg, Bedford regions will serve a total of 80 children in 10 classrooms.

Source: HumanKind. Data provided by HumanKind on October 13, 2021. Website: https://www.humankind.org/

Lynchburg Community Action Group (LYN CAG) is the provider of Head Start classrooms in central Virginia including Bedford and Amherst Counties and the city of Lynchburg. Offering both center-based classroom settings and home-based mobile classrooms, they work to ensure children receive the support they need to be ready for kindergarten. They work closely with Early Head Start (ages zero-3) offered by HumanKind, and public school's pre-Kindergarten programs at Amherst County Public Schools, Bedford County Public Schools, and Lynchburg City Public Schools to create a seamless early childhood experience for children. There are 290 Head Start slots throughout their service region that are all currently filled (with children ages 3-5). In addition, there are four Mobile Head Start classrooms. These mobile classrooms go into the neighborhoods of Head Start families to provide kindergarten readiness skills to children ages 3-5 and their family members.

There is currently a waiting list for Head Start slots in the region.

The Virginia Department of Social Services offers a search option by locality on their website for childcare centers (including Head Start and Early Head Start sites) at https://www.dss.virginia.gov/facility/search/cc.cgi.

ACCESS

"The National Academies of Sciences, Engineering, and Medicine define access to health care as the 'timely use of personal health services to achieve the best possible health outcomes.' Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities.

Lack of health insurance coverage may negatively affect health. Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations, and well-child visits that track developmental milestones.

In contrast, studies show that having health insurance is associated with improved access to health services and better health monitoring. One study demonstrated that when previously uninsured adults ages 60 to 64 became eligible for Medicare at age 65, their use of basic clinical services increased. Similarly, providing Medicaid coverage to previously uninsured adults significantly increased their chances of receiving a diabetes diagnosis and using diabetic medications.

Limited availability of health care resources is another barrier that may reduce access to health services and increase the risk of poor health outcomes. For example, physician shortages may mean that patients experience longer wait times and delayed care. Many health care resources are more prevalent in communities where residents are well-insured, but the type of insurance individuals have may matter as well. Medicaid patients, for instance, experience access issues when living in areas where few physicians accept Medicaid due to its reduced reimbursement rate. Expanding access to health services is an important step toward reducing health disparities."

Source: Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Healthy People 2030. Accessed July 9th, 2021. Retrieved from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/access-health-services

Insurance Coverage and its Impact on Health

"Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Compared to those who have health coverage, people without health insurance are more likely to skip preventive services and report that they do not have a regular source of health care. Adults who are uninsured are over three times more likely than insured adults to say they have not had a visit about their own health to a doctor or other health professional's office or clinic in the past 12 months. They are also less likely to receive recommended screening tests such as blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram (among women), and colon cancer screening. Part of the reason for poor access among the uninsured is that half do not have a regular place to go when they are sick or need medical advice, while the majority of insured people do have a regular source of care."

Source: Kaiser Family Foundation. The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act. Rachel Garfield Follow, Kendal, and Anthony Damico. Published: Jan 25, 2019. Accessed July 9th, 2021. Retrieved from: https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/

Uninsured Adults by Year

Locality	2016		2017		2018	
	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured
Amherst County	2387	13.1	2612	14.5	2579	14.3
Appomattox County	1262	13.9	1251	13.7	1273	13.8
Campbell County	4232	12.6	4469	13.4	4540	13.7
Lynchburg City	5623	12.9	5354	12.2	5776	13.0
Pittsylvania County	5106	14.3	5390	15.3	5165	14.8
Service Area	**18610**	**13.4**	**19076**	**13.8**	**19333**	**13.9**
Virginia	**606611**	**11.8**	**620551**	**12.1**	**618552**	**12.0**

Uninsured Children by Year

Locality	2016		2017		2018	
	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured
Amherst County	412	6	415	6	373	6
Appomattox County	212	6	236	7	221	6
Campbell County	611	5	625	6	607	5
Lynchburg City	594	5	670	6	633	5
Pittsylvania County	735	5	668	4	677	4
Service Area	**2564**	**5.5**	**2614**	**5.7**	**2511**	**5.4**
Virginia	**94398**	**5**	**97657**	**5**	**95977**	**5**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2016 - 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Privately Insured

Persons with Private Insurance by Type

Locality	Total Private	Private Employer-based	Private Direct-purchase	Private Tricare/Military
Amherst County	54.20%	48.90%	4.50%	0.90%
Appomattox County	53.70%	45.60%	5.30%	2.80%
Campbell County	54.30%	46.90%	7.00%	0.40%
Lynchburg City	47.70%	38.80%	8.30%	0.60%
Pittsylvania County	56.30%	44.30%	10.30%	1.70%
Service Area	**53.24%**	**44.90%**	**7.08%**	**1.28%**
Virginia	**60.00%**	**49.60%**	**6.60%**	**3.70%**

Table Source: Census_ACS_Table S2703. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

More than half of residents in the service area are utilizing private insurance (53%). Fewer residents in the service area have employer-based insurance compared to those in the Commonwealth. Fewer service area residents are provided Tri-Care insurance through the military. Persons purchasing insurance directly from a third-party insurer is higher in the service area than the overall Virginia rate. Private health insurance categories combined finds the service area with a difference of -6.76% for those with private health insurance compared with overall state rate. This difference is explained in the higher uninsured rates illustrated in the table above titled 'Uninsured Adults by Year,' and those persons covered through Medicaid and Medicare indicated in the following tables.

Population with Medicaid Coverage Alone

Locality	Total	Percent of Total Population
Amherst County	2,744	8.7%
Appomattox County	1,733	11.1%
Campbell County	5,565	10.2%
Lynchburg City	10,457	13.2%
Pittsylvania County	8,314	13.9%
Service Area	**5,763**	**11.4%**
Virginia	**719,551**	**8.7%**

Table Source: U.S. Census, ACS PUBLIC HEALTH INSURANCE COVERAGE BY TYPE AND SELECTED CHARACTERISTICS. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

"Medicaid is a joint federal and state program that: helps with medical costs for some people with limited income and resources and offers benefits not normally covered by Medicare, like nursing home care and personal care services."

Source: Medicare.gov. U.S. Centers for Medicare & Medicaid Services. Accessed July 9th, 2021. Retrieved from: https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicaid

Beginning in January 2019, Medicaid was expanded to Virginia residents earning up to 138% of the federal poverty level. Recently, on July 1, 2021, the Virginia General Assembly expanded Medicaid coverage to include comprehensive adult dental care. "An estimated 400,000 people were expected to become eligible for coverage under the expanded guidelines, but that number is higher now that the COVID pandemic has caused widespread job losses. By early 2020, about 375,000 people had gained coverage under the expanded eligibility guidelines. By December 2020, however, that number had grown to more than 494,000 people. When the job market rebounds after the pandemic recedes, some of those individuals will transition away from Medicaid.

About 138,000 people were previously in the coverage gap, not eligible for Medicaid in Virginia, and also not eligible for premium subsidies because their income was too low (i.e., under the poverty level). The expansion of Medicaid made coverage realistically available to this group. And people with income between 100 percent and 138 percent of the poverty level, who were previously eligible for significant premium subsidies and cost-sharing reductions in the exchange, became eligible for Medicaid instead as of 2019, with far lower out-of-pocket costs."

Source: Virginia and the ACA's Medicaid expansion. Accessed August 16, 2021. Retrieved from: https://www.healthinsurance.org/medicaid/virginia/

Based on the poverty rates among the localities that comprise the Lynchburg Service Area (see Socioeconomic Factors), the higher percentage of Medicaid recipients in the service area as compared to the overall rate of Medicaid recipients in Virginia is expected.

Population with Medicare Coverage Alone

Locality	Total	Percent of Total Population
Amherst County	2,616	8.3%
Appomattox County	877	5.6%
Campbell County	4,377	8.0%
Lynchburg City	3,883	4.9%
Pittsylvania County	5,490	9.1%
Service Area	**3,449**	**7.2%**
Virginia	**375,643**	**4.6%**

Table Source: U.S. Census, ACS PUBLIC HEALTH INSURANCE COVERAGE BY TYPE AND SELECTED CHARACTERISTICS. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

AVAILABILITY

Medically Underserved Areas

"Medically Underserved Areas and Medically Underserved Populations (MUAs and MUPs) identify geographic areas and populations with a lack of access to primary care services. These designations help establish health maintenance organizations or community health centers.

MUAs have a shortage of primary care health services within geographic areas such as:

- A whole county
- A group of neighboring counties
- A group of urban census tracts
- A group of county or civil divisions

MUPs have a shortage of primary care health services for a specific population subset within a geographic area. These groups may face economic, cultural, or language barriers to health care.

Some examples include:

- People experiencing homelessness
- People who are low-income
- People who are eligible for Medicaid
- Native Americans
- Migrant farm workers

Source: Health Resources and Services Administration. HRSA Workforce.
Website last reviewed: Feb 2021. Accessed July 9th, 2021.
Retrieved from https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups

Medically Underserved Area / Population Designation Status

Locality	*Designation Status*	*Service Area Name*	*MUA Index Score 1 (highest need) – 100 (lowest need)*
Amherst County	Yes	Low Income – Amherst County	60.8
Appomattox County	Yes	Low Income – Appomattox County	61
Campbell County	No		
Lynchburg City	Yes	East Lynchburg City	54.8
Pittsylvania County	Yes	Pittsylvania / Danville	60.6

Table Source: Health Resources & Services Administration. Medically Underserved Area and Populations. Accessed July 9th, 2021.
Retrieved from: https://data.hrsa.gov/tools/shortage-area/mua-find Retrieved from https://data.census.gov/

HPSAs – Primary Care, Dental & Mental Health

"Health Professional Shortage Areas (HPSAs) are designations that indicate health care provider shortages in:

- Primary care;
- Dental health; or
- Mental health

Shortages may be geographic, population, or facility-based. Explanations of these categories follow.

Geographic Area

A shortage of providers for the entire population within a defined geographic area.

Population Groups

A shortage of providers for a specific population group(s) within a defined geographic area (e.g., low income, migrant farmworkers, and other groups)

Facilities

Public or non-profit private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers. Medium to maximum security federal and state correctional institutions and youth detention facilities with a shortage of health providers. State or county hospitals with a shortage of psychiatric professionals (mental health designations only). A facility that is automatically designated as a HPSA by statute or through regulation without having to apply for a designation:

1. Federally Qualified Health Centers (FQHCs)—health centers that provide primary care to an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. All organizations receiving grants under Health Center Program Section 330 of the Public Health Service Act are FQHCs.
2. FQHC Look-A-Likes (LALs)—LALS are community-based health care providers that meet the requirements of the HRSA Health Center Program, but do not receive Health Center Program funding. An example of a FQHC Look-A-Like is the Community Access Network located in Lynchburg."
3. Indian Health Facilities
    a. Federal Indian Health Service (IHS), tribally run and Urban Indian health clinics
    b. Provide medical services to members of federally recognized tribes and Alaska Natives
4. IHS and Tribal Hospitals
    a. Federal Indian Health Service (IHS) and tribally run hospitals
    b. Provide medical services to members of federally recognized tribes and Alaska Natives
5. Dual-funded Community Health Centers/Tribal Clinics
    a. Health centers that receive funding from tribal entities and HRSA
    b. Provide medical services to members of federally recognized tribes and Alaska Natives
6. CMS-Certified Rural Health Clinics (RHCs)
    a. Outpatient clinics located in non-urbanized areas that are Centers for Medicare and Medicaid Services (CMS) certified and meet NHSC Site requirements (e.g., accept Medicaid and CHIP and provide services on a sliding fee scale)."

Source: Health Resources and Services Administration. HRSA Workforce. Website last reviewed: Feb 2021. Accessed July 9th, 2021. Retrieved from https://bhw.hrsa.gov/shortage-designation/hpsas

HPSA: Mental Health

Locality	HPSA Designation Type	Score
Amherst County	Low Income Population HPSA	16
Appomattox County	Low Income Population HPSA	16
Campbell County	Low Income Population HPSA	16
Lynchburg City	Federally Qualified Health Center and Low Income Population HPSA	21, 16
Pittsylvania County	Low Income Population HPSA	14

HPSA: Dental Care

Locality	HPSA Designation Type	Score
Amherst County	Low Income Population HPSA	15
Appomattox County	Low Income Population HPSA	18
Campbell County	Low Income Population HPSA	16
Lynchburg City	Federally Qualified Health Center	25
Pittsylvania County	Correctional Facility, Low Income Population HPSA	3, 17

HPSA: Primary Care

Locality	HPSA Designation Type	Score
Amherst County	Geographic HPSA	9
Appomattox County	Geographic HPSA	12
Campbell County	Geographic HPSA	9
Lynchburg City	High Needs Geographic HPSA	6
Pittsylvania County	Geographic HPSA	16

Table Source: Health Resources Services and Administration. Retrieved from https://data.hrsa.gov/data/about

Provider Availability: PCP, Dental and Mental Health Providers

Primary Care Provider to Population Ratio

Locality	2018	2019	2020
Amherst County	3954:1	4513:1	3958:1
Appomattox County	7738:1	7841:1	7921:1
Campbell County	4579:1	6112:1	6108:1
Lynchburg City	827:1	802:1	813:1
Pittsylvania County	15422:1	12252:1	12190:1
Virginia	**1310:1**	**1319:1**	**1325:1**

Dental Provider to Population Ratio

Locality	2018	2019	2020
Amherst County	5266:1	4524:1	4515:1
Appomattox County	7841:1	7921:1	7956:1
Campbell County	5501:1	6108:1	6098:1
Lynchburg City	920:1	955:1	934:1
Pittsylvania County	7657:1	6772:1	8622:1
Virginia	**1473:1**	**1457:1**	**1409:1**

Mental Health Provider to Population Ratio

Locality	2018	2019	2020
Amherst County	6319:1	6333:1	5268:1
Appomattox County	7841:1	7921:1	5304:1
Campbell County	9168:1	9162:1	6861:1
Lynchburg City	232:1	219:1	201:1
Pittsylvania County	6126:1	5079:1	5030:1
Virginia	**628:1**	**572:1**	**531:1**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2018 - 2020. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

In addition to Federally Qualified Health Centers (FQHCs) and FQHC Look-a-Likes (LAL) serving those living in Medically Underserved and Health Professional Shortage Areas, Free Clinics and Community Services Boards (CSBs) contribute to the safety net in the Lynchburg region. Free Clinics in Virginia provide services at no cost or low cost to patients. With Medicaid expansion, many of these clinics are now offering care to the low-income publicly insured populations. CSBs are the points of entry for publicly funded mental health, substance use disorder, and developmental services for intellectual disabilities and/or developmental disabilities. The Lynchburg service area includes the following safety net providers:

Organization	Facility Type	Localities Served	Website
Blue Ridge Medical Center	FQHC	Amherst, Appomattox	www.brmedical.org/
Johnson Health Center	FQHC	Amherst, Campbell, Lynchburg	www.jhcvirginia.org/
Piedmont Access to Health Services	FQHC	Pittsylvania/Danville	www.pathsinc.org/
Community Access Network	FQHC LAL, Free Clinic	Lynchburg	www.communityaccessnetwork.org/
Free Clinic of Central Virginia	Free Clinic	Adults who reside in the region	www.freeclinicva.org/
Danville – Pittsylvania Community Services	CSB	Pittsylvania/Danville	www.dpcs.org/
Horizon Behavioral Health	CSB	Amherst, Appomattox, Campbell, Lynchburg	www.horizonbh.org/

OVERALL HEALTH RANKINGS

"The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive. The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors." In Virginia, County Health Rankings are determined for 133 localities in the Commonwealth annually.

Source: Robert Wood Johnson Foundation, County Health Rankings & Roadmaps. Accessed July 9th, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-outcomes https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors

County Health Rankings

Locality	2019		2020		2021	
	Health Outcomes	Health Factors	Health Outcomes	Health Factors	Health Outcomes	Health Factors
Amherst	47	65	52	72	55	70
Appomattox	74	74	77	83	75	86
Campbell	53	78	46	78	44	74
Lynchburg City	81	82	86	81	72	60
Pittsylvania	68	92	87	97	90	98

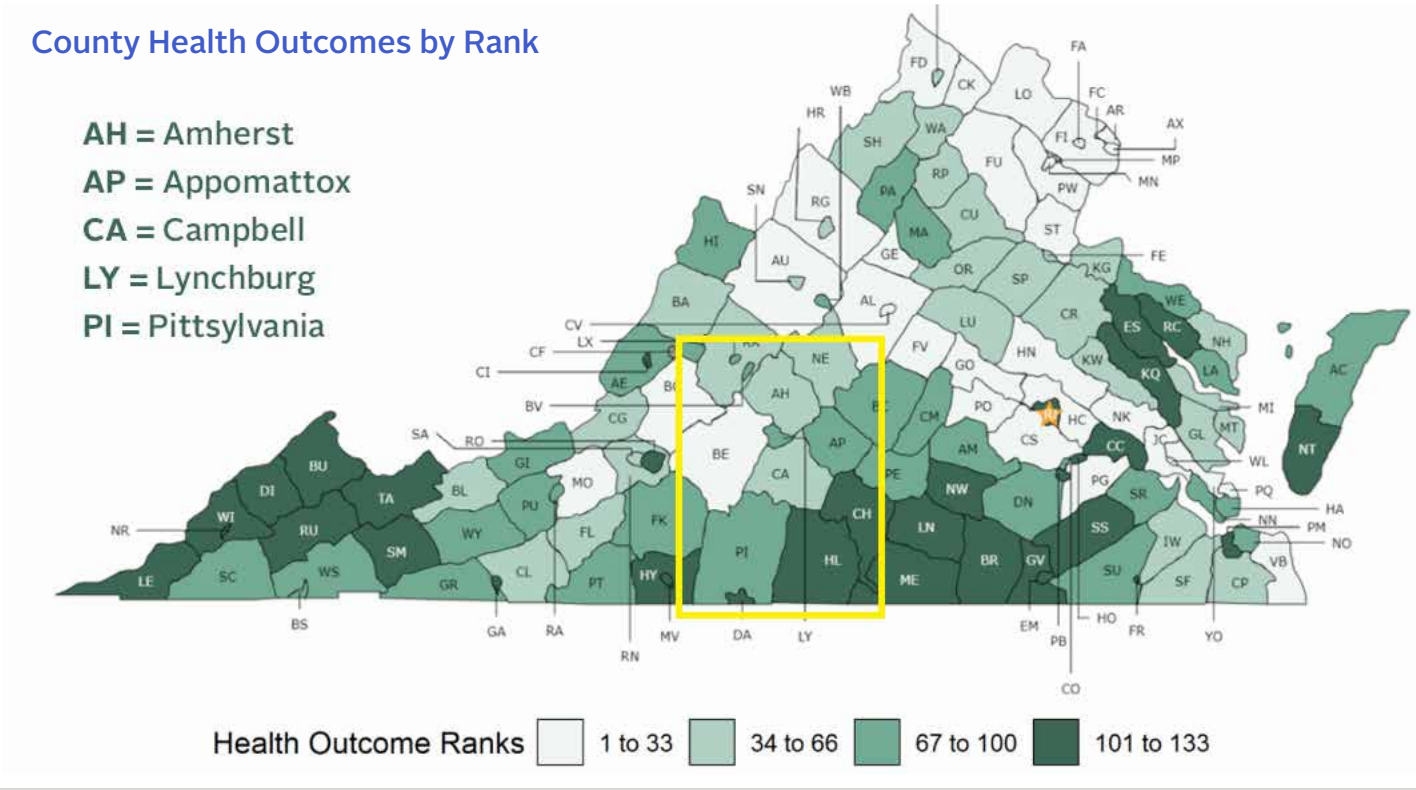
3 YR Change

Locality	Health Outcomes	Health Factors
Amherst	8	5
Appomattox	1	12
Campbell	-9	-4
Lynchburg City	-9	-22
Pittsylvania	22	6

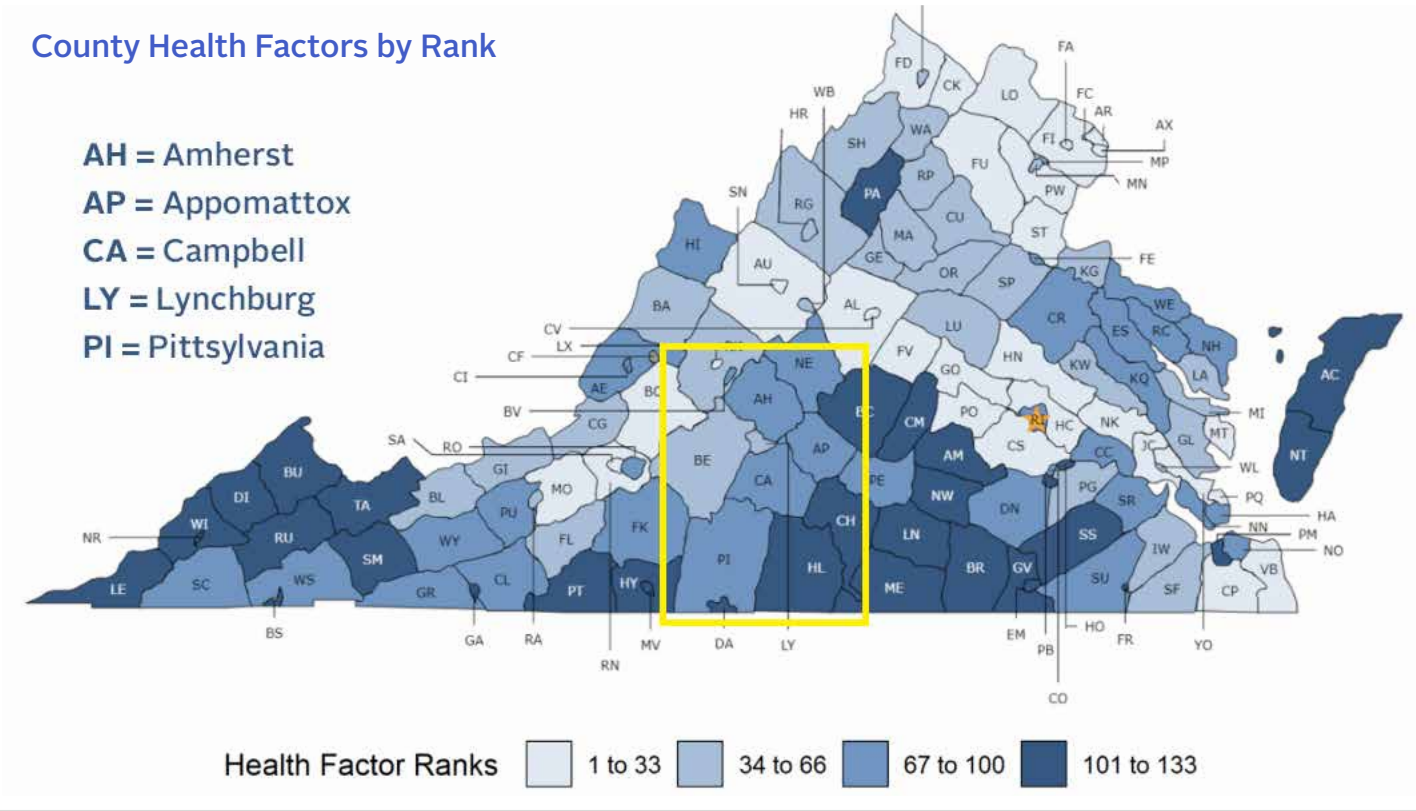
Note: "1" equals best; "133" equals worst.
Change: 'minus (-)' equals improving;
'plus (+)' equals worsening

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2019 - 2021. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

County Health Outcomes by Rank



County Health Factors by Rank



The service area shows health outcome improvement in Campbell and Lynchburg counties. There is a significant decline in health outcomes rank experienced by Pittsylvania as the county fell 22 places. Despite its decline, Pittsylvania is not in the lowest quartile (101-133) of Virginia localities. Campbell County matched its improvement in health outcomes with an improvement in health factor rankings. While Appomattox County remained consistent in health outcomes, the county dropped 12 points in health factors. The most improved city for health factors is Lynchburg. The health outcomes and health factors should be viewed in context of specific health and disease mortality and incidence data found in this assessment to evaluate their rankings.

Obesity and Physical Activity

"Excess weight, especially obesity, diminishes almost every aspect of health, from reproductive and respiratory function to memory and mood. Obesity increases the risk of several debilitating, and deadly diseases, including diabetes, heart disease, and some cancers. It does this through a variety of pathways, some as straightforward as the mechanical stress of carrying extra pounds and some involving complex changes in hormones and metabolism. Obesity decreases the quality and length of life, and increases individual, national, and global healthcare costs. Losing as little as 5 to 10 percent of body weight offers meaningful health benefits to people who are obese, even if they never achieve their 'ideal' weight, and even if they only begin to lose weight later in life."

Source: Harvard School of Public Health. Obesity Prevention Source. Accessed July 9th, 2021. Retrieved from https://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/

Percent of Adults with Obesity

Locality	2015	2016	2017
Amherst County	31.8	35.2	28.8
Appomattox County	32.6	47.4	40.7
Campbell County	34	35.6	38.4
Lynchburg City	28.8	35.4	35.5
Pittsylvania County	35.1	37.9	38.9
Service Area	**32.5**	**38.3**	**36.5**
Virginia	**28.8**	**29.8**	**30.5**

Table Source: County Health Rankings. Date of Table: 2019 - 2021. Year(s) Measured: 2015 - 2017. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Appomattox, Campbell and Pittsylvania have the highest obesity rates in the service area.

"Increased physical activity is associated with lower risks of type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. The role of the built environment is important for encouraging physical activity. Individuals who live closer to sidewalks, parks, and gyms are more likely to exercise."

Source: Robert Wood Johnson Foundation. County Health Rankings. Accessed July 9th, 2021. Retrieved from: https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/diet-exercise/access-to-exercise-opportunities

Percentage of Adults Age 20+ Reporting No Leisure-Time Physical Activity

Locality	2015	2016	2017
Amherst County	30	30	27
Appomattox County	27	37	30
Campbell County	27	33	31
Lynchburg City	23	26	24
Pittsylvania County	29	31	33
Service Area	**27**	**31**	**29**
Virginia	**22**	**23**	**22**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2015 - 2017. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

"Access to Exercise Opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Parks include local, state, and national parks. Recreational facilities include YMCAs as well as businesses identified by the following Standard Industry Classification (SIC) codes and include a wide variety of facilities including gyms, community centers, dance studios and pools."

Source: Robert Wood Johnson Foundation. County Health Rankings. Accessed July 9th, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/diet-exercise/access-to-exercise-opportunities

Percentage of Population with Access to Exercise Opportunities

Locality	2010 & 2019
Amherst County	54
Appomattox County	55
Campbell County	44
Lynchburg City	95
Pittsylvania County	29
Service Area	**55.4**
Virginia	**82**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2010 & 2019. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Access to Healthy Foods

"Limited Access to Healthy Foods estimates the percentage of the population that is low income and does not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas; in rural areas, it means living less than ten miles from a grocery store; in nonrural areas, less than one mile. 'Low income' is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size."

Source: Robert Wood Johnson Foundation. County Health Rankings. Accessed July 9th, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/diet-exercise/limited-access-to-healthy-foods

The Food Environment Index measures factors that contribute to a healthy food environment, from 0 (worst) to 10 (best) including proximity to healthy foods and income. "This measure includes access to healthy foods by considering the distance an individual lives from a grocery store or supermarket, locations for health food purchases in most communities, and the inability to access healthy food because of cost barriers.

There is strong evidence that food deserts are correlated with high prevalence of overweight, obesity, and premature death as supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores. Additionally, those with low income may face barriers to accessing a consistent source of healthy food. Lacking consistent access to food is related to negative health outcomes such as weight gain, premature mortality, asthma, and activity limitations, as well as increased health care costs."

Source: Robert Wood Johnson Foundation. County Health Rankings. Accessed August 16, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/diet-exercise/food-environment-index.

Note: Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best)

Food Environment Index

Locality	2015 & 2018
Amherst County	8.1
Appomattox County	8.5
Campbell County	8.4
Lynchburg City	7.3
Pittsylvania County	7.9
Service Area	**8.0**
Virginia	**8.8**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2015 & 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Alcohol Consumption

"Excessive alcohol consumption considers both the amount of alcohol consumed and the frequency of drinking. Although moderate alcohol use is associated with health benefits such as reduced risk of heart disease and diabetes, excessive alcohol use causes 88,000 deaths in the US each year. In 2015, 27% of people ages 18 and older reported binge drinking in the past month, while 7% reported heavy alcohol use in the past month. Over time, excessive alcohol consumption is a risk factor for hypertension, heart disease, fetal alcohol syndrome, liver disease, and certain cancers. In the short-term, excessive drinking is also linked to alcohol poisoning, intimate partner violence, risky sexual behaviors, and motor vehicle crashes. Alcohol-impaired crashes accounted for nearly one-third of all traffic-related deaths in 2016—more than 10,000 fatalities."

Source: Robert Wood Johnson Foundation. County Health Rankings. Accessed July 9th, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/alcohol-and-drug-use

Percentage of Adults Reporting Binge or Heavy Drinking

Locality	2016	2017	2018
Amherst County	16.0	16.5	17.9
Appomattox County	15.8	16.6	17.8
Campbell County	16.7	16.7	17.0
Lynchburg City	17.1	18.4	18.5
Pittsylvania County	15.0	15.1	17.0
Service Area	**16.1**	**16.7**	**17.6**
Virginia	**17.4**	**17.4**	**17.7**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2016 - 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Drug and Tobacco Use

"Each year, smoking kills 480,000 Americans, including about 41,000 from exposure to secondhand smoke. Smoking causes cancer, heart disease, stroke, diabetes, and lung diseases such as emphysema, bronchitis, and chronic airway obstruction, and can lead to lung cancer and heart disease in those exposed to secondhand smoke. On average, smokers die 10 years earlier than nonsmokers.

Tobacco is not only smoked. Smokeless tobacco, while less lethal than smoked tobacco, can lead to various cancers, gum and teeth problems, and nicotine addiction. Almost 6% of young adults use smokeless tobacco and half of new users are younger.

Tobacco use has real economic impacts for individuals and communities. It costs the nation about $170 billion annually to treat tobacco-related illnesses, and another $156 billion in productivity losses. In 2006, over $5 billion of that lost productivity was due to secondhand smoke.

Researchers estimate that tobacco control policies have saved at least 8 million Americans. Yet about 18% of adults still smoke. Each day, nearly 3,200 youth smoke their first cigarette, and 2,100 transition from occasional to daily smokers.

Continuing to adopt and implement tobacco control policies can motivate users to quit, help youth choose not to start, and improve the quality of the air we all breathe."

Source: Robert Wood Johnson Foundation. Community Health Rankings. Accessed July 9th, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/tobacco-use

Percentage of Adults Who are Current Smokers

Locality	2016	2017	2018
Amherst County	17	17	22
Appomattox County	17	17	22
Campbell County	16	19	21
Lynchburg City	18	17	20
Pittsylvania County	18	18	23
Service Area	**17.2**	**17.6**	**21.6**
Virginia	**15**	**16**	**15**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2016 - 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Opioid Use

"In the U.S., there were 67,367 drug overdose deaths reported in 2018, 4.1% fewer deaths than in 2017.

- The age-adjusted rate declined by 4.6% to 20.7 per 100,000 standard population. The decline follows an increasing trend in the rate from 6.1 in 1999 to 21.7 in 2017.
- Opioids were involved in 46,802 (a rate of 14.6) overdose deaths in 2018—nearly 70% of all overdose deaths.
- Deaths involving synthetic opioids other than methadone (including fentanyl and fentanyl analogs) continued to rise with more than 28,400 (a rate of 9.9) overdose deaths in 2018.
- The number of deaths involving prescription opioids declined to 14,975 (a rate of 4.6) in 2018 and those involving heroin dropped to 14,996 (a rate of 4.7).

In Virginia, 1,193 drug overdose deaths involved opioids in 2018 (a rate of 14.3).

- Among opioid-involved deaths, those involving prescription opioids decreased from 404 in 2017 (a rate of 4.7) to 326 in 2018 (a rate of 3.8).
- Deaths involving heroin or synthetic opioids other than methadone (mainly fentanyl and fentanyl analogs) remained stable with a respective 532 (a rate of 6.4) and 852 (a rate of 10.2) in 2018."

Source: National Institute for Drug Abuse. Virginia Opioid Summary. Last Updated April 3rd 2020. Accessed July 9th, 2021. Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/virginia-opioid-summary

Mortality Rates (per 100,000 Population) for overdose from any Opioid Use in 2018

Locality	Mortality Rate
Amherst County	0
Appomattox County	6.3
Campbell County	9.1
Lynchburg City	6.1
Pittsylvania County	16.4
Service Area	**7.6**
Virginia	**12.4**

Table Source: Virginia Department of Health, Division of Health Statistics. Date of Table: 2018. Year(s) Measured: 2018. Retrieved from https://www.vdh.virginia.gov/data/

Opioid Use *continued...*

Data provided by Virginia's Framework for Addiction Analysis and Community Transformation (FAACT) revealed that in 2019, the Lynchburg region had 34 fatal opioid overdoses of which 65% were attributed to Fentanyl/ Analog and 35% to Heroin or Prescription Drugs. The per capita death rate in the region was 13.91 per 100,000 as compared to 15.52 per 100,000 for Virginia as a whole and 75.1% of overdoses involving fentanyl or analogs.

Source: Virginia Office of the Chief Medical Examiner, Date of Data 2019. Provided by Virginia FAACT. October 12, 2021.

In 2020, overdose deaths in the United States reached a record 93,000 eclipsing the high of 72,000 deaths the year before (29% increase). The pandemic exacerbated this "overdose pandemic" which is being driven by fentanyl contaminated opioids and amphetamines. "The Centers for Disease Control and Prevention (CDC) reviewed death certificates to come up with the estimate for 2020 drug overdose deaths. The estimated of over 93,000 overdose deaths translates to an average of more than 250 deaths each day. The 21,000 increase is the biggest year-to-year jump since the count rose by 11,000 in 2016." During this time which coincides with the start of the pandemic, Virginia experienced a 42.1% increase in opioid overdose deaths according to the CDC.

Source: The Associated Press. "US overdose deaths hit record 93,000 in pandemic last year". July 14, 2021. Accessed July 14, 2021. Retrieved from https://apnews.com/article/overdose-deaths-record-covid-pandemic-fd43b5d91a81179def5ac596253b0304.
Source: Centers for Disease Control and Prevention. National Center for Health Statistics. National Vital Statistics Rapid Release. Provisional Drug Overdose Death Counts. Accessed October 12, 2021. Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

In 2020, Lynchburg City Schools conducted the Lynchburg Youth Survey in collaboration with Lynchburg School Health Advisory Board and Central Virginia Addiction and Recovery Resources. Lynchburg City Schools has been surveying youth in the school district since 1999. The survey is based on the Centers for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS) and was administered to 913 students in 8th, 10th, and 12th graders in the Fall of 2020. There was an overall response rate of 50%. The main topics addressed included: Unintentional Injury, Intentional Injury, Tobacco, Alcohol Drugs, Sexual Behavior, and Healthy Lifestyle.

"Although most questions addressing tobacco use indicated that local students engaged in this type of behavior at lower rates than statewide and nationally surveyed students, 7% of Lynchburg City students reported smoking cigarettes in the past 30 days. The reported frequency and number of cigarettes smoked remained low. The perception of risk of smoking as well as perception of parental and peer disapproval remained consistently high among Lynchburg City students. Lynchburg City students reported lower rates of using other tobacco products, including electronic vapor products than Virginia and national students. Similarly, the alcohol portion of the survey elicited responses indicating that the local students' engagement in behavior in this area is lower than that of other students in Virginia and nationally.

Lynchburg students engaged in drug use at lower rates than their Virginia and national peers. The most commonly reported illicit drug use across all grades was sniffing or inhaling glue, aerosol spray cans, or paints to get high."

Source: Lynchburg City Schools. 2020 Lynchburg Youth Survey Report. Accessed August 23, 2021. Retrieved at 2020 LYS.

Sexually Transmitted Infections

Chlamydia Incidence Rate Per 100,000 Population

Locality	2016	2017	2018
Amherst County	353.7	364	310.2
Appomattox County	361.2	459.2	331.6
Campbell County	275.5	298.1	319.9
Lynchburg City	667	774.1	712.4
Pittsylvania County	264.3	280.8	271
Service Area	**384.3**	**435.2**	**389.0**
Virginia	**471.4**	**500.3**	**507.3**

Gonorrhea Incidence Rate Per 100,000 Population

Locality	2016	2017	2018
Amherst County	69.5	76	79.1
Appomattox County	77.4	95.7	76.5
Campbell County	63.4	78.2	47.3
Lynchburg City	191.5	243.2	218.5
Pittsylvania County	61.6	104.5	68.6
Service Area	**92.7**	**119.5**	**98**
Virginia	**131.7**	**148.7**	**139.0**

Table Source: Centers for Disease Control . Date of Table: 2018. Year(s) Measured: 2016 - 2018. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx

Health Status

"Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in a population. Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures that consider how healthy people are while alive.

The use of self-rated health as a measure to compare health status benefits from its comprehensive, inclusive, and non-specific nature. Furthermore, a meta-analysis of the association between mortality and a single item assessing self-rated health found that people with 'poor' self-rated health had a twofold higher mortality risk than persons with 'excellent' self-rated health. This analysis concludes that a single measure that takes little time to collect and can be captured routinely is appropriate for measuring health among large populations. A study that investigated the reliability of the HRQoL questions included in the Behavioral Risk Factor Surveillance System (BRFSS) found high retest reliability for the self-reported health measure."

Source: Robert Wood Johnson Foundation. Community Health Rankings. Accessed July 9th, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-outcomes/quality-of-life/poor-or-fair-health

Persons Reporting Being in Poor or Fair Health by Percent

Locality	2016	2017	2018
Amherst County	16	16	20
Appomattox County	16	17	20
Campbell County	16	16	19
Lynchburg City	19	20	21
Pittsylvania County	18	18	22
Service Area	**17**	**17**	**20**
Virginia	**16**	**16**	**17**

Table Source: County Health Rankings. Date of Table: 2019 - 2021. Year(s) Measured: 2016 - 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Persons Reporting Physically Unhealthy Days in the Past Month

Locality	2016	2017	2018
Amherst County	3.6	3.6	4.4
Appomattox County	3.7	3.8	4.5
Campbell County	3.5	3.5	4.4
Lynchburg City	4.2	4.2	4.5
Pittsylvania County	3.8	3.9	4.6
Service Area	**3.8**	**3.8**	**4.5**
Virginia	**3.5**	**3.5**	**3.5**

Table Source: County Health Rankings. Date of Table: 2019 - 2021. Year(s) Measured: 2016 - 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Average Number of Poor Mental Health Days in Past 12 Months

Locality	2016	2017	2018
Amherst County	3.7	4.0	4.7
Appomattox County	3.8	4.0	4.7
Campbell County	3.8	3.9	4.8
Lynchburg City	4.0	4.5	4.7
Pittsylvania County	3.7	4.1	5.0
Service Area	**3.8**	**4.1**	**4.8**
Virginia	**3.5**	**3.8**	**4.0**

Table Source: County Health Rankings. Date of Table: 2019 - 2021. Year(s) Measured: 2016 - 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

According to the 2020 Lynchburg Youth Survey, "a concerning number of Lynchburg students across all grades reported feeling sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. The portion of Lynchburg high school students who reported this increased from 31% in 2015 to 39% in 2020, mirroring national data."

Source: Lynchburg City Schools. 2020 Lynchburg Youth Survey Report. Accessed August 23, 2021. Retrieved at 2020 LYS.

INCIDENCE RATES

All Cancer Types:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Amherst County	425.7	-1.4	422.5	-1.6	445.3	-0.8	*	*
Appomattox County	427.3	-0.7	441.6	-0.1	360.7	-3.0	*	*
Campbell County	419.3	-1.2	415.0	-1.3	431.3	2.7	615.9	*
Lynchburg City	453.0	0.3	445.5	0.1	468.2	0.1	521.7	*
Pittsylvania County	379.7	-1.5	373.1	-1.5	402.6	-1.2	*	*
Service Area	**421.0**	**-0.9**	**419.5**	**-0.9**	**421.6**	**-0.4**	**568.8**	*
Virginia	**416.1**	**-1.5**	**421.1**	**-1.5**	**438.9**	**-1.5**	**265.1**	**-2.1**

Note: '*' indicates suppressed data due to small numbers.

Table Source: National Cancer Institute. Date of Table: 2018. Year(s) Measured: 2013 - 2017. Retrieved from https://statecancerprofiles.cancer.gov/

Breast Cancer:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Amherst County	103.8	-0.2	100.7	0.0	107.5	*	*	*
Appomattox County	137.1	1.3	144.7	3.4	*	*	*	*
Campbell County	116.4	0.8	116.1	0.4	121.5	2.9	*	*
Lynchburg City	131.9	1.0	146.8	0.7	107.3	2.4	*	*
Pittsylvania County	122.2	0.9	117.7	0.9	141.8	1.7	*	*
Service Area	**122.3**	**0.8**	**125.2**	**1.1**	**119.5**	**2.3**		
Virginia	**416.1**	**-1.5**	**421.1**	**-1.5**	**438.9**	**-1.5**	**265.1**	**-2.1**

Note: '*' indicates suppressed data due to small numbers.

Table Source: National Cancer Institute. Date of Table: 2018. Year(s) Measured: 2013 - 2017. Retrieved from https://statecancerprofiles.cancer.gov/

Lung & Bronchus Cancer:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Amherst County	61.8	-3.1	63.5	-3.6	57.6	-1.5	*	*
Appomattox County	67.9	-0.4	74.9	0.8	*	*	*	*
Campbell County	66.6	-3.0	65.8	-3.4	71.9	-0.3	*	*
Lynchburg City	66.3	-1.1	56.9	-1.8	90.1	-0.6	*	*
Pittsylvania County	58.9	-1.9	61.7	-1.4	49.1	-4.5	*	*
Service Area	**64.3**	**-1.9**	**64.6**	**-1.9**	**67.2**	**-1.7**		
Virginia	**56.4**	**-2.2**	**58.2**	**-2.1**	**60.0**	**-1.6**	**24.2**	**-2.6**

Note: '*' indicates suppressed data due to small numbers.

Table Source: National Cancer Institute. Date of Table: 2018. Year(s) Measured: 2013 - 2017. Retrieved from https://statecancerprofiles.cancer.gov/

Colon - Rectum Cancer:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Amherst County	45.6	-3.3	44.3	-2.8	55.5	-3.2	*	*
Appomattox County	48.6	-1.3	45.9	-1.6	*	*	*	*
Campbell County	39.8	-2.8	40.3	-2.6	38.9	-3.0	*	*
Lynchburg City	42.0	-1.2	38.7	-1.5	48.6	-2.1	*	*
Pittsylvania County	43.3	-2.1	40.6	-2.7	51.4	-0.5	*	*
Service Area	**43.9**	**-2.1**	**42.0**	**-2.2**	**48.6**	**-2.2**		
Virginia	**35.2**	**-1.5**	**34.7**	**-1.1**	**40.9**	**-3.3**	**24.0**	**-2.9**

Note: '*' indicates suppressed data due to small numbers.

Table Source: National Cancer Institute. Date of Table: 2018. Year(s) Measured: 2013 - 2017. Retrieved from https://statecancerprofiles.cancer.gov/

Prostate Cancer:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Amherst County	82.4	18.3	67.5	34.7	138.8	-5.1	*	*
Appomattox County	72.0	-6.9	63.8	-5.9	*	*	*	*
Campbell County	77.6	-6.1	66.3	-6.7	145.6	-5.2	*	*
Lynchburg City	104.1	11.8	89.8	8.9	146.6	-2.8	*	*
Pittsylvania County	70.1	-1.8	54.7	-12.9	116.4	-4.6	*	*
Service Area	**81.2**	**3.1**	**68.4**	**3.6**	**136.9**	**-4.4**		
Virginia	**99.6**	**-0.9**	**82.3**	**-2.2**	**167.6**	**-1.3**	**67.6**	**2.0**

Note: '*' indicates suppressed data due to small numbers.

Table Source: National Cancer Institute. Date of Table: 2018. Year(s) Measured: 2013 - 2017. Retrieved from https://statecancerprofiles.cancer.gov/

LIFE EXPECTANCY & DEATH RATES

"Over the last four decades, life expectancy in the United States has largely risen, although certain groups have experienced slight decreases in their life expectancy, gaining the attention of mortality experts and the media. Recent headlines draw attention to the role of the opioid epidemic in this unusual downturn in life expectancy among non-Hispanic White adults. In considering what the future of the U.S. population may look like, we must address historical and recent shifts in life expectancy and understand that these shifts are the result of complex social, cultural, biological, and economic forces."

Source: U.S. Census. Living Longer: Historical and Projected Life Expectancy in the United States. By Lauren Medina, Shannon Sabo, and Jonathan Vespa. Published Feb 2020. Accessed July 9th, 2021. Retrieved from: https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1145.pdf

Life Expectancy by Average Number of Years Lived

Locality	2015-2017	2016-2018	2017-2019
Amherst County	79.0	78.4	78.0
Appomattox County	76.6	76.5	77.4
Campbell County	78.3	78.6	79.1
Lynchburg City	77.4	77.0	76.3
Pittsylvania County	78.0	77.0	76.7
Service Area	**77.9**	**77.5**	**77.5**
Virginia	**79.4**	**79.5**	**79.5**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2015 - 2019. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Standardizing rates allow the reviewer to make direct comparisons between two populations, regardless of population size and the age distribution of the population. The information in the tables below represent the death rate from all causes per locality, the service area and statewide for every 1,000 persons.

Deaths per 1,000 Population Rate

Locality	2017	2018	2019	3 YR AVG
Amherst County	11.3	11.5	12.2	11.7
Appomattox County	10.8	12.8	11.4	11.7
Campbell County	10.4	10.7	10.7	10.6
Lynchburg City	9.9	10.4	10.2	10.2
Pittsylvania County	12.0	12.7	12.6	12.4
Service Area	**10.9**	**11.6**	**11.4**	**11.3**
Virginia	**8.1**	**8.1**	**8.2**	**8.1**

Table Source: Virginia Department of Health, Division of Health Statistics. Date of Table: 2019. Year(s) Measured: 2017 - 2019. Retrieved from https://www.vdh.virginia.gov/data/

As a general health indicator each locality in the service area has a higher death rate among 1,000 residents than the overall state rate (8.1 as a 3-year average) with Pittsylvania County having the highest 3-year average rate at 12.4.

Death Rates by Race

The table below compares death rates among white, blacks, and other races as published by the Virginia Department of Health's, Division of Health Statistics. The death rate among Blacks in each of the three service areas approximates the death rate among Whites. The death rate among Blacks and Whites by individual locality are similar. "Other" races, where "Other" is the label used by the Virginia Department of Health, are lower than the death rate compared to Blacks and Whites. It should be noted that there were more data points for both Blacks and Whites for the four-year period than "Other".

Deaths per 1,000 Population Rate by Race

Locality	2017				2018				2019			
	Total	White	Black	Other	Total	White	Black	Other	Total	White	Black	Other
Amherst County	11.3	11.2	11.5	11.5	11.5	11.9	10.4	7.5	12.2	12.5	11.3	5.6
Appomattox County	10.8	10.7	11.7	-	12.8	11.9	16.4	-	11.4	11.8	10.0	16.5
Campbell County	10.4	10.8	9.1	5.5	10.7	10.8	10.7	1.1	10.7	11.2	8.6	4.4
Lynchburg City	9.9	10.1	10.4	1.0	10.4	10.5	11.1	3.7	10.2	10.7	9.6	3.9
Pittsylvania County	12.0	12.0	12.2	10.5	12.7	12.3	14.3	3.5	12.6	12.5	13.1	3.5
Service Area	**10.9**	**11.0**	**11.0**	**7.1**	**11.6**	**11.5**	**12.6**	**4.0**	**11.4**	**11.7**	**10.5**	**6.8**
Virginia	**8.1**	**8.8**	**7.8**	**2.8**	**8.1**	**8.8**	**7.8**	**2.8**	**8.2**	**8.9**	**7.9**	**3.5**

Note: "-" indicates insufficient data

3yr Average Death Rate, 2017 - 2019

Locality	Total	White	Black	Other
Amherst County	11.7	11.9	11.1	8.2
Appomattox County	11.7	11.5	12.7	16.5
Campbell County	10.6	10.9	9.5	3.7
Lynchburg City	10.2	10.4	10.4	2.9
Pittsylvania County	12.4	12.3	13.2	5.8
Service Area	**11.3**	**11.4**	**11.4**	**6.0**
Virginia	**8.1**	**8.8**	**7.8**	**3.0**

Table Source: Virginia Department of Health, Division of Health Statistics. Date of Table: 2019. Year(s) Measured: 2017 - 2019. Retrieved from https://www.vdh.virginia.gov/data/

While the mortality gap by race has decreased over the last decade, studies following COVID-19 expect those gains to be lost. "COVID-19 has generated a huge mortality toll in the United States, with a disproportionate number of deaths occurring among the Black and Latino populations. Measures of life expectancy quantify these disparities in an easily interpretable way. We project that COVID-19 will reduce US life expectancy in 2020 by 1.13 y. Estimated reductions for the Black and Latino populations are 3 to 4 times that for Whites. Consequently, COVID-19 is expected to reverse over 10 years of progress made in closing the Black–White gap in life expectancy and reduce the previous Latino mortality advantage by over 70%. Some reduction in life expectancy may persist beyond 2020 because of continued COVID-19 mortality and long-term health, social, and economic impacts of the pandemic."

Source: PNAS. Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations. February 2, 2021. Accessed July 9th, 2021. Retrieved from: https://www.pnas.org/content/118/5/e2014746118

Premature and Injury Death Rates

Premature age-adjusted mortality is an important and frequently referenced measure used to assess a population's health.

Premature Age Adjusted Mortality Rate per 100,000 Population Mortality Rate less than 75 Years of Age

Locality	2015 - 2017	2016 - 2018	2017 - 2019	AVG	YoY Change
Amherst County	355.9	366.9	377.9	366.9	5.82%
Appomattox County	393.3	397.0	377.0	389.1	-4.33%
Campbell County	373.3	369.9	354.2	365.8	-5.40%
Lynchburg City	414.6	424.4	452.9	430.6	8.46%
Pittsylvania County	383.5	409.2	421.8	404.8	9.08%
Service Area	**384.1**	**393.5**	**396.8**	**391.4**	**3.18%**
Virginia	**319.7**	**321.1**	**320.0**	**320.3**	**0.10%**

Table Source: County Health Rankings. Date of Table: 2019 - 2021. Year(s) Measured: 2015 - 2019 . Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Number of Deaths due to Injury per 100,000 Population

Locality	2013 - 2017	2014 - 2018	2015 - 2019	AVG	YoY Change
Amherst County	57.1	66.7	73.2	65.7	22.02%
Appomattox County	68.7	79.8	80.4	76.3	14.54%
Campbell County	75.2	79.3	84.4	79.6	10.86%
Lynchburg City	55.5	63.9	69.1	62.8	19.64%
Pittsylvania County	79.0	87.9	97.9	88.3	19.26%
Service Area	**67.1**	**75.5**	**81.0**	**74.6**	**17.14%**
Virginia	**60.2**	**62.8**	**64.7**	**62.6**	**6.88%**

Table Source: County Health Rankings. Date of Table: 2019 - 2021. Year(s) Measured: 2013 - 2019. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Suicide Death Rates

"According to the Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports, in 2019:

- Suicide was the tenth leading cause of death overall in the United States, claiming the lives of over 47,500 people.
- Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 44.
- There were nearly two and a half times as many suicides (47,511) in the United States as there were homicides (19,141).
- The total age-adjusted suicide rate in the United States increased 35.2% from 10.5 per 100,000 in 1999 to 14.2 per 100,000 in 2018, before declining to 13.9 per 100,000 in 2019.
- In 2019, the suicide rate among males was 3.7 times higher (22.4 per 100,000) than among females (6.0 per 100,000)."

Source: National Institute of Mental Health. Statistics. Last Updated May 2021. Accessed July 9th, 2021. Retrieved from: https://www.nimh.nih.gov/health/statistics/suicide

Suicide Death Rates *continued...*

Number of Deaths due to Suicide per 100,000 population, 2015 - 2019

Locality	Number of Deaths	Suicide Rate (Age-Adjusted)
Amherst County	23	14.92
Appomattox County	16	23.85
Campbell County	47	15.75
Lynchburg City	58	15.66
Pittsylvania County	69	21.63
Service Area	**213**	**18.36**
Virginia	**5836**	**13.20**

Table Source: County Health Rankings. Date of Table: 2019 - 2021. Year(s) Measured: 2015 - 2019. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

"Suicidal behavior among Lynchburg City students has remained relatively consistent since 2015, though the portion of 12th grade Lynchburg City students who reported attempting suicide in the past year (9%) was slightly higher than Virginia and national peers."

Source: Lynchburg City Schools. 2020 Lynchburg Youth Survey Report. Accessed August 23, 2021. Retrieved at 2020 LYS.

Stroke and Heart Disease Death Rates

Stroke Death Rate Age 35+ per 100,000 Population by Race

Locality	Total	White	Black	Hispanic
Amherst County	97.6	96.1	111.1	*
Appomattox County	92.3	83.6	101.0	*
Campbell County	77.2	80.5	91.5	*
Lynchburg City	79.0	102.4	132.2	*
Pittsylvania County	113.3	78.3	90.8	*
Service Area	**91.9**	**88.2**	**105.3**	*
Virginia	**74.1**	**71.4**	**97.1**	**41.2**

Note: '*' indicates suppressed data due to small numbers.

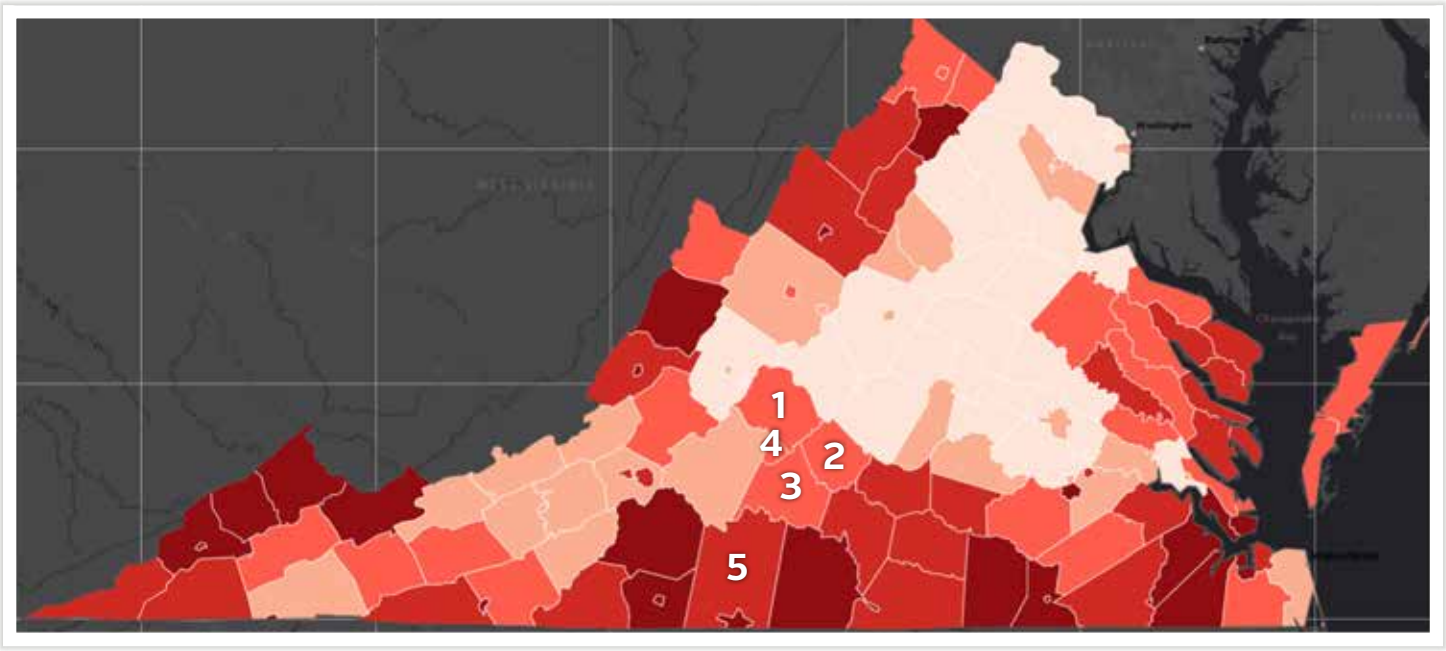
Table Source(s): CDC. Date of Table: 2018. Year(s) Measured: 2016 - 2018. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx

Heart Disease Death Rate Age 35+ per 100,000 Population by Race

Locality	Total	White	Black	Hispanic
Amherst County	329.6	319.8	397.3	*
Appomattox County	385.5	338.9	543.8	*
Campbell County	338.4	333.5	360.8	*
Lynchburg City	353.4	319.6	440.6	*
Pittsylvania County	326.3	321.5	363.0	*
Service Area	**346.6**	**326.7**	**421.1**	
Virginia	**292.3**	**294.0**	**364.6**	**123.1**

Note: '*' indicates suppressed data due to small numbers.

Table Source(s): CDC. Date of Table: 2018. Year(s) Measured: 2016 - 2018. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx

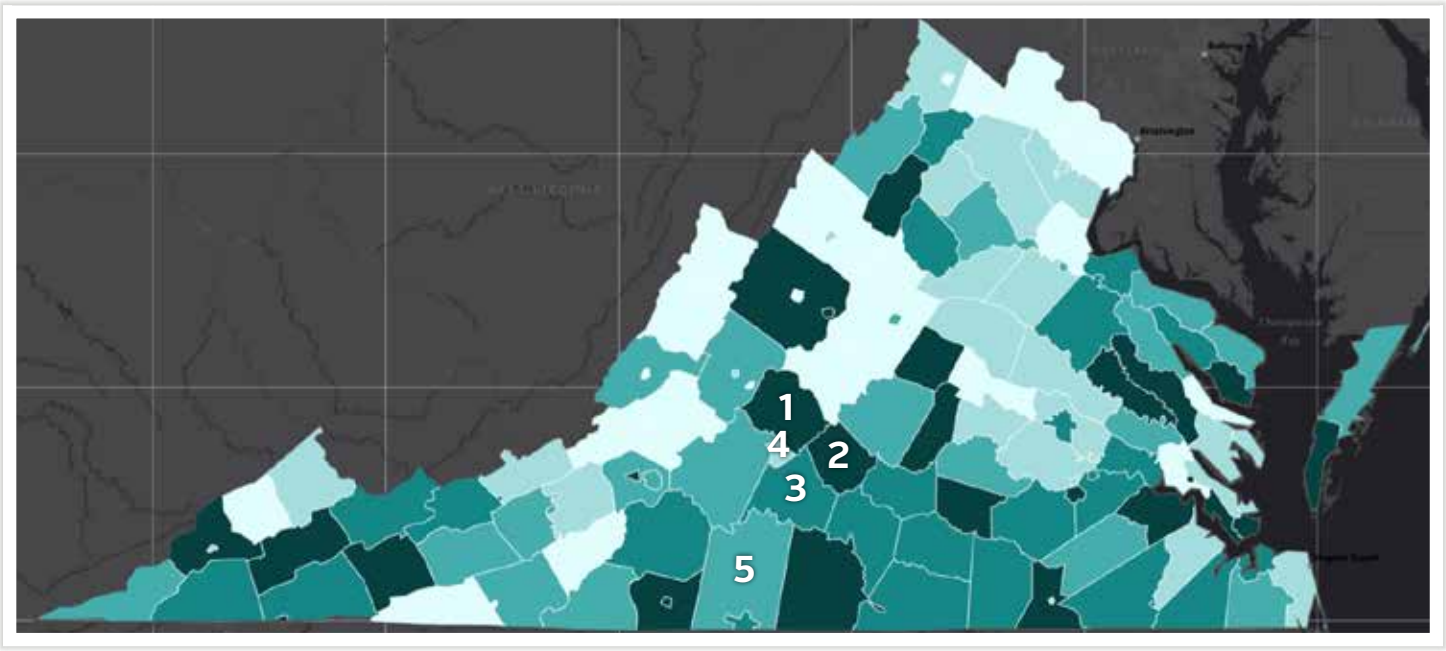


Hypertension Death Rate per 100,000 Population: Age 35+, 2017-2019

Locality	*Rate*
1. Amherst County	183.3
2. Appomattox County	188.1
3. Campbell County	188.8
4. Lynchburg City	185.6
5. Pittsylvania County	215.5
Service Area	**192.3**
Virginia	**172.8**

AGE-STANDARDIZED RATE PER 100,000
Insufficient Data (0)
84.5–137.7 (27)
137.8–183.0 (27)
183.1–213.9 (26)
214.0–251.2 (27)
251.3–745.9 (26)

Table and Map Source: Centers for Disease Control. Date of Table: 2019. Year(s) Measured: 2017 - 2019. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx



DIABETES (%)
Insufficient Data (0)
4.3–7.9 (27)
8.0–9.9 (27)
10.0–11.9 (26)
12.0–13.7 (27)
13.8–21.9 (26)

Diabetes Percentage, Age Adjusted for the Population Age 20+, 2017

Locality	*Percentage*
1. Amherst County	14.5
2. Appomattox County	15.9
3. Campbell County	12.9
4. Lynchburg City	8.9
5. Pittsylvania County	10.5
Service Area	**12.5**
Virginia	**11.0**

Table and Map Source: Centers for Disease Control . Date of Table: 2017. Year(s) Measured: 2017. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx

MATERNAL AND CHILD HEALTH INDICATORS

"Women in the United States are more likely to die from childbirth than women living in other developed countries. Some women have health problems that start during pregnancy, and others have health problems before they get pregnant that could lead to complications during pregnancy. Strategies to help women adopt healthy habits and get health care before and during pregnancy can help prevent pregnancy complications. In addition, interventions to prevent unintended pregnancies can help reduce negative outcomes for women and infants.

Women's health before, during, and after pregnancy can have a major impact on infants' health and well-being. Women who get recommended health care services before they get pregnant are more likely to be healthy during pregnancy and to have healthy babies. Strategies to help pregnant women get medical care and avoid risky behaviors — like smoking or drinking alcohol — can also improve health outcomes for infants."

Source: US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2030. Pregnancy and Childbirth. Accessed October 12, 2021. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth.

Prenatal Care Beginning in the First Trimester

Locality	2016	2017	2018
Amherst County	81%	81%	88%
Appomattox County	87%	85%	86%
Campbell County	89%	87%	85%
Lynchburg City	84%	83%	84%
Pittsylvania County	81%	73%	67%
Service Area	**84%**	**82%**	**82%**
Virginia	**84%**	**80%**	**78%**

Table Source: Kids Count Data Center - VA Kids . Date of Table: 2020. Year(s) Measured: 2016 - 2018 . Retrieved from https://datacenter.kidscount.org/

Total Infant Deaths by Place of Residence 2017

Locality	Number of Infant Deaths				Rates per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Amherst County	4	3	1		12.6	11.5	20.4	
Appomattox County	2	1	1		10.8	6.5	34.5	
Campbell County	1		1		2.1		13.5	
Lynchburg City	5	3	2		4.3	4.2	5.2	
Pittsylvania County	1	1			2.0	2.7		
Virginia	**524**	**270**	**202**	**52**	**5.3**	**4.4**	**9.6**	**3.0**

Total Infant Deaths by Place of Residence 2018

Locality	Number of Infant Deaths				Rates per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Amherst County	2	2			5.8	7.5		
Appomattox County	2	1	1		10.4	6.5	28.6	
Campbell County	2	2			4.1	5.0		
Lynchburg City	7	4	3		6.2	5.5	8.6	
Pittsylvania County	6	2	4		12.3	5.6	38.8	
Virginia	**558**	**301**	**204**	**53**	**5.6**	**4.9**	**9.7**	**3.1**

Total Infant Deaths by Place of Residence 2019

Locality	Number of Infant Deaths				Rates per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Amherst County	5	3	1	1	16.8	12.6	17.9	500.0
Appomattox County	1	1			4.9	6.2		
Campbell County	2	2			4	4.7		
Lynchburg City	12	5	5	2	10.6	6.6	14.9	48.8
Pittsylvania County	3	2	1		5.8	5.1	9.5	
Virginia	**570**	**280**	**226**	**64**	**5.9**	**4.7**	**10.6**	**4.0**

Table Source: Virginia Department of Health, Division of Health Statistics. Date of Table: 2017 - 2019. Year(s) Measured: 2017 - 2019 . Retrieved from https://www.vdh.virginia.gov/data/

Number of Teen Births per 1,000 Population, 2013 - 2019

Locality	Teen Birth Rate	Black	Hispanic	White
Amherst County	20.10	24.31	*	19.37
Appomattox County	25.55	21.41	*	26.74
Campbell County	19.56	31.91	*	16.75
Lynchburg City	13.32	32.40	13.12	7.13
Pittsylvania County	20.48	25.27	*	19.04
Virginia	**16.27**	**23.40**	**31.16**	**12.20**

Note: '*' indicates insufficient data

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2013 - 2019. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Birth Rate Per 1,000 Population

Locality	2017				2018				2019			
	Total	White	Black	Other	Total	White	Black	Other	Total	White	Black	Other
Amherst County	10.1	10.5	7.8	17.3	10.8	10.8	9.3	32	9.4	9.7	8.8	3.7
Appomattox County	11.9	12.3	9.2	37	12.1	12.2	11	34.8	12.8	12.7	12.2	33.1
Campbell County	8.8	8.7	8.8	14.2	8.9	8.8	8.9	12.3	9.1	9.4	7.9	7.7
Lynchburg City	14.4	13.3	16.1	21.7	13.8	13.1	14.4	20.3	13.8	13.6	14	14.5
Pittsylvania County	8.2	7.7	8.7	40.4	8	7.6	7.7	48.6	8.5	8.5	7.9	22.8
Service Area	10.7	10.5	10.1	26.1	10.7	10.5	10.3	29.6	10.7	10.8	10.2	16.4
Virginia	11.8	10.1	12	25.6	11.7	10.2	11.8	24.4	11.4	9.9	12	22.9

Table Source: Virginia Department of Health, Division of Health Statistics. Date of Table: 2017 - 2019. Year(s) Measured: 2017 - 2019 . Retrieved from https://www.vdh.virginia.gov/data/

Resident Low Weight Births by Percent of Total Live Births

Locality	2017				2018				2019			
	Total	White	Black	Other	Total	White	Black	Other	Total	White	Black	Other
Amherst County	9.7	9.2	14.3		6.7	6.4	10.2		7.7	7.1	10.7	
Appomattox County	5.9	3.9	17.2		12.5	9.8	25.7		8.4	5	23.7	
Campbell County	7.4	5.8	16.2	7.7	8.8	7	20		6.2	4.9	14.7	
Lynchburg City	9	6.5	14	6.3	7.6	4.8	13.8	4.9	8	5.4	13.4	9.8
Pittsylvania County	9.1	6.3	17.1	13	8.8	5.6	19.4	10.7	8	5.6	16.2	15.4
Service Area	8.2	6.3	15.8	9.0	8.9	6.7	17.8	7.8	7.7	5.6	15.7	12.6
Virginia	8.4	6.7	13.5	8	8.2	6.7	13.7	7.2	8.4	6.7	13.5	7.9

Table Source: Virginia Department of Health, Division of Health Statistics. Date of Table: 2017 - 2019. Year(s) Measured: 2017 - 2019 . Retrieved from https://www.vdh.virginia.gov/data/

PHYSICAL ENVIRONMENT

"The neighborhoods people live in have a major impact on their health and well-being. Healthy People 2030 focuses on improving health and safety in the places where people live, work, learn, and play.

Many people in the United States live in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. Racial/ethnic minorities and people with low incomes are more likely to live in places with these risks. In addition, some people are exposed to things at work that can harm their health, like secondhand smoke or loud noises.

Interventions and policy changes at the local, state, and federal level can help reduce these health and safety risks and promote health. For example, providing opportunities for people to walk and bike in their communities — like by adding sidewalks and bike lanes — can increase safety and help improve health and quality of life."

Source: Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Healthy People 2030. Accessed July 9th, 2021. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment

Water Quality

"My Water's Fluoride (MWF) allows people to learn about their community's drinking water fluoridation levels. MWF also provides information on the number of people served by the water system, the water source, and if the water system fluoridates its water supply. The U.S. Department of Health and Human Services recommends a level of 0.7 milligrams per Liter (mg/L) of fluoride in your drinking water. This is the level that prevents tooth decay and promotes good oral health."

Source: CDC. My Water's Fluoride. Accessed July 9th, 2021. Retrieved from: https://nccd.cdc.gov/doh_mwf/Default/AboutMWF.aspx

Public Water System Name	County	Population Served	Fluoridated	Fluoride Conc. Mg/L
AMHERST CO. SERVICE AUTHORITY (ACSA)	Amherst	12871	Yes	0.7
AMHERST, TOWN OF	Amherst	2070	Yes	0.7
ORCHARD HILLS ESTATES	Amherst	66	No	0.2
WOODLAND MOBILE HOME PARK	Amherst	93	No	0.2
APPOMATTOX WATER SYSTEM	Appomattox	1664	Yes	0.7
PAMPLIN CITY, TOWN OF	Appomattox	189	No	0.2
PINEVIEW ESTATES	Appomattox	25	No	0.2
501 TRAILER COURT	Campbell	274	No	0.2
ALTAVISTA, TOWN OF	Campbell	3639	Yes	0.7
BROOKNEAL, TOWN OF	Campbell	1418	Yes	0.7
CAMPBELL COUNTY CENTRAL SYSTEM	Campbell	20566	Yes	0.7
CAMPBELL COUNTY EAST SYSTEM	Campbell	2367	Yes	0.7
CASTLE CRAIG SUBDIVISION	Campbell	74	No	0
EASTBROOK MOBILE HOME COURT	Campbell	91	No	0.2
KNOLL WOODS/IVY ACRES	Campbell	236	No	0.2

Public Water System Name	County	Population Served	Fluoridated	Fluoride Conc. Mg/L
LAKESIDE MOBILE HOME PARK	Campbell	35	No	0
LOCUST GARDENS MHP	Campbell	85	No	0.2
MOUNTAIN REST ESTATES	Campbell	142	No	0.2
RUSTBURG CORRECTIONAL UNIT #9	Campbell	134	No	0.2
SUBURBAN TRAILER TOWN	Campbell	189	No	0.2
LYNCHBURG, CITY OF	Lynchburg City	76547	Yes	0.7
BEVRICH MOBILE HOME PARK	Pittsylvania	59	No	0.2
CACSADE MOBILE ESTATES	Pittsylvania	95	No	0
CHATHAM, TOWN OF	Pittsylvania	2363	Yes	0.7
CRESTVIEW TRAILER COURT	Pittsylvania	38	No	0
GRETNA, TOWN OF	Pittsylvania	2363	Yes	0.7
GRIT ROAD WATER SUPPLY	Pittsylvania	198	Yes	0.7
HILLCREST MOBILE HOME PARK	Pittsylvania	74	No	0.47
HURT, TOWN OF	Pittsylvania	1229	Yes	0.7
MOUNT CROSS ROAD PCSA	Pittsylvania	193	Yes	0.7
MOUNT HERMON PCSA	Pittsylvania	4314	Yes	0.7
RINGGOLD INDUSTRIAL PARK - PCSA	Pittsylvania	405	Yes	0.7
ROBIN COURT SUBDIVISION PCSA	Pittsylvania	38	No	0.2
ROUTE 58 WEST - PCSA	Pittsylvania	1191	Yes	0.7
RT. 29 NORTH - PCSA	Pittsylvania	1801	Yes	0.7
TIGHTSQUEEZE - PCSA	Pittsylvania	198	Yes	0.7
VISTA POINTE LANDING PCSA	Pittsylvania	122	No	0.2
WAYSIDE ACRES SUBDIVISION # 1	Pittsylvania	58	No	0.2
WAYSIDE ACRES SUBDIVISION # 2	Pittsylvania	45	No	0.2
WEST GRETNA ROAD ROUTE 40 PCSA	Pittsylvania	24	Yes	0.7
WOODROAM SUBDIVISION	Pittsylvania	76	No	0.2

Table Source: Centers for Disease Control. Date of Table: 2018. Year(s) Measured: 2016 - 2018. Retrieved from https://nccd.cdc.gov/doh_mwf/Default/Default.aspx

Housing Problems

"Good health depends on having homes that are safe and free from physical hazards. When adequate housing protects individuals and families from harmful exposures and provides them with a sense of privacy, security, stability and control, it can make important contributions to health. In contrast, poor quality and inadequate housing contributes to health problems such as infectious and chronic diseases, injuries and poor childhood development."

Source: Robert Wood Johnson Foundation. Community Health Rankings. Accessed July 9th, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-transit/severe-housing-problems

Percentage of Households with Severe Problems

Locality	2011-2015	2012-2016	2013-2017
Amherst County	12.2	12.8	12.3
Appomattox County	13.0	12.5	10.9
Campbell County	11.5	10.5	10.4
Lynchburg City	20.3	18.5	17.8
Pittsylvania County	11.9	11.6	11.3
Service Area	**13.8**	**13.2**	**12.5**
Virginia	**15.2**	**14.9**	**14.6**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2016 - 2018. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Note: Housing Problems include overcrowding, high housing costs, or lack of kitchen or plumbing facilities.

Residential Segregation

"Although most overtly discriminatory policies and practices promoting segregation, such as separate schools or seating on public transportation or in restaurants based on race, have been illegal for decades, segregation caused by structural, institutional, and individual racism still exists in many parts of the country. The removal of discriminatory policies and practices has impacted acts of racism, but has had little effect on structural racism, like residential segregation, resulting in lingering structural inequalities. Residential segregation is a key determinant of racial differences in socioeconomic mobility and, additionally, can create social and physical risks in residential environments that adversely affect health. Although this area of research is gaining interest, structural forms of racism and their relationship to health inequities remain under-studied.

Residential segregation remains prevalent in many areas of the country and may influence both personal and community well-being. Residential segregation of Black and White residents is considered a fundamental cause of health disparities in the US and has been linked to poor health outcomes, including mortality, a wide variety of reproductive, infectious, and chronic diseases, and other adverse conditions. Structural racism is also linked to poor-quality housing and disproportionate exposure to environmental toxins. Individuals living in segregated neighborhoods often experience increased violence, reduced educational and employment opportunities, limited access to quality health care and restrictions to upward mobility."

Source: County Health Rankings. Residential segregation. Accessed July 9th, 2021. Retrieved from: https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/social-and-economic-factors/family-social-support/residential-segregation-blackwhite

Residential Segregation Index, 2016–2018

Locality	Segregation Index
Amherst County	18
Appomattox County	7
Campbell County	22
Lynchburg City	35
Pittsylvania County	17
Virginia	**41**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: . Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Note: The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation).

Violent Crime Reported Offenses Rate per 100,000 Population

Locality	2014 & 2016
Amherst County	133
Appomattox County	114
Campbell County	199
Lynchburg City	423
Pittsylvania County	81
Service Area	**190**
Virginia	**207**

Table Source: County Health Rankings. Date of Table: 2021. Year(s) Measured: 2014 & 2016. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Domestic Violence

Domestic Violence also referred as "intimate partner violence (IPV) is abuse or aggression that occurs in a romantic relationship. "Intimate partner" refers to both current and former spouses and dating partners. IPV can vary in how often it happens and how severe it is. It can range from one episode of violence that could have lasting impact to chronic and severe episodes over multiple years. IPV is connected to other forms of violence and is related to serious health issues and economic consequences.

IPV affects millions of people in the United States each year. Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS) indicate:

- About 1 in 4 women and nearly 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact.
- Over 43 million women and 38 million men have experienced psychological aggression by an intimate partner in their lifetime.
- About 11 million women and 5 million men who reported experiencing contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime said that they first experienced these forms of violence before the age of 18."

Source: Centers for Disease Control and Prevention. Violence Prevention. Preventing Intimate Partner Violence. Accessed October 24, 2021. Retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html.

Domestic violence prevention programs are federal- and state-funded public or private, non-profit agencies that provide services to survivors of domestic violence and their children. Local domestic violence programs provide for the safety of battered adults and their children through the provision of emergency housing and transportation, crisis intervention, peer counseling, support, advocacy and information and referral. Funding also supports public awareness initiatives and the statewide Family Violence and sexual assault hotlines. In Virginia, the Domestic Violence Program is administered by the Virginia Department of Social Services which identifies, mobilizes, and monitors resources for victims of domestic violence. Close to 60,000 women and children are served annually across the Commonwealth.

Source: Commonwealth of Virginia. Virginia Department of Social Services. Domestic Violence. Accessed October 25, 2021. Retrieved from https://www.dss.virginia.gov/family/domestic_violence/index.cgi.

In 2021, the World Population Review cited that domestic violence against women in Virginia is 31.30% and 22.10% against men.

Source: World Population Review. Domestic Violence by State 2021. Accessed October 25, 2021. Retrieved from https://worldpopulationreview.com/state-rankings/domestic-violence-by-state.

In the Lynchburg region, the YWCA of Central Virginia's Domestic Violence Prevention Program's helps women, children, men, and families recover from abuse, resolve personal conflicts, improve self-esteem, and begin new lives. The primary feature of this program is two Virginia Sexual and Domestic Violence Action Alliance (VSDVAA) certified shelters as well as a hotline, referrals, and advocacy services. The shelters are in private, secure, and confidential places in both the City of Lynchburg and the Town of Altavista. YWCA Central Virginia serves the counties of Amherst, Appomattox, Bedford, Campbell, and Nelson and the city of Lynchburg. They reported the following statistics for 2018-2020:

YWCA of Centra Virginia Domestic Violence Prevention Center 2018-2020

		2018	2019	2020
Hotline	Arranged Emergency Transportation	223	71	72
	Counseling/Support	5058	4779	6370
	Criminal Justice Information Support	4333	3816	3476
	Crisis Intervention	2932	3269	3769
	Information & Referral	6005	5546	6900
	Safety Planning, including Legal Protections	5865	5393	6091
Shelter Services	Total All Shelter Provided	6144	5014	3748
Advocacy Service for Adults	Total Number of Adult Family Violence Victims Served	898	984	768
	Race/Ethnicity of Victim/Survivor (Victims may identify with more than one race)			
	African American/Black	294	308	183
	Asian/Pacific Islander	5	10	5
	Caucasian	565	631	558
	Hispanic/Latino	30	25	12
	Native American/Alaskan	0	4	5
	Other	5	16	11
	Primary Concerns for Victim on Initial Contact			
	1. Safety (feeling unsafe, threatened, or in danger of physical or emotional harm)	790	824	579
	2. Physical well-being (activity level, stress level, health issues/symptoms, sleep and eating patterns)	442	537	477
	3. Support/relationships (trust, relationships, within the community, family & friends)	262	402	279
	Advocacy Services Provided			
	Crisis Intervention	431	599	472
	Safety Planning Other	412	227	240
	Services to Address Basic Needs	646	667	483
	Transportation	87	66	91
	Legal Advocacy Services			
	Accompaniment Services -Civil	517	472	274
	Accompaniment Services -Criminal	103	121	176
	Accompaniment Services -Forensic Exam	13	7	1
	Assistance Filing a Family Abuse EPO/PPO (Juvenile and Domestic Court)	376	394	223
	Family Abuse EPO/PPO Petition Awarded	378	381	220
	Family Abuse EPO/PPO Petition Denied	5	6	13

Advocacy Service for Children	Total Number of Child Family Violence Victims Served	112	147	121
	Race/Ethnicity of Victim/Survivor (Victims may identify with more than one race)			
	African American/Black	56	45	26
	Asian/Pacific Islander	0	0	0
	Caucasian	40	73	86
	Hispanic/Latino	4	8	1
	Native American/Alaskan	0	2	0
	Other	12	21	11
	Advocacy Services Provided			
	Child Care	86	68	21
	Counseling/Support	92	128	111
	Crisis Intervention	35	53	58
	Safety Planning Other	80	67	32
	Services to Address Basic Needs	89	119	78

Source: YWCA Central Virginia. Annual Reports 2018-2020. Data provided by YWCA Central VA on October 14, 2021. Website: https://www.ywcacva.org/

Staff reported that the COVID-19 pandemic in 2020 created a perfect storm in terms of utilization of domestic violence services at YWCA of Central Virginia. The "Total Number of Adult and Child Family Violence Victims" served decreased as did many of the "Advocacy Services" while "Hotline" services rose. Anecdotally, several factors seemed to impact this trend. With a stay-at-home order, the victims, their abusers, and children were all at home. It made it difficult for the victims to reach out for support with the abuser present. Many avoided staying in shelters due to fear of contracting COVID-19 and stayed at home waiting to receive stimulus checks so that they had the financial resources to leave. In addition, many assumed the YWCA was closed, like many of the other social services early in the pandemic, when in fact their doors never closed. To counteract this perception, the YWCA began a marketing campaign messaging that they were open for business which increased service provision. Finally, the "Total All Shelter Provided" (total number of bed nights in shelter) dropped significantly in 2020 with the passage of CARES Act funding and dollars allocated to the Central Virginia Continuum of Care for rapid rehousing which was used for victims and their children in shelter.

Haven of the Dan River Region serves Pittsylvania County and the city of Danville by raising awareness about domestic violence and sexual assault, providing services to meet the needs of victims, and providing a safe shelter for victims and their children. In addition to providing shelter, services include Intimate Partner Violence Advocacy, Sexual Violence Advocacy, Support Groups, a Crisis Line, and Community Education. They reported the following statistics for 2019 and 2020:

Haven of Dan River Region Domestic Violence Program Report

	2019	2020
Hotline Services		
Total number of hotline services (unduplicated)	281	183
Shelter Services		
Shelter Services (due to DV)- Total Adult	31	19
Shelter Services (due to DV)- Total Child	21	15
Total All People Sheltered (due to DV)	52	34
Nights of Shelter Provided to Adults	866	935
Nights of Shelter Provided to Children	583	581
Total Nights of Shelter	*1449	*1516
Advocacy Services for Adults		
Total Number of Adult Family Violence Victims Served	58	68
Total Number of Adult Service Contacts	2055	1644
Advocacy Services for Children		
Total Number of Child Family Violence Victims Served	27	23
Total Number of Child Service Contacts	517	404

**Includes program shelter in 2019; program shelter and hotel room in 2020*

In 2020, they experienced a decrease in the number of "Shelter Services (due to Domestic Violence)" for adults and children served however there was an increase in "Total Nights of Shelter" and "Advocacy Services" for adults as compared to 2019. They report the greatest impact of the COVID-19 pandemic on their clients was an increase in calls requesting financial assistance and an increase in hotel accommodations due to the need for social distancing in their program shelter.

Source: Haven of the Dan River Region. Virginia Sexual and Domestic Violence Action Alliance VAdata reports 2019-2020. Data provided by Haven of Dan River Region October 25, 2021. Retrieved from https://havenofthedanriverregion.org/

Household Internet Access

Percentage of Households with Broadband Internet Connection, 2015 - 2019

Locality	Percent Broadband Access
Amherst County	69
Appomattox County	69
Campbell County	73
Lynchburg City	80
Pittsylvania County	72
Service Area	73
Virginia	84

Table Source: County Health Rankings. Date of Table: 2020. Year(s) Measured: 2015 - 2019. Retrieved from https://www.countyhealthrankings.org/app/virginia/2021/downloads

Commuting Patterns

Commuting Patterns by County of Residence

Locality	Worked in county of residence	Worked outside county of residence
Amherst County	35.9%	63.7%
Appomattox County	30.6%	69.1%
Campbell County	39.1%	60.5%
Lynchburg City	76.7%	22.2%
Pittsylvania County	38.5%	56.0%
Service Area	44.2%	54.3%
Virginia	48.5%	42.8%

Table Source: U.S. Census, ACS. COMMUTING CHARACTERISTICS BY SEX, Table S0801. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

"To say that the novel coronavirus (COVID-19) pandemic has changed the world would be an understatement — it's upended day-to-day lives across the globe. The pandemic has changed how we work, learn and interact as social distancing guidelines have led to a more virtual existence, both personally and professionally. Unsurprisingly, the pandemic has triggered a wave of mental health issues. Whether it's managing addiction, depression, social isolation or just the general stress that's resulted from COVID-19, we're all feeling it. It seems to especially be hitting younger people. Of those surveyed in an Ipsos poll, 55% reported experiencing mental health issues since the onset of the pandemic, including 74% of respondents in the 18-to-34-year-old age range. While much of the world has come to a stop at times during the pandemic, the need for health care has not. Yet, 38% of respondents to the poll commissioned by the Cleveland Clinic said they skipped or delayed preventive health care visits because of the pandemic even though health care providers have gone to great lengths to ensure that keeping those appointments are safe for everyone. Despite these concerns and the difficulties faced throughout the pandemic, those who responded to the survey also showed that they've managed to find positives in their experiences. Overall, 78% of those surveyed said that while quarantine and social distancing was difficult, it's made them value their relationships. Meanwhile, 65% said the pandemic has made them reevaluate how they spend their time and 58% said it's made them reevaluate their life goals. And while 58% say that the pandemic has changed their way of life forever, nearly three-quarters (72%) said that they still have hope for the future."

Source: Cleveland Clinic. Healthessentials. Here's How the Coronovirus Has Changed Our Lives. September 2020. Retrieved October 12, 2021 from https://health.clevelandclinic.org/heres-how-the-coronavirus-pandemic-has-changed-our-lives/

Cases, Hospitalizations and Death Rates

Since January 2020, there have been over 44,401,209 cases of COVID-19 reported in the United States at a case rate of 13,374 per 100,000 and sadly over 714,243 deaths. States with the highest case rates currently include Arkansas, Tennessee, Mississippi, Alabama, South Carolina, Florida, Wyoming, Rhode Island, North Dakota, and South Dakota. Tennessee case rates are the highest in the country at 18,360 per 100,000. Virginia ranks 44th in the nation.

Source: Centers for Disease Control and Prevention. COVID Data Tracker. Data as of October 12, 2021. Retrieved at https://covid.cdc.gov/covid-data-tracker/#cases_casesper100k

Since January 1, 2021, more than 353,000 deaths have been reported from COVID-19, about a thousand more than in the first 10 months of the pandemic in 2020 (352,000). There are key differences that may account for these changes, including the spread of the highly contagious delta variant, the lack of herd immunity due to low vaccination rates, and no widespread lockdowns as in the previous year.

The United States has experienced two significant surges since the start of the pandemic, one in January 2021 (after the holiday season) and before vaccinations were widely available in the Spring of 2021. A second wave hit in late summer of 2021. The first surge impacted primarily the elderly or medically vulnerable while the second wave became the pandemic of the unvaccinated. Experts agree that to prevent yet another surge, vaccination rates across the nation must improve.

Source: New York Daily News. More in US have died in 2021 from COVID-19 than 2020, Johns Hopkins data show. Accessed October 13, 2021. Retrieved from https://www.nydailynews.com/coronavirus/ny-covid-more-deaths-2021-than-in-2020-johns-hopkins-coronavirus-20211006-2fpfjpomqzflnkpjgqtxf6mioy-story.html.

"Currently, the Delta variant is the only variant classified as a Variant of Concern (VOC) in the United States. There are no variants classified as a Variant of Interest (VOI) and there are 10 variants classified as Variants Being Monitored (VBM). VBM do not pose a significant and imminent risk to public health in the United States due to their very low prevalence, which is currently estimated to be less than 0.1%.

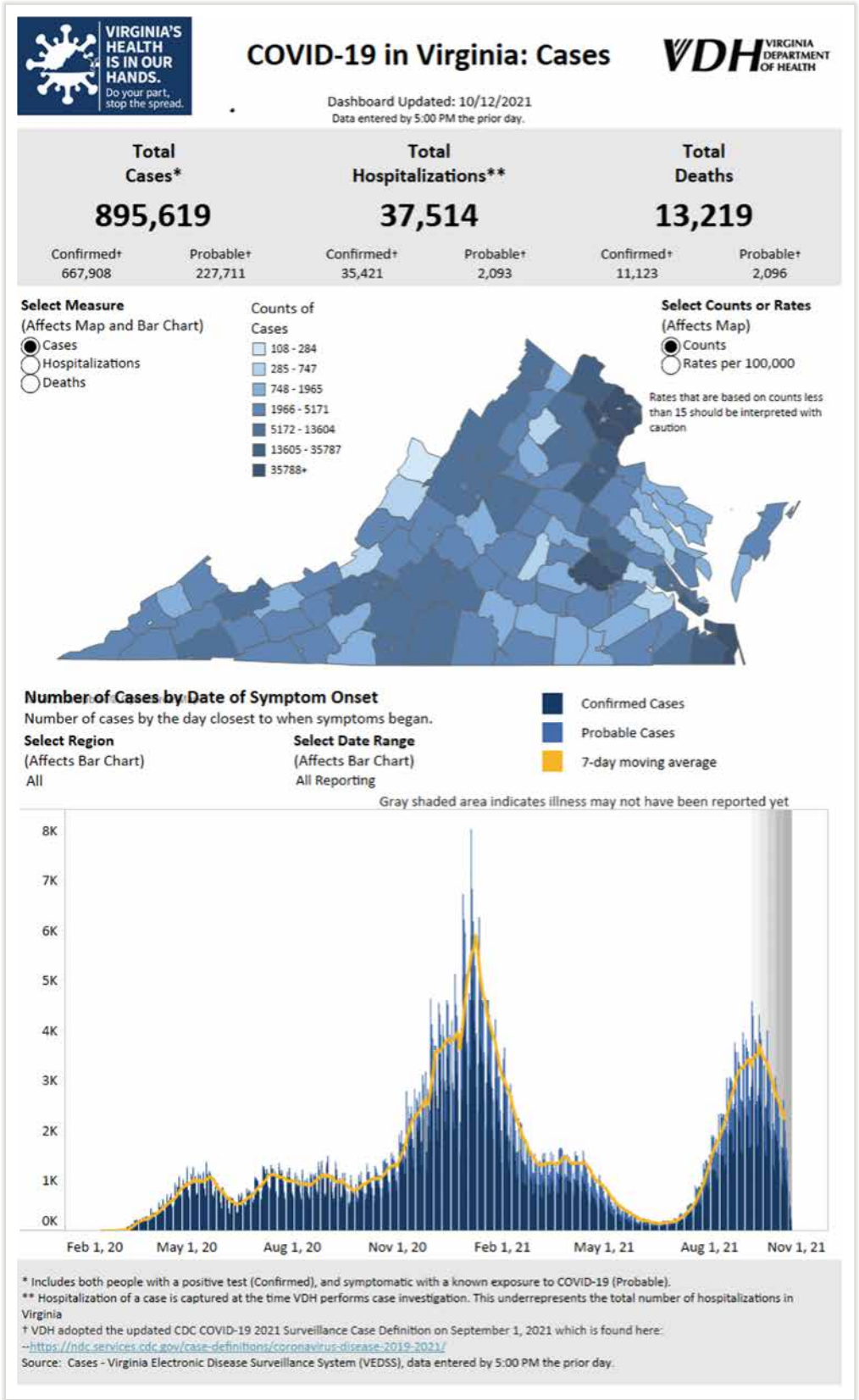
The Center for Disease Control and Prevention (CDC) Nowcast projections for the week ending October 2, 2021, estimate the national proportion of the Delta variant to be greater than 99%. Nowcast estimates indicate that Delta will continue to be the predominant variant circulating in all 10 U.S. Department of Health and Human Services (HHS) regions, circulating at greater than 99%."

Source: Centers for Disease Control and Prevention. COVID Data Tracker Weekly Review. Data as of October 8, 2021. Retrieved October 12, 2021 from https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html.

In a study conducted in Canada, the Delta variant has a 108% increase in the risk of hospitalization, a 235% increase rick of ICU admissions, and a 133% higher risk of death, compared with the original variant.

Source: MedicalNewsToday. Delta variant has 235% higher risk of ICU admission than original virus. October 8, 2021. Retrieved at https://www.medicalnewstoday.com/articles/delta-variant-has-235-percent-higher-risk-of-icu-admission-than-original-virus

The following graphic summarizes Virginia's cases, total hospitalizations and total deaths since February 2020. The "Number of Cases by Date of Symptom Onset" show two surges in cases that have occurred throughout the Commonwealth from November 2020 to February 2021 and then again from August 2021 to present. These surges reflect similar spikes in cases seen across the United States during approximately the same time period. During the first surge, the VOC's included the Alpha, Beta, and Gamma strains however the most recent surge is largely attributed to the Delta variant.



Graph: Virginia Department of Health, Division of Health Statistics. Updated October 12, 2021. Retrieved from https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-cases/

COVID-19 Cases, Hospitalizations & Deaths by Locality, updated October 7, 2021

Locality	Cases		Hospitalizations		Deaths	
	Total Count	Rate per 100,000	Total Count	Rate per 100,000	Total Count	Rate per 100,000
Amherst County	4,134	13,055	204	644	53	167
Appomattox County	2,265	14,298	105	663	34	215
Campbell County	6,734	12,250	308	560	127	231
Lynchburg City	11,256	13,706	436	531	174	212
Pittsylvania County	7,541	12,373	332	545	101	166
Service Area Total	31,930	-	1,385	-	489	-
Virginia	877,090	10,338	36,913	*-	12,908	152

*Virginia hospitalization rates were not publicly available at the time of this writing.

Table: Virginia Department of Health, Division of Health Statistics. Updated October 7, 2021. Retrieved from https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-cases/

In the Lynchburg region, there have been a reported 31,930 cases (3.6% of Virginia cases) since the start of the pandemic. All localities case rates are higher than the rate in Virginia led by Appomattox County with a rate of 14,298 per 100,000. In the region there have been 1,385 hospitalizations (3.8% of Virginia hospitalizations). As with case rates, the highest hospitalization rate is seen in Appomattox County. The region has experienced 489 total deaths due to COVID-19 with regional death rates higher than the rate in the Commonwealth as a whole.

Racial and Ethnic Disparities

"Racial and ethnic health disparities illuminate areas where significant health and disease inequity exists. Unfortunately, these disparities exist far too often in the United States and Virginia, and this is no different for key measures of the COVID-19 pandemic. Disparities in COVID-19 case, death and vaccination rates have been demonstrated in the United States and have been particularly unfavorable to Hispanic and Black populations. Life expectancy in the United States is projected to be reduced at least 3 times more for Hispanic and Black populations than for White populations as a result of COVID-19, wiping out ten years of progress in bridging the life expectancy gap between White and Black Americans. But opportunities exist as there is both an abundance of data being collected about and resources being directed to addressing COVID-19 and its complications. By recognizing these disparities and prioritizing strategies to address them, overall population health and that of the most at-risk subpopulations can be improved."

Source: Virginia Department of Health. COVID-19 Disparities by Race and Ethnicity in Virginia. March 8th 2021. Accessed July 9th, 2021. Retrieved from: https://www.vdh.virginia.gov/coronavirus/2021/03/08/covid-19-disparities-by-race-and-ethnicity-in-virginia/

Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity

Updated Sept. 9, 2021 Print

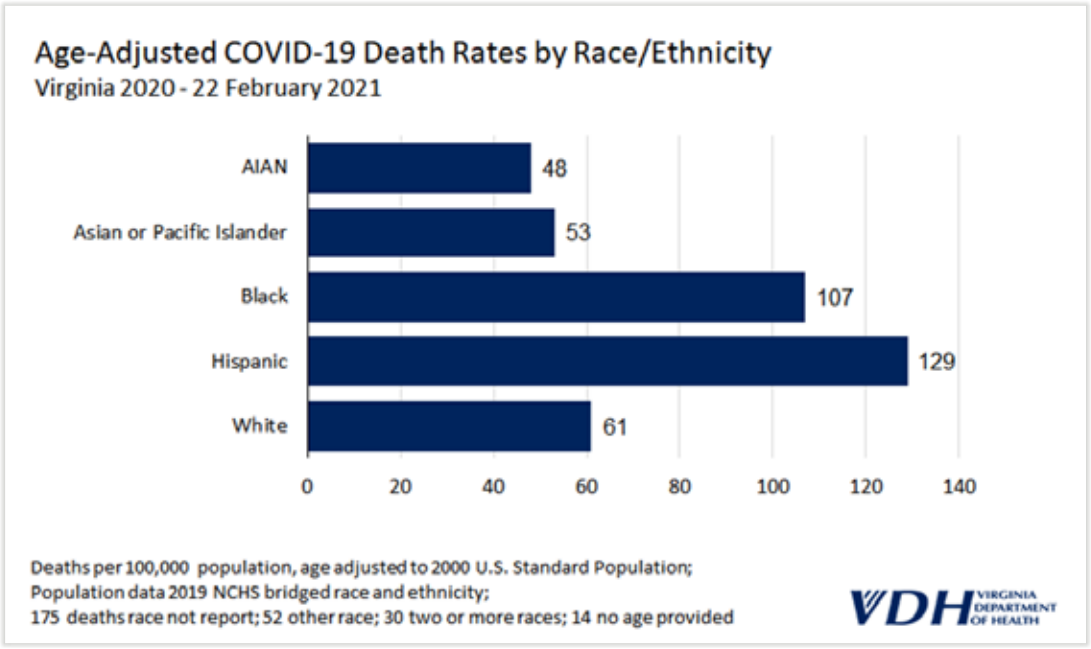
Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	1.7x	0.7x	1.1x	1.9x
Hospitalization[2]	3.5x	1.0x	2.8x	2.8x
Death[3]	2.4x	1.0x	2.0x	2.3x

Graph Source(s): Center for Disease Control and Prevention. Data & Surveillance. Special Populations Data: Hospitalization and Death by Race/Ethnicity. Date source was updated: September 9, 2021. Retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

It is important to note that these ratios of age-adjusted rates standardized to the 2019 U.S. intercensal population estimate. Calculations use only the 65% of case reports that have race and ethnicity; this can result in inaccurate estimates of the relative risk among groups.

Please note: this was the most up-to-date graphic for "Age-Adjusted COVID-19 Death Rates by Race/Ethnicity" for the state of Virginia as of October 12, 2021.

Graph Source(s): Virginia Department of Health, Division of Health Statistics. Year(s) Measured: 2020 – Feb 2021. Retrieved from https://www.vdh.virginia.gov/coronavirus/2021/03/08/covid-19-disparities-by-race-and-ethnicity-in-virginia/



COVID-19 Cases by Race and Health District — Central Virginia Health District as of October 12, 2021

Race/Ethnicity	Cases	%	Hospitalizations	%	Deaths	%
Asian or Pacific Islander	228	1%	5	0%	0	0%
Black	4062	12%	288	20%	96	18%
Latino	585	2%	22	2%	6	1%
Native American	72	0%	2	0%	3	1%
Other Race	250	1%	5	0%	0	0%
Two or More Races	220	1%	4	0%	0	0%
White	18157	53%	904	62%	425	79%
Not Reported	10937	32%	226	16%	9	2%
Total	**34511**	**100%**	**1456**	**100%**	**539**	**100%**

COVID-19 Cases by Race and Health District — Pittsylvania-Danville Health District as of October 12, 2021

Race/Ethnicity	Cases	%	Hospitalizations	%	Deaths	%
Asian or Pacific Islander	48	0%	1	0%	0	0%
Black	3832	28%	286	42%	84	30%
Latino	366	3%	10	1%	1	0%
Native American	23	0%	3	0%	1	0%
Other Race	43	0%	1	0%	0	0%
Two or More Races	52	0%	1	0%	0	0%
White	6293	46%	356	52%	190	68%
Not Reported	3172	23%	31	4%	3	1%
Total	**13829**	**100%**	**689**	**100%**	**279**	**100%**

COVID-19 Cases by Race and Health District — Virginia- Total as of October 12, 2021

Race/Ethnicity	Cases	%	Hospitalizations	%	Deaths	%
Asian or Pacific Islander	31342	3%	1532	4%	463	4%
Black	169476	19%	10760	29%	3269	25%
Latino	105612	12%	5342	14%	790	6%
Native American	1354	0%	59	0%	30	0%
Other Race	25557	3%	694	2%	69	1%
Two or More Races	9376	1%	235	1%	3	0%
White	405133	45%	17973	48%	8490	64%
Not Reported	147769	16%	919	2%	105	1%
Total	**895619**	**100%**	**37514**	**100%**	**13219**	**100%**

Note: Central Virginia Health District is defined by VDH as Amherst, Appomattox, Bedford, Campbell counties and Lynchburg city. Pittsylvania – Danville is defined as Pittsylvania and Danville Counties.

Table Source(s): Virginia Department of Health, Division of Health Statistics. Dashboard updated 10/12/21. Retrieved from https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-demographics/

When comparing percentages of cases, hospitalizations, and deaths, the Central Virginia Health District had a higher percentage of whites and the Pittsylvania-Danville Health District had a higher percentage of Blacks impacted by COVID-19 as compared to Virginia as a whole.

Community Transmission Rates

Community transmission rates tracks how much COVID-19 is spreading as well as how likely people are to be exposed to it and can be used as a guidance on masking in localities. They are measured as follows:

- Total new cases refers to a county's rate of new COVID-19 infections, reported over the past 7 days, per every 100,000 residents. To calculate this number, CDC divides the total number of new infections by the total population in that county. CDC multiplies this number by 100,000.
- Percent positivity refers to the percentage of positive COVID-19 tests in a county over the past 7 days. This number is based on reports from states on a specific type of test known as a Nucleic Acid Amplification Test (NAAT). To calculate this number, CDC divides the number of positive tests by the total number of NAATs performed in that county. CDC multiplies this number by 100 to calculate the percentage of all tests that were positive.

A higher number of total new cases and a higher percent positivity correspond with a higher level of community transmission. If the values for each of these two metrics differ (for example, if one indicates moderate and the other low), then the higher of the two should be used to make decisions about mask use in a county.

Source: Centers for Disease Control and Prevention. COVID-19. COVID-19 County Check Tool: Understanding Transmission Levels in Your County. Accessed October 12, 2021. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/more/aboutcovidcountycheck/index.html.

COVID-19 Community Transmission Rates

Locality	*Transmission Level*	*Rate of new cases per 100,000*	*% of PCR tests that are positive*	*Week of Report Date*
Amherst County	High	256.3	10.40%	9/26/21-10/2/21
Appomattox County	High	458.8	19.0%	9/26/21-10/2/21
Campbell County	High	320.7	19.0%	9/26/21-10/2/21
Lynchburg City	High	348.1	12.7%	9/26/21-10/2/21
Pittsylvania County	High	425.8	19.6%	9/26/21-10/2/21
Virginia Total	**High**	**262.9**	**8.6%**	**9/26/21-10/2/21**

Table Source(s): Virginia Department of Health, Division of Health Statistics.
Dashboard updated 10/12/21. Retrieved from https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-demographics/

County transmission rates are high in the Lynchburg service and in Virginia as a whole, however we are beginning to see a downward turn in these rates as of this writing (October 12, 2021).

Vaccinations

"The U.S. COVID-19 Vaccination Program began December 14, 2020. As of October 7, 2021, 399.6 million vaccine doses have been administered. Overall, about 216.3 million people, or 65.1% of the total U.S. population, have received at least one dose of vaccine. About 186.6 million people, or 56.2% of the total U.S. population, have been fully vaccinated. About 6.4 million additional/booster doses in fully vaccinated people have been reported. As of October 7, 2021, the 7-day average number of administered vaccine doses reported (by date of CDC report) to CDC per day was 948,921, a 30.5% increase from the previous week.

As of October 7, 2021, 94.7% of people ages 65 years or older have received at least one dose of vaccine and 83.8% are fully vaccinated. More than three-quarters (78%) of people ages 18 years or older have received at least one dose of vaccine and 67.6% are fully vaccinated. For people ages 12 years or older, 76.2% have received at least one dose of vaccine and 65.8% are fully vaccinated."

Source: Centers for Disease Control and Prevention. COVID Data Tracker Weekly Review. Data as of October 8, 2021. Retrieved October 12, 2021 from https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html.

COVID-19 Vaccination Rates As of October 7, 2021

Locality	*% Fully Vaccinated*	*Vaccination Rate (per 100,000)*
Amherst County	45.8%	45,847
Appomattox County	42.6%	42,650
Campbell County	44.6%	44,621
Lynchburg City	40.5%	40,470
Pittsylvania County	42.7%	42,682
Virginia	**60.7%**	**Not available**

Source: Centers for Disease Control and Prevention. Rates of COVID-19 Cases and Deaths by Vaccination Status. Data as of October 7, 2021. Accessed October 12, 2021. Retrieved from https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status.

Based on the table above, the percentage of those who are fully vaccinated in the Lynchburg service region is lower as compared to Virginia as a whole. Vaccination rates per 100,000 were not available for the state of Virginia as of this writing (October 12, 2021).

"The U.S. Food and Drug Administration (FDA) has expanded the use of a COVID-19 vaccine booster dose. The CDC now recommends that everyone 18 years and older who received the Johnson & Johnson/Janssen COVID-19 vaccine two or more months from their initial dose can receive a booster vaccine. For people who received a Pfizer-BioNTech or Moderna COVID-19 vaccine, certain groups are now eligible for a booster dose at 6 months or more after their initial 2-dose series. This includes people ages 65 years and older, and people ages 18 years and older who live in long-term care settings, have underlying medical conditions, or live or work in high-risk settings.

Vaccination remains the best way to protect yourself. CDC's COVID Data Tracker shows that in August 2021, people who were unvaccinated were 11 times more likely to die from COVID-19 than people who were fully vaccinated. People who were unvaccinated were 12 times more likely to be hospitalized with COVID-19 compared to people who were fully vaccinated."

Source: Centers for Disease Control and Prevention. COVID Data Tracker Weekly Review. Interpretive Summary for October 29, 2021. Accessed October 31, 2021. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html.

Centra's Response

As with health systems across the United States, Centra mobilized efforts to address the impact of COVID-19 in its service region. In early March of 2020, an incident command system was set up and by late March the first COVID-19 patient was admitted to Lynchburg General Hospital. Personal Protective Equipment, especially N95 and surgical masks, were in short supply and testing capacity was limited with long turn-around times for results. Both Lynchburg General Hospital (LGH), Centra's flagship hospital in Lynchburg, and Southside Community Hospital (SCH) in Farmville, converted existing floors into COVID-19 units including dedicated Intensive Care Units. Modular units were initially set up outside LGH's and SCH's Emergency Departments to isolate possible COVID-19 patients and suspected COVID-19 positive patients who presented at Bedford Memorial Hospital (BMH) in Bedford were stabilized and diverted to LGH for acute, intensive care. As of this writing, the most critically ill COVID patients in the region continue to be transferred to LGH from SCH and BMH.

With the FDA's Emergency Use Authorization for Pfizer and Moderna vaccines in December of 2020, Centra led efforts to vaccinate our own caregivers and many providers and allied health professionals outside of the system (Phase 1a) due to our ultra-cold freezer capacity. By mid-January of 2021, Health Districts and retail pharmacies were able to store and distribute vaccines. Centra continued to support these efforts by partnering with their localities and health departments to staff mass vaccination clinics. As of November 1, 2021, to provide a safe working environment for all Centra caregivers, Centra is requiring that all caregivers be fully vaccinated against COVID-19 (medical and religious exemptions apply). This requirement aligns with Centra's longstanding influenza vaccine requirement.

Centra caregivers across the entire system have been hailed for their resiliency, courage, and ability to work together across our large geographic footprint, maximizing resources and supporting each other especially during our peak surge times. More than 1200 caregivers pivoted to working remotely while our frontline staff worked tirelessly to care for those who were critically ill. Communities served by Centra, looked to the health system for leadership and guidance. Regular communications and meetings were held with public schools, higher education institutions, local governments, health districts, and non-profit organizations to share the latest information regarding COVID-19 and its impact in the communities we serve. Many of these meetings continue today.

Data from our Enterprise Analytics for Lynchburg General Hospital paints an interesting picture of two waves of the pandemic, the first that impacted the elderly and medically vulnerable populations and the second that impacted largely the younger and healthier, unvaccinated patients infected by the highly virulent delta variant. This analysis uses encounter data with admit dates between 11/01/2020 and 10/10/2021. There are 2,228 patients in the dataset. Inpatient admissions are divided into two groups based on their admit dates. In the first wave, there were 1,486 patients with admit dates between 11/01/2020 and 7/12/2021 (data defined as "OLD"). In the second wave, 742 patients were admitted between 7/13/2021 and 10/10/2021 (data defined as "NEW").

The following observations highlight, the differences between the "NEW" and the "OLD" patients:

- Increase in White patients, 78.8% versus 69.6% with a decrease in Black/African American patients, 17.8% versus 27.7%.
- Increase in Married patients (50.9% versus 46.0%) while a decrease in Widowed patients (14.2% versus 20.6%).
- More patients between 30-59 years old, 39.9% versus to 23.5%.
- Increase in percentage of patients admitted to ICU, 10.7% versus 9.1%.
- Higher percentage of patients at any point in ICU (24.9% versus 20.1%) or on a ventilator (17.1% versus 14.9%).
    - With patients age 30-59, the percentages are more distinct.
        - ICU: 24.3% versus 17.5%
        - Ventilator: 16.2% versus 11.7%
- Large decreases in percentage of patients with the following documented comorbidities.
    - COPD: 5.8% versus 10.8%
    - Diabetes: 28.8% versus 45.5%
    - Obesity: 31.0% versus 35.7%
- Increase in the percentage of patients with BMI greater than 30.0 (57.2% versus 53.4%).

PRIORITIZATION OF NEEDS

Prioritization of Needs

Upon completion of primary and secondary data collection, the Lynchburg Area Community Health Assessment Team (CHAT) was charged with prioritizing the needs of the community. A detailed "Prioritization of Needs Worksheet" was developed based on the importance placed on areas of need identified through two methods:

1. **Responses from the Community Health Survey**
    a. Q2A: What do you think are the most important issues that affect health in our community? (Health Factors) (n= 4403 survey responses)
    b. Q2B: What do you think are the most important issues that affect health in our community? (Health Conditions or Outcomes) (n= 4374 survey responses)
    c. Q3: Which health care services are hard to get in our community? (n= 4325 responses)
    d. Q4. Which social/support resources are hard to get in our community? (n= 4227 responses)
2. 2. **Responses from the Stakeholders' Focus Group/ Survey**
    a. Q1. What are the top 5 greatest needs in the community(s) you serve? (n= 253 responses)

These responses were sorted in an Excel workbook and clustered together by "Area of Need" categories. Relevant responses to each question and how they were ranked (% of responses) were listed under the corresponding "Area of Need" categories. Altogether, there were 37 main priority areas of need identified. The detailed worksheet and list of 37 priority areas can be found in the Appendix.

On August 23, 2021, a virtual meeting was held to present a summary of the primary and secondary data to the CHAT members. Additionally, members received final drafts of the Community Health Survey, Stakeholders Focus Group/Survey, and Secondary Data prior to the meeting. After that meeting, from September 1, 2021 to September 10, 2021, CHAT members were asked to rank the top five priority areas of need (out of the 37 identified) in Survey Monkey, with 1 being the greatest need and 5 being the 5th greatest need. CHAT members were asked to use the data presented on August 23 and the detailed Prioritization of Needs Worksheet to help with their decision-making. The survey link and instructions on how to complete the prioritization of needs exercise were emailed to CHAT members. Forty-nine (49) CHAT members completed the prioritization of need survey.

Upon completion, the data was analyzed. In Survey Monkey, for ranking questions, the average ranking for each answer choice is calculated to determine which answer choice was most preferred overall. The answer choice with the largest average ranking (weighted score) is the most preferred choice. Weighted scores are applied in reverse of the ranking. For example, the respondent's most preferred choice (which they rank as #1) has the largest weight.

On September 13, 2021, the final CHAT meeting was held to present the 2021 Lynchburg Area Prioritization of Needs. The rankings and weighted scores for all 37 priority areas are presented in the following table. The shaded area in the table represents the top 10 rankings.

2021 Lynchburg Area Prioritization of Needs
All Priority Areas of Need- Ranking & Scoring

Ranking	Priority Area of Need	Score	Ranking	Priority Area of Need	Score
1	Access of Healthcare Services	34.68	20	Transportation	27.33
2	Mental Health and Substance Use Disorders & Access to Services	34.19	21	Dental Care & Dental Problems	26.88
3	Childcare	33.82	22	Health Education and Literacy	26.62
4	Poverty & Economic Assistance	33.82	23	Overweight/Obesity	26.4
5	Aging and Eldercare	33.62	24	End of Life Care and Services	21.57
6	COVID-19 Pandemic	33.18	25	Environmental Health	20.86
7	Housing	32.00	26	Families	20.33
8	Child Abuse/Neglect	31.50	27	Physical Activity	19.50
9	Banking/Financial Assistance	31.25	28	Social Isolation	18.64
10	Cancer Care	31.13	29	Maternal/Child Health	16.14
11	Chronic Disease	30.82	30	Safety and Violent Crime	15.71
12	Food Insecurity and Nutrition	30.42	31	Legal Services	13.83
13	Equity, Inclusion & Diversity	29.83	32	Technology	12.25
14	Employment / Job assistance	29.75	33	Outreach	10.33
15	Collaboration	29.63	34	Veterans Services	9.75
16	Education and Literacy	29.42	35	Vision Care	9.63
17	Domestic Violence	29.25	36	Unsafe Driving Practices	7.29
18	Accidents in the home	28.67	37	Sexual Health	6.83
19	Disability	27.9			
Total Responses					49

Based on the CHAT members feedback and consultation with Centra leadership, the following adjustments were made to the top 10 rankings.

- "Childcare" and "Child Abuse/Neglect" were grouped together under the title "Issues Impacting Children and their Families".
- "Poverty and Economic Assistance" was renamed to "Poverty" as "Economic Assistance" was redundant with "Banking/Financial Assistance".
- The "COVID-19 Pandemic" was removed as a Priority Area of Need. From a Centra and community perspective, the impact of the pandemic will continue to be an overarching factor and area of focus in the next three years. It was agreed that the majority of the highly ranked "Priority Areas of Need" have been, and will continue to be, impacted by the pandemic. As an overarching factor, the impact of COVID-19 will be addressed in the development of Implementation Plans both at the health system and community level.
- The Priority Area of Need "Banking/Financial Assistance" was renamed to "Financial Stability" however banking and financial assistance will still be addressed under this priority area.

- "Cancer Care" was collapsed into "Access to Healthcare Services". "Cancers" previously presented in the Detailed Worksheet under "Cancer Care" were grouped in with "Chronic Disease". Priority areas are reflective of the County Health Rankings' four categories for Health Factors including Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment. All these health factors are viewed through the lens of equity, inclusion, and diversity.

The following table presents the final Top 10 Priority Areas of Need for 2021 as compared to the priorities in 2018. New priority areas for 2021 include:

- Issues Impacting Children and their Families
  - o Childcare
  - o Child
- Aging and Eldercare
- Financial Stability
- Equity, Inclusion and Diversity

These rankings will be used by Centra, the Partnership for Healthy Communities and community leaders/stakeholders to develop Implementation Plans that will respond to these needs over the next three years.

Lynchburg Area Top 10 Priority Areas of Need 2018 and 2021 Compared

Ranking	*2018*	*2021*
1	Poverty	Access to Healthcare Services
2	Access to affordable health care & access to healthcare	Mental Health and Substance Use Disorders & Access to Services
3	Access to affordable housing	Issues Impacting Children and their Families: • Childcare • Child Abuse/Neglect
4	Access to healthy food	Poverty
5	Access to mental health services & mental health problems	Aging and Eldercare
6	Transportation	Housing
7	Substance use: alcohol & illegal drug use	Financial Stability
8	Overweight/Obesity	Chronic Disease
9	Diabetes	Food Insecurity and Nutrition
10	Poor Eating Habits	Equity, Inclusion & Diversity

COMMUNITY RESOURCES

Community Resources describe the available resources in the region that can be used to address "Priority Areas of Need" identified in the 2021 Lynchburg Area Community Health Needs Assessment.

Community Resources

A list of resources that includes organizations that currently address one or more of the top 10 Priority Areas of Need for the Lynchburg Area was developed in collaboration with United Way of Central Virginia's 2-1-1 Information and Referral system, from Stakeholder Focus Group responses and resource lists provided by service lines. This list will inform Centra and other community stakeholders about existing programs and resources when developing their implementation plans. The list of Community Resources can be found in the Appendix.

In addition to this resource list, the following highlights national, state and local policies and programs that address the 2021 Lynchburg Priority Areas of Need.

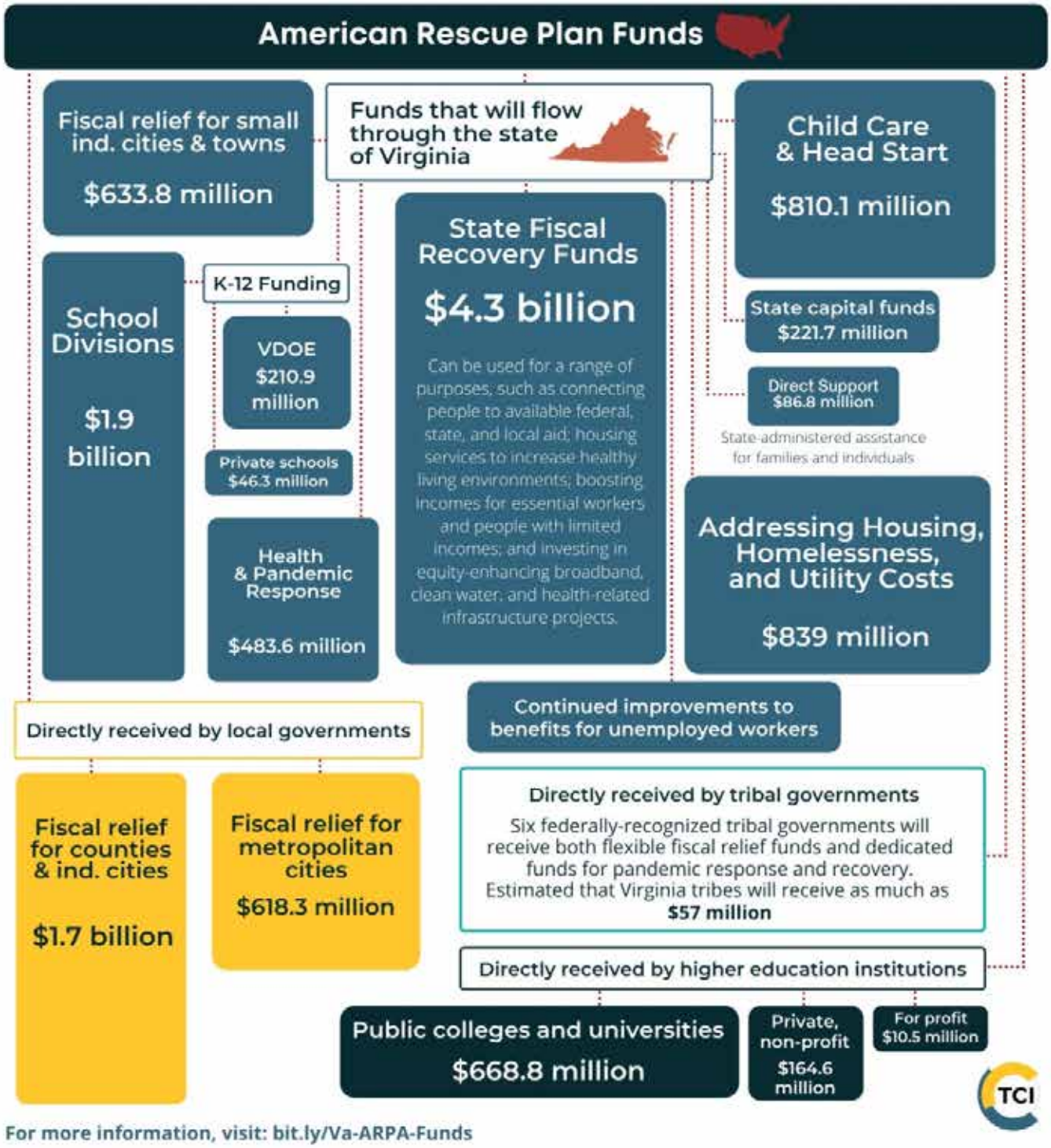
The American Rescue Plan Act (2021)

The American Rescue Plan Act (ARPA) was signed into law by President Biden in March 2021. Through the Coronavirus State and Local Fiscal Recovery Fund (SLFRF), it guarantees direct relief to cities, towns and villages in the United States. The purpose of this one-time funding is to assist in recovering from the public health emergency and its negative economic impacts of the pandemic. Virginia was awarded $7.2 billion of which $4.3 billion will go to the state and $2.9 will go directly to localities. (https://www.wvtf.org/news/2021-05-11/how-much-is-your-community-getting-from-arpa). In the summer of 2021, Virginia's House of Delegates, Senate, and Governor agreed on how to spend $3.5 billion of the $4.3 billion in flexible federal funding for the state.

The following depicts how ARPA funds will flow through the Commonwealth addressing the needs of the most vulnerable populations in Virginia including those that we serve in the Lynchburg region.

How ARPA Funds Will Flow to Virginia Communities

The American Rescue Plan Act (ARPA) of 2021 provides flexible and targeted funding for the state of Virginia, all Virginia cities and counties, public and private universities, and Virginia tribes, as well as direct relief for families. Each type of funding has different timing and other restrictions, therefore Virginia's state and local policymakers will face important decisions about how to use these funds. This summary focuses on those funds that will flow through the state and local governments and does not include the substantial direct assistance to Virginia families in the form of stimulus checks, improved tax credits, and improved healthcare marketplace subsidies.



Source: The Commonwealth Institute. Use of ARPA Funds a Step Forward, More to be Done to Build a Just Future. Accessed at https://thecommonwealthinstitute.org/the-half-sheet/use-of-arpa-funds-a-step-forward-more-to-be-done-to-build-a-just-future/. Retrieved November 7, 2021.

Access to Healthcare Services

In July of 2021, Centra and UVA Health announced a strategic clinical affiliation to increase access close to home for patients in the Centra service regions for advanced health care and innovative treatments. Through this new affiliation, these independent health systems will further collaboration in these new areas:

- **Malignant hematology (disorders of blood cells):** UVA Health malignant hematology experts will hold regular clinics at Centra's Alan B. Pearson Regional Cancer Center to consult with patients and local medical oncologists. This strategic collaboration will offer UVA Health's comprehensive expertise and services in hematologic malignancies (lymphoma, leukemia, multiple myeloma and related cancers of the blood) and access to cutting edge clinical trials of the most promising new therapeutics, accelerating the time to transplant for eligible candidates while reducing patient travel requirements by offering initial consultations and post-treatment care closer to patients' homes.
- **Kidney transplant:** UVA Health transplant specialists will hold clinics in Lynchburg to evaluate patients for kidney transplants. A nurse navigator will be assigned to coordinate locally-provided health care services with Centra providers before transplant and to coordinate the transfer of care back to Lynchburg nephrologists after transplant. These clinics will improve organ waitlist times and provide expert care where and when patients need it.
- **Recruitment of specialist physicians:** The two health systems will collaborate on the recruitment of specialist physicians in certain clinical specialties to enhance access to care for these services within the Centra service area. Physician teams from both health systems, including these specialists, will provide joint patient care conferences, share expertise, and offer some services through telemedicine.

This affiliation will build on Centra's existing partnerships with UVA Health that have demonstrated success in providing comprehensive and exceptional patient care throughout Central Virginia. Centra already collaborates with UVA Health on high-risk pregnancies, gynecology-oncology, telestroke, and dialysis. A committee, composed of leaders from both health systems, has been formed to oversee this expanded affiliation.

Medicaid Expansion (Medical and Dental Benefits)

Medicaid expansion in Virginia took effect in January 2019. By early 2020, about 375,000 people had gained coverage under the expanded eligibility guidelines (residents earning up to 138% of the federal poverty level). By December 2020, this number increased to more than 494,000 due to the pandemic and widespread job losses increasing access to care to those who otherwise would have fallen through the cracks.

(https://www.healthinsurance.org/medicaid/virginia/)
Effective July 1, 2021, adults receiving full Medicaid benefits are now eligible for comprehensive dental care. Expansion of Medicaid will continue to be a strong safety net as our community rebuilds itself after the pandemic.

Broadband/Internet Access

In October of 2021, Governor Northam announced that Virginia has received a record number of local and private sector applications to match state broadband investments, putting the Commonwealth on track to become one of the first states to achieve universal broadband access by 2024. Virginia anticipates more than $2 billion in total broadband funding, thanks to local and private sector matching funds that go beyond the $874 million in state appropriations since the Governor took office in 2018.

(https://www.governor.virginia.gov/newsroom/all-releases/2021/october/headline-910054-en.html)

Mental Health and Substance Use Disorders

In July 2021, Governor Northam proposed a $485.2 million spending package in the next biennial budget (2022-2024) which is designed to reduce pressure on state behavioral health facilities by pledging almost $224 million to increase support for state hospitals, community-based providers, and substance abuse prevention and treatment programs across Virginia. The proposed funding package would rely on discretionary funds and block grants from the federal emergency relief dollars from ARPA and Consolidated Appropriations Act funds (passed in December 2020). Additional provisions in the package include:

- $30 million in federal funding for crisis services this year and next year as a step toward long-term funding;
- $30 million for treatment of people with substance use disorders, as well as support services;
- $5 million for permanent supportive housing in Northern Virginia for people leaving institutional care or trying to avoid it;
- $4 million over four years for the new "Marcus Alert" system to rely on mental health professionals instead of law enforcement to respond to psychiatric emergencies;
- $2.4 million for personal protective equipment and infection control at behavioral health institutions, which suffered COVID-19 outbreaks that killed 25 patients and two employees last year; and
- $50 million in capital projects to improve water, sewage and ventilation systems at state institutions.

(https://richmond.com/news/state-and-regional/govt-and-politics/northam-pitches-485-2-million-package-for-behavioral-health-with-eye-toward-next-budget/article_541abec7-68b6-555c-96fc-56145Oa37b05.html#tncms-source=signup)

Regarding substance use legislation, on July 1, 2019, the legal age to purchase tobacco products in Virginia increased from 18 to 21 years of age. On July 1, 2021, marijuana was legalized for adults in Virginia with retail sales beginning in July of 2024.

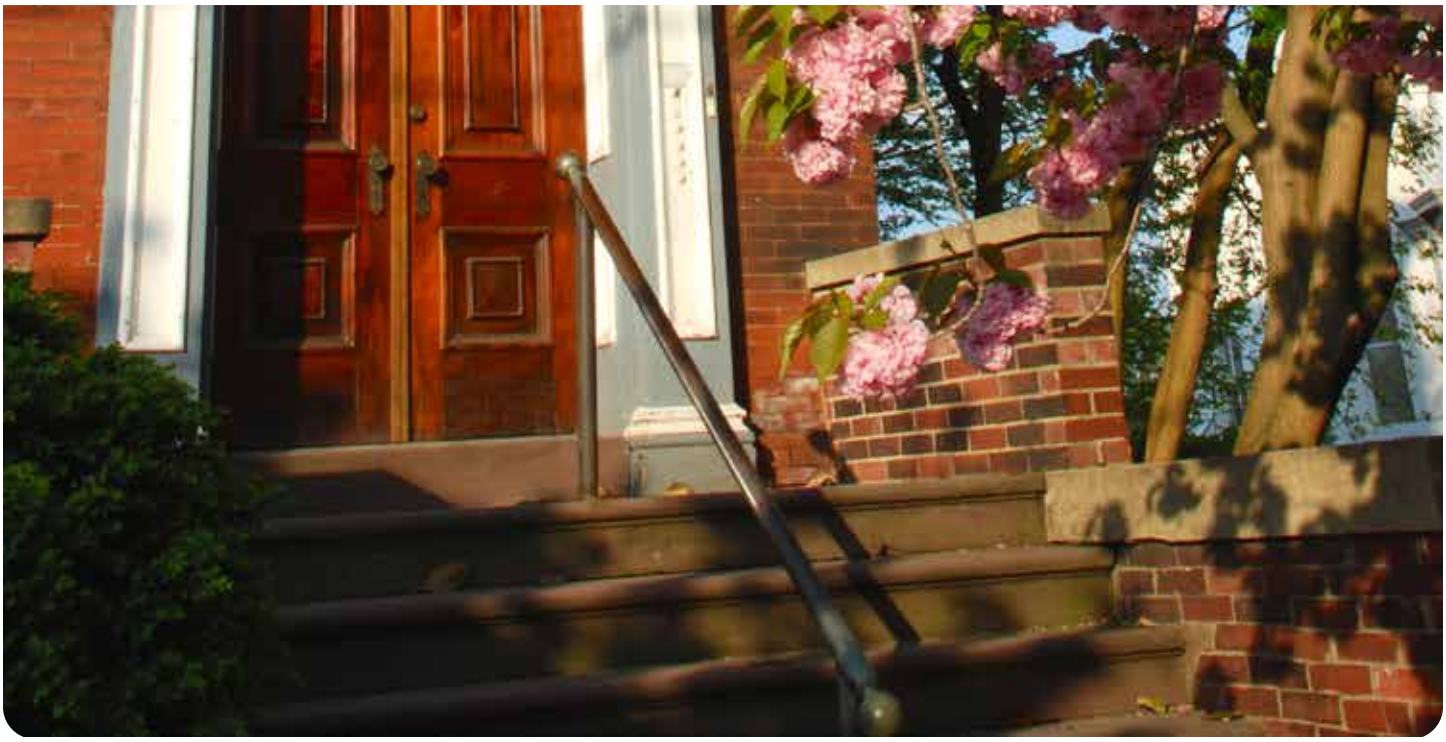
Partnerships and Coalitions:

In addition to the Partnership for Healthy Communities described throughout this assessment, the following partnerships and coalitions are addressing one or more of the 2021 Priority Areas of Need.

- Bridges to Progress, a Poverty Reduction Initiative ***(www.lynchburgva.gov/bridgestoprogress)***
  - Addressing poverty, early childhood care and education, education, food insecurity, housing, health/mental health, equity, inclusion and diversity in the city of Lynchburg
- Central Virginia Continuum of Care ***(https://centralvirginiacoc.org/)***
  - Addressing housing in the Lynchburg region
- Lynchburg Tomorrow ***(https://www.lynchburgfoundation.org/glcf-news/323-glcf-joins-with-university-of-lynchburg-and-city-leaders-in-new-community-venture.html)***
  - Addressing access to affordable healthcare and food insecurity in the city of Lynchburg
- Smart Beginnings Central Virginia ***(https://unitedwaycv.org/smart-beginnings/)***
  - Addressing early childhood education in the Lynchburg and Bedford region
- The Health Collaborative ***(https://www.thehealthcollab.com/)***
  - Addressing issues impacting the health of the Pittsylvania/Danville region
- The Kids First Collaborative ***(https://newsadvance.com/news/local/in-an-effort-to-break-the-poverty-cycle-three-lynchburg-area-nonprofits-team-up/article_ec8295b8-f659-11eb-bcd9-7fce6275492b.html?utm_medium=social&utm_source=email&utm_campaign=user-share)***
  - Addressing childcare and afterschool programs, youth mentoring and empowerment, and other social determinants of health in the city of Lynchburg

EVALUATION OF IMPACT

This Evaluation of Impact presents the actions Centra took system-wide across its three service regions (Bedford, Farmville, and Lynchburg areas) to address the significant health needs from the 2018 Community Health Needs Assessment.



Evaluation of Impact

In 2018, Centra completed the triennial Community Health Needs Assessments (CHNA) for Centra Bedford Memorial Hospital headquartered in Bedford, Virginia; Centra Southside Community Hospital headquartered in Farmville, Virginia; and Centra Hospital (Centra Lynchburg General Hospital, Virginia Baptist Hospital, Specialty Hospital) headquartered in Lynchburg, Virginia. Once on staggered calendars, Centra moved to have all three regional CHNA's completed in the same calendar year in 2018. Additionally, the Partnership for Healthy Communities was formed which is a planning initiative led by Centra, the Community Access Network, and the Central Virginia, Piedmont, and Pittsylvania/Danville Health Districts, the Bedford Community Health Foundation, Greater Lynchburg Community Foundation, Johnson Health Center, and United Way of Central Virginia. These partners were committed to regional alignment of a collaborative and rigorous needs assessment process that resulted in action-oriented solutions to improve the health of the communities they serve.

A Prioritization of Needs process identified ten priority areas which were similar for each region. In March 2019, a Centra leadership team met to develop system-wide implementation plans for 2019-2022 to address the following: (1) Access to affordable healthcare; (2) Access to mental health services and mental health problems; (3) Substance use and alcohol & illegal drug use; and (4) Access to healthy foods and alignment with overweight, obesity; poor eating habits; diabetes; hypertension; and active living. In addition, an administrative priority area addressing the CHNA's and Implementation Planning process was developed. The target population for the implementation plans include (1) medically underserved, low-income or minority populations and those suffering from chronic disease; (2) those living in the geographic area served by the hospital; and (3) targeted populations (i.e. children, women, seniors, cancer patients). A strong focus has been placed on those living in poverty in the service area.

The COVID-19 pandemic brought a halt to some of the goals and strategies developed for these priority areas in 2020 and 2021. Our progress for the 2019-2022 implementation plans is as follows:

Priority Area: **Access to affordable healthcare**

Goal: **Provide increased and varied access to healthcare opportunities which are tailored to the needs of the community served by Centra**

Strategy 1: Commission a study to further define "affordable", "accessible" care based on the findings of the 2018 Centra Community Health Needs Assessment.

Action Step: This action item was met. A cross-tab analysis of the 2018 Centra Community Health Survey data was completed in 2019. In 2020, follow-up with members of the Partnership for Healthy Communities occurred to further identify the needs/target population for healthcare services.

Strategy 2: Increase the availability of appointments with Centra primary care providers (PCP).

Action Step: Determine the provider and support staff needed to expand services at PCP practices. This action item was met. The benchmark is Medical Group Management Association (MGMA) staff to provider ratio; service line strategy to increase access and decrease cost; and per patient per day standards (Relative Value Units).

Action Step: Create capacity to allow open-access primary care appointments within 3 to 4 days of appointment request. Work addressing this action step is underway but has yet to be met.

Action Step: Provide PCP appointments 7 days/week at selected sites. This action item was 80% complete in 2020. Centra now has Urgent Care facilities in Danville and Forest and some Centra Medical Group practices (Gretna, Amherst, Brookneal, Village) have opened on Saturdays. Currently Centra is considering having an Urgent Care 7 days/week in each region.

New Action Step: To address remote access to appointments during the pandemic, Centra Health established a Telehealth Task Force in April 2020 to ensure that we are addressing the short-term, pandemic-related telehealth needs of the organization while also establishing a foundation to support a long-term telehealth strategy. At the outset of the pandemic, the task force provided guidance and education on the different telehealth platforms available for use in the context of relaxed enforcement of HIPPA regulations during the public health emergency. At the time, Centra had a contract with only one telehealth company (amwell) but providers were able to use other tools such as Facetime, Zoom, and Doximity. To measure utilization, we established a dashboard to track telehealth services by patients (reported by age and zip code) as well as providers (reported by provider name and practice area). We saw a marked spike in telehealth utilization in April and May of 2020 (peaking at 3,700 visits) with a gradual decrease from June 2020 through 2021. The majority of visits occurred for patients living within an hour of a Centra Medical Group practice but also included patients in more remote locations. During the 2021 calendar year, we've seen most of the telehealth visits occurring in patients aged 46-65 and those over 65 years. Looking at practices, telehealth is used most often by Urgent Care, Behavioral Health and Primary Care. Additionally, patients in more remote locations had difficulty accessing telehealth services due to lack of consistent broadband access. Even for patients with an adequate cell signal, telehealth utilizes more data than telephone or text services and patients with limited data plans found themselves quickly bumping up against their monthly cap. To address this, the task force is partnering with Centra's Department of Community Health to consider ways to partner with community resources (e.g. libraries, businesses) to establish wireless hot-spots in rural communities. This, along with Governor Northam's planned investment in Virginia's broadband system (https://www.governor.virginia.gov/newsroom/all-releases/2021/october/headline-910054-en.html) should provide more reliable access for our rural patients.

Strategy 3: Improve coordination of care and communication of resources.

Action Step: Conduct an inventory of available hospital and community resources in Centra service areas related to the 2018 CHNA top 10 priority areas. This action item is 75% complete. A list of resources is included in the 2018 CHNA however this has yet to be organized by priority area.

Action Step: Identify gaps in resources & develop action plan to address these gaps. Capacity issues especially during the pandemic were apparent. In 2021, Centra was invited by the Virginia Hospital and Healthcare Association to pilot a closed-loop referral system for social determinants of health (Unite VA) which will help engage community resources and providers. Funding for the pilot was provided by CARES Act dollars. We anticipate launching the Unite VA platform in test sites across the health system in December 2021.

Action Step: Continue to develop Patient Navigators in Centra service areas. This action item is 50% complete. Patient navigators in 2020 began serving Cardiology, COPD, insurance, oncology, and primary care service lines. A Primary Care strategy is being developed for the LGH Emergency Department to refer to the Community Access Network. Efforts in 2020 were to make sure they are documenting in HealtheCare (part of HealtheIntent). Performance Improvement is helping with this process and tracking utilization.

Strategy 4: Study an expansion of the Centra Paramedicine program to the entire Centra service region.

Action Step: Commission a study of regional expansion of program. This action item is complete. There was a 53.5% reduction in readmissions in 2019 related to the program. The program began by targeting Piedmont Community Health Plan beneficiaries (PCHP) within a 10 mile radius. In 2020, the program had expanded to now include PCHP, COPD, Pulmonary, Cardiovascular, Mother Baby, ICU syndrome, and CMG-Village with four Full-Time Equivalent positions. They are covering our entire service area.

Strategy 5: Explore strategies to remove transportation barriers to care.

Action Step: Inventory existing transportation programs for publicly insured patients. This action item is complete. Medicaid providers include Logisticare, VA Premier, Deyo (Magellan), Southeast Transit (Optima and Anthem), National Med Trans, Uber Medical, and Lyft.

Action Step: Partner with community-based programs addressing transportation barriers. This work has continued and is still an opportunity for our communities. Leadership and coordination is needed. The Paramedicine program was a part of the COVID-19 homeless transportation and follow-up program.

Strategy 6: Evaluate provider-based billing and its impact on access to healthcare services.

Action Step: Conduct a financial analysis of loss of volume secondary to cost/care avoidance vs. revenue gain secondary to provider-based billing (PBB) revenue created. This action item is complete. Analysis of Cardiology and Hematology showed a profit margin impact. Urology is PBB as well. Telehealth does not have a facility component and therefore is a cost-efficient manner for patients to receive care. Telehealth visits picked up system wide including PBB clinics due to COVID-19.

Priority Area: **Access to mental health services and mental health problems**

Goal: **Provide Increased access to, and integration of, mental health services which are tailored to the needs of the community served by Centra.**

Strategy 1: Integrate mental health services in primary care and specialty offices.

Action Step: Continue to integrate mental health services into Centra Medical Group (CMG) practices. A large number of Centra patients have mental health and substance use disorders. The following service lines have Licensed Clinical Social Workers- all 3 PACE sites and Centra Medical Group practices (Cardiology, Nationwide, Farmville Medical Center, Danville, Bariatrics, Forest Women's Center and Substance Abuse Clinic). Next to integrate are Neurosciences, Village and Pain Management. Hospice and Pearson Cancer Center have integration as well (non-CMG).

Action Step: Expand integrated services to long-term care facilities and CMG practices in Amherst and Farmville. This work continues. Telehealth option was available in 2020 at Fairmont Crossing. It is important to note that in 2021, Centra sold its four long-term care and skilled nursing facilities to Hill Valley Healthcare and LifeSpire of Virginia. The facilities include Guggenheimer Health and Rehab and Summit Health and Rehab in Lynchburg, Oakwood Manor in Bedford, and Fairmont Crossing in Amherst.

Action Step: Expand hours for mental health services at integrated practices. This work continues. Centra's focus has been on expanding sites prior to the COVID-19 pandemic. The Addiction Treatment Center expanded to evening groups and services.

Strategy 2: Decrease utilization of the Emergency Department (ED) for mental health & substance use services.

Action Step: Integrate mental health providers / LCSW or advanced practice clinician(s) (APN's) to provide services in the ED. This action item is 75% complete. Two psychiatric APN's were hired for Lynchburg General and Southside Community Hospitals. A consultation pathway is in place and a position posted for onsite leadership. Future ideas include: Expand Centra 24/7 and telehealth to prevent patients from going to the ED. Divert behavioral health patients from ED at triage.

Action Step: Explore options for patient transportation that have a history of hospitalization due to mental illness. This action item is 50% complete. Transportation barriers can serve as a surrogate for mental health issues. Addiction Treatment Center provides transportation with a SAMHSA grant. Cab and bus passes are available.

Action Step: Conduct an analysis of treatment of dental pain by prescribing opioids in ED's. No action was taken on this item as of October 2021.

Strategy 3: Deliver mental health services more effectively in the community.

Action Step: Partner with regional Community Services Boards (CSB's) and safety net providers to address mental health access & capacity issues in the community. This action item is 50% complete. In the Farmville region, Crossroads CSB was not open to in-person visits for much of 2020. In the Bedford and Lynchburg regions, Horizons CSB stabilization unit was shut down. The Community Access Network (a FQHC Look-a-like) expanded its services in Bedford and Lynchburg.

Action Step: Advocate collaboratively with community partners for increased reimbursement for mental health inpatient & outpatient services to handle the onslaught of patients. Centra is represented at the state level (Virginia Hospital and Healthcare Association; Virginia Behavioral Health Taskforce) and locally through Bedford Area Resource Council, Poverty to Progress (Lynchburg), and South Central VA Nonprofit Network (Farmville).

Priority Area: **Substance use and alcohol and illegal drug use**

Goal: **Decrease substance use through prevention efforts & increased access to substance abuse services.**

Strategy 1: Reduce the stigma of substance use disorders

Action Step: Support community-based prevention & education efforts focused on substance use. This action item is complete. Centra opened CMG's Addiction Treatment Center in Lynchburg which offers medication-assisted treatment for outpatients. In addition, the medical director for CMG Piedmont Psychiatric Center in Lynchburg conducted education programs on substance use.

Action Step: Education programs with Centra staff and providers were conducted and focused on substance use. The medical director for CMG Piedmont Psychiatric Center presented at CMG's All Provider meeting in 2019 on the topic of Substance Use and he presented at a conference at University of Lynchburg in October 2020. Work is ongoing (re: other programs and provision of education)

Strategy 2: Support the development and/or expansion of coordinated substance use treatment programs

Action Step: Study provision of suboxone treatment in the Emergency Department. The medical director for CMG Piedmont Psychiatric Center and team are currently collaborating with ED providers/leaders to initiate suboxone induction in ED.

Action Step: Develop Primary Care Provider Opioid Administration Plan (PIP). This action item has not been addressed fully as of this writing.

Action Step: Expand Pain Management Clinic Services. Hired a medical provider in November 2019 to provide pain management services in the Southside Community Hospital region (this position was vacated in January 2019).

Action Step: Inventory existing inpatient & outpatient recovery programs in the service area. This action item has not been fully addressed as of this writing other than what is presented in the "Resources" section of the 2021 Community Health Needs Assessment.

Action Step: Actively participate in regional Opioid Task Forces. The medical director for CMG Piedmont Psychiatric Center represents Centra as part of the Central Virginia Addiction and Recovery Resources team.

Priority Area: **Access to healthy foods and alignment with overweight, obesity; poor eating habits; diabetes; hypertension; active living**

Goal: **Increase access to healthy foods that support healthy behaviors.**

Strategy 1: Focus educational and marketing efforts on the importance of making healthy choices across the life-cycles.

Action Step: Inventory existing community resources & partner with nonprofits providing programs focused on healthy foods & behaviors. Listing of food pantries and other food providers included in 2018 and the 2021 CHNA's for all regions.

Action Step: Inventory products developed as a result of Centra Foundation & Centra Community Benefit funding focused on healthy eating and healthy lifestyle behaviors. A Patient Booklet was produced in 2020 with Marketing and is distributed to patients at all hospitals. Whole 30 Diet Program (was beta tested in 2020 pre-COVID at Virginia Baptist Hospital) and could be exported externally.

Action Step: Participate in health fairs and other outreach opportunities that address healthy eating and its impact on chronic disease. Health fairs and outreach opportunities were halted in 2020 due to COVID-19 pandemic.

Strategy 2: Explore options to provide affordable, healthy meals to the Centra community as a whole.

Action Step: Determine the feasibility of production of affordable healthy packaged meals program. Code Fresh has not been operating since the Summer of 2019 and could be utilized in these efforts due to the pandemic.

Administrative Priority Area: **Community Health Needs Assessment (CHNA) and Implementation Plan (IP)**

Goal: **Centra will be responsive to the needs of the communities it serves through a robust, comprehensive Community Health Needs Assessment and Implementation Planning process.**

Strategy 1: Develop a system-wide infrastructure to administer and evaluate the triennial CHNA and Implementation Plans for the Centra Service Areas.

Action Step: Develop a team that will focus on the execution of the CHNA/IP by determining the roles and responsibilities of the team within the health system. The Department of Community Health launched in January 2020. Staff for the department includes a Director and two Coordinators.

Action Step: Develop position descriptions and hire new and/or assign existing staff to the team. This action item is completed.

Action Step: Develop internal leadership team focused on implementing and evaluating the system-wide priority areas & goals. The Community Benefit Committee, appointed by Centra's Board of Directors, oversees the work of the department of Community Health. No internal Centra leadership team has been developed as of this writing.

Action Step: Conduct cross-tab analysis of 2018 Centra Community Health Survey data to further identify the needs/target population for each priority areas. Completed in 2019.

Action Step: Execute and evaluate the IP annually. This action item was addressed in 2020 and 2021.

Action Step: Attend and participate in community partnerships and coalitions that are addressing similar priorities and goals. Many of these activities were limited in 2020 due to the COVID-19 pandemic. The Senior Vice President and Chief Transformation Officer, Community Health Director and Coordinators represent Centra through virtual meetings in 2020 and 2021.

Action Step: Centra Foundation & Centra Community Benefit Committee will align internal funding strategies to support priority needs. In 2020, $175,000 was provided to support community grants that funded non-profit organizations addressing food insecurity and basic needs impacted by the COVID-19 pandemic. Since 2021, the Department of Community Health oversees all community-based grants and sponsorship funding under the direction of the Community Benefit Committee. By December 2021, we will invest almost $1.5 million in grants and sponsorships in the communities served by Centra.

APPENDIX

The following documents are included as appendices:

1. 2021 Lynchburg Area Community Health Survey Tool (English and Spanish)
2. 2021 Lynchburg Area Community Health Survey- Full Report
3. 2021 Lynchburg Area Stakeholders' Directory
4. 2021 Centra Stakeholders' Survey
5. 2021 Lynchburg Area Prioritization of Needs Survey and Detailed Worksheet
6. 2021 Lynchburg Area Community Resources

WE WANT TO CREATE A HEALTHIER LYNCHBURG REGION FOR ALL WHO LIVE, WORK, AND PLAY HERE.

PLEASE TELL US WHAT YOU NEED TO LIVE A HEALTHIER LIFE!

<u>PLEASE COMPLETE OUR SURVEY</u>. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

- ***Complete the survey online at* centrahealth.com/CHNA**

  OR

- ***Scan the QR code***

  OR

- ***Complete the attached paper survey***

YOU WILL GET THE CHANCE TO WIN A $25 Walmart GIFT CARD.
To thank you for filling out the survey, you can enter a drawing to receive a $25.00 gift certificate to Walmart. There will be four chances to win. If you would like to enter the drawing, please complete the information below. Your contact information will not be linked to your survey answers. The drawing will take place in July of 2021 and winners will be contacted.

Thank you very much for your help,

Centra Department of Community Health

Please complete the information below if you would like to be entered into a drawing for a $25.00 Gift Certificate to Walmart. Winners will be contacted in July of 2021.

Name: _____

Address: _____

_____

Phone: _____

Email: _____

FOR OFFICE USE ONLY: Site of Collection: _____ Date: _____

Centra Health, in partnership with the Partnership for Healthy Communities and the Central Virginia Health District, is working with community leaders to learn more about what you need to be healthy. Please answer the following questions with the best answer or answers. All surveys will be kept confidential. Thank you for taking the time to complete this survey. Surveys can be mailed to Centra Department of Community Health, 1901 Tate Springs Rd, Lynchburg VA 24501. You must be over 18 to complete this survey. Please complete this survey only once.

LYNCHBURG AREA COMMUNITY HEALTH SURVEY

HEALTH OF THE COMMUNITY

1. Where do you live?

❒ Amherst Co. ❒ Appomattox Co. ❒ Campbell Co. ❒ Pittsylvania Co. ❒ City of Danville ❒ City of Lynchburg

❒ Other: _____

2. What do you think are the most important issues that affect health in our community? (*Please check all that apply*)

Health Factors

❒ Access to affordable housing
❒ Access to healthy foods
❒ Accidents in the home (e.g., falls, burns, cuts)
❒ Alcohol and illegal drug use
❒ Aging problems
❒ Bullying
❒ Cell phone use / texting and driving / distracted driving
❒ Child abuse / neglect
❒ Domestic Violence
❒ Environmental health (e.g., water quality, air quality, pesticides, etc.)
❒ Gang activity
❒ Homicide
❒ Housing problems (e.g., mold, bed bugs, lead paint)
❒ Injuries
❒ Lack of exercise
❒ Neighborhood safety
❒ Not getting "shots" to prevent disease
❒ Not using seat belts / child safety seats / helmets
❒ Poor eating habits
❒ Prescription drug abuse
❒ Sexual assault
❒ Social isolation
❒ Transportation problems
❒ Tobacco use / smoking / vaping
❒ Unsafe sex
❒ Other: _____

Health Conditions or Outcomes

❒ Cancers
❒ COVID-19 / coronavirus
❒ Dental problems
❒ Diabetes
❒ Disability
❒ Grief
❒ Heart disease and stroke
❒ High blood pressure
❒ HIV / AIDS
❒ Infant death
❒ Lung disease
❒ Mental health problems
❒ Overweight / obesity
❒ Stress
❒ Suicide
❒ Teenage pregnancy
❒ Other: _____

3. Which health care services are hard to get in our community? *(Please check all that apply)*

❒ Adult dental care
❒ Alternative therapy (e.g., herbal, acupuncture, massage)
❒ Ambulance services
❒ Cancer care
❒ Child dental care
❒ Chiropractic care
❒ Dermatology
❒ Domestic violence services
❒ Eldercare
❒ Emergency room care
❒ End of life / hospice / palliative care
❒ Family doctor
❒ Immunizations
❒ Inpatient hospital
❒ Lab work
❒ LGBTQ
❒ Medication / medical supplies
❒ Mental health / counseling
❒ Physical therapy
❒ Preventive care (e.g., yearly check-ups)
❒ Programs to stop using tobacco products
❒ Specialty care (e.g., heart doctor)
❒ Substance use services – drug and alcohol
❒ Urgent care / walk-in clinic
❒ Vision care
❒ Women's health services
❒ X-rays / mammograms
❒ None
❒ Other: _____
❒ COVID-19 has made one or more of the services I selected hard to get

4. Which social / support resources are hard to get in our community? *(Please check all that apply)*

❒ Affordable / safe housing
❒ Banking / financial assistance
❒ Childcare
❒ Domestic violence assistance
❒ Education and literacy
❒ Employment / job assistance
❒ Food benefits (SNAP, WIC)
❒ Grief / bereavement counseling
❒ Health insurance
❒ Healthy food
❒ Legal services
❒ Medication assistance
❒ Medical debt assistance
❒ Rent / utilities assistance
❒ TANF (Temporary Assistance for Needy Families)
❒ Transportation
❒ Unemployment benefits
❒ Veterans services
❒ Other: _____
❒ COVID-19 has made one or more of the services I selected hard to get

GENERAL HEALTH QUESTIONS

5. What keeps you from being healthy? (*Please check <u>all</u> that apply*)

- ❒ Afraid to have check-ups
- ❒ Can't find providers that accept my insurance
- ❒ Childcare
- ❒ Cost
- ❒ Don't know what types of services are available
- ❒ Don't like accepting government assistance
- ❒ Don't trust doctors / clinics / my insurance
- ❒ Have no regular source of healthcare
- ❒ High co-pay
- ❒ Lack of evening and weekend services
- ❒ Language services
- ❒ Location of offices
- ❒ Long waits for appointments
- ❒ No health insurance
- ❒ No transportation
- ❒ Nothing keeps me from being healthy
- ❒ Other:_____

6. Do you use medical care services?

❒ **<u>Yes</u> - Check where you go for medical care** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Doctor's Office
- ❒ Emergency Room
- ❒ Urgent Care / Walk-in Clinic
- ❒ Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Health Department
- ❒ Veterans Administration Medical Center
- ❒ Online / Telehealth / Virtual Visit
- ❒ Other:_____

7. How long has it been since you last visited a doctor or other healthcare provider for a routine checkup? (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never visited a doctor or other healthcare provider for a routine checkup
- ❒ Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19

8. Do you use dental care services?

❒ **<u>Yes</u> – Check where you go for dental care** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Dentist's Office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Veterans Administration Medical Center
- ❒ Urgent Care / Walk-in Clinic
- ❒ Mission of Mercy Project
- ❒ Other:_____

9. How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists such as orthodontists. (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never visited a dentist or dental clinic for any reason.
- ❒ Within the past year I have chosen not to see a dentist or dental specialist or have postponed or cancelled a visit because of COVID-19

10. Do you use mental health, alcohol use, or drug use services?

❒ **<u>Yes</u> – check where you go for services** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Horizon Behavioral Health
- ❒ Doctor / Counselor's office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Online / Telehealth / Virtual Visits
- ❒ Veterans Administration Medical Center
- ❒ Urgent Care / Walk-in Clinic
- ❒ Other:_____

11. How long has it been since you last used mental health, alcohol use, or drug use services for any reason? (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never used mental health, alcohol use, or drug use services for any reason
- ❒ Within the past year I have chosen not to see a mental health or substance use provider or counselor or have postponed or cancelled a visit because of COVID-19

12. Have you been told by a doctor that you have… (*Please check all that apply*)

- ❒ Asthma
- ❒ Cancer
- ❒ Depression or anxiety
- ❒ Drug or alcohol problems
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High blood sugar or diabetes
- ❒ Cerebral palsy
- ❒ High cholesterol
- ❒ HIV / AIDS
- ❒ Mental health problems
- ❒ Obesity / overweight
- ❒ Stroke / cerebrovascular disease
- ❒ I have no health problems
- ❒ Other:_____

13. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?_____Days

14. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? _____Days

15. During the past 30 days: (*Please check all that apply*)

- ❒ I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion
- ❒ I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)
- ❒ I have taken prescription drugs to get high
- ❒ I have used marijuana
- ❒ I have used other illegal drugs (e.g., meth, cocaine, heroin, ecstasy, crack, LSD, etc.)
- ❒ None of these

16. Please check one of the following for each statement	**Yes**	**No**	**Not Applicable**
I have been to the emergency room in the past 12 months.	❒	❒	
I have been to the emergency room for an injury in the past 12 months (e.g., motor vehicle crash, fall, poisoning, burn, cut, etc.).	❒	❒	
I have been a victim of domestic violence or abuse in the past 12 months.	❒	❒	
I take the medicine my doctor tells me to take to control my chronic illness.	❒	❒	❒
I can afford medicine needed for my health conditions.	❒	❒	❒
Does your community support physical activity? (e.g., parks, sidewalks, bike lanes, etc.)	❒	❒	
In the area that you live, is it easy to get affordable fresh fruits and vegetables?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?	❒	❒	❒
Do you feel safe where you live?	❒	❒	

17. In the past 7 days, how many days were you physically active for a total of at least 30 minutes? (Add up all the time you spend in any kind of physical activity that increased your heart rate and made you breathe hard for some of the time.)

❒ 0 days ❒ 1 day ❒ 2 days ❒ 3 days ❒ 4 days ❒ 5 days ❒ 6 days ❒ 7 days

18. Where do you get the food that you eat at home? (*Please check all that apply*)

- ❒ Back-pack or summer food programs
- ❒ Community garden
- ❒ Corner store / convenience store / gas station
- ❒ Dollar store
- ❒ Farmers' market
- ❒ Food bank / food pantry
- ❒ Grocery store
- ❒ Home garden
- ❒ I do not eat at home
- ❒ I regularly receive food from family, friends, neighbors, or my church
- ❒ Meals on Wheels
- ❒ Take-out / fast food / restaurant
- ❒ Other:_____

19. During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice. (*Please check one*)

- ❒ I did not eat fruits or vegetables during the past 7 days
- ❒ 1 – 3 times during the past 7 days
- ❒ 4 - 6 times during the past 7 days
- ❒ 1 time per day
- ❒ 2 times per day
- ❒ 3 times per day
- ❒ 4 or more times per day

20. In the past 7 days, how many times did all or most of your family living in your house eat a meal together?

- ❒ Never
- ❒ 1 – 2 times
- ❒ 3 – 4 times
- ❒ 5 – 6 times
- ❒ 7 times
- ❒ More than 7 times
- ❒ Not Applicable / I live alone

21. How connected do you feel with the community and those around you?

❒ Very connected ❒ Somewhat connected ❒ Not connected

22. Where do you sleep most often? (*Please check <u>one</u>*)

❒ In a home I own or rent
❒ Stay with friends or family because of financial issues
❒ In a shelter or transitional housing program
❒ In a group home, hospital, or treatment program
❒ In a hotel or motel
❒ Outside, in a car, abandoned building, or public space

23. Do you have access to reliable transportation? ❒ Yes ❒ No

24. What type of transportation do you use most often?

❒ I drive
❒ Bike or walk
❒ Friends / family drive me
❒ Public transit (i.e., bus, shuttle, similar)
❒ Other transit service (name):_____
❒ Taxi (including Uber / Lyft)
❒ Ridesharing / Carpooling
❒ Other:_____

DEMOGRAPHIC INFORMATION AND HEALTH INSURANCE

25. Which of the following describes your current type of health insurance? (*Please check <u>all</u> that apply*)

❒ COBRA
❒ Dental Insurance
❒ Employer provided insurance
❒ Government (VA, TRICARE)
❒ Health Savings / Spending Account
❒ Individual / Private Insurance / Marketplace / Obamacare
❒ Medicaid
❒ Medicare
❒ Medicare Supplement
❒ No Dental Insurance
❒ No Health Insurance

26. If you have no health insurance, why don't you have insurance? (*Please check <u>all</u> that apply*)

❒ Not applicable – I have health insurance
❒ I don't understand Marketplace / Obamacare options
❒ Not available at my job
❒ Student
❒ Too expensive / cost
❒ Unemployed / no job
❒ Other:_____

27. What is your Zip Code? _____ **28. What is your age?** _____

29. What is your gender identity? ❒ Male ❒ Female ❒ Non-binary ❒ Other:_____

30. What is your height? _____feet_____inches **31. What is your weight?** _____pounds

32. How many people live in your home (including yourself)?

Number of children (0 - 17 years of age) _____ Number of adults age 18 - 64_____ Number of adults age 65 or older_____

33. What is your highest education level completed?

❒ Less than high school
❒ Some high school
❒ High school diploma / GED
❒ Associates degree
❒ Bachelors degree
❒ Masters / PhD degree

34. What race/ethnicity do you identify with? (*Please check <u>one</u>*)

❒ Native Hawaiian / Pacific Islander
❒ American Indian / Alaskan Native
❒ Asian
❒ Hispanic / Latino
❒ Black / African American
❒ White
❒ More than one race
❒ Decline to answer
❒ Other: _____

35. What is your marital status?

❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partnership

36. What is your yearly household income?

❒ $0 - $10,000
❒ $10,001 - $20,000
❒ $20,001 - $30,000
❒ $30,001 - $40,000
❒ $40,001 - $50,000
❒ $50,001 - $60,000
❒ $60,001 - $70,000
❒ $70,001 - $100,000
❒ $101,001 and above

37. What is your current employment status?

❒ Full-time
❒ Part-time
❒ Unemployed
❒ Self-employed
❒ Retired
❒ Homemaker
❒ Student
❒ Disabled

38. Is there anything else we should know about your (or someone living in your home) needs to stay healthy?

_____

_____

_____

Thank you for helping make the greater Lynchburg Area a healthier place to live, work, and play!

QUEREMOS CREAR UNA REGIÓN DE LYNCHBURG MÁS SALUDABLE PARA TODOS LOS QUE VIVEN, TRABAJAN Y JUEGAN AQUÍ.

¡DÍGANOS QUÉ NECESITA PARA VIVIR UNA VIDA MÁS SALUDABLE!

<u>COMPLETE NUESTRA ENCUESTA</u>. TODA LA INFORMACIÓN SE MANTENDRÁ CONFIDENCIAL.

- ***Complete la encuesta en línea en* centrahealth.com/CHNA**

  O

- ***escanee el código QR***

  O

- ***complete la encuesta en papel adjunta.***

TENDRÁ LA OPORTUNIDAD DE GANAR UNA TARJETA REGALO DE Walmart DE $25. *Para agradecerle que haya completado la encuesta, puede participar en un sorteo para recibir un certificado de regalo de $25.00 para Walmart. Habrá cuatro oportunidades de ganar. Si desea ingresar al sorteo, complete la información a continuación. Su información de contacto no estará vinculada a sus respuestas a la encuesta. El sorteo tendrá lugar en julio de 2021 y los ganadores serán contactados.*

Muchas gracias por su ayuda,

Centra Department of Community Health

Complete la información a continuación si desea que le incluyan en un sorteo para un certificado de regalo de $25.00 para Walmart. Los ganadores serán contactados en julio de 2021.

Nombre: _____

Dirección: _____

_____

Teléfono: _____

Correo electrónico: _____

PARA USO EXCLUSIVO EN LA CONSULTA: Centro de recogida: _____ Fecha: _____

Centra Health, en sociedad con Partnership for Healthy Communities y el Central Virginia Health District, está trabajando con líderes de la comunidad para saber más sobre lo que necesita para estar sano. Responda a las siguientes preguntas con la mejor respuesta o las mejores respuestas. Todas las encuestas se mantendrán confidenciales. Gracias por dedicar su tiempo a completar esta encuesta. Las encuestas se pueden enviar por correo postal al Department of Community Health, 1901 Tate Springs Rd, Lynchburg VA 24501. Debe tener más de 18 años para completar esta encuesta. Complete esta encuesta solo una vez.

ENCUESTA DE SALUD COMUNITARIA DEL ÁREA DE LYNCHBURG

SALUD DE LA COMUNIDAD

1. ¿Dónde vive?

❒ Condado de Amherst ❒ Condado de Appomattox ❒ Condado de Campbell ❒ Condado de Pittsylvania ❒ Ciudad de Danville ❒ Ciudad de Lynchburg

❒ Otro: _____

2. ¿Cuáles cree que son los problemas más importantes que afectan a la salud de nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

<u>Factores de salud</u>

❒ Acceso a una vivienda accesible
❒ Acceso a alimentos saludables
❒ Accidentes en el hogar (p. ej., caídas, quemaduras, cortes)
❒ Consumo de alcohol y drogas ilegales
❒ Problemas de envejecimiento
❒ Acoso
❒ Uso del teléfono móvil/mensajes de texto y conducción/conducción distraída
❒ Abuso/descuido infantil
❒ Violencia doméstica
❒ Salud ambiental (p. ej., calidad del agua, calidad del aire, pesticidas, etc.)
❒ Actividad de pandillas
❒ Homicidio
❒ Problemas de vivienda (p. ej., moho, chinches, pintura de plomo)
❒ Lesiones
❒ Falta de ejercicio
❒ Seguridad del vecindario
❒ No recibir "inyecciones" para prevenir enfermedades
❒ No usar cinturones de seguridad/sillas de seguridad para niños/cascos
❒ Malos hábitos alimenticios
❒ Abuso de fármacos con receta
❒ Agresión sexual
❒ Aislamiento social
❒ Problemas de transporte
❒ Tabaquismo/fumar/vapear
❒ Sexo sin protección
❒ Otro: _____

<u>Afecciones o consecuencias médicas</u>

❒ Tipos de cáncer
❒ COVID-19/coronavirus
❒ Problemas dentales
❒ Diabetes
❒ Discapacidad
❒ Aflicción
❒ Cardiopatía y accidente cerebrovascular
❒ Presión arterial alta
❒ VIH/SIDA
❒ Muerte en menores de 1 año
❒ Enfermedad pulmonar
❒ Problemas de salud mental
❒ Sobrepeso/obesidad
❒ Estrés
❒ Suicidio
❒ Embarazo en la adolescencia
❒ Otro: _____

3. ¿Qué servicios de atención médica son difíciles de obtener en nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

❒ Cuidado dental en adultos
❒ Terapia alternativa (p. ej., a base de hierbas, acupuntura, masaje)
❒ Servicios de ambulancia
❒ Atención oncológica
❒ Cuidado dental infantil
❒ Atención quiropráctica
❒ Dermatología
❒ Servicios de violencia doméstica
❒ Cuidado de personas mayores
❒ Atención en urgencias
❒ Final de la vida/cuidados paliativos
❒ Médico de cabecera
❒ Inmunizaciones
❒ Hospitalización
❒ Análisis de laboratorio
❒ LGBTQ
❒ Medicamentos/suministros médicos
❒ Salud mental/orientación
❒ Fisioterapia
❒ Atención preventiva (p. ej., revisiones anuales)
❒ Programas para dejar de usar productos de tabaco
❒ Atención especializada (p. ej., cardiólogo)
❒ Servicios de consumo de sustancias: drogas y alcohol
❒ Atención de urgencias/Puesto de asistencia sanitaria básica
❒ Cuidado de la vista
❒ Servicios médicos para mujeres
❒ Radiografías/mamografías
❒ Ninguno
❒ Otro: _____
❒ La COVID-19 ha hecho que uno o más de los servicios que he seleccionado sean difíciles de obtener

4. ¿Qué recursos sociales/de apoyo son difíciles de obtener en nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

- ❒ Vivienda accesible/segura
- ❒ Asistencia bancaria/financiera
- ❒ Guardería
- ❒ Asistencia para la violencia doméstica
- ❒ Educación y alfabetización
- ❒ Empleo/asistencia laboral
- ❒ Beneficios alimentarios (SNAP, WIC)
- ❒ Asesoramiento sobre duelo/sentimiento de pérdida
- ❒ Seguro médico
- ❒ Alimentos saludables
- ❒ Servicios jurídicos
- ❒ Asistencia con medicamentos
- ❒ Asistencia en deudas médicas
- ❒ Asistencia con el alquiler/servicios públicos
- ❒ Asistencia temporal para familias con necesidades (Temporary Assistance for Needy Families, TANF)
- ❒ Transporte
- ❒ Beneficios de desempleo
- ❒ Servicios para veteranos
- ❒ Otro: _____
- ❒ La COVID-19 ha hecho que uno o más de los servicios que he seleccionado sean difíciles de obtener

PREGUNTAS DE SALUD GENERAL

5. ¿Qué le impide estar sano? *(Marque <u>todas</u> las que correspondan)*

- ❒ Temo tener revisiones
- ❒ No puedo encontrar proveedores que acepten mi seguro
- ❒ Guardería
- ❒ Costo
- ❒ No sé qué tipos de servicios están disponibles
- ❒ No me gusta aceptar asistencia gubernamental
- ❒ No confío en los médicos/clínicas/mi seguro
- ❒ No tengo una fuente regular de atención médico
- ❒ Copago alto
- ❒ Falta de servicios nocturnos y de fin de semana
- ❒ Servicios de idiomas
- ❒ Ubicación de las oficinas
- ❒ Largos períodos de espera para las citas
- ❒ Sin seguro médico
- ❒ Sin transporte
- ❒ Nada me impide estar sano
- ❒ Otro: _____

6. ¿Utiliza servicios de atención médica?

❒ **<u>Sí</u> - Marque dónde acude para recibir atención médica (*marque <u>todas</u> las que correspondan*)** ❒ **<u>No</u>**

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Consultorio del médico
- ❒ Servicio de urgencias
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Centro de salud con calificación federal (p. ej., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Departamento de Salud
- ❒ Veterans Administration Medical Center
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Otro: _____

7. ¿Cuánto tiempo ha pasado desde que visitó por última vez a un médico u otro proveedor de atención médica para una revisión de rutina? *(Marque <u>una</u> opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he acudido a un médico ni a otro proveedor de atención médica para una revisión de rutina
- ❒ En el último año, he decidido no ver a un proveedor de atención médica o he pospuesto o cancelado una visita debido a la COVID-19

8. ¿Utiliza servicios de cuidado dental?

❒ **<u>Sí</u> – Marque dónde acude para recibir atención dental (*marque <u>todas</u> las que correspondan*)** ❒ **<u>No</u>**

- ❒ Consultorio del dentista
- ❒ Servicio de urgencias
- ❒ Centro de salud con calificación federal (p. ej., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Veterans Administration Medical Center
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Misión del proyecto Mercy
- ❒ Otro: _____

9. ¿Cuánto tiempo ha pasado desde que visitó por última vez un dentista o clínica dental por cualquier motivo? Incluya visitas a especialistas dentales como ortodoncistas. *(Marque <u>una</u> opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he visitado a un dentista o clínica dental por ningún motivo.
- ❒ En el último año, he decidido no ver a un dentista o especialista dental o he pospuesto o cancelado una visita debido a la COVID-19

10. ¿Utiliza servicios de salud mental, o para el consumo de alcohol o drogas?

❒ **Sí - Marque dónde acude para recibir los servicios (*marque todas las que correspondan*)**

- ❒ Horizon Behavioral Health
- ❒ Consultorio del médico/orientador
- ❒ Servicio de urgencias
- ❒ Centro de salud con calificación federal (p. ej., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Veterans Administration Medical Center
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Otro: _____

❒ **No**

11. ¿Cuánto tiempo ha pasado desde que utilizó por última vez servicios de salud mental, para el consumo de alcohol o de drogas por cualquier motivo? *(Marque una opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he utilizado servicios de salud mental, para consumo de alcohol o de drogas por ningún motivo
- ❒ En el último año, he decidido no ver a un proveedor de salud mental o de consumo de sustancias u orientador o he pospuesto o cancelado una visita debido a la COVID-19

12. ¿Le ha dicho un médico que tiene...? (*Marque todas las que correspondan*)

- ❒ Asma
- ❒ Cáncer
- ❒ Depresión o ansiedad
- ❒ Problemas con las drogas o el alcohol
- ❒ Cardiopatía
- ❒ Presión arterial alta
- ❒ Nivel alto de azúcar en sangre o diabetes
- ❒ Parálisis cerebral
- ❒ Colesterol alto
- ❒ VIH/SIDA
- ❒ Problemas de salud mental
- ❒ Obesidad/sobrepeso
- ❒ Accidente/enfermedad cerebrovascular
- ❒ No tengo problemas de salud
- ❒ Otro: _____

13. Pensando en su salud física, que incluye enfermedad física y lesión, ¿durante cuántos días de los últimos 30 días su salud física no fue buena? _____ días

14. Pensando en su salud mental, que incluye estrés, depresión y problemas emocionales, ¿durante cuántos días de los últimos 30 días su salud mental no fue buena? _____ días

15. Durante los últimos 30 días: *(Marque todas las que correspondan)*

- ❒ He tomado 5 o más bebidas alcohólicas (si es hombre) o 4 o más bebidas alcohólicas (si es mujer) durante una ocasión
- ❒ He utilizado productos de tabaco (cigarrillos, tabaco sin humo, cigarrillos electrónicos, etc.)
- ❒ He tomado medicamentos con receta para drogarme
- ❒ He consumido marihuana
- ❒ He consumido otras drogas ilegales (p. ej., metanfetaminas, cocaína, heroína, éxtasis, crac, LSD, etc.)
- ❒ Ninguno de estas

16. Marque una de las siguientes opciones para cada afirmación	**Sí**	**No**	**No corresponde**
He acudido a urgencias en los últimos 12 meses.	❒	❒	
He estado en urgencias por una lesión en los últimos 12 meses (p. ej., accidente de un vehículo de motor, choque, caída, intoxicación, quemadura, corte, etc.).	❒	❒	
He sido víctima de violencia o abuso doméstico en los últimos 12 meses.	❒	❒	
Tomo el medicamento que mi médico me dice que tome para controlar mi enfermedad crónica.	❒	❒	❒
Puedo pagar los medicamentos necesarios para mis afecciones médicas.	❒	❒	❒
¿Su comunidad apoya la actividad física? (p. ej., parques, aceras, carriles para bicicletas, etc.)	❒	❒	
En la zona donde vive, ¿es fácil obtener frutas y verduras frescas accesibles?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía suficiente dinero para comprar la comida que usted o su familia necesitaban?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía dinero suficiente para pagar su alquiler o hipoteca?	❒	❒	❒
¿Se siente seguro donde vive?	❒	❒	

17. En los últimos 7 días, ¿cuántos días practicó actividad física durante un total de al menos 30 minutos? (Sume todo el tiempo que dedique a cualquier tipo de actividad física que aumente su frecuencia cardíaca y le haga respirar con dificultad durante parte del tiempo).

❒ 0 días ❒ 1 día ❒ 2 días ❒ 3 días ❒ 4 días ❒ 5 días ❒ 6 días ❒ 7 días

18. ¿Dónde consigue la comida que come en su hogar? *(Marque <u>todas</u> las que correspondan)*

❒ Programas de comida de mochila o de verano
❒ Jardín comunitario
❒ Tienda de conveniencia/estación de servicio
❒ Tienda todo por 1 dólar
❒ Mercado
❒ Banco de alimentos/despensa de alimentos
❒ Supermercado
❒ Huerta familiar
❒ No como en casa
❒ Habitualmente recibo comida de mi familia, amigos, vecinos o de mi iglesia
❒ Programa Meals on Wheels
❒ Comida para llevar/comida rápida/restaurante
❒ Otro: _____

19. Durante los últimos 7 días, ¿cuántas veces ha comido frutas y verduras? No cuente jugo de frutas ni de verduras. *(Marque <u>una</u> opción)*

❒ No he comido frutas ni verduras durante los últimos 7 días
❒ 1 a 3 veces durante los últimos 7 días
❒ 4 a 6 veces durante los últimos 7 días
❒ 1 vez por día
❒ 2 veces por día
❒ 3 veces por día
❒ 4 o más veces por día

20. En los últimos 7 días, ¿cuántas veces comieron juntos todos o la mayoría de los miembros de su familia que viven en su casa?

❒ Nunca ❒ 1 a 2 veces ❒ 3 a 4 veces ❒ 5 a 6 veces ❒ 7 veces ❒ Más de 7 veces ❒ No corresponde/Vivo solo

21. ¿En qué medida se siente conectado con la comunidad y las personas que le rodean?

❒ Muy conectado ❒ Algo conectado ❒ No conectado

22. ¿Dónde duerme con más frecuencia? *(Marque <u>una</u> opción)*

❒ En una casa que poseo o alquilo
❒ Con amigos o familiares debido a problemas económicos
❒ En un refugio o en un programa de vivienda de transición
❒ En un hogar de grupo, hospital o programa de tratamiento
❒ En un hotel o motel
❒ Fuera, en un coche, en un edificio abandonado o en un espacio público

23. ¿Tiene acceso a un transporte fiable? ❒ Sí ❒ No

24. ¿Qué tipo de transporte utiliza con más frecuencia?

❒ Conduzco
❒ Bicicleta o andando
❒ Mis amigos/familiares me llevan
❒ Transporte público (es decir, autobús, servicio de enlaces, similar)
❒ Otro servicio de transporte (nombre): _____
❒ Taxi (incluido Uber/Lyft)
❒ Uso compartido de vehículos
❒ Otro: _____

INFORMACIÓN DEMOGRÁFICA Y SEGURO MÉDICO

25. ¿Cuál de las siguientes opciones describe su tipo actual de seguro médico? *(Marque <u>todas</u> las que correspondan)*

❒ COBRA
❒ Seguro dental
❒ Seguro proporcionado por el empleador
❒ Gobierno (VA, TRICARE)
❒ Cuenta de ahorros/gastos médica
❒ Seguro individual/privado/Marketplace /Obamacare
❒ Medicaid
❒ Medicare
❒ Complemento de Medicare
❒ Sin seguro dental
❒ Sin seguro médico

26. Si no tiene seguro médico, ¿por qué no tiene seguro? *(Marque <u>todas</u> las que correspondan)*

❒ No corresponde; tengo seguro médico
❒ No entiendo las opciones de Marketplace/Obamacare
❒ No disponible en mi trabajo
❒ Estudiante
❒ Demasiado caro/costo
❒ Desempleado/sin trabajo
❒ Otro: _____

27. ¿Cuál es su código postal? _____ **28. ¿Cuál es su edad?** _____

29. ¿Cuál es su identidad de género? ❒ Hombre ❒ Mujer ❒ No binario ❒ Otro: _____

30. ¿Cuál es su estatura? _____pies _____pulgadas **31. ¿Cuál es su peso?** _____libras

32. ¿Cuántas personas viven en su casa (incluido usted)?

Cantidad de niños (de 0 a 17 años de edad) _____ Cantidad de adultos de 18 a 64 años _____ Cantidad de adultos de 65 años o más _____

33. ¿Cuál es su nivel de educación completo más alto?

- ❒ Menos que la escuela secundaria
- ❒ Algo de la escuela secundaria
- ❒ Título de escuela secundaria/GED
- ❒ Técnico superior
- ❒ Licenciatura
- ❒ Máster/doctorado

34. ¿Con qué raza/origen étnico se identifica? *(Marque <u>una</u> opción)*

- ❒ Nativo de Hawái/islas del Pacífico
- ❒ Nativo estadounidense/Nativo de Alaska
- ❒ Asiático
- ❒ Hispano/Latino
- ❒ Negro/Afroestadounidense
- ❒ Blanco
- ❒ Más de una raza
- ❒ Rehúso responder
- ❒ Otro: _____

35. ¿Cuál es su estado civil?

❒ Casado/a ❒ Soltero/a ❒ Divorciado/a ❒ Viudo/a ❒ En pareja

36. ¿Cuáles son los ingresos anuales de su familia?

- ❒ $0 a $10 000
- ❒ $10 001 a $20 000
- ❒ $20 001 a $30 000
- ❒ $30 001 a $40 000
- ❒ $40 001 a $50 000
- ❒ $50 001 a $60 000
- ❒ $60 001 a $70 000
- ❒ $70 001 a $100 000
- ❒ $101 001 y más

37. ¿Cuál es su situación laboral actual?

- ❒ A tiempo completo
- ❒ A tiempo parcial
- ❒ Desempleado
- ❒ Autónomo
- ❒ Jubilado
- ❒ Tareas domésticas
- ❒ Estudiante
- ❒ Discapacitado/a

38. ¿Hay algo más que deberíamos saber sobre sus necesidades (o las de alguien que vive en su hogar) para mantenerse sano?

_____

_____

_____

¡Gracias por ayudar a convertir el área metropolitana de Lynchburg en un lugar más saludable para vivir, trabajar y jugar!

WE WANT TO CREATE A HEALTHIER PITTSYLVANIA COUNTY FOR ALL WHO LIVE, WORK, AND PLAY HERE.

PLEASE TELL US WHAT YOU NEED TO LIVE A HEALTHIER LIFE!

<u>PLEASE COMPLETE OUR SURVEY</u>. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

- ***Complete the survey online at* centrahealth.com/CHNA**

  OR

- ***Scan the QR code***

  OR

- ***Complete the attached paper survey***

YOU WILL GET THE CHANCE TO WIN A $25 Walmart GIFT CARD.
To thank you for filling out the survey, you can enter a drawing to receive a $25.00 gift certificate to Walmart. There will be four chances to win. If you would like to enter the drawing, please complete the information below. Your contact information will not be linked to your survey answers. The drawing will take place in July of 2021 and winners will be contacted.

Thank you very much for your help,

Centra Department of Community Health

Please complete the information below if you would like to be entered into a drawing for a $25.00 Gift Certificate to Walmart. Winners will be contacted in July of 2021.

Name: _____

Address: _____

_____

Phone: _____

Email: _____

FOR OFFICE USE ONLY: Site of Collection: _____ Date: _____

Centra Health, in partnership with the Partnership for Healthy Communities and the Central Virginia Health District, is working with community leaders to learn more about what you need to be healthy. Please answer the following questions with the best answer or answers. All surveys will be kept confidential. Thank you for taking the time to complete this survey. Surveys can be mailed to Centra Department of Community Health, 1901 Tate Springs Rd, Lynchburg VA 24501. You must be over 18 to complete this survey. Please complete this survey only once.

LYNCHBURG AREA COMMUNITY HEALTH SURVEY

HEALTH OF THE COMMUNITY

1. Where do you live?

❒ Amherst Co. ❒ Appomattox Co. ❒ Campbell Co. ❒ Pittsylvania Co. ❒ City of Danville ❒ City of Lynchburg

❒ Other: _____

2. What do you think are the most important issues that affect health in our community? (*Please check all that apply*)

Health Factors

❒ Access to affordable housing
❒ Access to healthy foods
❒ Accidents in the home (e.g., falls, burns, cuts)
❒ Alcohol and illegal drug use
❒ Aging problems
❒ Bullying
❒ Cell phone use / texting and driving / distracted driving
❒ Child abuse / neglect
❒ Domestic Violence
❒ Environmental health (e.g., water quality, air quality, pesticides, etc.)
❒ Gang activity
❒ Homicide
❒ Housing problems (e.g., mold, bed bugs, lead paint)
❒ Injuries
❒ Lack of exercise
❒ Neighborhood safety
❒ Not getting "shots" to prevent disease
❒ Not using seat belts / child safety seats / helmets
❒ Poor eating habits
❒ Prescription drug abuse
❒ Sexual assault
❒ Social isolation
❒ Transportation problems
❒ Tobacco use / smoking / vaping
❒ Unsafe sex
❒ Other: _____

Health Conditions or Outcomes

❒ Cancers
❒ COVID-19 / coronavirus
❒ Dental problems
❒ Diabetes
❒ Disability
❒ Grief
❒ Heart disease and stroke
❒ High blood pressure
❒ HIV / AIDS
❒ Infant death
❒ Lung disease
❒ Mental health problems
❒ Overweight / obesity
❒ Stress
❒ Suicide
❒ Teenage pregnancy
❒ Other: _____

3. Which health care services are hard to get in our community? *(Please check all that apply)*

❒ Adult dental care
❒ Alternative therapy (e.g., herbal, acupuncture, massage)
❒ Ambulance services
❒ Cancer care
❒ Child dental care
❒ Chiropractic care
❒ Dermatology
❒ Domestic violence services
❒ Eldercare
❒ Emergency room care
❒ End of life / hospice / palliative care
❒ Family doctor
❒ Immunizations
❒ Inpatient hospital
❒ Lab work
❒ LGBTQ
❒ Medication / medical supplies
❒ Mental health / counseling
❒ Physical therapy
❒ Preventive care (e.g., yearly check-ups)
❒ Programs to stop using tobacco products
❒ Specialty care (e.g., heart doctor)
❒ Substance use services – drug and alcohol
❒ Urgent care / walk-in clinic
❒ Vision care
❒ Women's health services
❒ X-rays / mammograms
❒ None
❒ Other: _____
❒ COVID-19 has made one or more of the services I selected hard to get

4. Which social / support resources are hard to get in our community? *(Please check all that apply)*

❒ Affordable / safe housing
❒ Banking / financial assistance
❒ Childcare
❒ Domestic violence assistance
❒ Education and literacy
❒ Employment / job assistance
❒ Food benefits (SNAP, WIC)
❒ Grief / bereavement counseling
❒ Health insurance
❒ Healthy food
❒ Legal services
❒ Medication assistance
❒ Medical debt assistance
❒ Rent / utilities assistance
❒ TANF (Temporary Assistance for Needy Families)
❒ Transportation
❒ Unemployment benefits
❒ Veterans services
❒ Other: _____
❒ COVID-19 has made one or more of the services I selected hard to get

GENERAL HEALTH QUESTIONS

5. What keeps you from being healthy? (*Please check <u>all</u> that apply*)

- ❒ Afraid to have check-ups
- ❒ Can't find providers that accept my insurance
- ❒ Childcare
- ❒ Cost
- ❒ Don't know what types of services are available
- ❒ Don't like accepting government assistance
- ❒ Don't trust doctors / clinics / my insurance
- ❒ Have no regular source of healthcare
- ❒ High co-pay
- ❒ Lack of evening and weekend services
- ❒ Language services
- ❒ Location of offices
- ❒ Long waits for appointments
- ❒ No health insurance
- ❒ No transportation
- ❒ Nothing keeps me from being healthy
- ❒ Other:_____

6. Do you use medical care services?

❒ **<u>Yes</u> - Check where you go for medical care** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Doctor's Office
- ❒ Emergency Room
- ❒ Urgent Care / Walk-in Clinic
- ❒ Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Health Department
- ❒ Veterans Administration Medical Center
- ❒ Online / Telehealth / Virtual Visit
- ❒ Other:_____

7. How long has it been since you last visited a doctor or other healthcare provider for a routine checkup? (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never visited a doctor or other healthcare provider for a routine checkup
- ❒ Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19

8. Do you use dental care services?

❒ **<u>Yes</u> – Check where you go for dental care** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Dentist's Office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Veterans Administration Medical Center
- ❒ Urgent Care / Walk-in Clinic
- ❒ Mission of Mercy Project
- ❒ Other:_____

9. How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists such as orthodontists. (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never visited a dentist or dental clinic for any reason.
- ❒ Within the past year I have chosen not to see a dentist or dental specialist or have postponed or cancelled a visit because of COVID-19

10. Do you use mental health, alcohol use, or drug use services?

❒ **<u>Yes</u> – check where you go for services** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Horizon Behavioral Health
- ❒ Doctor / Counselor's office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Online / Telehealth / Virtual Visits
- ❒ Veterans Administration Medical Center
- ❒ Urgent Care / Walk-in Clinic
- ❒ Other:_____

11. How long has it been since you last used mental health, alcohol use, or drug use services for any reason? (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never used mental health, alcohol use, or drug use services for any reason
- ❒ Within the past year I have chosen not to see a mental health or substance use provider or counselor or have postponed or cancelled a visit because of COVID-19

12. Have you been told by a doctor that you have… (*Please check all that apply*)

- ❒ Asthma
- ❒ Cancer
- ❒ Depression or anxiety
- ❒ Drug or alcohol problems
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High blood sugar or diabetes
- ❒ Cerebral palsy
- ❒ High cholesterol
- ❒ HIV / AIDS
- ❒ Mental health problems
- ❒ Obesity / overweight
- ❒ Stroke / cerebrovascular disease
- ❒ I have no health problems
- ❒ Other:_____

13. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?_____Days

14. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? _____Days

15. During the past 30 days: (*Please check all that apply*)

- ❒ I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion
- ❒ I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)
- ❒ I have taken prescription drugs to get high
- ❒ I have used marijuana
- ❒ I have used other illegal drugs (e.g., meth, cocaine, heroin, ecstasy, crack, LSD, etc.)
- ❒ None of these

16. Please check one of the following for each statement	**Yes**	**No**	**Not Applicable**
I have been to the emergency room in the past 12 months.	❒	❒	
I have been to the emergency room for an injury in the past 12 months (e.g., motor vehicle crash, fall, poisoning, burn, cut, etc.).	❒	❒	
I have been a victim of domestic violence or abuse in the past 12 months.	❒	❒	
I take the medicine my doctor tells me to take to control my chronic illness.	❒	❒	❒
I can afford medicine needed for my health conditions.	❒	❒	❒
Does your community support physical activity? (e.g., parks, sidewalks, bike lanes, etc.)	❒	❒	
In the area that you live, is it easy to get affordable fresh fruits and vegetables?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?	❒	❒	❒
Do you feel safe where you live?	❒	❒	

17. In the past 7 days, how many days were you physically active for a total of at least 30 minutes? (Add up all the time you spend in any kind of physical activity that increased your heart rate and made you breathe hard for some of the time.)

❒ 0 days ❒ 1 day ❒ 2 days ❒ 3 days ❒ 4 days ❒ 5 days ❒ 6 days ❒ 7 days

18. Where do you get the food that you eat at home? (*Please check all that apply*)

- ❒ Back-pack or summer food programs
- ❒ Community garden
- ❒ Corner store / convenience store / gas station
- ❒ Dollar store
- ❒ Farmers' market
- ❒ Food bank / food pantry
- ❒ Grocery store
- ❒ Home garden
- ❒ I do not eat at home
- ❒ I regularly receive food from family, friends, neighbors, or my church
- ❒ Meals on Wheels
- ❒ Take-out / fast food / restaurant
- ❒ Other:_____

19. During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice. (*Please check one*)

- ❒ I did not eat fruits or vegetables during the past 7 days
- ❒ 1 – 3 times during the past 7 days
- ❒ 4 - 6 times during the past 7 days
- ❒ 1 time per day
- ❒ 2 times per day
- ❒ 3 times per day
- ❒ 4 or more times per day

20. In the past 7 days, how many times did all or most of your family living in your house eat a meal together?

- ❒ Never
- ❒ 1 – 2 times
- ❒ 3 – 4 times
- ❒ 5 – 6 times
- ❒ 7 times
- ❒ More than 7 times
- ❒ Not Applicable / I live alone

21. How connected do you feel with the community and those around you?

❒ Very connected ❒ Somewhat connected ❒ Not connected

22. Where do you sleep most often? (*Please check <u>one</u>*)

❒ In a home I own or rent
❒ Stay with friends or family because of financial issues
❒ In a shelter or transitional housing program
❒ In a group home, hospital, or treatment program
❒ In a hotel or motel
❒ Outside, in a car, abandoned building, or public space

23. Do you have access to reliable transportation? ❒ Yes ❒ No

24. What type of transportation do you use most often?

❒ I drive
❒ Bike or walk
❒ Friends / family drive me
❒ Public transit (i.e., bus, shuttle, similar)
❒ Other transit service (name):_____
❒ Taxi (including Uber / Lyft)
❒ Ridesharing / Carpooling
❒ Other:_____

DEMOGRAPHIC INFORMATION AND HEALTH INSURANCE

25. Which of the following describes your current type of health insurance? (*Please check <u>all</u> that apply*)

❒ COBRA
❒ Dental Insurance
❒ Employer provided insurance
❒ Government (VA, TRICARE)
❒ Health Savings / Spending Account
❒ Individual / Private Insurance / Marketplace / Obamacare
❒ Medicaid
❒ Medicare
❒ Medicare Supplement
❒ No Dental Insurance
❒ No Health Insurance

26. If you have no health insurance, why don't you have insurance? (*Please check <u>all</u> that apply*)

❒ Not applicable – I have health insurance
❒ I don't understand Marketplace / Obamacare options
❒ Not available at my job
❒ Student
❒ Too expensive / cost
❒ Unemployed / no job
❒ Other:_____

27. What is your Zip Code? _____ **28. What is your age?** _____

29. What is your gender identity? ❒ Male ❒ Female ❒ Non-binary ❒ Other:_____

30. What is your height? _____feet_____inches **31. What is your weight?** _____pounds

32. How many people live in your home (including yourself)?

Number of children (0 - 17 years of age) _____ Number of adults age 18 - 64_____ Number of adults age 65 or older_____

33. What is your highest education level completed?

❒ Less than high school
❒ Some high school
❒ High school diploma / GED
❒ Associates degree
❒ Bachelors degree
❒ Masters / PhD degree

34. What race/ethnicity do you identify with? (*Please check <u>one</u>*)

❒ Native Hawaiian / Pacific Islander
❒ American Indian / Alaskan Native
❒ Asian
❒ Hispanic / Latino
❒ Black / African American
❒ White
❒ More than one race
❒ Decline to answer
❒ Other: _____

35. What is your marital status?

❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partnership

36. What is your yearly household income?

❒ $0 - $10,000
❒ $10,001 - $20,000
❒ $20,001 - $30,000
❒ $30,001 - $40,000
❒ $40,001 - $50,000
❒ $50,001 - $60,000
❒ $60,001 - $70,000
❒ $70,001 - $100,000
❒ $101,001 and above

37. What is your current employment status?

❒ Full-time
❒ Part-time
❒ Unemployed
❒ Self-employed
❒ Retired
❒ Homemaker
❒ Student
❒ Disabled

38. Is there anything else we should know about your (or someone living in your home) needs to stay healthy?

_____

_____

_____

Thank you for helping make the greater Lynchburg Area a healthier place to live, work, and play!

QUEREMOS CREAR UN CONDADO DE PITTSYLVANIA MÁS SALUDABLE PARA TODOS LOS QUE VIVEN, TRABAJAN Y JUEGAN AQUÍ.

¡DÍGANOS QUÉ NECESITA PARA VIVIR UNA VIDA MÁS SALUDABLE!

<u>COMPLETE NUESTRA ENCUESTA.</u> TODA LA INFORMACIÓN SE MANTENDRÁ CONFIDENCIAL.

- ***Complete la encuesta en línea en*** **centrahealth.com/CHNA**

  O

- ***escanee el código QR***

  O

- ***complete la encuesta en papel adjunta.***

TENDRÁ LA OPORTUNIDAD DE GANAR UNA TARJETA REGALO DE Walmart DE $25. *Para agradecerle que haya completado la encuesta, puede participar en un sorteo para recibir un certificado de regalo de $25.00 para Walmart. Habrá cuatro oportunidades de ganar. Si desea ingresar al sorteo, complete la información a continuación. Su información de contacto no estará vinculada a sus respuestas a la encuesta. El sorteo tendrá lugar en julio de 2021 y los ganadores serán contactados.*

Muchas gracias por su ayuda,

Centra Department of Community Health

Complete la información a continuación si desea que le incluyan en un sorteo para un certificado de regalo de $25.00 para Walmart. Los ganadores serán contactados en julio de 2021.

Nombre: _____

Dirección: _____

_____

Teléfono: _____

Correo electrónico: _____

PARA USO EXCLUSIVO EN LA CONSULTA: Centro de recogida: _____ Fecha: _____

Centra Health, en sociedad con Partnership for Healthy Communities y el Central Virginia Health District, está trabajando con líderes de la comunidad para saber más sobre lo que necesita para estar sano. Responda a las siguientes preguntas con la mejor respuesta o las mejores respuestas. Todas las encuestas se mantendrán confidenciales. Gracias por dedicar su tiempo a completar esta encuesta. Las encuestas se pueden enviar por correo postal al Department of Community Health, 1901 Tate Springs Rd, Lynchburg VA 24501. Debe tener más de 18 años para completar esta encuesta. Complete esta encuesta solo una vez.

ENCUESTA DE SALUD COMUNITARIA DEL ÁREA DE LYNCHBURG

SALUD DE LA COMUNIDAD

1. ¿Dónde vive?

❒ Condado de Amherst ❒ Condado de Appomattox ❒ Condado de Campbell ❒ Condado de Pittsylvania ❒ Ciudad de Danville ❒ Ciudad de Lynchburg

❒ Otro: _____

2. ¿Cuáles cree que son los problemas más importantes que afectan a la salud de nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

<u>Factores de salud</u>

❒ Acceso a una vivienda accesible
❒ Acceso a alimentos saludables
❒ Accidentes en el hogar (p. ej., caídas, quemaduras, cortes)
❒ Consumo de alcohol y drogas ilegales
❒ Problemas de envejecimiento
❒ Acoso
❒ Uso del teléfono móvil/mensajes de texto y conducción/conducción distraída
❒ Abuso/descuido infantil
❒ Violencia doméstica
❒ Salud ambiental (p. ej., calidad del agua, calidad del aire, pesticidas, etc.)
❒ Actividad de pandillas
❒ Homicidio
❒ Problemas de vivienda (p. ej., moho, chinches, pintura de plomo)
❒ Lesiones
❒ Falta de ejercicio
❒ Seguridad del vecindario
❒ No recibir "inyecciones" para prevenir enfermedades
❒ No usar cinturones de seguridad/sillas de seguridad para niños/cascos
❒ Malos hábitos alimenticios
❒ Abuso de fármacos con receta
❒ Agresión sexual
❒ Aislamiento social
❒ Problemas de transporte
❒ Tabaquismo/fumar/vapear
❒ Sexo sin protección
❒ Otro: _____

<u>Afecciones o consecuencias médicas</u>

❒ Tipos de cáncer
❒ COVID-19/coronavirus
❒ Problemas dentales
❒ Diabetes
❒ Discapacidad
❒ Aflicción
❒ Cardiopatía y accidente cerebrovascular
❒ Presión arterial alta
❒ VIH/SIDA
❒ Muerte en menores de 1 año
❒ Enfermedad pulmonar
❒ Problemas de salud mental
❒ Sobrepeso/obesidad
❒ Estrés
❒ Suicidio
❒ Embarazo en la adolescencia
❒ Otro: _____

3. ¿Qué servicios de atención médica son difíciles de obtener en nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

❒ Cuidado dental en adultos
❒ Terapia alternativa (p. ej., a base de hierbas, acupuntura, masaje)
❒ Servicios de ambulancia
❒ Atención oncológica
❒ Cuidado dental infantil
❒ Atención quiropráctica
❒ Dermatología
❒ Servicios de violencia doméstica
❒ Cuidado de personas mayores
❒ Atención en urgencias
❒ Final de la vida/cuidados paliativos
❒ Médico de cabecera
❒ Inmunizaciones
❒ Hospitalización
❒ Análisis de laboratorio
❒ LGBTQ
❒ Medicamentos/suministros médicos
❒ Salud mental/orientación
❒ Fisioterapia
❒ Atención preventiva (p. ej., revisiones anuales)
❒ Programas para dejar de usar productos de tabaco
❒ Atención especializada (p. ej., cardiólogo)
❒ Servicios de consumo de sustancias: drogas y alcohol
❒ Atención de urgencias/Puesto de asistencia sanitaria básica
❒ Cuidado de la vista
❒ Servicios médicos para mujeres
❒ Radiografías/mamografías
❒ Ninguno
❒ Otro: _____
❒ La COVID-19 ha hecho que uno o más de los servicios que he seleccionado sean difíciles de obtener

4. ¿Qué recursos sociales/de apoyo son difíciles de obtener en nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

- ❒ Vivienda accesible/segura
- ❒ Asistencia bancaria/financiera
- ❒ Guardería
- ❒ Asistencia para la violencia doméstica
- ❒ Educación y alfabetización
- ❒ Empleo/asistencia laboral
- ❒ Beneficios alimentarios (SNAP, WIC)
- ❒ Asesoramiento sobre duelo/sentimiento de pérdida
- ❒ Seguro médico
- ❒ Alimentos saludables
- ❒ Servicios jurídicos
- ❒ Asistencia con medicamentos
- ❒ Asistencia en deudas médicas
- ❒ Asistencia con el alquiler/servicios públicos
- ❒ Asistencia temporal para familias con necesidades (Temporary Assistance for Needy Families, TANF)
- ❒ Transporte
- ❒ Beneficios de desempleo
- ❒ Servicios para veteranos
- ❒ Otro: _____
- ❒ La COVID-19 ha hecho que uno o más de los servicios que he seleccionado sean difíciles de obtener

PREGUNTAS DE SALUD GENERAL

5. ¿Qué le impide estar sano? *(Marque <u>todas</u> las que correspondan)*

- ❒ Temo tener revisiones
- ❒ No puedo encontrar proveedores que acepten mi seguro
- ❒ Guardería
- ❒ Costo
- ❒ No sé qué tipos de servicios están disponibles
- ❒ No me gusta aceptar asistencia gubernamental
- ❒ No confío en los médicos/clínicas/mi seguro
- ❒ No tengo una fuente regular de atención médico
- ❒ Copago alto
- ❒ Falta de servicios nocturnos y de fin de semana
- ❒ Servicios de idiomas
- ❒ Ubicación de las oficinas
- ❒ Largos períodos de espera para las citas
- ❒ Sin seguro médico
- ❒ Sin transporte
- ❒ Nada me impide estar sano
- ❒ Otro: _____

6. ¿Utiliza servicios de atención médica?

❒ **<u>Sí</u> - Marque dónde acude para recibir atención médica (*marque <u>todas</u> las que correspondan*)** ❒ **<u>No</u>**

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Consultorio del médico
- ❒ Servicio de urgencias
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Centro de salud con calificación federal (p. ej., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Departamento de Salud
- ❒ Veterans Administration Medical Center
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Otro: _____

7. ¿Cuánto tiempo ha pasado desde que visitó por última vez a un médico u otro proveedor de atención médica para una revisión de rutina? *(Marque <u>una</u> opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he acudido a un médico ni a otro proveedor de atención médica para una revisión de rutina
- ❒ En el último año, he decidido no ver a un proveedor de atención médica o he pospuesto o cancelado una visita debido a la COVID-19

8. ¿Utiliza servicios de cuidado dental?

❒ **<u>Sí</u> – Marque dónde acude para recibir atención dental (*marque <u>todas</u> las que correspondan*)** ❒ **<u>No</u>**

- ❒ Consultorio del dentista
- ❒ Servicio de urgencias
- ❒ Centro de salud con calificación federal (p. ej., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Veterans Administration Medical Center
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Misión del proyecto Mercy
- ❒ Otro: _____

9. ¿Cuánto tiempo ha pasado desde que visitó por última vez un dentista o clínica dental por cualquier motivo? Incluya visitas a especialistas dentales como ortodoncistas. *(Marque <u>una</u> opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he visitado a un dentista o clínica dental por ningún motivo.
- ❒ En el último año, he decidido no ver a un dentista o especialista dental o he pospuesto o cancelado una visita debido a la COVID-19

10. ¿Utiliza servicios de salud mental, o para el consumo de alcohol o drogas?

❒ **Sí - Marque dónde acude para recibir los servicios (*marque todas las que correspondan*)**

- ❒ Horizon Behavioral Health
- ❒ Consultorio del médico/orientador
- ❒ Servicio de urgencias
- ❒ Centro de salud con calificación federal (p. ej., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Veterans Administration Medical Center
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Otro: _____

❒ **No**

11. ¿Cuánto tiempo ha pasado desde que utilizó por última vez servicios de salud mental, para el consumo de alcohol o de drogas por cualquier motivo? *(Marque una opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he utilizado servicios de salud mental, para consumo de alcohol o de drogas por ningún motivo
- ❒ En el último año, he decidido no ver a un proveedor de salud mental o de consumo de sustancias u orientador o he pospuesto o cancelado una visita debido a la COVID-19

12. ¿Le ha dicho un médico que tiene...? (*Marque todas las que correspondan*)

- ❒ Asma
- ❒ Cáncer
- ❒ Depresión o ansiedad
- ❒ Problemas con las drogas o el alcohol
- ❒ Cardiopatía
- ❒ Presión arterial alta
- ❒ Nivel alto de azúcar en sangre o diabetes
- ❒ Parálisis cerebral
- ❒ Colesterol alto
- ❒ VIH/SIDA
- ❒ Problemas de salud mental
- ❒ Obesidad/sobrepeso
- ❒ Accidente/enfermedad cerebrovascular
- ❒ No tengo problemas de salud
- ❒ Otro: _____

13. Pensando en su salud física, que incluye enfermedad física y lesión, ¿durante cuántos días de los últimos 30 días su salud física no fue buena? _____ días

14. Pensando en su salud mental, que incluye estrés, depresión y problemas emocionales, ¿durante cuántos días de los últimos 30 días su salud mental no fue buena? _____ días

15. Durante los últimos 30 días: *(Marque todas las que correspondan)*

- ❒ He tomado 5 o más bebidas alcohólicas (si es hombre) o 4 o más bebidas alcohólicas (si es mujer) durante una ocasión
- ❒ He utilizado productos de tabaco (cigarrillos, tabaco sin humo, cigarrillos electrónicos, etc.)
- ❒ He tomado medicamentos con receta para drogarme
- ❒ He consumido marihuana
- ❒ He consumido otras drogas ilegales (p. ej., metanfetaminas, cocaína, heroína, éxtasis, crac, LSD, etc.)
- ❒ Ninguno de estas

16. Marque una de las siguientes opciones para cada afirmación	**Sí**	**No**	**No corresponde**
He acudido a urgencias en los últimos 12 meses.	❒	❒	
He estado en urgencias por una lesión en los últimos 12 meses (p. ej., accidente de un vehículo de motor, choque, caída, intoxicación, quemadura, corte, etc.).	❒	❒	
He sido víctima de violencia o abuso doméstico en los últimos 12 meses.	❒	❒	
Tomo el medicamento que mi médico me dice que tome para controlar mi enfermedad crónica.	❒	❒	❒
Puedo pagar los medicamentos necesarios para mis afecciones médicas.	❒	❒	❒
¿Su comunidad apoya la actividad física? (p. ej., parques, aceras, carriles para bicicletas, etc.)	❒	❒	
En la zona donde vive, ¿es fácil obtener frutas y verduras frescas accesibles?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía suficiente dinero para comprar la comida que usted o su familia necesitaban?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía dinero suficiente para pagar su alquiler o hipoteca?	❒	❒	❒
¿Se siente seguro donde vive?	❒	❒	

17. En los últimos 7 días, ¿cuántos días practicó actividad física durante un total de al menos 30 minutos? (Sume todo el tiempo que dedique a cualquier tipo de actividad física que aumente su frecuencia cardíaca y le haga respirar con dificultad durante parte del tiempo).

❒ 0 días ❒ 1 día ❒ 2 días ❒ 3 días ❒ 4 días ❒ 5 días ❒ 6 días ❒ 7 días

18. ¿Dónde consigue la comida que come en su hogar? *(Marque <u>todas</u> las que correspondan)*

❒ Programas de comida de mochila o de verano
❒ Jardín comunitario
❒ Tienda de conveniencia/estación de servicio
❒ Tienda todo por 1 dólar
❒ Mercado
❒ Banco de alimentos/despensa de alimentos
❒ Supermercado
❒ Huerta familiar
❒ No como en casa
❒ Habitualmente recibo comida de mi familia, amigos, vecinos o de mi iglesia
❒ Programa Meals on Wheels
❒ Comida para llevar/comida rápida/restaurante
❒ Otro: _____

19. Durante los últimos 7 días, ¿cuántas veces ha comido frutas y verduras? No cuente jugo de frutas ni de verduras. *(Marque <u>una</u> opción)*

❒ No he comido frutas ni verduras durante los últimos 7 días
❒ 1 a 3 veces durante los últimos 7 días
❒ 4 a 6 veces durante los últimos 7 días
❒ 1 vez por día
❒ 2 veces por día
❒ 3 veces por día
❒ 4 o más veces por día

20. En los últimos 7 días, ¿cuántas veces comieron juntos todos o la mayoría de los miembros de su familia que viven en su casa?

❒ Nunca ❒ 1 a 2 veces ❒ 3 a 4 veces ❒ 5 a 6 veces ❒ 7 veces ❒ Más de 7 veces ❒ No corresponde/Vivo solo

21. ¿En qué medida se siente conectado con la comunidad y las personas que le rodean?

❒ Muy conectado ❒ Algo conectado ❒ No conectado

22. ¿Dónde duerme con más frecuencia? *(Marque <u>una</u> opción)*

❒ En una casa que poseo o alquilo
❒ Con amigos o familiares debido a problemas económicos
❒ En un refugio o en un programa de vivienda de transición
❒ En un hogar de grupo, hospital o programa de tratamiento
❒ En un hotel o motel
❒ Fuera, en un coche, en un edificio abandonado o en un espacio público

23. ¿Tiene acceso a un transporte fiable? ❒ Sí ❒ No

24. ¿Qué tipo de transporte utiliza con más frecuencia?

❒ Conduzco
❒ Bicicleta o andando
❒ Mis amigos/familiares me llevan
❒ Transporte público (es decir, autobús, servicio de enlaces, similar)
❒ Otro servicio de transporte (nombre): _____
❒ Taxi (incluido Uber/Lyft)
❒ Uso compartido de vehículos
❒ Otro: _____

INFORMACIÓN DEMOGRÁFICA Y SEGURO MÉDICO

25. ¿Cuál de las siguientes opciones describe su tipo actual de seguro médico? *(Marque <u>todas</u> las que correspondan)*

❒ COBRA
❒ Seguro dental
❒ Seguro proporcionado por el empleador
❒ Gobierno (VA, TRICARE)
❒ Cuenta de ahorros/gastos médica
❒ Seguro individual/privado/Marketplace /Obamacare
❒ Medicaid
❒ Medicare
❒ Complemento de Medicare
❒ Sin seguro dental
❒ Sin seguro médico

26. Si no tiene seguro médico, ¿por qué no tiene seguro? *(Marque <u>todas</u> las que correspondan)*

❒ No corresponde; tengo seguro médico
❒ No entiendo las opciones de Marketplace/Obamacare
❒ No disponible en mi trabajo
❒ Estudiante
❒ Demasiado caro/costo
❒ Desempleado/sin trabajo
❒ Otro: _____

27. ¿Cuál es su código postal? _____ **28. ¿Cuál es su edad?** _____

29. ¿Cuál es su identidad de género? ❒ Hombre ❒ Mujer ❒ No binario ❒ Otro: _____

30. ¿Cuál es su estatura? _____pies _____pulgadas **31. ¿Cuál es su peso?** _____libras

32. ¿Cuántas personas viven en su casa (incluido usted)?

Cantidad de niños (de 0 a 17 años de edad) _____ Cantidad de adultos de 18 a 64 años _____ Cantidad de adultos de 65 años o más _____

33. ¿Cuál es su nivel de educación completo más alto?

- ❒ Menos que la escuela secundaria
- ❒ Algo de la escuela secundaria
- ❒ Título de escuela secundaria/GED
- ❒ Técnico superior
- ❒ Licenciatura
- ❒ Máster/doctorado

34. ¿Con qué raza/origen étnico se identifica? *(Marque <u>una</u> opción)*

- ❒ Nativo de Hawái/islas del Pacífico
- ❒ Nativo estadounidense/Nativo de Alaska
- ❒ Asiático
- ❒ Hispano/Latino
- ❒ Negro/Afroestadounidense
- ❒ Blanco
- ❒ Más de una raza
- ❒ Rehúso responder
- ❒ Otro: _____

35. ¿Cuál es su estado civil?

❒ Casado/a ❒ Soltero/a ❒ Divorciado/a ❒ Viudo/a ❒ En pareja

36. ¿Cuáles son los ingresos anuales de su familia?

- ❒ $0 a $10 000
- ❒ $10 001 a $20 000
- ❒ $20 001 a $30 000
- ❒ $30 001 a $40 000
- ❒ $40 001 a $50 000
- ❒ $50 001 a $60 000
- ❒ $60 001 a $70 000
- ❒ $70 001 a $100 000
- ❒ $101 001 y más

37. ¿Cuál es su situación laboral actual?

- ❒ A tiempo completo
- ❒ A tiempo parcial
- ❒ Desempleado
- ❒ Autónomo
- ❒ Jubilado
- ❒ Tareas domésticas
- ❒ Estudiante
- ❒ Discapacitado/a

38. ¿Hay algo más que deberíamos saber sobre sus necesidades (o las de alguien que vive en su hogar) para mantenerse sano?

_____

_____

_____

¡Gracias por ayudar a convertir el área metropolitana de Lynchburg en un lugar más saludable para vivir, trabajar y jugar!

2021 Centra Community Health Needs Assessment- Lynchburg Area

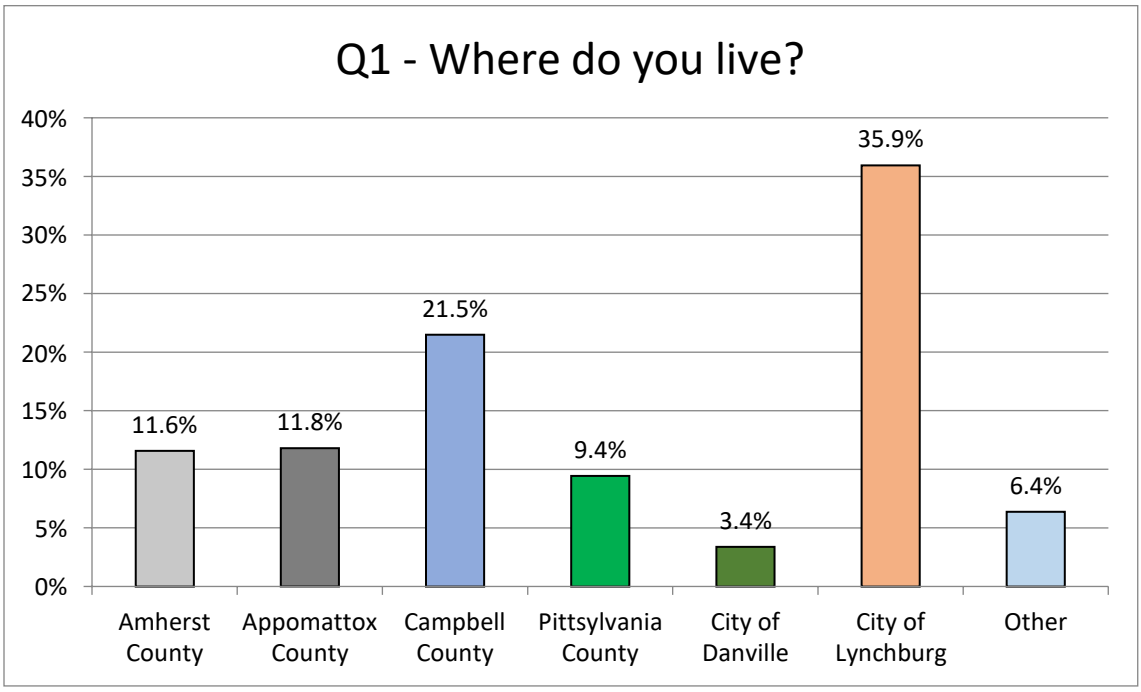
Community Health Surveys
FINAL

Prepared by: **Christopher Nye, Consultant**
Health Access Strategies, Stuarts Draft, Virginia

A Community Health Survey was administered to Lynchburg Area residents, 18 years of age and older, from April 12, 2021 to June 15, 2021. The survey tool was developed by Carilion Clinic and Healthy Roanoke Valley headquartered in Roanoke, Virginia and adopted by Centra and the Partnership for Healthy Communities in both 2018 and 2021. The survey includes standardized questions that address the County Health Rankings' four health factors that influence health (Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment) and health outcomes (Length of Life and Quality of Life). Many of the questions were developed from national survey tools from the Centers for Disease Control and Prevention, Healthy People 2020, and the Behavior Risk Factor Surveillance System so that local data can be compared to state and national data, benchmarks and targets. The survey tool can be found in the Appendix.

The Community Health Survey was administered both electronically through a publicly available link via Survey Monkey and through paper surveys (which were in turn entered into Survey Monkey). Paper surveys were available in both English and Spanish. A total of 4,450 surveys were collected. All survey respondents were offered the opportunity to enter a raffle to win a $25 gift card if they completed the survey.

The survey link was advertised in local newspapers, on social media, on Centra's website and through a mass email to all Centra staff. In addition to marketing the survey to the general population, attempts were made to oversample the target population in the service area. Members of the Community Health Assessment Team (CHAT) who serve and represent the target population, were asked to assist in advertising and distributing the survey (both electronically and paper) to their client base. However, engaging these target populations was more difficult in 2021 due to the COVID-19 pandemic and the virtual nature of the services provided during this time as well as possible technology barriers that impact our target populations (i.e., lack of internet access, lack of access to smart phones, computers, etc.).

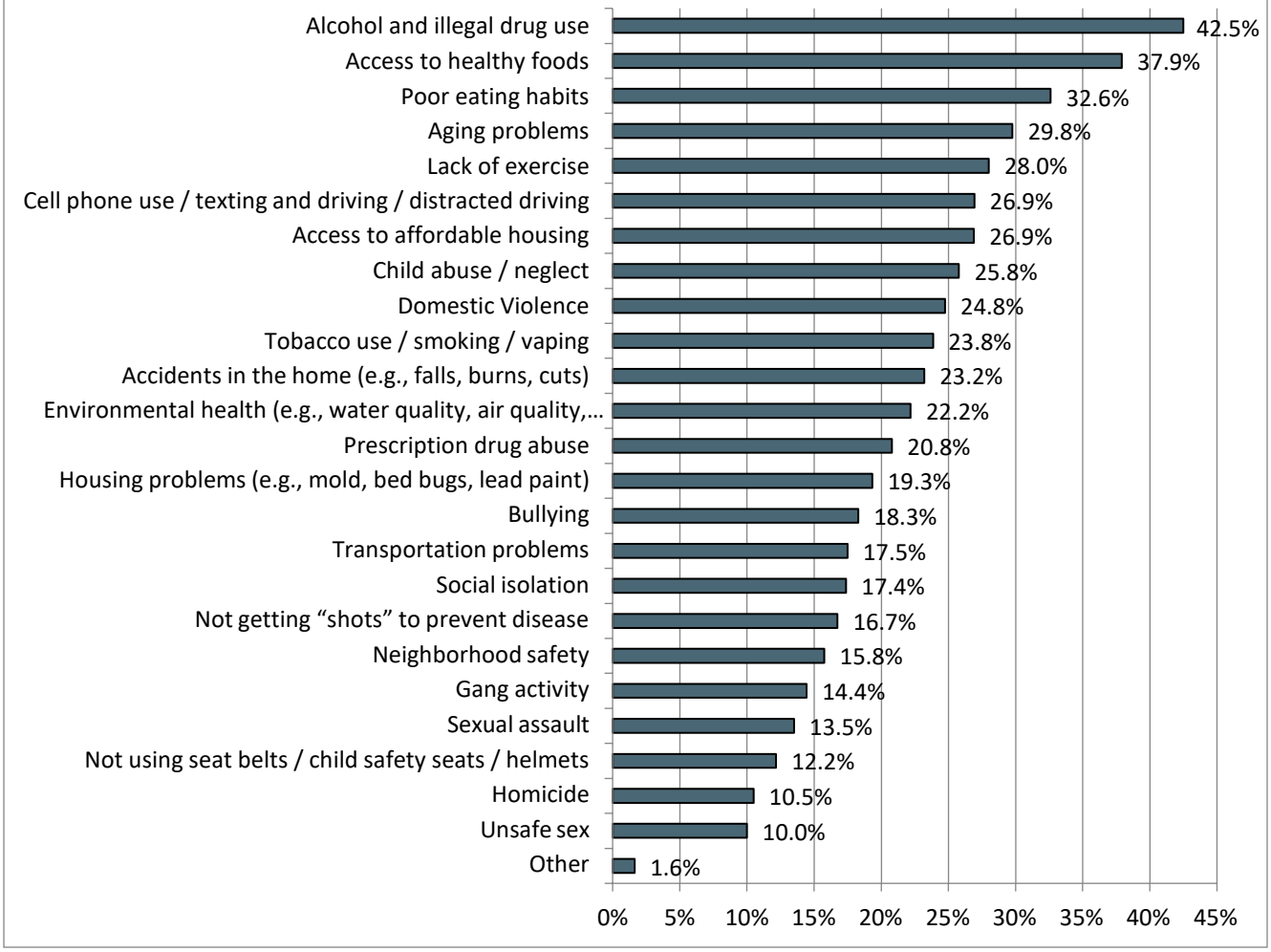


	Percent	Responses
Amherst County	11.6%	510
Appomattox County	11.8%	520
Campbell County	21.5%	947
Pittsylvania County	9.4%	416
City of Danville	3.4%	149
City of Lynchburg	35.9%	1,584
Other	6.4%	281
	Answered	**4,407**
	Skipped	**43**

Q1. Other responses Where do you live?		
Code	**Responses**	**Percent**
Out of State	127	47%
Bedford county	75	28%
Charlottesville city	9	3%
Albemarle county	6	2%
Roanoke city	6	2%
Amherst county	5	2%
Prince William county	5	2%
Fairfax county	4	1%
Nelson county	4	1%
Bedford city	2	1%
Loudon county	2	1%
Montgomery county	2	1%
Richmond city	2	1%
Arlington county	1	0%
Buckingham county	1	0%
Campbell county	1	0%
Charlotte county	1	0%
Chesapeake city	1	0%
Covington city	1	0%
Danville city	1	0%
Falls Church city	1	0%
Franklin county	1	0%
Halifax county	1	0%
Hanover county	1	0%
Lynchburg city	1	0%
Manassas city	1	0%
Martinsville city	1	0%
Newport News City	1	0%
Prince Edward county	1	0%
Stafford county	1	0%
N/A	4	1%
Total	**270**	**100%**

In the Lynchburg region, 270 respondents chose “other” for their selection. Of these “other” responses, 127 or 47% indicated that they were out of state residents; 75 responses or 28% indicated that they were residents of Bedford county. The remaining 68 responses or 25% were made up of various surrounding cities and counties.

Q2A - What do you think are the most important health factor issues that affect health in our community? (Respondents could check more than one)



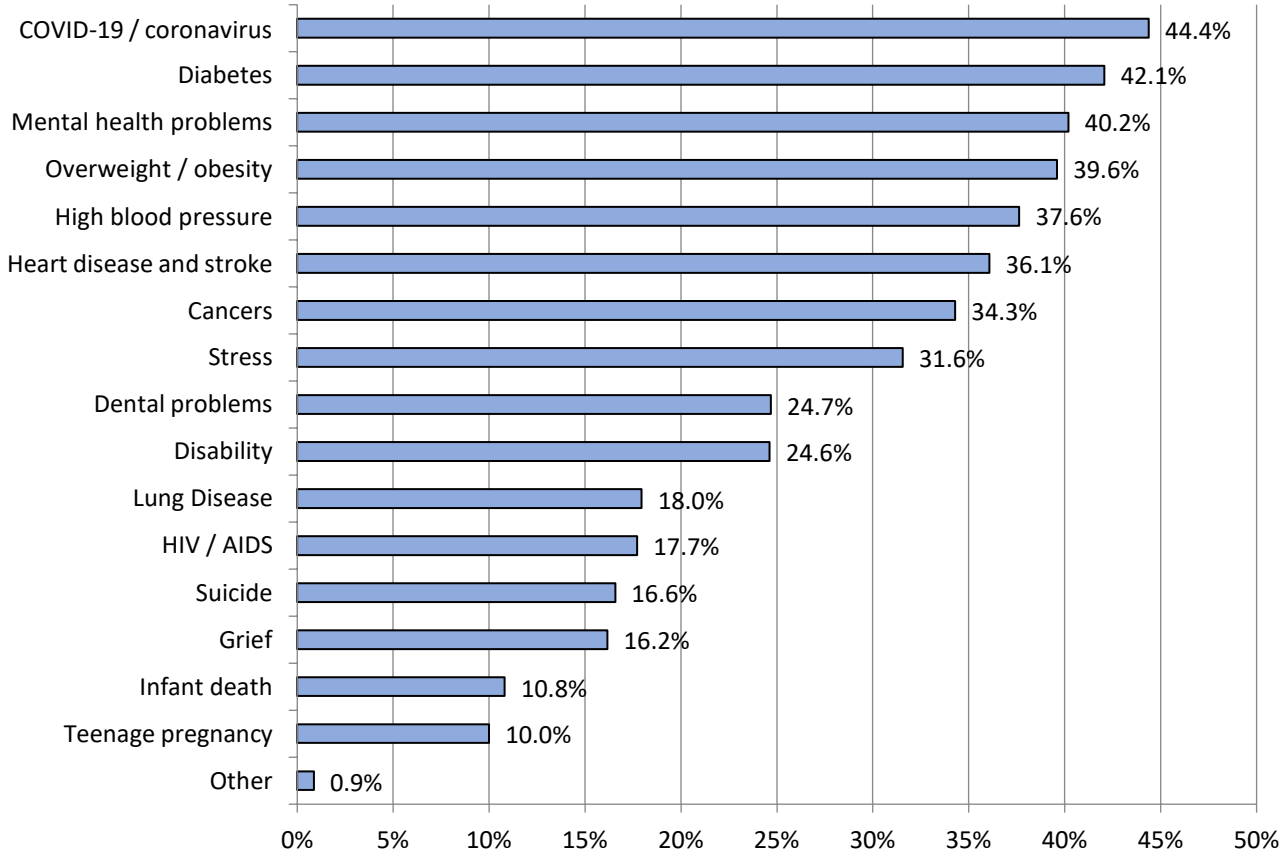
	Percent	Responses
Alcohol and illegal drug use	42.5%	1,871
Access to healthy foods	37.9%	1,669
Poor eating habits	32.6%	1,435
Aging problems	29.8%	1,310
Lack of exercise	28.0%	1,233
Cell phone use / texting and driving / distracted driving	26.9%	1,186
Access to affordable housing	26.9%	1,184
Child abuse / neglect	25.8%	1,135
Domestic Violence	24.8%	1,090
Tobacco use / smoking / vaping	23.8%	1,050
Accidents in the home (e.g., falls, burns, cuts)	23.2%	1,021
Environmental health (e.g., water quality, air quality, pesticides, etc.)	22.2%	976
Prescription drug abuse	20.8%	915
Housing problems (e.g., mold, bed bugs, lead paint)	19.3%	851
Bullying	18.3%	805
Transportation problems	17.5%	770
Social isolation	17.4%	765
Not getting "shots" to prevent disease	16.7%	737
Neighborhood safety	15.8%	694
Gang activity	14.4%	635
Sexual assault	13.5%	594
Not using seat belts / child safety seats / helmets	12.2%	535
Homicide	10.5%	462
Unsafe sex	10.0%	440
Other	1.6%	72
	Answered	**4,403**
	Skipped	**34**

2021 respondents ranked alcohol and illegal drug as the most important health factor. Alcohol and illegal drug use were ranked in the top five of 2018 responses with 30.1% of respondents selecting this factor. Access to healthy foods was also highly ranked in 2018 with 26.9% of all responses. Poor eating habits increased significantly from the 2018 assessment (15.8%) to 32.6% in 2021. Aging problems doubled in the percentage of responses from 2018 (14.3%) to 2021 (29.8%). Lack of exercise increased approximately 12% from 2018 (16.3%) to 28% in 2021.

Q2a. Other responses What do you think are the most important issues that affect health in our community? Health factors:		
Code	**Responses**	**Percent**
Mental health/illness	14	17%
Affordable/accessible healthcare	10	12%
Poverty	6	7%
Access to mental health care	5	6%
Covid 19	4	5%
Gun violence	3	4%
Health literacy/health education	3	4%
Internet access	3	4%
Racism	3	4%
Access to affordable healthy foods	2	2%
Affordable/accessible health insurance	2	2%
childcare	2	2%
Early childhood education	2	2%
Education attainment	2	2%
Affordable dental care	1	1%
Affordable home health services	1	1%
Disability	1	1%
Eldercare	1	1%
Equity	1	1%
Financial instability	1	1%
Jobs- livable wage, training	1	1%
Obesity	1	1%
Road rage	1	1%
Suicide	1	1%
Transportation	1	1%
Unemployment	1	1%
Unhealthy relationships	1	1%
All of the above	3	4%
N/A	6	7%
Total	**83**	**100%**

In the Lynchburg region, 83 respondents chose “other” for their selection. Of these “other” responses, 14 responses or 17% identified mental health/illness as the most important health factor that affects the health in the community; 10 respondents or 12% identified affordable/accessible healthcare as the most important health factor that affects community health. Poverty followed closely behind with 6 responses (7%). Additional issues are listed in the table above.

Q2B - What do you think are the most important health condition or outcome issues that affect health in our community? (Respondents could check more than one)

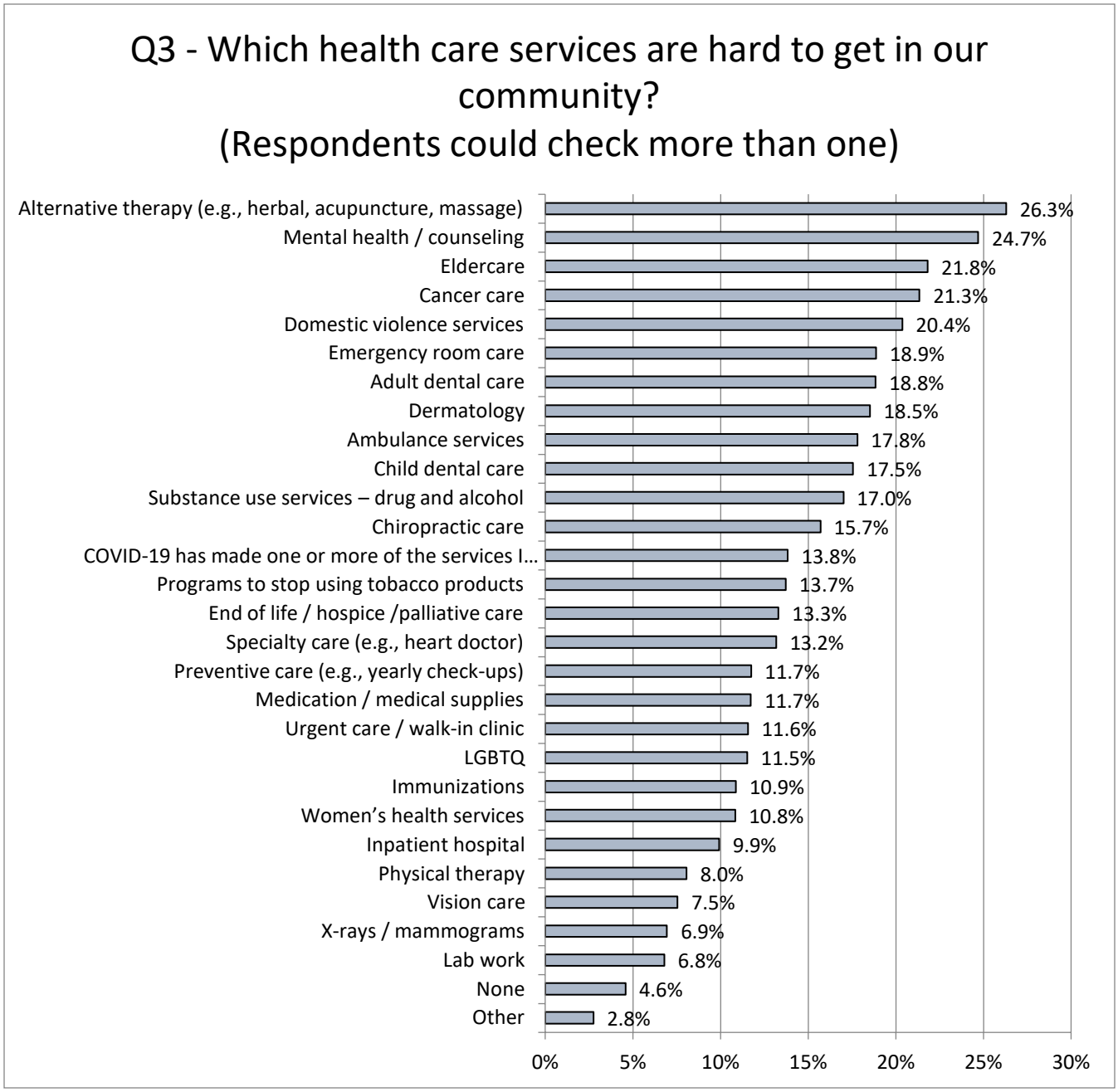


	Percent	Responses
COVID-19 / coronavirus	44.4%	1,941
Diabetes	42.1%	1,840
Mental health problems	40.2%	1,758
Overweight / obesity	39.6%	1,732
High blood pressure	37.6%	1,646
Heart disease and stroke	36.1%	1,578
Cancers	34.3%	1,500
Stress	31.6%	1,380
Dental problems	24.7%	1,080
Disability	24.6%	1,077
Lung Disease	18.0%	785
HIV / AIDS	17.7%	775
Suicide	16.6%	725
Grief	16.2%	707
Infant death	10.8%	473
Teenage pregnancy	10.0%	437
Other	0.9%	38
	Answered	**4,373**
	Skipped	**66**

COVID-19 was ranked most frequently among health conditions or outcomes cited by 2021 respondents. Of course, this was not an option in the 2018 assessment. Ranked health conditions or outcome issues that directly address diabetes or are significant risk factors for other chronic diseases included obesity and high blood pressure. Of particular note, in 2018, respondents indicated that mental health problems were 29% of respondents' five selections, and in 2021 that number increased to 40%. This increase may be impacted by COVID-19 and the fact that health care "factors" and health care "issues" were broken into separate questions in 2021.

Q2b. Other responses What do you think are the most important issues that affect health in our community? Conditions/Outcomes:		
Code	**Responses**	**Percent**
Mental health/illness	7	19%
Substance abuse/addiction	3	8%
Racial inequity	2	6%
Tick-borne illness	2	6%
Activities for teens	1	3%
Chronic disease	1	3%
Coordination of care	1	3%
Eldercare	1	3%
Family/societal destruction	1	3%
Health disparities	1	3%
Home health	1	3%
Media scare tactics	1	3%
Overworked	1	3%
Partisan politics/polarization of issues	1	3%
Perinatal support	1	3%
Post-traumatic stress disorder	1	3%
Protected health information	1	3%
Sexually transmitted disease	1	3%
Smoking	1	3%
Violence	1	3%
All of the above	2	6%
N/A	4	11%
Total	**36**	**100%**

In the Lynchburg region, 36 respondents chose "other" for their selection. Of these "other" responses, 7 or 19% identified mental health/illness as the most important condition/outcome that affects the health in the community; 3 respondents or 8% identified substance abuse/addiction as the most important condition/outcome that affects community health. Racial inequity and tick-borne illness followed closely behind, each having 2 responses or 6%. Additional responses are listed in the table above.


Q3 - Which health care services are hard to get in our community?
(Respondents could check more than one)
Alternative therapy (e.g., herbal, acupuncture, massage) 26.3%
Mental health / counseling 24.7%
Eldercare 21.8%
Cancer care 21.3%
Domestic violence services 20.4%
Emergency room care 18.9%
Adult dental care 18.8%
Dermatology 18.5%
Ambulance services 17.8%
Child dental care 17.5%
Substance use services – drug and alcohol 17.0%
Chiropractic care 15.7%
COVID-19 has made one or more of the services I… 13.8%
Programs to stop using tobacco products 13.7%
End of life / hospice /palliative care 13.3%
Specialty care (e.g., heart doctor) 13.2%
Preventive care (e.g., yearly check-ups) 11.7%
Medication / medical supplies 11.7%
Urgent care / walk-in clinic 11.6%
LGBTQ 11.5%
Immunizations 10.9%
Women's health services 10.8%
Inpatient hospital 9.9%
Physical therapy 8.0%
Vision care 7.5%
X-rays / mammograms 6.9%
Lab work 6.8%
None 4.6%
Other 2.8%
0% 5% 10% 15% 20% 25% 30%

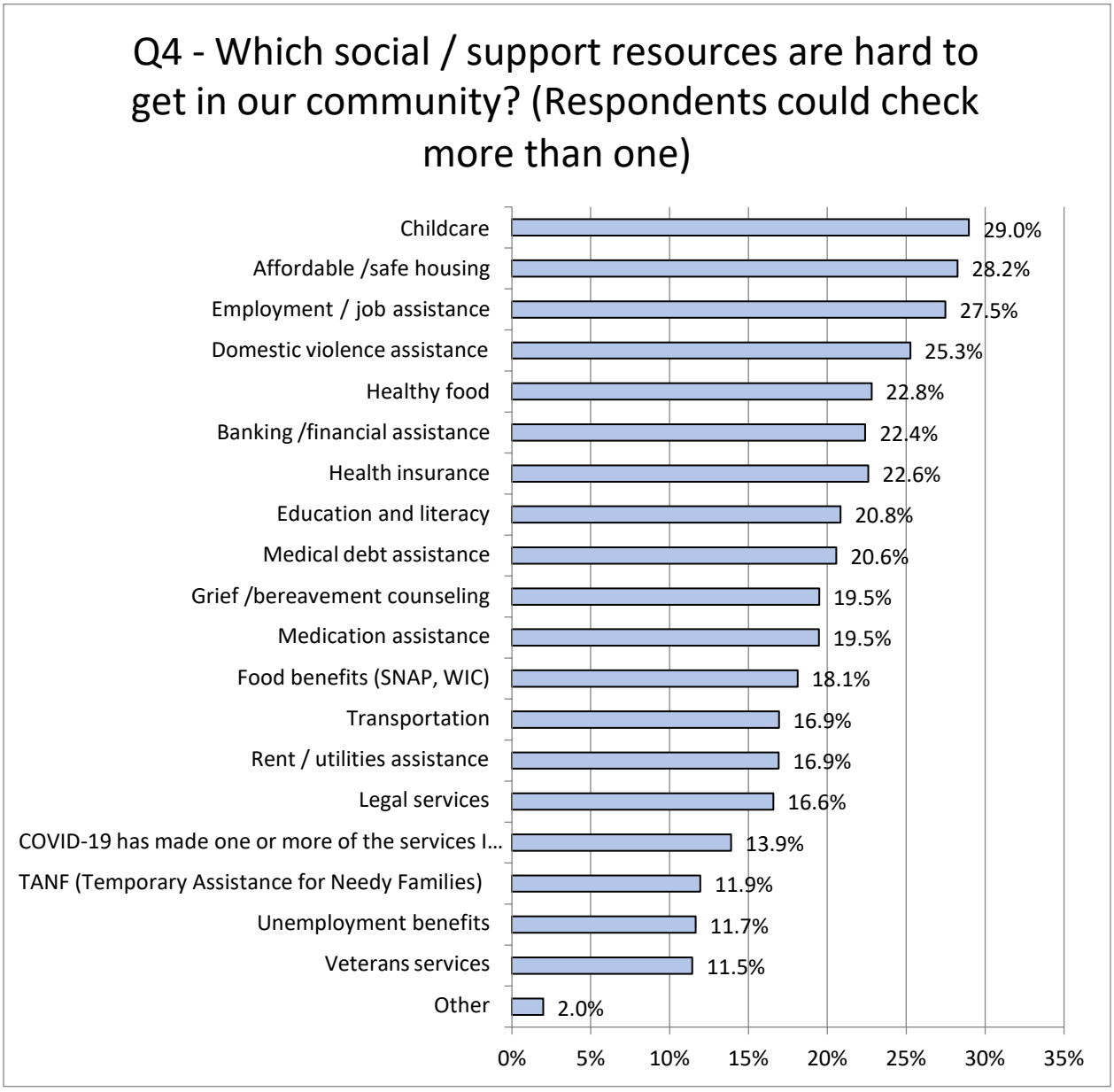
	Percent	Responses
Alternative therapy (e.g., herbal, acupuncture, massage)	26.3%	1,137
Mental health / counseling	24.7%	1,068
Eldercare	21.8%	943
Cancer care	21.3%	923
Domestic violence services	20.4%	881
Emergency room care	18.9%	816
Adult dental care	18.8%	815
Dermatology	18.5%	801
Ambulance services	17.8%	770
Child dental care	17.5%	759
Substance use services – drug and alcohol	17.0%	736
Chiropractic care	15.7%	679
COVID-19 has made one or more of the services I selected hard to get	13.8%	598
Programs to stop using tobacco products	13.7%	593
End of life / hospice /palliative care	13.3%	575
Specialty care (e.g., heart doctor)	13.2%	570
Preventive care (e.g., yearly check-ups)	11.7%	508
Medication / medical supplies	11.7%	507
Urgent care / walk-in clinic	11.6%	500
LGBTQ	11.5%	498
Immunizations	10.9%	470
Women's health services	10.8%	469
Inpatient hospital	9.9%	429
Physical therapy	8.0%	348
Vision care	7.5%	326
X-rays / mammograms	6.9%	300
Lab work	6.8%	294
None	4.6%	198
Other	2.8%	119
	Answered	**4,325**
	Skipped	**114**

In 2021, the respondents indicated that Alternative therapies were the hardest to get service in the community (compared to 22.2% and a ranking of six among 2018 respondents). Mental health and counseling services were cited by almost 25% of 2021 respondents, down slightly from 28% in 2018. Eldercare was consistent from 2018 (20.4%) to 2021 (22%). Cancer care was broken out from the category of "Specialty care" in 2018. Adult dental care ranked high in both assessments (28% in 2018 and 19% in 2021). It is important to note that beginning July 1, 2021, Virginia Medicaid started providing adult dental service to Medicaid beneficiaries for the first time.

Q3. Other responses What health care services are hard to get in our community?		
Code	**Responses**	**Percent**
Specialty care	16	13%
Family doctor	15	13%
Cost of services	8	7%
Access to mental health services	6	5%
Access to mental health services- pediatric	5	4%
Health literacy/health education	4	3%
Pediatric care	4	3%
Access to substance use/abuse services	3	3%
Centra PACE	3	3%
Overweight/obesity care	3	3%
Accessible Urgent care/walk-ins	2	2%
Emergency room care	2	2%
Home health	2	2%
Urgent cares lack of Medicaid acceptance	1	1%
Access to geriatric psychiatric services	1	1%
Access to healthcare- geographic barriers	1	1%
Access to mental health services- inpatient	1	1%
Occupational therapy	1	1%
Special needs support	1	1%
Activities for teens	1	1%
Appointment times- long waits	1	1%
Appointment times- limited after hours	1	1%
Cancer cares limited Medicaid acceptance	1	1%
Child abuse services	1	1%
Coordination of care	1	1%
Cost of medications	1	1%
Covid 19	1	1%
Domestic violence	1	1%
Eldercare & socialization	1	1%
Health disparities- minority populations	1	1%
Health insurance- limitations of	1	1%
Home visiting care	1	1%
Inadequate care	1	1%
Perinatal support	1	1%
Plastic surgery after weight loss	1	1%
Poverty	1	1%
Prevention programs	1	1%
Safe sidewalks	1	1%
Substance abuse services- home based	1	1%

Substance abuse services- outpatient & residential beds for youth	1	1%
Transportation for disabled/elderly	1	1%
Unaware of available resources	1	1%
Veteran's care	1	1%
All of the above	3	3%
N/A	14	12%
Total	**120**	**100%**

In the Lynchburg region, 120 respondents chose “other” for their selection. Of these “other” responses, 16 or 13% identified specialty care as the health service that is hardest to get in the area; 15 respondents or 13% identified that a family doctor was the hardest service to get. Cost of services (7%) and access to mental health services including pediatrics (9% combined) were identified as well as a multitude of other services.

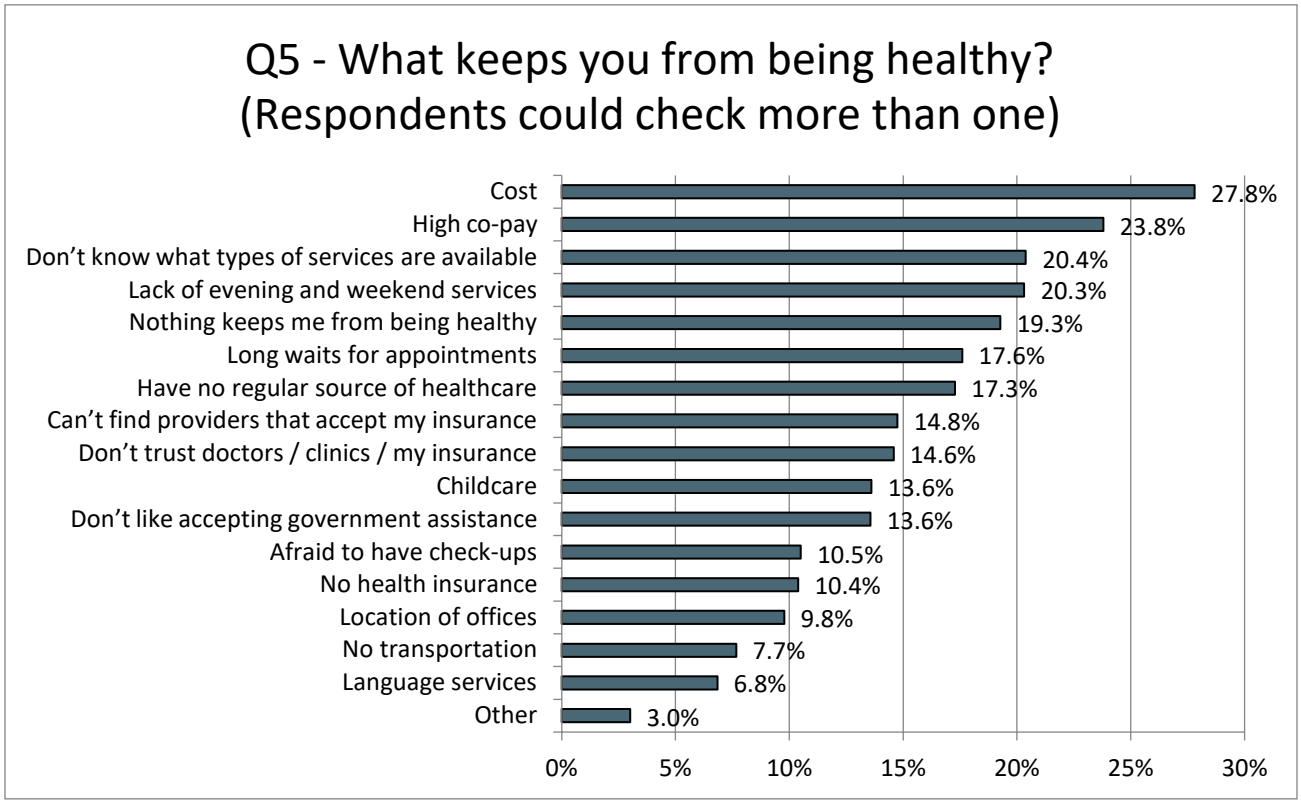

Q4 - Which social / support resources are hard to get in our community? (Respondents could check more than one)
Childcare
29.0%
Affordable /safe housing
28.2%
Employment / job assistance
27.5%
Domestic violence assistance
25.3%
Healthy food
22.8%
Banking /financial assistance
22.4%
Health insurance
22.6%
Education and literacy
20.8%
Medical debt assistance
20.6%
Grief /bereavement counseling
19.5%
Medication assistance
19.5%
Food benefits (SNAP, WIC)
18.1%
Transportation
16.9%
Rent / utilities assistance
16.9%
Legal services
16.6%
COVID-19 has made one or more of the services I...
13.9%
TANF (Temporary Assistance for Needy Families)
11.9%
Unemployment benefits
11.7%
Veterans services
11.5%
Other
2.0%
0%
5%
10%
15%
20%
25%
30%
35%

	Percent	Responses
Childcare	29.0%	1,225
Affordable /safe housing	28.2%	1,194
Employment / job assistance	27.5%	1,162
Domestic violence assistance	25.3%	1,068
Healthy food	22.8%	964
Health insurance	22.6%	955
Banking /financial assistance	22.4%	947
Education and literacy	20.8%	881
Medical debt assistance	20.6%	869
Grief /bereavement counseling	19.5%	824
Medication assistance	19.5%	823
Food benefits (SNAP, WIC)	18.1%	766
Transportation	16.9%	716
Rent / utilities assistance	16.9%	715
Legal services	16.6%	701
COVID-19 has made one or more of the services I selected hard to get	13.9%	588
TANF (Temporary Assistance for Needy Families)	11.9%	505
Unemployment benefits	11.7%	493
Veterans services	11.5%	484
Other	2.0%	84
	Answered	**4,227**
	Skipped	**212**

Childcare and affordable and safe housing were cited by 2021 respondents as the most difficult services to get in the community. Affordable and safe housing also ranked high in the 2018 assessment at 38% (ranked first among 2018 services that were hard to get in the community). While childcare was not an option in 2018, the 2018 Lynchburg Region stakeholder survey respondents cited "childcare" as the fourth greatest need. Domestic violence services increased significantly from the 2018 assessment (11.9%) to 25.3% for the 2021 assessment.

Q4. Other responses Which social/support services resources are hard to get in our community?		
Code	**Responses**	**Percent**
Access to mental health services	5	7%
Eldercare	5	7%
Centra PACE	4	5%
Access to affordable healthy foods	3	4%
Home health	3	4%
Health literacy/health education	2	3%
Mental health	2	3%
Access to affordable services	1	1%
Access to affordable safe housing	1	1%
Activities for teens	1	1%
Case Management- pediatric	1	1%
Centra billing	1	1%
Childcare	1	1%
Education- STEM	1	1%
Family Support	1	1%
Food assistance programs	1	1%
Homeless shelters	1	1%
Internet	1	1%
Lack of emergency care	1	1%
Long term care	1	1%
Parenting classes	1	1%
Provider shortage	1	1%
Qualification of services- barriers	1	1%
Substance use recovery programs	1	1%
Unaware of available resources	1	1%
All of the above	2	3%
N/A	29	40%
Total	**73**	**100%**

In the Lynchburg region, 73 respondents chose “other” for their selection. Of these “other” responses, 5 responses or 7% identified that both access to mental health services and eldercare are the social/support services and resources that are hardest to get in the community; 4 respondents or 5% identified that Centra Pace was the hardest service to attain as well as a multitude of other social support/social services.



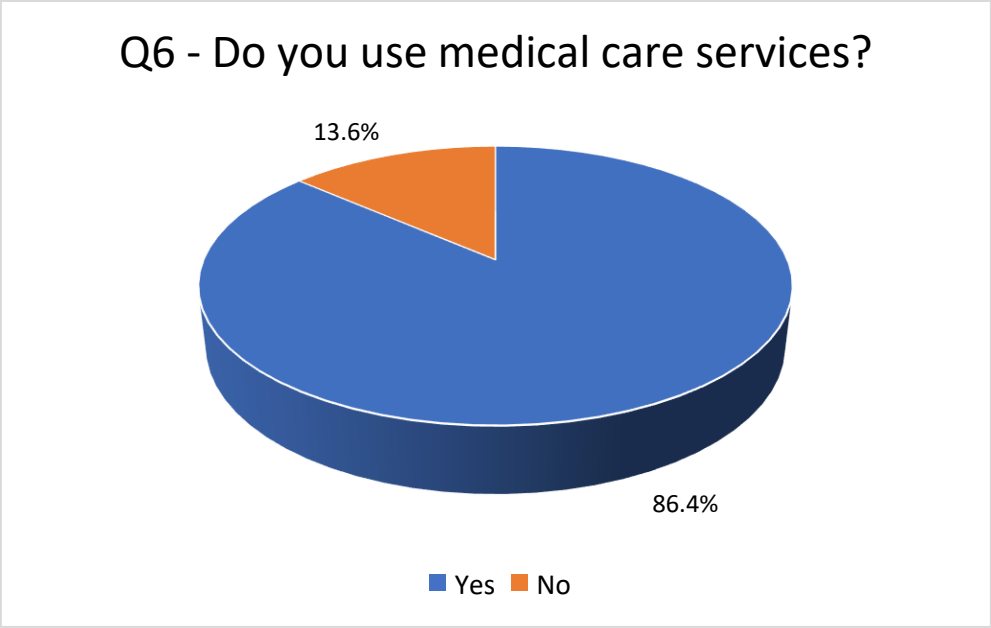
	Percent	Responses
Cost	27.8%	1,199
High co-pay	23.8%	1,026
Don't know what types of services are available	20.4%	879
Lack of evening and weekend services	20.3%	876
Nothing keeps me from being healthy	19.3%	831
Long waits for appointments	17.6%	759
Have no regular source of healthcare	17.3%	745
Can't find providers that accept my insurance	14.8%	636
Don't trust doctors / clinics / my insurance	14.6%	629
Childcare	13.6%	587
Don't like accepting government assistance	13.6%	585
Afraid to have check-ups	10.5%	453
No health insurance	10.4%	448
Location of offices	9.8%	422
No transportation	7.7%	331
Language services	6.8%	295
Other	3.0%	130
	Answered	**4,311**
	Skipped	**128**

In 2018, the response "Nothing keeps me from being healthy" was not an option. The 2018 assessment had a similar question, "What do you feelQ13 prevents you from getting the services you need?" In 2021, the top two reasons respondents felt kept them from being healthy were identical to the top two reasons respondents felt were obstacles to getting the services they needed in 2018. Cost was 28% in 2021 and 48% in 2018. High co-pays were 28% in 2018 and 24% in 2021. "Don't know what types of services are available" increased to 20.4% in 2021 from 16.7% in 2018. Lack of evening and weekend services decreased slightly in 2021 to 20% from 22% in 2018. Long waits for appointments decreased to 17.6% in 2021 compared to 25.7% in 2018. No health insurance dropped as a reason from 13% in 2018 to 10% in 2021.

Q5. Other responses What Keeps you from being Healthy?		
Code	**Responses**	**Percent**
Lack of time	19	15%
Lack of motivation, willpower	15	12%
Provider shortage	11	9%
My job	10	8%
Don't trust doctors/clinics/insurance	9	7%
Difficulty getting appointments	3	2%
Access to affordable, healthy foods	2	2%
Age	2	2%
Chronic condition	2	2%
Covid 19	2	2%
Fear	2	2%
Health literacy/health education	2	2%
Lack of communication	2	2%
Lack of consistent provider	2	2%
Lack of recreational facilities	2	2%
Stress	2	2%
Access to dental services	1	1%
Access to holistic services	1	1%
Affordable health insurance	1	1%
Coordination of care	1	1%
Cost of care	1	1%
Doctor's office- long waits	1	1%
Emergency room- long waits	1	1%
Lack of urgent care	1	1%
Paperwork/hassle	1	1%
Police	1	1%
Psychiatrist shortage	1	1%

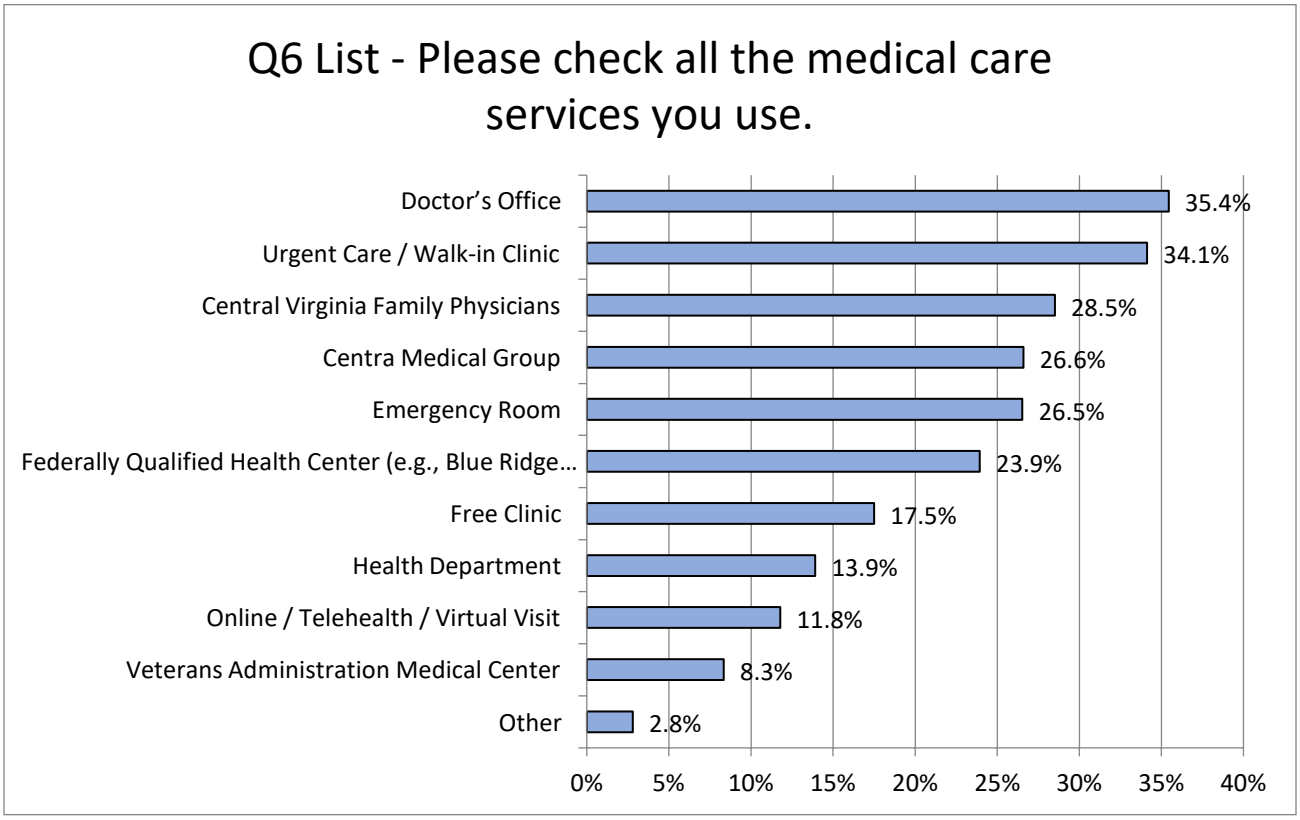
Safety- neighborhoods	1	1%
Substance use	1	1%
Transportation	1	1%
Walkability of neighborhoods	1	1%
N/A	27	21%
Total	**129**	**100%**

In the Lynchburg region, 129 respondents chose “other” for their selection. Of these “other” responses, 19 or 15% identified that lack of time was the main thing that kept them from being healthy; 15 respondents or 12% identified that a lack of motivation and willpower kept them from being healthy; 11 respondents or 9% said it was provider shortages that made being healthy challenging while 10 respondents or 8% claimed it was due to their job as well as additional factors as listed above



	Percent	Responses
Yes	86.4%	3,492
No	13.6%	550
	Answered	**4,042**
	Skipped	**396**

The number of respondents who indicated that they use medical services increased slightly from the 2018 number (84.5% in 2018) to 86.4% in 2021.



	Percent	Responses
Doctor's Office	35.4%	1,450
Urgent Care / Walk-in Clinic	34.1%	1,396
Central Virginia Family Physicians	28.5%	1,166
Centra Medical Group	26.6%	1,088
Emergency Room	26.5%	1,085
Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)	23.9%	979
Free Clinic	17.5%	716
Health Department	13.9%	569
Online / Telehealth / Virtual Visit	11.8%	482
Veterans Administration Medical Center	8.3%	341
Other	2.8%	114
	Answered	**4,092**
	Skipped	**347**

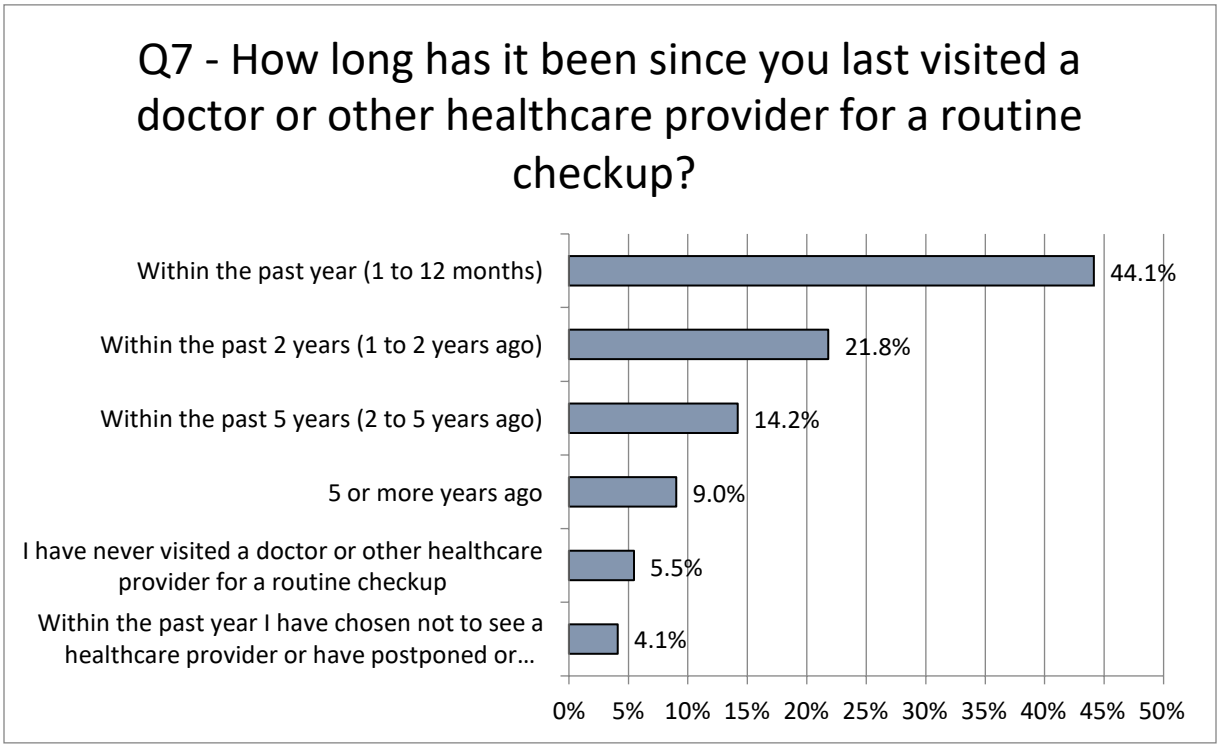
The generic "Doctor's Office" was the top response in 2018 and 2021 but dropped from 57% in 2018 to 35% in 2021. Respondents selecting Centra Medical Group increased slightly to 28.5%% in 2021 from 25% in 2018. Respondents indicating that they used the Emergency Room rose from 24.7% in 2018 to 26.5% in 2021. Urgent Care or Walk-in Clinic showed a large increase from 23% in 2018 to 34% in 2021. The use of the region's Federally Qualified Health Center increased from 15.8% in 2018 to 24% in 2021. The option online/telehealth/virtual visit was not an option for this

question in the 2018 assessment however, 1.8% of respondents answered "Centra 24/7 virtual visit" that year.

Q6. Other responses If Yes, where do you go for medical care?		
Code	**Responses**	**Percent**
Centra PACE	28	27%
UVA Health	13	13%
Dentist	5	5%
Out of state doctors	4	4%
Women's Health of Central VA	4	4%
Chiropractor	3	3%
Doctors' office	3	3%
Optician/Ophthalmologist	3	3%
OrthoVirginia	3	3%
CMG Piedmont Psychiatric Center	2	2%
Counseling/psychiatry	2	2%
Johnson Health Center	2	2%
Piedmont Eye Center	2	2%
Planned parenthood	2	2%
PTC Wellness Centers- BWXT	2	2%
Acupuncture	1	1%
America's Best Contacts & Eyeglasses	1	1%
CMG Pain Management	1	1%
CMG Women's Center	1	1%
Dentist- Brady & Crist Dentists	1	1%
Dentist- Dr. R. Kelly Golden	1	1%
Direct Primary Care	1	1%
F. Read Hopkins Pediatric Associates	1	1%
Hill City Pharmacy	1	1%
Hospice	1	1%
In between providers	1	1%
Lynchburg Gynecology	1	1%
Lynchburg Nephrology	1	1%
MyEyeDr	1	1%
Naturopath	1	1%
Oncologist	1	1%
Online/telehealth/virtual	1	1%
Orthodontist	1	1%
Physician's Treatment Center	1	1%

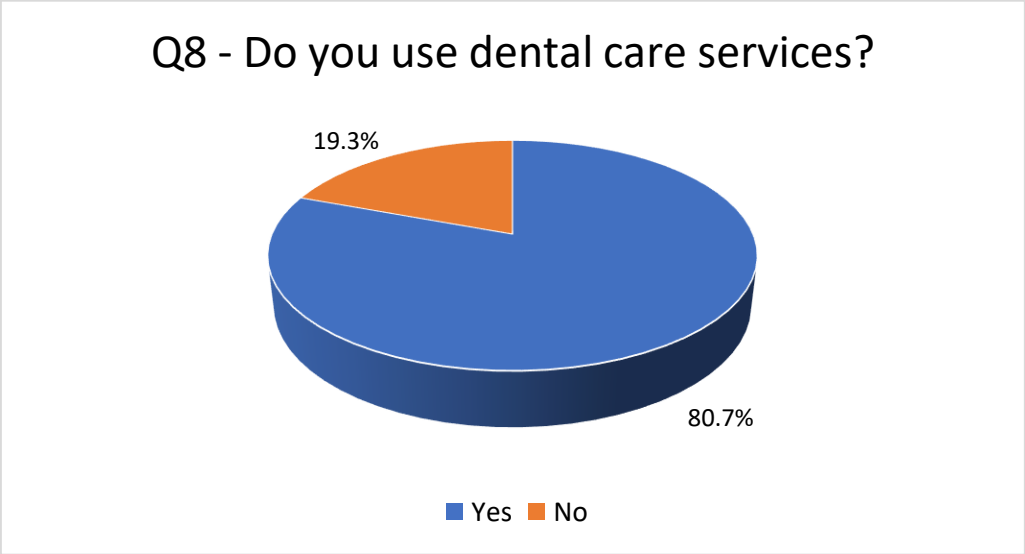
Pulmonologist	1	1%
Seven Hills Dermatology	1	1%
Specialists	1	1%
Specialty care (non Centra)	1	1%
Wellness center	1	1%
N/A	2	2%
Total	**104**	**100%**

In the Lynchburg region, 104 respondents chose “other” for their selection. Of these “other” responses, 28 or 27% said that they utilized the Centra PACE facility for medical care;13 respondents or 13% stated they traveled to UVA health for their medical care; as well as other additional sites/practices as listed in the table above.



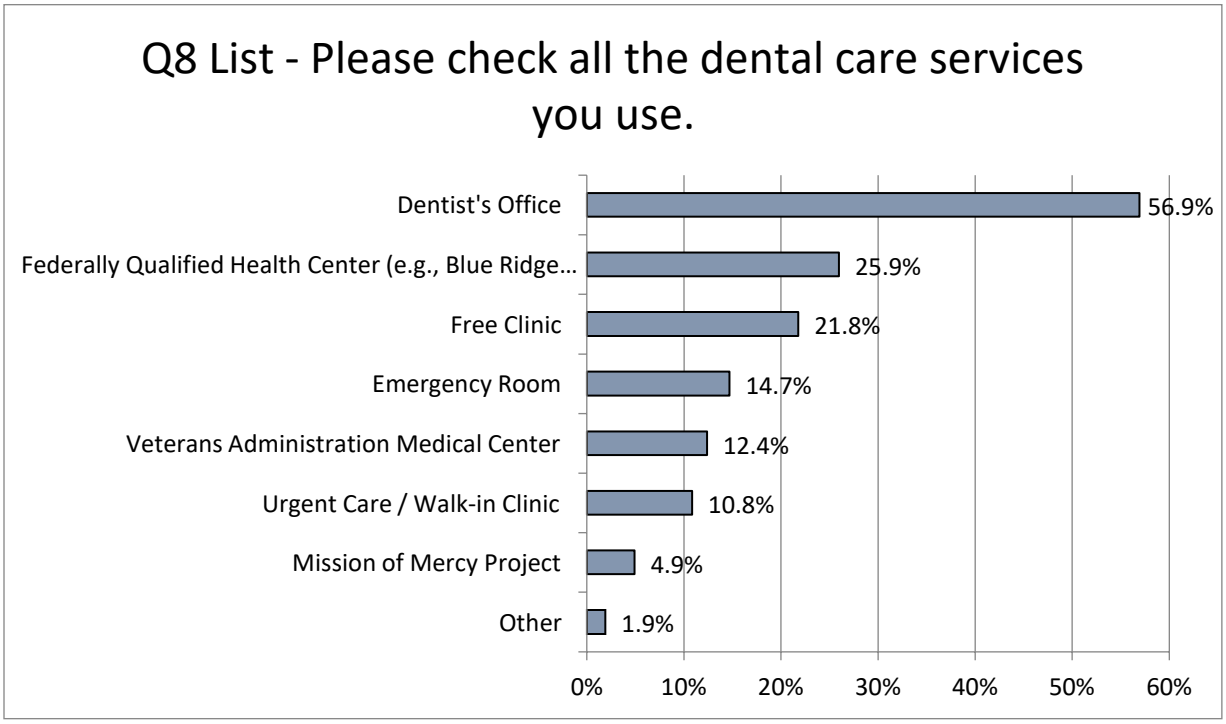
	Percent	Responses
Within the past year (1 to 12 months)	44.1%	2,279
Within the past 2 years (1 to 2 years ago)	21.8%	1,126
Within the past 5 years (2 to 5 years ago)	14.2%	732
5 or more years ago	9.0%	466
I have never visited a doctor or other healthcare provider for a routine checkup	5.5%	282
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	4.1%	212
	Answered	**5,164**
	Skipped	**73**

The number of respondents indicating that they last visited a healthcare provider for a routine check-up within the past year dropped dramatically from 77% in 2018 to 44% in 2021. The number of respondents who had not visited a healthcare provider for a routine check-up within the past five increased from 5% in 2018 to 9% in 2021. Additionally, 4.1% reported not seeing, postponing, or cancelling visits with their healthcare providers due to COVID-19.



	Percent	Responses
Yes	80.7%	3,368
No	19.3%	808
	Answered	**4,176**
	Skipped	**263**

The number of respondents indicating that they use dental care services increased 6.4% from 2018 (74.3%) to 80.7% in 2021.

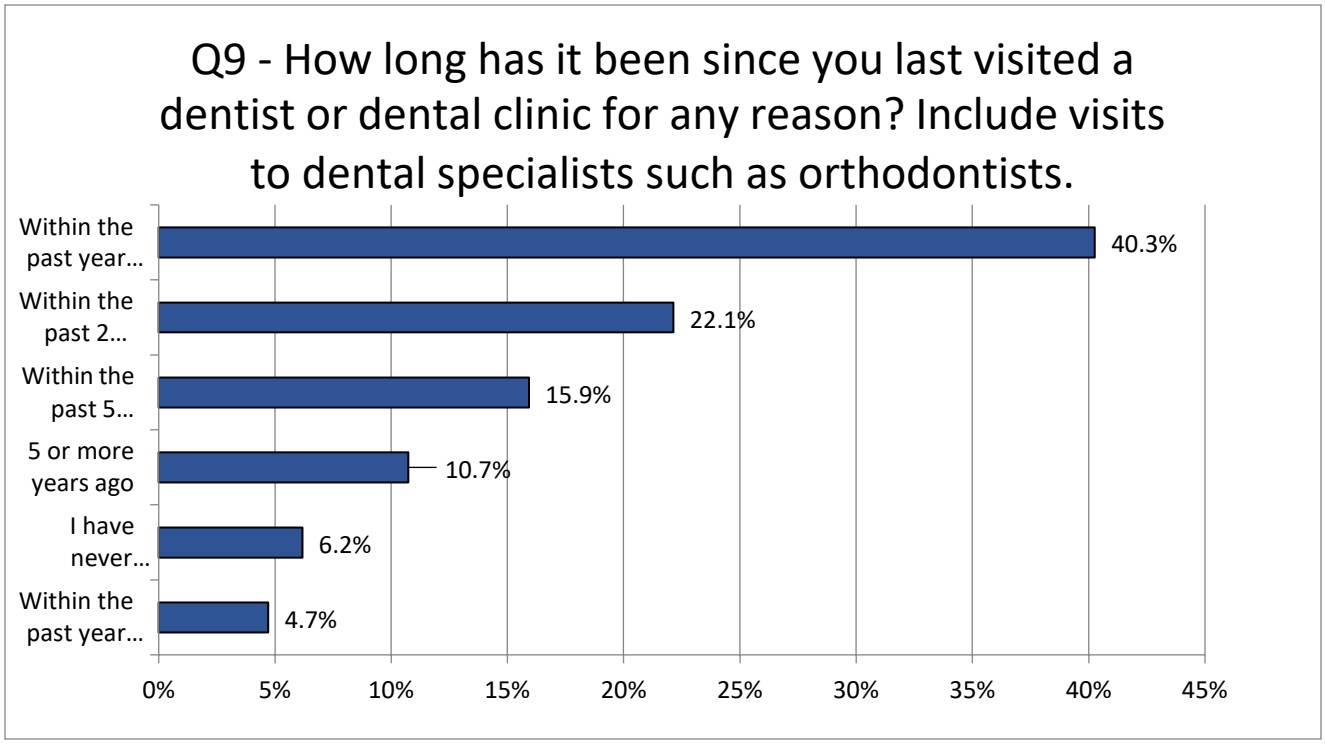


	Percent	Responses
Dentist's Office	56.9%	2,241
Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)	25.9%	1,022
Free Clinic	21.8%	858
Emergency Room	14.7%	579
Veterans Administration Medical Center	12.4%	487
Urgent Care / Walk-in Clinic	10.8%	427
Mission of Mercy Project	4.9%	193
Other	1.9%	75
	Answered	**3,939**
	Skipped	**500**

The number of respondents selecting the generic response "Dentist's Office" decreased from 84% in 2018 to 57% in 2021. The use of "Free Clinic" for dental services increased in 2021 to 22% from just 6% in 2018. Respondents using "Urgent Care or Walk-in Clinic" increased dramatically to almost 11% in 2021 from 1% in 2018. Respondents using Federally Qualified Health Center (Johnson Health Center or Community Access Network) more than quadrupled from 2018 (6%) to 26% in 2021. Respondents using "Mission of Mercy Project" for dental services was almost 0% in 2018 to 5% in 2021. Use of the Emergency Room for dental services increased almost significantly from 2% in 2018 to 14.7% in 2021. The number of respondents who reported have dental insurance in 2021 (24.9%) decreased as compared to 2018 (30.2%)

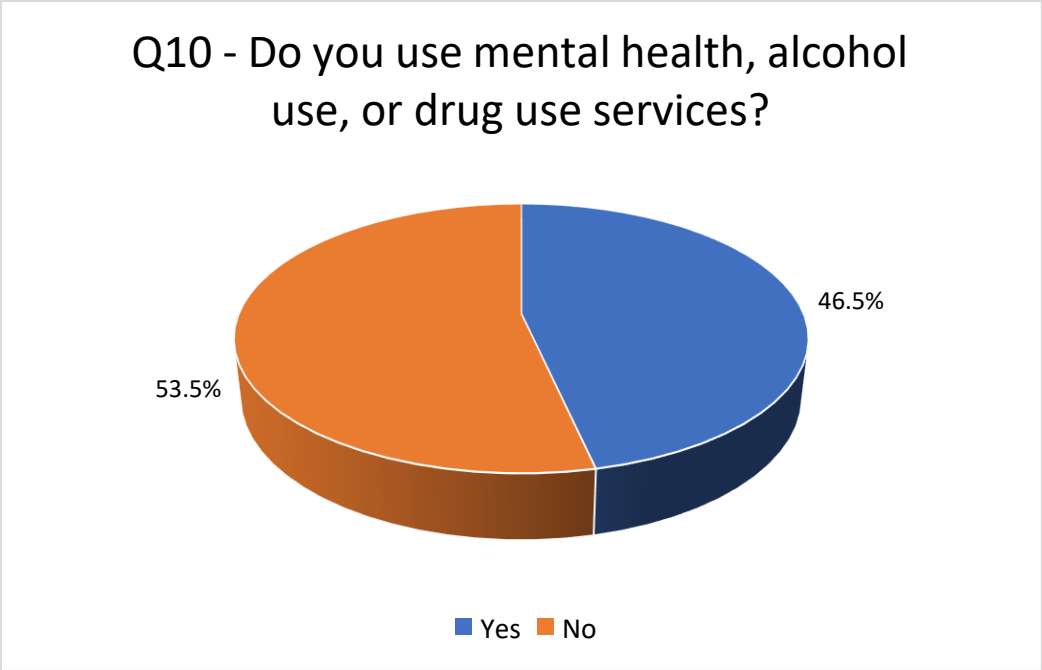
Q8. Other responses Check all Dental Services that you use:		
Code	**Responses**	**Percent**
Centra PACE	5	10%
Dentures	3	6%
Oral surgeon	3	6%
Orthodontist	3	6%
No recent appointment	2	4%
Aspen Dental	2	4%
Periodontist	2	4%
Too expensive	2	4%
VCU School of Dentistry	2	4%
Women's Health of Central VA	1	2%
Affordable Dentures	1	2%
Cannot get an appointment	1	2%
Central Virginia Health Services	1	2%
Dentist office	1	2%
Johnson Health Center	1	2%
Lynchburg Dental Center	1	2%
Lynchburg Family Dentistry	1	2%
Never visited a dentist for any reason	1	2%
Need an appointment	1	2%
No recent appointment- COVID	1	2%
Not available with Medicare/Medicaid	1	2%
Out of town dentist	1	2%
Periodontal Health Associates	1	2%
Telehealth	1	2%
N/A	9	19%
Total	**48**	**100%**

In the Lynchburg region, 48 respondents chose “other” for their selection. Of these “other” responses, 5 responses or 10% said that they utilized the Centra PACE facility for their dental care services; while 6% each said that they used Dentures, an oral surgeon, and an orthodontist for dental services The remainder of responses are included in the table above.



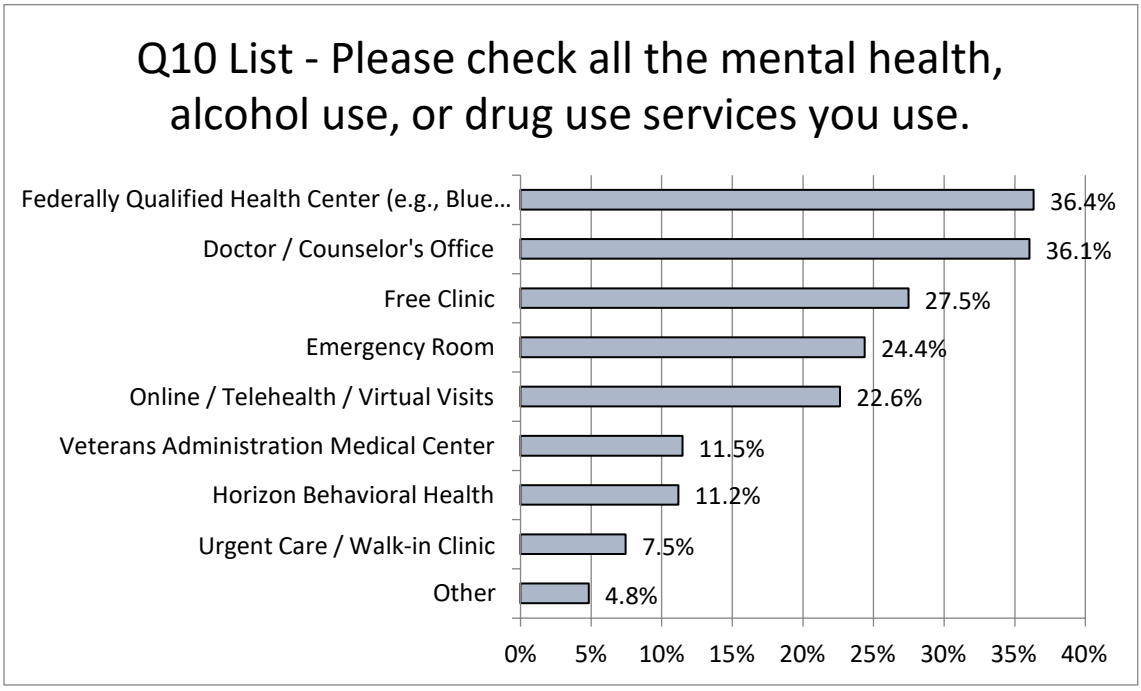
	Percent	Responses
Within the past year (1 to 12 months)	40.3%	2,055
Within the past 2 years (1 to 2 years ago)	22.1%	1,130
Within the past 5 years (2 to 5 years ago)	15.9%	813
5 or more years ago	10.7%	548
I have never visited a dentist or dental clinic for any reason	6.2%	316
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	4.7%	241
	Answered	**5,103**
	Skipped	**84**

The number of respondents who have visited a dentist or dental clinic in the last 12 months fell from 63% in 2018 to 40% in 2021. More people reported having not visited the dentist or dental clinic within the past two years in 2021 (22%) than in 2018 (12%) as well as within the past 5 years (15.9% in 2021 compared to 10.6% in 2018). The number of respondents who had not visited a dentist or dental clinic in the past five or more years decreased from 14.4% in 2018 to 10.7% in 2021. Finally, almost 5% of respondents reported not seeing, postponing, or cancelling visits with their healthcare providers due to COVID-19.



	Percent	Responses
Yes	46.5%	1,981
No	53.5%	2,276
	Answered	**4,257**
	Skipped	**182**

The number of respondents indicating that they use mental health, alcohol or drug use services increased dramatically from 17.6% in 2018 to 46.5% in 2021.

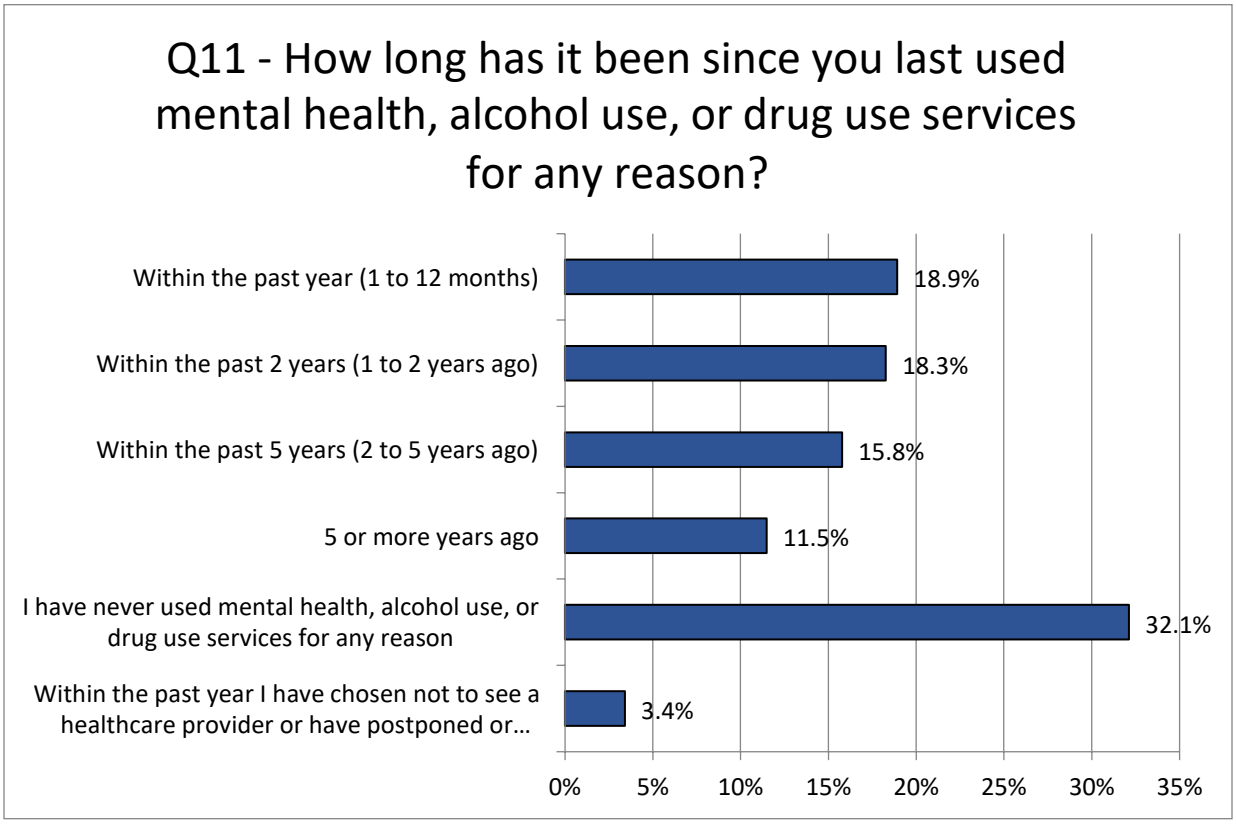


	Percent	Responses
Federally Qualified Health Center (e.g., Blue Ridge Medical Center, Community Access Network, Johnson Health Center)	36.4%	984
Doctor / Counselor's Office	36.1%	976
Free Clinic	27.5%	744
Emergency Room	24.4%	660
Online / Telehealth / Virtual Visits	22.6%	613
Veterans Administration Medical Center	11.5%	311
Horizon Behavioral Health	11.2%	303
Urgent Care / Walk-in Clinic	7.5%	202
Other	4.8%	131
	Answered	**2,707**
	Skipped	**1,742**

The number of respondents who used Horizon Behavioral Health for services fell from 57% in 2018 to 11% in 2021. Online, telehealth, or virtual visits were not an option for respondents in 2018. More than 1 out of 5 respondents using mental health, alcohol use, or drug use services indicated such a visit. The number of respondents using the Free Clinic or a Federally Qualified Health Center both increased significantly from 2018 (4.1% Free Clinic; 15% FQHC) to 2021 (Free Clinic 27.5%; FQHC 36.4%). The generic response, "Doctor or Counselor's Office," was combined from two separate responses from 2018 – "Doctor'sOffice" and "Counselor's Office." These two responses in 2018 were approximately 13.5% and 23.4%, respectively, while combined for 2021, the percentage of responses was 36% - relatively unchanged between assessment years. The use of the Emergency Room increased significantly from 9.4% in 2018 to 24.4% in 2021.

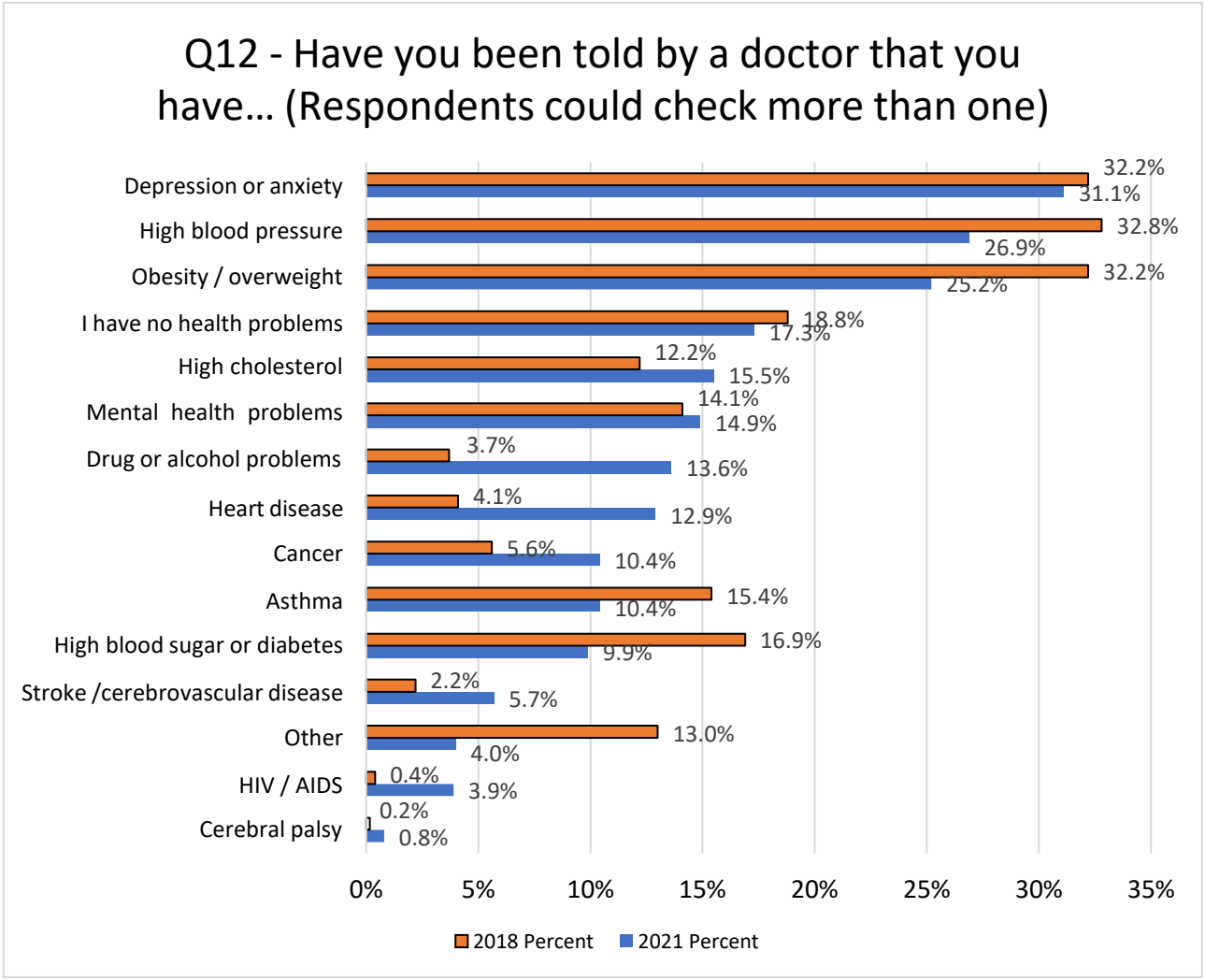
Q10. Other responses If yes, which mental health services do you use?			
Code	**Responses**	**Percent**	
CMG Piedmont Psychiatric Center	8	8%	
Centra PACE	5	5%	
Doctors/counselors	2	2%	
Doctors/counselors- out of town	2	2%	
Employee Assistance Program	2	2%	
Liberty University Counseling	2	2%	
Substance abuse programs- AA/NA/Al-Anon	2	2%	
Cardiologist	1	1%	
Christian Counseling Services	1	1%	
LifePush	1	1%	
Substance abuse programs- Roads to Recovery	1	1%	
Support Groups	1	1%	
Substance abuse programs-Lynchburg Comprehensive Treatment Center	1	1%	
Telehealth	1	1%	
The Gateway Program	1	1%	
Thomas Road Baptist Church Counseling	1	1%	
Wishing You Well Counseling Center	1	1%	
N/A	65	66%	
Total	**98**	**100%**	

In the Lynchburg region, 98 respondents chose “other” for their selection. Of these “other” responses, 8 responses or 8% said that they utilized CMG Piedmont Psychiatric Center for mental health services; 5 respondents or 5% said they utilized the Centra PACE facility; as well as additional other services.



	Percent	Responses
Within the past year (1 to 12 months)	18.9%	915
Within the past 2 years (1 to 2 years ago)	18.3%	883
Within the past 5 years (2 to 5 years ago)	15.8%	763
5 or more years ago	11.5%	555
I have never used mental health, alcohol use, or drug use services for any reason	32.1%	1,553
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	3.4%	165
	Answered	**4,834**
	Skipped	**295**

Within the past year, 19% or about one out of five of respondents used mental health, alcohol use, or drug use services. An additional 3.4% of respondents did not seek services due to COVID-19. The Substance Abuse & Mental Health Data Archive cites 18.6% of Virginians (age 18 or older) had "Any Mental Illness in 2018-19." Alcohol use disorder among Virginians 18 or older was 5.4% in 2018-2019 and illicit drug use other than marijuana in the past 30 days (2015 onward) among Virginians 18 and older was 2.9%. (SAMHDA. Interactive NSDUH State Estimates. Substance Abuse & Mental Health Data Archive. Accessed July 14, 2021 at https://pdas.samhsa.gov/saes/state)


Q12 - Have you been told by a doctor that you have… (Respondents could check more than one)
Depression or anxiety
High blood pressure
Obesity / overweight
I have no health problems
High cholesterol
Mental health problems
Drug or alcohol problems
Heart disease
Cancer
Asthma
High blood sugar or diabetes
Stroke /cerebrovascular disease
Other
HIV / AIDS
Cerebral palsy
32.2%
31.1%
32.8%
26.9%
32.2%
25.2%
18.8%
17.3%
12.2%
15.5%
14.1%
14.9%
3.7%
13.6%
4.1%
12.9%
5.6%
10.4%
15.4%
10.4%
16.9%
9.9%
2.2%
5.7%
13.0%
4.0%
0.4%
3.9%
0.2%
0.8%
0%
5%
10%
15%
20%
25%
30%
35%
2018 Percent
2021 Percent

	Percent	Responses
Depression or anxiety	31.1%	1,334
High blood pressure	26.9%	1,153
Obesity / overweight	25.2%	1,084
I have no health problems	17.3%	742
High cholesterol	15.5%	667
Mental health problems	14.9%	638
Drug or alcohol problems	13.6%	586
Heart disease	12.9%	555
Cancer	10.4%	448
Asthma	10.4%	446
High blood sugar or diabetes	9.9%	423
Stroke /cerebrovascular disease	5.7%	246
Other	4.0%	171
HIV / AIDS	3.9%	168
Cerebral palsy	0.8%	34
	Answered	**4,294**
	Skipped	**145**

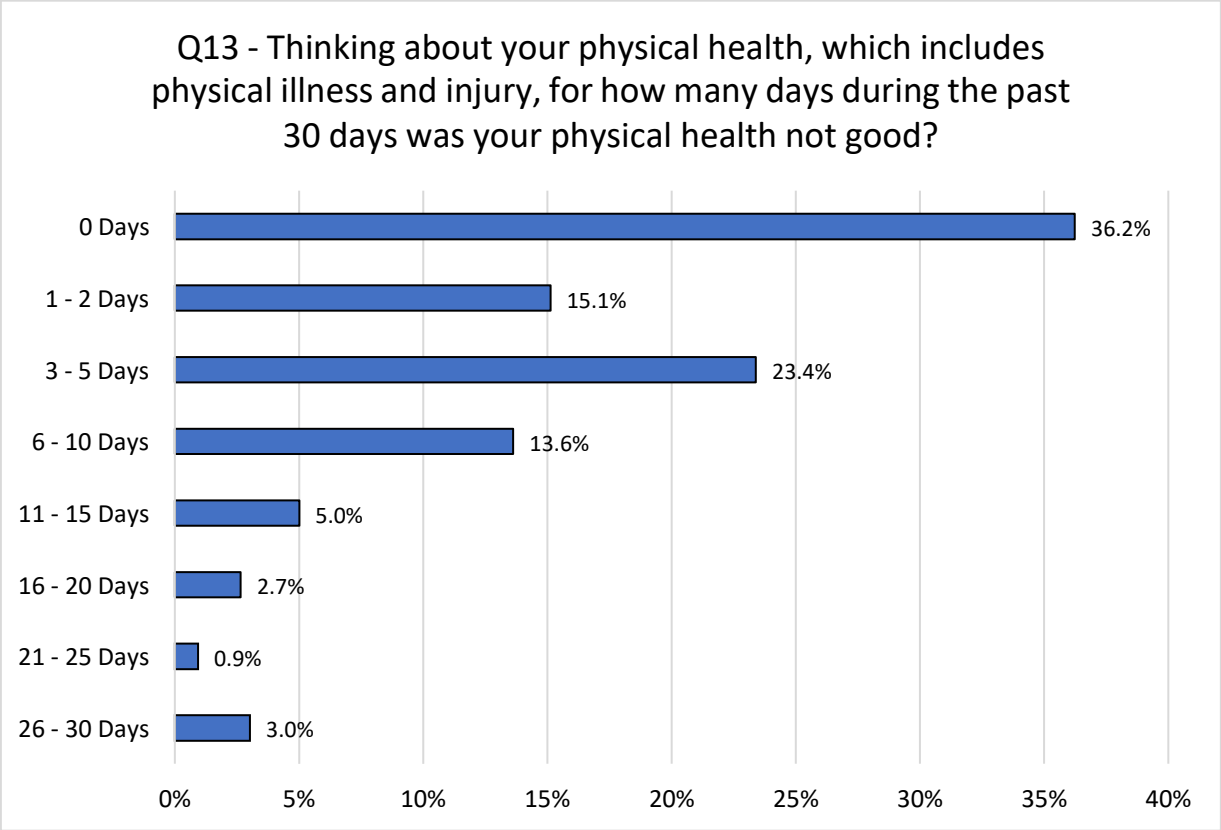
When looking at the chart of responses regarding whether or not the respondent has been told by a doctor that they have a certain condition, the trend among disorders is largely consistent between 2018 and 2021. Again, depression or anxiety was one of the top conditions, followed by high blood pressure, and overweight/obesity. Less respondents to the 2021 assessment have been told that they have high cholesterol (15% in 2021 compared to 21% in 2018). The largest disparities were among respondents who have been told they have a drug or alcohol problem (up almost 10% in 2021) and heart disease (up approximately 9%).

Q12. Other responses Have been told by a Doctor that you have:		
Code	**Responses**	**Percent**
Arthritis	12	6%
Hypothyroidism	9	5%
Allergies	8	4%
Migraines	8	4%
Irritable bowel syndrome	7	4%
Diabetes	6	3%
Fibromyalgia	6	3%
Auto immune disorder	5	3%
Anemia	4	2%
Chronic Obstructive Pulmonary Disease	4	2%
Mental health	4	2%
Polycystic ovary syndrome	4	2%
Renal disease/disorder	4	2%

Thyroid issues	4	2%
Cancer	3	2%
Chronic pain	3	2%
Epilepsy/seizure disorder	3	2%
Gastroesophageal Reflux Disease	3	2%
Osteoporosis	3	2%
Sleep Apnea	3	2%
Atrial fibrillation	2	1%
Blood clotting disorder	2	1%
Blood Pressure issues	2	1%
Hypercholesterolemia	2	1%
Endometriosis	2	1%
Gout	2	1%
Hashimoto's disease	2	1%
Hypercholesterolemia	2	1%
Knee issues/replacement	2	1%
Multiple Sclerosis	2	1%
Orthopedic issues	2	1%
Parkinson's Disease	2	1%
Pulmonary Disease	2	1%
Supraventricular tachycardia	2	1%
Tachycardia	2	1%
Tick-borne illness	2	1%
Addison's disease	1	1%
BRCA Gene positive	1	1%
Carpal Tunnel Syndrome	1	1%
Celiac disease	1	1%
Chiari malformation Type 2	1	1%
Cirrhosis	1	1%
Colon polyps	1	1%
Connective Tissue disease	1	1%
Coronary Artery Disease (CABG)	1	1%
Covid	1	1%
Cutaneous urticaria pigmentosa	1	1%
Deaf mute	1	1%
Dermatology issues	1	1%
Dry eye	1	1%
Dysautonomia	1	1%
Dysmenorrhea	1	1%
Glaucoma	1	1%
Graves’ disease	1	1%

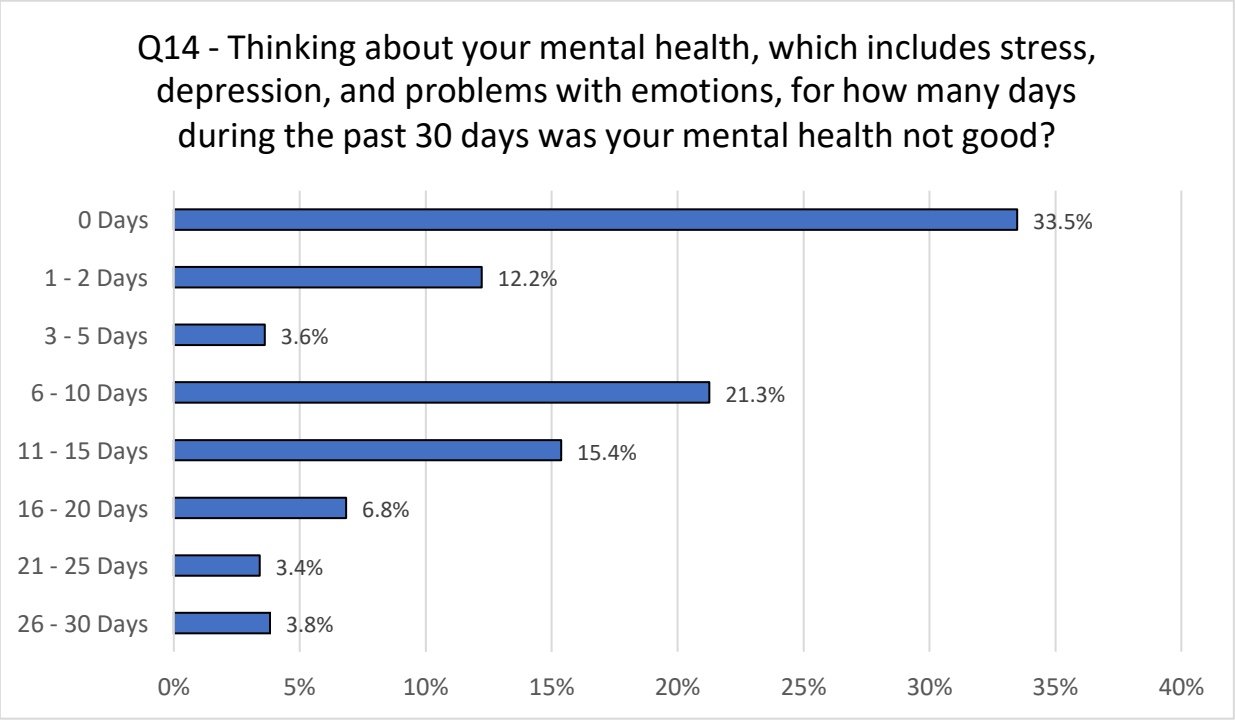
Headaches	1	1%
Hearing loss	1	1%
Heart Valve Repair	1	1%
Hyperparathyroidism	1	1%
Hypoglycemia	1	1%
Liver disorder	1	1%
Lung infection	1	1%
Mitral Valve Prolapse	1	1%
Musculoskeletal issues	1	1%
Mycobacterium avium-intracellular tuberculosis	1	1%
Neuropathy	1	1%
Osteopenia	1	1%
Ovarian cyst	1	1%
Pre-diabetes	1	1%
Raynaud's phenomenon	1	1%
Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome	1	1%
Scleroderma	1	1%
Scoliosis	1	1%
Tarsi's Coalition	1	1%
Temporomandibular Joint (TMJ) disorder	1	1%
Tickborne infection	1	1%
Ulcerative colitis	1	1%
Venous insufficiency	1	1%
Vitamin D deficiency	1	1%
N/A	11	6%
Total	**188**	**100%**

In the Lynchburg region, 188 respondents chose “other” for their selection. Of these “other” responses, 12 (6%) identified that they had been diagnosed with arthritis by a Physician;9respondents or 5% said they had been diagnosed with hypothyroidism; 8 respondents or 4% stated they had a diagnosis of allergies while 8 respondents or 4% said they were diagnosed with migraines. Additional diagnoses are included in the table above.



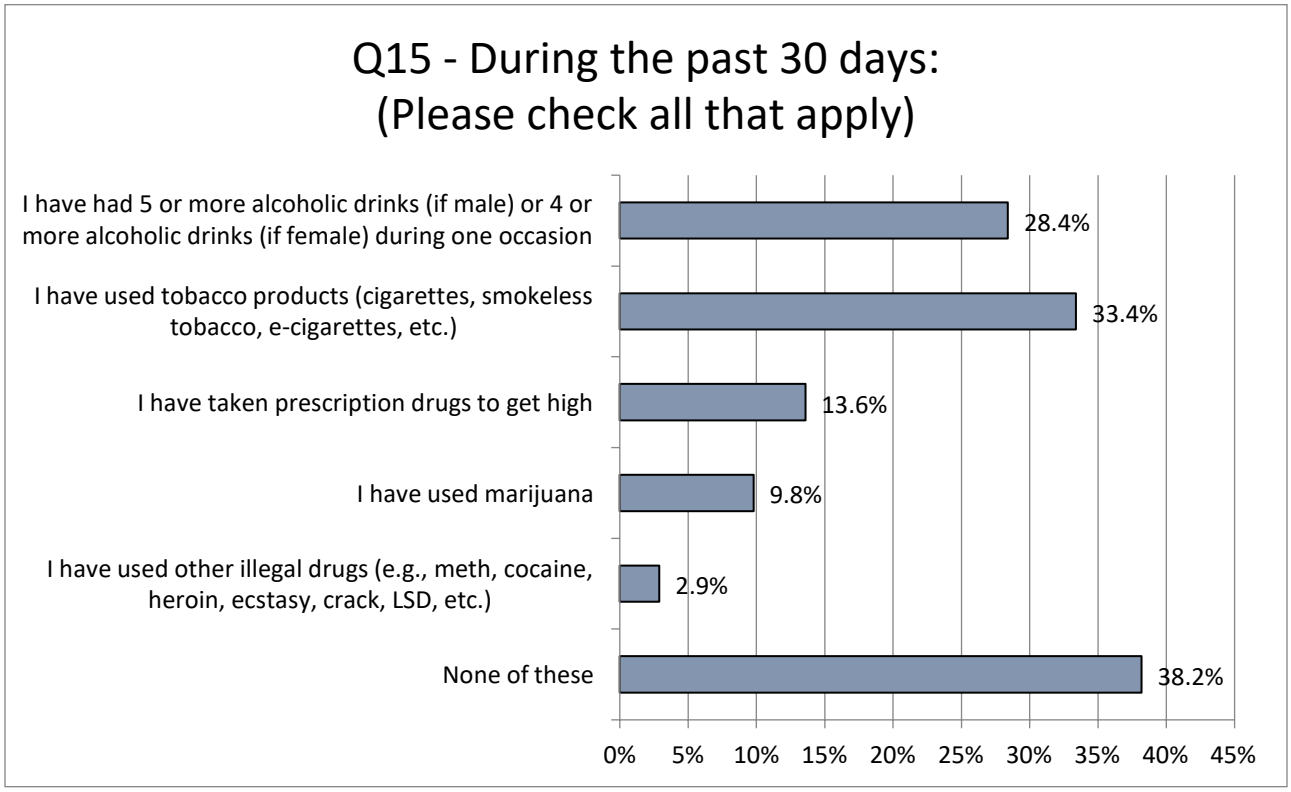
Days	Percent	Responses
0 Days	36.2%	1,162
1 - 2 Days	15.1%	485
3 - 5 Days	23.4%	750
6 - 10 Days	13.6%	437
11 - 15 Days	5.0%	161
16 - 20 Days	2.7%	85
21 - 25 Days	0.9%	30
26 - 30 Days	3.0%	97
	Responses	**3,207**
	Skipped	**695**

The 2021 assessment breaks out 2018's assessment from 0-5 days to 0 days, 1 to 2 days, and 3 to 5days. Combined the number of persons who reported that their health was not good from 0 to 5 days was 78% in 2018 compared to 74.5% in 2021. There was an increase in the number of respondents who said their health was not good for 6 to 15 days in 2021 (18.6% in 2021, 11.9% in 2018). There was only a small change from the 2018 assessment to the 2021 assessment among respondents answering 16 to 20 days (2.7% in 2021 compared to 2.4% in 2018) as well as those answering 21 to 25 days (0.9% in 2021 compared to 1.3% in 2018). The percentage of respondents indicating that their physical health was not good for 26 to 30 days decreased from 6.2% in 2018 to 3% in 2021.



Days	Percent	Responses
0 Days	33.5%	1,150
1 - 2 Days	12.2%	420
3 - 5 Days	3.6%	124
6 - 10 Days	21.3%	730
11 - 15 Days	15.4%	528
16 - 20 Days	6.8%	235
21 - 25 Days	3.4%	117
26 - 30 Days	3.8%	131
	Responses	**3,435**
	Skipped	**704**

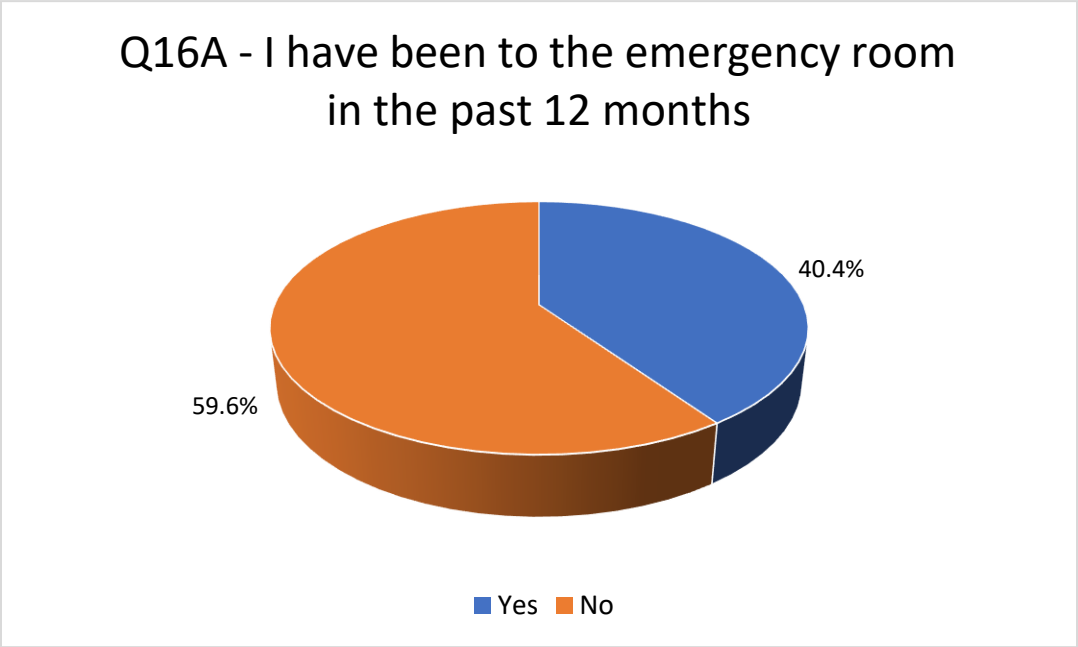
The percentage of 2021 respondents who felt their mental health was not good for more than 15 days in the last 30 days decreased from 15.2% in 2018 to 14%. The percentage of persons who felt their mental health was not good between 6 and 15 days increased significantly between assessments (13.9% in 2018 compared to 36.7% in 2021). Fewer reported that their mental health was not good for 0-5 days in 2021 (49.3%) as compared to 2018 (70.9%). The impact of COVID-19 should be considered as a contributor to this increase.



	Percent	Responses
I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion	28.4%	1,222
I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)	33.4%	1,439
I have taken prescription drugs to get high	13.6%	587
I have used marijuana	9.8%	422
I have used other illegal drugs (e.g., meth, cocaine, heroin, ecstasy, crack, LSD, etc.)	2.9%	127
None of these	38.2%	1,648
	Answered	**4,310**
	Skipped	**129**

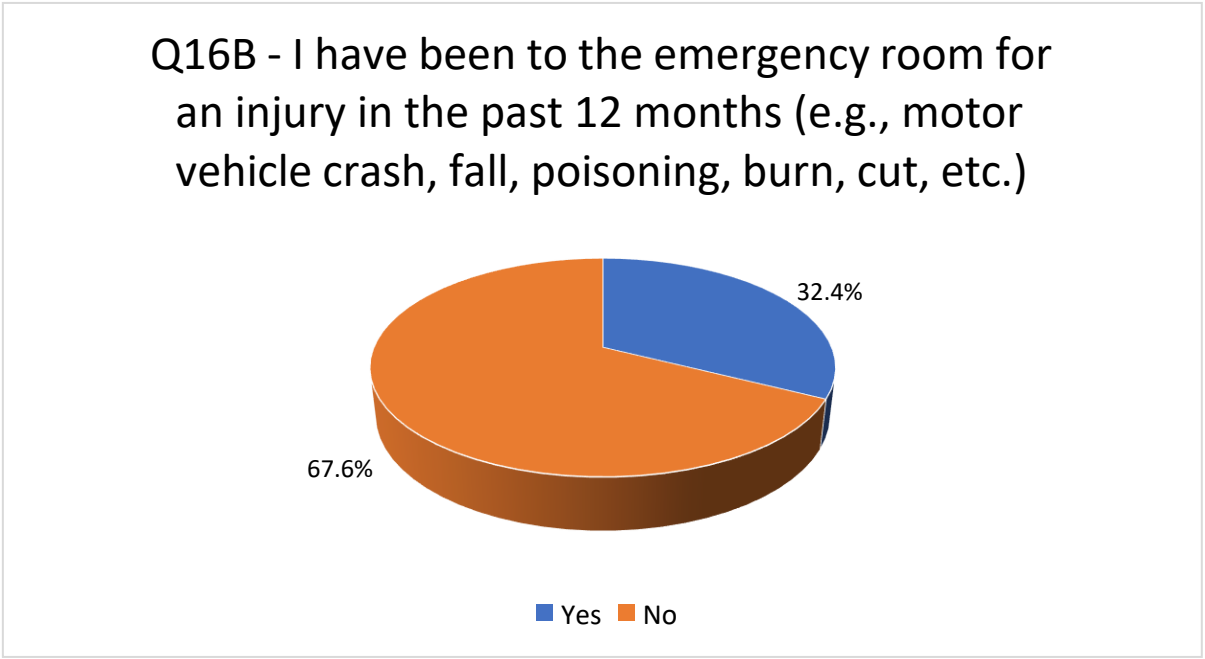
There was a decrease in the number of respondents who indicated that they used tobacco products from 2018 (53%) to 2021 (33.4%). There was also a decrease in the number of persons who had had alcoholic drinks (five or more for males or four or more for females) in the past 30 days (42% for 2018 respondents and 28.4% for 2021 respondents). More 2021 respondents indicated that they have taken prescription drugs to get high – approximately 13.6% in 2021 compared to just 1.6% in 2018. Those who used other illegal drugs (including marijuana) was 7.7% in 2018. In 2021, illegal drug use excluded marijuana with 2.9% of respondents reporting illegal drug use and 9.8% reporting having used marijuana. On July 1, 2021, recreational use of marijuana became legal in Virginia although retail sales will not begin until 2024.

Alcohol use disorder among Virginians 18 or older was 5.4% in 2018-2019 and illicit drug use other than marijuana in the past 30 days (2015 onward) among Virginians 18 and older was 2.9%. (SAMHDA. Interactive NSDUH State Estimates. Substance Abuse & Mental Health Data Archive. Accessed July 14, 2021 at https://pdas.samhsa.gov/saes/state)



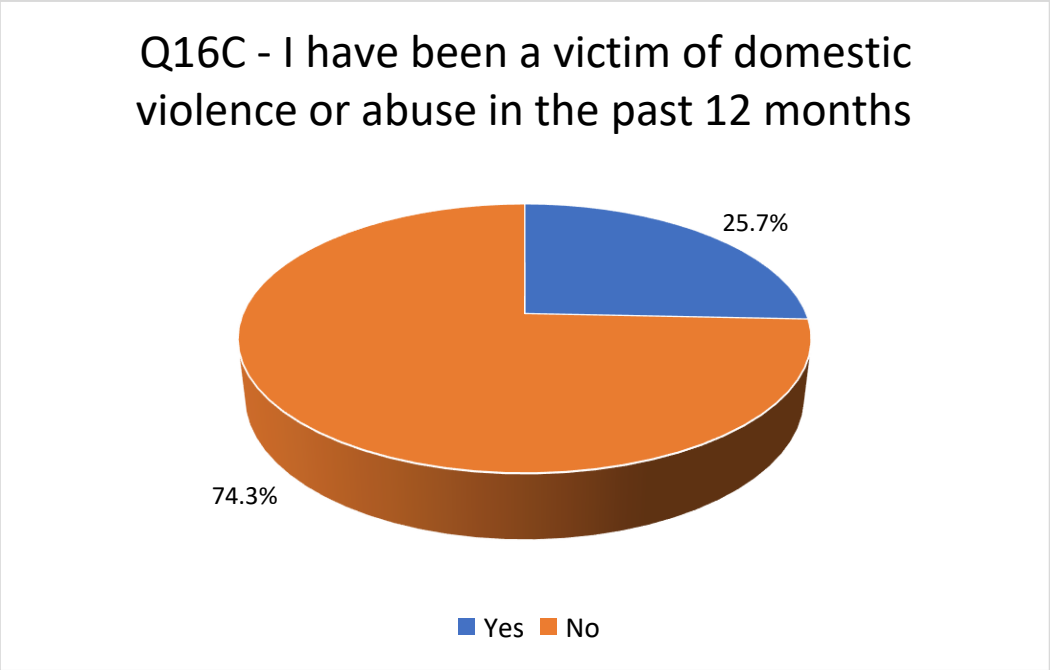
	Percent	Responses
Yes	40.4%	1,742
No	59.6%	2,575
	Answered	**4317**
	Skipped	**122**

The number of respondents who indicated that they had been to the Emergency Room in the past 12 months increased from 28% in 2018 to 40.4% in 2021. In 2019, approximately 22% of adults aged 18 and over had visited the ED in the past 12 months (Centers for Disease Control and Prevention. National Health Statistics. *Emergency Department Visit Rates by Selected Characteristics*: *United States, 2018*. Accessed July 19, 2021 at https://www.cdc.gov/nchs/products/databriefs/db401.htm).



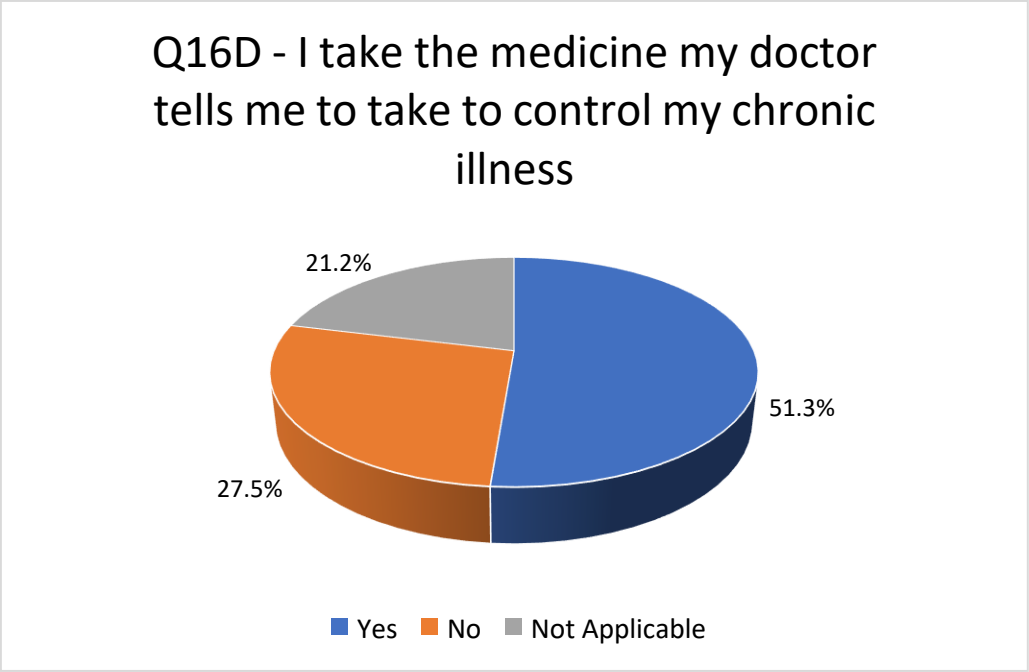
	Percent	Responses
Yes	32.4%	1,401
No	67.6%	2,918
	Answered	**4,319**
	Skipped	**120**

The number of respondents indicating that they had used the emergency room for an injury in the last 12 months was close to four times that in 2018 (8.6%) than in 2018 (32.4%).



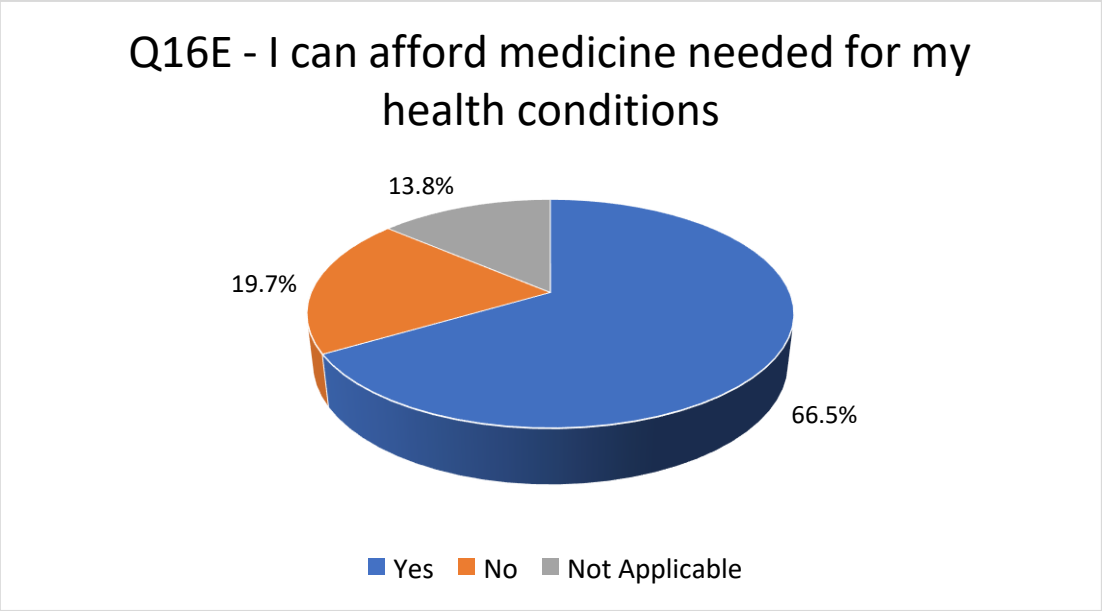
	Percent	Responses
Yes	25.7%	1,109
No	74.3%	3,212
	Answered	**4,321**
	Skipped	**118**

The number of respondents who reported that they had been victims of domestic violence in the last 12 months was seven times the number from 2018 (3.6%) to 2021 (25.75%). These responses are relatively close to the statistics in Virginia according to the World Population Review, that cited domestic violence against women in Virginia is 33.6% and 28.6% against men (National Coalition Against Domestic Violence (2019). *Domestic violence in Virginia.* Accessed July 13, 2021, from www.ncadv.org/files/Virginia.pdf).



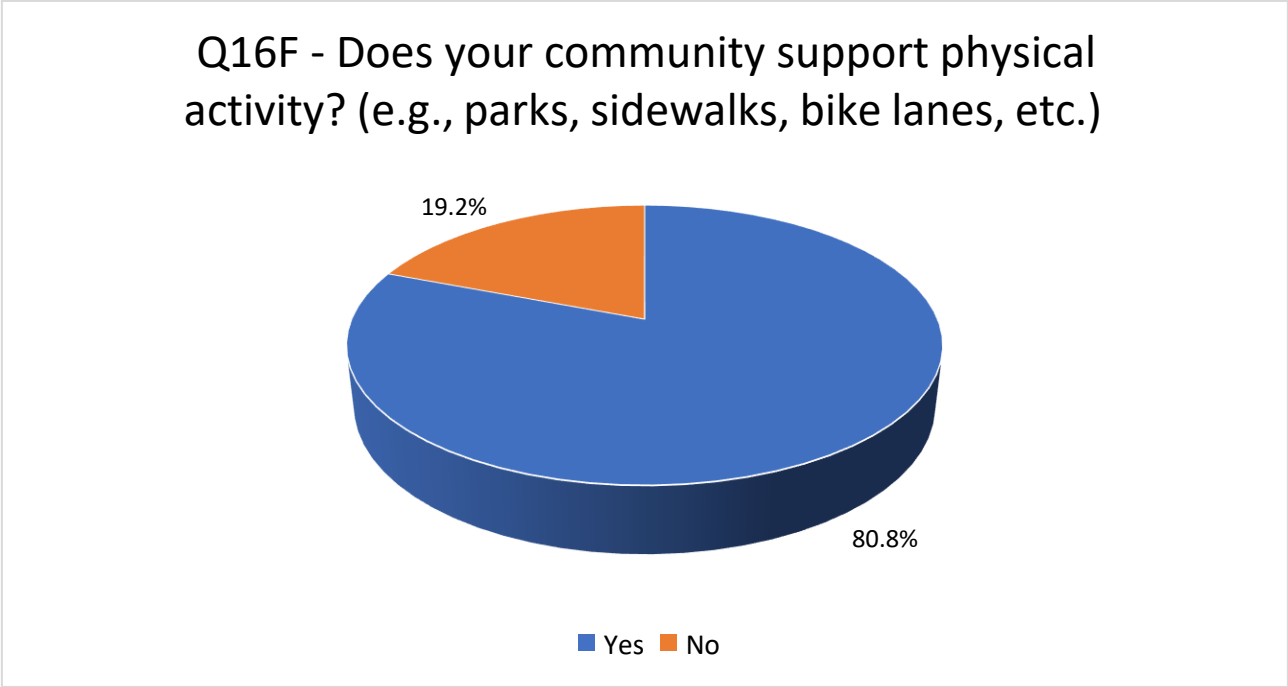
	Percent	Responses
Yes	51.3%	2,204
No	27.5%	1,183
Not Applicable	21.2%	910
	Answered	**4,297**
	Skipped	**142**

The number of respondents indicating that they take the medicine that their doctor tells them to take increased 14% from 36.6% in 2018 to 51.3% in 2021.



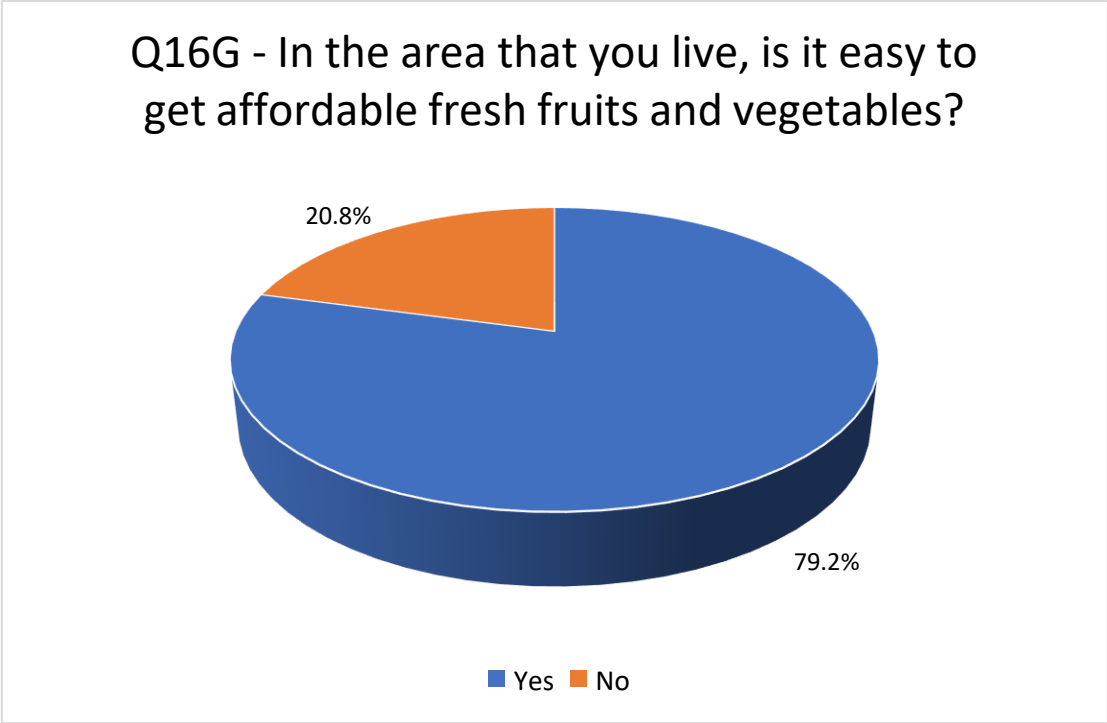
	Percent	Responses
Yes	66.5%	2,863
No	19.7%	848
Not Applicable	13.8%	592
	Answered	**4,303**
	Skipped	**136**

The number of respondents indicating that they can afford the medicine needed for their health conditions increased 9% from 57.5% in 2018 to 66.5% in 2021 while those reporting "no" remained about the same as reported in 2018 (21%).



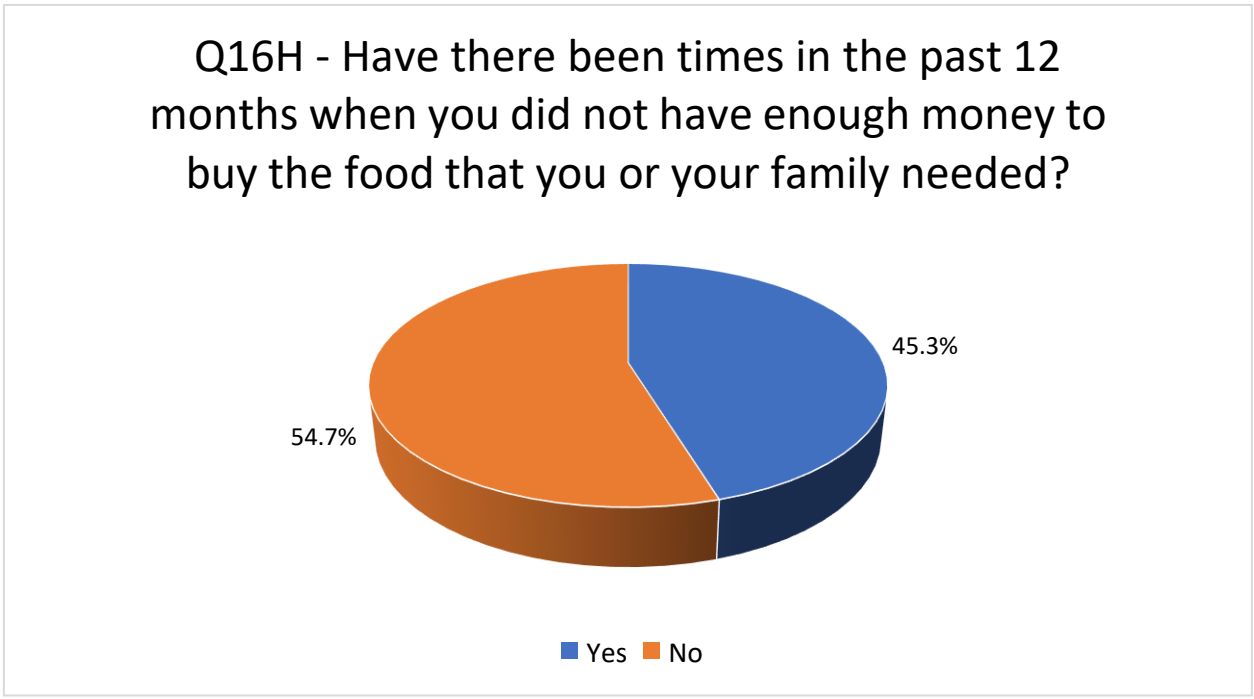
	Percent	Responses
Yes	80.8%	3,482
No	19.2%	826
	Answered	**4,308**
	Skipped	**131**

There was a significant increase in the number of respondents who indicated that their community supported physical activity in 2021 (80.8%) compared to 53% of respondents in 2018. Access to physical activity "spaces" is important as regular exercise reduces the number of risk factors (such as obesity) associated with many health conditions.



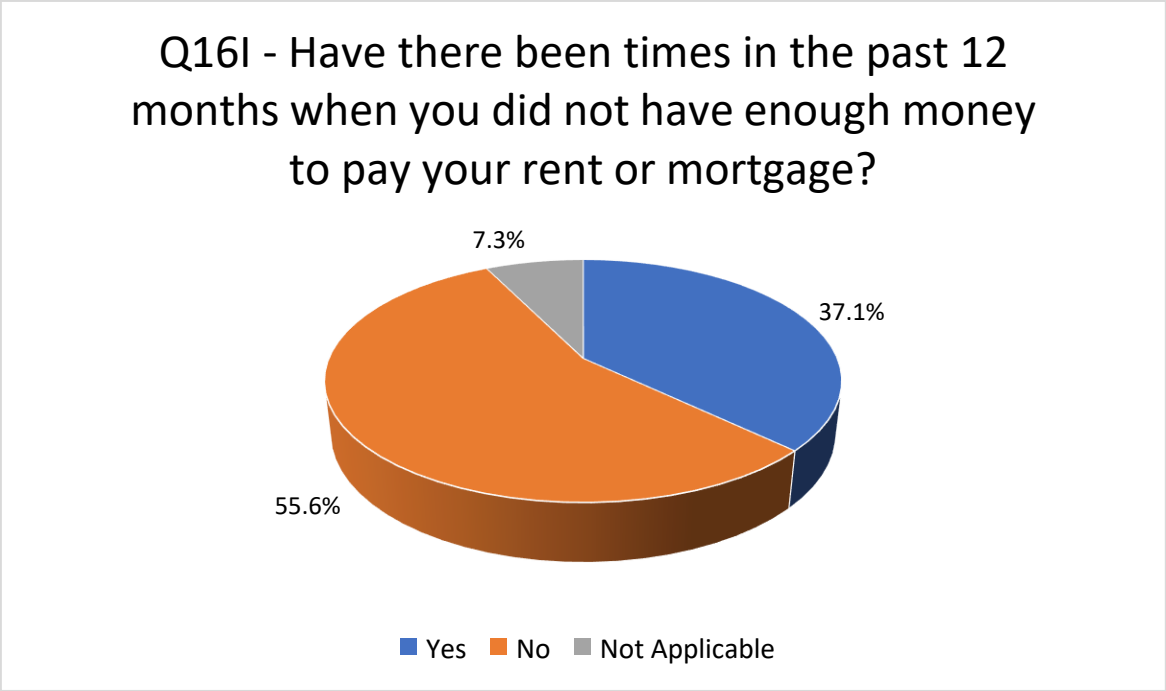
	Percent	Responses
Yes	79.2%	3,418
No	20.8%	897
	Answered	**4,315**
	Skipped	**134**

The number of respondents indicating that it was easy to get affordable fresh fruits and vegetables increased from 68.3% in 2018 to 79.2% in 2021. "According to the 2015—2020 Dietary Guidelines for Americans, healthy eating patterns include a variety of vegetables; fruits, especially whole fruits; grains, at least half of which are whole grains; fat-free or low-fat dairy; protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), unsalted nuts and seeds, and soy products; and oils. Some research has shown that increased access to healthy foods corresponds with healthier dietary practices." (U.S. Department of Health and Human Services, Office of Disease Prevention and Promotion. (January 2020). Access to Foods that Support Healthy Eating Patterns. Healthy People 2030. Accessed July 13, 2021, at https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/access-foods-support-healthy-eating-patterns)



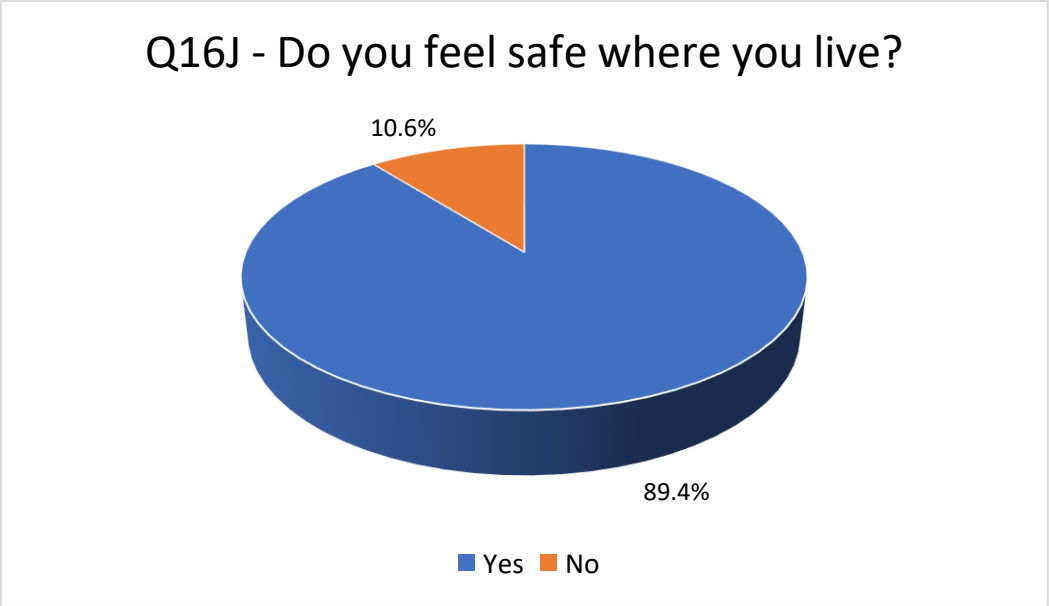
	Percent	Responses
Yes	45.3%	1,957
No	54.7%	2,366
	Answered	**4,323**
	Skipped	**116**

The number of respondents who indicated that there had been times when they did not have enough money to buy the food they or their family increased from 2018 (30.3%) to 2021 (45.3%).



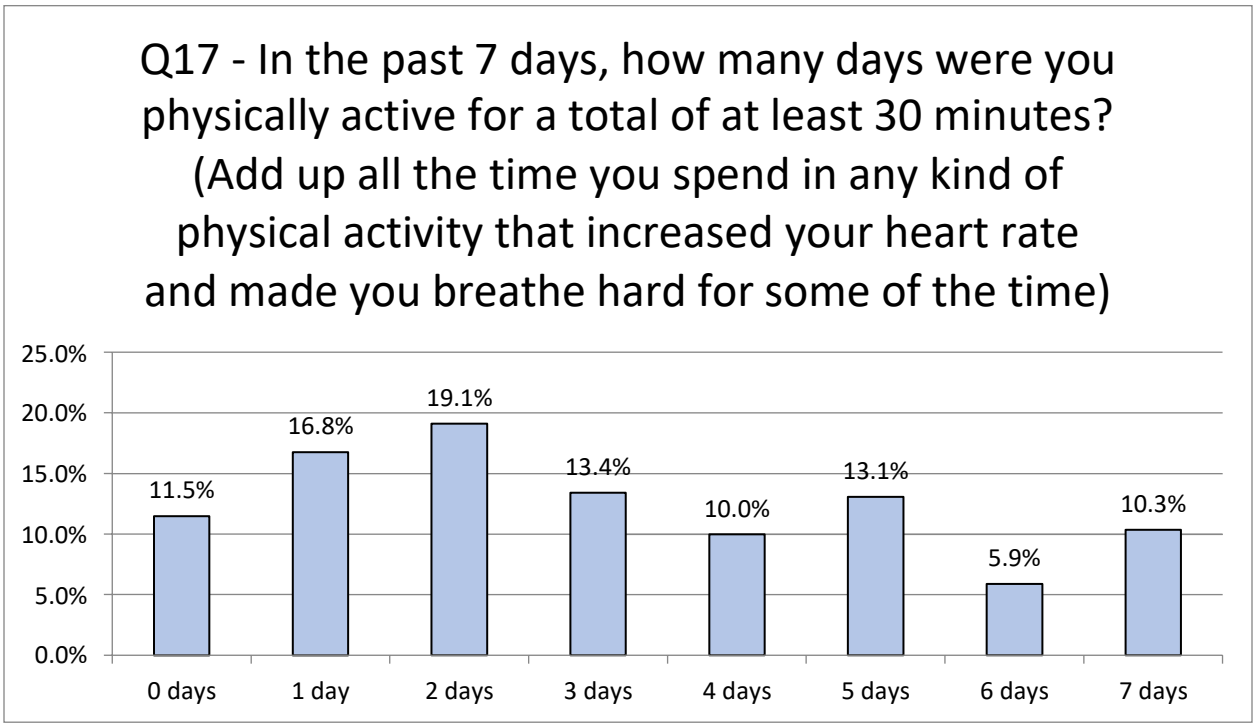
	Percent	Responses
Yes	37.1%	1,602
No	55.6%	2,403
Not Applicable	7.3%	314
	Answered	**4,319**
	Skipped	**120**

The percentage of respondents who did not have enough money in the past 12 months to pay rent or mortgage rose from 2018 (24.8%) to 2021 (37.1%).



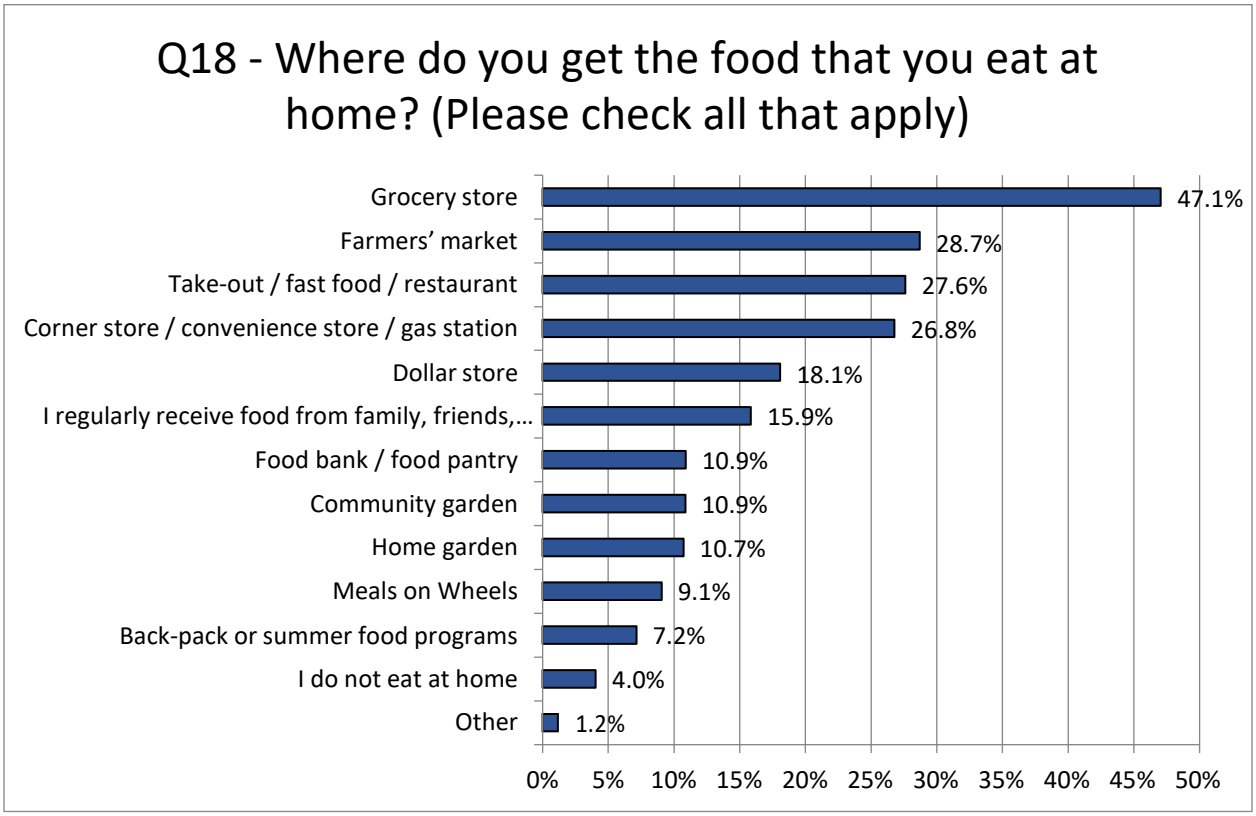
	Percent	Responses
Yes	89.4%	3,868
No	10.6%	461
	Answered	**4,329**
	Skipped	**110**

The number of respondents who felt safe where they live remained essentially the same from 2018 (90.2%) to 2021 (89.4%).



	Percent	Responses
0 days	11.5%	497
1 day	16.8%	725
2 days	19.1%	826
3 days	13.4%	580
4 days	10.0%	431
5 days	13.1%	565
6 days	5.9%	255
7 days	10.3%	447
	Answered	**4,326**
	Skipped	**113**

The number of respondents who were physically active five or more days per week decreased from 32.2% in 2018 to 29.3% in 2021. The number of respondents who were active three to four days per week fell from 28.3% in 2018 to 23.4% in 2021. The number of respondents who were active one or two days per week increased from 27% in 2018 to 36% in 2021.



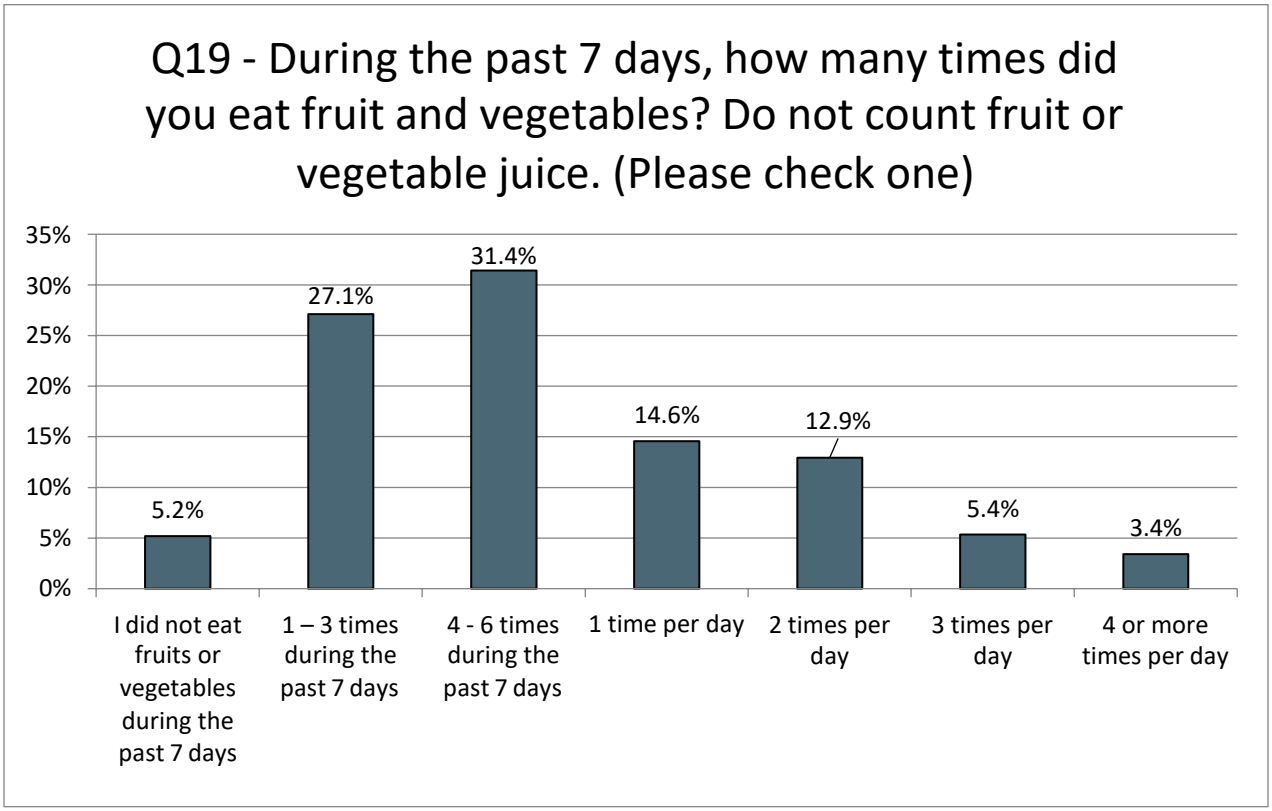
	Percent	Responses
Grocery store	47.1%	2,038
Farmers' market	28.7%	1,243
Take-out / fast food / restaurant	27.6%	1,196
Corner store / convenience store / gas station	26.8%	1,160
Dollar store	18.1%	784
I regularly receive food from family, friends, neighbors, or my church	15.9%	687
Food bank / food pantry	10.9%	472
Community garden	10.9%	471
Home garden	10.7%	465
Meals on Wheels	9.1%	393
Back-pack or summer food programs	7.2%	310
I do not eat at home	4.0%	175
Other	1.2%	50
	Answered	**4,331**
	Skipped	**78**

In 2021 respondents to this question appear to be getting their food from sources other than the grocery store. In 2018, the number of respondents indicating that got food from the grocery store was 97.6% and in 2021 that number was less than half at 47%. The percent of respondents getting food from dollar stores decreased from 2018 (21%) to 18% in 2021 however more respondents in 2021 reported getting food from a corner store, etc. (26.8%) compared to 2018 (10.6%). Fewer

respondents in 2021 got their food from home gardens than in 2018 (10.7% compared to 19.7%) while a larger number used community gardens in 2021 (10.9%) as in 2018 (2.7%). The number of respondents getting take-out/fast food/or restaurant food fell from 47% in 2018 to 27.6% in 2021 More respondents in 2021 reported receiving food from family, friends, neighbors, or their church (15.9%) than in 2018 (11.7%) while those relying on Meals on Wheels (9.1%) and Back-pack or summer food programs (7.2%) increased exponentially in 2021 compared to 2018 (2.7% and 1.4% respectively). Additionally in 2021, 4% of respondents reported they do not eat at home compared to 0.5% in 2018.

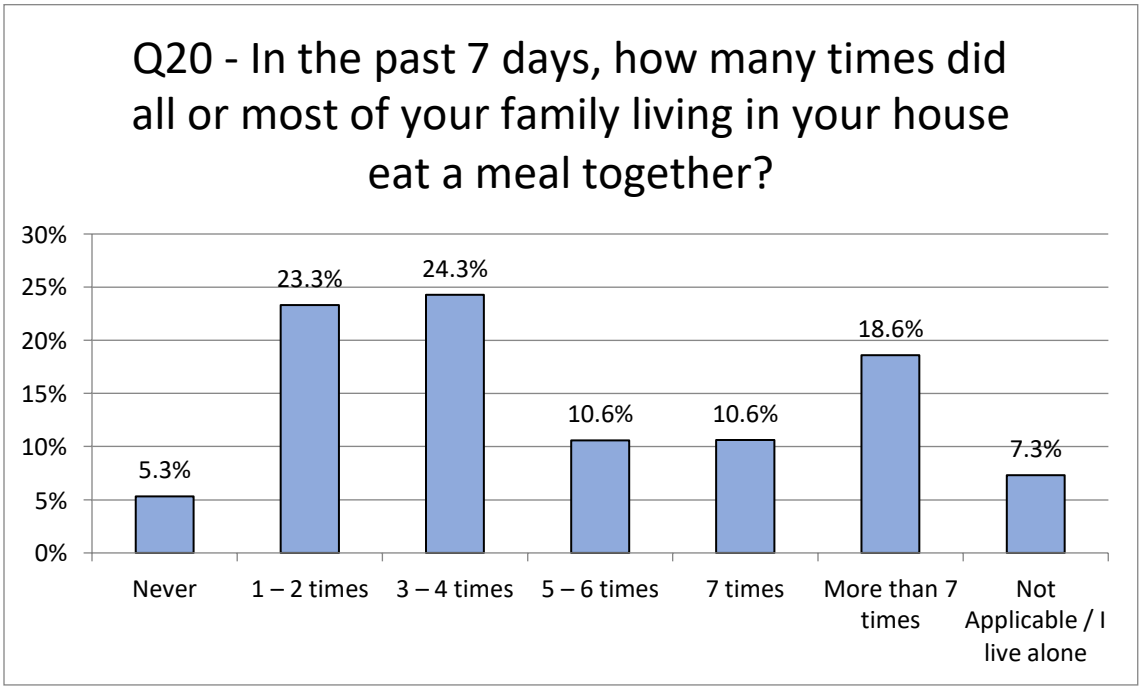
Q18. Other responses Where do you get the food that you eat at home?		
Code	**Responses**	**Percent**
Food subscription/delivery service	14	33%
Lynchburg Grows	6	14%
Community Supported Agriculture	4	9%
Grocery store	3	7%
Home	3	7%
Supplemental Nutrition Assistance Program Electronic Benefits Transfer (SNAP EBT)	3	7%
Centra Pace	1	2%
Family meals together	1	2%
Family, friends	1	2%
Free and Reduced School Lunch Program	1	2%
Hunting	1	2%
Lynchburg Daily Bread	1	2%
Mom's Meals	1	2%
Nutritional supplements- feeding tube	1	2%
Raise livestock	1	2%
School Lunch Program	1	2%
Total	**43**	**100%**

In the Lynchburg region, 43 respondents chose "other" for their selection. Of these "other" responses, 14 or 33% identified that they got their food from a food subscription or delivery service; 6 people or 14% identified that their food came from Lynchburg Grows; while 4 (9%) said their food came from a community support agriculture. Additional responses are listed in the table above.



	Percent	Responses
I did not eat fruits or vegetables during the past 7 days	5.2%	226
1 – 3 times during the past 7 days	27.1%	1,180
4 - 6 times during the past 7 days	31.4%	1,366
1 time per day	14.6%	634
2 times per day	12.9%	563
3 times per day	5.4%	233
4 or more times per day	3.4%	148
	Answered	**4,350**
	Skipped	**89**

Approximately 36% of respondents ate fruit and vegetables on a daily basis but is less than the rate in 2018 (45.1%). The federal fruit and vegetable recommendations vary by age and sex. Adult women need at least 1½ cups of fruit and 2½ cups of vegetables each day and adult men need at least 2 cups of fruit and 3½ cups of vegetables each day (Centers for Disease Control and Prevention. Only 1 in 10 Adults Get enough Fruits and Vegetables. Retrieved July 27, 2021 from https://www.cdc.gov/nccdphp/dnpao/division-information/media-tools/adults-fruits-vegetables.html). The CDC recommends learning more from the U.S. Department of Agriculture (USDA). The USDA has created an online food plan recommendation based on a person's age, sex, and physical activity. The reader can access the food plan resource at https://www.myplate.gov/myplate-plan.

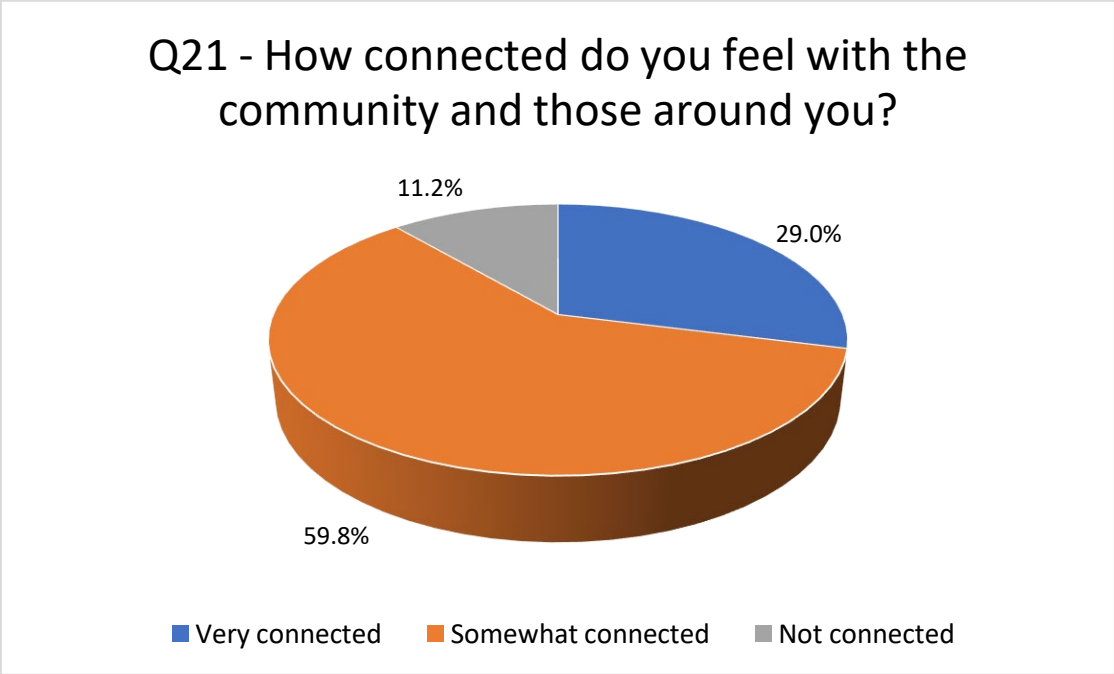


	Percent	Responses
Never	5.3%	231
1 – 2 times	23.3%	1,011
3 – 4 times	24.3%	1,053
5 – 6 times	10.6%	459
7 times	10.6%	460
More than 7 times	18.6%	807
Not Applicable / I live alone	7.3%	317
	Answered	**4,338**
	Skipped	**101**

In the Lynchburg Area, 35% of respondents ate together between three and six times a week. Those eating meals together seven or more times per week in 2021 was 29.2% compared to 18.3% in 2018.

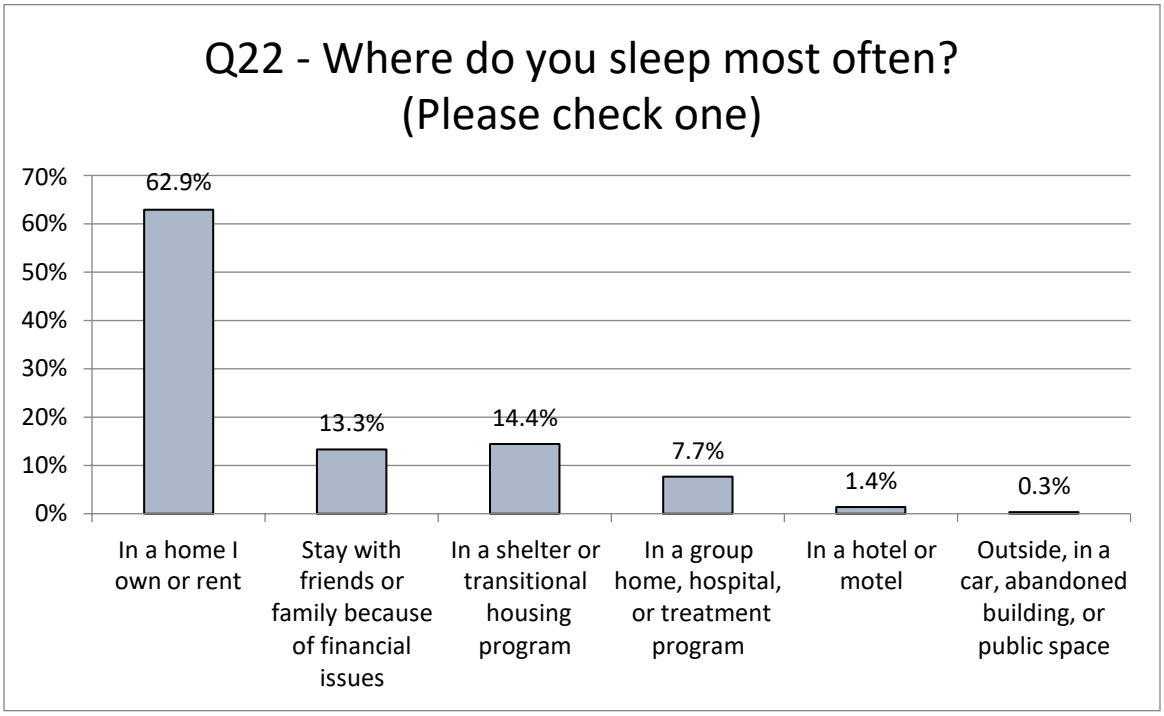
"Over the past three decades, family time at the dinner table and family conversation, in general, has declined by more than 30%. Families with children under age 18 report having family dinners three to four times per week. One third (33%) of families with 11 to 18-year-olds only eat one or two meals a week together. Only one fourth (25%) eat seven or more family meals per week. The experience at the meal table has also declined in quality with the increase in distractions, such as television watching, text messaging, phone conversations and social media. Barriers to family meals cited by parents include: too little time, child and adult schedule challenges, and food preparation. Most parents, however, say they place a high value on family meals, ranking them above every other activity (including vacations, playing together and religious services) in helping them connect with their families and children. Most wish they had more family dinners (American College of Pediatricians. The Benefits of the Family Table. (February 2021). Retrieved July 27, 2021 from https://acpeds.org/position-statements/the-benefits-of-the-family-table).

"Regular family dinners are associated with lower rates of depression, and anxiety, and substance abuse, and eating disorders, and tobacco use, and early teenage pregnancy, and higher rates of resilience and higher self-esteem. Kids who grow up having family dinners, when they're on their own tend to eat more healthily and to have lower rates of obesity." "Although it's interesting in affluent families, the numbers have gone up, and in low-income families they've gone down, which I think speaks to the extra stressors of having to work extra jobs, having unpredictable schedules, not having as much access to healthy food." Anderson, J. (Host) (2021, April 1). [Audio podcast transcription]. Harvard EdCast: The Benefit of Family Mealtime: Anne Fishel, Executive Director of the Family Dinner Project, helps families find fun, creative, and easy ways to make meals a reality. https://www.gse.harvard.edu/news/20/04/harvard-edcast-benefit-family-mealtime



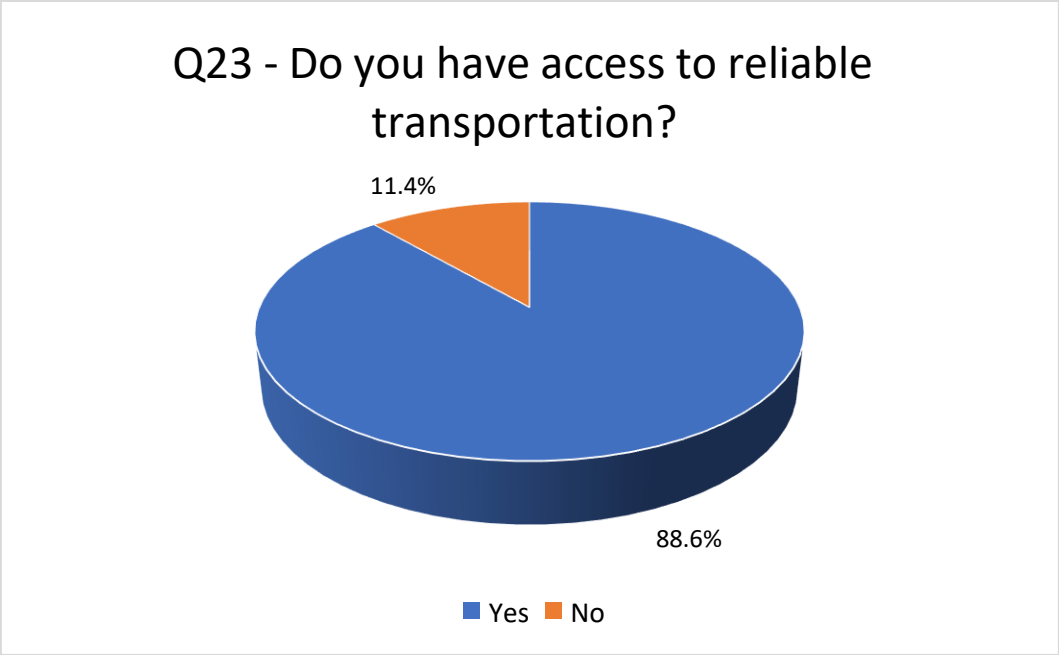
	Percent	Responses
Very connected	29.0%	1,261
Somewhat connected	59.8%	2,602
Not connected	11.2%	489
	Answered	**4,352**
	Skipped	**87**

The percentage of respondents who felt somewhat connected to the community and those around them increased from 2018 (54%) to almost 60% in 2021. The number of respondents who felt very connected remained steady from 30% in 2018 to 29% in 2021. The number of respondents who felt not connected decreased to 11% in 2021 from 16% in 2021.



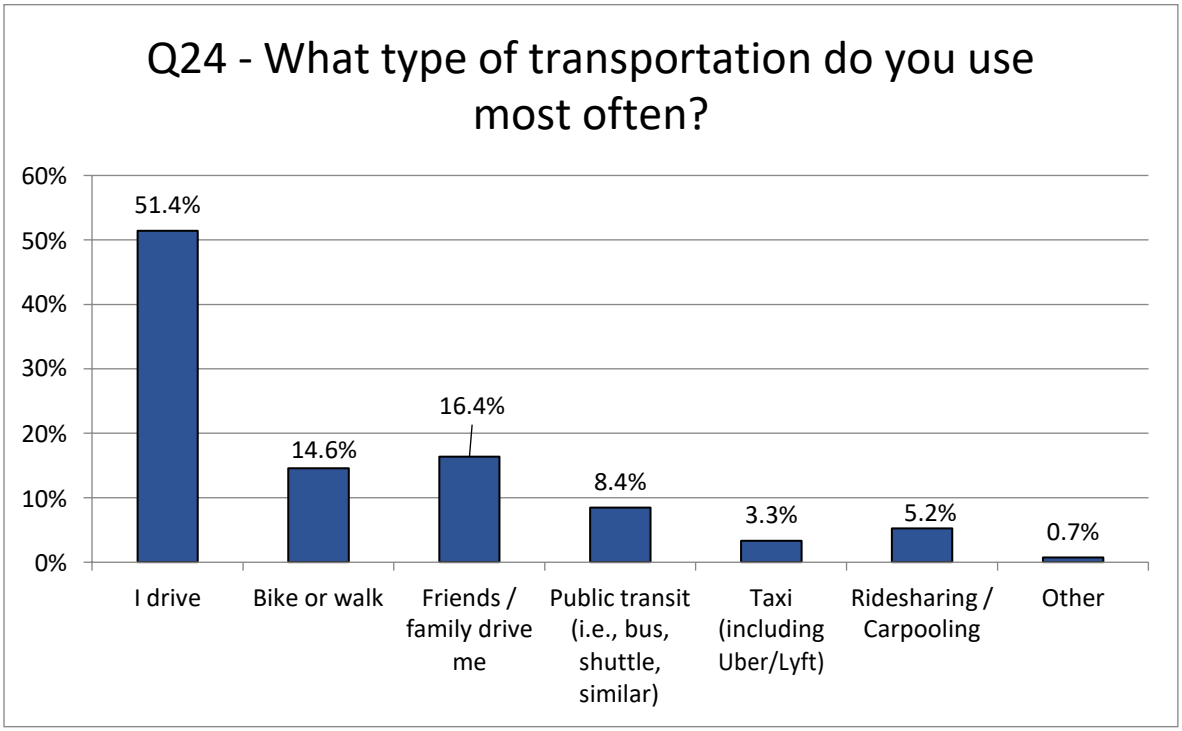
	Percent	Responses
In a home I own or rent	62.9%	2,739
Stay with friends or family because of financial issues	13.3%	579
In a shelter or transitional housing program	14.4%	628
In a group home, hospital, or treatment program	7.7%	334
In a hotel or motel	1.4%	60
Outside, in a car, abandoned building, or public space	0.3%	13
	Answered	**4,353**
	Skipped	**86**

In 2021, 63% of respondents slept most often in their own homes. The combined percentage of respondents that did not sleep in their own home or with friends or family and were not in a group home, hospital, or treatment program was 16.1%. "As of January 2020, Virginia had an estimated 5,957 experiencing homelessness on any given day, as reported by Continuums of Care to the U.S. Department of Housing and Urban Development (HUD)." As a percent, the rate of total homelessness in Virginia is 1.1%. (United States Interagency Council on Homelessness. (2021). *Virginia Homelessness Statistics.* Accessed July 13, 2021, at https://www.usich.gov/homelessness-statistics/va/)



	Percent	Responses
Yes	88.6%	3,844
No	11.4%	495
	Answered	**4,339**
	Skipped	**100**

Approximately 89% of respondents indicated that they had access to reliable transportation. This question was not a question on the 2018 assessment. However, the 2018 assessment included how many vehicles were owned, leased, or available for regular use by the respondent and those in their household. The percentage indicating zero (0) was 11.3%.

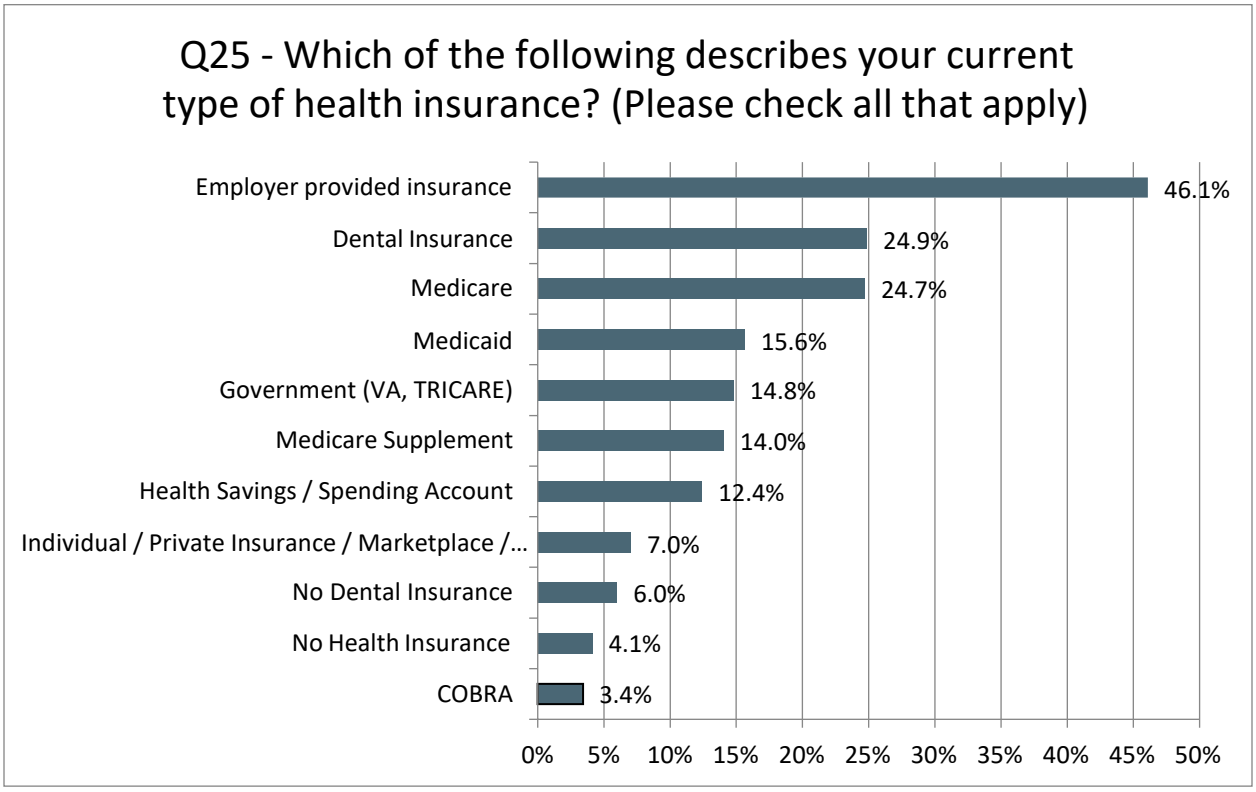


	Percent	Responses
I drive	51.4%	2,210
Bike or walk	14.6%	626
Friends / family drive me	16.4%	704
Public transit (i.e., bus, shuttle, similar)	8.4%	363
Taxi (including Uber/Lyft)	3.3%	142
Ridesharing / Carpooling	5.2%	225
Other	0.7%	30
	Answered	**4,300**
	Skipped	**139**

In 2021, 51% indicated that they drove. In 2018, 86% indicated that the mode of transportation that that they "typically used" was a car. 2018 respondents were able to select multiple answers. This makes comparisons between the assessment years difficult. However, the number of 2021 respondents who indicated that they use public transportation increased slightly from 7.3% in 2018 to 8.4% in 2021.

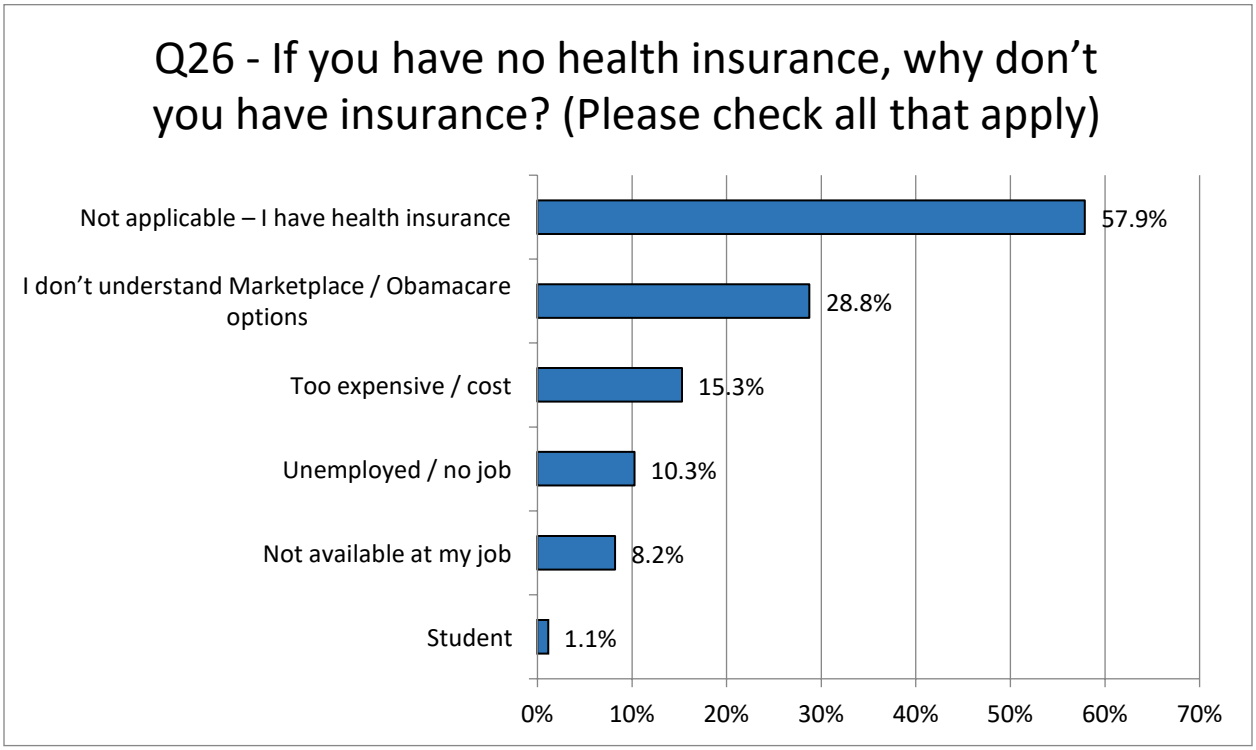
Q24. Other responses What type of transportation do you use most often?		
Code	**Responses**	**Percent**
Centra PACE	8	40%
Friends/family	4	20%
Scooter	2	10%
Anthem Transportation	1	5%
Bike	1	5%
Borrow a car	1	5%
Drive a car	1	5%
UnitedHealth Group Transportation	1	5%
Walk	1	5%
Total	**20**	**100%**

In the Lynchburg region, 20 respondents chose "other" for their selection. Of these "other" responses, 8 or 40% identified that their main form of transportation was through the Centra PACE facility; 4 responses or 20% identified that their family or friends transported them while 2 respondents or 10% said they utilized scooters with additional responses in the table above.



	Percent	Responses
Employer provided insurance	46.1%	2,005
Dental Insurance	24.9%	1,082
Medicare	24.7%	1,074
Medicaid	15.6%	680
Government (VA, TRICARE)	14.8%	644
Medicare Supplement	14.0%	611
Health Savings / Spending Account	12.4%	540
Individual / Private Insurance / Marketplace / Obamacare	7.0%	306
No Dental Insurance	6.0%	261
No Health Insurance	4.1%	180
COBRA	3.4%	149
	Answered	**4,350**
	Skipped	**89**

More respondents in 2018 indicated that they had employer provided insurance than in 2021 (55% in 2018 compared to 46% in 2021). The number of respondents indicating that they had no insurance fell significantly from 9% in 2018 to 4.1% in 2021. The number of respondents indicating that they had dental insurance decreased to 25% in 2021 from 30% in 2018. Respondents indicating that they had either Medicare, or a Medicare supplement, increased to 38.7% from 24.4% in 2018 while slightly fewer respondents reported they had Medicaid (15.6%) in 2021 compared to 16.6% in 2018. The 2021 respondents indicated that they were currently on a COBRA plan increased from 0.4% in 2018 to 3.4% in 2021.

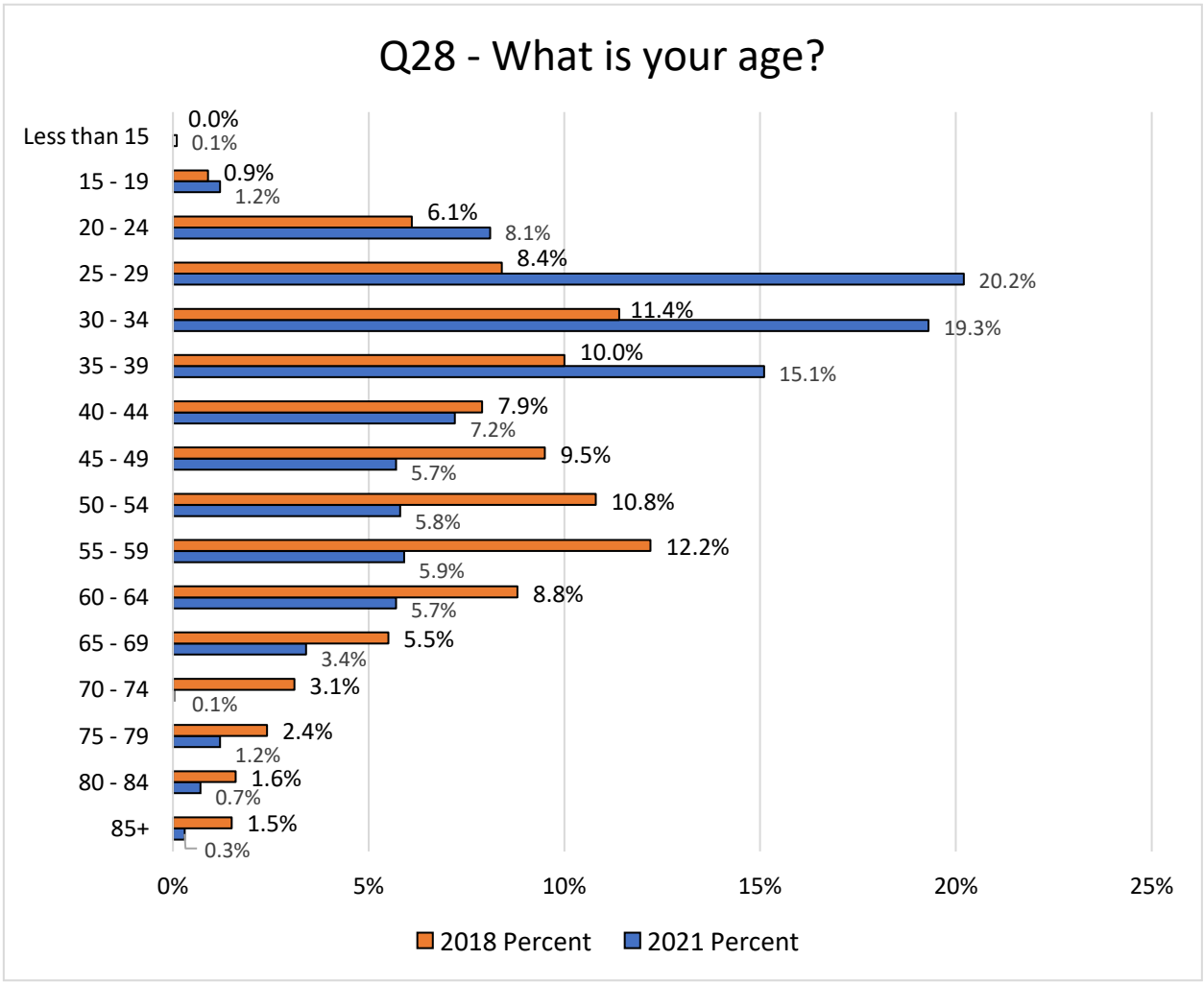


	Percent	Responses
Not applicable – I have health insurance	57.9%	2,135
I don't understand Marketplace / Obamacare options	28.8%	1,061
Too expensive / cost	15.3%	564
Unemployed / no job	10.3%	379
Not available at my job	8.2%	303
Student	1.1%	42
	Answered	**3,688**
	Skipped	**712**

The number of respondents indicating that health insurance was too expensive in 2018 was consistent to the percentage choosing this answer in 2021 (14% compared to 15% in 2021). There were more responses to unemployed/no job respondents in 2021 (10.3%) as compared to 2018 (7.1%). More 2021 respondents indicated that health insurance was not available at their job (8.2%) than 2018 respondents 4%. A significantly larger percent of respondents in 2021 (28.8%) reported they don't understand the Marketplace/Obamacare as compared to 2018 (1.7%).

Q26. Other responses If you have no health insurance, why don't you?		
Code	**Responses**	**Percent**
I use Centra PACE	3	10%
Self-pay	3	10%
Shared plan	2	7%
Unemployed	2	7%
Do not understand services	1	3%
Medicare- dental & vision coverage are hard to get	1	3%
Not available at job	1	3%
N/A	16	55%
Total	**29**	**100%**

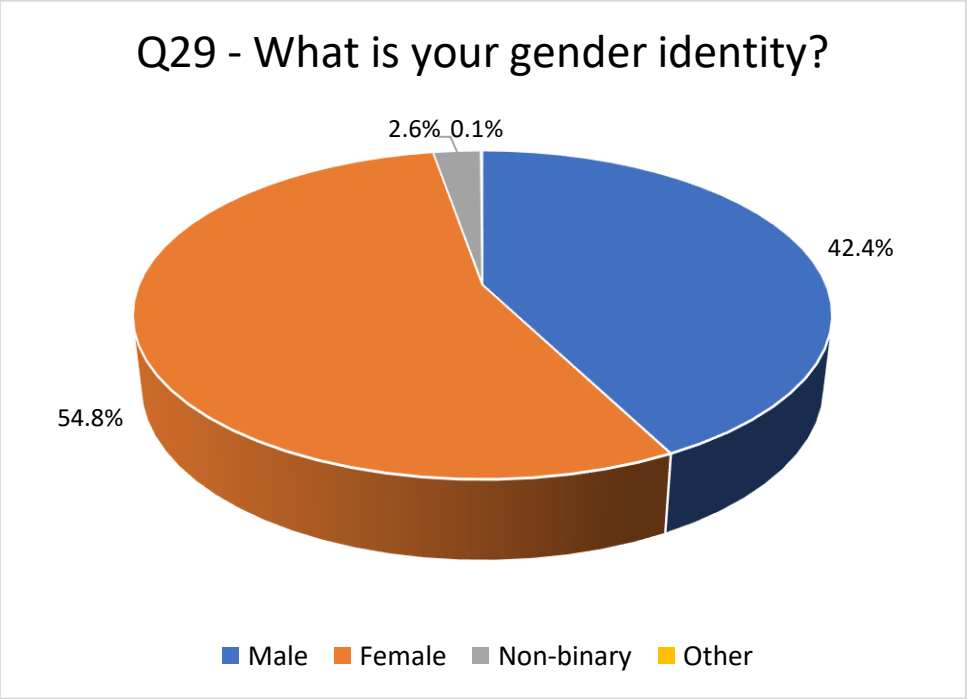
In the Lynchburg region, 29 respondents chose "other" for their selection. Of these "other" responses, 3 or 10% stated their main reason for not having health insurance was either because they used Centra PACE facilities or because they were self-pay; 2 responses or 7% identified they were either on a shared plan or unemployed; while the remainder reported that they did not understand services, the dental and vision coverage was difficult to get for Medicare beneficiaries, or health insurance was not available through their job.


Q28 - What is your age?
Less than 15
15 - 19
20 - 24
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 - 69
70 - 74
75 - 79
80 - 84
85+
0.0%
0.1%
0.9%
1.2%
6.1%
8.1%
8.4%
20.2%
11.4%
19.3%
10.0%
15.1%
7.9%
7.2%
9.5%
5.7%
10.8%
5.8%
12.2%
5.9%
8.8%
5.7%
5.5%
3.4%
3.1%
0.1%
2.4%
1.2%
1.6%
0.7%
1.5%
0.3%
0%
5%
10%
15%
20%
25%
2018 Percent
2021 Percent

Age	2021 Percent	Frequency
Less than 15	0.1%	4
15 - 19	1.2%	47
20 - 24	8.1%	325
25 - 29	20.2%	809
30 - 34	19.3%	773
35 - 39	15.1%	604
40 - 44	7.2%	287
45 - 49	5.7%	227
50 - 54	5.8%	232
55 - 59	5.9%	234
60 - 64	5.7%	226
65 - 69	3.4%	137
70 - 74	0.1%	3
75 - 79	1.2%	47
80 - 84	0.7%	28
85+	0.3%	13
	Answered	**3,996**
	Skipped	**337**

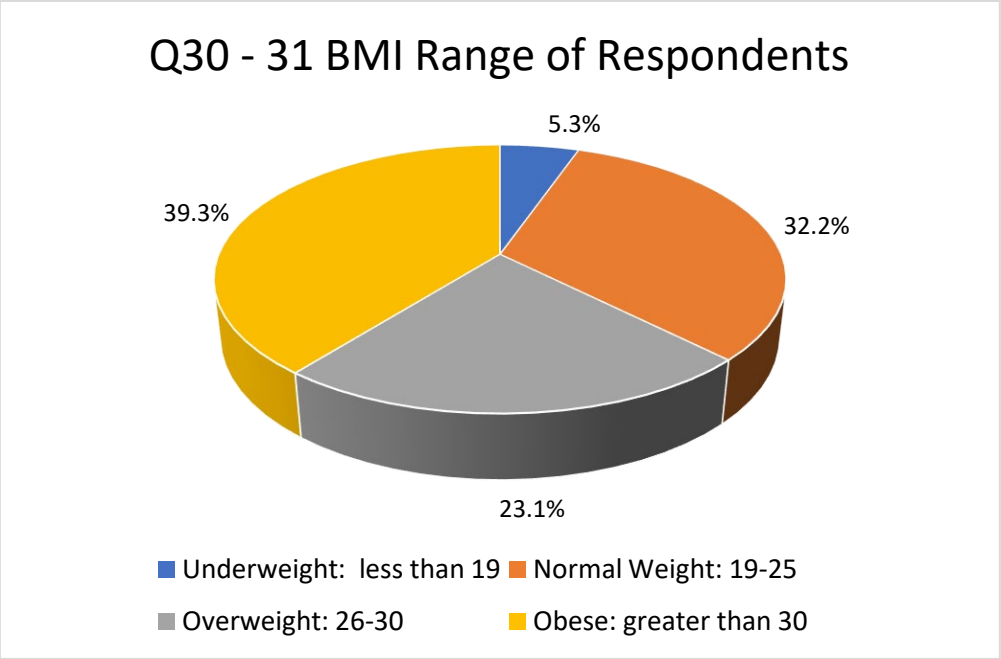
Median Age	35
Mean Age	39.3
Age Range	12 - 96

The percentage of respondents age 25 to 39 in 2021 nearly doubled to 54.6% from 28.8% in 2018. The number or respondents in 2018 age 40 to 64 was 49.2%. The number of respondents in this age group fell to 30.3% in 2021. The rate of respondents age 65 and older decreased to 5.6% in 2021 from 14.1% in 2018. The average median and mean ages in 2021 (35 and 39.3 respectively) were lower than in 2018 (47 and 47.3 respectively) with minimal differences in the age range for the two assessment years.



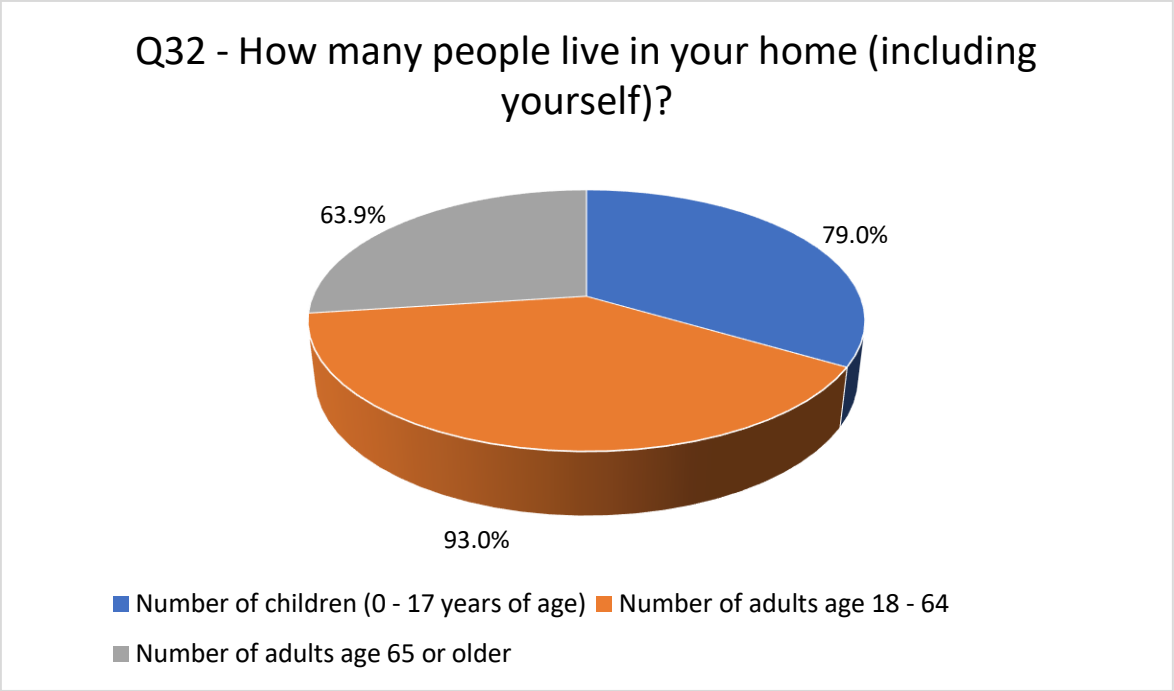
	Percent	Responses
Male	42.4%	1,843
Female	54.8%	2,382
Non-binary	2.6%	114
Other	0.1%	4
	Answered	**4,343**
	Skipped	**96**

The number of male respondents increased from 20% in 2018 to 42% in 2021. Males represent 48% of the service area's population (U.S. Census). Virginia's male population is 49.2% of the overall population (U.S. Census).



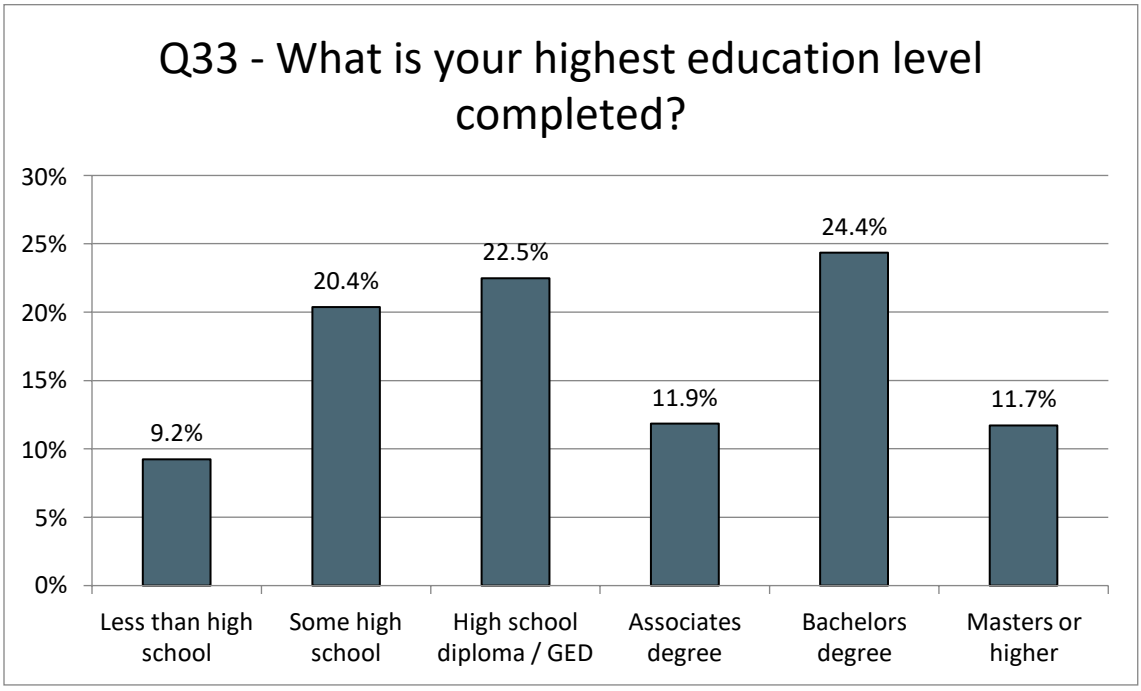
BMI Range	Percent	Frequency
Underweight: less than 19	5.3%	135
Normal Weight: 19-25	32.2%	818
Overweight: 26-30	23.1%	587
Obese: greater than 30	39.3%	998
	100.0%	**2,538**

The number of respondents whose BMI fell into the obese range decreased from 46% in 2018 to 39.3% in 2021. The number of Virginians that are obese was 31.9% in 2019 (United Health Foundation. America's Health Rankings. *Annual Report.* Accessed July 15, 2021, at https://www.americashealthrankings.org/explore/annual/measure/Obesity/state/VA). The respondents who are overweight remained essentially the same from 2018 (24%) to 2021 (23%). Respondents with a normal BMI range in 2021 increased to 32% of respondents compared to 26% of respondents in 2018. Please note that the respondents self-reported their height and weights.



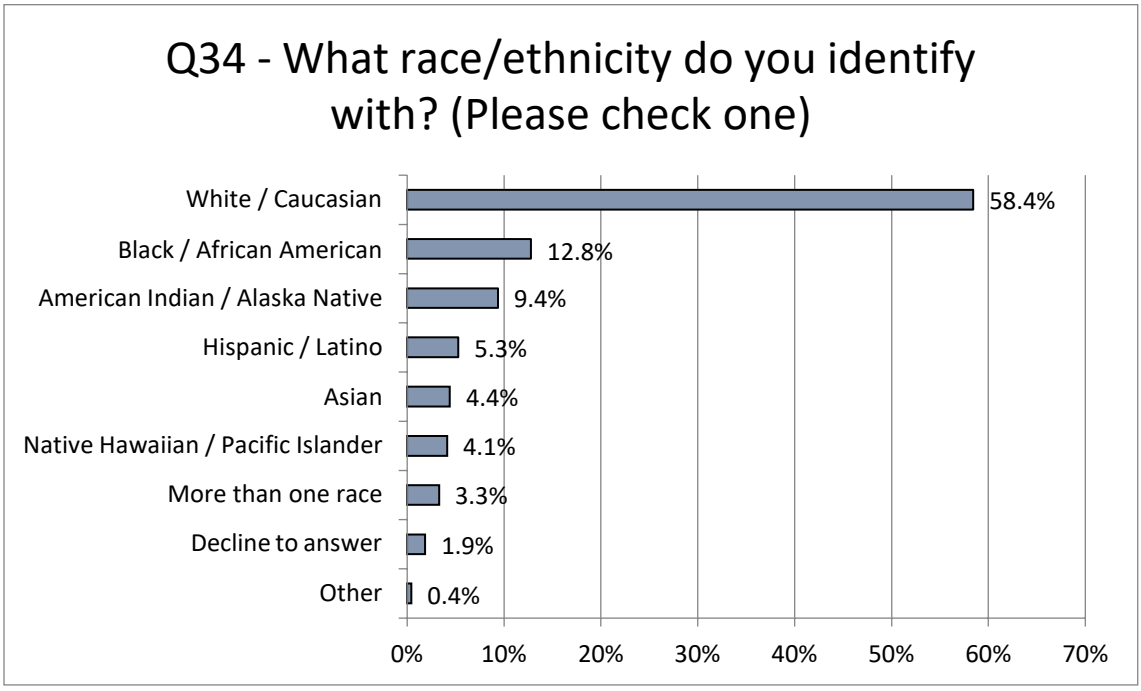
	Percent	Responses	Avg. Number in Home
Number of children (0 - 17 years of age)	79.0%	3,244	3.7
Number of adults age 18 - 64	93.0%	3,818	
Number of adults age 65 or older	63.9%	2,623	
	Answered	**4,104**	
	Skipped	**335**	

The number of respondents who had one or more children age 0 to 17 was 62% in 2018 compared to 79% in 2021. The number of adults age 18 to 64 living in the respondents' homes increased five percent from 2018 to 2021 (88% in 2018 and 93% in 2021). The number of adults age 65 or older increased in 2021 to 64% from 41% in 2018. The average number in the home among respondents was 3.7, while the service area average household size was 2.37 (U.S Census. American Community Survey, 2019: ACS 5-Year Estimates Subject Tables. Households and Families. Table S1101. Accessed July 21, 2021, at https://data.census.gov/.)



	Percent	Responses
Less than high school	9.2%	398
Some high school	20.4%	879
High school diploma / GED	22.5%	969
Associates degree	11.9%	511
Bachelor's degree	24.4%	1,050
Masters or higher	11.7%	505
	Answered	**4,312**
	Skipped	**127**

The number of respondents indicating that they had a degree (Associates – Masters or higher) remained the same from 2018 to 2021 (48%). The percent of 2021 respondents indicating that they had less than a high school diploma or GED was 9.2% compared to 29.6% in 2018. For persons age 25 and over residing in the Lynchburg Area, 14% had less than a high school education or equivalence (U.S. Census). Those who had graduated from high school or equivalency was 32.5% (U.S. Census), higher than the 2021 respondent rate 22.5%. The percentage of persons in the service area with a Bachelor's Degree or higher was 15.5% (U.S. Census), significantly lower than the 2021 respondent percentage of 36.1%. Respondents with an Associate's degree were not compared to area statistics as the U.S. Census includes Associate's Degree attainment in a category with "Some College" (U.S. Census, Table S1501).

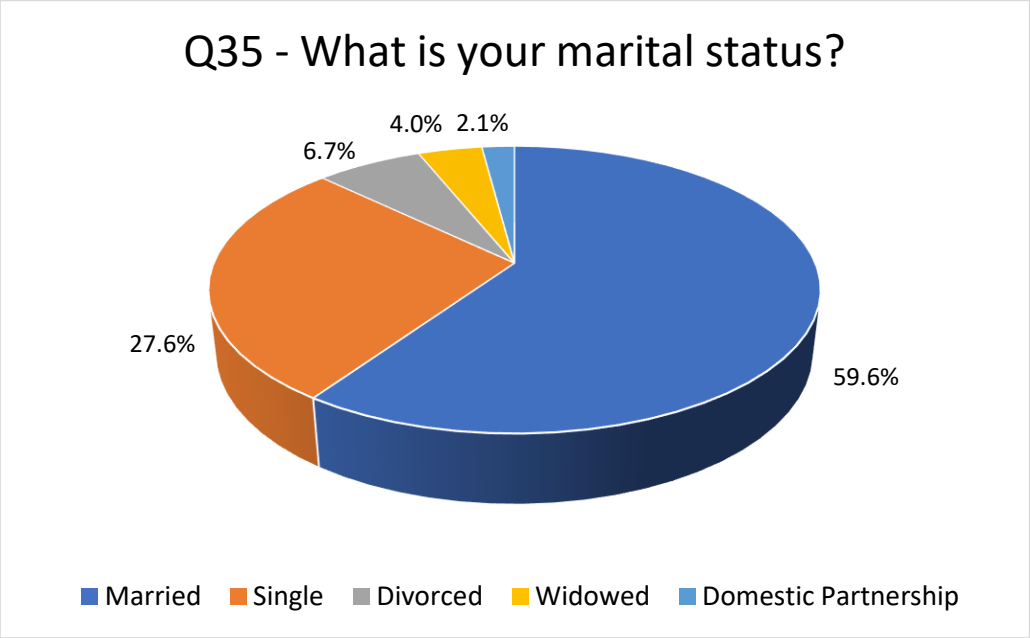


	Percent	Responses
White / Caucasian	58.4%	2,538
Black / African American	12.8%	556
Hispanic / Latino	5.3%	230
Asian	4.4%	191
American Indian / Alaska Native	9.4%	407
Native Hawaiian / Pacific Islander	4.1%	179
More than one race	3.3%	143
Decline to answer	1.9%	81
Other	0.4%	19
	Answered	**4,344**
	Skipped	**95**

The number of White respondents decreased from 69% in 2018 to 58% in 2021. This number is lower than the overall percentage of the White population in the service area – 75.3% (U.S. Census). The number of respondents indicating they are Black or African-American fell from 2018 (25.5%) to 2021(13%) compared to 20% in the service area (U.S. Census). The service area percentage of Hispanics or Latino is 2.7% (U.S. Census). The number of Hispanic or Latino respondents in 2021 was 5.3%, increasing from just .8% in 2018. There was a significant increase in those reporting to be Asian (4.4%), American Indian/Alaska Native (9.4%) and Native Hawaiian/Pacific Islander (4.1%) in 2021 as compared to 2018 (0.81%; 0.81%; and 0.2%respectively). Service area population numbers for these groups were 0.9% Asian, 0.3% American Indian/Alaskan Native, and 0.0% for Native Hawaiian/Pacific Islander.

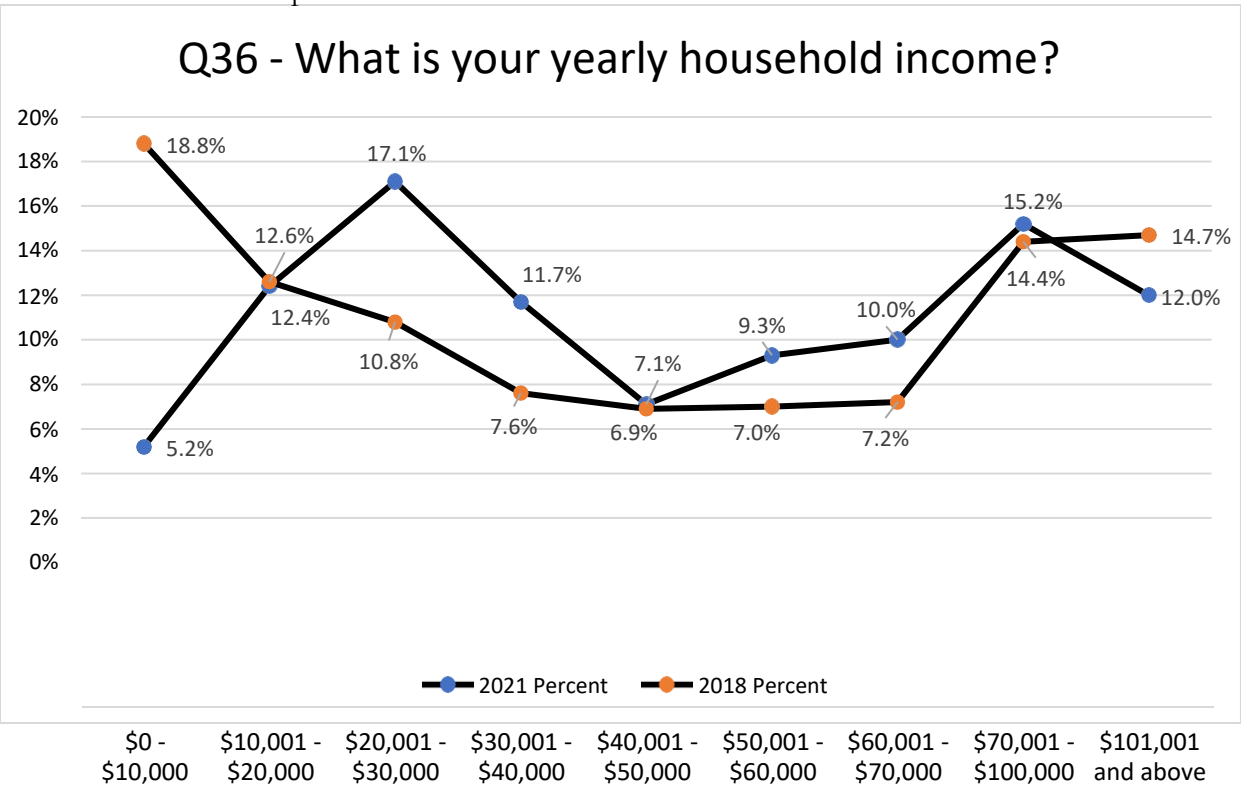
Q34. Other responses What Race/ethnicity do you Identify with?		
Code	**Responses**	**Percent**
Nationality- United States	2	20%
Caucasian/Hispanic	2	20%
Multi-racial	2	20%
Monacan Indian	1	10%
N/A	3	30%
Total	**10**	**100%**

In the Lynchburg region, 10 respondents chose "other" for their selection. Of these "other" responses, 20% (2 responses) identified their nationality (United States), Caucasian/Hispanic or multi-racial as their race/ethnicity while 1 respondent (10%) identified as Monacan Indian.



	Percent	Responses
Married	59.6%	2,580
Single	27.6%	1,195
Divorced	6.7%	291
Widowed	4.0%	175
Domestic Partnership	2.1%	89
	Answered	**4,330**
	Skipped	**109**

The percentage of persons responding that they were married in the 2021 assessment increased 9.2% over the 2018 response (50.4%). The percentage of widowed respondents decreased from 5.8% in 2018 to 4% in 2021. The number of divorced respondents fell to 6.7% of 2021 respondents from 11.7% of 2018 respondents.



	2021 Percent	Responses
$0 - $10,000	5.2%	219
$10,001 - $20,000	12.4%	521
$20,001 - $30,000	17.1%	722
$30,001 - $40,000	11.7%	493
$40,001 - $50,000	7.1%	298
$50,001 - $60,000	9.3%	391
$60,001 - $70,000	10.0%	423
$70,001 - $100,000	15.2%	642
$101,001 and above	12.0%	507
	Answered	**4216**
	Skipped	**223**

Respondents in 2021 reflected a large variance from the lowest household income categories (at or below $20,000) from 2018 respondents (17.6% of 2021 respondents compared to 31.4% of 2018 respondents). The 2021 respondents comprised a higher percentage of households from $20,001 to $40,000 (28.8%) than in 2018 (18.4%). The number of respondents with a household income of

over $100,000 was slightly higher in 2018 (14.7%%) than that of 2021 respondents (12%).

Analysis of Poverty Status Among Survey Respondents

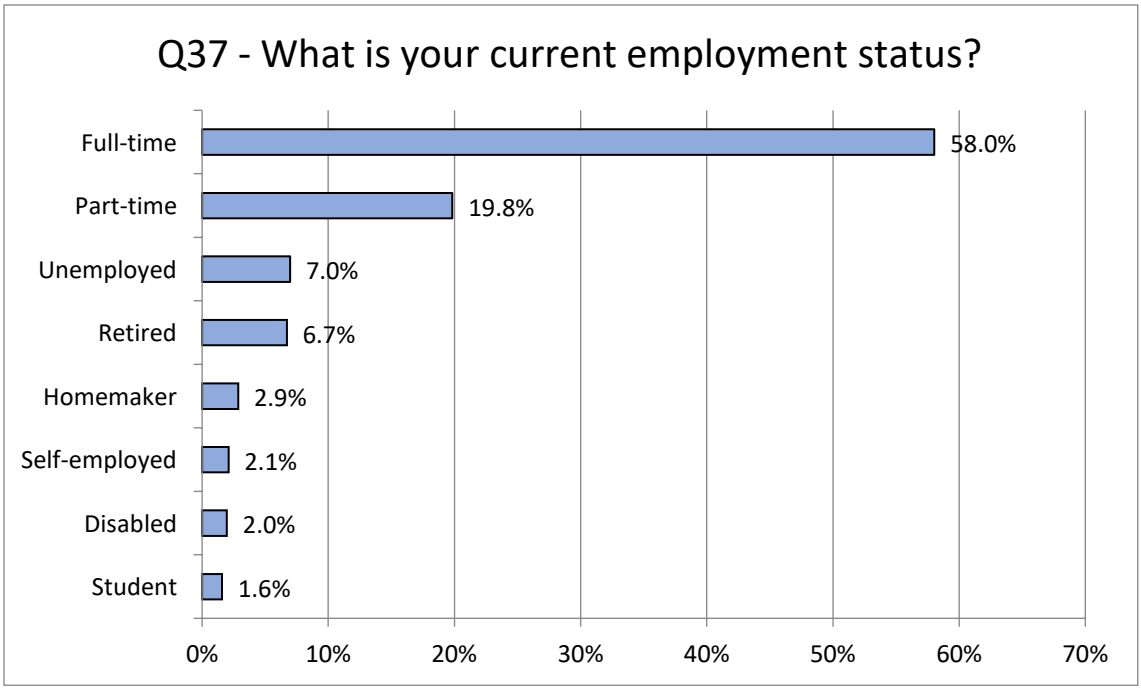
Household Size	Number	Self-Reported Household Income Category							<100% FPL	<200% FPL
		0-10,000	10,001-20,000	20,001-30,000	30,001-40,000	40,001-50,000	50,001-60,000	60,001-70,000		
1	375	47	37						12.5%	22.4%
2	782	36	50	103					4.6%	24.2%
3	779	15	91	122	96				13.6%	41.6%
4	739	18	98	113	83	51			15.7%	49.1%
5	620	16	92	119	63	43	47		36.6%	61.3%
6	328	12	50	69	51	19	23	43	39.9%	81.4%
7	126	12	13	20	16	6	20	17	48.4%	82.5%
8	71	10	7	13	8	4	3	11	53.5%	78.9%
Total	**3,820**	**166**	**438**	**559**	**317**	**123**	**93**	**71**	**19.9%**	**46.3%**

Although survey income categories do not align with the Federal Poverty Level guidelines (FPL), respondent poverty status can still be estimated at levels below 100% and 200% of the FPL. Based on the FPL, the number of respondents in each household size noted above in yellow would fall below 100% of the FPL. The number of responses in blue would fall below 200% of the FPL. Combining these values represent respondents whose household income falls below 200% of the FPL. A respondent's household income will often fall between FPL category minimum and maximum limits. For example, a respondent's household income that is $11,500 would still be below 100% of the federal poverty level but would be placed in the survey's $10,001 to $20,000 income category because it cannot be determined that the respondent's household income is, in fact, below 100% of the poverty level, between 100% and 150% of the FPL, or at some point over 150% FPL. However, it can be determined that this income is still below 200% of the FPL. In 2021, a minimum of 20% of respondents represented in the table above had incomes below 100% of the FPL and 46.3% had incomes below 200% FPL. The total number of households in the table above represent 90.6% of all income respondents.

Federal Poverty Level Guideline Table

Household Size	100% FPL	150% FPL	200% FPL	300% FPL
1	$ 12,760	$ 18,140	$ 25,520	$ 38,320
2	$ 17,240	$ 25,860	$ 34,480	$ 51,720
3	$ 21,720	$ 32,580	$ 43,440	$ 65,160
4	$ 26,200	$ 39,300	$ 52,400	$ 78,600
5	$ 30,680	$ 46,020	$ 61,360	$ 92,040
6	$ 35,160	$ 52,740	$ 70,320	$ 105,480
7	$ 39,640	$ 59,460	$ 79,280	$ 158,560
8	$ 44,120	$ 66,180	$ 88,240	$ 176,480

FPL table reproduced from table listed by Medicare Plan Finder accessed July 29, 2021 at https://www.medicareplanfinder.com/medicare/federal-poverty-level/



	Percent	Responses
Full-time	58.0%	2499
Part-time	19.8%	854
Unemployed	7.0%	300
Retired	6.7%	289
Homemaker	2.9%	123
Self-employed	2.1%	90
Disabled	2.0%	84
Student	1.6%	68
	Answered	**4307**
	Skipped	**132**

The rate of 2021 respondents employed full-time was consistent with 2018 respondents for this status (58% compared to 55%). The number of unemployed was more than double the rate for the 2018 respondents than 2021 respondents (14.7% compared to 7%). The number of part-time employed respondents was 20% in 2021 compared to 12.3% in 2018. The 2018 assessment reflected more retired respondents (12%) than 2021 respondents (6.7%).

Lynchburg Stakeholder Focus Group Directory

Date: 5/10/2021

Last Name, First Name	Organization
Abell, Randi	YMCA of Central Virginia
Ailsworth, Melody	Reach Out and Read
Anderson, Keith Ramon	Liberty University
Andrews, Stephanie	YWCA
Best, Marsha	Lighthouse Community Center
Blades, Shelley	Lynchburg Grows
Bodine, Bill	Greater Lynchburg Community Foundation
Bond, Kim	Centra
Booth, Brian	Greater Lynchburg Transit Company
Brown, Susan	Centra
Bruffy, Amanda	Centra Pearson Cancer Center
Bryant, Christopher	Central Virginia Community College Education Foundation
Buchanan, Mary	Bedford Memorial Hospital
Burdette, Brad	Appomattox Social Services
Callaham, Veronica	LACIL
Coleman, William	Lynchburg Community Action Group
Coles, Cynthia	Mt. Carmel Baptist Church
Cooke, Taylor	Johnson Health Center
Cooper, Jamie	Boys & Girls Club
Davis, Januwaa	Horizon
Delzingaro, Christina	Community Access Network
Dixon, Tracy	Lynchburg Daily Bread
Dolan, MaryJane	Mayor of City of Lynchburg
Elliott, Michael	Chief Transformation Officer at Centra
Farmer, Shawne	Interfaith Outreach
Foster, Dominique	Lynchburg City Schools
Foster, Kim	Virginia Department of Health
Gibson, Sherrina	Virginia Health Catalyst
Graf, Linnaya	Liberty University
Graham, George	Centra
Hansen, Mary	Girls on the Run
Hemke, Jennifer	Centra
Horan, Leah	Community Health Solutions
Horsley, Cristy	CASA
Hughes, John	Assistant City Manager
Jackson-Gillis, Ayanna	Liberty University
Jones, Jennifer	Lynchburg Parks and Recreation

Jones, Jenny	Centra
Kable, Lynn	Amherst Glebe Arts Response
Kennedy, Christine	Lynchburg Regional Business Alliance
Knight, Kelly	Centra
Laine, Terry	Community Health Solutions
Lockewood, Lindsey	Central Virginia Department of Health
Love, Jamey	Lynchburg Parks and Recreation
Marshall, Nat	BWXT
McCloskey, Corrin	Centra
McFaddin, Nora	Danville Pittsylvania Cancer Association
Meador, Alisha	City of Lynchburg Economic Development
Miles, Shannon	Centra
Miller, Darren	Centra Pastoral Care
Monk, Suny	Sweetbriar College
Morris, Harry	Centra
Murphy-Anderson, Cheryl	Central Virginia Alliance for Community Living
Nolen, Kristen	Miriam's House
Onafowokan, Dammy	Horizon
Overbey, Stuart	Lynchburg Grows
Parker, Jay	YMCA of Central Virginia
Pletke, Patricia	Centra Medial Group Hospice
Price, Kim	Centra
Price, Tonya	University of Lynchburg
Ramsey, Robin	FREE Foundation
Redding, John	Ann Wilcox Memorial Foundation
Richardson, Margaret	Community Member
Roberts, Dennis	Holy Trinity Lutheran Church
Schoonmaker, Timothy	Centra
Serda, January	Fear 2 Freedom
Shabestar, Kris	Meals on Wheels
Sheehan, Mark	Boys & Girls Club
Smiley-Mason, Jeane	Gleaning for the World
Smith, Jeff	Rush Homes
Stronza, Allison	CASA
Taylor, Lisa	Bank of the James
Tomlin, Chelsey	Johnson Health Center
Treacy, Dabney	Academy Center of the Arts
Tuite, Lisa	Pittsylvania County Public Library
Tweedy, Becky	Meals on Wheels
Vail, Elizabeth	American Heart Association
Varner, Bill	United Way of Central Virginia

Vincent, Donna	PPL Foundation
Wiggins, Jeffery	Centra
Wilder, Sterling	Jubilee Family Center
Wise, Dawn	United Way of Central Virginia
Young, Amanda	Institute for Advanced Learning and Research
Young, Ken	Central Virginia Alliance for Community Living
Young, Pat	Centra

CENTRA

2021 Stakeholders Focus Group Survey

Please complete the following questions:

What are the greatest issues/needs in the community(s) you serve? (List up to 5) 1. 2. 3. 4. 5.
How has the COVID-19 pandemic impacted these needs?
Of the needs listed, what is one issue/need we can work on together to create a healthier community?
What are one or two ways we can work together on this issue/need?
Are there localities or populations that are especially vulnerable to this issue/need?
What resources are available in the community to address this issue/need?
Are there gaps in these resources that we need to address?

2021 Lynchburg Area Prioritization of Needs Worksheet
Rank the Top 5 Greatest Needs
Instructions: Rank the following "Areas of Need" from 1 to 5
(1 is the greatest need)

Ranking	Area of Need
	Access to healthcare services
	Accidents in the home
	Aging and Eldercare
	Cancer Care
	Child abuse/neglect
	Childcare
	Chronic Disease
	Collaboration
	COVID-19 Pandemic
	Dental Care & Dental Problems
	Disability
	Domestic Violence
	Education and Literacy
	Employment / Job assistance
	End of Life Care and Services
	Environmental Health
	Equity, Inclusion & Diversity
	Families
	Financial Stability
	Food Insecurity and Nutrition
	Health Education and Literacy
	Housing
	Legal Services
	Maternal/Child Health
	Mental Health and Substance Use Disorders & Access to Services
	Overweight/Obesity
	Outreach
	Physical Activity
	Poverty & Economic Assistance
	Safety and Violent Crime
	Sexual Health
	Social Isolation
	Technology
	Transportation
	Unsafe Driving Practices
	Veterans Services
	Vision Care
	Other
	Other

2021 Lynchburg Area Prioritization of Needs Worksheet
Rank the Top 5 Greatest Needs
Instructions: Rank the following "Areas of Need" from 1 to 5
(1 is the greatest need)

	CHS 2021 (n= 4403)	CHS 2021 (n= 4373)	CHS 2021 (n=4325)	CHS 2021 (n=4227)	Stakeholder Focus Group (n=253)
Area of Need	**What do you think are the most important issues that affect health in our community? (Check all that apply) Health Factors % Responses**	**What do you think are the most important issues that affect health in our community? (Check all that apply) Health Conditions % Responses**	**Which health care services are hard to get in our community? % Responses**	**Which social/support resources are hard to get in our community? % Responses**	**What are the top 5 greatest needs in the community(s) you serve? % Reponses**
Access to healthcare services	x		x	x	x
Access to care					8.70%
Alternative therapy			26.30%		
Ambulance services			17.80%		
Chiropractic care			15.70%		
Dermatology			18.50%		
Emergency room care			18.90%		
Health insurance				22.60%	
Immunizations			10.90%		
Inpatient hospital			9.90%		
Lab work			6.80%		
Medication / medical supplies			11.70%		
Medication assistance				19.50%	
Not getting “shots” to prevent disease	17.50%				
Physical therapy			8.00%		
Preventive care (e.g., yearly check-ups)			11.70%		
Specialty care (e.g., heart doctor)			13.20%		
Urgent care / walk-in clinic			11.60%		
Women’s health services			10.80%		
X-rays / mammograms			6.90%		
Accidents in the home	x				
Accidents in the home (e.g., falls, burns, cuts)	29.80%				
Aging and Eldercare	x		x		x
Aging problems	28.00%				
Eldercare			21.80%		
Elderly					1.20%
Cancer Care		x	x		
Cancer care			21.30%		
Cancers		42%			
Child abuse/neglect	x				
Child abuse / neglect	25.80%				

Childcare				x	x
Childcare				29.00%	
Childcare					9.10%
Chronic Disease		x			
Diabetes		40%			
Heart disease and stroke		34%			
High blood pressure		32%			
HIV / AIDS		25%			
Lung Disease		18%			
Collaboration					x
Collaboration					0.40%
COVID-19 Pandemic		x	x	x	
COVID-19 / coronavirus		44%			
COVID-19 has made one or more of the services I selected hard to get			13.80%		
COVID-19 has made one or more of the services I selected hard to get				13.90%	
Dental Care & Dental Problems		x	x		x
Access to Dental Care					0.40%
Adult dental care			18.80%		
Child dental care			17.50%		
Dental problems		40%			
Disability		x			
Disability		38%			
Domestic Violence	x		x	x	x
Domestic Violence	24.80%				
Domestic Violence					0.40%
Domestic violence assistance				25.30%	
Domestic violence services			20.40%		
Sexual assault	13.50%				
Education and Literacy				x	x
Education					4.30%
Education and literacy				20.80%	
Employment / Job assistance				x	x
Employment / job assistance				27.50%	
Healthcare Workforce					1.60%
Unemployment benefits				11.70%	
Workforce					5.50%
End of Life Care and Services		x	x	x	
End of life / hospice /palliative care					
Grief			13.30%		
Grief /bereavement counseling		36%		19.50%	
Environmental Health	x				
Environmental health (e.g., water quality, air qua	23.80%				
Equity, Inclusion & Diversity					x
Equity, Inclusion & Diversity					1.20%
Racism					1.60%

Families					x
Families					0.80%
Financial Stability				x	
Banking /financial assistance				22.40%	
Food Insecurity and Nutrition	x			x	x
Access to healthy foods	32.60%				
Food benefits (SNAP, WIC)				18.10%	
Food Insecurity and Nutrition					8.70%
Healthy Food				22.80%	
Poor eating habits	15.80%				
Health Education and Literacy					x
Health Education					1.60%
Health Literacy					1.20%
Housing	x			x	x
Access to affordable housing	37.90%				
Affordable /safe housing				28.20%	
Housing					8.70%
Housing problems (e.g., mold, bed bugs, lead pai	20.80%				
Rent / utilities assistance				16.90%	
Legal Services				x	
Legal services				16.60%	
Maternal/Child Health		x			x
Infant death		25%			
Teen Pregnancy					0.40%
Teenage pregnancy		1%			
Mental Health and Substance Use Disorders & Access to Services	x	x	x		x
Access to mental health services					14.60%
Alcohol and illegal drug use	42.50%				
Mental health / counseling			24.70%		
Mental health problems		18%			
Prescription drug abuse	14.40%				
Stress		11%			
Substance use					2.40%
Substance use services – drug and alcohol			17.00%		
Suicide		10%			
Programs to stop using tobacco products			13.70%		
Tobacco use / smoking / vaping	10.50%				
Overweight/Obesity		x			x
Obesity					0.40%
Overweight / obesity		16%			
Outreach					x
Outreach					0.80%
Physical Activity	x				x
Lack of exercise	19.30%				
Physical Activity					2.80%

Poverty & Economic Assistance				x	x
Economic Disparities					1.20%
Medical debt assistance				20.60%	
Poverty					7.50%
TANF (Temporary Assistance for Needy Families)				11.90%	

Safety and Violent Crime	x				
Bullying	26.90%				
Gang activity	23.20%				
Homicide	22.20%				
Neighborhood safety	18.30%				
Sexual Health	x		x		
LGBTQ Services			11.50%		
Unsafe sex	1.60%				
Social Isolation	x				
Social isolation	12.20%				
Technology					x
Technology					1.60%
Transportation	x			x	x
Transportation				16.90%	
Transportation					12.60%
Transportation problems	10.00%				
Unsafe Driving Practices	x				
Cell phone use / texting and driving / distracted	26.90%				
Not using seat belts / child safety seats / helmets	17.40%				
Veterans Services				x	
Veterans services				11.50%	
Vision Care			x		
Vision care			7.50%		

Lynchburg Area Community Resources 2021	
Adult Protective Services Adult Protective Services -DSS Campbell County Social Services	**Housing** College Hill Apartments Hillcrest Apartments (Seniors) James Crossing Apartments Jericho Outreach Ministries John Early Apartments Raintree Village Apartments Lynchburg Covenant Fellowship Lynchburg Redevelopment and Housing Authority Mill Woods Apartments McGurk House (Seniors) Pinecrest Apartments RUSH Homes (Disabled) The Meadows Apartments (Disabled) USDA Rural Development Wesley Apartments (Seniors) Coordinated Homeless Intake & Access (CHIA) VA Rent Relief Program
Budget & Credit Counseling Money Management International Clearpoint Credit Counseling Solutions	**Housing Weatherization/Rehabilitation** Central Virginia Alliance for Community Living (Senior) Lynchburg Community Action Group Interfaith Rebuilds
Child Care Financial Assistance Lynchburg Community Action Group Lynchburg Social Services Campbell County Social Services Smart Beginnings of Central VA	**Job Counseling, Training, & Placement** Career Support Systems Central VA Community College Goodwill Industries HumanKind Job Corps Virginia Jubilee Family Center Lynchburg Community Action Group Lynchburg Sheltered Industries Virginia Career Works Virginia Department of Rehabilitative Services Virginia Employment Commission Region 2000 Workforce Investment Board
Child Care Resources & Referrals HumanKind/Presbyterian Homes 2-1-1 Virginia Smart Beginnings of Central VA	**Legal Assistance** Virginia Lawyer Referral Virginia Legal Aid Society
Child/Infant Car Seats Lynchburg Police Department Lynchburg Health Department Campbell County Health Department	**Local Government/Tourist Information** Lynchburg Regional Business Alliance Downtown Lynchburg Association Lynchburg Municipal Government Offices Visitors' Information Center Altavista Area Chamber of Commerce Campbell County Government Services
Child Protective Services CASA of Central VA– Lynchburg Child Protective Services-DSS	**Medical/Dental Assistance** Community Access Network FAMIS Free Clinic of Central Virginia James River Dental Clinic

	Johnson Health Center Lynchburg Health Department Campbell County Health Department VA Medical Center Rustburg Community Health Center
Children & Family Recreation Lynchburg Parks & Recreation Department Boys & Girls Club of Greater Lynchburg Campbell County Parks & Recreation Department YMCA	**Mental Health** Mental Health America of Virginia Hope for Tomorrow Counseling Array Tele-behavioral Health Services Blackwater Counseling Center Piedmont Psychiatry Center Johnson Health Center The Motherhood Collective Anderson Counseling Horizon Behavioral Health Light Counseling Central VA community Services Thriveworks Counseling National Counseling Group Restoring Peace Counseling Services Compass Behavioral Solutions Embrace Health Solutions Christian Counseling Services Inc Wyndhurst Counseling & Wellness Advanced Psychotherapeutics, PLLC.
Clothing Lynchburg Baptist Association Lighthouse Community Center Park View Community Mission Salvation Army	**Parenting Skills/Family Support** Child Support Enforcement Anderson Counseling Bridges Residential Services & Treatment Center Community Access Network Family Preservation Services Boys & Girls Club of Greater Lynchburg Horizon Behavioral Health Lynchburg City Schools Parent Center Center for Family Studies & Educational Advancement – University of Lynchburg Madeline Centre Couples and Kids Central VA HumanKind- Health Families of VA Patrick Henry Family Services The Motherhood Collective Campbell County Cooperative Extension Kinship Navigator **Pregnancy/Motherhood/Women's Health:** The Motherhood Collective Postpartum Support Virginia Blue Ridge Pregnancy Center La Leche League Centras Lactation Help Warm Line St. Thomas Moore's Diaper Assistance Program New life Doula Service Special Treasure Doula Service CVA Doulas Birth in Color Lynchburg Women's Health Services Forest Women's Center Johnson Health Center OB/GYN Lynchburg Family Practice Residency Center CMG Southside Women's Center

Commonwealth Attorney Lynchburg Commonwealth Attorney Campbell County Commonwealth Attorney VA legal Aid **Courts** Circuit- Lynchburg/Campbell County General District- Lynchburg/Campbell County Juvenile & Domestic Relations- Lynchburg/Campbell County	**Prescription Assistance** FamilyWize Discount Card Free Clinic of Central Virginia/MedsHelp Johnson Health Center-Medication Assistance Program (MAP) GoodRx **Pharmacy Delivery Services** Hill City Pharmacy- Forest & Lynchburg Timberlake Health & Wellness CVS: Langhorne Road Kroger
Community Partnerships & Coalitions Bridges of Central Virginia Bridges to Progress Blue Ridge Re-entry Council Central Virginia Public Information Network Healthy Outcomes through Prevention & Education (HOPE) Lynchburg Community Care Collaborative Live Healthy Lynchburg Central Virginia Continuum of Care The Partnership for Healthy Communities	**Public Safety/Disaster Relief** American Red Cross – Historic Virginia Chapter American Red Cross - Blue Ridge Lynchburg Emergency Communication Center Lynchburg Emergency Management Lynchburg Police Department Altavista Police Department Brookneal Police Department Campbell County Sheriff's Office
Community Foundations Centra Foundation Centra Community Health Greater Lynchburg Community foundation United Way of Central Virginia Lynchburg City Schools Foundation	**Re-entry/Returning Citizens** Lynchburg Community Action Group, Inc.Interfaith Outreach Association Virginia Career Works Virginia Cares Blue Ridge Re-entry Council Virginia Dept of Corrections
Crisis Sexual Assault Response Program - YWCA Suicide Hotline Family Violence & Sexual Assault Hotline RAIIN Hotline for sexual violence National Suicide Prevention Line Domestic Violence Prevention Center- YWCA	**Senior Services** Adult Care Center of Central Virginia Central Virginia Alliance for Community Living/ADRC Generation Solutions Home Instead Senior Care Westminster-Canterbury Meals on Wheels Dept. of Aging & Rehabilitative Services Campbell County Parks & Recreation
Disability Services/Rehabilitation ARC of Central Virginia Lynchburg Area Center for Independent Living (LACIL) Lynchburg Sheltered Industries RUSH Homes VA Department of Rehabilitative Services ADRC-Aging and Disability Resource Center Special Olympics	**Shelters/Transitional Housing** Homeless Intake (CHIA) Salvation Army Hand Up Lodge Miriam's House The Gateway- LYNCAG YWCA Domestic Violence Shelter YWCA Residential Housing Frannie's House

Economic/Neighborhood Development Citizens for a Clean Lynchburg Office of Economic Development Lynchburg Community Development/Planning Lynchburg Small Business Development Center Lynchburg Regional Business Alliance SCORE Altavista Area Chamber of Commerce	**Social Services (SNAP, TANF, Medicaid)Assistance** Departments of Social Services: Campbell County Amherst County City of Lynchburg Appomattox County Community Access Network
Education ACE of Central Virginia Lynchburg City Schools Campbell County Schools Lynchburg Beacon of Hope LCS Empowerment Center at Boys & Girls Club LCS Education Foundation Partners in Education (PIE) Hutcherson Early Learning Program Laurel Regional School Rivermont School Smart Beginnings of Central VA School Health Advisory Board **Education Special Needs** Hutcherson Early Learning Program Infant & Toddler Connection Laurel Regional Rivermont School Special Olympics	**Substance Abuse Treatment/Transitional Housing** Horizon Behavioral Health- The Courtland Center Pathways Residential Treatment Center The Gateway Program Elim Home- TRBC Oxford House Our Father's House The Haven UP Foundation Celebrate Recovery Roads to Recovery Alive RVA (Addiction recovery support line) Addiction Allies Lynchburg Comprehensive Treatment Center Johnson Health Center Community Access Network- Hope Initiative March of Dimes
Emergency Financial Assistance Interfaith Outreach Association Lynchburg Community Action Group Salvation Army Lynchburg Social/Human Services Campbell County Social/Human Services United Way of Central Virginia St. Thomas More Catholic Church Park View Community Mission Thomas Road Baptist Church DAWN	**Transportation** Greater Lynchburg Transit Company Logisticare Johnson Health Center- Appointment Transportation

Food/Food Pantries Blue Ridge Area Food Bank Court St. Baptist Church Churches for Urban Ministry Daily Bread (Soup Kitchen) FARRR Foundation (The Lighthouse) Fairview Christian Church (Food Pantry/Soup Kitchen) Love & Truth Community Church Park View Community Mission (Food Pantry/Soup Kitchen) Salvation Army Smyrna Seventh Day Adventist Church Hyland Heights Baptist Church Fairview UMC Fellowship Church of Christ Immanuel Baptist Interfaith Outreach Ministries Lynchburg First Church of Nazarene Minerva Glass Community Service Center Red Truck Food Ministry Shekijah Preparation Assembly Timberlake UMC Virginia Cooperative Extension Piedmont Community Impact Organization	**Unemployment Assistance** Virginia Employment Commission Virginia Career Works Career Support Systems Goodwill Job & Employment Center
Health Department **Central Virginia Health District** Lynchburg Health Department Amherst County Health Department Campbell County Health Department Bedford County Health Department Buena Vista/Rockbridge Health Department Appomattox County Health Department Nelson County Health Department **Danville/Pittsylvania Health District** Danville Health Department Pittsylvania County Health Department	**Veterans** Lynchburg Area Veterans Council Virginia Dept of Veterans Services