2025

Community Health Needs Assessment

ValleyHealth

Letter from the CEO

Dear Community Members,

It is with great pride and purpose that I present to you Valley Health's 2025 Community Health Needs Assessment (CHNA)—a comprehensive and collaborative effort to better understand and improve the health and well-being of the communities we serve across the Northern Shenandoah Valley and Eastern Panhandle.

This report reflects the voices, experiences, and insights of thousands of residents, community organizations, and public health partners. It is the result of a meaningful partnership between Valley Health, local health departments in Virginia and West Virginia, nonprofit organizations, and community leaders. Together, we have worked to identify the most pressing health challenges and the social conditions that shape them—from access to care and mental health services to housing, transportation, and food security.

Key findings from the CHNA include:

- A growing need for expanded access to healthcare, particularly in rural areas, including pediatric, aging, and behavioral health services.
- A strong call to prioritize mental health, reduce stigma, and improve crisis response and community-based support.
- Recognition of the impact of social determinants of health, such as housing affordability, transportation barriers, and social isolation.
- The importance of economic stability, workforce development, and coordinated support to address poverty, homelessness, and food insecurity.

These insights were made possible through robust community engagement, including over 3,600 survey responses, interviews with community partners, and organizational assessments. The survey process was especially vital—it allowed us to hear directly from residents about their lived experiences, concerns, and hopes for a healthier future. This kind of input is not only valuable—it is essential. Community surveys give us the clearest picture of what matters most to the people we serve and help ensure that our strategies are responsive, inclusive, and equitable.

As we move forward, this CHNA will serve as the foundation for our Community Health Improvement Plan (CHIP)—a roadmap for collaborative action. We are committed to working alongside our partners to address these challenges and build a healthier, more just future for all.

Thank you to everyone who contributed to this assessment. Your voices are shaping the future of health in our region.

In partnership,

Mark Nantz, MHA
President and Chief Executive Officer, Valley Health

ValleyHealth

Letter from the Core Team

To the Communities served by Valley Health,

We are pleased to share with you the 2025 Community Health Needs Assessment (CHNA) - a vital resource to guide our collective efforts toward a healthier community. This report is the result of a meaningful collaboration between Valley Health, the region's health departments, community members and organizations, undertaken with the shared goal of understanding and improving the health of everyone in the Northern Shenandoah Valley and Eastern Panhandle.

This assessment reflects more than just data—it reflects the lived experiences, challenges, and strengths of our community. It examines the factors that influence health in our region, identifies priority areas of need, and outlines opportunities for community-driven action. It provides a guide to help us understand where we are, where we want to go, and how we can move forward—together.

This assessment marks a concerted effort from Valley Health and the Lord Fairfax Health District to turn participants into partners on a CHNA, recognizing that no single organization can achieve community health alone. Our collaboration reflects a growing recognition that addressing the root causes of health outcomes requires broad-based engagement and shared responsibility across the public health system, healthcare, and community-based organizations. By joining forces, we are able to deepen community input, better align resources, and elevate a more comprehensive, inclusive, and public health–centered approach to the assessment.

A key shift in this CHNA is complementary to a traditional healthcare-centric lens, one that centers on health outcomes and the social drivers of health - the conditions in which people live, learn, work, and play. We acknowledge that access to medical care is only one component of health. Equally, if not more important, are the structural and systemic factors such as education, housing, employment, transportation, food security, and access to safe and supportive environments. These social conditions affect certain populations in our region, leading to health disparities that must be addressed through intentional, collaborative action. Understanding these disparities is a critical first step. We must also actively work to remove barriers, amplify community voices, and strengthen partnerships with those who are most affected. We are committed to continuing this work alongside our community partners, who bring essential insight, leadership, and trust to the process.

We invite you to explore the findings in this report with a shared sense of purpose and possibility. Let it be a catalyst for conversation, collaboration, and action across all sectors of our community. We are deeply grateful to our local government agencies, nonprofit organizations, community groups, and residents who contributed their time, perspectives, and expertise to this assessment.

Together, we can build a healthier, more just future for all who call the Northern Shenandoah Valley and Eastern Panhandle home.

In partnership,

The Core Team

VDH Virginia Department of Health

Lord Fairfax Health District

ValleyHealth

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Purpose

A Community Health Needs Assessment (CHNA) is a systematic evaluation of a community's health status, used to identify key health challenges and available resources. The information gathered through this assessment is valuable to community organizations and agencies and provides updated and timely data regarding the community and its wellbeing. As part of that process, a community health steering committee was established with a guiding mission and vision in order to prioritize the array of needs identified through the assessment process. The data collected from this assessment will inform decision-making, prioritization of health problems, and development of plans to improve the health of the community. Key terminology and abbreviations can be found in Appendix F and G.

Federal regulations require that tax-exempt hospital facilities conduct a CHNA every three years and develop an implementation strategy that addresses priority community health needs. Tax-exempt hospitals are also required to report information about community benefits they provide on IRS Form 990, Schedule H. As specified in the instructions to IRS Form 990, Schedule H, community benefits are defined as programs or activities that provide treatment and/or promote health and healing as a response to identified community needs.

This CHNA is a joint report that was done in partnership with community members and partners. It represents shared health needs relative to the primary and secondary service areas of Valley Health's six hospitals: Hampshire Memorial Hospital, Page Memorial Hospital, Shenandoah Memorial Hospital, War Memorial Hospital, Warren Memorial Hospital and Winchester Medical Center. Valley Health's hospitals and the health departments in Virginia and West Virginia serve overlapping communities, encouraging collaboration in conducting the CHNA. Community health needs will be stated in reference to the entire shared service area, but material differences in the communities found in the assessment report will be attributed to the hospital within the community mentioned. This CHNA is being adopted as a joint report for all Valley Health facilities.

Moving Forward

This report provides a snapshot of our community's current health and is intended to drive meaningful, actionable change. Identifying problems without pursuing solutions is ineffective, and this report aims to do both. Valley Health and the LFHD will publish their CHNA/CHA and CHIP reports together, highlighting that broad community collaboration is essential to building healthier communities.

As outlined on page 11, the MAPP 2.0 process continues beyond the CHNA. The Community Health Improvement Plan (CHIP) builds on CHNA findings to create a collaborative, community-driven strategy for addressing key issues.

The CHIP process includes:

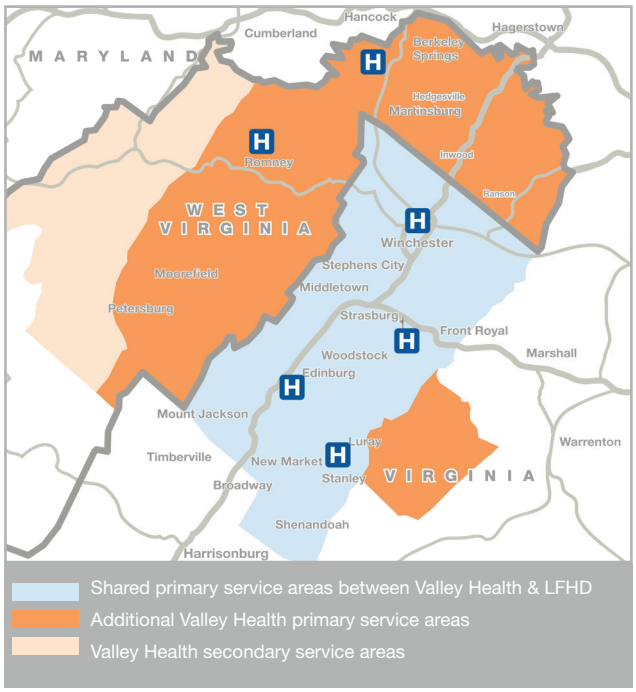
- Identifying priority concerns from the CHNA.
- Analyzing each issue's root causes and influences.
- Engaging community members and partners to set goals, strategies, and action plans.
- Selecting strategies aligned with desired outcomes.
- Defining measurable goals and tracking progress with objectives, timelines, and responsibilities.
- Implementing and continuously evaluating the CHIP.

Service Area

Valley Health began its journey to bring better quality health to local communities in 1994. When Winchester Medical Center and Warren Memorial Hospital collaborated, a vision to better serve the region was realized. The vision was to unite communities through quality healthcare and meet their unique needs by providing access to advanced medical technologies and services. With hospitals and medical facilities in West Virginia and the Top of Virginia region, Valley Health is a community partner.

Based in Winchester, Virginia, Valley Health is composed of six core hospitals: Hampshire Memorial Hospital, Page Memorial Hospital, Shenandoah Memorial Hospital, War Memorial Hospital, Warren Memorial Hospital and Winchester Medical Center. Valley Health includes 604 licensed inpatient beds, 166 long-term care beds, over 6,000 employees, and a medical staff of more than 600 professionals. The service area of Winchester Medical Center, Valley Health's largest hospital and regional referral center, includes the primary and secondary service areas of the other Valley Health hospitals.

- Winchester Medical Center: Primary and Secondary Service Area Community includes thirteen counties and Winchester City: Clarke, Frederick, Page, Rappahannock, Shenandoah, Warren, and Winchester City in Virginia, and Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral and Morgan counties in West Virginia.
- Warren Memorial Hospital: Primary and Secondary Service Area Community includes the shared counties of Page, Rappahannock, Shenandoah, and Warren in Virginia.
- Shenandoah Memorial Hospital: Primary and Secondary Service Area Community includes the shared counties of Page, Shenandoah, and Warren in Virginia.
- Page Memorial Hospital: Primary and Secondary Service Area Community includes the shared counties of Page, Rappahannock, Shenandoah, and Warren in Virginia.



- War Memorial Hospital: Primary and Secondary Service Area Community includes the shared counties of Berkeley, Hampshire, and Morgan counties in West Virginia.
- Hampshire Memorial Hospital: Primary and Secondary Service Area Community includes the shared counties of Hampshire, Hardy, Mineral and Morgan counties in West Virginia.

The following report focuses on the shared service areas of Valley Health, the Lord Fairfax Health District (indicated below in blue), as well as the shared health districts in the Eastern Panhandle of West Virginia. This area includes Clarke, Frederick, Page, Shenandoah, and Warren counties and the City of Winchester. The Valley Health primary service areas (indicated in green) and secondary services areas (indicated in grey) are show in the map below, in addition the shared primary service areas between Valley Health and the Lord Fairfax Health District.

An additional report encompassing the entire Valley Health service area, including its primary and secondary service areas, is available online at https://www.valleyhealthlink.com/about-us/our-community-commitment/community-health-needs/.

Executive Summary

• Access to Health & Wellness Services

Access to affordable, quality, and timely clinical care is an essential part of treating and managing health conditions — enabling individuals to live longer, healthier lives.

- Many individuals face barriers to accessing needed care services, such as: financial barriers, availability of services, transportation limitations, and stigma.
- Connections to nearby support services can be influential on a person's wellbeing and quality of life by providing them opportunities to access needed resources.
- Improved access to medical and mental healthcare services was identified as a potential community solution by survey respondents.

• Nutrition & Physical Wellbeing

Numerous chronic health conditions, like obesity, type 2 diabetes, heart disease, cancer, kidney and liver diseases, and poor mental health, are linked to poor nutrition and lack of physical activity.

- Incorporating healthy eating and active living practices can support overall health and wellbeing while reducing risk factors for chronic diseases.
- Our localities experience chronic diseases at similar or higher percentages than VA with high percentages of no leisure physical activity time.
- In the Blue Ridge area, 1 in 9 people are food insecure. This increases a person's risk of chronic diseases, adverse birth outcomes, and poor mental health.

• Mental Health

Poor mental health adversely affects a person's quality of life because of its broad negative health and social consequences.

- Concerns regarding mental health have been increasing, and data shows that adults experiencing frequent mental distress has increased consistently over time in the US, VA, and locally.
- One's mental health is influenced by not only biological factors, but also the environmental and societal factors in a person's life.
- Mental health conditions often require specialized providers for the support and treatment needed to ensure the best outcomes. Financial barriers and provider availability are two limiting factors for people to access these services.

• Housing

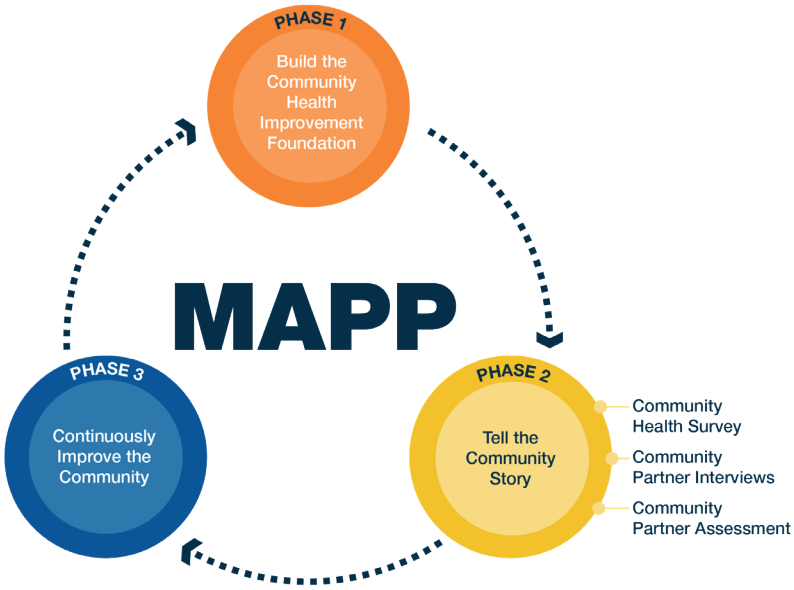
Affordable, good quality, safe, and stable housing supports health. Living without access to these resources can create poor health that worsens over time, especially among at-risk populations.

- The availability of affordable and safe housing is an increasing concern by community members, who recognize the issue of people struggling to pay rent or resorting to living in substandard living conditions.
- Poor housing conditions are associated with health concerns such as respiratory illnesses and infections, lead poisoning, injuries, and poor mental health.
- Addressing housing as a public health issue serves as a key social driver of health.

Methodology

MAPP 2.0 Process

The primary framework used for this assessment was the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) designed by the National Association of County and City Health Officials (NACCHO). MAPP 2.0 is a community-driven strategic planning process to achieve health equity. MAPP 2.0 provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action, resulting in a community health needs assessment (CHNA) and a community health implementation plan (CHIP).



Multiple assessments were conducted in this process to understand the picture of health within the Northern Shenandoah Valley and the Eastern Panhandle from a variety of perspectives. Both qualitative and quantitative assessment methods were used in this process. Surveys and focus groups/interviews were the primary methods of collecting primary data regarding the perceived health and community concerns as well as organizational capacities in our area.

The MAPP process consists of three phases:

1. **Build the Community Health Improvement Foundation:** This phase brings together partner organizations and people to plan the CHA/CHIP and establish the goals and to define the tasks, timeline, and expectations of the process.
2. **Tell the Community Story:** This phase gathers data through its three assessments and analyzes the collected data. The CHA report is completed in this phase.
3. **Continuously Improve the Community:** The CHIP is developed during this phase. Key issues are prioritized, and strategies to address these issues are identified, carried out, and evaluated.

This document details the data collected from the Phase 2 assessments:

- **Community Health Survey:** Data collected directly from community members from a survey to gain insight towards the needs of the community and its significant community health concerns and the most impactful ways to respond to those problems.
- **Community Partner Interviews:** Data collected through focus groups and interview sessions to better understand the impact of community health concerns in the surrounding area.
- **Community Partner Assessment:** Data collected from community organizations through survey responses about organizational services and capacity to address community concerns.

While the MAPP 2.0 process provided significant guidelines while conducting this process, alterations to the process were made to best fit the needs, desires, and capabilities of the community. Specifically, the names of the MAPP 2.0 assessments were changed to better reflect the efforts and goals of each assessment.

Structure

Two primary groups of individuals assisted in the planning of this CHNA, the Core Group and the Steering Committee. These groups gave input about conducting the assessments, what the community would like to see, and provided essential feedback regarding our progress and this document. In addition to these groups, a broad group of community organizations met quarterly and was provided an update, by the Core Team, on the assessment's progress and next steps.

Core Team: This group lays the groundwork for MAPP 2.0 by devoting time or funding, regularly supports and leads the MAPP process to ensure it moves forward, and consists of leaders from both the health system and health department:

Jason Craig, EdD, Director of Community Health, Valley Health

Tara Blackley, MA, MPH, MBA, Health Director, LFHD

Katherine Schroeder, MPH, Population Health Manager, LFHD

Clarissa Bonnefond, MPH, Epidemiologist, LFHD

Leea Shirley, RN, Nurse Manager, LFHD

Susie Hammock, MS, Change Management Specialist, LFHD

Steering Committee: This group gives the MAPP process direction and represents the community's populations and organizations. This team included individuals from the Virginia and West Virginia health departments, the United Way, local government, the Community Services Board, and community organizations.

Key Participating Organizations:

AIDS Response Effort (ARE)

Blue Ridge Care

Blue Ridge Habitat for Humanity

Blue Ridge Independence at Home

EA Hawes

Frederick County Public Schools

Hampshire County Health Department

Healthy Families

Jefferson County Health Department

Local Government Officials

Lord Fairfax Health District

Page County Community Action Team (CAT) Post-acute Care Centers

Seniors First

Shenandoah Alliance for Shelter

Shenandoah University

United Way of the Northern Shenandoah Valley

Valley Health

Virginia Cooperative Extension

Winchester Public Schools

Community Assessments

Community Health Survey

Background: The survey's objective is to better understand the community's perceived health needs by allowing community members and organizations to contribute feedback and gain insight into local health needs.

Survey Distribution: The Community Health Survey was available from November 1, 2024, to March 1, 2025. It was available online and in paper format in both English and Spanish. A link to the survey was sent to individuals with a registered 'MyChart' account associated with Valley Health, and outreach from Community Health Workers (CHWs) was used to share the survey with traditionally underrepresented populations. CHWs used small incentives, such as gift cards, to encourage participation. Additional outreach included a social media campaign, targeted mailings to asset limited and income constrained households, and print campaigns in select communities. A total of 3,636 surveys were collected. Of those, 3557 were attributed to the Valley Health primary and secondary service areas of Virginia and West Virginia.

Methodology: Survey data analysis required consolidating and adjusting responses to appropriately account for or exclude responses. Some reasons for the variability in answers include misspellings, misinterpretation of what was being asked, and incomplete responses. Spelling errors were corrected to the closest matching response. This was especially common in free-text fields.

Demographics

Respondents were asked to provide basic demographic information, including age, sex, race/ethnicity, zip code, education level, household income, and number of people in the home. Some fields were left blank, resulting in slight variability in category totals.

Strengths

- **Robust Response Volume:** A total of 3,636 surveys were collected, with 3,557 attributed to Valley Health's primary and secondary service areas—providing a strong foundation for analysis.
- **Comprehensive Geographic Coverage:** High participation from Virginia localities—especially Frederick (30.7%), Shenandoah (13.2%), and Warren (12.1%)—ensures regional Virginia representation.
- **Strong Representation of Older Adults:** Over 60% of respondents were aged 55 and older, offering valuable insights into the needs of aging populations.
- **High Female Participation:** Women comprised 73.4% of respondents, contributing rich perspectives on women's health and caregiving roles.
- **Well-Educated Sample:** More than half (56.0%) of respondents held a college degree or higher, which may enhance the quality and reliability of self-reported data.
- **Diverse Income Range:** Respondents reported a wide range of household incomes, with 36.8% earning over $95,000 and 11.4% earning between $14,501 and $32,000—supporting socioeconomic comparisons.

Limitations

- **Underrepresentation of Younger Adults:** Only 11.1% of respondents were under age 35, limiting insights into the health needs and behaviors of younger populations.
- **Gender Imbalance:** Male respondents accounted for just 26.2% of the sample, which may skew findings toward female health priorities.
- **Limited Racial and Ethnic Diversity:** The sample was predominantly White (89.3%), with low representation from Black (2.6%), Hispanic/Latino (2.7%), and other racial/ethnic groups.
- **Language Homogeneity:** Nearly all respondents (98.4%) reported speaking English at home, limiting the inclusion of non-English-speaking perspectives.
- **Educational Skew:** The high proportion of college-educated respondents may not reflect the broader community's educational attainment.

The following table details the demographics of all survey respondents.

	Attribute	Respondents (#)	Respondents (%)
Locality	Clarke	149	4.2%
	Frederick	1080	30.7%
	Page	252	7.2%
	Rappahannock	10	0.3%
	Shenandoah	464	13.2%
	Warren	425	12.1%
	Winchester CIty	202	5.7%
	Berkeley	402	11.4%
	Grant	9	0.3%
	Hampshire	164	4.7%
	Hardy	62	1.8%
	Jefferson	122	3.5%
	Mineral	23	0.7%
	Morgan	157	4.5%
Age Range	15 – 24	119	3.3%
	25 – 34	277	7.8%
	35 – 44	466	13.1%
	45 – 54	511	14.4%
	55 – 64	756	21.3%
	65 – 74	895	25.2%
	75+	530	14.9%
Sex	Another	16	0.4%
	Female	2,609	73.4%
	Male	931	26.2%

	Attribute	Respondents (#)	Respondents (%)
Race/Ethnicity	Black/African American	94	2.6%
	Hispanic/Latino	95	2.7%
	Other	71	2.0%
	Two or More Races	122	3.4%
	White	3,172	89.3%
Language	English	3,500	98.4%
	Non-English	57	1.6%
Education	College Degree or Higher	1,991	56.0%
	Did not complete High School	82	2.3%
	High School Diploma/GED	665	18.7%
	Some College	816	23.0%
Employment	Full-Time	1,565	44.0%
	Not Employed	284	8.0%
	Part-Time	291	8.2%
	Retired	1,370	38.5%
	Student	46	1.3%
Annual Household Income	$14,501 – $32,000	405	11.4%
	$32,001 – $50,000	617	17.4%
	$50,001 – $95,000	987	27.8%
	Less than $14,500	231	6.5%
	Over $95,000	1306	36.8%
Number of People in the Home	1	651	0.4%
	2	1,644	46.4%
	3	522	26.2%
	4	394	11.1%
	5	199	5.6%
	6 or more	110	3.1%

Survey Summary

The Community Health Survey featured seven primary questions to gain insight towards the needs of the community and its significant community health concerns and the most impactful ways to respond to those problems. Below are visualizations for the results of the survey. A complete breakdown of these results can be found in Appendix A.

The voices of our community, as captured through the health needs assessment survey, revealed a strong alignment in concerns across all localities. What we heard was clear: people care deeply about their health—both physical and mental—and they are eager to see meaningful changes in the conditions that shape their daily lives. While some differences emerged between localities, these deviations highlighted specific, localized needs that deserve focused attention.

Residents consistently emphasized the importance of living longer, healthier lives. Physical health remains a top concern, with cancer and heart disease standing out as the most urgent issues. These conditions were viewed as more pressing than obesity or diabetes, suggesting a need for targeted prevention, education, and treatment efforts. At the same time, mental health was repeatedly highlighted as a critical component of overall well-being. Many community members expressed a strong desire for better access to mental health services and support, underscoring the need to treat mental health with the same urgency as physical health.

Beyond individual health conditions, the environment in which people live plays a powerful role in shaping health outcomes. The survey brought to light several environmental challenges that directly impact health, stress levels, and quality of life. Among the most pressing were the high cost of housing, the limited availability of affordable homes, difficulty accessing healthy foods, and the growing issue of social isolation. These are not just matters of comfort or convenience—they are fundamental to the health and stability of individuals and families.

Economic stability also emerged as a major theme. Many residents pointed to low income, homelessness, and food insecurity as persistent barriers to achieving good health. These challenges often overlap, creating a cycle that is difficult to break without coordinated community support and comprehensive resources.

Together, these findings paint a picture of a community that is aware, engaged, and ready for action. The responses provide valuable insight into what residents perceive as the most significant health concerns, offering a roadmap for where efforts should be focused. Increasing access to healthcare is essential. This includes expanding the availability of both medical and behavioral health services, reducing wait times, and ensuring affordability for all residents. Mental health care, in particular, must be prioritized, with more providers, integrated services, and community-based support systems.

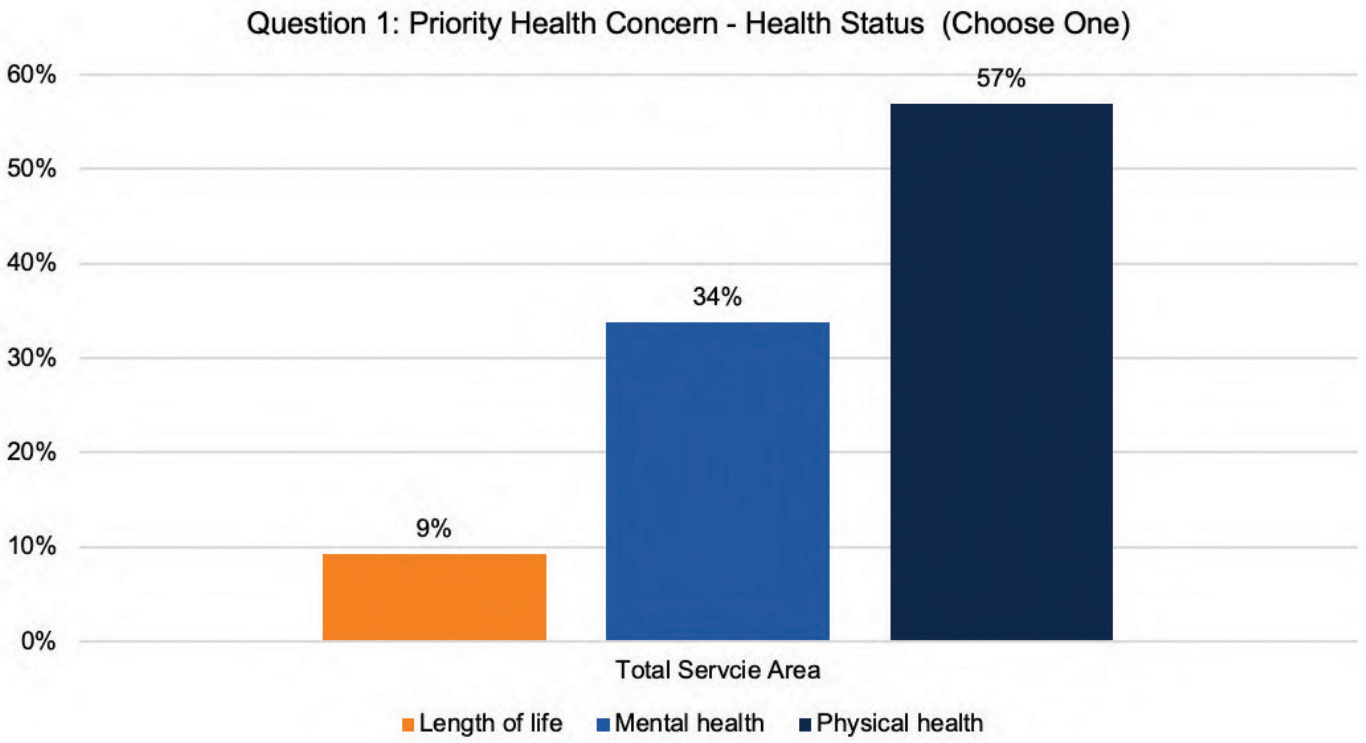
Preventive care is another critical area of focus. Enhancing access to cancer screenings and early detection services can lead to better outcomes and reduced long-term negative outcomes. Similarly, promoting physical activity and nutrition education will empower individuals to make healthier lifestyle choices and prevent chronic conditions before they develop.

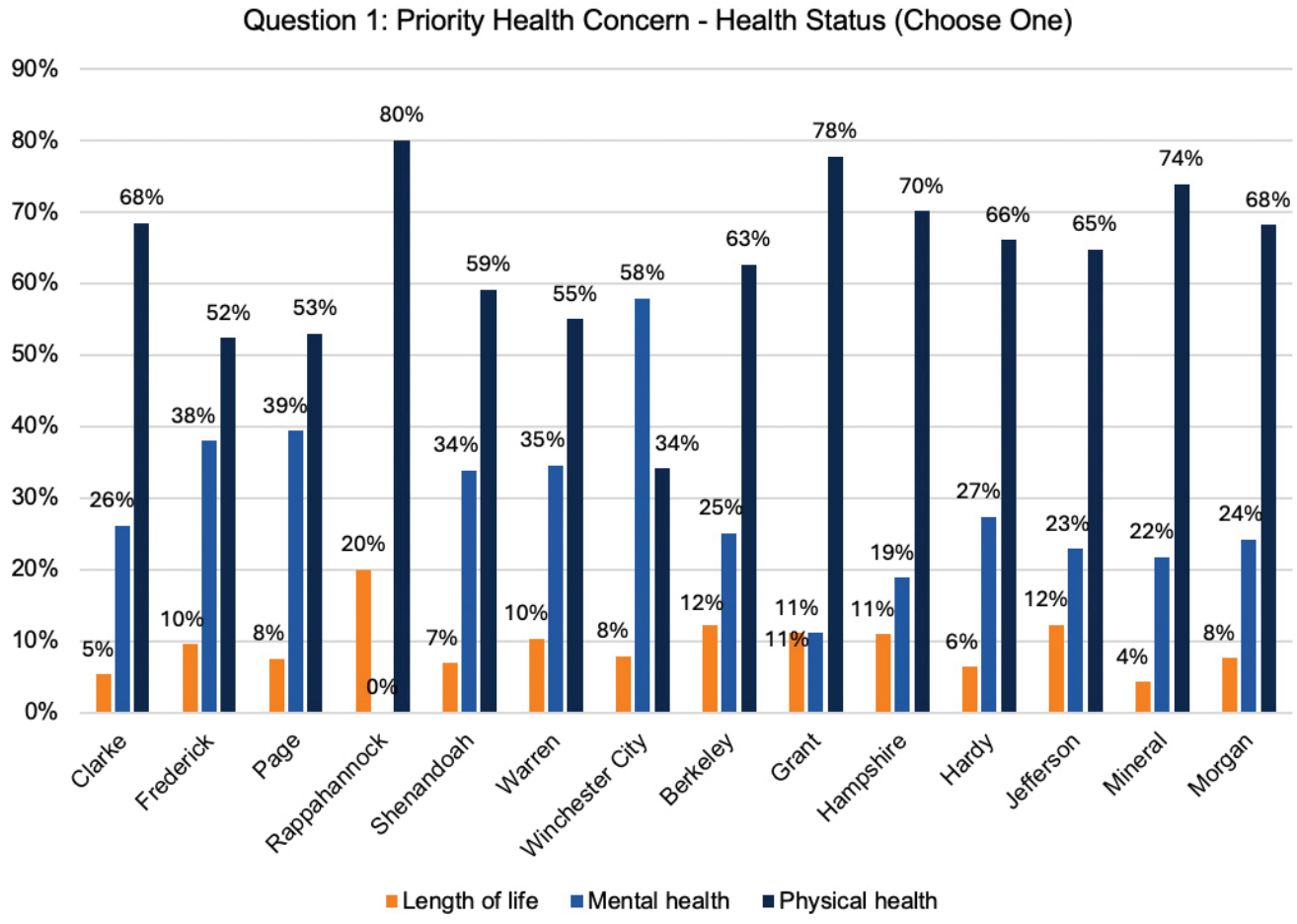
Substance use and alcohol treatment services must be strengthened to meet growing needs. This involves not only increasing the number of treatment options but also reducing stigma and improving pathways to recovery.

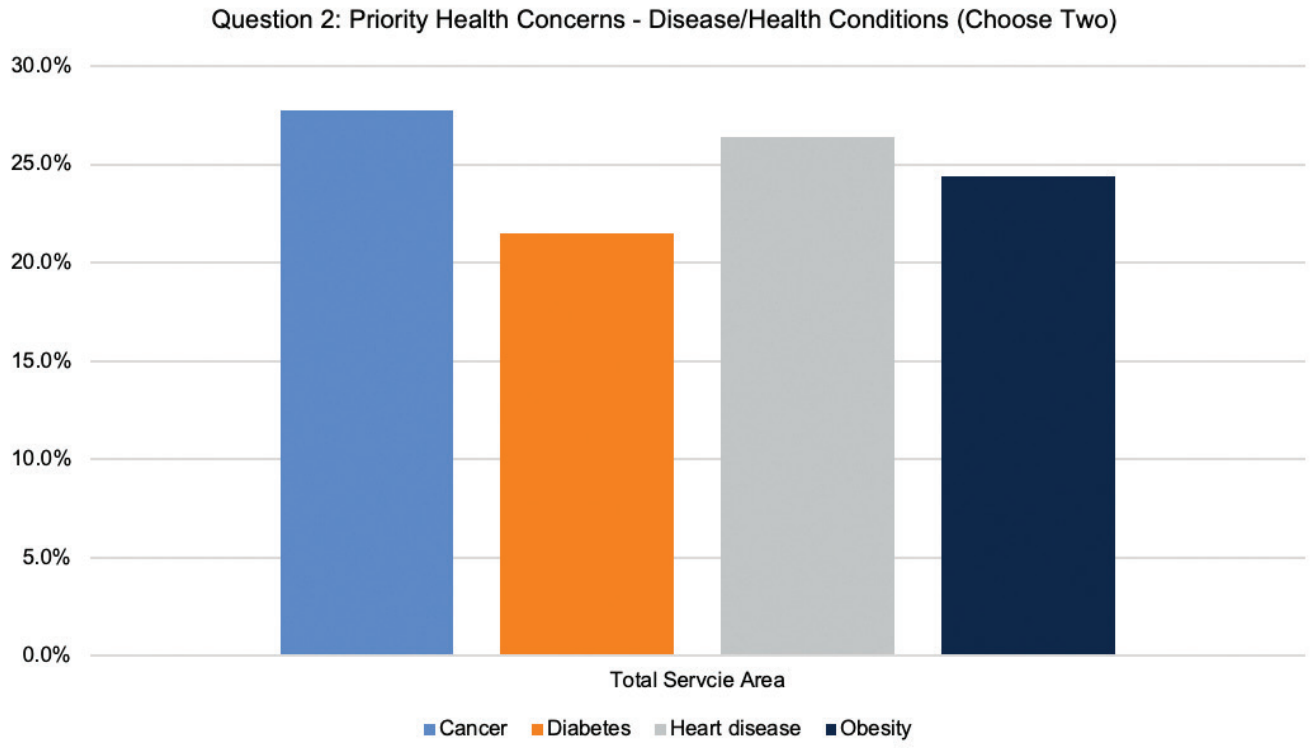
Addressing the social determinants of health is equally important. Expanding affordable housing options will provide the stability necessary for individuals and families to thrive. At the same time, increasing access to aging

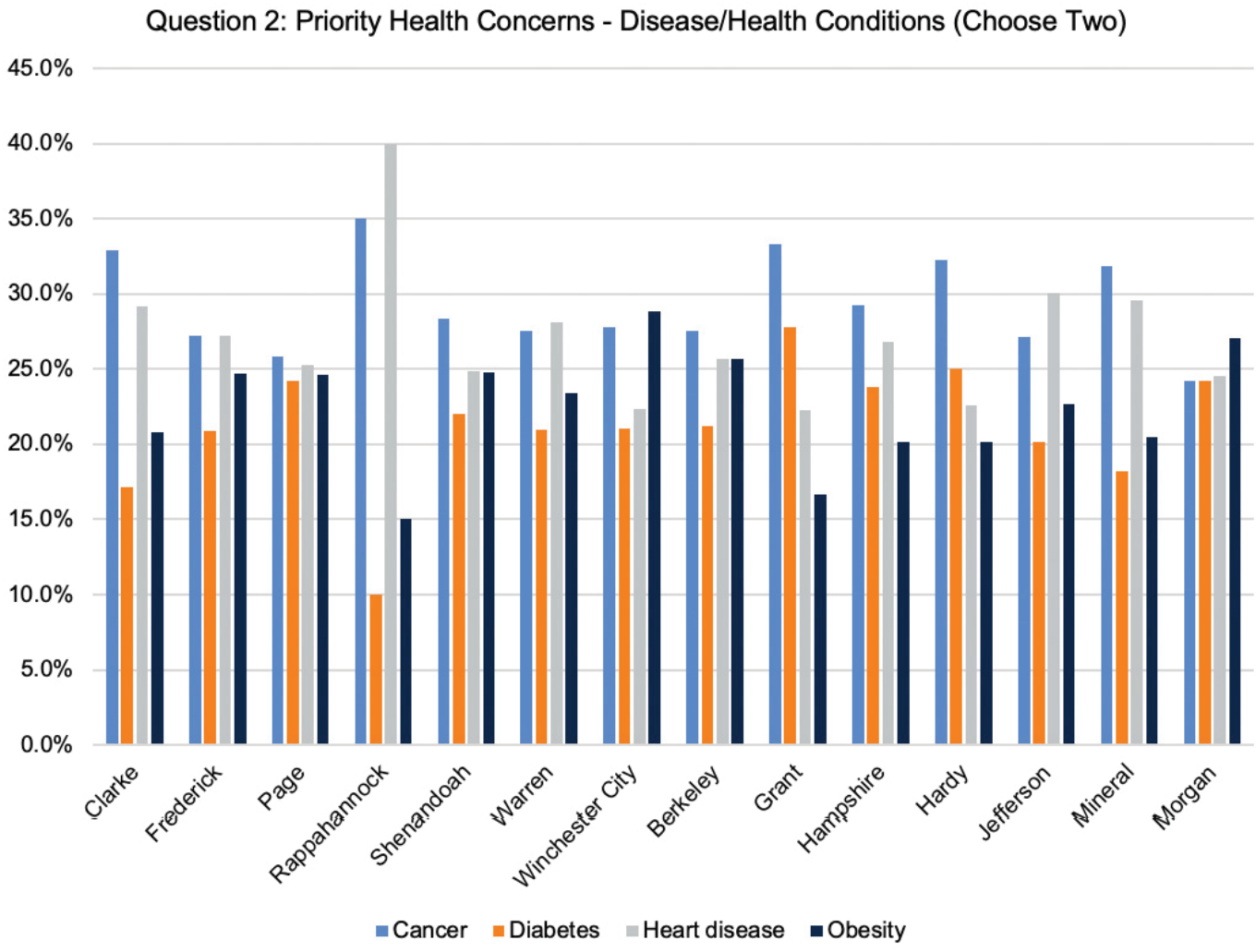
services will ensure that older adults receive the care, support, and engagement they need to maintain their health and independence.

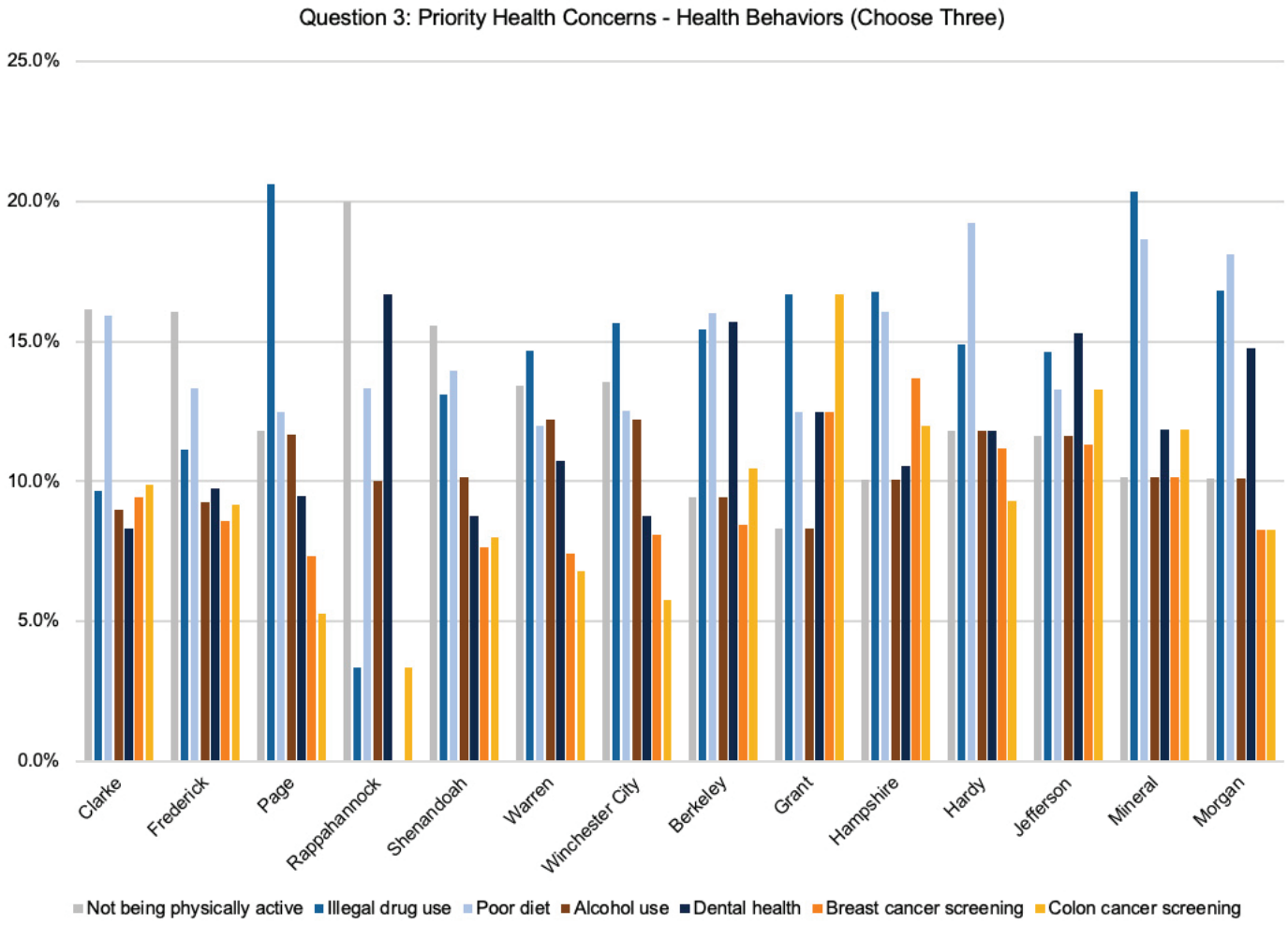
Together, these solutions form a comprehensive approach to building a healthier, more equitable community—one where every person has the opportunity to live a longer, healthier life. Ultimately, these results not only reflect the current state of health in our community but also serve as a foundation for developing a Community Health Improvement Plan (CHIP). This plan will aim to address the concerns raised and guide strategic, impactful actions to improve health outcomes across the region.

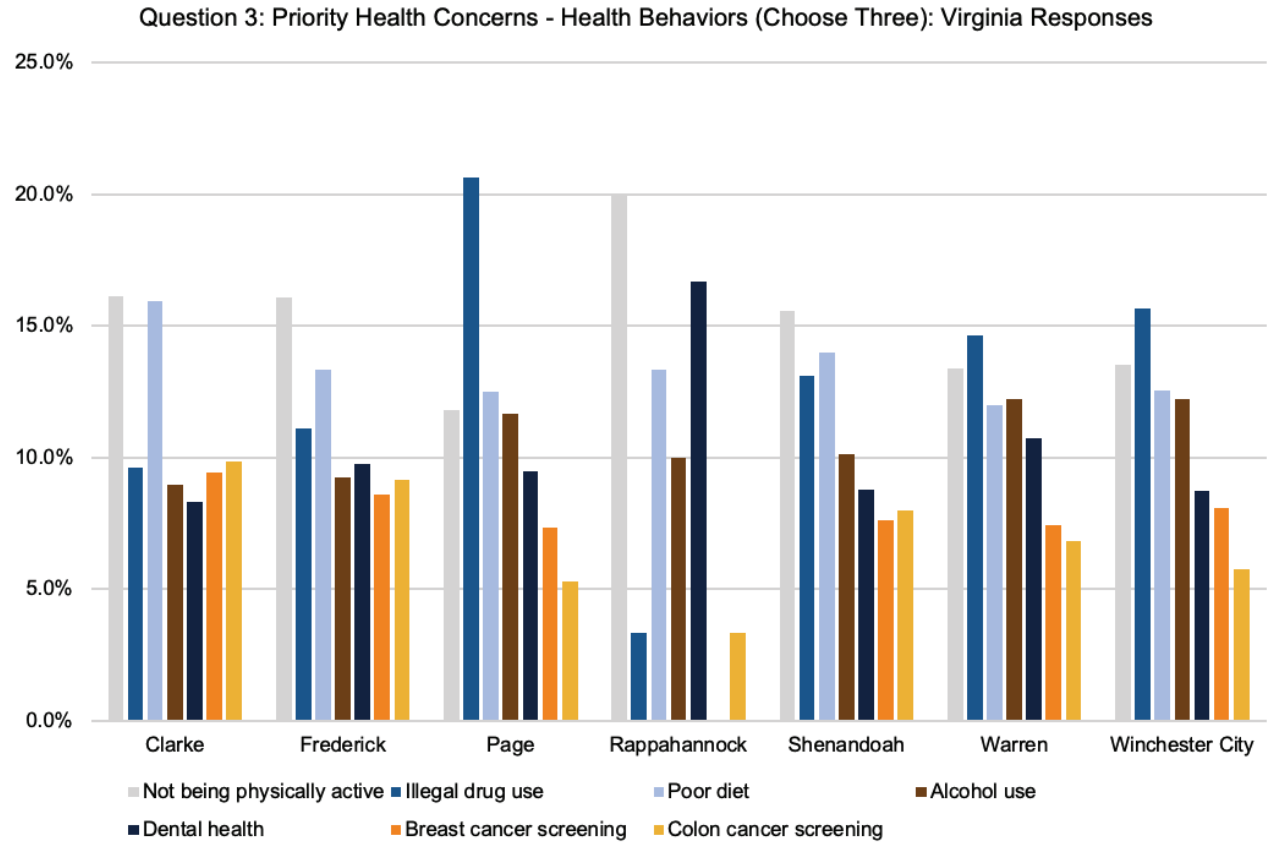

Question 1: Priority Health Concern - Health Status (Choose One)
60%
50%
40%
30%
20%
10%
0%
9%
34%
57%
Total Servcie Area
Length of life
Mental health
Physical health

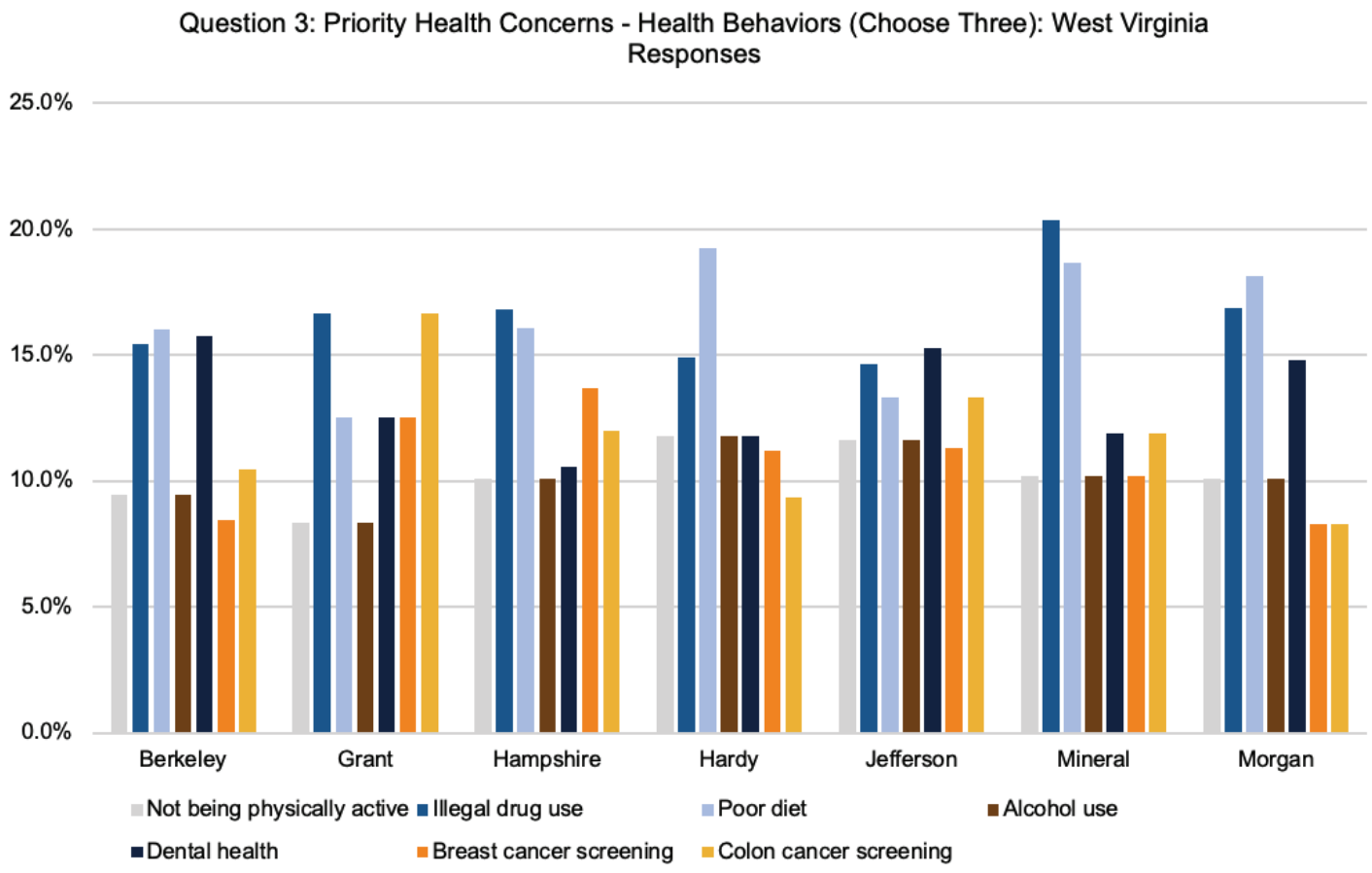

Question 1: Priority Health Concern - Health Status (Choose One)
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Clarke 5% 26% 68%
Frederick 10% 38% 52%
Page 8% 39% 53%
Rappahannock 20% 0% 80%
Shenandoah 7% 34% 59%
Warren 10% 35% 55%
Winchester City 8% 58% 34%
Berkeley 12% 25% 63%
Grant 11% 11% 78%
Hampshire 11% 19% 70%
Hardy 6% 27% 66%
Jefferson 12% 23% 65%
Mineral 4% 22% 74%
Morgan 8% 24% 68%
Length of life
Mental health
Physical health


Question 2: Priority Health Concerns - Disease/Health Conditions (Choose Two)
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Total Servcie Area
Cancer
Diabetes
Heart disease
Obesity

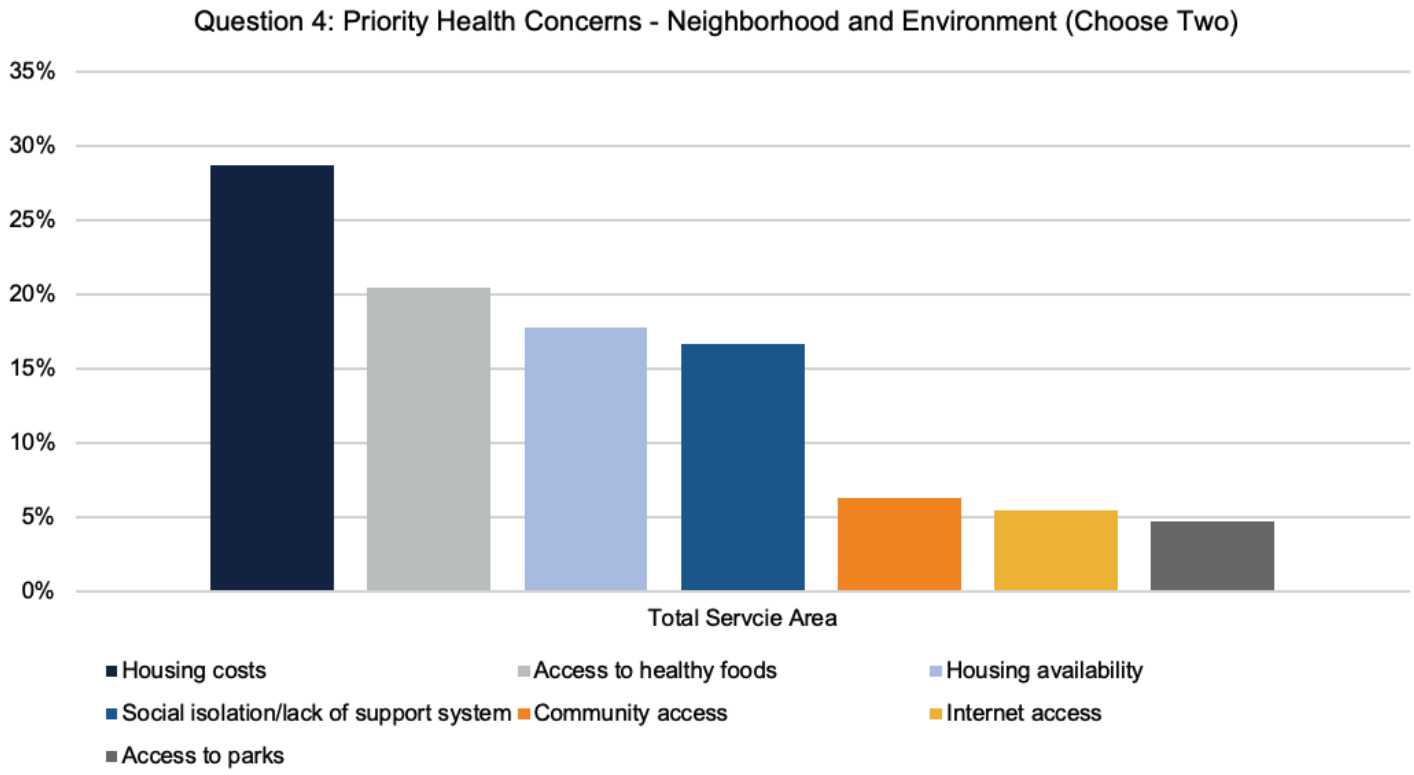

Question 2: Priority Health Concerns - Disease/Health Conditions (Choose Two)
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Clarke
Frederick
Page
Rappahannock
Shenandoah
Warren
Winchester City
Berkeley
Grant
Hampshire
Hardy
Jefferson
Mineral
Morgan
Cancer
Diabetes
Heart disease
Obesity


Question 3: Priority Health Concerns - Health Behaviors (Choose Three)
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Clarke
Frederick
Page
Rappahannock
Shenandoah
Warren
Winchester City
Berkeley
Grant
Hampshire
Hardy
Jefferson
Mineral
Morgan
Not being physically active
Illegal drug use
Poor diet
Alcohol use
Dental health
Breast cancer screening
Colon cancer screening

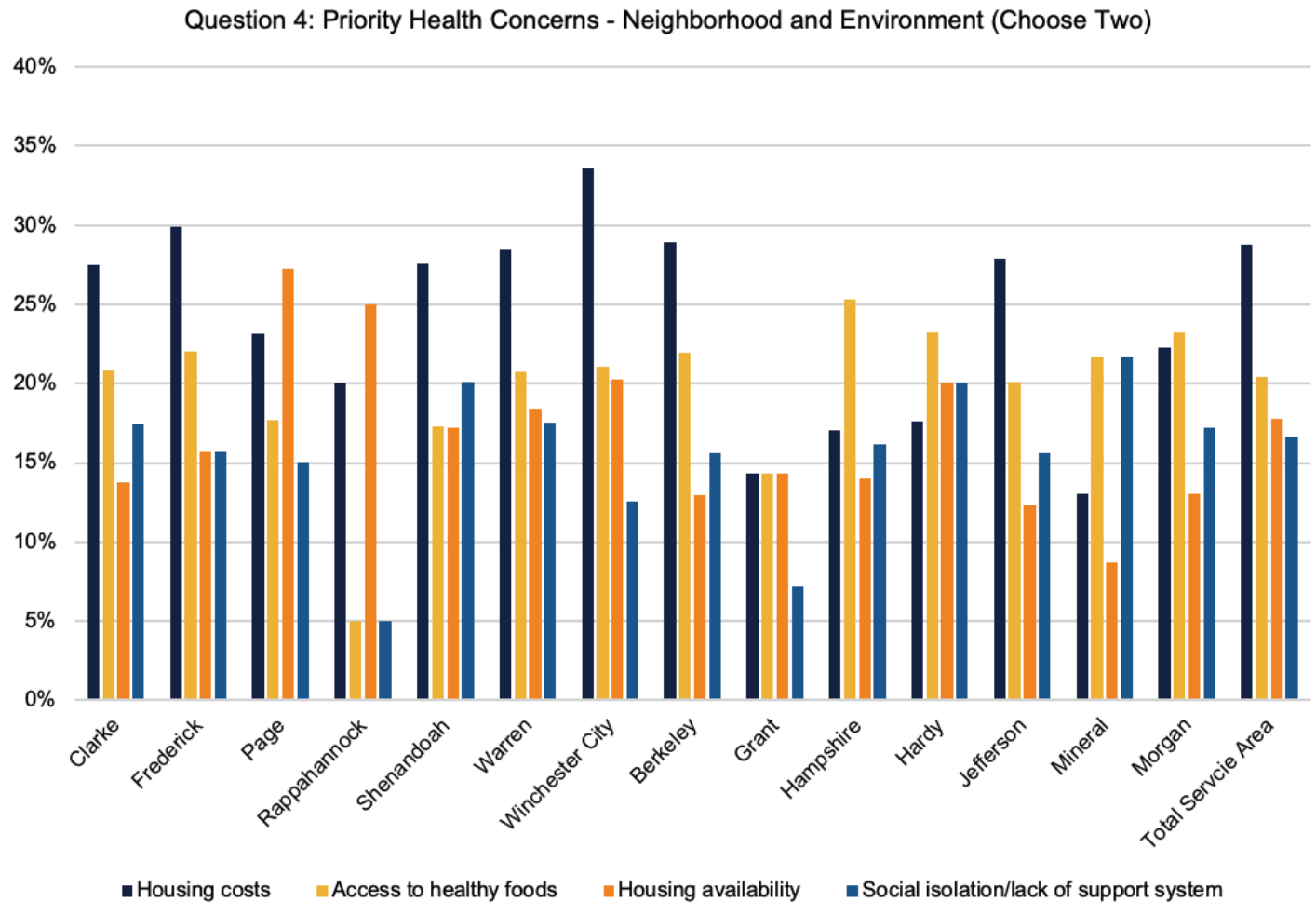

Question 3: Priority Health Concerns - Health Behaviors (Choose Three): Virginia Responses
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Clarke
Frederick
Page
Rappahannock
Shenandoah
Warren
Winchester City
Not being physically active
Illegal drug use
Poor diet
Alcohol use
Dental health
Breast cancer screening
Colon cancer screening

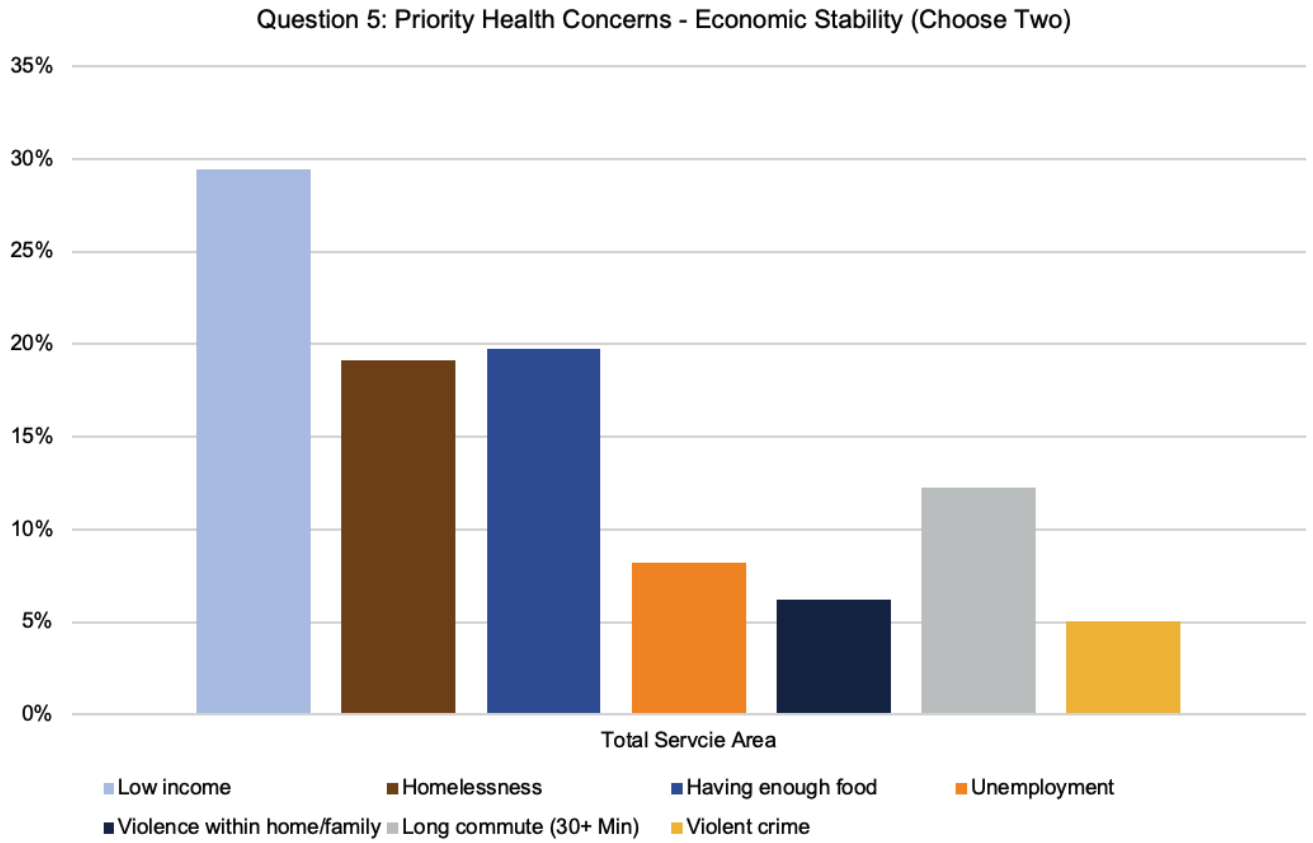


(Other options: smoking & tobacco, vaccinations, vape use, marijuana use, sexual activity)

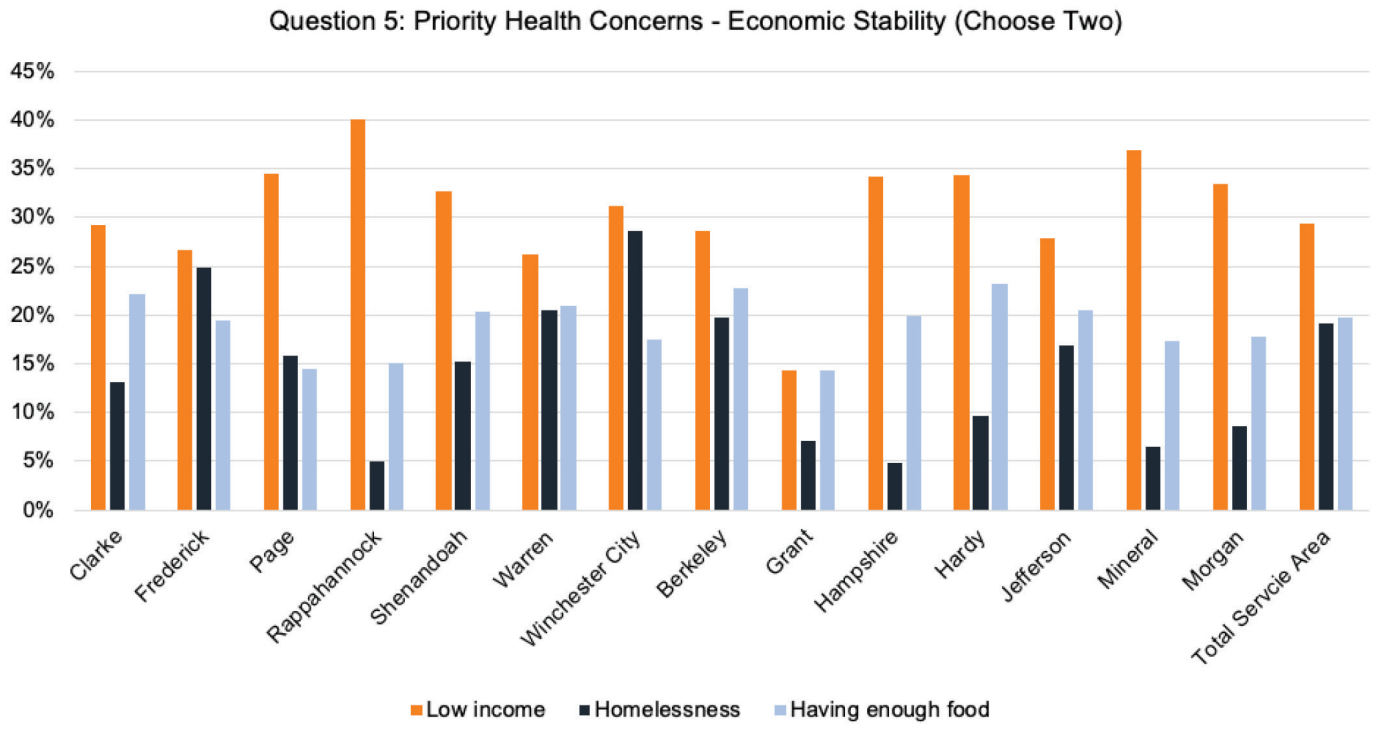


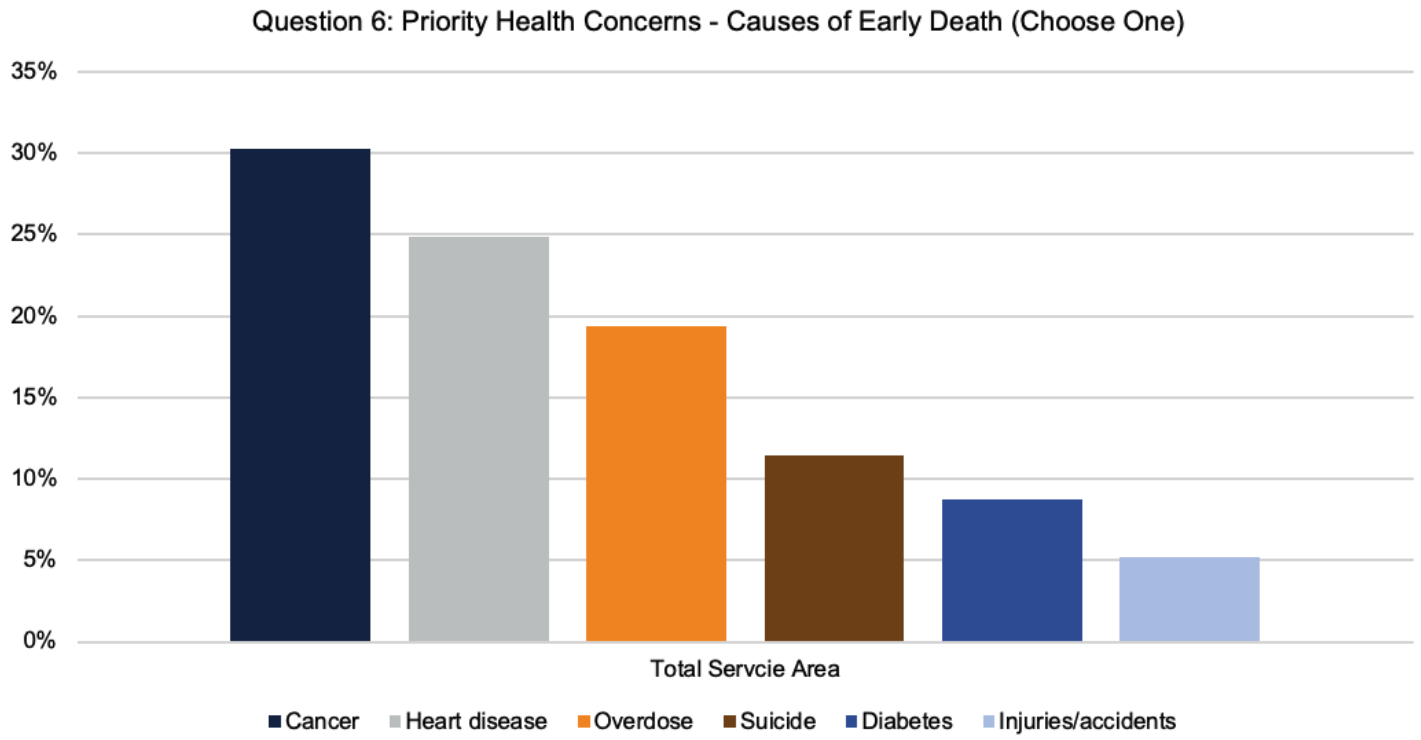
Other options: access to parks, community access, and internet access)



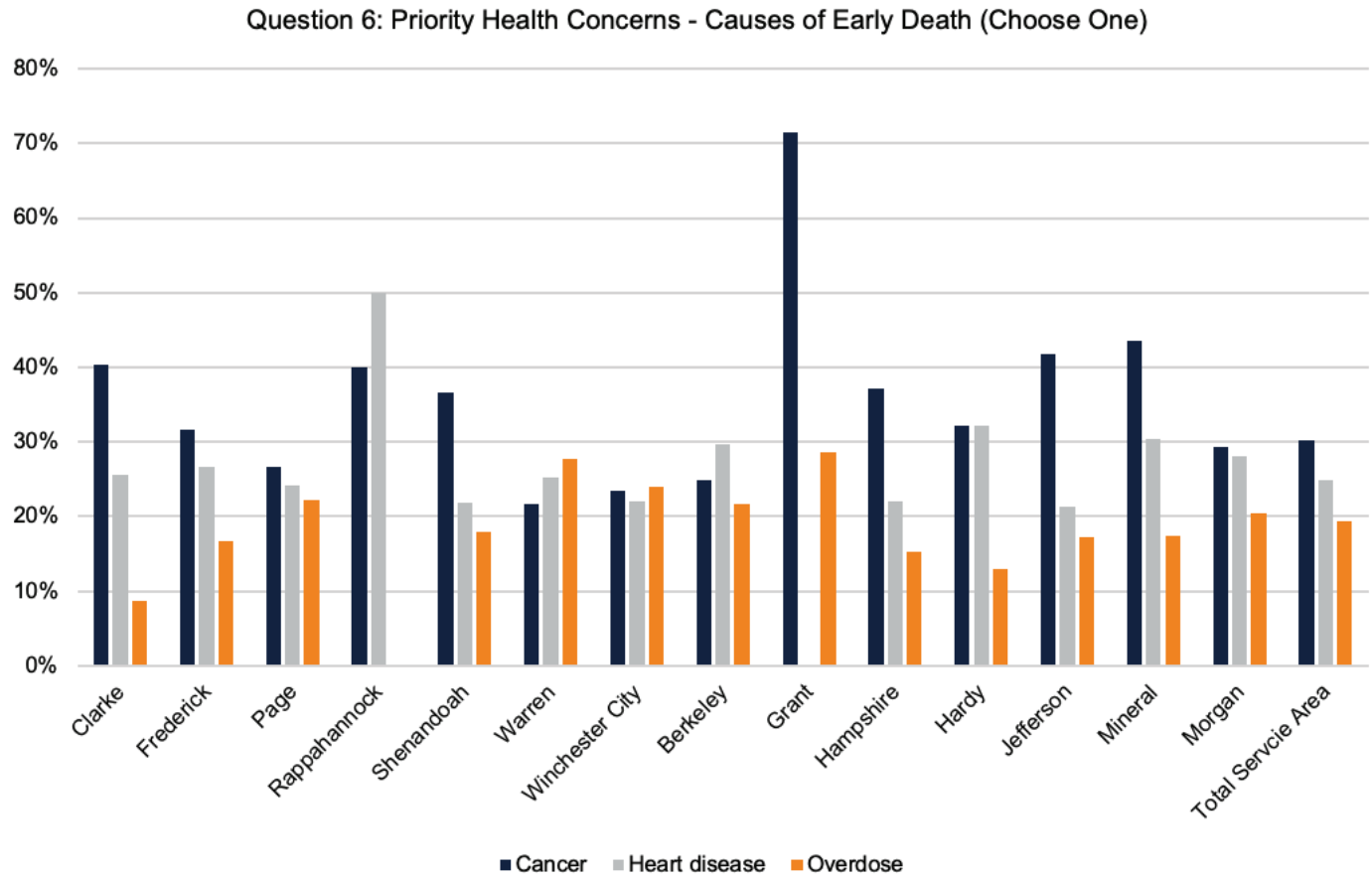


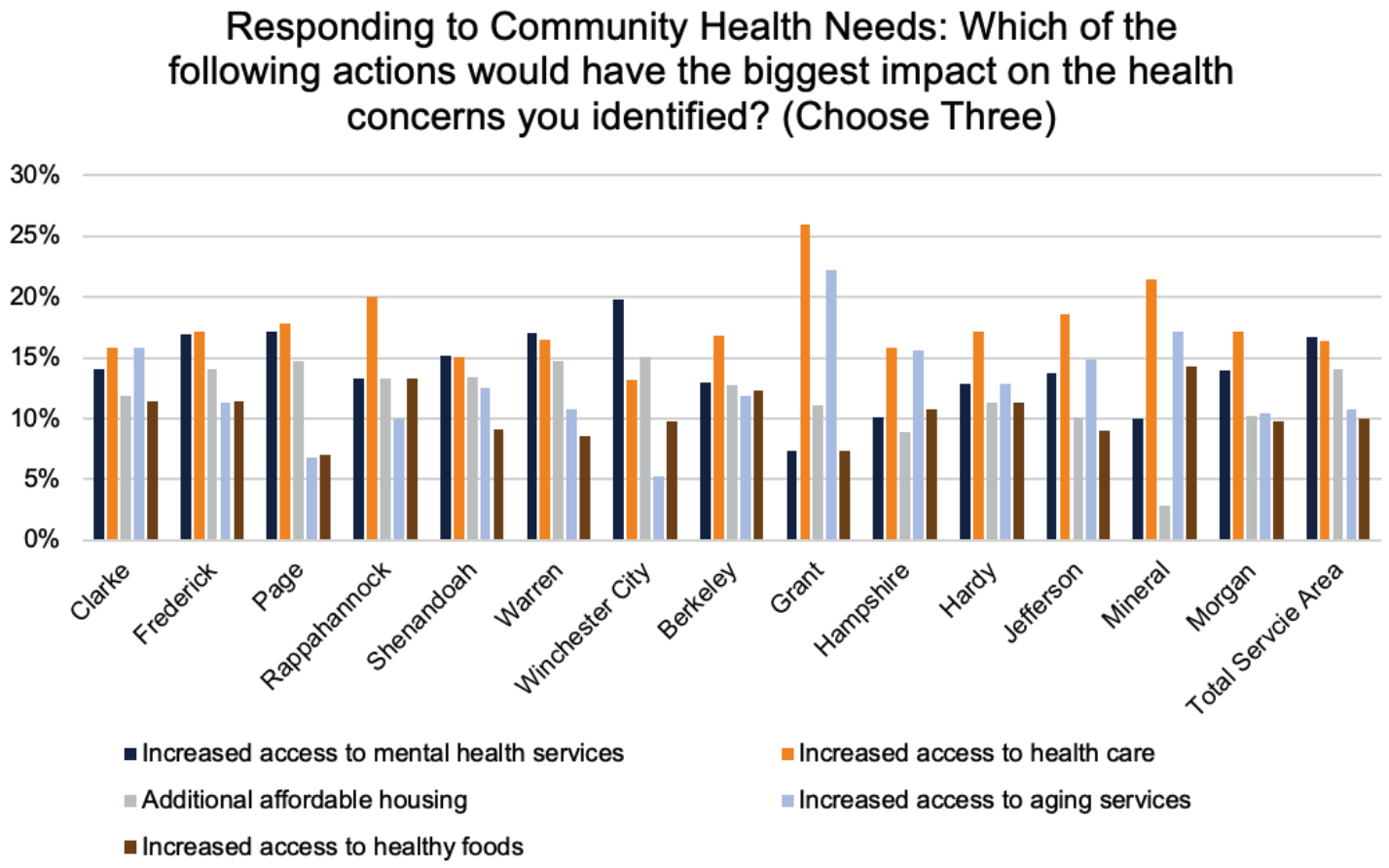
(Other options: unemployment, violence in family/home, long commute, and violent crime)



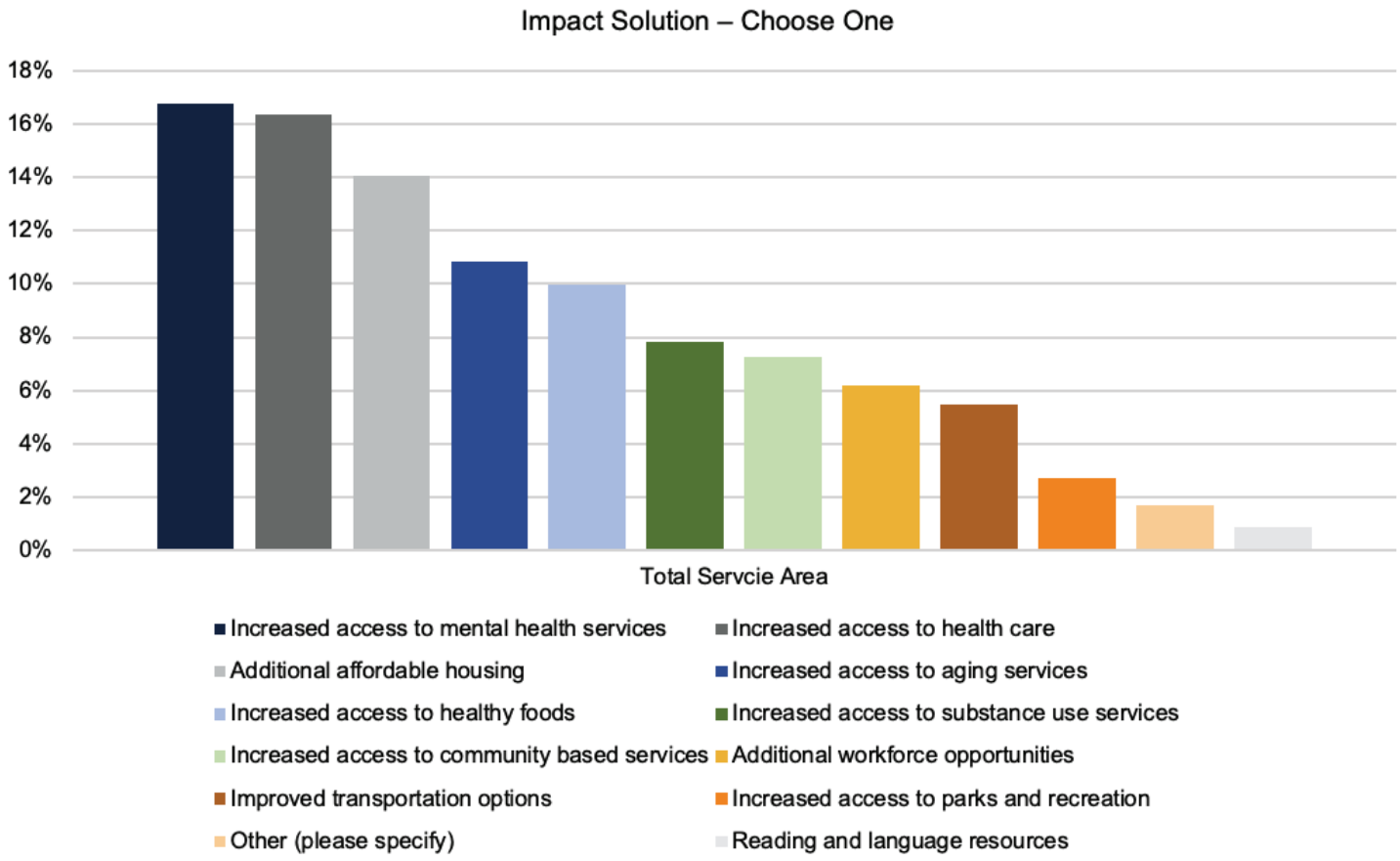


(Other options: suicide, diabetes, and injuries/accidents)





(Other options: Increased access to substance use services, increased access to community-based services, additional workforce opportunities, improved transportation options, increased access to parks and recreation, reading & language services, and other—please specify


Impact Solution – Choose One
18%
16%
14%
12%
10%
8%
6%
4%
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Total Servcie Area
Increased access to mental health services
Increased access to health care
Additional affordable housing
Increased access to aging services
Increased access to healthy foods
Increased access to substance use services
Increased access to community based services
Additional workforce opportunities
Improved transportation options
Increased access to parks and recreation
Other (please specify)
Reading and language resources

Community Partner Interviews

Introduction

Background: Community Health Interview Sessions, also known as Community Context Assessment in the MAPP 2.0 process, were conducted as a portion of the 2025 Community Health Needs Assessment to better understand the factors affecting health within the community. Each interview was in a group setting for 60 minutes where individuals were asked various questions framed around community health concerns, the populations affected, whether the concerns have gotten better or worse, and potential solutions for these concerns.

Methodology: Concerns from all localities within the service area are included in these summaries, because each interview session was conducted with individuals from across the service area. These generalizations may not be accurate for all localities but identify any exceptions within the summaries.

Key Themes

Health & Health Care: Continuing to improve access to healthcare remains one of the most urgent needs identified across the region, especially with increases in population. Residents consistently reported challenges in accessing timely primary, specialty, and diagnostic care due to provider shortages and long wait times. In the rural service areas, these issues are even more pronounced, with fewer providers and greater distances to travel. Additionally, pediatric care was also described as being particularly limited, making it difficult for children to receive adequate medical attention.

To address these concerns, expanding healthcare access through mobile clinics, telehealth services, and school-based health programs was discussed, as was a need for end of life and aging services to be scaled up to meet the needs of a growing elderly population.

Additional mental health and substance use services are still needed. Current services are insufficient to meet rising demand, especially among youth, seniors, and rural populations. Solutions include increasing the availability of mental health providers, integrating behavioral health into primary care, and expanding crisis intervention and prevention programs. Addressing stigma, generational trauma, and trust issues are vital to ensuring individuals feel safe seeking help.

Preventive care efforts, such as cancer screenings, and chronic disease management must be strengthened. Additionally, promoting physical activity and nutrition education will support healthier lifestyles and reduce the burden of preventable conditions.

Neighborhood & Built Environment: Transportation is a major infrastructural barrier to health and well-being, particularly in rural areas. Many residents lack access to reliable public transit, making it difficult to reach healthcare services, grocery stores, employment, and other essential resources. While programs like “WinReady” have improved access in Winchester, rural and low-income communities remain underserved.

To overcome these barriers, transportation solutions must be expanded. This includes rural shuttle services, ride-share partnerships, and community-based transit programs that prioritize access to medical and social services.

Housing and homelessness are also pressing concerns. The shortage of affordable housing has worsened due to rising rents and the proliferation of short-term rentals, especially in rural areas. Homelessness is increasing, particularly among seniors, low-income families, and individuals with chronic health conditions. Expanding affordable housing initiatives and supportive housing programs is essential to providing stability and improving health outcomes.

Economic Stability: Financial hardship is a widespread issue affecting residents' ability to maintain healthy lives. High medical costs—regardless of insurance status—along with rising housing prices and the inability to afford nutritious food, are common challenges. These economic pressures are especially burdensome for families and individuals on fixed incomes.

Addressing these issues requires a multi-pronged approach: increasing access to affordable healthcare, expanding housing support, and improving access to healthy food options. Additionally, workforce development and job training programs can help residents secure stable employment and improve their economic resilience. Strengthening the healthcare workforce is also critical to ensuring consistent, high-quality care across the region.

Social & Community Context: Social isolation is a growing concern, particularly among older adults, rural residents, and individuals with disabilities. The weakening of family support systems has made caregiving and aging in place more difficult, contributing to both mental and physical health challenges.

To combat isolation and strengthen community ties, local organizations—including faith-based groups and nonprofits—play a vital role. Expanding senior engagement programs, community centers, and volunteer networks can help rebuild social connections and provide essential support.

Despite these challenges, the region benefits from a strong network of active nonprofit organizations that are committed to improving quality of life. Continued collaboration among these groups will be key to addressing complex social and health issues.

Education: Health literacy and the ability to navigate healthcare systems are significant barriers for many residents. A lack of understanding about insurance, available services, and how to access care prevents individuals from advocating for themselves and managing their health effectively.

Improving health literacy through targeted education, outreach, and service coordination is essential. Programs that teach residents how to navigate healthcare and social services, understand their health conditions, and make informed decisions will empower individuals and improve outcomes. Special attention should be given to culturally appropriate communication and outreach strategies to ensure inclusivity and effectiveness.

Community Partner Assessment

Introduction

Background: The Community Partner Assessment (CPA) is a survey designed to gather insights from community organizations, agencies, businesses, and service providers about the populations they serve, the services they offer, and their capacity to meet community needs. This assessment complements other components of the Community Health Assessment (CHA) by providing a snapshot of the region's organizational infrastructure and its ability to respond to identified health priorities. The survey instrument is included in Appendix D.

Methodology: The CPA consisted of 22 questions, which were analyzed using thematic coding to identify common patterns and insights. Responses were grouped into key categories reflecting organizational focus areas, populations served, and perceived capacity to address community health needs.

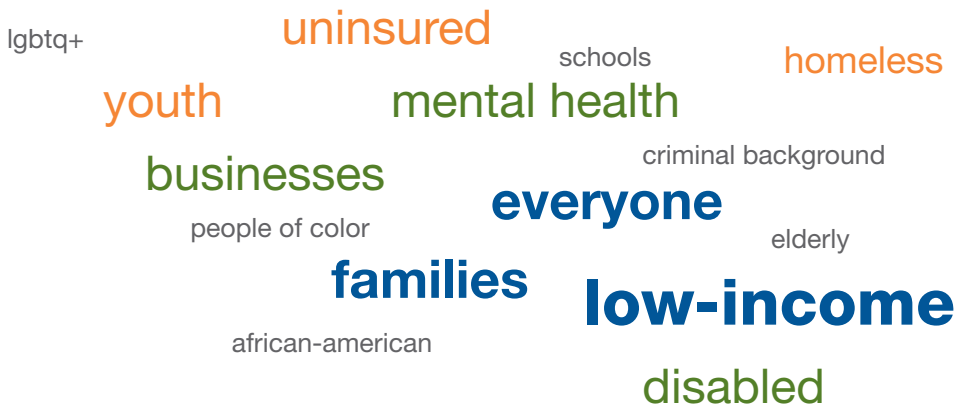
Results

Organizational Representation: A total of 24 unique organizations participated in the CPA, representing a diverse sample of sectors including local and state government, public health clinics, education, social services, housing, mental health, faith-based organizations, and independent living. Notably, 77% of respondents identified as nonprofit organizations, underscoring the critical role of the nonprofit sector in community health.

Populations Served: Most organizations (approximately 80%) reported serving all individuals regardless of race or racial identity. However, only 63% indicated they had the capacity to serve individuals who speak English as a second language. Among those, three organizations reported having bilingual staff, and four had access to a medical translation line—highlighting a potential gap in language accessibility.

All organizations reported serving members of the LGBTQ+ community. However, 21% acknowledged that they are not fully ADA accessible, limiting their ability to serve individuals with disabilities. Despite this, qualitative responses indicated a strong commitment to inclusivity, with many organizations expressing a willingness to make accommodations to meet client needs.

Priority Populations: Respondents identified a wide range of priority populations, including older adults, low-income families, individuals with disabilities, and those experiencing homelessness. This word cloud visually represents the frequency of these mentions, emphasizing the diversity of needs across the region.

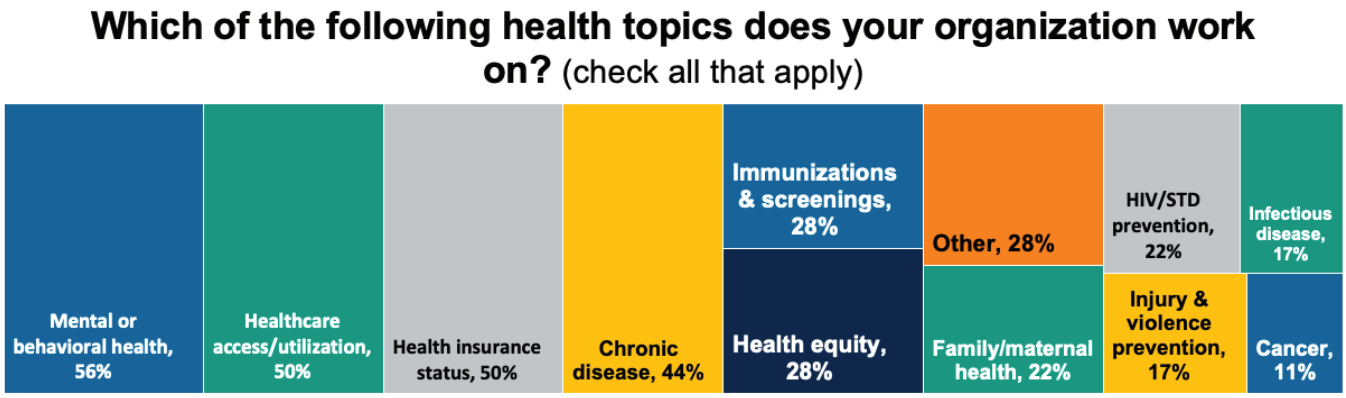


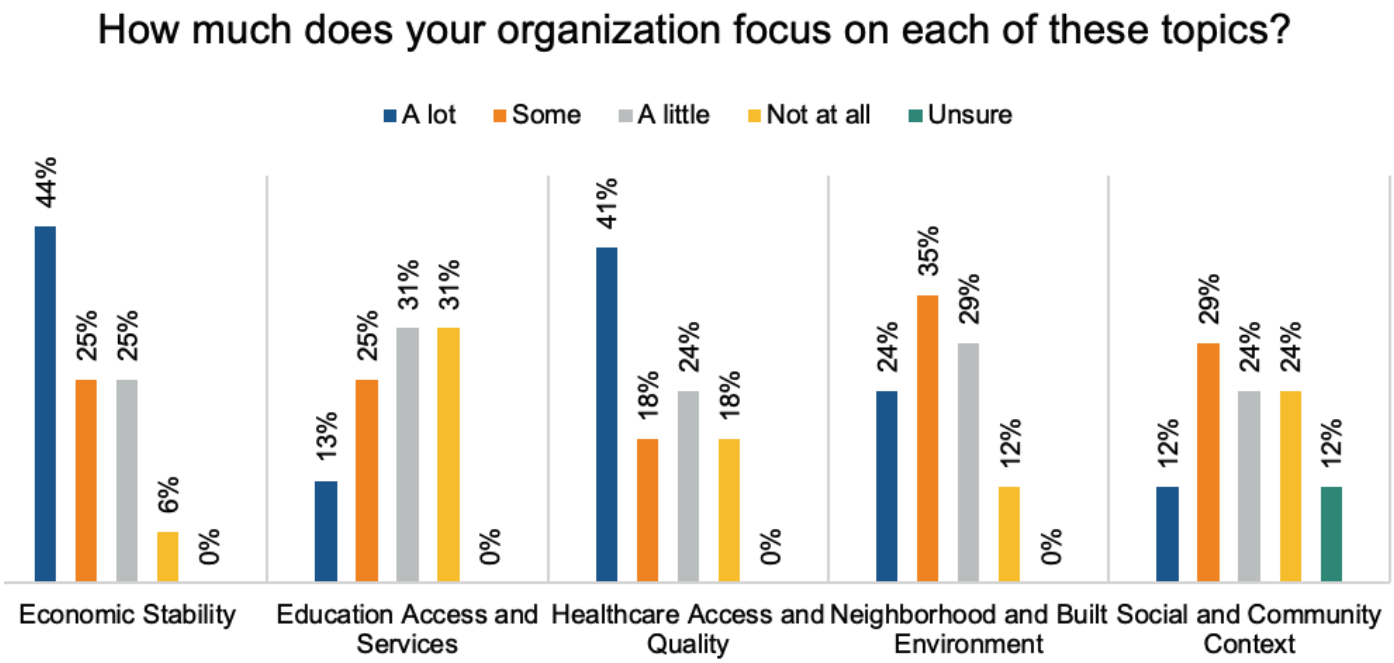
Organizational Focuses: Organizations were asked to categorize their work with the five domains of the Social Determinants of Health (SDOH):

- **Economic Stability**
- **Education Access and Services**
- **Healthcare Access and Quality**
- **Neighborhood and Built Environment**
- **Social and Community Context**

The majority of organizations reported focusing heavily on economic stability and healthcare access and quality, reflecting alignment with the top community health priorities identified in the survey and interviews. Fewer organizations reported strong engagement in education access and social/community context, suggesting potential areas for growth or collaboration.

Health Focuses: Below are the identified health focuses of the responding organizations, if any. Other responses were environmental & soil health, healthy eating, nutrition, and physical activity.





Organizational Capacity: Of the surveyed organizations, there was an even split between organizations that believe they have sufficient capacity to meet the needs of their clients and those who believe the opposite. The factors that contribute to the inability to meet the needs of their clientele are needing more funding to support the work, inability to fill vacant positions, and needing more volunteers.

Community Data Profile

Background

This section aims to identify patterns and trends in community health by utilizing secondary, quantitative data. Much of this data is collected from state or federal organizations, like the Virginia Department of Health (VDH) and Centers for Disease Control (CDC), or other public health organizations such as County Health Ranking and Roadmaps. The data below reflects the most up to date information at the time of writing. Secondary data can take years to compile and publish, so this may result in data from 2022 or 2023 being the most recent year.

Note that some tables in this assessment include grayed boxes. This graying indicates a data point that is worse than the state average and is meant to help the reader interpret the large amounts of data contained within the table.

Demographics

Demographic data is essential for understanding the context of the health and social data we collect, as it helps identify who is most affected by specific issues and reveals patterns across age, race, income, education, and other factors. By analyzing this information, we can better tailor programs, policies, and resources to meet the unique needs of different groups within a community.

Total Population per Locality

The resident population of the Valley Health service area varies across its localities and is comprised of both rural and urban areas.

Total Population*			
Virginia	8,624,499	**West Virginia**	1,793,716
Clarke Co.	15,060	**Jefferson Co.**	61,264
Frederick Co.	93,355	**Berkeley Co.**	138,562
Page Co.	23,750	**Morgan Co.**	17,649
Rappahannoack Co.	7,409	**Hampshire Co.**	23,793
Shenandoah Co.	44,630	**Hardy Co.**	14,335
Warren Co.	41,104	**Grant Co.**	10,921
Winchester City	27,981	**Mineral Co.**	26,867

The population of LFHD containing Winchester City, Clarke, Frederick, Page, Shenandoah, and Warren counties has increased by 8.1% from 2014 to 2023 which indicates a faster growing population than the Virginia population increase (4.8%) over the same timeframe*. Among the LFHD localities, Frederick County has the fastest growing population with an increase of 16% from 2023 to 2024.

The Eastern Panhandle of West Virginia has experienced notable population growth from 2020 to 2025, in contrast to much of the rest of the state, which has seen population decline.

* US Census Bureau, American Community Survey. 2019-23.

** Virginia Department of Health, Population Demographics Dashboard. 2014-2023.

Key growth counties:

- Berkeley County: +12.9% growth since 2020
- Jefferson County: +6.2% growth since 2020
- Hardy County: +2.8% growth

While some counties in the region—such as Morgan, Mineral, Hampshire, and Grant—have experienced slight declines (a combined loss of about 2,400 residents), the Eastern Panhandle overall saw a net gain of approximately 12,000 residents.

This growth of the area is largely attributed to the region's proximity to Washington, D.C., making it attractive for commuters and new residents seeking more affordable living options.

Age Distribution

The Valley Health service area exhibits a clear trend toward an aging population, with notable differences between localities in both Virginia and West Virginia. In the Lord Fairfax Health District (LFHD), which includes Winchester City, Clarke, Frederick, Page, Shenandoah, and Warren counties, the population skews older than the Virginia state average. Rural counties in particular—such as Page and Shenandoah—have a significantly higher proportion of residents aged 65 and older, while all localities except Winchester City have fewer individuals under age 44 compared to the state average. This suggests a decline in younger families and a growing need for services tailored to older adults.

Similarly, in the West Virginia service area, the population is older than the state average. Rural counties such as Morgan, Mineral, Hampshire, and Grant have a higher concentration of older adults and fewer younger residents. Only Berkeley and Jefferson counties maintain a younger demographic profile closer to the state average. These patterns reflect broader demographic shifts, including outmigration of younger populations and aging in place among long-term residents.

Total Population by Age Group, Percent*	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
Age 0-4	5.7%	3.7%	5.6%	5.0%	5.6%	5.2%	6.1%	3.1%
Age 5-17	16.2%	15.3%	17.3%	14.9%	15.8%	16.4%	16.3%	15.7%
Age 18-24	9.3%	7.3%	7.4%	6.9%	7.4%	7.7%	11.2%	3.9%
Age 25-34	13.6%	9.1%	12.1%	11.2%	11.1%	13.5%	13.4%	10.6%
Age 35-44	13.5%	10.8%	13.1%	11.4%	11.9%	12.5%	12.6%	11.0%
Age 45-54	12.6%	14.4%	12.6%	13.2%	11.9%	13.0%	11.3%	10.8%
Age 55-64	12.9%	17.6%	13.8%	15.7%	14.5%	15.0%	12.0%	17.5%
Age 65+	16.3%	21.8%	18.2%	21.8%	21.9%	16.7%	17.1%	27.6%

* US Census Bureau, American Community Survey. 2019-23.

Total Population by Age Group, Percent*	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Age 0-4	5.0%	4.7%	6.1%	4.1%	4.9%	5.0%	5.0%	4.9%
Age 5-17	17.0%	15.8%	19.8%	12.8%	15.0%	14.5%	14.4%	15.5%
Age 18-24	12.5%	8.9%	11.5%	6.9%	10.2%	9.5%	9.0%	11.1%
Age 25-34	12.0%	12.3%	14.3%	10.2%	10.2%	10.2%	10.5%	11.2%
Age 35-44	12.1%	13.0%	13.7%	10.8%	10.7%	10.5%	10.5%	11.9%
Age 45-54	12.8%	13.1%	13.1%	13.1%	14.3%	13.2%	13.7%	13.0%
Age 55-64	14.0%	13.2%	13.2%	13.2%	15.9%	14.9%	14.5%	13.9%
Age 65+	20.9%	18.0%	15.1%	28.0%	23.8%	22.7%	22.9%	20.5%

The implications for healthcare planning are significant. An aging population increases demand for chronic disease management, geriatric care, home health services, and long-term care facilities. It also underscores the importance of expanding access to aging services, transportation, and social support systems to reduce isolation and promote healthy aging. Healthcare systems and community organizations must proactively adapt to meet the evolving needs of this growing senior population across both states.

Race

Race is a social construct used to group people based on shared physical or social characteristics. While it has no biological basis, understanding racial composition is essential for identifying health disparities and tailoring interventions.

Across the Valley Health service area, the population is predominantly White. In Virginia localities, especially rural areas like Page and Shenandoah counties, there is limited racial diversity, with significantly lower representation of Black and Asian residents compared to state averages. In West Virginia, diversity is more concentrated in Berkeley and Jefferson counties, while rural counties remain largely homogenous.

These patterns have important implications because communities with limited racial diversity may lack culturally competent services or targeted outreach for minority populations. Conversely, areas with greater diversity may require multilingual resources and inclusive programming to address the needs of historically underserved groups.

Understanding the difference in racial makeup is beneficial to better understand the district as a whole, but also each locality and what the potential implications may be. Certain racial groups can be predisposed to health conditions, and understanding a community and its makeup is essential to addressing these health disparities.

* US Census Bureau, American Community Survey. 2019-23.

Total Population by Race Alone*	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
White	61.7%	84.7%	82.4%	92.5%	86.9%	83.7%	69.0%	91.4%
Black	18.8%	6.0%	4.2%	1.9%	2.9%	5.1%	9.2%	4.1%
Asian	6.9%	1.3%	1.9%	0.4%	1.3%	1.2%	2.3%	1.4%
American Indian or Alaska Native	0.3%	0.3%	0.5%	0.1%	0.1%	0.1%	0.3%	0.6%
Native Hawaiian or Pacific Islander	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
Some Other Race	4.1%	4.3%	5.4%	1.2%	2.7%	4.4%	8.1%	0.5%
Two or More Races	8.2%	3.5%	5.5%	4.0%	6.1%	5.5%	11.2%	2.5%

Total Population by Race Alone*	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
White	90.9%	87.8%	85.9%	95.5%	96.5%	93.5%	97.0%	94.3%
Black	3.3%	6.4%	8.5%	1.3%	1.4%	3.6%	1.3%	2.8%
Asian	0.8%	1.9%	1.4%	0.6%	0.4%	0.9%	0.3%	0.6%
American Indian or Alaska Native	0.1%	0.5%	0.4%	0.4%	0.3%	0.2%	0.2%	0.3%
Native Hawaiian or Pacific Islander	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%
Some Other Race	0.5%	0.5%	2.7%	0.5%	0.5%	0.5%	0.5%	0.5%
Two or More Races	4.4%	3.3%	3.7%	2.1%	1.4%	1.7%	1.2%	2.0%

* US Census Bureau, American Community Survey. 2019-23.

Ethnicity

Ethnicity refers to shared cultural traits such as language, ancestry, and traditions. In the U.S., Hispanic/Latino identity is the most commonly measured ethnic category.

In Virginia, the overall percentage of Hispanic/Latino residents in the Valley Health service area aligns with the state average, but this is largely driven by urban areas like Winchester City. Rural counties have lower representation. In West Virginia, Berkeley, Jefferson, and Hardy counties have higher Hispanic/Latino populations, while other counties fall below the state average of 2.0%.

These demographic differences highlight the need for culturally responsive services, particularly in areas with growing Hispanic/Latino populations. Language access, health literacy, and culturally tailored outreach are critical to reducing disparities in care and outcomes.

Total Population by Ethnicity Alone*	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
Hispanic or Latino Population	10.7%	7.1%	11.7%	2.4%	8.8%	6.7%	20.1%	5.1%
Non-Hispanic Population	89.3%	92.9%	88.3%	97.6%	91.2%	93.3%	80.0%	94.9%

Total Population by Ethnicity Alone*	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Hispanic or Latino Population	2.0%	8.0%	6.7%	1.9%	1.8%	4.5%	1.1%	1.3%
Non-Hispanic Population	98.0%	92.0%	93.3%	98.1%	98.2%	95.5%	98.9%	98.7%

* US Census Bureau, American Community Survey. 2019-23.

Gender

The gender distribution across the Valley Health service area is relatively balanced between male and female residents. However, survey respondents were heavily female (73.4%) potentially influencing the prioritization of health concerns such as caregiving, reproductive health, and aging services.

This gender imbalance in survey participation suggests the need for targeted engagement strategies to better capture male perspectives and ensure that health planning reflects the needs of all genders.

Total Population by Gender*	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
Male	**49.4%**	48.7%	50.4%	50.0%	49.1%	50.8%	49.8%	50.5%
Female	**50.6%**	51.3%	49.6%	50.0%	50.9%	49.2%	50.2%	49.5%

Total Population by Gender*	**West Virginia**	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
Male	**49.9%**	49.9%	49.9%	51.0%	51.5%	51.2%	50.2%	49.8%
Female	**50.1%**	50.1%	50.2%	49.1%	48.5%	48.8%	49.8%	50.2%

*US Census Bureau, American Community Survey. 2019-23.

Language Spoken at Home

English is the predominant language spoken at home across the Valley Health service area. However, Winchester City and the West Virginia counties of Berkeley, Jefferson, and Hardy have higher proportions of non-English speakers, particularly Spanish-speaking households.

These linguistic patterns underscore the importance of language access in healthcare and public health communication. While most localities fall below state averages for non-English speakers, the presence of language minorities in specific areas necessitates bilingual staff, translation services, and culturally appropriate materials to ensure equitable access to care.

Language Spoken at Home*	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
English Only	**82.8%**	90.4%	88.3%	96.6%	90.2%	93.2%	79.5%	94.7%
Non-English, All	**17.2%**	9.6%	11.7%	3.4%	9.8%	6.8%	20.5%	5.3%
Spanish	**7.9%**	6.7%	9.3%	2.2%	7.2%	4.6%	15.6%	1.6%
Other Indo-European languages	**3.8%**	1.9%	1.3%	0.4%	1.2%	1.5%	3.7%	2.1%
Asian and Pacific Islander languages	**3.8%**	0.8%	0.9%	0.3%	0.6%	0.5%	0.7%	1.1%
Other languages	**1.8%**	0.2%	0.2%	0.4%	0.7%	0.1%	0.6%	0.5%

Language Spoken at Home*	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
English Only	**97.5%**	93.4%	94.1%	97.9%	99.4%	96.2%	99.0%	98.5%
Non-English, All	**2.5%**	6.6%	5.9%	2.1%	0.6%	3.8%	1.0%	1.5%
Spanish	**0.8%**	2.0%	2.0%	0.8%	0.2%	1.6%	0.8%	0.8%
Other Indo-European languages	**1.1%**	2.1%	2.1%	1.1%	0.2%	1.1%	0.1%	0.4%
Asian and Pacific Islander languages	**0.4%**	1.1%	1.1%	0.2%	0.1%	0.7%	0.1%	0.2%
Other languages	**0.2%**	1.4%	0.7%	0.1%	0.1%	0.4%	0.0%	0.1%

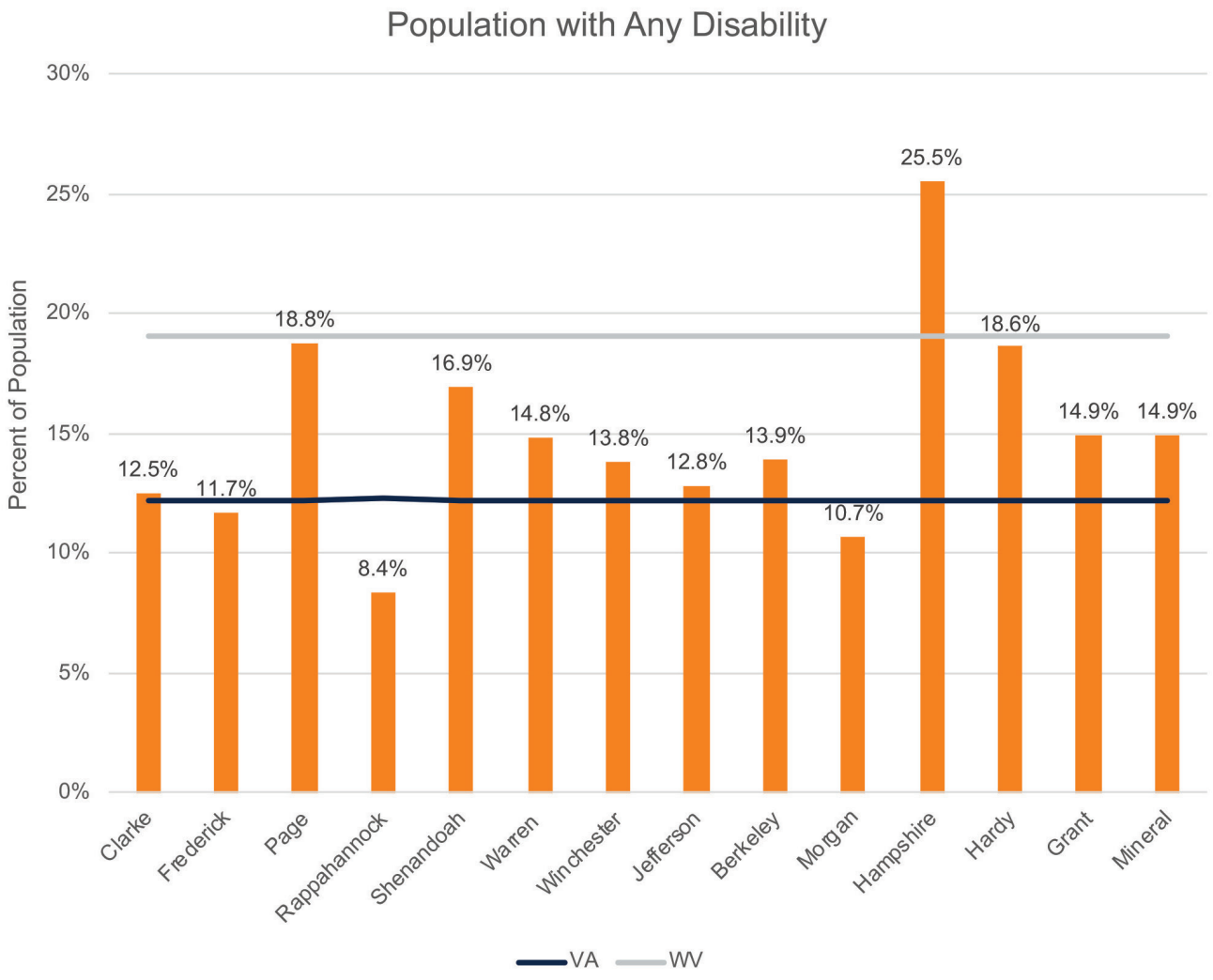
* US Census Bureau, American Community Survey. 2019-23.

Population with Any Disability, Percent*

Disability status is a key indicator of community support needs. Disabilities may include mobility, hearing, vision, cognitive, or self-care limitations.

In Virginia, Page and Shenandoah counties report higher disability rates, likely linked to their older populations. While Clarke and Frederick counties align with the state average (12.3%), the overall LFHD average is higher, indicating a need for expanded supportive services. In West Virginia, Hampshire County has the highest local rate at 25.5%, but all service area counties remain below the state average of 19.1%.

These findings suggest that aging and disability are closely intertwined in rural communities. Ensuring ADA accessibility, transportation, and home-based services will be essential to support independence and quality of life for residents with disabilities.



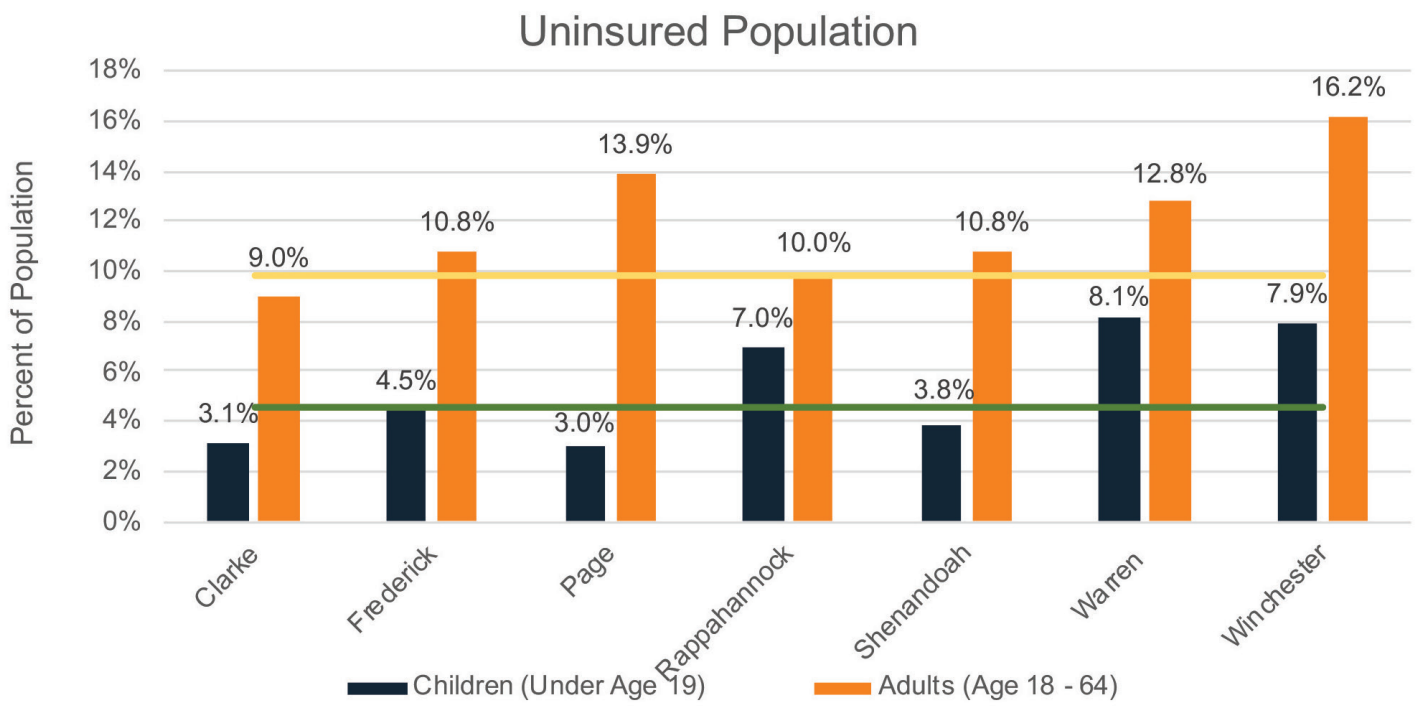
Access to Care

Access to healthcare is a foundational component of community well-being, yet disparities persist across the Valley Health service area. This section explores three key indicators—insurance coverage, provider availability, and life expectancy—to assess how access varies by locality.

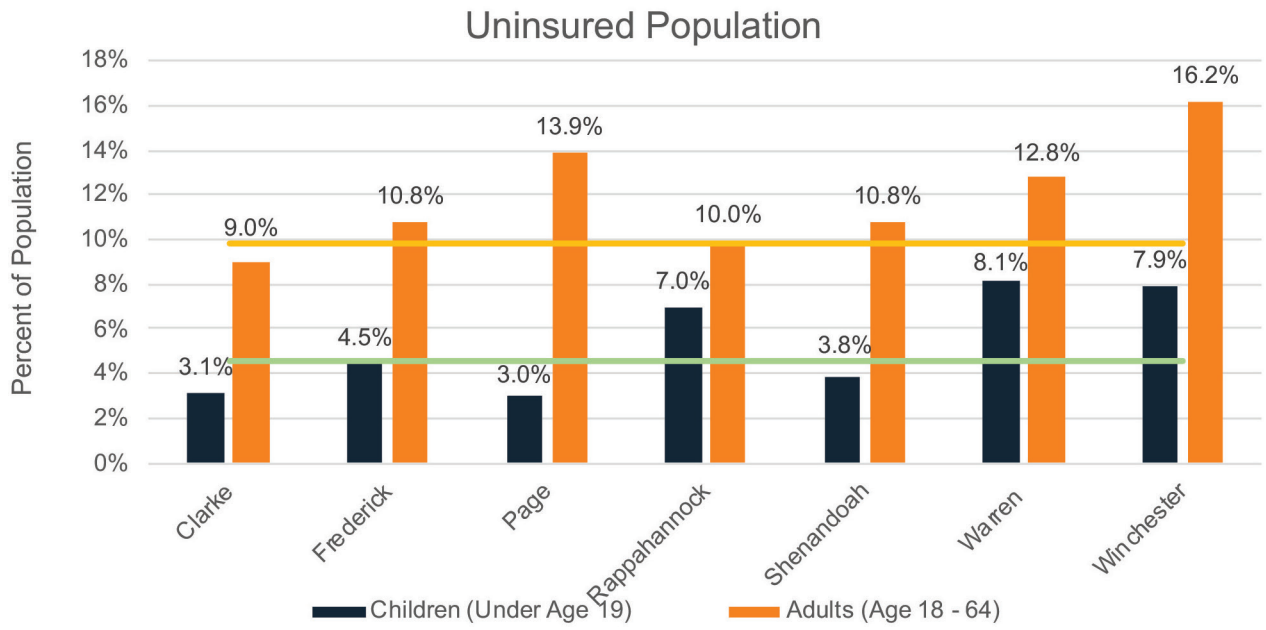
The data reveal a clear pattern: rural and economically disadvantaged localities face significant barriers to care, including higher uninsured rates and fewer healthcare providers. These disparities contribute to poorer health outcomes and lower life expectancy. Addressing these gaps will require targeted investments in provider recruitment, insurance outreach, and transportation infrastructure to ensure equitable access to care across the Valley Health service.

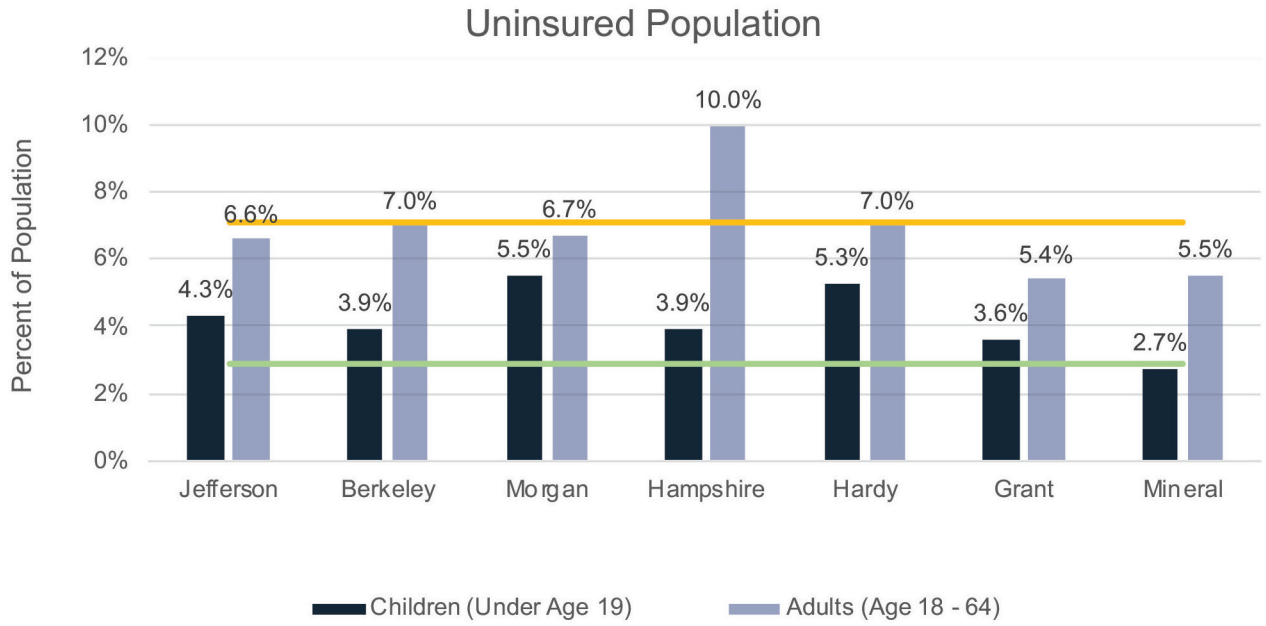
Uninsured Population

Children under 19 in the Valley Health service area experience slightly higher uninsured rates than the Virginia (4.6%) and West Virginia (2.9%) state averages. Notably, Rappahannock, Winchester City, and Warren County report well above the Virginia average, signaling a critical gap in pediatric coverage. In West Virginia, Mineral County is the only in the service area to report below state average. All other counties exceed the state, highlighting similar concerns. Among adults aged 18–64, uninsured rates also surpass state benchmarks. All counties except Clarke exceed Virginia's average of 9.8%, while Hampshire is the only county above West Virginia's 7.1% average. These rates suggest that many working-age adults may delay or forgo care due to cost concerns, increasing the risk of untreated conditions and preventable complications.



* US Census Bureau, Small Area Health Insurance Estimates. 2019-23.


Uninsured Population
Percent of Population
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
9.0%
4.5%
3.1%
10.8%
13.9%
3.0%
10.0%
7.0%
10.8%
3.8%
12.8%
8.1%
16.2%
7.9%
Clarke
Frederick
Page
Rappahannock
Shenandoah
Warren
Winchester
Children (Under Age 19)
Adults (Age 18 - 64)


Uninsured Population
Percent of Population
12%
10%
8%
6%
4%
2%
0%
6.6%
4.3%
7.0%
3.9%
6.7%
5.5%
10.0%
3.9%
7.0%
5.3%
5.4%
3.6%
5.5%
2.7%
Jefferson
Berkeley
Morgan
Hampshire
Hardy
Grant
Mineral
Children (Under Age 19)
Adults (Age 18 - 64)

Healthcare Providers

Provider shortages compound access issues, particularly in rural areas. In Virginia, all localities fall below the state average for primary care, mental health, and dental providers—except Winchester City, which benefits from a concentration of Valley Health services. For example, Page County has only 25 primary care providers per 100,000 residents, compared to 256 in Winchester. Mental health and dental provider rates follow similar patterns, with Winchester far exceeding regional and state averages.

In West Virginia, provider availability is also limited. All counties fall below the state average for primary care and dental providers, with the exception of mental health providers in Berkeley County. Hardy County, for instance, has just 14.1 primary care providers per 100,000 residents—less than one-fifth of the state average. These shortages mean longer wait times, greater travel distances, and reduced access to timely care, particularly for residents without reliable transportation or flexible work schedules.

Healthcare Providers, Rate per 100,000 Population	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
Primary Care Providers*	**74.6**	33.6	44.8	25.2	33.5	58.6	255.9	27.02
Mental Health Providers**	**264.0**	91.0	102.0	55.0	82.0	122.0	822.0	107.53
Dental Providers*	**75.0**	33.0	13.0	17.0	33.0	36.0	243.0	26.67

Healthcare Providers, Rate per 100,000 Population**	**West Virginia**	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
Primary Care Providers	**75.8**	58.14	42.02	52.4	25.8	14.1	63.7	29.8
Mental Health Providers	**196.1**	136.99	208.33	79.4	97.1	76.9	137	85.5
Dental Providers	**58.5**	30.49	50.25	28.6	34.1	35.2	54.6	33.6

* US Department of Health & Human Services, Health Resources and Services Administration, HRSA. 2021.

** Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). 2024.

*** County Health Rankings & Roadmaps, 2025.

Life Expectancy at Birth

Life expectancy reflects the cumulative impact of healthcare access and social determinants of health. In Virginia, Frederick and Rappahannock counties exceed the state average of 77.6 years, while Page County lags behind at 73.9 years. In West Virginia, all localities in the Valley Health service area exceed the state average of 72.1 years, with Jefferson County leading at 75.9 years and Hardy County lowest at 72.7 years.

These variations underscore the relationship between healthcare infrastructure and health outcomes. Counties with better provider access and lower uninsured rates tend to have higher life expectancy, while underserved areas face greater health risks and shorter lifespans.

Life Expectancy at Birth, Years	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
Life Expectancy*	**77.6**	77.3	78.5	73.9	76.6	74.7	74.2	78.8

Life Expectancy at Birth, Years	**West Virginia**	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
Life Expectancy*	**72.1**	75.9	73.3	73.1	74.4	72.7	74.3	73.6

* County Health Rankings & Roadmaps, 2025.

Cancer

Cancer remains a leading health concern across the Valley Health service area, with significant variation in incidence rates by cancer type and geography. The most commonly reported cancers in the region are breast, lung, and colorectal, each presenting unique challenges and disparities.

Breast cancer continues to be the most frequently diagnosed cancer among women in both Virginia and West Virginia. Page (431.4), Shenandoah (414.6) and Winchester (425.6) fall above the state average for Virginia of 412. While the state average for West Virginia is 124.7 per 100,000, several counties in the Valley Health service area fall below this benchmark, including Hampshire (122.8), Hardy (94.7), and Grant (119.9), and Berkeley (122.3) counties, with Jefferson (126.9) county as the only above the state average, indicating a need to maintain and expand access to mammography and early detection services, particularly in rural areas where screening rates are lower.

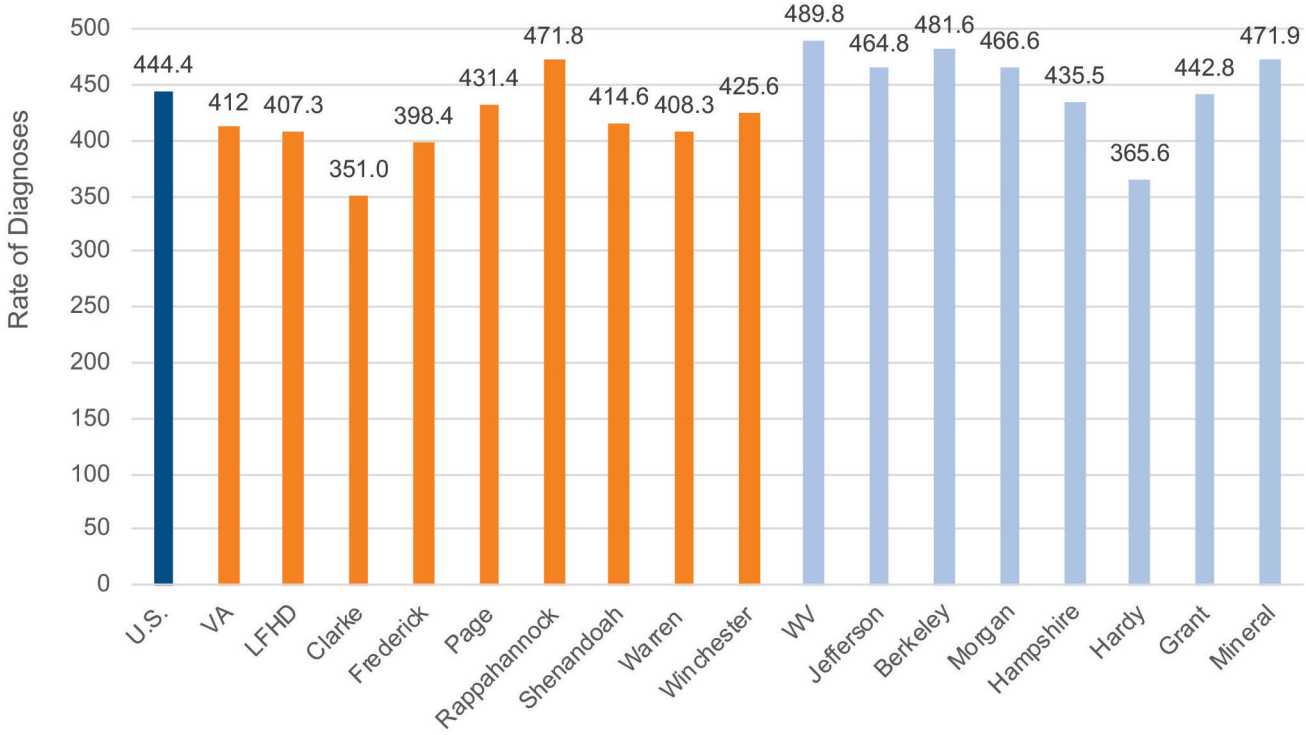
Colorectal cancer, though less common than breast or lung cancer, shows notable geographic disparities. Rappahannock County in Virginia reports a significantly elevated incidence rate of 53.6 per 100,000—well above the Virginia average of 33.9. In West Virginia, most counties fall below the state average of 44.3, but the persistently moderate rates in Jefferson (42.9) Grant (38.3) and Mineral (37.8) suggest opportunities for increased outreach and education around colorectal screening, especially among populations with limited access to preventive care.

Lung cancer remains a critical concern due to its high mortality and strong association with tobacco use. The West Virginia state average of 76.1 per 100,000 is significantly higher than Virginia's 51.4, and several counties in the Valley Health region reflect this burden. Page County, Virginia (70.5), and Morgan County, West Virginia (86.9), both exceed their respective state averages, correlating with high smoking prevalence in these areas. These findings underscore the urgent need for comprehensive tobacco cessation programs and lung cancer screening initiatives, particularly in counties with elevated smoking rates and limited access to pulmonary care.

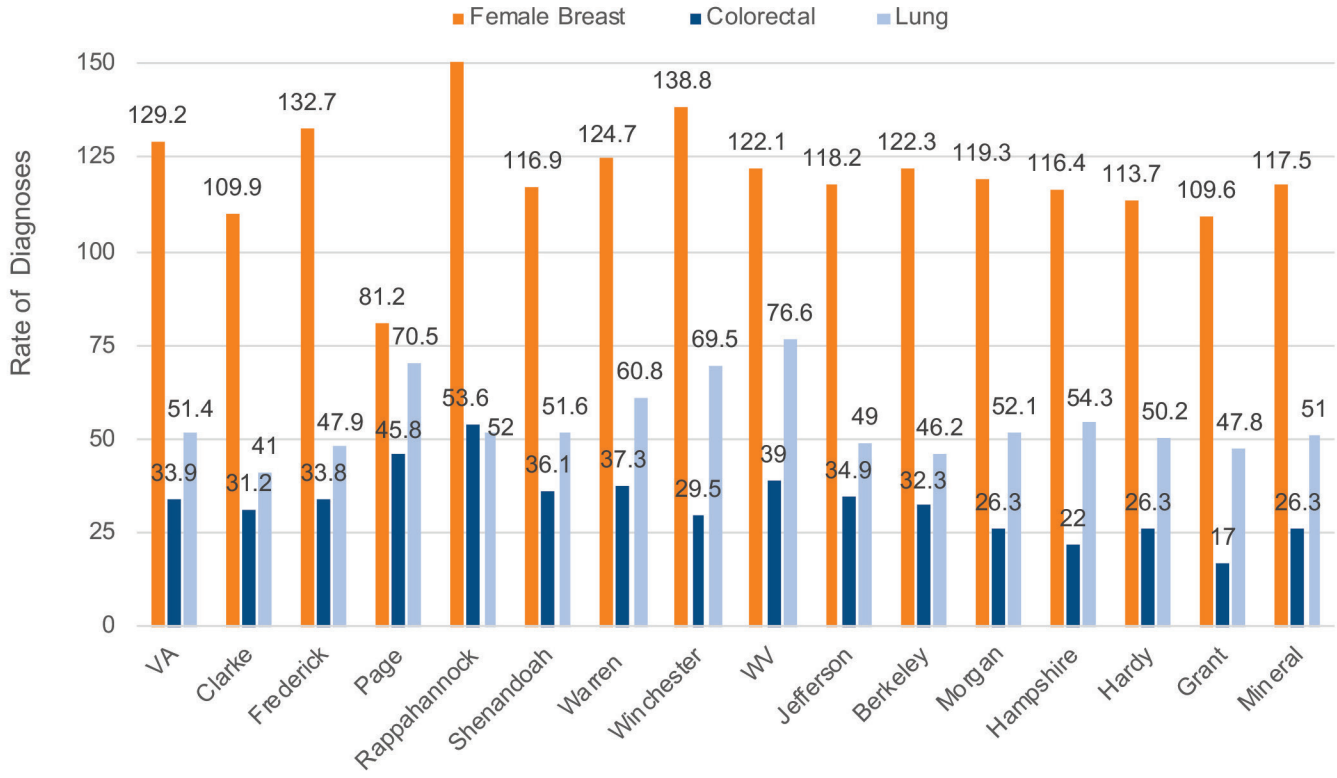
Overall, cancer incidence in the Valley Health service area reflects broader state and national trends, while also revealing localized disparities that require tailored strategies. These include expanding access to cancer screenings (such as mammography, colonoscopy, and low-dose CT for lung cancer), enhancing public education on modifiable risk factors like smoking, diet, and physical inactivity, and improving care coordination for early detection and treatment—especially in rural and underserved communities. Through these efforts, Valley Health and its partners can work toward reducing the cancer burden and improving outcomes for all residents across the region.*

* Virginia Cancer Registry. 2017-2021. WV Office of Epidemiology and Prevention Services, 2016-2020

Overall Cancer Incidence, Rate Per 100,000 Population



Cancer Incidence by Type, Rate Per 100,000 Population



Chronic Conditions

Chronic conditions remain a significant health challenge across the Valley Health service area, with notable variation between Virginia and West Virginia localities. In general, Virginia counties report higher rates of chronic conditions compared to their state average, while many West Virginia counties fall below their state benchmarks—though both regions face persistent health burdens that require targeted attention.

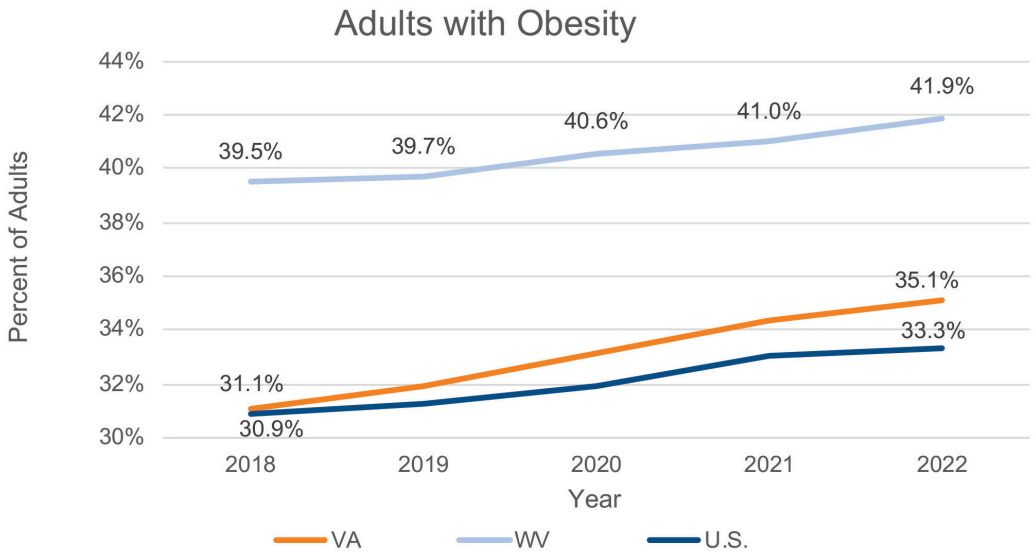
Clarke County in Virginia and Jefferson, Berkeley, and Morgan counties in West Virginia report the fewest chronic conditions above their respective state averages. However, obesity stands out as a widespread concern, with many counties exceeding state averages. This trend is particularly alarming given that obesity rates in the Lord Fairfax Health District (LFHD) have increased by 5% over the past five years, outpacing growth in Virginia, West Virginia, and the U.S. overall.

Chronic Obstructive Pulmonary Disease (COPD) is significantly elevated in Page (8.2%), Warren (7.9%), Shenandoah (8.0%), Hampshire (14.6%) and Grant (17%) counties—areas that also report high smoking rates and elevated levels of total tooth loss among adults 65 and older. These patterns reinforce the link between tobacco use and respiratory and oral health outcomes, highlighting the need for integrated tobacco cessation and dental health programs.

Coronary heart disease rates are also above average in several counties, including Page (6.4%) and Shenandoah (6.3%) in Virginia. These figures point to the need for expanded cardiovascular screening, lifestyle interventions, and chronic disease management—particularly in rural areas where access to care may be limited.

Asthma and high blood pressure are consistently prevalent across the region. Asthma rates hover around or above 10% in nearly all counties, while high blood pressure affects over 30% of adults in most localities—reaching as high as 37.1% in Berkely County, WV. These conditions often co-occur with other chronic illnesses and are influenced by environmental and behavioral factors, including housing quality, air pollution, and physical inactivity.

Diabetes and high cholesterol, while not as widespread, still pose significant risks. Winchester City exceeds the Virginia average for both conditions, with 12.3% of adults diagnosed with diabetes and 32.9% with high cholesterol. In West Virginia, diabetes rates are highest in Hardy (18.0%), Grant (18.7%) and Mineral (16.8%) counties, reflecting the broader burden of metabolic disease in the region.



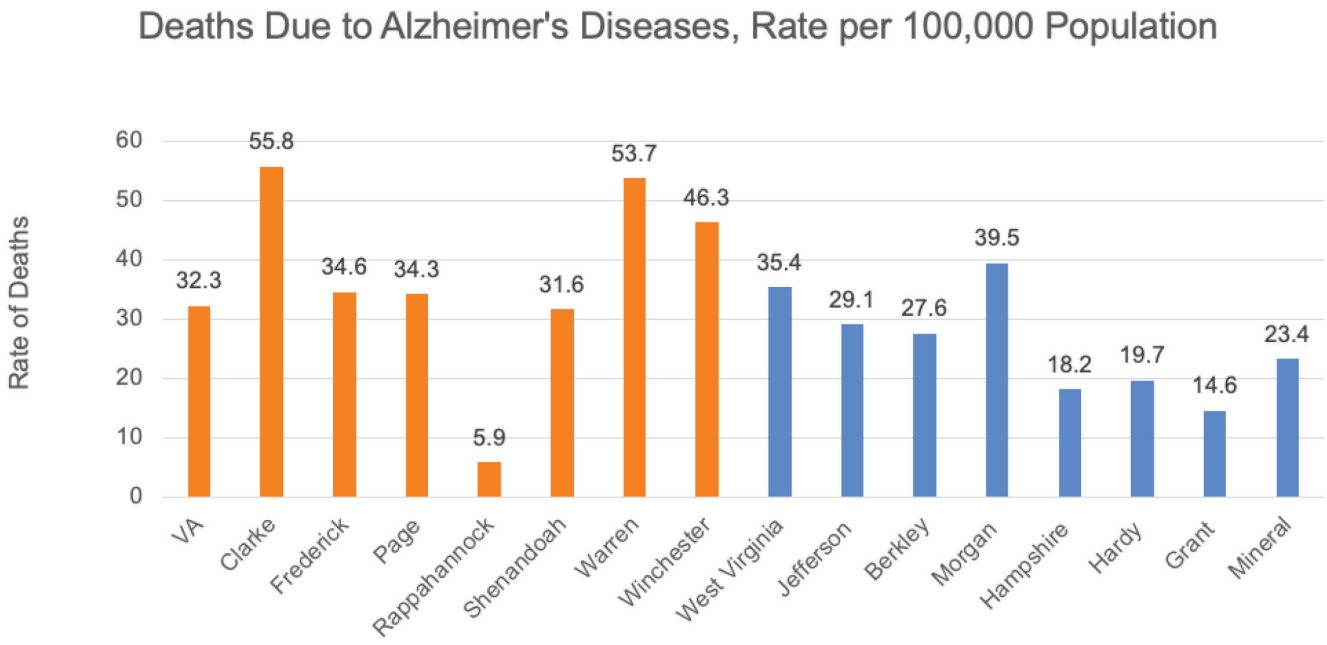
Chronic Conditions, Percent of Population (Age Adjusted)*	Indicator Attribute	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
Chronic Obstructive Pulmonary Disease (COPD)	Adults Age 18+ with	**6.0%**	6.0%	6.9%	8.2%	8.0%	7.9%	7.1%	7.4%
Coronary Heart Disease	Adults Age 18+ Ever Diagnosed	**5.4%**	5.3%	5.7%	6.4%	6.3%	6.2%	6.0%	5.7%
Current Asthma	Adults Age 18+ with	**10.0%**	9.8%	10.5%	10.6%	10.5%	10.6%	10.4%	10.6%
High Blood Pressure	Adults Age 18+ with	**31.5%**	29.9%	32.0%	32.7%	32.4%	31.5%	33.1%	29.1%
High Cholesterol	Adults Age 18+ with	**32.8%**	32.0%	31.6%	32.7%	32.3%	32.6%	32.9%	31.9%
Obesity	Adults Age 18+ with	**35.3%**	34.1%	37.6%	40.2%	37.9%	38.1%	37.9%	36.1%
Ever Having a Stroke	Adults Age 18+	**3.0%**	2.7%	2.9%	3.3%	3.4%	3.3%	3.3%	3.0%
Total Teeth Lost	Adults Age 65+	**11.4%**	7.3%	7.4%	16.4%	11.7%	15.4%	11.0%	10.4%
Diabetes	Adults Age 18+ Ever Diagnosed	**11.4%**	9.7%	11.0%	11.1%	11.4%	11.2%	12.3%	10.7%

*Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.

Chronic Conditions, Percent of Population (Age Adjusted)*	Indicator Attribute	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Chronic Obstructive Pulmonary Disease (COPD)	Adults Age 18+ with	**11.6%**	8.1%	8.6%	11.1%	10.6%	11.0%	9.2%	7.2%
Coronary Heart Disease	Adults Age 18+ Ever Diagnosed	**11.6%**	6.7%	6.7%	7.9%	7.8%	7.7%	6.8%	6.1%
Current Asthma	Adults Age 18+ with	**11.8%**	11.3%	11.6%	12.4%	12.5%	12.5%	11.7%	11.6%
High Blood Pressure	Adults Age 18+ with	**40.2%**	37.1%	35.9%	35.3%	36.6%	35.7%	35.9%	32.7%
High Cholesterol	Adults Age 18+ with	**37.5%**	32.3%	32.8%	32.6%	32.4%	33.7%	31.4%	30.2%
Obesity	Adults Age 18+ with	**39.1%**	40.3%	38.5%	42.0%	42.9%	41.1%	43.1%	34.8%
Ever Having a Stroke	Adults Age 18+	**5.1%**	3.2%	3.1%	3.8%	3.8%	3.7%	3.3%	2.8%
Total Teeth Lost	Adults Age 65+	**20.4%**	15.5%	18.6%	24.3%	24.0%	18.4%	14.2%	14.3%
Diabetes	Adults Age 18+ Ever Diagnosed	**15.6%**	12.2%	11.5%	13.4%	13.9%	13.0%	11.9%	11.9%

*Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.

Alzheimer's disease is another growing concern. Clarke, Warren, and Winchester report death rates from Alzheimer's that exceed the Virginia average, while Morgan County surpasses the West Virginia average. With an aging population across the service area, the need for dementia care, caregiver support, and age-friendly community planning is becoming increasingly urgent.



Infectious Diseases

Infectious disease rates present a compelling narrative about the evolving landscape of communicable diseases in the Northern Shenandoah Valley and Eastern Panhandle of West Virginia. It underscores the persistent and emerging challenges posed by sexually transmitted infections (STIs) and other communicable diseases. Infectious diseases, particularly STIs, remain a pressing public health concern in the Valley Health service area. These conditions affect individuals across all demographics and, if left untreated, can lead to serious complications such as infertility, chronic pain, and increased susceptibility to HIV.

The most recent data reveals a mixed picture.

Chronic Hepatitis C stands out as a significant concern, especially in Winchester, where the rate (210.9 per 100,000) is more than four times the Virginia state average (51.3). Other localities like Warren (107.1) and Page (67.4) also report elevated rates, suggesting a need for expanded screening and long-term care strategies. All counties in West Virginia are below the state average of 214.7 with Berkeley county the highest at 181.9.

Chlamydia remains the most frequently reported STI, with Winchester again leading the region at 525.0 per 100,000—surpassing even the Virginia average of 472.8. This trend is mirrored in Berkeley County, WV (316.4), which also exceeds the West Virginia average of 303.0. These high rates may reflect both increased transmission and better detection in areas with more robust healthcare infrastructure.

Syphilis, particularly in its early stages, is on the rise nationally and locally. While most jurisdictions report rates below the Virginia average (20.8), Winchester again exceeds this benchmark (25.0). This trend is concerning given the resurgence of syphilis nationally and its potential for severe health outcomes if untreated.

Gonorrhea and HIV/AIDS show more localized spikes. Winchester and Berkeley report higher-than-average rates of both, with Winchester's HIV/AIDS rate (271.4) approaching the state average of 337.8. These figures suggest that urban centers may be experiencing more concentrated transmission, possibly due to higher population density, greater testing access, or other social determinants.

Tuberculosis (TB), while less prevalent, still appears sporadically, with Shenandoah County (4.4) and Winchester (3.6) slightly above the Virginia average (2.4). Though numbers are low, TB remains a critical concern due to its potential for outbreaks, especially in vulnerable populations. The West Virginia state average is 0.3, with Berkeley coming in higher at 1.6 individuals per 100,000.

It is important to note the impact of COVID-19 on STI testing and reporting. Testing access was reduced during the height of the pandemic (2020–2021), many clinics reduced hours or temporarily closed, limiting access to routine STI screening and treatment. Resources and personnel were diverted toward COVID-19 response, reducing capacity for STI services. This resulted in reduced testing which led to fewer diagnosed cases in official surveillance data, causing underreporting that masked true STI prevalence.

New Reports of Disease, Rates per 100,000 Population*	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
Acute Hepatitis C	**0.4**	0.0	1.1	0.0	0.0	2.4	3.6	0.0
Chronic Hepatitis C	**51.3**	33.2	59.0	67.4	62.7	107.1	210.9	58.5
Total Early Syphilis	**20.8**	0.0	4.3	12.6	6.7	4.9	25.0	0.0
Chlamydia	**472.8**	116.4	237.5	172.7	272.0	253.3	525.0	118.4
Gonorrhea	**158.3**	38.8	29.2	33.7	31.0	66.9	123.1	29.6
HIV/AIDS Infections**	**337.8**	165.0	140.9	107.5	101.9	185.3	271.4	96.4

New Reports of Disease, Rates per 100,000 Population***	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Acute Hepatitis C****	**6.4**	2.2	1.4	1.4	1.7	1.7	1.4	1.4
Chronic Hepatitis C****	**385.0**	103.0	252.0	26.0	36.0	16.0	11.0	40.0
Total Early Syphilis****	**10.9**	6.8	7.7	0.0	0.0	7.0	0.0	0.0
Chlamydia*****	**303.0**	169.7	316.4	95.1	168.3	341.2	164.2	193.5
Gonorrhea****	**54.7**	33.9	71	57.4	21.3	7	18.2	29.8
HIV/AIDS Infections***	**97**	*	5	0	0	0	0	*

* VDH, Virginia Electronic Disease Surveillance System (VEDSS). Assessed via VEDSS, 2023.
** Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2023.
***West Virginia Department of Health and Human Services, Office of Epidemiology an Preventative Services, 2023.
****West Virginia Department of Health and Human Services, Office of Epidemiology an Preventative Services, 2022.
*****Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2023.

New Reports of Disease, Rates per 100,000 Population*	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
Tuberculosis	**2.4**	0.0	1.1	0.0	4.4	2.4	3.6	0
	West Virginia	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
Tuberculosis*	**.3**	0	1.64	0	0	0	0	0

Health Behaviors

The health behaviors of a community have a direct impact on its overall health outcomes. Risky behaviors, such as smoking or physical inactivity, tend to worsen health outcomes, while preventative behaviors, like regular screenings and healthy eating, contribute to improved health. This relationship is illustrated in the data: Page County has the highest rates of current smokers and has the highest incidence rate of lung cancer in the LFHD. While not every case of lung cancer is caused by smoking, a higher prevalence of smokers in a population is often associated with increased rates of smoking-related diseases, including cancer.

Risky Behaviors

Valley Health service areas exhibit elevated rates of several risky health behaviors compared to state averages, underscoring the need for focused public health interventions. Smoking remains a significant concern, with Page (19.0%), Warren (18.8%), and Shenandoah (17.3%) all exceeding Virginia's average of 13.7%, while in West Virginia, Hardy (26.2%), Berkely (24.8%), and Hampshire (26.1%) surpass their state average of 22.9%.

Binge drinking is elevated in Clarke (21.1%), Page (20.0%), and Warren (19.9%) compared to Virginia's 18.4%, and all West Virginia service area counties exceed their state average of 12.2%, with Jefferson (15.8%) Berkely (15.0%) and Grant (15.6)%0 among the highest counties.

Physical inactivity is widespread in Virginia's service areas, with all localities except Clarke (20.2%) exceeding the state average of 21.0%, including Winchester (24.1%) and Page (23.9%). In West Virginia, Grant (36.7%) is the only county above the state average of 30.0%, suggesting some relative strengths in other areas.

Sleep health is another concern, with insufficient sleep affecting 39.0% of adults in Warren and 38.1% in Shenandoah, both above Virginia's average of 36.8%. In West Virginia, the issue is more pronounced, with Grant (47.3%) and Hardy (43.9%) reporting the highest rates.

* West Virginia Department of Health and Human Services, Office of Epidemiology an Preventative Services, 2023.

These patterns highlight clear areas for targeted health promotion across the Valley Health service area, including tobacco cessation, alcohol misuse prevention, physical activity initiatives, and sleep health education, all of which are essential to improving long-term health outcomes and reducing disparities across the region.

Percent of Adults Age 18+ Engaging in Health Behavior – Risky**	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
Current Smokers	**13.7%**	14.3%	15.5%	19.0%	17.3%	18.8%	15.7%	10.7%
Current E-Cigarette Users**	**7.7%**	-	-	-	-	-	-	-
Smokeless Tobacco Users***	**3.1%**	-	-	-	-	-	-	-
Binge Drinking in the Past 30 Days**	**18.4%**	21.1%	19.7%	20.0%	19.6%	19.9%	18.2%	19.8%
Insufficient Sleep**	**36.8%**	36.5%	36.1%	36.9%	38.1%	39.0%	36.4%	37.7%
No Leisure-Time Physical Activity**	**21.0%**	20.2%	22.6%	23.9%	23.9%	23.7%	24.1%	22.5%

Percent of Adults Age 18+ Engaging in Health Behavior – Risky*	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Current Smokers	**22.9%**	20.7%	24.8%	22.7%	26.1%	26.2%	17.8%	18.5%
Current E-Cigarette Users	**6.6%**	8.1%	7.7%	4.6%	3.8%	1.6%	4.0%	7.2%
Smokeless Tobacco Users	**8.3%**	4.1%	5.6%	5.9%	7.7%	9.4%	11.8%	7.8%
Binge Drinking in the Past 30 Days	**12.2%**	15.8%	15.0%	10.6%	12.3%	10.1%	15.6%	11.0%
Insufficient Sleep**	**41.3%**	37.4%	36.4%	41.6%	40.5%	43.9%	47.3%	38.7%
No Leisure-Time Physical Activity	**30.0%**	15.8%	27.4%	24.8%	26.4%	29.2%	36.7%	26.5%

– Data unavailable or unreliable at locality level

* Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2018-2022.

** Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.

*** Virginia Department of Health, Division of Population Health Data, Behavioral Risk Factor Surveillance Survey, 2022.

Preventative Behaviors

While risky behaviors tend to increase the likelihood of injury, disease, and death, preventive behaviors are essential for improving health outcomes and reducing long-term healthcare costs. Regular screenings, vaccinations, and routine check-ups play a critical role in early detection and disease prevention. Across the Lord Fairfax Health District (LFHD) in Virginia, engagement in preventive health behaviors generally trails state averages, with some notable gaps that highlight opportunities for improvement.

Blood pressure medication use among adults with hypertension is relatively consistent across both Virginia and West Virginia service areas. In Virginia, rates range from 59.0% in Rappahannock to 61.5% in Winchester, aligning with the state average of 61.5%. In West Virginia, rates are slightly higher in some counties, such as Hardy (63.8%) and Hampshire (63.1%), suggesting better adherence to hypertension management in those areas.

Cancer screening rates show more variation. Mammography rates in Virginia dip in Page (72.9%) and Shenandoah (73.0%), while West Virginia counties like Morgan (72.0%) and Hardy (73.7%) show similarly low rates, falling below their respective state averages. Colorectal cancer screening is lowest in Shenandoah (58.0%) and also lags in several West Virginia counties, including Hardy (58.0%) and Hampshire (58.9%), compared to Virginia's 62.8% and West Virginia's average of around 61.5–64.7%. These figures point to a need for increased outreach and access to cancer screening services across both states.

Percent of Population Engaging in Health Behavior – Preventative	**Indicator Attribute**	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
Taking Blood Pressure Medicine*	Adults Age 18+ with Hyperten-sion	61.5%	59.4%	59.7%	60.2%	61.3%	59.7%	61.5%	59.0%
Recent Mammography**	Females Age 50-74	78.3%	78.2%	78.7%	72.9%	73.0%	73.4%	74.6%	73.2%
Colorectal Cancer Screening**	Adults Age 45-75	62.8%	63.6%	63.7%	61.5%	58.0%	59.8%	61.0%	61.3%
Cervical Cancer Screening***	Females Age 21-65	84.3%	85.3%	84.3%	82.2%	82.6%	83.3%	83.2%	84.9%
Recent Dental Visit**	Adults Age 18+	67.5%	69.0%	66.0%	63.3%	63.2%	63.8%	64.0%	63.1%
Recent Cholesterol Screening*	Adults Age 18+	86.2%	84.9%	85.8%	83.5%	83.9%	82.4%	84.5%	85.1%
Annual Checkup in the Past Year**	Adults Age 18+	77.7%	76.3%	76.2%	76.2%	76.3%	75.2%	77.6%	75.5%

* Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2021.
** Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.
*** Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2020.

Percent of Population Engaging in Health Behavior – Preventative	Indicator Attribute	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Taking Blood Pressure Medicine*	Adults Age 18+ with Hypertension	60.1%	60.1%	62.0%	63.1%	63.8%	62.3%	61.6%
Recent Mammography**	Females Age 50-74	78.8%	79.3%	72.0%	77.4%	73.7%	73.6%	78.2%
Colorectal Cancer Screening**	Adults Age 45-75	61.5%	64.7%	59.7%	58.9%	58.0%	61.8%	60.7%
Cervical Cancer Screening*	Females Age 21-65	-	-	-	-	-	-	-
Recent Dental Visit**	Adults Age 18+	61.8%	60.6%	57.9%	52.0%	49.4%	50.0%	55.7%
Recent Cholesterol Screening*	Adults Age 18+	87.3%	86.0%	84.8%	84.7%	83.8%	82.1%	86.0%

Dental care access is a consistent challenge across the region. In Virginia, all LFHD counties fall below the state average of 67.5%, with Page (63.3%) and Shenandoah (63.2%) among the lowest. West Virginia counties report even lower rates, with Hardy (49.4%) and Grant (50.0%) significantly below the state average, indicating a more acute need for dental health services and education in those areas.

Routine checkups and cholesterol screenings are slightly more consistent across both states. Virginia counties hover just below the state average of 77.7% for annual checkups, while West Virginia counties show similar patterns. Cholesterol screening rates are relatively strong in both states, with most counties reporting rates in the low-to-mid 80% range, close to or slightly below their respective state averages.

Immunization

Vaccination rates, however, are a major concern across the entire service area. In Virginia, flu shot participation is well below the state average of 32.3%, with Page (21.4%) and Shenandoah (23.4%) among the lowest. COVID-19 vaccination rates are even more concerning, with Page reporting just 6.8% of the population vaccinated. In West Virginia, COVID-19 vaccination rates are similarly low, ranging from 12.3% in Berkeley to just 3.2% in Hardy and 3.7% in Grant. These figures reflect a widespread hesitancy or access issue that could leave communities vulnerable to future outbreaks. Flu vaccination rates, however, are notably higher in West Virginia counties, with Berkeley (48.0%) and Jefferson (46.0%) exceeding Virginia's average, suggesting stronger uptake of seasonal immunizations in those areas.

Of particular concern are MMR (measles, mumps, rubella) vaccination rates, especially in light of the 2025 measles outbreak in West Texas and recent cases in Virginia. While Virginia's overall MMR coverage is relatively high,

*Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2021.
**Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.

several LFHD counties fall short. Clarke and Warren counties, in particular, report significantly lower rates of MMR series completion among children, which may be linked to rising vaccine exemptions. These gaps in immunization coverage increase the risk of outbreaks of vaccine-preventable diseases and highlight the importance of reinforcing vaccine education and access.

Together, these trends suggest a pressing need to strengthen public health messaging and access to preventive care services across both Virginia and West Virginia service areas. Increasing participation in routine screenings, dental care, and immunizations—especially for flu, COVID-19, and MMR—will be critical to improving community health resilience and preventing the spread of infectious diseases.

Vaccination Rate, Percent of Total Population	**Indicator Attribute**	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
COVID-19*		**13.7%**	12.4%	9.8%	6.8%	9.2%	8.1%	10.4%	12.5%
Flu*		**32.3%**	26.3%	27.3%	21.4%	23.4%	22.4%	27.3%	21.4%
MMR**	2 year olds, at least 1 dose	**89.3%**	83.4%	92.4%	84.1%	76.1%	81.2%	86.3%	95.0%
	5 year olds, series complete	**76.3%**	67.3%	64.0%	81.2%	65.5%	61.2%	75.7%	40.8%
	7 year olds, at least 1 dose	**>95%**	76.9%	81.5%	93.4%	79.2%	78.3%	93.5%	84.5%
	7 year olds, series complete	**84.5%**	69.8%	72.9%	83.5%	68.5%	64.7%	82.8%	76.0%

Percent of Population Engaging in Health Behavior – Preventative* **	**West Virginia**	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
COVID-19	**9.8%**	12.3%	7.9%	6.6%	5.1%	3.2%	3.7%	6.6%
Flu	**43.0%**	46.0%	48.0%	35.0%	38.0%	36.0%	36.0%	45.0%

*Virginia Department of Health, Respiratory Disease Dashboard

**Virginia Department of Health, Virginia MMR Vaccine Dashboard

***West Virginia Department of Health, Respiratory Disease Dashboard

Injury and Violence

Injury-related mortality remains a significant public health concern across the Northern Shenandoah Valley and neighboring West Virginia counties. The data reveal notable disparities in injury death rates, motor vehicle crash fatalities, firearm-related deaths, and homicides.

In the Virginia counties of Clarke, Frederick, Page, Shenandoah, Warren, Winchester, and Rappahannock, injury death rates range from 70 per 100,000 in Frederick County to 133 in Rappahannock County. Most counties exceed the Virginia state average of 75. Motor vehicle crash deaths are also elevated in several counties, with Clarke County reporting the highest rate at 24 per 100,000, more than double the state average of 11 per 100,000. Firearm fatalities are particularly concerning in Page County, which reports a rate of 20 per 100,000, significantly higher than the state average of 13 per 100,000. Although homicide data is limited, Winchester reports a rate of 5 per 100,000, slightly below the state average of 6 per 100,000.

In the bordering West Virginia counties of Jefferson, Berkeley, Morgan, Hampshire, Hardy, Grant, and Mineral, injury death rates are substantially higher than in Virginia. Most counties exceed 125 per 100,000, with Hampshire County reporting the highest at 157 per 100,000. Motor vehicle crash deaths are also elevated, with Grant County peaking at 34 per 100,000. Firearm fatalities are a significant concern in Hardy County, which reports a rate of 30 per 100,000, nearly double the West Virginia state average of 18 per 100,000. Homicide data is again limited, but Berkeley County reports a rate of 5 per 100,000, close to the state average of 6 per 100,000.

These findings highlight the disproportionate burden of injury and violence in rural counties. Motor vehicle crashes and firearm-related fatalities are leading contributors to injury deaths in the region. The presence of data gaps, indicated by missing values, underscores the need for improved local surveillance and reporting systems to better inform prevention strategies and resource allocation.

Injury Indicators, Per 100,000 Population*	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
Injury Deaths	**75**	97	70	104	87	98	84	133
Homicides	**6**	-	2	-	3	-	5	-
Motor Vehicle Crash Deaths	**11**	24	13	21	15	13	9	-
Firearm Fatalities	**13**	-	10	20	15	14	11	-

Injury Indicators, Rate Per 100,000 Population*	**West Virginia**	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
Injury Deaths	**146**	112	141	141	157	125	152	111
Homicides	**6**	3	5	-	-	-	-	-
Motor Vehicle Crash Deaths	**16**	13	14	17	29	25	34	13
Firearm Fatalities	**18**	13	14	17	12	30	-	15

* County Health Rankings & Roadmaps, 2025.

Maternal and Child Health

Maternal and child health is a cornerstone of community well-being and a critical indicator of health equity. Across the Valley Health service area, which spans both Virginia and West Virginia, significant disparities persist in birth outcomes, prenatal care access, and maternal risk factors. These disparities are shaped by geography, socioeconomic status, and systemic barriers to care. The data reveal a complex picture of maternal and child health across the Valley Health service area. While some localities demonstrate strong outcomes, others face persistent challenges.

Infant and Maternal Mortality

In Virginia's Lord Fairfax Health District (LFHD), the overall infant mortality rate (4.4 per 1,000 live births) is better than the state average (5.8). However, localized disparities are stark: Page and Shenandoah counties report rates of 9.6, significantly higher than the state average. In West Virginia, the state average is the same at 5.8, but there is limited data in service area counties.

Maternal mortality in Virginia remains a concern, particularly for Black mothers, who experience a rate of 62.3 per 100,000 live births—nearly double the state average of 34.5. Within LFHD, only Frederick County reported maternal deaths (21.0); all other localities reported zero. West Virginia maternal mortality data was not disaggregated in the CHNA, but related indicators suggest elevated risk.

Birth Outcomes: Low Birth Weight and Preterm Births

Low birth weight and preterm births are key predictors of infant health complications. In Virginia, Winchester City reports the highest rate of low birth weight (9.7%), while Clarke County reports the lowest (1.3%). Preterm birth rates range from 12.3% in Shenandoah to 2.6% in Clarke. In West Virginia, low birth weight rates are 9.8% and in most counties under that state except for Mineral County at 11.4%.

Teen Pregnancy and Prenatal Care

Teen pregnancy remains a challenge across both states. In Virginia, Winchester (28.4) and Page (21.2) exceed the state average of 15.2 per 1,000 females aged 15–19. In West Virginia, Hardy (21.3), Mineral (11.1), Morgan (11.1), Hampshire (12.1), and Grant (14.3) also surpass the state average of 9.5 for age 10-19.

Access to early prenatal care is uneven. In Virginia, Page County has the highest percentage of mothers receiving late or no prenatal care (10.7%). In West Virginia, the issue is more acute: only 8.2% of mothers in Mineral County and 6.1% in Grant County received prenatal care in the first trimester, compared to the state average of 5.5%.

Smoking During Pregnancy

Smoking during pregnancy is a preventable risk factor linked to poor birth outcomes. In Virginia, Page (5.7%) and Warren (4.3%) exceed the state average of 2.6%. In West Virginia, the issue is more widespread: smoking rates during pregnancy range from 6% in Jefferson to 11.9% in Mineral. The state average is 12.4% for the state of West Virginia.

Maternal & Child Health Indicators*	Indicator Attribute	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
Infant Mortality	Rate per 1,000 Live Births	**5.8**	0.0	5.2	9.6	9.6	2.0	0.0
Maternal Mortality	Rate Per 100,000 Live Births	**34.5**	0.0	21.0	0.0	0.0	0.0	0.0
Low Birth Weight	Percent of Total Live Births	**8.5%**	1.3%	6.9%	7.2%	7.8%	6.1%	9.7%
Preterm Births	Percent of Total Live Births	**9.8%**	2.6%	9.0%	8.1%	12.3%	9.0%	10.2%
Neonatal Abstinence Syndrome (NAS)	Rate per 1,000 Birth Hospitalizations	**4.6**	7.6	5.6	10.5	6.4	9.6	5.6
Teen Pregnancy	Age 15-19, Rate Per 1,000 Females	**15.2**	8.4	10.7	21.2	16.4	12.9	28.4
Mothers with Late or No Prenatal Care	Percent of Total Live Births	**5.8%**	4.0%	5.3%	10.7%	9.6%	9.1%	9.8%
Maternal Opioid Use Disorder	Rate Per 1,000 Delivery Hospitalizations	**5.0**	7.6	6.7	15.4	4.3	25.8	5.9
Smoking During Pregnancy	Percent of Total Live Births	**2.6%**	0.7%	1.3%	5.7%	2.9%	4.3%	3.8%

* Virginia Department of Health, Maternal & Child Health Indicator Dashboard. 2023.

Maternal & Child Health Indicators*	Indicator Attribute	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Infant Mortality	Rate per 1,000 Live Births	**5.8%**	-	4.7%	-	-	-	-	-
Low Birth Weight	Percent of Total Live Births	**9.8%**	8.0%	8.6%	7.2%	9.4%	8.4%	5.2%	11.4%
Preterm Births	Percent of Total Live Births	**13.1%**	9.1%	10.2%	9.4%	8.4%	7.0%	9.6%	12.0%
Teen Pregnancy	Age 10-19, Rate Per 1,000 Females	**9.5%**	4.5%	5.2%	11.1%	12.1%	21.3%	14.3%	11.1%
Mothers with Late or No Prenatal Care	Percent of Total Live Births	**5.5%**	-	4.5%	-	-	-	6.1%	8.2%
Smoking During Pregnancy	Percent of Total Live Births	**12.4%**	6.0%	6.0%	8.7%	10.9%	9.1%	7.0%	11.9%

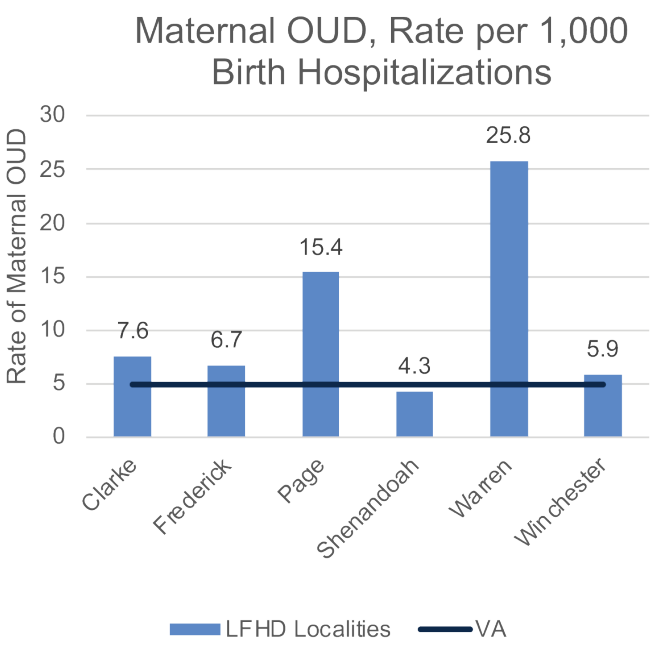
* West Virginia Health Statistics Center, Vital Statistics System. 2023

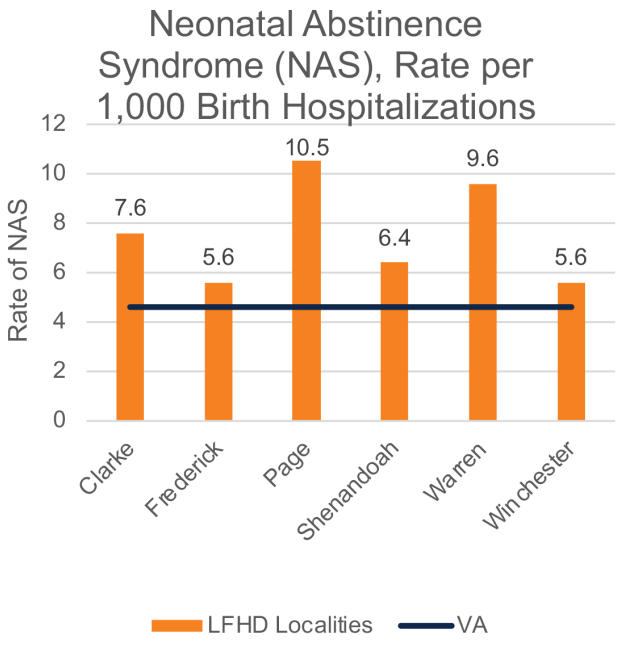
Substance Use and Neonatal Outcomes

Substance use continues to pose serious risks to maternal and infant health across the Valley Health service area. Neonatal Abstinence Syndrome (NAS) rates in Virginia are highest in Page (10.5) and Warren (9.6), more than double the state average of 4.6 per 1,000 births. These rates closely mirror maternal opioid use disorder (OUD) rates, with Warren (25.8) and Page (15.4) far exceeding the Virginia average of 5.0. Shenandoah is the only locality below the state average for both indicators.

In West Virginia, while NAS and OUD rates are not detailed in the CHNA, elevated smoking during pregnancy and teen pregnancy rates suggest similar substance-related challenges. Smoking during pregnancy is notably high in Hampshire (16.7%), Hardy (15.9%), and Grant (15.0%), compared to Virginia's average of 2.6%.

These trends highlight the urgent need for integrated maternal health and substance use services, including early screening, treatment access, and community-based support. Addressing these issues is essential to improving birth outcomes and reducing long-term health risks for both mothers and infants.





Mental Health and Substance Use Disorder

Mental health and substance use remain deeply interconnected and pressing public health challenges across the Valley Health service area. Data from both Virginia and West Virginia counties reveal elevated rates of mental distress, depression, suicide, and substance-related mortality, underscoring the urgent need for expanded services, community-based interventions, and stigma reduction.

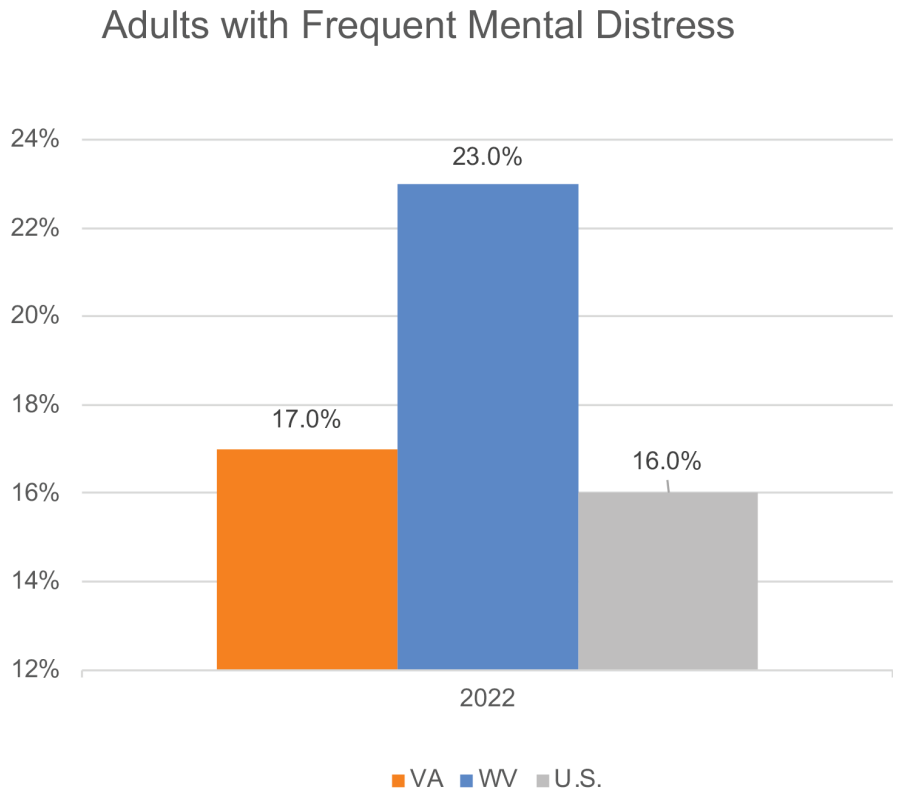
Across the region, frequent mental distress affects a significant portion of the population, with rates ranging from 18% to 24%—consistently above the Virginia state average of 17% and approaching or exceeding West Virginia's 23%. Depression is similarly widespread, with prevalence rates exceeding 25% in nearly all counties, and reaching as high as 31.6% in Grant County, WV. These figures reflect a growing mental health burden that is particularly acute in rural areas, where access to care is often limited.

Suicide rates further highlight the severity of the crisis. Clarke County, VA reports a suicide death rate of 32.3 per 100,000—more than double the state average of 14.2. Other counties, including Page (21.1), Hardy (28.3), and Morgan (20.7), also report rates well above state benchmarks. These deaths are not isolated incidents but indicators of systemic gaps in mental health support, crisis intervention, and community resilience.

Substance use is a compounding factor. Drug overdose deaths in Page (33.4) and Winchester (28.9) exceed the Virginia average of 28.7 per 100,000. In West Virginia, overdose mortality is even more alarming, with state rates at 73.1 per 100,000 and counties like Berkeley and Jefferson reporting high emergency department (ED) visit volumes. These trends are mirrored in ED visit rates, where Page, Shenandoah, and Warren counties all exceed the state average of 57.8 per 100,000.

Alcohol-impaired driving deaths also remain a concern, particularly in rural counties. Morgan County, WV reports that 43% of all driving deaths involve alcohol. These figures suggest a need for stronger prevention efforts, enforcement, and community education.

The data also reveal a troubling correlation between mental health distress and substance use. Counties with high rates of depression and suicide often also report elevated overdose deaths and ED visits. This pattern is especially pronounced in Page County, which consistently ranks among the highest in mental distress, depression, suicide, and overdose indicators.

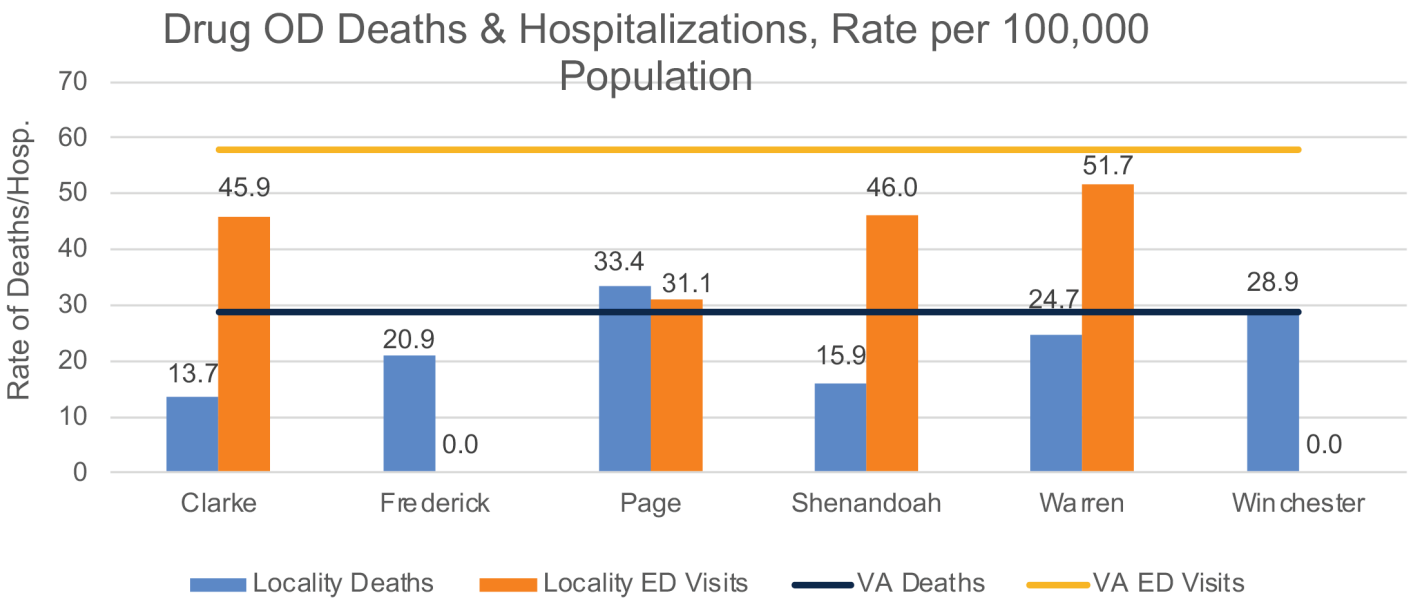


Mental Health Indicators	Indicator Attribute	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
Frequent Mental Distress*	Percent	**17%**	18%	19%	20%	19%	20%	18%
Depression**	Percent, Adults Age 18+	**23.0%**	25.2%	26.5%	27.0%	26.3%	26.3%	24.5%
Deaths Due to Suicide***	Rate Per 100,000 Population	**14.2**	32.3	16.7	21.1	13.3	11.9	10.9
Drug Overdose Deaths (All Substances)**	Rate per 100,000 Population	**28.7**	13.7	20.9	33.4	15.9	24.7	28.9
Drug Overdose ED Visits**	Rate per 100,000 Population	**57.8**	45.9	48.2*	31.1	46.0	51.7	48.2*
Alcohol-Impaired Driving Deaths****	Rate per 100,000 Population	**1.6**	5.4	3.9	3.4	3.2	1.0	0.0

*Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.
**Virginia Department of Health, Drug Overdose Dashboard. 2023.
***Virginia Department of Health, Injury and Violence Deaths. 2023.
****US Department of Transportation, National Highway Traffic Safety Administration, Fatality Reporting System. 2018-2022.

Mental Health Indicators[31]	Indicator Attribute	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Frequent Mental Distress*	Percent	**23%**	19%	20%	21%	23%	24%	24%	22%
Depression**	Percent, Adults Age 18+	**31.1%**	25.1%	26.1%	28%	29.7%	29%	30.4%	27.6%
Deaths Due to Suicide***	Rate Per 100,000 Population	**20**	18	18	22	16	29	–	19
Drug Overdose Deaths (All Substances)****	Rate per 100,000 Population	**78**	55	77	63	60	48	48	44
Drug Overdose ED Visits	2024 Count	**6073**	104	378	41	34	–	49	96
Alcohol-Impaired Driving Deaths	Percent of total driving deaths	**26%**	29%	35%	43%	19%	29%	32%	9%

*Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.
**Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2018-2022.
***National Institute on Minority Health and Health Disparity, HDPulse. 2019-2023
****West Virginia Health Statistics Center, Vital Statistics System. 2023.


Drug OD Deaths & Hospitalizations, Rate per 100,000 Population
Rate of Deaths/Hosp.
70
60
50
40
30
20
10
0
45.9
13.7
20.9
0.0
33.4
31.1
46.0
15.9
51.7
24.7
28.9
0.0
Clarke
Frederick
Page
Shenandoah
Warren
Winchester
Locality Deaths
Locality ED Visits
VA Deaths
VA ED Visits

Social Drivers of Health

The health of individuals and communities is shaped not only by access to medical care but also by the broader social and environmental conditions in which people live, work, learn, and by age. These Social Drivers of Health (SDOH)—also referred to as social determinants of health—include housing, transportation, food access, education, employment, and social support. They are foundational to health outcomes and are deeply intertwined with the disparities observed across the Valley Health service area.

Housing and Economic Stability

Housing affordability and availability emerged as critical concerns. In Winchester City, 33.8% of households are cost-burdened, significantly higher than the Virginia average of 26.7%. Page County and Shenandoah County also report elevated burdens at 24.9% and 24.7%, respectively. In contrast, West Virginia counties such as Morgan and Hardy report lower cost burdens (6.3% and 7.2%), but face challenges like long commute times and limited housing stock.

Economic hardship is widespread. Winchester City's total poverty rate is 19.3%, nearly double the Virginia average of 9.9%, and its child poverty rate is 29.2%. In West Virginia, Hardy and Grant counties report total poverty rates of 17.6% and 16.6%, respectively. These figures reflect systemic barriers to health, including limited access to childcare, job training, and stable employment..

Food Access and Transportation

Food insecurity is a persistent issue. Winchester City leads the region with a rate of 17.1%, followed by Page (13.8%) and Shenandoah (13.9%) counties. In West Virginia, Hardy (15.1%) county is the highest rate, but the state rate is significantly higher at 15.7%. These rates reflect both economic constraints and geographic barriers to accessing nutritious food.

Transportation challenges compound these issues. In Warren County, 59.0% of residents face long commutes, the highest in the region. Hampshire county reports long commute rates at 68% the highest for all service areas, limiting access to healthcare, employment, and essential services.

Social Isolation and Community Context

Social isolation is a growing concern, particularly among older adults and rural residents. In Shenandoah County, 20.1% of residents report experiencing social isolation or lacking a support system. This isolation is linked to poorer mental health outcomes and reduced quality of life.

Education and Workforce Development

Educational attainment varies widely. Page County has the highest percentage of adults without a high school diploma (16.1%) and the lowest rates of higher education, correlating with poorer health outcomes and limited economic mobility. In contrast, Clarke and Jefferson counties report higher levels of educational attainment, which are associated with better health indicators.

Workforce development is a key opportunity. Median household incomes across the region fall below the living wage for a household with one adult and two children. For example, Page County's median income is $27,870, while the living wage is $41,870. This gap underscores the need for job training and employment support programs.

Organizational Capacity and Community Response

Community organizations are actively addressing SDOH, with 43.8% focusing “a lot” on economic stability and 41.2% on healthcare access. However, fewer organizations are engaged in education access (12.5%) and social/community context (11.8%), highlighting areas for growth.

Capacity challenges persist. Only 63% of organizations can serve non-English-speaking populations, and 21% are not fully ADA accessible. These limitations hinder service delivery to marginalized groups.

Poverty, Percent*	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
Total Population in Poverty	**9.9%**	6.9%	7.1%	9.5%	12.3%	11.3%	19.3%	9.5%
Children in Poverty	**12.7%**	8.8%	9.0%	7.4%	20.0%	17.5%	29.2%	14%

Poverty, Percent*	**West Virginia**	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
Total Population in Poverty	**16.7%**	9.0%	12.6%	11.0%	14.2%	17.6%	16.6%	14.3%
Children in Poverty	**21.4%**	10.9%	12.7%	18.0%	25.2%	22.2%	21.9%	19.8%

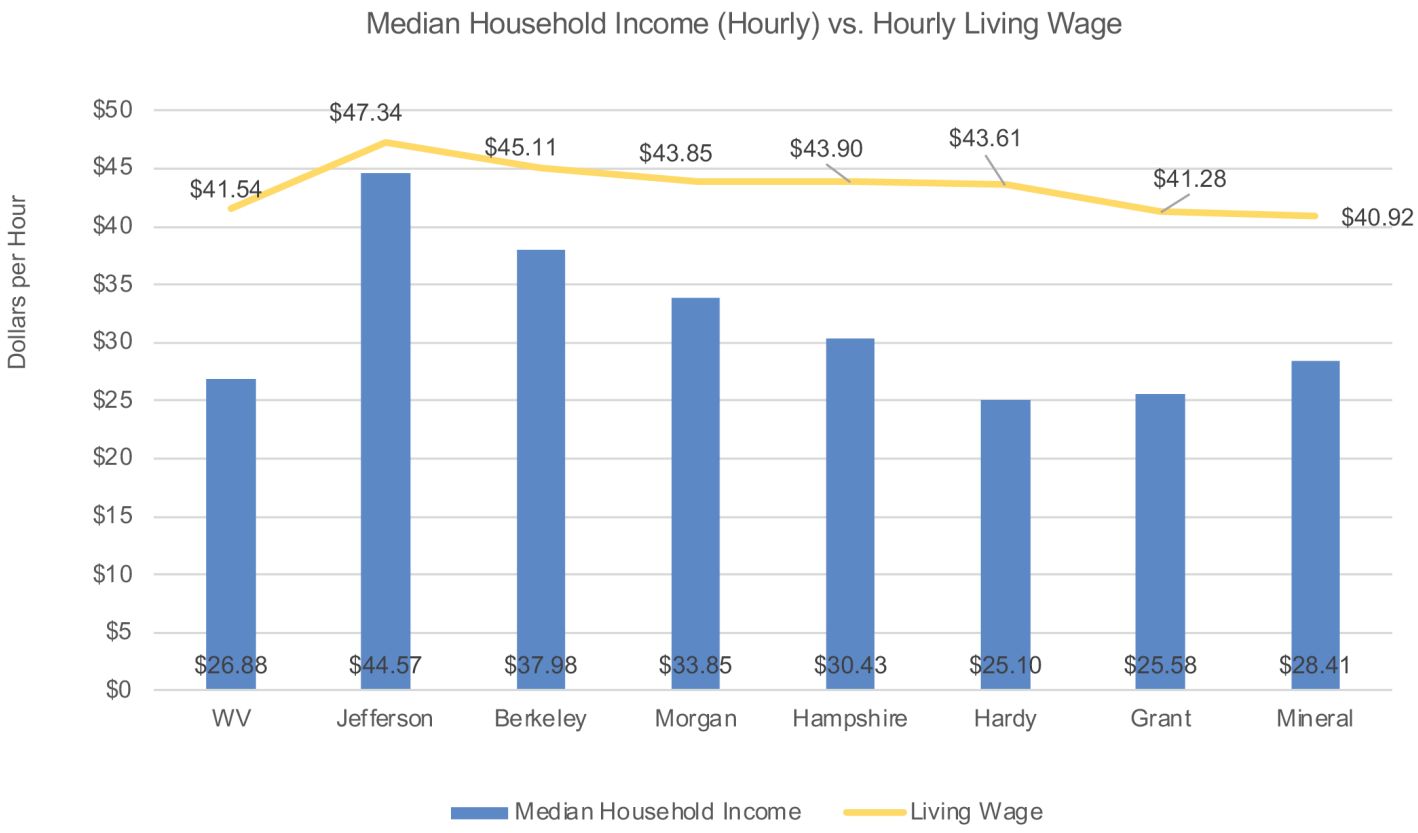
* US Census Bureau, American Community Survey. 2019-23.

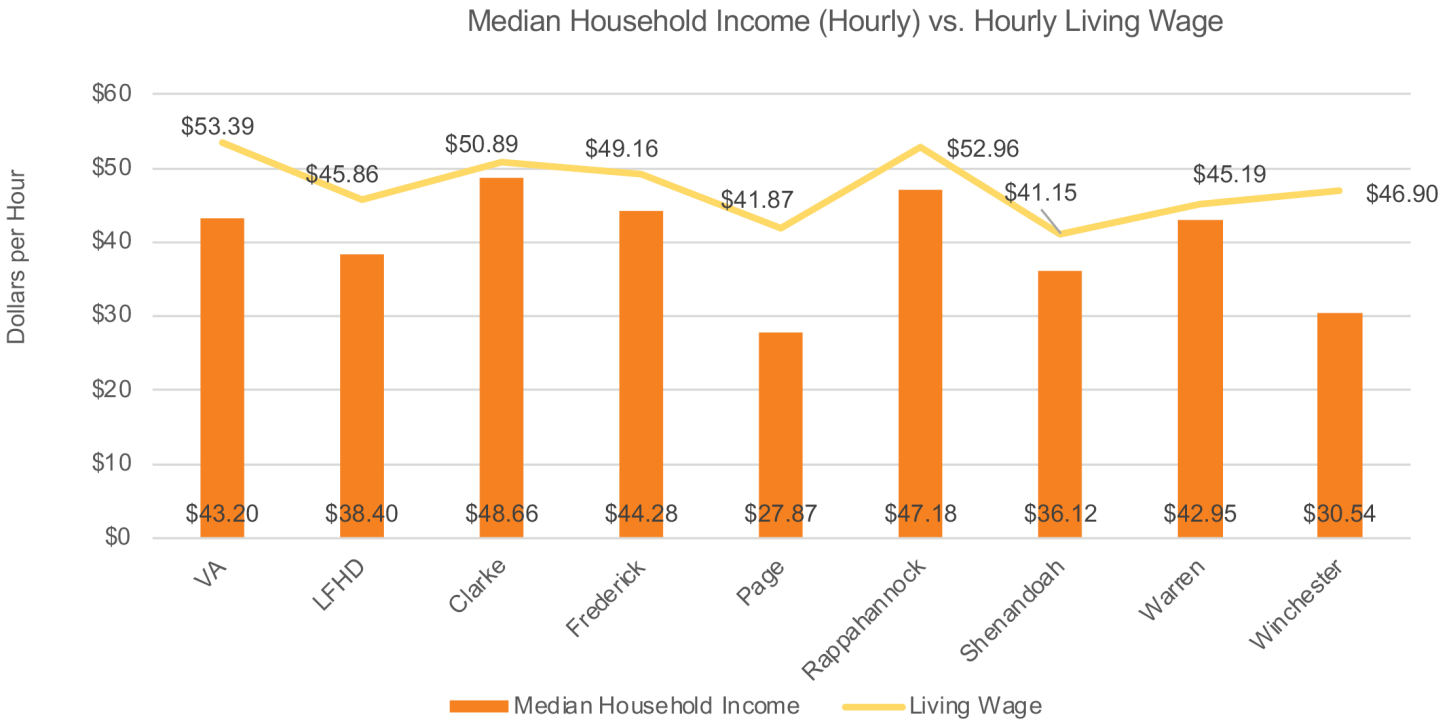
Social Drivers of Health Indicators, Percent*	Indicator Attribute	West Virginia	Jefferson	Berkeley	Morgan	Hampshire	Hardy	Grant	Mineral
Cost Burdened Households		**10.3%**	10.6%	10.1%	6.3%	7.2%	8.0%	7.8%	7.4%
Children in Single-Parent Households		**24.1%**	35.4%	26.4%	33.7%	30.5%	36.7%	25.0%	31.2%
Children Enrolled in Preschool	Age 3-4	**4.7%**	3.5%	3.3%	4.6%	2.9%	2.2%	7.7%	4.4%
Long Commute Driving Alone		**35.0%**	58.0%	40.1%	59.0%	68.0%	34.0%	31.0%	29.0%
Food Insecurity**		**15.7%**	10.2%	11.7%	11.8%	14.8%	15.1%	13.0%	13.4%

Social Drivers of Health Indicators, Percent*	Indicator Attribute	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock
Cost Burdened Households		**26.7%**	21.8%	19.2%	24.9%	24.7%	25.3%	33.8%	21.2%
Children in Single-Parent Households		**23.6%**	12.6%	21.6%	17.3%	25.3%	19.3%	32.7%	8.7%
Children Enrolled in Preschool	Age 3-4	**46.1%**	41.2%	40.5%	46.7%	50.9%	41.0%	41.2%	43.1%
Long Commute Driving Alone		**40.0%**	54.0%	40.0%	48.0%	46.0%	59.0%	21.0%	59.0%
Food Insecurity**		**11.0%**	10.0%	10.0%	14.0%	14.0%	13.0%	16.0%	11.2%

* US Census Bureau, American Community Survey. 2019-23.

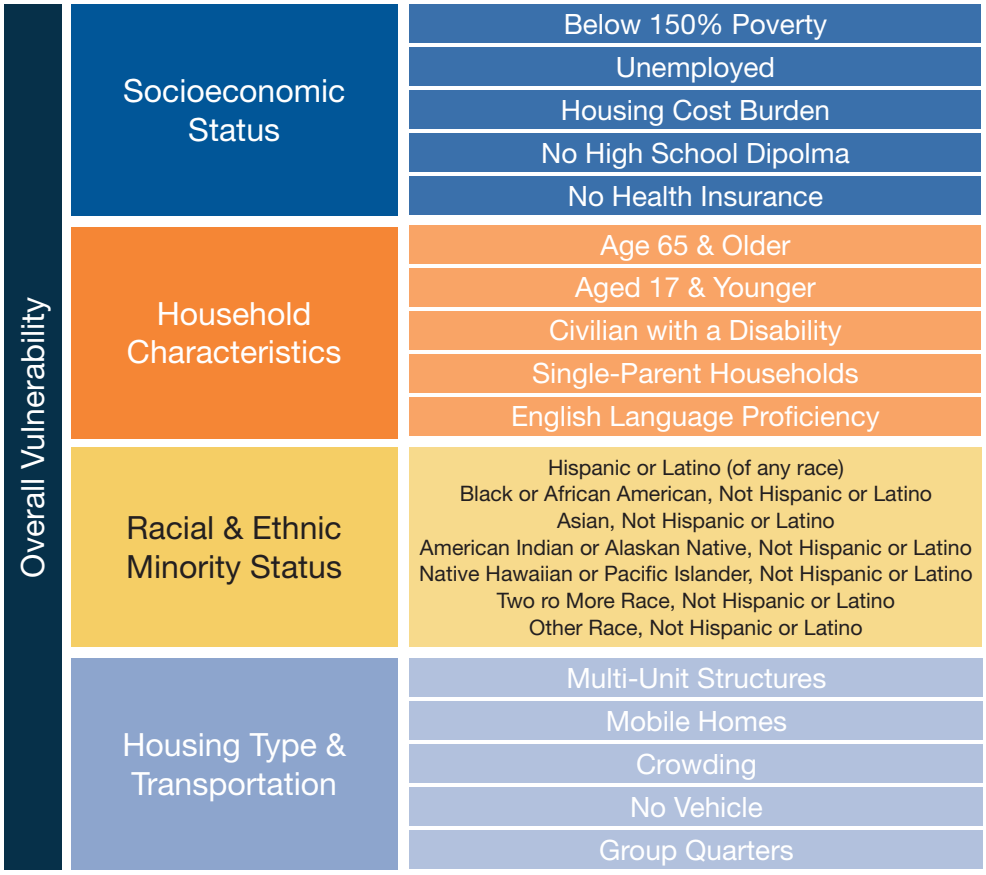
** Feeding America, Map the Meal Gap. 2023.


Median Household Income (Hourly) vs. Hourly Living Wage
Dollars per Hour
$50
$45
$40
$35
$30
$25
$20
$15
$10
$5
$0
$41.54
$47.34
$45.11
$43.85
$43.90
$43.61
$41.28
$40.92
$26.88
$44.57
$37.98
$33.85
$30.43
$25.10
$25.58
$28.41
WV
Jefferson
Berkeley
Morgan
Hampshire
Hardy
Grant
Mineral
Median Household Income
Living Wage


Median Household Income (Hourly) vs. Hourly Living Wage
Dollars per Hour
$60
$50
$40
$30
$20
$10
$0
$53.39
$45.86
$50.89
$49.16
$41.87
$52.96
$41.15
$45.19
$46.90
$43.20
$38.40
$48.66
$44.28
$27.87
$47.18
$36.12
$42.95
$30.54
VA
LFHD
Clarke
Frederick
Page
Rappahannock
Shenandoah
Warren
Winchester
Median Household Income
Living Wage

Social Vulnerability Index

The Social Vulnerability Index (SVI), developed by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR), is designed to identify communities that may require additional support during public health emergencies and disasters. At the core of this index is the variable RPL_THEMES, which represents the overall percentile ranking of social vulnerability for a given geographic unit.



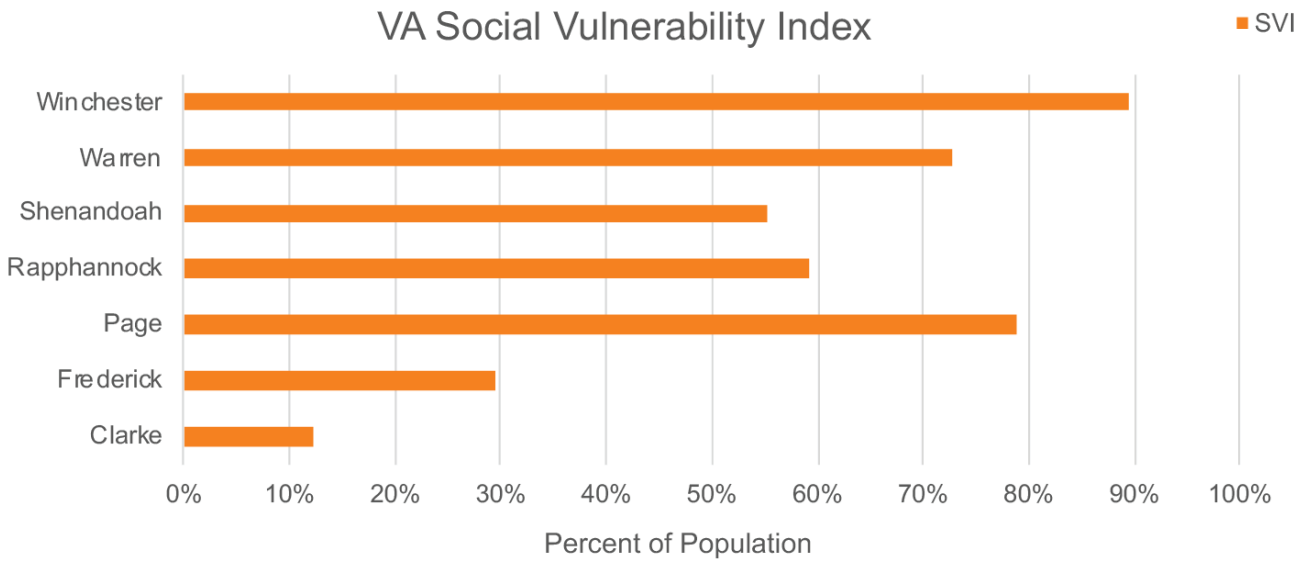
The SVI is based on 16 variables sourced from the U.S. Census Bureau's American Community Survey (ACS). These variables are organized into four thematic domains: socioeconomic status; household composition and disability; minority status and language; and housing type and transportation. Each domain captures a distinct dimension of vulnerability, reflecting factors such as poverty, age, language barriers, and housing conditions. To construct the index, each variable is first transformed into a percentile rank within the geographic scope (either state or national). These ranks, known as empirical percentiles (EPLs), indicate how a community compares to others in terms of vulnerability for that specific variable.

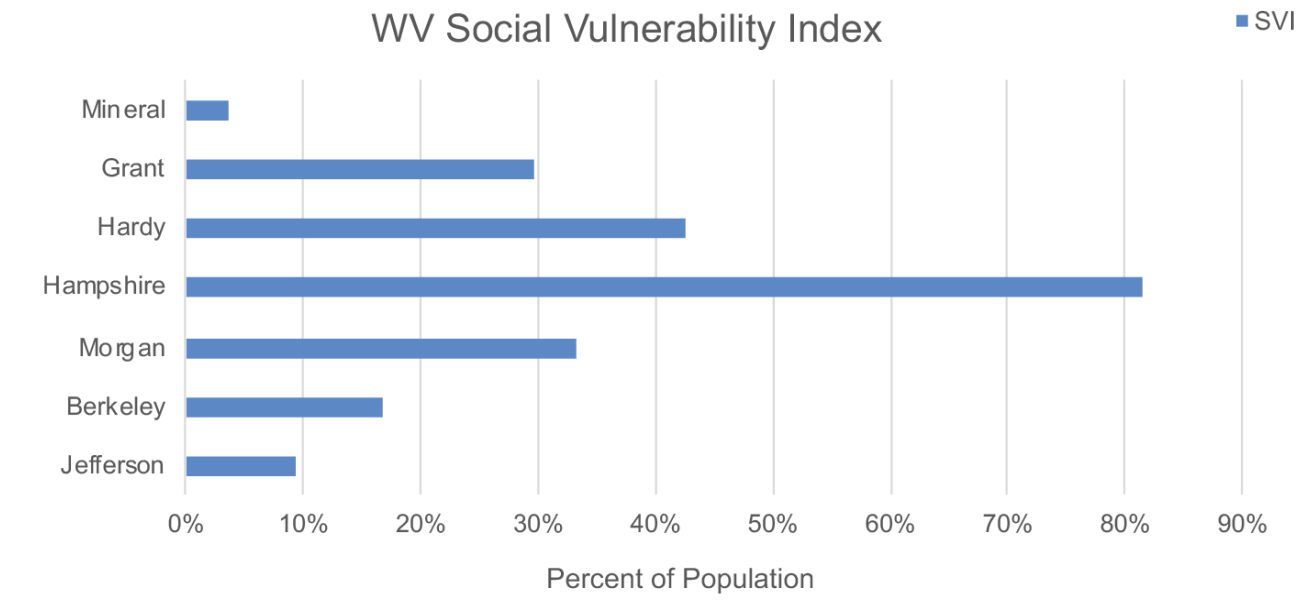
Within each theme, the EPLs of the constituent variables are summed to produce a raw theme score. These raw scores are then ranked to generate theme-specific percentile scores, labeled RPL_THEME1 through RPL_THEME4. The four raw theme scores are also summed to create a composite vulnerability score, which reflects the cumulative burden of vulnerability across all themes. This composite score is then ranked among all geographic units to produce the final RPL_THEMES value. This value ranges from 0 (least vulnerable) to 1 (most vulnerable), offering a comprehensive measure of overall social vulnerability.

The RPL_THEMES score serves as a critical tool for public health officials, emergency planners, and policymakers. It enables data-driven decision-making by highlighting communities that may face disproportionate challenges during crises, thereby supporting equitable resource allocation and targeted intervention strategies.

Hampshire, Page and Winchester City show the greatest cumulative burden of vulnerability, suggesting higher needs for community support and resources; while Mineral, Jefferson, Clarke, and Frederick show the lowest cumulative burden of vulnerability*

* Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2022.


VA Social Vulnerability Index
SVI
Winchester
Warren
Shenandoah
Rapphannock
Page
Frederick
Clarke
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Percent of Population


WV Social Vulnerability Index
SVI
Mineral
Grant
Hardy
Hampshire
Morgan
Berkeley
Jefferson
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Percent of Population

Education

Adult education levels are closely linked to the overall health and well-being of a community. Higher educational attainment is associated with better health outcomes, greater access to healthcare, and healthier lifestyles. In contrast, communities with lower education levels often face economic challenges, limited job opportunities, and increased rates of chronic illness. Education also plays a key role in shaping the health and future success of the next generation. Expanding adult education opportunities can help reduce health disparities and strengthen a community's long-term resilience.

Adult Education Level, Percent*	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**	**Rappahannock**
No High School Diploma	**8.7%**	7.2%	10.9%	16.1%	11.0%	11.0%	13.5%	7.5%
High School Only	**23.9%**	27.7%	30.8%	46.1%	41.1%	34.6%	28.8%	26.1%
Some College	**18.2%**	20.9%	20.6%	16.9%	18.3%	23.4%	20.1%	17.5%
Associate's Degree	**7.8%**	7.0%	7.4%	5.7%	8.3%	6.5%	6.0%	6.9%
Bachelor's Degree	**23.3%**	23.2%	17.9%	9.4%	12.3%	15.0%	18.0%	22.4%
Graduate or Professional Degree	**18.2%**	14.1%	12.4%	5.9%	9.1%	9.6%	13.6%	19.6%

Adult Education Level, Percent*	**West Virginia**	**Jefferson**	**Berkeley**	**Morgan**	**Hampshire**	**Hardy**	**Grant**	**Mineral**
No High School Diploma	**11.9%**	9.4%	10.2%	13.1%	12.8%	13.5%	14.2%	11.7%
High School Only	**31.2%**	28.3%	29.7%	32.5%	30.9%	33.1%	34.0%	30.2%
Some College	**19.4%**	20.1%	19.8%	18.7%	19.2%	18.9%	17.6%	19.0%
Associate's Degree	**6.5%**	7.2%	6.8%	6.1%	6.3%	6.0%	5.9%	6.4%
Bachelor's Degree	**17.1%**	20.5%	18.9%	15.2%	16.3%	15.0%	14.8%	16.7%
Graduate or Professional Degree	**13.9%**	14.5%	13.6%	11.4%	12.3%	11.5%	10.5%	12.0%

In the table above, Page, Morgan, Hardy and Grant Counties stand out with percentages that are discrepant to the state averages. Page county does have the highest percentage of adults without a high school diploma (16.1%) and the most adult residents with only a high school education (46.1%), far above state averages. In contrast, Clarke County closely mirrors the Virginia state average, with strong rates of bachelor's (23.2%) and graduate degrees (14.1%) similar to Berkeley and Jefferson counties in West Virginia .

* US Census Bureau, American Community Survey. 2019-23.

Mineral, Jefferson and Rappahannock are the only counties that do not fall short of state averages in higher education, with Page particularly low, with 9.4% earning a bachelor's and 5.9% earning a graduate degree.

These gaps highlight how educational attainment, and the opportunities it brings, varies widely across the region.

Identified Community Health Needs

HEALTH

- Healthcare Access
- Cancer & Early Detection
- Diabetes
- Obesity
- Dental & Tooth Loss
- Chronic Hepatitis C
- Substance Use Disorders
- Mental Health

BEHAVIORS

- Smoking & Nicotine Use
- Binge Drinking
- Lack of Physical Activity
- Motor Vehicle Deaths & Hospitalizations

SDOH/COMMUNITY

- Aging Resources
- Poverty & Cost Burden
- Food Insecurity & Access to Healthy Foods
- Housing Access, Costs, & Homelessness
- Transportation
- Social Isolation

Appendices

Appendix A: Results

The 2025 Community Health Needs Assessment (CHNA) for Valley Health paints a comprehensive picture of health across the Northern Shenandoah Valley and Eastern Panhandle of West Virginia. Drawing from community surveys, partner interviews, and public health data, the report identifies key health challenges, disparities, and opportunities for action.

Community Health Insights

Across the region, physical health remains the top concern, with cancer and heart disease consistently reported as the most pressing conditions. However, in Winchester City, mental health emerged as the leading issue—likely influenced by a younger respondent base. Obesity was the top concern among middle-aged adults and higher-income households, while diabetes was most frequently cited by Black/African American and Hispanic/Latino respondents.

Health behaviors such as alcohol use, illegal drug use, and poor diet were widely reported, with some variation by locality and demographic group. Housing costs, access to healthy foods, and social isolation were the most cited environmental concerns, particularly among low-income and single-person households.

Economic instability was a common thread, with low income identified as the top concern in every locality. Notably, men were more likely to cite food insecurity, while women emphasized homelessness. Overdose was the leading perceived cause of early death in Warren and Winchester, especially among younger adults and larger households.

When asked how to improve community health, residents overwhelmingly prioritized increased access to mental health services, healthcare, and affordable housing. Non-English speakers emphasized healthcare access and workforce opportunities, while those without a high school diploma prioritized food access.

Virginia Trends

In Virginia, rural counties like Page and Warren face significant provider shortages, with Page reporting just 25.2 primary care providers per 100,000 residents—far below the state average. Uninsured rates are also elevated, particularly in Winchester (16.2%).

Cancer and heart disease are the leading causes of early death, with Page County showing the highest lung cancer rate in the region. Mental distress and suicide rates are also elevated, especially in Clarke and Page counties. Obesity and COPD are prevalent in Page and Shenandoah.

Social determinants such as housing cost burden and food insecurity are most acute in Winchester, Page, and Shenandoah. Transportation barriers are significant in Warren, where 59% of residents face long commutes.

Economically, Winchester and Shenandoah exceed the state poverty average, and Page's median income falls well below the living wage. Injury and firearm-related deaths are also disproportionately high in Page and Rappahannock counties.

West Virginia Trends

West Virginia counties served by Valley Health face even more pronounced challenges. Hardy and Hampshire counties have some of the lowest provider rates in the state, and prenatal care access is critically low in Grant and Hardy.

Mental health indicators are concerning, with depression rates exceeding 30% in Grant and suicide rates high in Hardy and Morgan. Overdose deaths are especially prevalent in Berkeley, Hampshire, Jefferson, and Morgan counties.

Long commutes and food insecurity are widespread, particularly in Hardy, Hampshire, and Mineral. Preschool enrollment is low in Hardy and Grant, limiting early childhood development opportunities.

Poverty rates in Hardy and Grant exceed the state average, and median incomes fall well below living wage thresholds. Injury and firearm fatalities are alarmingly high, especially in Hampshire and Hardy counties.

Winchester Medical Center

Healthcare Access & Quality

- High provider density (255.9 PCPs per 100,000), but serves surrounding areas with significant shortages.
- Strong infrastructure for specialty care, but disparities persist in rural service areas.

Physical & Mental Health

- Highest STI rates in the region (Chlamydia: 525.0 per 100,000).
- Elevated mental health distress and depression (24.5% of adults).
- Overdose death rate: 28.9 per 100,000, matching state average.
- HIV/AIDS rate: 271.4 per 100,000 — significantly above the Virginia average.
- Tuberculosis (TB): 3.6 per 100,000 — above the state average.
- Mental health was the top concern in the community survey for Winchester.

Social Determinants of Health

- Winchester City reports 33.8% of households are cost-burdened.
- Food insecurity rate: 16%, highest in the region.
- High rates of social vulnerability (SVI: 0.89).

Economic Stability & Environment

- Poverty rate: 19.3% (double the VA average).
- Child poverty: 29.2%.
- Median income: $63,532 vs. living wage of $97,552.
- Hourly median income: $30.54 vs. living wage of $46.90

Warren Memorial Hospital

Healthcare Access & Quality

- Serves areas with long wait times and limited access to pediatric care.
- Prenatal care access below state average.

Physical & Mental Health

- High maternal opioid use disorder rate: 25.8 per 1,000 births.
- Obesity (38.1%) and smoking (18.8%) exceed state averages.
- Binge drinking: 19.9%.
- Smoking during pregnancy: 4.3%.
- Lower rates of breast and colorectal cancer screening compared to state averages.

Social Determinants of Health

- 59% of residents face long commutes.
- Housing cost burden: 25.3%.
- Food insecurity: 13%.

Economic Stability & Environment

- Injury death rate: 98 per 100,000.
- Firearm fatalities: 14 per 100,000.
- Hourly median income: $42.95 vs. living wage of $45.19.

Shenandoah Memorial Hospital

Healthcare Access & Quality

- Limited access to dental and mental health providers.
- Prenatal care access below state average.

Physical & Mental Health

- COPD (8.0%) and coronary heart disease (6.3%) exceed state averages.
- Suicide rate: 13.3 per 100,000.
- Mental distress: 19%.
- Tuberculosis (TB): 4.4 per 100,000 — highest in the region.
- Colorectal screening rate at 58%, below the Virginia average (62.8%).

Social Determinants of Health

- 20.1% report social isolation.
- Food insecurity: 14%.
- Housing cost burden: 24.7%.

Economic Stability & Environment

- Child poverty: 20%.
- Hourly median income: $36.12 vs. living wage of $41.15.
- Injury death rate: 87 per 100,000.

Page Memorial Hospital

Healthcare Access & Quality

- Lowest provider density in the region (25.2 PCPs per 100,000).
- High rates of late or no prenatal care (10.7%).

Physical & Mental Health

- Highest lung cancer rate in LFHD (70.5 per 100,000).
- Smoking during pregnancy: 5.7%.
- NAS rate: 10.5 per 1,000 births.
- Overdose death rate: 33.4 per 100,000.
- Syphilis rate: 12.6 per 100,000 — approaching the state average.

Social Determinants of Health

- Housing availability is a top concern.
- Food insecurity: 14%.
- Social vulnerability index: 0.79.

Economic Stability & Environment

- Hourly median income: $27.87 vs. living wage of $41.87.
- High poverty and low educational attainment (16.1% without high school diploma).
- Injury death rate: 104 per 100,000.

War Memorial Hospital

Healthcare Access & Quality

- Serves Morgan and Hampshire counties with low provider access.
- Limited prenatal care access and aging services.

Physical & Mental Health

- High overdose and suicide rates in Morgan County.
- Depression and mental distress exceed state averages.

Social Determinants of Health

- Long commutes and food insecurity in Hampshire and Morgan.
- High rates of smoking and physical inactivity.

Economic Stability & Environment

- Hampshire: highest injury death rate in WV (157 per 100,000).
- Median income below living wage in all service counties.

Hampshire Memorial Hospital

Healthcare Access & Quality

- Severe provider shortages (25.8 PCPs per 100,000).
- Only 45.6% of mothers receive prenatal care in first trimester.
- Mother with late or no prenatal care (8.2% in Mineral County).
- ADA accessibility and language access are limited.

Physical & Mental Health

- High maternal and infant mortality (9.4 per 1,000).
- Smoking during pregnancy: 16.7%.
- Obesity: 42.9%.

Social Determinants of Health

- High social isolation and transportation barriers.
- Preschool enrollment and housing access below state averages.

Economic Stability & Environment

- Poverty rate: 14.2%.
- Children in poverty: 25.2%
- Hourly median income: $30.43 vs. living wage of $43.90.
- Firearm fatalities: 12 per 100,000.

Survey Questions	LFHD Total	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Rappahannock	Berkeley	Jefferson	Morgan	Hampshire	Grant	Hardy	Mineral
In each category, select the priority health concern(s) in your community.															
1. Health Status (1)															
Physical health	1377	102	565	133	274	234	69	8	251	79	107	115	7	41	17
Mental health	969	39	410	99	157	147	117	0	101	28	38	30	1	17	5
Length of life	222	8	103	19	32	44	16	2	49	15	12	18	1	4	1
Total	**2568**	**149**	**1078**	**251**	**463**	**425**	**202**	**10**	**401**	**122**	**157**	**163**	**9**	**62**	**23**
2. Disease & Health Conditions (2)															
Cancer	1415	98	584	127	262	233	111	7	220	66	76	95	6	40	14
Heart disease	1352	87	584	124	230	238	89	8	206	73	77	88	4	28	13
Obesity	1255	62	530	121	229	198	115	3	206	55	85	66	3	25	9
Diabetes	1083	51	448	119	204	177	84	2	169	49	76	77	5	31	8
Total	**5105**	**298**	**2146**	**491**	**925**	**846**	**399**	**20**	**801**	**243**	**314**	**326**	**18**	**124**	**44**
3. Health Behaviors (3)															
Not being physically active	1147	72	519	87	216	171	82	6	199	66	85	75	3	25	10
Illegal drug use	1018	43	359	152	182	187	95	1	155	44	65	70	4	24	12
Poor diet	1017	71	431	92	194	153	76	4	161	40	70	67	3	31	11
Alcohol use	796	40	299	86	141	156	74	3	95	35	39	42	2	19	6
Dental health	734	37	315	70	122	137	53	5	158	45	57	44	3	19	7
Breast cancer screening	623	42	277	54	106	95	49	0	85	34	32	57	3	18	6
Colon cancer screening	612	44	296	39	111	87	35	1	105	40	32	50	4	15	7
Smoking and tobacco use	535	27	214	57	106	89	42	4	93	22	31	34	0	14	5
Vaccinations	475	37	211	40	84	75	28	4	61	20	33	26	2	7	3
Vape use	412	23	158	37	86	73	35	0	50	15	17	15	0	8	1
Marijuana use	177	4	86	12	24	33	18	2	13	3	6	5	1	3	0
Sexual activity	138	6	65	11	17	20	19	0	29	2	4	7	2	3	1
Total	**7684**	**446**	**3230**	**737**	**1389**	**1276**	**606**	**30**	**1204**	**366**	**471**	**492**	**27**	**186**	**69**
4. Neighborhood & Environment (2)															
Housing costs	1476	82	647	114	256	243	134	4	232	68	70	56	2	22	6
Access to healthy foods	1048	62	477	87	161	177	84	1	176	49	73	83	2	29	10
Housing availability	912	41	339	134	160	157	81	5	104	30	41	46	2	25	5
Social isolation/lack of support system	853	52	340	74	187	150	50	1	125	38	54	53	1	25	10
Community access	322	16	138	24	69	51	24	2	58	17	20	20	3	7	5

Internet access	281	39	116	45	35	40	6	4	49	20	39	43	4	13	6
Access to parks	243	6	106	14	61	36	20	3	58	22	17	27	0	4	5
Total	**5135**	**298**	**2163**	**492**	**929**	**854**	**399**	**20**	**802**	**244**	**314**	**328**	**14**	**125**	**47**
5. Economic Stability (2)															
Low income	1482	87	575	169	303	223	125	8	230	68	105	112	2	43	17
Homelessness	1084	39	537	78	141	174	115	1	158	41	27	16	1	12	3
Having enough food	993	66	419	71	189	178	70	3	182	50	56	65	2	29	8
Long commute (30+ Min)	573	52	212	68	120	104	17	6	71	46	51	78	5	24	5
Unemployment	426	21	184	48	65	66	42	2	52	20	34	26	1	7	6
Violence within home/family	329	19	112	49	69	61	19	0	43	7	28	18	2	7	1
Violent crime	243	14	122	8	41	45	13	0	66	12	13	12	1	3	6
Total	**5130**	**298**	**2161**	**491**	**928**	**851**	**401**	**20**	**802**	**244**	**314**	**327**	**14**	**125**	**46**
6. Cause of Early Death (1)															
Cancer	772	60	339	65	169	92	47	4	101	51	46	60	5	20	10
Heart disease	635	38	286	59	101	107	44	5	119	26	44	36	0	20	7
Overdose	495	13	180	54	83	117	48	0	87	21	32	25	2	8	4
Suicide	293	7	131	32	48	51	24	1	35	8	10	6	0	3	0
Diabetes	224	19	75	21	44	38	27	0	38	10	20	20	0	5	1
Injuries/accidents	132	12	62	13	17	18	10	0	21	6	5	16	0	6	1
Total	**2551**	**149**	**1073**	**244**	**462**	**423**	**200**	**10**	**401**	**122**	**157**	**163**	**7**	**62**	**23**
7. Which of the following actions would have the biggest impact on the health concerns you identified above? (3)															
Increased access to mental health services	1289	63	550	127	212	217	120	4	157	50	66	50	2	24	7
Increased access to health care	1260	71	557	132	210	210	80	6	203	68	81	78	7	15	6
Additional affordable housing	1083	53	455	109	187	188	91	4	154	37	48	44	3	21	2
Increased access to aging services	833	71	368	50	175	137	32	3	143	54	49	77	6	24	12
Increased access to healthy foods	768	51	370	52	127	109	59	4	148	33	46	53	2	21	10
Increased access to substance use services	603	20	197	67	117	140	62	0	87	28	35	28	2	16	4
Increased access to community based services	558	47	223	37	121	78	52	2	103	30	44	44	3	12	6
Additional workforce opportunities	476	25	162	81	93	63	52	1	55	22	33	39	1	14	7
Improved transportation options	421	29	172	56	67	64	33	1	80	28	39	39	0	12	2
Increased access to parks and recreation	208	9	97	17	45	29	11	2	46	8	12	26	1	2	2
Other (please specify)	129	3	54	10	28	30	4	2	25	6	16	11	0	4	3
Reading and language resources	66	5	33	2	10	7	9	1	7	1	2	3	0	4	0
Total	**7694**	**447**	**3238**	**740**	**1392**	**1272**	**605**	**30**	**1208**	**365**	**471**	**492**	**27**	**169**	**61**

Number in parentheses indicates the number of selections each respondent was instructed to choose for the question.

Full Demographic results of the survey are available on page 16 within the Community Health Survey Analysis.

Appendix C:
Community Health Needs Assessment Survey

ValleyHealth
Healthier, together.

SHENANDOAH UNIVERSITY

VDH VIRGINIA DEPARTMENT OF HEALTH

2025 Community Health Survey

This survey is intended to gather your feedback and input about health needs in the community where you live. The results will be used to find the most pressing concerns that can be addressed through the community working together. Please use the QR code on the reverse side if you would like to complete the survey online. ***Thank you!***

Significant Community Health Concerns

In each category, select the priority health concern(s) in your community. (Please check only the number shown.)

1. Health Status (Choose **ONE**)
   - ☐ Length of life
   - ☐ Physical health
   - ☐ Mental health

2. Disease/Health Conditions (Choose **TWO**)
   - ☐ Cancer
   - ☐ Diabetes
   - ☐ Heart disease
   - ☐ Obesity

3. Health Behaviors (Choose **THREE**)
   - ☐ Alcohol use
   - ☐ Breast cancer screening
   - ☐ Colon cancer screening
   - ☐ Dental health
   - ☐ Illegal drug use
   - ☐ Marijuana use
   - ☐ Not being physically active
   - ☐ Poor diet
   - ☐ Sexual activity
   - ☐ Smoking and tobacco use
   - ☐ Vaccinations
   - ☐ Vape use

4. Neighborhood and Environment (Choose **TWO**)
   - ☐ Access to healthy foods
   - ☐ Access to parks
   - ☐ Community access
   - ☐ Housing availability
   - ☐ Housing costs
   - ☐ Internet access
   - ☐ Social isolation/lack of support system

5. Economic Stability (Choose **TWO**)
   - ☐ Having enough food
   - ☐ Homelessness
   - ☐ Long commute (30+ Min)
   - ☐ Low income
   - ☐ Unemployment
   - ☐ Violence within home/family
   - ☐ Violent crime

6. Causes of Early Death (Choose **ONE**)
   - ☐ Cancer
   - ☐ Diabetes
   - ☐ Heart Disease
   - ☐ Injuries/accidents
   - ☐ Overdose
   - ☐ Suicide

Responding to Community Health Needs

Which of the following actions would have the biggest impact on the health concerns you identified above? (Choose **THREE**)

- ☐ Increased access to health care
- ☐ Increased access to mental health services
- ☐ Increased access to substance use services
- ☐ Increased access to aging services
- ☐ Additional workforce opportunities
- ☐ Improved transportation options
- ☐ Increased access to healthy foods
- ☐ Increased access to community based services
- ☐ Increased access to parks and recreation
- ☐ Additional affordable housing
- ☐ Reading and language resources
- ☐ Other: _____

Please complete the remainder of survey on reverse side.

General Demographic Information:

City: _____

State: _____ Zip Code: _____

County:_____

Sex:
- ☐ Male
- ☐ Female
- ☐ Another

Age:
- ☐ 15-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75+

Race/Ethnicity:
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Middle Eastern/N. African
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Two or More Races

Primary Language:_____

Education:
- ☐ Did not complete HS
- ☐ HS Diploma/GED
- ☐ Some College
- ☐ College Degree or Higher

Household Income:
- ☐ Less than $14,500
- ☐ $14,501 - $32,000
- ☐ $32,001 - $50,000
- ☐ $50,001 - $95,000
- ☐ Over $95,000

Number of People in Home: _____

Employment:
- ☐ Full-Time
- ☐ Part-Time
- ☐ Student
- ☐ Retired
- ☐ Not employed

Thank you for your responses. Please return completed surveys to the address below by January 31, 2025. If you would like more information about this community project, please contact us at communityhealth@valleyhealthlink.com.

ATTN: COMMUNITY HEALTH SURVEY
VALLEY HEALTH
PO BOX 3340
WINCHESTER, VA 22604-9836

Prefer to complete the survey online?
Use QR code to the right or visit valleyhealthlink.com/survey.

Would you like to receive the survey results?

Please provide your email address: _____

Encuesta de Salud Comunitaria 2025

Esta encuesta tiene como objetivo recopilar sus comentarios y opiniones sobre las necesidades de salud en la comunidad en la que vive. Los resultados se utilizarán para identificar las preocupaciones más urgentes que se pueden abordar mediante el trabajo conjunto de la comunidad. Utilice el código QR que se encuentra en el reverso si desea completar la encuesta en línea. ¡Gracias!

Preocupaciones Importantes para La Salud de la Comunidad

En cada categoría, seleccione los problemas de salud prioritarios de su comunidad. (Marque solo el número que se indica).

1. Estado de salud (Elija **UNA**)
   - ☐ Duración de la vida
   - ☐ Salud física
   - ☐ Salud mental
2. Enfermedades/condiciones de salud (Elija **DOS**)
   - ☐ Cáncer
   - ☐ Diabetes
   - ☐ Enfermedad cardíaca
   - ☐ Obesidad
3. Comportamiento de salud (Elija **TRES**)
   - ☐ Uso de alcohol
   - ☐ Detección de cáncer de mama
   - ☐ Detección de cáncer de colon
   - ☐ Salud dental
   - ☐ Consumo de drogas ilegales
   - ☐ Consumo de marihuana
   - ☐ No realizar actividad física
   - ☐ Mala alimentación
   - ☐ Actividad sexual
   - ☐ Tabaquismo y consumo de tabaco
   - ☐ Vacunas
   - ☐ Uso de cigarrillos electrónicos
4. Vecindario y medio ambiente (elija **DOS**)
   - ☐ Acceso a alimentos saludables
   - ☐ Acceso a parques
   - ☐ Acceso a la comunidad
   - ☐ Disponibilidad de vivienda
   - ☐ Costos de vivienda
   - ☐ Acceso a Internet
   - ☐ Aislamiento social/falta de sistema de apoyo
5. Estabilidad económica (Elija **DOS**)
   - ☐ No tener suficiente comida
   - ☐ No tener hogar
   - ☐ Desplazamiento lejano (más de 30 Min)
   - ☐ Bajos ingresos
   - ☐ Desempleo
   - ☐ Violencia domestica
   - ☐ Delitos violentos
6. Causas de muerte prematuras (Elija **UNA**)
   - ☐ Cáncer
   - ☐ Diabetes
   - ☐ Enfermedades cardiacas
   - ☐ Lesiones/accidentes
   - ☐ Sobredosis
   - ☐ Suicidio

Respondiendo a las Necesidades de Salud de la Comunidad

¿Cuál de las siguientes acciones tendría el mayor impacto en los problemas de salud que identificó anteriormente? (Elija **TRES**)

- ☐ Mayor acceso a la atención médica
- ☐ Mayor acceso a los servicios de salud mental
- ☐ Mayor acceso a los servicios para el consumo de sustancias
- ☐ Mayor acceso a los servicios para personas mayores
- ☐ Oportunidades laborales adicionales
- ☐ Mejores opciones de transporte
- ☐ Mayor acceso a alimentos saludables
- ☐ Mayor acceso a servicios comunitarios
- ☐ Mayor acceso a parques y recreación
- ☐ Viviendas asequibles
- ☐ Recursos de lectura y lenguaje
- ☐ Otros: _____

Por favor, complete el resto de la encuesta en la parte de atrás.

Información demográfica general:

Ciudad: _____

Estado: _____ Código postal: _____

Condado: _____

Sexo:
☐Hombre
☐Mujer
☐Otro

Edad:
☐ 15-24 ☐ 55-64
☐ 25-34 ☐ 65-74
☐ 35-44 ☐ 75+
☐ 45-54

Raza/Etnicidad:
☐ Indio americano/nativo de Alaska
☐ Asiático
☐ Negro/Afro-American
☐ Hispano/latino
☐ De Oriente Medio/norte de África
☐ Nativo de Hawái/isleño del Pacífico
☐ Blanco
☐ De dos o más razas

Idioma principal: _____

Educación:
☐ No completó la escuela secundaria
☐ Diploma de escuela secundaria/GED
☐ Algunos estudios universitarios
☐ Título universitario o superior

Ingresos en el Hogar:
☐ Menos de $14,500
☐ $14,501 - $32,000
☐ $32,001 - $50,000
☐ $50,001 - $95,000
☐ Más de $95,000

Número de personas en el hogar: _____

Empleo:
☐ Tiempo completo
☐ Tiempo parcial
☐ Estudiante
☐ Jubilado
☐ Sin empleo

Gracias por sus respuestas. Envíe las encuestas completadas a la siguiente dirección antes del 31 de enero de 2025. Si desea obtener más información sobre este proyecto comunitario, contáctenos a communityhealth@valleyhealthlink.com.

Enviar a: COMMUNITY HEALTH SURVEY VALLEY HEALTH
PO BOX 3340
WINCHESTER, VA 22604-9836

¿Prefieres completar la encuesta en línea?
Utiliza el código QR que aparece a la derecha o visita valleyhealthlink.com/survey.

¿Quieres recibir los resultados de la encuesta?

Por favor proporcione su dirección de correo electrónico: _____

Appendix B: Complete Community Health Survey Results

Appendix D: Community Partner Interview Facilitation Guide

1. What services are provided as part of your organization's mission and where do you provide those services?

2. In your opinion, what are the **biggest issues or concerns** facing the people served by your organization, as well and community you serve?
   - Additional Prompts: How do aspects of our 'built environment' (like housing, schools, neighborhoods, infrastructure, and open spaces) influence these issues or concerns in the surrounding community?
   - How have items like recent economic development, zoning, transportation, and safety changes impacted the community's ability to live healthy lives?

3. Over the past couple years, have these issues been **improving, staying the same or getting worse, and why**?
   - Additional Prompts: Have the populations in need changed or do we have different populations that we need to make sure we pay attention to?

4. **Where** and for what population groups in the community are each of these issues most pronounced? (City/Town, County, road corridor, hospital service area, …)

5. What issues do people served by your organization encounter when attempting to **access health or social services** for themselves and/or their families? (Not available, travel to get, where to, …)

6. Please discuss the major **factors that are contributing to (driving) poor health status** among people served by your organization (or population groups about which you have particular knowledge).
   - Additional Prompts: When examining the healthcare system of the community, what barriers limit access to care when needed?

7. What organizations (including coalitions and informal groups) are working to collaboratively address any of the problems mentioned?

8. What community assets could play a role in addressing these needs?
   - Additional Prompts: What is supportive of health and well-being in your community?

9. What specific initiative(s) would you recommend be implemented to address the most pressing access or health status problems in the community (or for population groups about which you have particular knowledge)?
   - Additional Prompts: What areas of public health disease prevention would be most beneficial to your community?

Appendix E: Community Partner Assessment survey

Your Organization

1. What is the full name of your organization? _____

2. Which best describes your position or role in your organization?

- ☐ Administrative staff
- ☐ Front line staff
- ☐ Supervisor (not senior management)
- ☐ Senior management level/unit or program lead
- ☐ Leadership team
- ☐ Community member
- ☐ Community leader
- ☐ Other: _____

3. Which of the following best describe(s) your organization? (check all that apply)

- ☐ Local health department
- ☐ State health department
- ☐ Other city government agency
- ☐ Other county government agency
- ☐ Other state government agency
- ☐ Private hospital
- ☐ Public hospital
- ☐ Private clinic
- ☐ Public clinic
- ☐ Emergency response
- ☐ Schools/education (PK–12)
- ☐ College/university
- ☐ Library
- ☐ Non-profit organization
- ☐ Grassroots community organizing group/organization
- ☐ Social service provider
- ☐ Housing provider
- ☐ Mental health provider
- ☐ Neighborhood association
- ☐ Foundation/philanthropy
- ☐ For-profit organization/private business
- ☐ Faith-based organization
- ☐ Center for Independent Living
- ☐ Other: _____

4. What racial/ethnic populations does your organization work with? (check all that apply)

- ☐ Black/African American
- ☐ African
- ☐ Native American/Indigenous/Alaska Native
- ☐ Latinx/Hispanic
- ☐ Asian/Asian American
- ☐ Pacific Islander/Native Hawaiian
- ☐ Middle Eastern/North African
- ☐ White/European
- ☐ Other: _____

5. Does your organization work with immigrants, refugees, asylum seekers, and other populations who speak English as a second language?

- ☐ Yes. Please specify: _____
- ☐ No
- ☐ Unsure

6. Does your organization offer services for transgender, nonbinary, and other members of the LGBTQIA+ community?

☐ Yes—we provide services specifically for the LGBTQIA+ community

☐ Somewhat—we provide general services and LGBTQIA+ individuals could use those services

☐ No—LGBTQIA+ populations are not welcome

☐ Unsure

7. Does your organization offer services specifically for people with disabilities?

☐ Yes—we provide services specifically for people with disabilities

☐ Somewhat—we are wheelchair accessible and compliant with the American Disabilities Act but are not specifically designed to serve people with disabilities

☐ No—our organization is not specifically designed to serve people with disabilities

☐ Unsure

8. Does your organization work with other populations or groups who are not addressed in the previous questions? For example, groups identifiable by gender, socioeconomic status, education, disability, immigration status, religion, insurance status, housing status, occupation, age, neighborhood, and involvement in the criminal legal system.

☐ Yes. Please specify: _____

☐ No

☐ Unsure

9. Does your organization have access to interpretation and translation services?

☐ Yes. Please specify: _____

☐ No

☐ Unsure

10. Who are your priority populations?

11. Do the staff and others in your organization reflect the demographics of the community you serve?

☐ Yes

☐ No

☐ Unsure

Topic Area Focus

12. How much does your organization focus on each of these topics?

- **Economic Stability:** The connection between people's financial resources—income, cost of living, and socioeconomic status—and their health. This includes issues such as poverty, employment, food security, and housing stability

  ☐ a) A lot ☐ b) A little ☐ c) Not at all ☐ d) Unsure

- **Education Access and Services:** The connection of education to health and well-being. This includes issues such as graduating from high school, educational attainment in general, language and literacy, and early childhood education and development.

  ☐ a)A lot ☐ b) A little ☐ c) Not at all ☐ d) Unsure

- **Healthcare Access and Quality:** The connection between people's access to and understanding of health services and their own health. This includes issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.

  ☐ a) A lot ☐ b) A little ☐ c) Not at all ☐ d) Unsure

- **Neighborhood and Built Environment:** The connection between where a person lives—housing, neighborhood, and environment— and their health and well-being. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety.

  ☐ a) A lot ☐ b) A little ☐ c) Not at all ☐ d) Unsure

- **Social and Community Context:** The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, violence, and incarceration.

  ☐ a) A lot ☐ b) A little ☐ c) Not at all ☐ d) Unsure

13. Which of the following categories does your organization work on/with? (check all that apply)

- ☐ Arts and culture
- ☐ Businesses and for-profit organizations
- ☐ Criminal legal system
- ☐ Disability/independent living
- ☐ Early childhood development/childcare
- ☐ Education
- ☐ Community economic development
- ☐ Economic security
- ☐ Environmental justice/climate change
- ☐ Faith communities
- ☐ Family well-being
- ☐ Financial institutions (e.g., banks, credit unions)
- ☐ Food access and affordability (e.g., food bank)
- ☐ Food service/restaurants
- ☐ Gender discrimination/equity
- ☐ Government accountability
- ☐ Healthcare access/utilization
- ☐ Housing
- ☐ Human services
- ☐ Immigration
- ☐ Jobs/labor conditions/wages and income
- ☐ Land use planning/development
- ☐ LGBTQIA+ discrimination/equity
- ☐ Parks, recreation, and open space
- ☐ Public health
- ☐ Public safety/violence
- ☐ Racial justice
- ☐ Seniors/elder care
- ☐ Transportation
- ☐ Utilities
- ☐ Veterans' issues
- ☐ Violence
- ☐ Youth development and leadership
- ☐ Other: _____

14. Which of the following health topics does your organization work on? (check all that apply)

- ☐ Cancer
- ☐ Chronic disease (e.g., asthma, diabetes/obesity, cardiovascular disease)
- ☐ Family/maternal health
- ☐ Immunizations and screenings
- ☐ Infectious disease
- ☐ Injury and violence prevention
- ☐ HIV/STD prevention
- ☐ Healthcare access/utilization
- ☐ Health equity
- ☐ Health insurance/Medicare/Medicaid
- ☐ Mental or behavioral health (e.g., PTSD, anxiety, trauma)
- ☐ Physical activity m. Tobacco and substance use and prevention
- ☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)/food stamps
- ☐ None of the above/Not applicable
- ☐ Other: _____

Organizational accountability & Capacities

15. In 1–2 sentences, describe the people impacted by your organization and the work you are doing.

_____

_____

_____

16. Does your organization have an advisory board of community members, stakeholders, youth, or others who are impacted by your organization?

☐ Yes ☐ No ☐ Unsure

17. Does your organization have sufficient capacity to meet the needs of your clients/ members? For example, do you have enough staff/funding/support to do your work?

☐ Yes ☐ No

☐ Unsure. Please elaborate: _____

Data & Systems

18. Does your organization conduct assessments (e.g., of basic needs, community health, neighborhood)?

☐ Yes. Please describe what they assess: _____

☐ No

☐ Unsure.

19. What data does your organization collect? (check all that apply)

☐ Demographic information about clients or members

☐ Access and utilization data about services provided and to whom

☐ Evaluation, performance management, or quality improvement information about services offered

☐ Data about health status

☐ Data about health behaviors

☐ Data about conditions and social determinants of health (e.g., housing, education, or other conditions)

☐ Data about systems of power, privilege, and oppression

☐ We don't collect data

☐ Other: _____

20. What policy/advocacy work does your organization do? (check all that apply)

- ☐ Develop close relationships with elected officials
- ☐ Educate decision-makers and respond to their questions
- ☐ Respond to requests from decision-makers
- ☐ Use relationships to access decision-makers
- ☐ Write or develop policy
- ☐ Advocate for policy change
- ☐ Build capacity of impacted individuals/communities to advocate for policy change
- ☐ Lobby for policy change
- ☐ Mobilize public opinion on policies via media/communications
- ☐ Contribute to political campaigns/political action committees (PACs)
- ☐ Voter outreach and education
- ☐ Legal advocacy
- ☐ Other

Appendix F: Key Terminology

Public health and healthcare professionals have written this document. Though conscious efforts have been made to make this information as accessible and understandable as possible, some concepts may be unfamiliar to some. We recognize the need for clear explanations regarding key terminology and abbreviations and the following subsections include such.

Below are terms and the associated definitions of those terms. These are included to provide additional background for terms that may not be commonly used and understood by those with limited understanding of public health language.

Age-Adjusted Rate – Almost all diseases or health outcomes occur at different rates in different age groups. Most chronic diseases, including most cancers, occur more often among older people. Other outcomes, such as many types of injuries, occur more often among younger people. The age distribution determines what the most common health problems in a community will be. One way of examining the pattern of health outcomes in communities of different sizes is to calculate an incidence or mortality rate, which is the number of new cases or deaths divided by the size of the population. In chronic diseases and injuries, rates are usually expressed in terms of the number of cases/deaths per 100,000 people per year.

Built Environment – The human-made surroundings that influence overall community health, including the individual behaviors that drive health. The built environment includes many types of physical elements, such as homes, sidewalks, and public transportation.

Case Count – Public health uses surveillance case definitions, which are a uniform set of criteria to define a disease. Case definitions enable public health officials to classify and count cases consistently across jurisdictions. A case count is the total number of occurrences for a disease or condition that public health has determined meets the surveillance case definition.

Crude Rate – The calculation of the number of times an event (cases of disease, deaths, etc.) occurs in the population of interest during a given time period. Crude rates do not account for confounding factors such as an individual's age. A standard practice in health statistics is to present rates per 100,000 population. Since the number of events depends, in part, on the size of the population, crude rates provide a standardized way to compare outcomes between groups. For example: comparing rates among counties.

Data Suppression – The counts for many data indicators can be small. This can present a problem not only related to confidentiality protection but also for data interpretation. Rates based on small numbers can be unstable, fluctuating a lot from year to year, and unreliable, not providing the true picture of the health problem. To overcome these potential problems, indicators at the locality level with small numbers are suppressed per the standard set by the data's source.

Health Disparities – The differences in health outcomes, such as life expectancy, mortality, health status, and prevalence of health conditions. These disparities can be driven by many factors, like social or economic inequities.

Health Equity – This is achieved when everyone can attain their full potential for health and wellbeing.

Health Outcome – The physical and mental well-being of residents in a community. It is measured by how long they live and their quality of life (feeling healthy, comfortable, and able to enjoy life events).

Incidence – The number of new cases of disease having their onset during a prescribed period of time. It is often expressed as a rate.

Indicator – A measure or data that describe community conditions currently and over time (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate).

Prevalence – The number of cases of a disease, number of infected people, or number of people with another attribute present during a particular interval of time. It is often expressed as a rate.

Primary Data – Data collected directly, for example through surveys, listening sessions, interviews, or observations.

Qualitative Data – Information that is summarized without numbers and typically in textual or narrative format (e.g., focus group notes, questionnaire responses, or observational notes).

Quantitative Data – Data expressing a certain quantity, amount, or range. Usually there are numerical measurements associated with the data.

Secondary Data – Data that have already been collected by another group or for another purpose.

Social Drivers of Health (SDOH) – The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into five domains: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. This concept may also be referred to as Social Determinants of Health.

Appendix G: List of Abbreviations

Below is a list of abbreviations that can be found throughout the report.

ADA – Americans with Disabilities Act

AIDS – Acquired Immunodeficiency Syndrome

ALICE – Asset Limited, Income Constrained, and Employed

CDC – Centers for Disease Control and Prevention

CHA – Community Health Assessment

CHNA – Community Health Needs Assessment

CHIP – Community Health Improvement Plan

CHW – Community Health Workers

COPD – Chronic Obstructive Pulmonary Disease

COVID-19 – Coronavirus Disease 2019

CPA – Community Partner Assessment

FPL – Federal Poverty Line

GED – General Education Development

HIV – Human Immunodeficiency Virus

LFHD – Lord Fairfax Health District

LGBTQ+ – Lesbian, Gay, Bisexual, Transgender, Queer, Plus

MAPP – Mobilizing for Action through Planning and Partnerships

MMR – Measles, Mumps, and Rubella

NACCHO – National Association of County and City Health Officials

NAS – Neonatal Abstinence Syndrome

OCD – Obsessive-Compulsive Disorder

OD – Overdose

OUD – Opioid Use Disorder

PCP – Primary Care Provider

SDOH – Social Drivers of Health

SES – Socioeconomic Status

STI – Sexually Transmitted Infection

SVI – Social Vulnerability Index

TB – Tuberculosis

TES – Total Early Syphilis

US – United States of America

VA – Virginia

VDH – Virginia Department of Health

WV – West Virginia