2023-2025 Implementation Strategy

For the 2022 Community Health Needs Assessment

ValleyHealth

Winchester Medical Center

Winchester Medical Center Implementation Strategy Plan

Introduction

The **2022 Community Health Needs Assessment** (CHNA) is a strategic tool that helps Valley Health pursue its mission of serving our community by improving health. The Patient Protection and Affordable Care Act of 2010 requires not-for-profit hospitals to conduct Community Health Needs Assessments every three years. The purpose of the assessment is to identify and prioritize the health needs of the residents of the hospital's service area, particularly those who experience health inequities. After assessments were completed for each Valley Health hospital, an **Implementation Strategy Plan** was developed to address the identified health needs.

The Community Health Needs Assessment involved the contributions of over 2,000 individuals through virtual interviews, surveys, in-person community response sessions, and in-person interviews with vulnerable populations from area homeless shelters and food pantries. Key stakeholder groups included community residents, members of faith-based organizations, health care providers, elected officials, members of the Valley Health Community Advisory Council, health professionals, and leadership from each of Valley Health's six hospitals. The CHNA is a report based on quantitative, qualitative and relative data that assesses health issues in our community and the community's access to services related to those issues. Frameworks of social determinants of health and health equity guided the process of the CHNA.

The Implementation Strategy Plan (ISP) addresses priority needs identified in the CHNA, describing how the hospital intends to respond to the need or identifying it as one that will not be addressed and why. The strategies have been developed with a focus on leveraging Valley Health's programs and resources to achieve sustainable solutions that address health disparities and close gaps in healthcare access. The identified strategies are not intended to be a comprehensive list of all of the many ways the needs of the community are addressed by Valley Health, but rather specific actions the hospital commits to undertaking and monitoring from 2023-2025. Initial collaboration with hospital and community leaders established the impact list and alignment was sought among system leaders to compliment planning efforts around the community health needs. The impact of the chosen strategies will be communicated to the community and further alignment will establish partnerships and related measurable effects.

The hospital may amend the ISP as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs included here. This plan and its strategies will be evaluated annually and may be refocused to account for such changes in the community or health system landscape.

Methodology: Identifying Priority Health Issues

1. **Establish the Assessment Infrastructure**
   A Community Advisory Council (CAC) was established with representation for each of Valley Health's acute care operations, critical care access hospitals, clinical service lines, community members, Finance and Treasury Affairs, and Planning and Business Development. The CAC reviewed Internal Revenue Service and Department of Health requirements and established the project timeline and implementation strategy.

2. **Conduct Community Health Needs Assessment**
   Community health needs for each Valley Health hospital were identified by collecting and analyzing data and information from primary and secondary data sources. Primary data sources included a community health survey, key informant interviews and community response sessions. Demographic, economic, and health data was gathered for the Valley Health service area. Valley Health's internal data was supplemented by data from other governmental and industry sources. The principal findings of recent health assessments conducted by other organizations were reviewed as well.

3. **Analyze Data**
   In July and August 2022, Valley Health led a facilitated process with leadership from each Valley Health hospital, community stakeholders and members of the Community Advisory Council, to understand key health issues identified in the 2022 Community Health Needs Assessment (CHNA). The implementation strategy planning process involved a series of work sessions, including an orientation session and review of the 2022 identified needs, an analysis of internal hospital resources, a review of evidenced-based best practices, a cataloging of potential community partners, and meetings to align the implementation strategies discussed with current planning initiatives throughout the system.

4. **System Prioritization of Community Needs**
   Through a series of over twenty work sessions conducted at all six Valley Health hospitals, priority health needs were identified and solution-driven implementation strategies were developed. The prioritized health needs were grouped into key categories, allowing for a system wide community health improvement plan for those needs that overlap in all six hospital service areas. Targeted strategies for community specific needs are presented in this report. The work group process outlined above served as a means for further understanding what community programs and resources are available and served as a forum for discussing ways to collaborate to better meet the needs identified in the Community Health Needs Assessment.

5. **Identify Resources/Community Collaboration**
   Valley Health will seek out community partners to address the prioritized health needs. This process will engage both long-standing and new, non-traditional partners in collaborative problem solving. Possible partners may include community and educational organizations, local business, housing and transportation services, and faith-based organizations. Both process and outcome measures will be tracked and reported on a quarterly basis.

The strategy team at each Valley Health hospital worked to prioritize their community's needs using the following criteria:

- Prevalence and degree of need
- Focus on equity and accessibility: understanding the presence of disparities and health issues that disproportionately affect populations by race or ethnicity
- Build on or enhances current work within the system or community and aligns with Valley Health's Strategic Plan
- Ability to demonstrate achievable and measurable outcomes
- Ability to leverage community partnerships

6. **Development of Community Health Implementation Strategy Plan**

The Implementation Strategy Plan includes a description of identified strategies and how resources will be leveraged through collaborative partnerships across all six Valley Health hospitals. This approach allows Valley Health to leverage resources and opportunities throughout the organization and has the ability to affect change across multiple communities. The collaborative approach enhances Valley Health's ability to address complex needs and engages leaders from marketing, behavioral health, information systems, data analytics, patient experience, care coordination, the medical group, ambulatory services, and EPIC.

To evolve the Implementation Strategy Plan, Valley Health's leaders will align the prioritized needs with best practice models and available resources and define action steps, timelines, and potential partners. The team will continue to focus on health equity to understand the scale and severity of identified needs and their impact on the most vulnerable populations. The identified implementation strategies will utilize system and local resources to improve health for the community with intentional focus on our low-income, underserved, and uninsured populations. Valley Health is approaching these strategies by identifying the drivers behind the health and well-being of our patients throughout the entire patient experience. This focus requires developing strategies that include the social, economic and environmental roots of well-being that are evident at the community level as well as health issues identified in our clinics and hospitals.

7. **Plan for Monitoring Progress**

Each hospital plan specifies the goals and objectives for addressing the prioritized community health needs. Additionally, each plan identifies the actions to be taken, collaborations that will be instituted, the resources required, and the measures of success. Hospital leadership and the Community Advisory Council will utilize a dashboard with specific measures to gauge progress throughout the three-year duration. The CAC will meet on a quarterly basis to assess progress and make adjustments as required.

8. **Board Adoption and Public Availability of the Community Health Needs Assessment/ Community Health Implementation Strategy Plan**

The Community Advisory Council that includes Valley Health Board of Trustees representation was engaged throughout the Community Health Needs Assessment process by reviewing progress, providing feedback and endorsing the resulting work product. The Valley Health Board of Trustees adopted the Community Health Needs Assessment final report on December 13, 2022 and the Implementation Strategy Plan report on April 11, 2023. Reports have been published electronically on the Valley Health website with hard copies available upon request at each hospital.

Definition of Prioritized Health Needs for Implementation Strategy Planning

Health needs identified during the community health needs assessment process were grouped into the following categories:

Health Needs Valley Health Will Address

1. **Health Behaviors & Chronic Disease:** Chronic diseases are typically conditions that last one year or more and require ongoing medical treatment or limit activities of daily living or both. Chronic diseases are leading drivers of health care costs and are some of the leading causes of death and disability in the United States. A lack of physical activity is a contributing factor to being overweight and obese, and is connected to a wide range of health problems and chronic diseases among all age groups. The co-occurring health problems and diseases include high cholesterol, hypertension, diabetes, heart disease, stroke, some cancers, and more.

2. **Mental Health & Substance Abuse:** Mental health includes both mental health conditions and behavioral problems. Poor mental health can cause negative outcomes for both those suffering and the people around them. It can impact children's ability to learn in school and adults' ability to be productive in the workplace and provide a stable and nurturing environment for their families. Poor mental or behavioral health frequently contributes to or exacerbates problems with physical health and illness. Substance abuse includes the use of illicit substances; misuse of legal over-the-counter and prescription medications; and abuse of alcohol and tobacco. Substance abuse affects not only substance abusers, but those around them; negatively impacting health, safety and risky behaviors, including violence and crime, adult productivity, students' ability to learn, and families' ability to function.

3. **Access to Primary, Preventive & Clinical Care:** Access to care services through a doctor's or dentist's office, clinic or other appropriate provider is an important element of a community's health care system. Access to health care services is vital to the health of the community's residents. The ability to access care is influenced by many factors including insurance coverage and the ability to afford services, the availability and location of health care providers, understanding where to find services when needed, and reliable personal or public transportation. Place-based solutions bring care to the patient either near or where they reside.

4. **Social & Economic Factors:** Income levels, employment and economic self-sufficiency are all considered social determinants of health and correlate with the prevalence of a range of health problems. People with lower incomes or who are unemployed and underemployed are less likely to have health insurance and are less able to afford out of pocket health care and housing related expenses. Lower income is associated with increased difficulties such as securing reliable transportation for medical care or the ability to purchase an adequate quantity of healthy, fresh food on a regular basis.

Needs Valley Health Will Not Directly Address

No healthcare organization can address all of the health needs present in its community. Valley Health and each of its hospitals are committed to serving the community by adhering to its mission, focusing on core competencies, and using limited resources strategically in order to continue to provide a range of important health care services and community benefits.

To have the greatest impact on the health and wellbeing of the community, Valley Health will be directing its limited resources to the prioritized community health needs. The Implementation Strategy Plan will not address the following identified needs:

1. **Physical Environment:** The physical environment is where individuals live and work. People interact with their physical environment every day through the air they breathe, water they drink, houses they live in, and the transportation they access. Poor physical environment can affect our ability to live long and healthy lives. Physical environment includes looking at the safety of the air and water for a community as well as examining the available transportation and housing burdens, lack of plumbing, internet, and long commutes to work.

2. **Health Outcomes:** Each year over a million people are diagnosed with cancer and the cost of cancer care continues to rise. Some cancers are preventable and there are steps that can be taken to improve the quality of life for cancer survivors and detect cancers in the early and treatable phase. Some risk factors can be reduced to prevent certain types of cancer. Smoking, exposure to the sun and tanning beds, obesity, and excessive alcohol use are all examples of risk factors, which put a person at high risk for developing cancer. Premature death is a long-term health outcome, the effects on which might not be realized until years after a program or policy is implemented. Motor vehicle crashes are one of the leading causes of death in the United States and the lifetime economic costs can be enormous.

3. **Maternal and Child Health:** Maternal and child health indicators, including teen pregnancy and infant mortality, should be considered when evaluating the health of a community. The rate of teen pregnancy is an important health statistic in any community for reasons that include concerns for the health of the mother and child, the financial and emotional ability of the mother to care for the child, and the ability of the mother to complete her secondary education and earn a living.

While these needs are not specifically addressed in the Implementation Strategy Plan, existing Valley Health programs and services impact these areas. Although not ideally suited to be the lead organization in addressing all of the health needs identified by the CHNA, Valley Health will continue to collaborate with community organizations that are more closely aligned and suited to have an impact on these issues.

Prioritized Health Need #1: Health Behaviors and Chronic Disease

Key Findings

- Frederick, Page, Shenandoah, Warren counties, and Winchester City in Virginia, and Grant County in West Virginia reported adult obesity rates higher than their state averages.
- Physical inactivity was reported higher than the Virginia average of 25 percent for six out of the seven Virginia counties, and four out of seven West Virginia counties reported higher than the West Virginia average of 30 percent.
- Areas that reported higher access to exercise opportunities include Winchester City in Virginia, and Grant, and Hardy counties in West Virginia.
- Clarke, Page, Rappahannock, Shenandoah, Warren counties reported higher percentages of excessive drinking than the commonwealth average of 17 percent, and in West Virginia, Berkeley, Jefferson, Mineral and Morgan counties reported higher percentages of excessive drinking that the state average of 15 percent.
- Alcohol-impaired driving deaths were reported higher than state averages for Frederick County in Virginia, and Berkeley, Hampshire, and Morgan counties in West Virginia.
- Mortality due to malignant neoplasms (cancer), chronic lower respiratory disease, influenza/pneumonia, and suicide rates were greater than the commonwealth average for six of the seven counties in Virginia.
- For all seven West Virginia counties mortality due to cancer, heart disease, chronic lower respiratory diseases, nephritis and nephrosis, influenza and pneumonia, and suicide rates were greater than West Virginia and national averages.
- Berkeley, Frederick, Hampshire, Jefferson, Mineral, Morgan, Shenandoah, and Warren counties reported unintentional-injury related mortality at a higher rate than the Virginia, West Virginia and national averages for that cohort. The overall populations of Virginia counties reported higher rates of mortality related to suicide than commonwealth averages.
- Clarke, Frederick, Page, Warren, and Winchester City residents experienced cancer mortality rates higher than the commonwealth and national averages for lung and bronchus.
- Breast cancer rates were highest in Frederick and Shenandoah counties, and Winchester City.
- Prostate cancer was reported higher than both the commonwealth and national averages in Shenandoah and Warren counties, and Winchester City.
- Berkeley, Hampshire, and Morgan County residents experienced cancer mortality rates higher than the West Virginia and National averages for colorectal cancer. Berkeley, Hampshire, and Morgan counties reported Cancer Mortality rates higher than both West Virginia national averages for lung and bronchus. Berkeley, Jefferson, and Mineral counties showed the highest rates for breast cancer in the WMC’s community.
- Commenting on the contributing factors to poor health status, interview participants mentioned nutrition and diet, low physical activity and exercise, and food insecurity. Many commented on the lack of affordable, healthy food choices in some parts of the community.

Strategy #1: Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Increase in the number of residency site rotations. (2024-2025)
- Improve patient experience related care continuum. (2023-2025)

Community-based Partnership Metrics

- Mission Critical Partner | Good Samaritan Free Clinic
  Establish two additional clinics for nurse education & follow-up with increased learning about chronic disease management (2023-2024)

Strategy #2: Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

Hospital-based Metrics

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

Strategy #3: Evaluate **Mobile Health** Services for local employers and community members to create a preventive care and screening option that supports the socio-economic needs of the employed, rural, and underserved areas of the community.

Hospital-based Metrics

- Evaluate mobile care and screening options for the community. (2023-2025)

Strategy #4: Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

Hospital-based Metrics

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

Community-based Partnership Metrics

- Community Health Impact Partner | Wheels for Wellness
  Increase volunteer drivers in order to support increase in new client applications for area medical transportation needs (2023-2024)

Prioritized Health Need #2: Mental Health and Substance Abuse

Key Findings

- Nine of the 13 counties in WMC's Community reported poor mental health days higher than their state's average according to the *County Health Rankings* report.
- Clarke, Page, Rappahannock, Shenandoah, and Warren counties reported higher percentages of excessive drinking than the state average of 17 percent, and in West Virginia, Berkeley, Jefferson, Mineral and Morgan counties reported higher percentages of excessive drinking than the state average of 15 percent.
- Mental health days (physically unhealthy days) were reported higher than the state average (4.2) for all seven Virginia counties.
- Alcohol-impaired driving deaths were reported higher than state averages for Frederick County in Virginia, and Berkeley, Hampshire, and Morgan counties in West Virginia.
- Substance abuse was a major concern and mentioned frequently by key informant interview participants. It was portrayed as a growing and serious issue within the community.

Strategy #1: Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Improve patient experience related care continuum. (2023-2025)

Community-based Partnership Metrics

- Mission Critical Partner | NSVSAC
  - Increase by 10, for a total of 25, the number of clients served by NWRADTC (2023-2024)
  - Reduce recidivism and criminal activity for graduates from the NWRADTC, maintaining recidivism rates <30% (2023-2024)
  - Roll out fifty REVIVE community trainings (2023-2024)
  - Distribute 100 GMAR kits and measure consumer feedback (2023-2024)
- Mission Critical Partner | Child Safe Center-Child Advocacy Center
  - Provide 500 trauma screenings and risk assessments with subsequent treatment modalities, with 80% reduction in trauma symptoms (2023-2024)
  - Provide 1000 therapy sessions, of which 100 will be telehealth and assess 200 alleged child abuse victims (2023-2024)
- Community Health Impact Partner | Concern Hotline
  - Offer suicide safety trainings with special focus on rural, disadvantaged communities (2023-2024)
  - Provide 24 hour suicide and personal crisis hotline(2023-2024)
- Community Health Impact Partner | Winchester Rescue Mission
  - Deploy and provide virtual mental health services through Teledoc (2023-2024)

Strategy #2: Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

Hospital-based Metrics

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

Strategy #3: Establish a behavioral health integration model within the primary care settings with the support of mental health professionals and psychiatric provider consultation as part of a **Behavioral Health Continuum**.

Hospital-based Metrics

- Connect primary care practices with psychiatric consultation capabilities. (2024-2025)
- Establish a standardized assessment tool in practice to monitor patient progress (24 Clinics). (2024-2025)
- Staff will complete psychological safety training as part of annual mandatory review coursework. (2023-2025)
- Valley Health will operate or collaborate to expand suicide prevention coverage to patient service areas. (2023-2025)

Community-based Partnership Metrics

- Community Health Impact Partner | Concern Hotline
    - Offer suicide safety trainings with special focus on rural, disadvantaged communities (2023-2024)
    - Provide 24 hour suicide and personal crisis hotline (2023-2024)

Strategy #4: Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

Hospital-based Metrics

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

Community-based Partnership Metrics

- Community Health Impact Partner | Wheels for Wellness
    - Increase volunteer drivers in order to support increase in new client applications for area medical transportation needs (2023-2024)

Prioritized Health Need #3: Access to Primary, Preventative, Clinical Care

Key Findings

- In 2021, the WMC community accounted for 90.2 percent of the hospital's inpatients and emergency department discharges. The majority (86.4 percent) of the hospital's inpatients originated from the primary service area. Approximately 45 percent of emergency department visits originated from Winchester City and Frederick County.
- Population characteristics and change play a role in influencing the health issues of and service needed by communities. The total population in the WMC's community is expected to grow 6.4 percent from 2021 to 2026.
- The Winchester community is experiencing lower ratio rates when it comes to the number of primary care physicians per 100,000 populations and the number of dentists available within the region. In addition, while there have been some growth in providers, there is a need for additional access to mental health providers. The Winchester community is below the Virginia ratio in several counties for these types of providers, according to the *County Health Rankings* report. In West Virginia, ratio rates for mental health providers are lower in all areas except Berkeley County. The need of primary care physicians, dentists, and mental health providers were higher than the state average for all of WMC's community, except for Winchester City for both dental and mental health providers, and Berkeley County for mental health
- All Virginia counties except Frederick and Shenandoah had uninsured rates higher than the commonwealth and national averages. Rappahannock County, and Winchester City had reported uninsured rates higher than the other Virginia counties.
- Since January 1, 2019, more adults living in Virginia have access to quality, low-cost, health insurance through Virginia Medicaid. Covered adults include individuals ages 19-64 with income at or below 138% of the federal poverty limit. As of August 2022, there are 679,591 enrolled members in the commonwealth of Virginia.
- West Virginia's leaders opted to expand Medicaid under the Affordable Care Act (ACA) starting on January 1, 2014, providing coverage to low-income adults, most of whom have jobs but no option for employer-sponsored health insurance. As of May 2022, West Virginia has enrolled 622,788 individuals in Medicaid and CHIP — a net increase of 75.7% since the first Marketplace Open Enrollment Period.
- Clarke, Page, Rappahannock, and Warren counties, and Winchester City reported higher uninsured percentages higher than Virginia (8.4%) and national (8.7%) averages. Berkeley, Hampshire, Morgan, Grant, and Mineral counties in West Virginia had uninsured population percentages higher than the West Virginia state average of 5.9%.
- In West Virginia the uninsured rate decreased from 6.5 percent to 5.9 percent, and in Virginia there was a decrease from 9.9 percent to 8.4 percent during the reporting period.
- The percent of female Medicare enrollees that received mammography screenings in Grant (42%) and Mineral (52%) Counties in West Virginia percentages were higher than the state average of 42 percent.

- The preventable hospital stay rate is higher than the state average for Frederick, Page, Shenandoah, Warren, and Winchester City in Virginia, and Grant County in West Virginia.
- Both Clarke and Winchester City reported higher flu vaccination rates than the commonwealth average of 51 percent in Virginia, and Berkeley and Mineral counties in West Virginia higher than that state average of 42 percent.
- Key informant interviews mentioned that there is a need to promote the importance of health screenings among women aged 40-50 years old.
- In key informant interviews, concerns about access to care, as well as the need for specialty care, were the most frequently mentioned factors contributing to poor health.
- Lack of accessible or reliable transportation to health care appointments and a lack of providers who accept new Medicaid and even Medicare patients were the most frequently mentioned specific access to care issues in interviews, especially for low-income individuals and senior citizens.

Strategy #1: Connect the community to the services needed to improve their health and ensure health equity using **Education and Navigation**.

Hospital-based Metrics

- Conduct an equity assessment on the current data collection methods and establish REaL, SOGI, and SDOH data reports. (2023-2025)
- Establish referral pathways to access primary, specialty and clinical care (2024-2025)
- Increase in the number of residency site rotations. (2024-2025)
- Improve patient experience related care continuum. (2023-2025)

Community-based Partnership Metrics

- Mission Critical Partner | Sinclair Clinic
    - Serve 2,200 uninsured or Medicaid covered individuals (2023-2024)
- Community Health Impact Partner | WATTS
    - Reduce ED visits by operating thermal and day shelters and providing self-care education to clients of the program (2023-2024)
- Community Health Impact Partner | Literacy Volunteers
    - Launch health literacy program, measuring success utilizing pre/post health literacy assessments (2023-2024)

Strategy #2: Create a digital health center that is consistent, effective, and prepared to serve and connect multiple clinical programs simultaneously utilizing **Telehealth** capabilities.

Hospital-based Metrics

- Enable the hospital and ambulatory care settings with technology to provide remote virtual care. (2023-2024)
- Increase in the number of community access points within community based care environments. (2023-2025)

Strategy #3: Establish a behavioral health integration model within the primary care settings with the support of mental health professionals and psychiatric provider consultation as part of a **Behavioral Health Continuum**.

Hospital-based Metrics

- Connect primary care practices with psychiatric consultation capabilities. (2024-2025)
- Establish a standardized assessment tool in practice to monitor patient progress (24 Clinics). (2024-2025)
- Staff will complete psychological safety training as part of annual mandatory review coursework. (2023-2025)
- Valley Health will operate or collaborate to expand suicide prevention coverage to patient service areas. (2023-2025)

Community-based Partnership Metrics

- Community Health Impact Partner | Winchester Rescue Mission
    - Deploy and provide virtual mental health services through Teledoc (2023-2024)

Strategy #4: Establish a **Transportation Network** of staff, volunteers and community partners to support compliance with medical needs and abate barriers to social determinants of health due to transportation.

Hospital-based Metrics

- Assess transportation options for patients within the community. (2023-2025)
- Navigation, coordination and tracking of patient transportation through the Patient Logistics Center (2023-2025)

Community-based Partnership Metrics

- Community Health Impact Partner | Wheels for Wellness
    - Increase volunteer drivers in order to support increase in new client applications for area medical transportation needs (2023-2024)

Prioritized Health Need #4: Social & Economic Factors

Key Findings

- All Virginia counties in the community had a higher percentage than the commonwealth average of residents aged 25 and older who did not graduate high school. Page County experienced a slight increase of 20 percent of non-graduates compared to the previous2019 assessment showing 19.6 percent of non-graduates.
- Grant, Hampshire, Hardy, and Morgan counties in West Virginia had higher percentages of non-graduates than the state average of 13.8 percent. Berkeley and Jefferson counties have higher percentages of residents who completed a college degree than the state average of 29.1 percent.
- In Virginia, three of the seven counties reported higher percentages of households with income less than $25,000 than the Virginia commonwealth average of 15 percent. In West Virginia, all seven counties reported percentages lower than the state average of 25.8 percent, however, four of those counties reported household incomes greater than the national average of 18 percent.
- Page and Shenandoah counties, and Winchester City reported median household income levels below the state and national averages. In West Virginia, Hardy, Morgan, Grant and Mineral counties also reported median household income levels below the state and national averages.
- Unemployment rates are shown for December 2019-July 2022. Post-pandemic unemployment rates are higher than pre-pandemic rates across all counties in our region with the exception of Page County.
- In 2019, Page County reported the highest unemployment rate among Virginia counties in the WMC community, and Hardy County reported the highest unemployment rate for West Virginia counties. The unemployment rate for Page County reported a slight increase from previous year, and is higher than Virginia and national averages.
- Clarke, Rappahannock, Berkeley, Jefferson, and Mineral counties reported the highest percentage of students completing high school.
- The highest unemployment rate for WMC's community was in Page County.
- The highest percentages of children in poverty were reported for Hampshire, Page, Rappahannock, Shenandoah, and Warren counties, and Winchester City.
- Children in single households were reported higher for Mineral and Warren counties, and Winchester City.
- Winchester City, Hardy and Morgan counties reported the highest violent crime rates for WMC's community.
- Frederick and Shenandoah counties had a higher number of offenses for property crimes, including burglary, compared to other counties within WMC's community. Offenses reported for larceny were also comparatively high in Frederick and Jefferson counties. Frederick County had the highest number of reported offenses of motor vehicle thefts compared to other counties within the service area.
- The highest percentages of students receiving free or reduced lunches for the WMC Community were located in Page County and Winchester City, VA.
- Interview participants believe that low income housing and poverty were the top issues contributing to poor health status and limited care. Other income-related factors noted

include difficulty with securing transportation to medical appointments and homelessness.

- From the community health survey, low income and financial challenges were reported. For survey respondents who reported not being able to always get the care they needed, affordability and lack of insurance coverage were the reasons most frequently mentioned.

Strategy #1: Develop Community Collaborations to address disparities involving social determinants of health and health equity.

Hospital-based Metrics

- Increase community collaborative relationships

Community-based Partnership Metrics

- Mission Critical Partner | Healthy Families Northern Shenandoah Valley
  - Improve maternal health outcomes & child development, through home visiting services & promotion of positive parent-child relationships (2023-2024)
  - Connect families to resources for substance abuse, depression, and food insecurity, fostering health equity (2023-2024)
- Mission Critical Partner | Our Health
  - Assess Unite Us utilization in VH service area, updating the Unite Virginia Referrals Quick Guide and increase partner agencies participating in Unite Us (2023-2024)
- Mission Critical Partner | Good Samaritan Free Clinic
  - Define 85% of GSFHC population through use of demographic report derived from EMR data in order to identify and address health disparities (2023-2024)
- Community Health Impact Partner | Literacy Volunteers
  - Launch health literacy program, measuring success utilizing pre/post health literacy assessments (2023-2024)