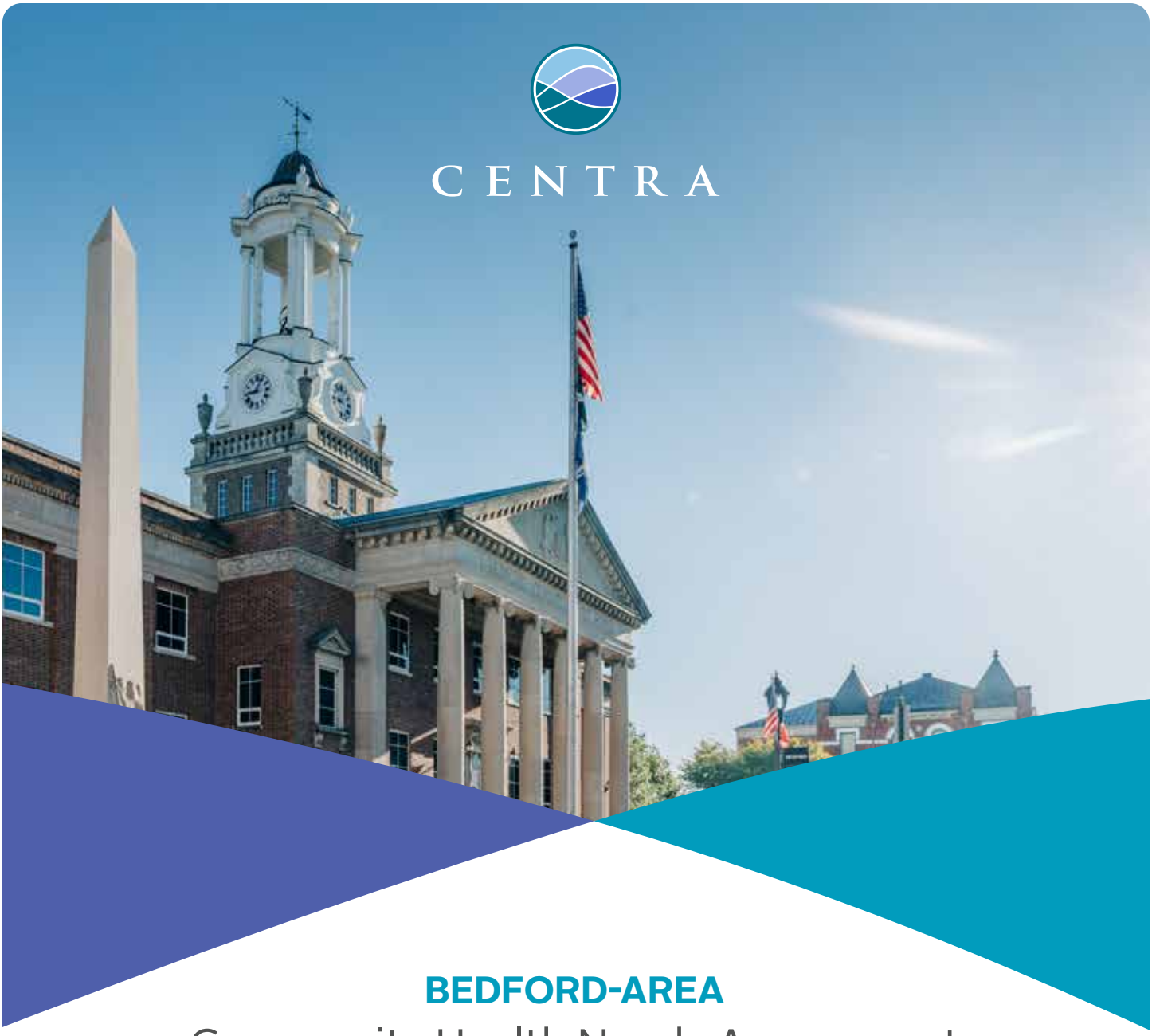

CENTRA

BEDFORD-AREA
Community Health Needs Assessment
2024–2027

TOWN OF BEDFORD AND BEDFORD COUNTY

www.CentraHealth.com/Community-Resources/Community-Health#CHNA

Centra Bedford Memorial Hospital

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ACKNOWLEDGEMENTS

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The 2024 Bedford Area Community Health Needs Assessment (CHNA) was the result of numerous hours of leadership and service by the following individuals, institutions, and partnerships.

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Centra Health is pleased to provide the triennial 2024 Community Health Needs Assessment (CHNA) for Centra Bedford Memorial Hospital located in Bedford, Virginia. For the purposes of this report, the service area is referred to as the Bedford Area and includes the town of Bedford and the county of Bedford. The CHNA provides an overview of the health status of the communities served by the health system. It is the intent of this report to provide readers with a deeper understanding of the needs of the Bedford Area as well as to guide Centra Health, and its community partners and stakeholders, in developing Implementation Plans to address the prioritized needs identified as part of the assessment process. The Community Health Needs Assessment and Prioritization of Needs was approved by the Centra Community Benefit Committee on November 22, 2024, the Centra Bedford Memorial Hospital Board of Directors on December 3, 2024, and the Centra Board of Directors on December 9, 2024.

The impact of the COVID-19 pandemic was a key component of the 2021 Community Health Needs Assessment. While the immediate crisis phase has passed, COVID-19's ripple effects continue to shape Virginia's public health landscape and policy priorities. Since 2022, the impact of COVID-19 on the health of Virginians has evolved significantly. While the severity of the illness has generally declined due to increased vaccination and the availability of effective treatments, COVID-19 continues to affect public health and social systems. Virginia experienced a reduction in severe cases and deaths compared to earlier years, largely attributed to widespread immunity from vaccination and previous infections. However, the virus still poses challenges, particularly for vulnerable populations such as the elderly and those with preexisting conditions.

The state's public health policy has transitioned from emergency measures to integrated management of COVID-19 alongside other respiratory illnesses like influenza. This includes continued vaccine availability, updated booster recommendations, and increased access to testing and treatment options. The Virginia Department of Health has also shifted towards tracking COVID-19 data through broader respiratory illness dashboards and wastewater surveillance to monitor trends.

The pandemic has also highlighted social determinants of health, with lasting impacts on mental health, educational attainment, and healthcare access. Virginia's response included increased support for mental health services, efforts to mitigate educational disruptions, and policies aimed at addressing disparities exposed by the pandemic. The state has adapted social policies, promoting telehealth and flexible work arrangements, which have had positive long-term effects on health equity and access.

In 2024, a Community Health Assessment Team (CHAT) composed of over 81 individuals with a broad representation of community leaders and cross-sector stakeholders acted to oversee, advise, and support the CHNA activities. On average, 39 individuals attended each of the four meetings conducted throughout the assessment. This team was committed to regional alignment of a collaborative and rigorous needs assessment process that result in action-oriented solutions to improve the health of the communities they serve. The Bedford Area Resource Council (BARC) is a network of non-profit, for profit, state and local government agencies, and citizens who serve the Town and County of Bedford and work to respond to needs identified in the triennial Centra Community Health Needs Assessments. Many of the BARC members also serve on the CHAT. The Central Virginia Health District served as a pivotal partner in 2024, participating in the planning of the CHNA as well as leading efforts in the collection of our primary data. In addition, the University of Lynchburg's Research Center team was engaged in the revisions and analysis of the primary data.

The 2024 Bedford Area Community Health Needs Assessment focused on lifting the voice of the community through the collection of 765 Community Health Surveys as well as conducting a stakeholder focus group and 4 target population focus groups. In addition, over 75 sources of publicly available secondary data were collected.

Key Findings

Please note: *Due to the small population size of the town of Bedford, publicly available secondary data is often unavailable for the town. Therefore, most secondary data is presented in the 2024 Bedford Area Community Health Needs Assessment for Bedford County only.*

The data for the Community Health Needs Assessment is reported using the framework for the County Health Rankings from the University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation. Until 2024, these rankings, released annually, measure the health of a community, and rank them against all other counties within a state. In Virginia, there are 133 localities that are ranked annually. The County Health Rankings for Bedford County for 2021-2023 are in the 1st quartile for "Health Outcomes", which is a measure of morbidity and mortality and how healthy a locality is today, and the 1st and 2nd quartile for "Health Factors", which represent the factors that influence the health of a community in the future.

County Health Rankings

Locality	2021		2022		2023		3 YR Change	
	Health Outcomes	Health Factors	Health Outcomes	Health Factors	Health Outcomes	Health Factors	Health Outcomes	Health Factors
Bedford	32	38	30	30	25	30	-7	-8

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

WORSE
BETTER

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

In 2024, the County Health Rankings & Roadmaps introduced several key updates to enhance the assessment and comparison of health across U.S. counties. Notably, the changes include a shift from purely state-based comparisons to tools that allow for direct comparisons across all counties nationwide. This new approach aims to provide a more comprehensive understanding of health outcomes regardless of state boundaries. Counties are assigned composite scores for health outcomes and health factors that fall into (1 of 10) for health outcomes and/or (1 of 9) for health factors, grouping localities in terms of healthiest to least healthiest counties in the country. The lower the number, the healthier the locality. For health outcomes, communities ranked 1–5 are the healthiest, with those ranked 6–10 being the least healthy. For health factors, communities ranked 1–5 are the healthiest, while those ranked 6–9 are the least healthy.

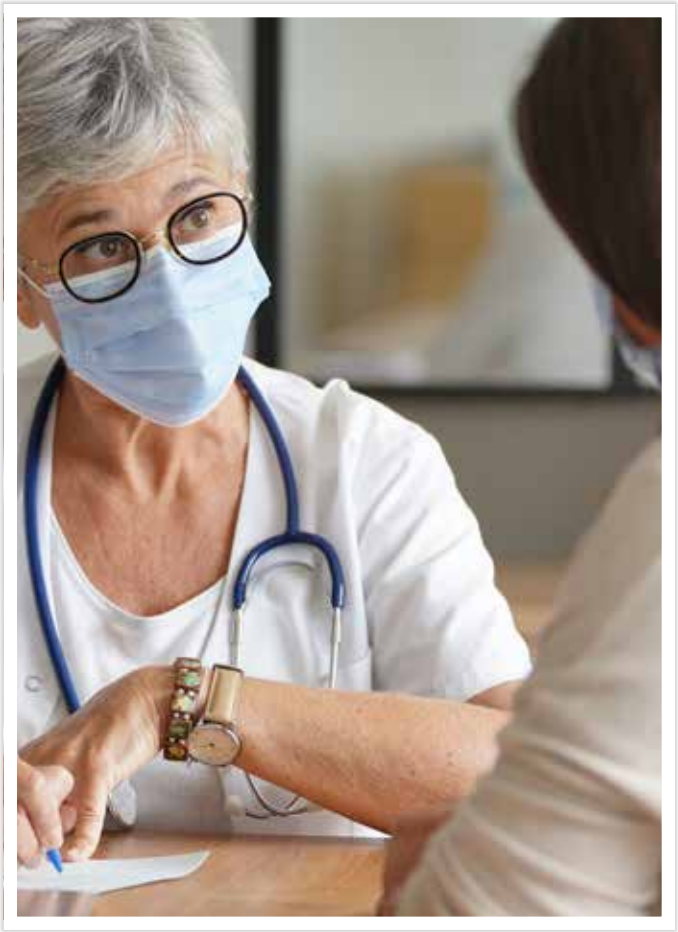
The updated framework now emphasizes factors like housing affordability, income levels, educational attainment, and access to recreational spaces. Additionally, the data incorporates more nuanced racial and ethnic groupings, better reflecting diverse community identities based on updated census information. New visualization tools also help to present data on health outcomes (like life expectancy) and health determinants more clearly, aiming to support local and national initiatives for health equity.

The County Health Rankings for the Bedford Area for 2024 reveal distinct changes in Bedford County's scoring, ranking it unhealthy for both health outcomes and health factors as compared to similar localities nationally. With the previous methodology, the County was ranked as one of the healthiest localities in Virginia.

Health Outcomes		
County	*National Group Rank*	*Health Group Range*
Bedford	8	-0.72 to -0.4

Health Factors		
County	*National Group Rank*	*Health Group Range*
Bedford	7	-0.67 to -0.44

1	2	3	4	5	6	7	8	9	10



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

Demographics, Social and Economic Status

According to the U.S. Census, the total population for Bedford County is 80,848 where 49.6% of the population is male and 50.54% is female. The total population in the town of Bedford is 6,777 where 44.6% of the population is male and 55.4% is female. The median age for Bedford County is 47.6 compared to 38.7 in Virginia. Approximately 23% of the population in Bedford County and 19.2% in the town of Bedford is 65 years of age or older which is higher than those 65 years of age or older living in Virginia (16%) and a slight increase since 2021. Approximately 83.6% of those living in Bedford County are White, 6.0% are Black, and 2.8% are Hispanic or Latino. In the town of Bedford, 71.8% are White, 17.6% are Black, and 2.5% are Hispanic or Latino.

The median household income in Bedford County is $71,751 as compared to $85,873 in Virginia with White and Black populations having higher median household incomes than Hispanic or Latino. In the town of Bedford, the median household income is $41,154. Approximately 24.8% of the population in Bedford County and 44.2% of the population in the town of Bedford lives at or below 200% of the Federal Poverty Level as compared to 36.6% in Virginia. Additionally, approximately 28% of the 32,510 households in Bedford County are classified as ALICE (Asset Limited, Income Constrained, Employed) as compared to 29% of households in Virginia. ALICE is a way of defining and understanding the struggles of households that earn above the Federal Poverty Level, but not enough to afford basic household needs (i.e., cost of living outpaces what they earn).

Of the public school-aged children, 56.86% (5,157) in the service area are eligible for free and reduced lunches as compared to 58.1% of children in the Commonwealth. It is important to note that of the 19 schools in the district, 11 schools located in the town of Bedford and in the western part of the County have a significantly higher number of students eligible for free and reduced lunch rates ranging from 74% to 100%. One hundred percent (100%) of students who attend Bedford Primary School, located in the town of Bedford, are eligible for free and reduced lunches due to the Community Eligibility Provision (CEP). The CEP in Virginia allows high-poverty schools to provide free breakfast and lunch to all students without collecting individual applications. Approximately 12.5% of children under 18 years of age live below the Federal Poverty Level in Bedford County as compared to 12.8% in Virginia.

Although unemployment rates were decreasing in 2018 and 2019 across the Commonwealth, there was an almost doubling of these rates in 2020 because of the COVID-19 pandemic at 6.4% in the service area. However, these rates have slowly improved since the end of the pandemic with the rate in Bedford County at 2.9% in 2023 as compared to 2.9% in Virginia. In Bedford County, of the population age 25 and over, educational attainment is 7.5% for less than high school graduate; 29.4% for high school graduate or equivalent; 30.5% for some college or associate's degree; and 32.6% for bachelor's degree or higher.

Of the 2024 Community Health Survey respondents, the majority lived in the service area (85%). US Census population data for the service area was used as a comparison to determine whether there was a good representation of survey respondents living in the region. More survey respondents lived in the town of Bedford (33%) as compared to population statistics data for the town (8%) and fewer respondents reported living in Bedford County (52%) as compared to 92% of the population that live in the county (US Census). In 2024, 45% of respondents reported their age as 25-54 years and 52% reported their age as 55 and older. In comparison, the US Census reports that 35% of the service area population is aged 25-54 years and 39% of the population is aged 55 and older. In 2021, 64% of respondents were 25-54 years of age and 33% were 55 and older. In 2024, we saw a decrease in the number of male respondents (19%) as compared to 29% of respondents in 2021. Conversely, 79% of respondents were female in 2024 as compared to 70% in 2021. Approximately 87% of 2024 survey respondents were White, 5% were Black/African American, and 2% Hispanic/Latino as compared to US Census statistics where 83% of the service area population is White, 7% is Black/African American, and 3% is Hispanic/Latino. The shift in survey demographics in 2024 may be because

there was still a "stay at home" mandate in 2021 when the previous survey was collected, and younger respondents may have been more likely to complete it while at home and not in the workforce.

Fewer survey respondents in 2024 (9%) reported an annual income of $20,000 or less per year as compared to 2021 (14%). In addition, there was a slight decrease in the number of respondents who reported incomes of $20,001 to $40,000 in 2024 (12%) as compared to 2021 (18%). This income level may represent the number of respondents who are ALICE (Asset Limited, Income Constrained, Employed). There was a 10% increase in the number reporting household incomes of over $101,000 or more per year in 2024 (36%) as compared to 2021 (26%). Education attainment rates continue to be roughly the same for respondents in 2024 as compared to 2021 with 21% reporting having a high school diploma/GED, 16% with an associate's degree, and 28% with a bachelor's degree, while there was an increase in those with a Masters/PhD degree (27%). In 2024, over half of respondents were employed full-time similar to 2021, with 3% reporting being unemployed in 2024 compared to 5% in 2021. Fifty percent (50%) more respondents reported being retired in 2024 (24%) compared to 2021 (11%). In 2024, fewer respondents reported not having enough money in the past 12 months to pay for rent or mortgage (15%) and not having enough money in the past 12 months to buy food (18%). Approximately 14% could not afford to pay for their medications in 2024.

Fewer respondents reported that they had been a victim of domestic violence or abuse in the past 12 months in 2024 (2%) as compared to 2021 (8%) and fewer reported that they did not feel safe where they lived in 2024 (3%) compared to 2021 (9%). When asked which social/support resources are hard to get in the community, the top 5 resources included (1) affordable/safe housing; (2) childcare; (3) transportation; (4) healthy food; and (5) employment/job assistance.

Health Behaviors

According to County Health Rankings data, the obesity rate for Bedford County is 36% as compared to 34% in Virginia. Approximately the same proportion of adults in Bedford County report no-leisure time physical activity (21%) as compared to 20% in the Commonwealth. There was only a slight increase in Bedford Area Community Health Survey respondents (36%) who met physical activity guidelines of 150 minutes of aerobic activity weekly in 2024 as compared to 35% in 2021.

Approximately 40% of Community Health Survey respondents reported that their neighborhoods don't support physical activity (compared to 22% in 2021) while 15% reported that it is not easy to get affordable fresh fruits and vegetables in their neighborhoods (compared to 23% in 2021). There was almost a 25% increase in the number of respondents who reported that they get their food from grocery stores (99%) and a slight increase in the percent who reported getting the food they eat at home as take-out/fast food food/restaurant (43%) or from a home garden (23%) while 20% get their food at a Farmers market. Many respondents did not meet the minimum requirements for daily fruit and vegetable consumption in 2024.

Data for Bedford County reveals that 17% of adults binge or drink heavily (18% in Virginia) while 7% are current tobacco smokers (13% in Virginia). In 2024, 8% of Community Health Survey respondents reported using tobacco products and 13% reported binge drinking during one occasion in the past month, a decrease compared to responses in 2021 (20% and 24% respectively). No respondents reported taking prescription drugs to get high or using illicit drugs; while there was a 2% in those who reported using marijuana products (6%).

Since 2021, the opioid epidemic in Virginia has remained a severe public health crisis. Opioid-related deaths continue to be alarmingly high, driven largely by fentanyl or analogs. In 2022, the opioid-related death rate in Virginia was approximately 26 per 100,000 residents. Opioid overdose death rates in Bedford County were 32.6 per 100,000 representing a change of 27.5 per 100,000 from 2018 to 2022.

In 2022, diagnoses rates in Bedford County for Chlamydia and Gonorrhea, both sexually transmitted illnesses, were 184.7 per 100,000 and 66.1 per 100,000 as compared to rates of 593.1 per 100,000 and 155.7 per 100,000 in Virginia respectively. The 3-year average rates of newly diagnosed cases of HIV were lower in Bedford County (3.7 per 100,000) compared to Virginia (9.7 per 100,000).

Clinical Care

Bedford County is designated as a federal Medically Underserved Area and as Health Professional Shortage Areas for Primary Care, Mental Health, and Dental. There is one Federally Qualified Health Center (FQHC) and one Community Services Board that serve the area.

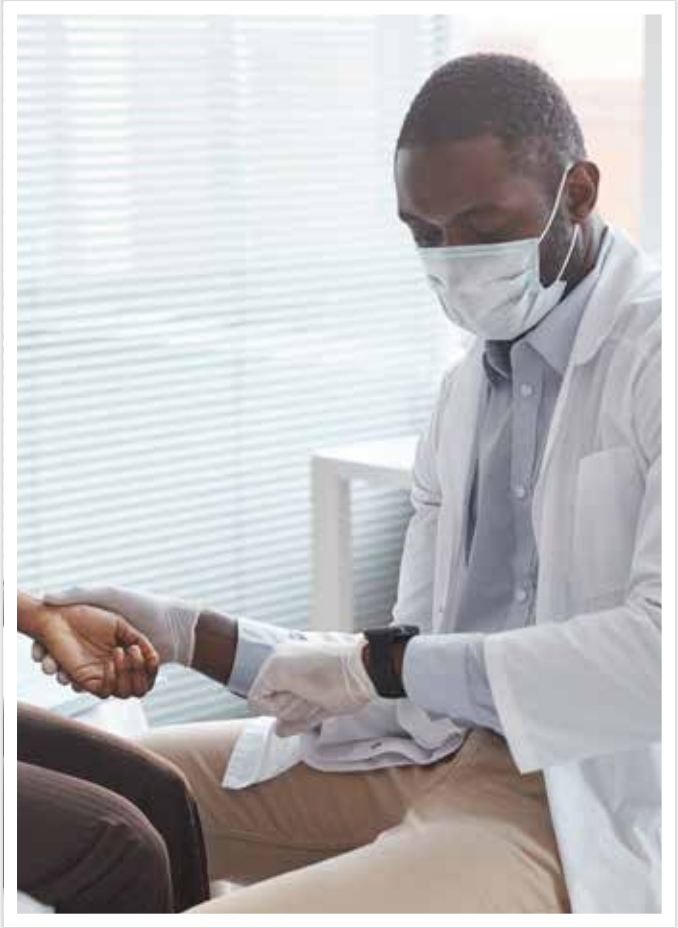
Over 97% of Community Health Survey respondents reported using medical services. Of those who use medical services, 60% reported using Centra Medical Group as their top choice for care while there was an increase in the use of Urgent Care/ Walk-in Clinic (48%), Doctor's Office (45%), Emergency Room (32%), and telehealth (18%). There was no change in the percent of respondents who use Central Virginia Family Physicians (28%) and a slight decrease in those using the FQHC (5%), Health Department (3%), Veterans Administration Medical Center (2%) and the Free Clinic (2%) as compared to 2021 survey responses.

Respondents reported a slight decrease in utilization of dental services from 92% in 2021 to 88% in 2024. Of those who use dental services, 77% reported having a dental exam within the past 12 months, an increase from 61% in 2021. The majority used a Dentist Office (99%) and fewer used FQHC's, the Free Clinic, Emergency Room, Urgent Care/Walk-in Clinics, and the Veterans Administration Medical Center for dental care as compared to respondents in 2021.

The number of respondents indicating that they use mental health, alcohol or drug abuse services decreased from 32% in 2021 to 16% in 2024. Approximately 84% who utilized these services used Doctor/Counselor's office for care and 25% used telehealth, an increase since 2021. Fewer reported using FQHC's (6%), the Community Services Board (10%), the Emergency Room (4%), the Free Clinic (3%), Veterans Administration (2%) and Urgent Care (1%) in 2024.

Insurance status reported by 2024 survey respondents, included 59% with Employer provided insurance (53% in 2021), 38% with dental insurance (31% in 2021), 26% with Medicare (17% in 2021) and 9% with Medicaid (10% in 2021). Three percent (2%) of respondents reported having no health insurance (1% in 2021). In comparison, according to the County Health Rankings in 2024, 9% of adults under age 65 in Bedford County are uninsured similar to 9% in Virginia. Additionally, the US Census reports that 7.7% of those living in Bedford County have Medicare, 8.5% have Medicaid, and 75.5% are privately insured.

When asked which healthcare services are hard to get in the community, survey respondents reported (1) memory care services; (2) substance use services-drug and alcohol; (3) prescription medication/medical supplies; (4) mental health/counseling; and (5) adult dental care. When asked what prevents them from being healthy, survey respondents reported (1) long waits for appointments; (2) cost; (3) lack of evening and weekend services; (4) lack of doctors/dentists accepting new patients; and (5) nothing keeps me from being healthy.



Physical Environment

The physical environment can impact a wide range of health and quality-of-life outcomes and include such factors as the natural environment, transportation, the built environment, housing, exposure to toxic substances, and physical barriers especially for those living with disabilities. Data for Bedford County reveals that 8% of households have severe housing problems as compared to 14% of households in Virginia. Housing problems include overcrowding, high housing costs, or lack of kitchen or plumbing facilities. The residential segregation for Bedford County (the degree to which two or more groups live separately from one another in a geographic area) is at a segregation index of 36 as compared to 51 in Virginia.

Community Health Survey respondents were asked where they sleep most often. In 2024, 96% of respondents slept most often in their own homes compared to 70% in 2021. Fewer reported staying with friends or family because of financial issues, in a shelter or transitional home, or in a group home/treatment program as compared to respondents in 2021.

Approximately 96% of respondents in 2024 indicated that they had access to reliable transportation compared to 90% in 2021. When asked what type of transportation they use most often, 93% indicated that they drove, relied on others to drive them (5%) or used public transit (1%).

Since the onset of the COVID-19 pandemic, Virginia has significantly accelerated efforts to expand broadband access, recognizing its essential role in education, telehealth, and economic activities. Virginia aims to achieve universal broadband coverage using public and private sources including federal COVID relief funds. According to County Health Rankings, 85% of households in Bedford County have broadband internet connection for the years 2018-2022 as compared to 89% in Virginia.

Health Outcomes

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

Length of Life

In Bedford County, the life expectancy by average number of years lived is 77.8 years as compared to 78.1 in Virginia. Disparities can be found with lower life expectancy for Blacks living in Bedford County (76.4 years). The premature death rate per 100,000 population for Bedford County is 362.2 as compared to 361.9 in Virginia. Again, these rates are higher for Blacks (419.8 per 100,000). In Bedford County, death rates are higher for overall deaths; deaths due to injury; and stroke. Service area death rates for stroke and heart disease were higher for Blacks compared to Whites. Overall cancer incidence rates are higher for all cancers, breast, lung, colon and rectal cancers as compared to rates in Virginia while cancer incidence rates are higher for Blacks in the service area for all cancers, prostate, breast, and lung cancers.

Suicide rates in Bedford County per 100,000 population are higher (18.7) than the overall state rate (13.4).

Quality of Life

Low birth weights by percent of total live births on average were lower in Bedford County (6.3%) compared to the Commonwealth (8.3%). When presented by race, low birth weights are slightly higher for Whites (6.6%) as compared to Blacks (5.1%). Teen birth rates are measured as number of births per 1000 female population ages 15-19 and the rate for Bedford County is the same as the rate in Virginia (13 births per 1000). However, racial disparities exist where the rate is higher for Black teens (16 per 1,000) as compared to Whites (13 per 1,000).

In 2024, when thinking about their health in the past month, 40% of survey respondents reported that their physical health was not good for 1 to 13 days and 13% reported their physical health was not good for 14 to 30 days. When thinking about their mental health in the past month, 36% reported their mental health was not good for 1 to 13 days and 10% reported their mental health was not good for 14 to 30 days. Secondary data for the service area revealed that persons reporting the average number of physically unhealthy days (3.6) and average number of poor mental health days (5.1) in the past month was slightly higher for Bedford County as compared to Virginia (3.2 and 4.9).

Survey respondents diagnosed with a chronic condition reported having obesity/overweight, high blood pressure, depression or anxiety, high cholesterol, and arthritis most frequently.

One Stakeholder and four Target Population focus group meetings were held in the Bedford Area. The Stakeholders' focus group meeting was held with 33 cross-sector non-profit organizations, service providers, business leaders, and local government officials. The Target Population focus group meetings were held with 19 residents who represented various demographic characteristics (i.e. race/ethnicity, gender and age) in the service area. Participants were asked questions regarding the needs in the community, resources available to address those needs (including any gaps in resources), and how we can work together to create healthier communities. Areas of need identified by both stakeholders and target populations included access to healthcare, mental health care and drug abuse treatment, transportation, food insecurity, and affordable housing. Additionally, stakeholders identified affordable childcare, awareness of resources, broadband access, domestic abuse, and elder care as needs in the service area. The target population also focused on cost of services, language barriers, community engagement and more accessible outdoor and recreational spaces.

Community Need

The 2024 Community Health Survey respondents were asked what are the most important issues that affect health in our community by ranking both health factors and health conditions/ outcomes. The top 10 responses were as follows:

	Health Factors	
1	**Aging problems**	61%
2	**Alcohol and illegal drug use**	51%
3	**Poor eating habits**	49%
4	**Access to affordable housing**	49%
5	**Distracted driving (cell phone use/ texting and driving)**	47%
6	**Lack of exercise**	45%
7	**Access to healthy foods**	45%
8	**Tobacco use/ smoking/ vaping**	33%
9	**Cell phone use (social media)**	31%
10	**Child abuse/neglect**	30%

	Health Conditions or Outcomes	
1	**Mental health problems**	67%
2	**Overweight/ obesity**	57%
3	**Diabetes**	57%
4	**Drug/ alcohol problems**	56%
5	**Cancers**	55%
6	**Heart disease and stroke**	51%
7	**Sedentary lifestyle (physical inactivity)**	49%
8	**Stress**	48%
9	**Alzheimer's/ Dementia**	48%
10	**High blood pressure**	48%

Prioritization of Needs

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

1. **Responses from the Community Health Survey**
    a. Q3A: What do you think are the most important issues that affect health in our community? (Health Factors) (n= 670 survey respondents)
    b. Q3B: What do you think are the most important issues that affect health in our community? (Health Conditions or Outcomes) (n= 670 survey respondents)
    c. Q4: Which healthcare services are hard to get in our community? (n= 667 respondents)
    d. Q5: Which social/support resources are hard to get in our community? (n= 653 respondents)
    e. Q6: What keeps you from being healthy? (n= 595)
2. **Responses from the Stakeholders' & Target Population Focus Groups**
    a. Q1: Stakeholders - What are the top 5 greatest needs in the community(s) you serve? (n= 33 participants, 1 meeting conducted)
    b. Q1: Target Population - What are the top 5 greatest needs in your community(s) around health and wellness? (n=15 participants, 3 meetings conducted)
    Please note: *Analysis of the "Spanish-speaking" Target Population Focus Group meeting (4 participants) was not available in time to include in the detailed worksheet.*

To develop a list of priority needs for 2024, the top 10 responses to the five survey questions (Q3A-Q6) were sorted in an Excel workbook along with the top 11 community needs identified by the Stakeholder Focus Group and the top 7 community needs identified by the 3 Target Population Focus Groups (Q1). In addition, the top 10 Priority Areas of Need for the Bedford Service Area in 2021 were included. Altogether there were 18 Areas of Need.

On October 4, 2024, an in-person CHAT meeting was held to prioritize the top 10 priority areas of need for the 2024 Bedford Area Community Health Needs Assessment. There were 33 in attendance and members were asked to rank the 18 Areas of Need from 1 to 10. The answer choice with the most responses had the largest weight and was ranked as #1 and the answer choice with the least responses had the smallest weight and was ranked as #18.

The top 10 priority areas are reflective of the County Health Rankings' four categories for Health Factors including Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment. At Centra, we view all these health factors through the lens of equity, inclusion, and diversity.

The following table presents the final Top 10 Priority Areas of Need for 2024 as compared to the priorities in 2021. New priority areas for 2024 include:

- **Food Insecurity & Nutrition**
- **Coordination of Resources & Outreach**

Bedford Area Top 10 Priority Areas of Need | *2021 and 2024 Compared*

Ranking	*2021*	*2024*
1	**Mental Health and Substance Use Disorders & Access to Services**	**Mental Health & Substance Use Disorders & Access to Services**
2	**Access to healthcare services**	**Access to Healthcare Services**
3	**Issues Impacting Children & their Families: Childcare Child abuse/neglect**	**Food Insecurity and Nutrition**
4	**Transportation**	**Issues Impacting Children & their Families: Child Abuse & Neglect Childcare**
5	**Aging and Eldercare**	**Homelessness & Housing**
6	**Chronic Disease**	**Transportation**
7	**Employment / Job assistance**	**Aging and Eldercare**
8	**Financial Stability**	**Dental Care & Dental Problems**
9	**Housing**	**Coordination of Resources & Community Outreach**
10	**Dental Care & Dental Problems**	**Chronic Disease**

PROJECT BACKGROUND

This section highlights Centra's services and programs, a project overview, and description of the service area, target population and methodology for the 2024 Bedford-Area Community Health Needs Assessment.

PROJECT BACKGROUND

Organizational Overview

Centra Health (Centra) is a regional nonprofit healthcare system based in Lynchburg, Virginia. With more than 7,500 employees, 550 employed providers and physicians and a medical staff of nearly 1,100 providing care in 50 locations, Centra serves over 500,000 people as the dominant provider of critical medical services in central and southern Virginia. Over the last three years, the system's net revenue grew from $1.2 billion in 2020 to $1.3 billion in 2023.

Centra was created in 1987 through the merger of Lynchburg General (LGH) and Virginia Baptist (VBH) Hospitals. In 2006, Southside Community Hospital (CSCH) in Farmville became a Centra affiliate. In 2014, Centra acquired full ownership of Bedford Memorial Hospital (BMH), in the town of Bedford, which is its fourth hospital. In addition to these flagship facilities, the system includes Centra Specialty Hospital, a long-term acute care hospital, a regional standalone emergency department, health and rehabilitation centers, a cancer center, a nursing school and sites and providers serving a geography of approximately 9,000 square miles. Centra services also include residential and outpatient mental health facilities, home health and hospice programs, mammography centers, a sleep disorders center and a center for wound care and hyperbaric medicine. Centra is home to the Central Virginia Center for Simulation and Virtual Learning, the only center in Virginia that offers a full range of simulation experiences. In October 2024, Centra welcomed Richard Tugman to the role of president and Chief Executive Officer.

Centra Bedford Memorial Hospital (CBMH) is a full-service medical facility with a special emphasis on outpatient surgery, emergency services, cardiology care, and rehabilitative services. The facility offers 24-hour emergency care to a local community of approximately 80,000 residents. CBMH is a licensed 50-bed acute care facility. CBMH has an estimated 1,800 admissions and 24,000 emergency department visits annually.

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

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

Centra Heart and Vascular Institute (HVI) is home to many heart and vascular services. In addition to providing general cardiology care, HVI includes cardiothoracic surgery, vascular surgery, bariatrics, endocrinology and wound care specialties. They also offer advanced cardiac imaging and other diagnostic tests. HVI has locations throughout the Centra footprint including Lynchburg, Farmville, Gretna, Moneta, Bedford and Amherst.

Centra Medical Group (CMG) is a network of local family practices, primary care providers and medical and surgical specialists. With almost 600 employed providers, specialists and surgeons covering the greater Lynchburg area and spanning from Danville to Farmville, Moneta and Bedford, CMG provides the community with primary care providers, cardiologists, cardiothoracic surgeons, gerontologists, neurosurgeons, physiatrists, psychiatrists, therapists and urologists. CMG-Lynchburg Family Medicine Residency is a training ground for future Family Physicians. Many of the physicians at the side hold academic appointments with the University of Virginia, Virginia Commonwealth University, Edward Via College of Osteopathic Medicine or Liberty University.

The Centra Foundation was established in 1993 to develop and direct resources for the support of Centra. Over the past five years, on average the Centra Foundation contributed $4 million annually in support of Centra programs to help our regional not-for-profit healthcare system provide quality care and meet the critical healthcare needs of over 500,000 people in our local communities, regardless of ability to pay. The Centra Foundation has a net asset portfolio of $84 million and gifts in 2023 totaled $3.66 million.

Centra's Community Health Services, formed in 2020, exists "to improve the health and quality of life for the communities we serve". This includes system-wide triennial Community Health Needs Assessments (CHNA) and Implementation Plans, community-based grants, and Community Benefit Reporting. From 2021-2023, Centra awarded over $3.8 million in community grants to our non-profit partners, addressing the CHNA priority needs in the community and projects of regional importance. In 2024, we anticipate awarding $1.5 million in grants. For more information, please visit https://www.centrahealth.com/community-resources/community-health to review the 2021-2023 Centra Community Benefit and Impact Report.

Central Virginia Accountable Care Collaborative (CVACC), or Centra Alliance, which is an accountable care organization (ACO) was formed to collectively create processes and clinical initiatives that are designed to control costs, improve quality of care of the community and improve the patient experience. Centra will develop the expertise to manage risk as it transitions from a "volume to value" orientation and focuses on population health. Centra Alliance will further the adoption of new models of reimbursement, care management, electronic record integration, data analysis, and physician alignment to support high-quality, affordable care to the communities we serve.

Scope and Purpose of Community Health Needs Assessment

The scope of this Community Health Needs Assessment pertains to Centra Bedford Memorial Hospital.

Centra defines its triennial Community Health Needs Assessment (CHNA) as a continuous process for evaluating the health needs of the communities served. It is used to support the system's "Just Cause" which is "partnering with you to live your best life." Centra's new Strategic Plan, launched in 2022, serves as our compass, guiding us toward the mission "to improve the health and quality of life for the communities we serve." Our vision is to "Pursue Excellence. Inspire Hope. Advance Health and Healing." Guided by the 2021 Community Health Needs Assessment (CHNA), the plan emphasizes Community Heath and Value-Based Care as one of 5 key pillars. The plan focuses on addressing local and regional health needs by fostering strategic partnerships, expanding access, and creating value to transform community health. Diversity, Equity, and Inclusion (DE&I) is embedded across all efforts, ensuring we meet the diverse needs of those we serve. Through collaboration with stakeholders, Centra remains committed to improving health and quality of life for all. For more information on Centra's Strategic Plan, please visit https://www.centrahealth.com/strategic-plan.

In addition, the CHNA and Implementation Plan is used to guide the actions of the Centra Board of Directors' Community Benefit Committee, which provides community-based grant and sponsorship funding to area non-profit organizations addressing prioritized needs identified through the triennial CHNA. Lastly, the completion of both the triennial Community Health Needs Assessment and successful execution of the associated Implementation Plan ensures compliance with the Patient Protection and Affordable Care Act of 2010 which is promulgated in regulation by the Internal Revenue Service as documented annually in Centra's Form 990- Schedule H.

Project Overview

Social Determinants of Health (SDOH) are non-medical factors that influence health outcomes, including the environments in which people are born, grow up, work, live, and age. These factors include:

- **Economic stability**
- **Education and employment access**
- **Neighborhood and physical environment**
- **Social connectedness**
- **Access to quality healthcare**

These conditions together shape the well-being and quality of life of individuals and communities while contributing to major health disparities. For instance, individuals in neighborhoods with limited access to nutritious food or safe recreational spaces are more likely to experience chronic diseases such as obesity and diabetes. Conversely, environments that promote physical activity, such as those with bike lanes and parks, encourage healthier lifestyles and reduce risks of illness.

Marginalized groups, such as those in low-income or rural areas, often face systemic barriers to these determinants, resulting in poorer outcomes and shorter life expectancies. Addressing these disparities requires collaboration between public health organizations and partners in sectors like education, transportation, and housing to enhance social supports, improve infrastructure, and ensure equitable access to essential resources.

Source: Centers for Disease Control and Prevention (CDC) – Social Determinants of Health: Know What Affects Health. https://www.cdc.gov/health-equity-chronic-disease/social-determinants-of-health-and-chronic-disease/index.html
Data Retrieved: 11/15/2024

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries
Data Retrieved: 11/15/2024

Hospitals and health systems play a vital role in serving their communities by addressing social needs, ensuring equitable access to care, improving population health outcomes, and "bolstering the local economy and quality of life by hiring local workers and contractors, buying locally through their procurement strategies, and building new clinical facilities in neighboring communities. These activities often lead these hospitals to be called 'anchor institutions.' These increasingly frequent forms of community investment by health care organizations typically flow either from their charitable purpose or from their long-term mission of providing community benefit. In places with relatively high-functioning systems, stakeholders from community organizations, government agencies, foundations, banks, and nonprofits collaborate to articulate clear community priorities, develop a pipeline of investable opportunities that advance those priorities, and shape the context of policies and processes so that investments can move forward."

Source: Center for Community Investment, Initiative for Responsible Investment, & Robert Wood Johnson Foundation. Improving Community Health by Strengthening Community Investment. https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf435716
Data Retrieved: 11/15/2024

In Virginia, a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are a Virginia Department of Health (VDH) requirement for all health districts every 5 years. Overseen by the Public Health Accreditation Board, these processes are crucial for identifying and addressing health disparities across the state. A key initiative in this work is "Partnering for a Healthy Virginia," launched in 2018. This partnership, forged between the Virginia Department of Health (VDH) and the Virginia Hospital and Healthcare Association (VHHA), coordinates efforts of hospitals, local health departments, and community stakeholders to enhance population health through shared resources, technical support, and best practices and address community health improvement.

The COVID-19 pandemic underscored the importance of leveraging data and building strong community partnerships to improve health outcomes. In response, in September 2022, VDH and VHHA launched the Virginia Community Health Improvement Data Portal, developed in partnership with the Center for Applied Research and Engagement (CARES), to improve access to health data. The Virginia Community Health Improvement Data Portal is a tool that provides users with comprehensive information on the health status of their communities, from chronic disease to infant mortality.

Source: Virginia Department of Health. https://www.vdh.virginia.gov/blog/2022/10/17/vdh-and-the-virginia-hospital-healthcare-association-launch-community-health-data-portal/; https://www.vdh.virginia.gov/community-health-assessments/
Data Retrieved: 11/15/2024

To ensure we all have the opportunity to live in vibrant healthy communities, it is important to assess the strengths, weaknesses and unique resources across all sectors of each community and to listen to those who live, work and play there. A community-driven assessment provides the data and information that allows us to act and develop goals and strategies that can contribute to long-lasting social changes and positive health outcomes. Recognizing the importance of these collaborative efforts, Centra, local Health Districts, University of Lynchburg,

and other community stakeholders partnered in 2024 to conduct Community Health Needs Assessments across Centra's service region.

The Central Virginia Health District (CVHD) serves Lynchburg City and Amherst, Appomattox, Bedford, and Campbell counties. There is a health department in each locality with the mission to "nurture the community's wellbeing by practicing public health, meeting the needs of the present while planning for the future". CVHD's broad scope of services includes Nursing, WIC, Environmental Health, Infant & Toddler Connection, Population Health (community engagement, CHW's, PRS', public relations) , and Vital Records. Many programs and services take place in the community and in collaboration with partnering organizations. The addition of Community Health Workers over the past few years has enhanced targeted outreach and the ability to reach more community members who face disparities and inequities. CVHD will use the CHNA to develop a community health improvement plan that is data driven and will help guide their work over the next three years.

Centra engaged with the ***University of Lynchburg Research Center (URC)*** to support and guide primary data collection for the Community Health Survey, Stakeholder Focus Groups, and Target Population Focus Groups, including analyzing the Bedford Area Community Health Survey and Focus Groups. Located in Lynchburg, Virginia, the University of Lynchburg, established in 1903, is a private institution known for its commitment to diversity, inclusivity, and academic excellence across undergraduate, graduate, and doctoral programs. The URC is a vital hub for research, fostering collaboration among faculty, students, and external partners to promote intellectual inquiry and community engagement. Its work aligns closely with the university's mission to support scholarly collaboration and address pressing community needs.

A ***Community Health Assessment Team (CHAT)*** with over 81 individuals and a broad representation of community leaders and cross-sector stakeholders in the service area was developed. The role of the CHAT is to oversee, advise and assist in CHNA data collection activities, prioritize needs, and participate in the development of the Implementation Plan as appropriate. On average, 39 individuals attended each of the four meetings conducted throughout the assessment. A list of these individuals is presented in the "Acknowledgements" section of this report.

CHNA activities began in September 2023 and concluded in early October 2024 with the Prioritization of Needs. A timeline and work plan were created for the 2024-2025 CHNA and Implementation Planning (IP) process for all Centra catchment areas. The work plan included primary data collection (Community Health Survey, Stakeholders' Focus Group, and Target Population Focus Groups) as well as secondary data collection. Due to the lifting of COVID-19 restrictions, we were able to host four target population focus group meetings for this CHNA, unlike in 2021 when these in-person meetings were not possible. This allowed us to engage more directly with the community and gather valuable input.

2024-2025 Bedford-Area CHNA & IP Activities	*Date*
Data Collection: Primary & Secondary Data	September 2023 – April 2024
CHAT: Launch of CHNA activities	January 26, 2024
CHAT: Stakeholder Focus Group Meeting	April 30, 2024
CHAT: Presentation of Primary & Secondary Data	August 23, 2024
CHAT: Prioritization of Needs	October 4, 2024
Target Population Focus Groups	March 2024 – May 2024
Approval by Community Benefit Committee **Approval by Centra Bedford Memorial Hospital Board of Directors** **Presentation to Centra Executive Leadership** **Approval by Centra Board of Directors**	November 22, 2024 December 3, 2024 December 4, 2024 December 9, 2024
Implementation Planning	January 2025 – April 2025
Centra Board Approval of Implementation Plan	By May 15, 2025

Centra Board of Directors, Community Benefit Committee, and Executive Leadership have been kept informed of the 2024 CHNA process through updates from the Community Benefit Chair and Vice President of Community Health.

The 2024 Bedford Area Community Health Needs Assessment (CHNA) and Prioritization of Needs (PON) was approved by the Centra Community Benefit Committee on November 22, 2024. This committee includes members of both the Centra Board of Directors and the Centra Foundation Board of Directors and provides oversight of the health system's community benefit activities. Final approval of the 2024 CHNA and PON by the Centra Bedford Memorial Hospital Board of Directors occurred on December 3, 2024, and by the Centra Board of Directors on December 9, 2024. The Community Health Needs Assessment was made publicly available on the Centra website prior to December 31, 2024, and was widely shared with the Community Health Assessment Team and other key community stakeholders and leaders.

Service Area

The service area for the 2024 Bedford Area Community Health Needs Assessment includes Bedford County and the town of Bedford (localities served by the Central Virginia Health District). The service area was determined by assessing 80% of the hospital discharges for Centra Bedford Memorial Hospital by zip code and locality for the years of 2021 – 2023.

Source: Cerner EMR Data via Enterprise Data Warehouse
Data Retrieved: January 18, 2024

The findings revealed:

Discharge Summary by Zip Codes Representing 80% of Discharges

Locality	# of Discharges	% of Total Discharges
Bedford, Town	26,724	38.8
Bedford, County	17,954	26.06
***Campbell**	1,749	2.54
***Lynchburg, City**	9,009	13.08
Total	55,436	80.48

**Campbell and the city of Lynchburg will be included in the 2024 Centra Lynchburg Area Community Health Needs Assessment.*

Bedford County, nestled in the Piedmont Region at the foothills of the Blue Ridge Mountains, is one of Virginia's fastest-growing counties and a key part of the Lynchburg Metropolitan Statistical Area. Known for its rolling hills, scenic landscapes, and vibrant outdoor offerings, the county boasts popular destinations like Smith Mountain Lake—a hub for boating, fishing, and watersports—and the renowned Appalachian Trail, which attracts hikers and nature lovers from near and far. Its proximity to the Blue Ridge Parkway adds to its appeal, making it a year-round destination for outdoor enthusiasts. While Bedford County's roots lie in its agricultural heritage, its economy has diversified, encompassing industries such as nuclear energy, advanced manufacturing, and wireless communications. Designated as one of Virginia's Technology Zones, Bedford fosters innovation and economic growth, while the Town of Bedford benefits from its status as a Virginia Enterprise Zone. Visitors and residents alike enjoy charming accommodations, local dining, and vibrant community events. (https://www.bedfordcountyva.gov/home)

The Town of Bedford, situated at the base of the Peaks of Otter and just 9 miles from the Blue Ridge Parkway, is surrounded by some of the most stunning scenery in Central Virginia. The area is rich in history and culture, with notable landmarks including: The National D-Day Memorial, which honors the brave soldiers, including the Bedford Boys, who made the ultimate sacrifice during the D-Day invasion of World War II, the historic Elks National Home, Thomas Jefferson's Poplar Forest, and the Avenel Plantation. Centrally located between Roanoke and Lynchburg—just 25 miles from each—Bedford offers small-town charm with big-city accessibility. It is also only 178 miles from Washington, D.C., making it an appealing destination for both tourists and commuters. Centra Bedford Memorial Hospital, located in the heart of the Town of Bedford, serves as a central hub for quality healthcare services in the area. Whether exploring the outdoors, diving into history, or participating in cultural festivities, Bedford County and The Town of Bedford offers something for everyone. (https://www.bedfordva.gov/)

Target Population

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

Methodology

The 2024 Bedford Area Community Health Needs Assessment (CHNA) "lifted the voice of the community" (primary data) and included a collection of over 75 sources of publicly available secondary data. In addition, information about existing community resources was gathered. Primary data included findings from a Community Health Survey, Stakeholders' Focus Group, and Target Population Focus Groups. Details on the specific methodology and findings of the primary and secondary data components are included in following sections of this assessment.

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

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

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

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

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

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

PRIMARY DATA

Collection of primary data allows us to "lift the voice of the community" by engaging with vulnerable populations and cross-sector stakeholders who serve these populations. It is a key driver in the development of prioritized needs for each of Centra's service regions. In 2024, a Community Health Survey, stakeholder focus groups, and target population focus groups provided primary data that was used for identification and prioritization of needs.

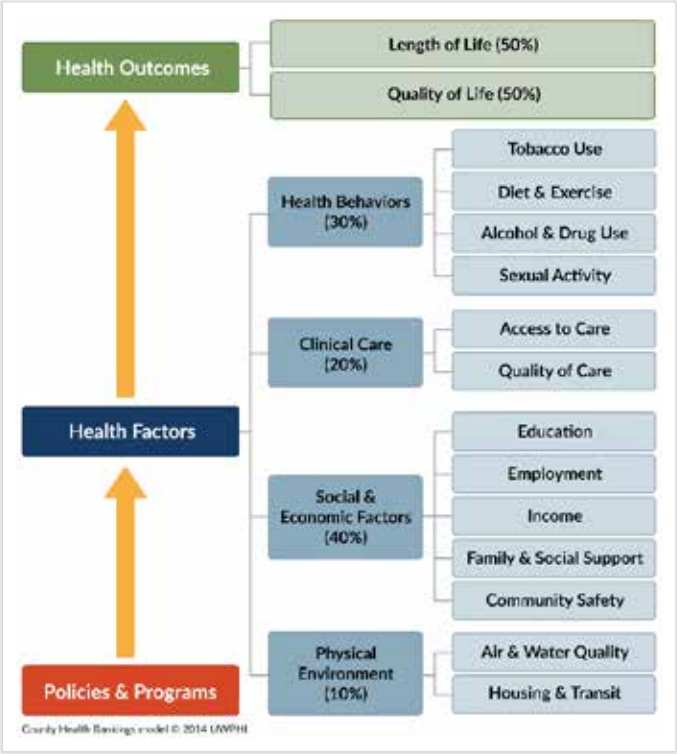
COMMUNITY HEALTH SURVEY

A Community Health Survey was administered to Bedford Area residents, 18 years of age and older, from February 1, 2024 to March 31, 2024. The survey includes standardized questions that address the County Health Rankings' four health factors that influence health (Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment) and health outcomes (Length of Life and Quality of Life). Many of the questions were developed from national survey tools from the Centers for Disease Control and Prevention, Healthy People 2030, and the Behavior Risk Factor Surveillance System so that local data can be compared to state and national data, benchmarks and targets. In 2024, Centra, local Health Districts, and the University of Lynchburg conducted comprehensive reviews and revisions of the survey questions to reduce bias and enhance accessibility. Key updates included adding more response options to questions related to health behaviors, health factors, health conditions, and available community services. Many of these response options align with those used by the CDC's National Health and Nutrition Examination Survey (NHANES). Additionally, the "gender" question was expanded to better reflect diverse identities, now including non-binary, transgender, and genderqueer options.

The Community Health Survey was administered both electronically through a publicly available link via Survey Monkey and through paper surveys (which were in turn entered into Survey Monkey). Paper surveys were available in both English and Spanish to address possible technology barriers that impact our target populations (i.e. lack of broadband internet access, lack of access to smartphones, challenges related to usability). These issues are amplified for rural populations, where broadband access is often limited. Older adults and people with disabilities often struggle with internet access and usability due to limited digital literacy. Even when they have internet access, many lack the technical skills to navigate online platforms effectively. Additionally, concerns about online security and privacy further discourage these groups from engaging with digital services, especially those with low health literacy. Language barriers also affect non-native English speakers. In total, 765 surveys were collected, including 100 paper surveys (constituting 13% of responses), while 665 were completed electronically. All survey respondents were offered the opportunity to enter a raffle to win a $15 gift card if they completed the survey.

The survey link was advertised in local newspapers, on social media, on Centra's website, flyers, billboards, podcasts, and through a mass email to all Centra staff. In addition to marketing the survey to the general population, attempts were made to oversample the target population in the service area. Members of the Community Health Assessment Team (CHAT), who serve and represent the target population, were asked to assist in advertising and distributing the survey (both electronically and paper) to their client base.

The University of Lynchburg Research Team utilized data generated by Survey Monkey to conduct a thorough analysis of the Bedford Area Community Health Survey, employing MySQL, a powerful Database Management System (DMS), along with Python programming language. This effective methodology streamlined the process. Although the responses that follow provide a comprehensive analysis of the survey, it is important to note that analysis of the "Other" response option in certain questions was not conducted, and is signified by an "N/A" in those questions.



Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. Retrieved 10/30/24 www.countyhealthrankings.org

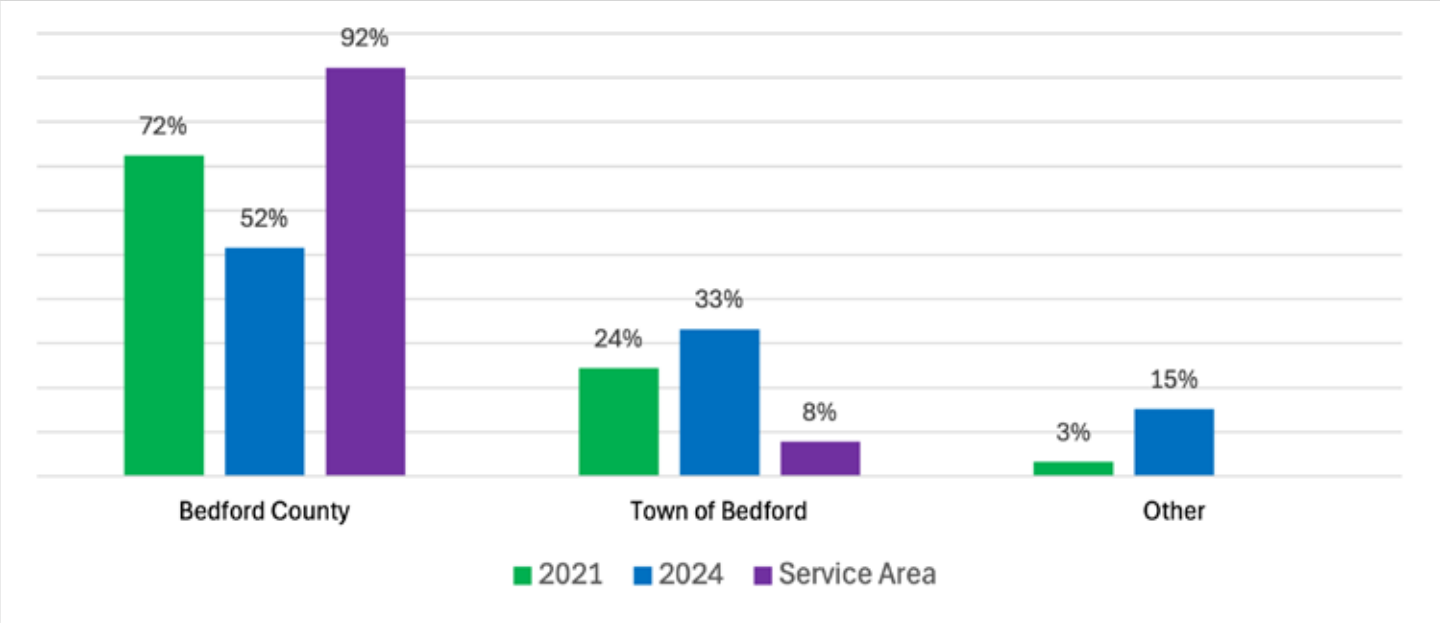
This year's 2024 survey presented some challenges, including inconsistencies in how paper surveys were collected and instances where respondents selected multiple options on paper surveys when they were asked to "check one". Additionally, while 13% of responses were paper surveys, community outreach to our target populations was less than anticipated as evidenced by our survey respondents' demographic information. While our community partners who serve our target populations contributed to the distribution of paper surveys, the sampling underrepresented certain pockets of our target population. However, these insights offer valuable lessons for future improvements. For the 2027 Community Health Needs Assessment, we aim to strengthen outreach strategies to better reach our target populations and will work closely with key stakeholders for recommendations on improving survey collection. To reduce errors and speed up data analysis, we plan to collect all surveys electronically using a boots on the ground approach to sampling our target population. We also will continue to align survey questions with national databases like the U.S. Census, Virginia Vital Statistics, Centers for Disease Control and Prevention (CDC), National Health and Nutrition Examination Survey (NHANES), and Healthy People 2030. Additionally, we may consider streamlining the survey by reducing the number of questions to encourage higher completion rates.

The County Health Rankings Model was used as the framework to summarize the findings of the 2024 Bedford Community Health Survey that follow. This framework is based on a model of community health that emphasizes the many factors that influence how long and how well we live. The Rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).

Demographic Profile of Respondents

The demographic profile of respondents compares trends from the 2021 and 2024 surveys, highlighting changes over time. U.S. Census data is also incorporated for the Bedford Service Area, which includes the Town of Bedford and Bedford County. This broader data helps contextualize survey results, offering a clearer view of the population characteristics across the communities served.

Where do you live?

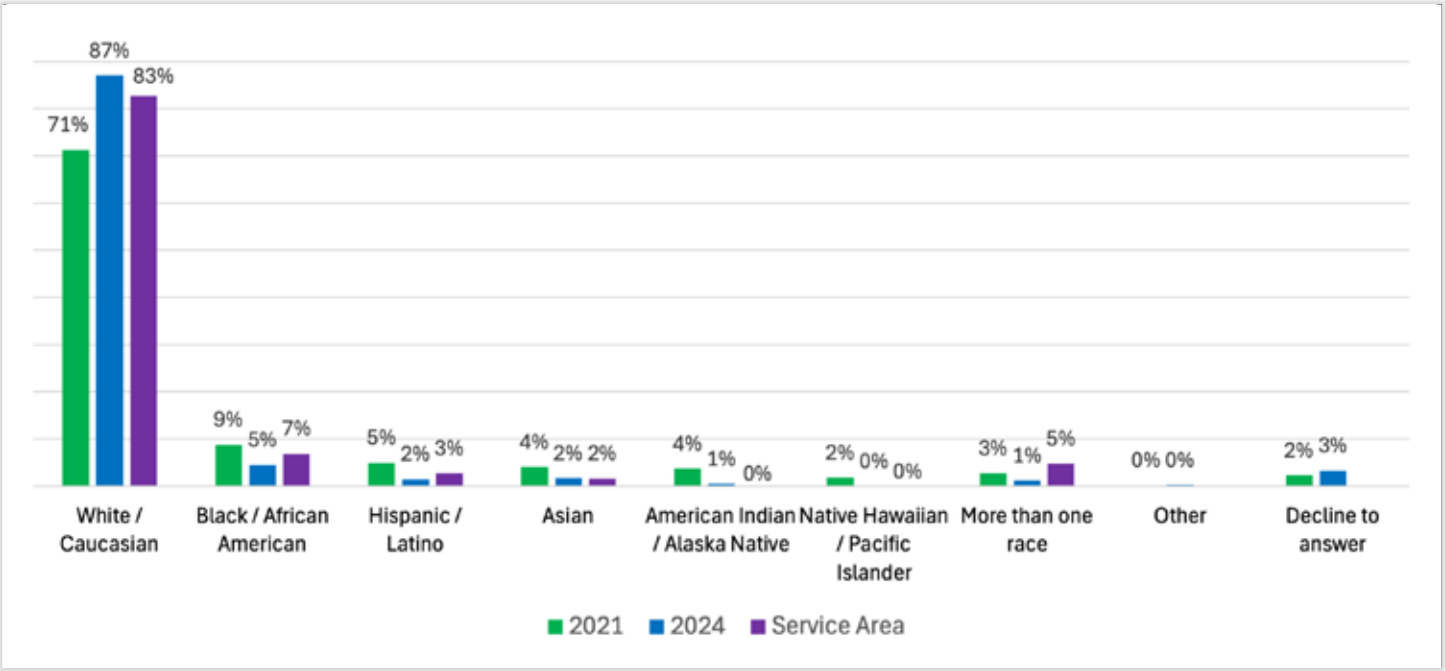


Where do you live?	2021	2024	Service Area (U.S. Census)
Bedford County	72%	52%	92%
Town of Bedford	24%	33%	8%
Other	3%	15%	
Total Answered	851	764	
Skipped	5	1	

Table Source: US Census. American Fact Finder. Table DP05. American Community Survey 2018 – 2022 Demographic and Housing Estimates Retrieved from https://factfinder.census.gov 04/09/2024

Most respondents were from the Service Area. The Town of Bedford saw a significant increase in participation, rising from 24% in 2021 to 33% in 2024, even though the town accounts for only 8% of the Area's population. In contrast, Bedford County responses dropped sharply from 72% in 2021 to 52% in 2024, despite representing 92% of the Service Area's population. Respondents from other localities made up 15% of the total responses.

What race/ethnicity do you identify with?



What race/ethnicity do you identify with?	*2021*	*2024*	*Service Area (U.S. Census)*
White / Caucasian	71%	87%	83%
Black / African American	9%	5%	7%
Hispanic / Latino	5%	2%	3%
Asian	4%	2%	2%
American Indian / Alaska Native	4%	1%	0%
Native Hawaiian / Pacific Islander	2%	0%	0%
More than one race	3%	1%	5%
Other	0%	0%	
Decline to answer	2%	3%	
Total Answered	832	600	
Skipped	19	165	

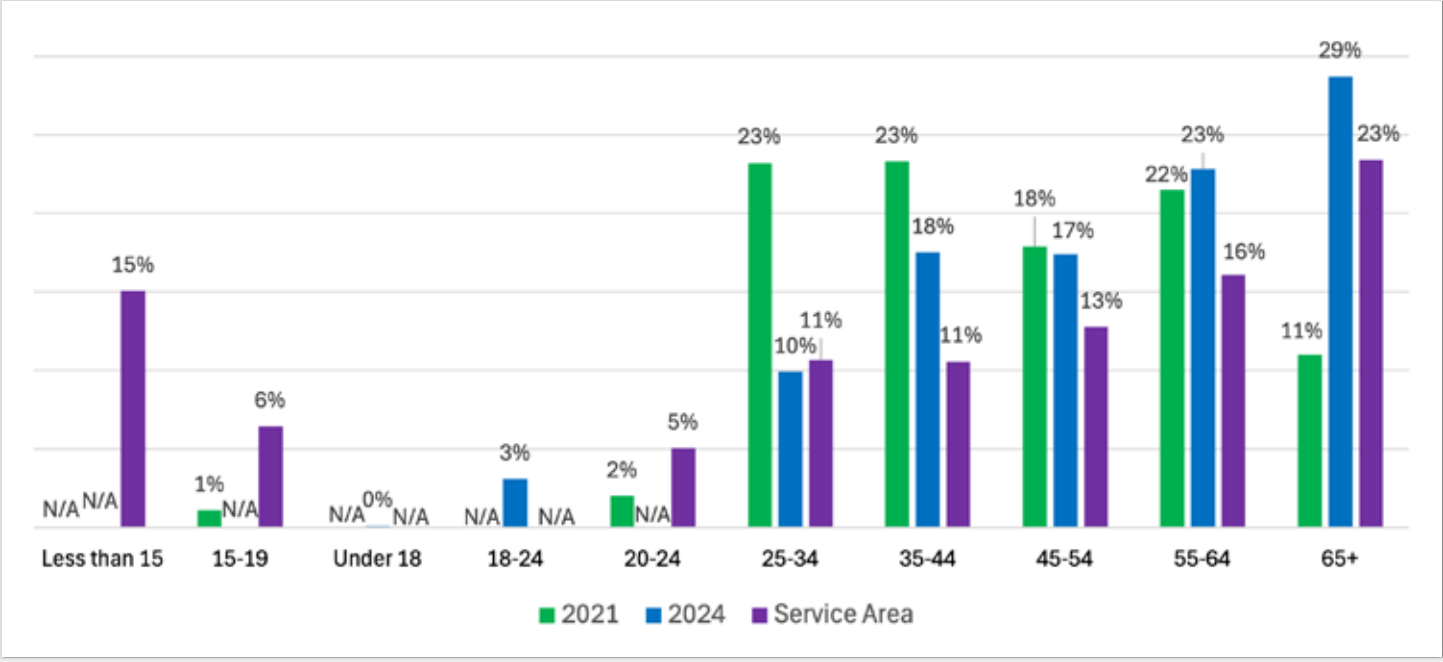
Table Source: US Census. American Fact Finder. Table DP05. American Community Survey 2018 – 2022 Demographic and Housing Estimates Retrieved from https://factfinder.census.gov 04/09/2024

In 2021, 71% of respondents identified as White/Caucasian, increasing to 87% in 2024, closely matching the 83% White population of the Service Area (U.S. Census). The percentage of Black/African American respondents decreased from 9% in 2021 to 5% in 2024, below the 7% representation in the Service Area.

Hispanic/Latino respondents dropped significantly from 5% in 2021 to 2% in 2024, similar to the Service Area's 3%. This suggests stability but highlights a need for continued outreach to maintain or increase participation.

There was also a sharp decline in Asian (2%), American Indian/Alaska Native (1%), and Native Hawaiian/Pacific Islander (0%) respondents in 2024, compared to 2021 (4%, 4%, and 2%, respectively). The Service Area population for these groups is 2% Asian, 0% American Indian/Alaska Native, and 0% Native Hawaiian/Pacific Islander.

What is your age?



What is your age?	2021	2024	Service Area (U.S. Census)
Less than 15	N/A	N/A	15%
15-19	1%	N/A	6%
Under 18	N/A	0%	N/A
18-24	N/A	3%	N/A
20-24	2%	N/A	5%
25-34	23%	10%	11%
35-44	23%	18%	11%
45-54	18%	17%	13%
55-64	22%	23%	16%
65+	11%	29%	23%
Total Answered	820	762	
Skipped	35	3	

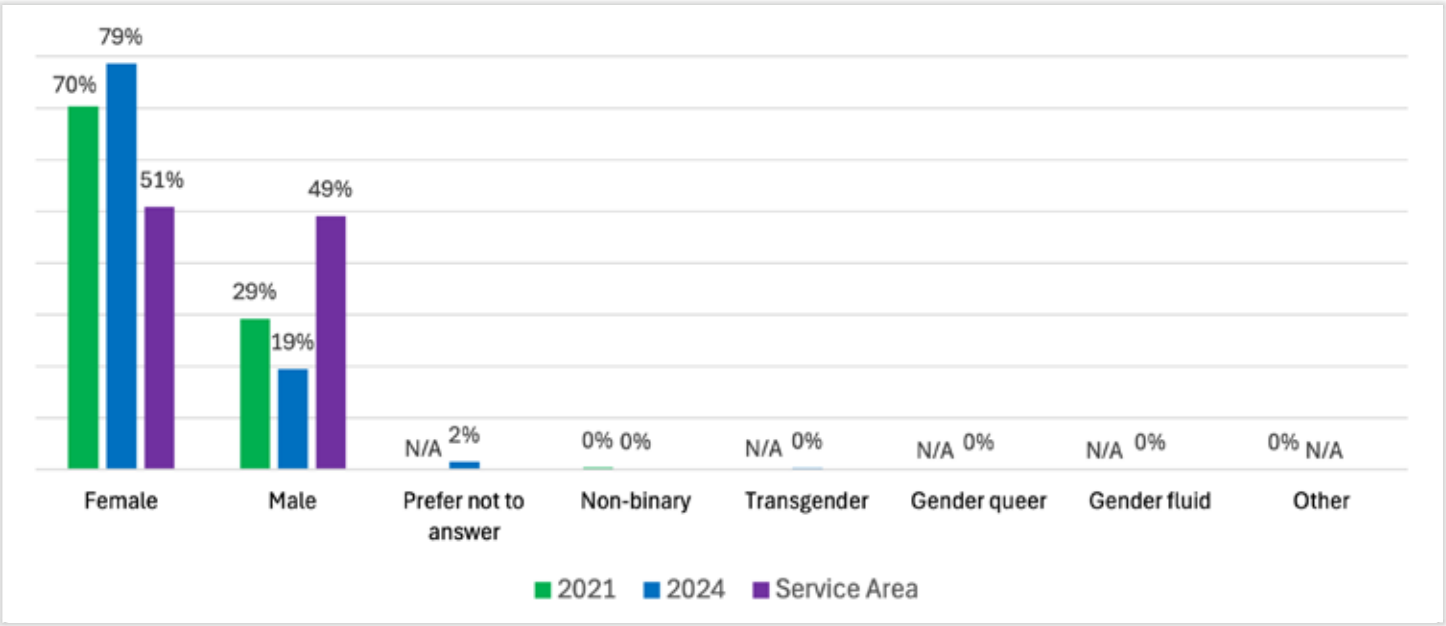
Table Source: US Census. American Fact Finder. Table DP05. American Community Survey 2018 – 2022 Demographic and Housing Estimates Retrieved from https://factfinder.census.gov 04/09/2024

The "N/A" values in the data reflect a change in how age groups were categorized, shifting from an open-ended format to predefined options in the 2024 Community Health Needs Assessment. This change may explain some data gaps for younger populations.

Respondents aged 25 to 34 dropped from 23% in 2021 to 10% in 2024, while those aged 35 to 44 fell from 23% to 18%. Respondents aged 55 to 64 slightly increased from 22% in 2021 to 23% in 2024, exceeding the Service Area's 16%.

Respondents aged 45 to 54 remained steady, with 18% in 2021 and 17% in 2024, higher than the Service Area's 13%. The biggest change was among respondents aged 65 and older, rising sharply from 11% in 2021 to 29% in 2024, surpassing the Service Area's 23% and showing growing participation from seniors.

What is your gender identity?



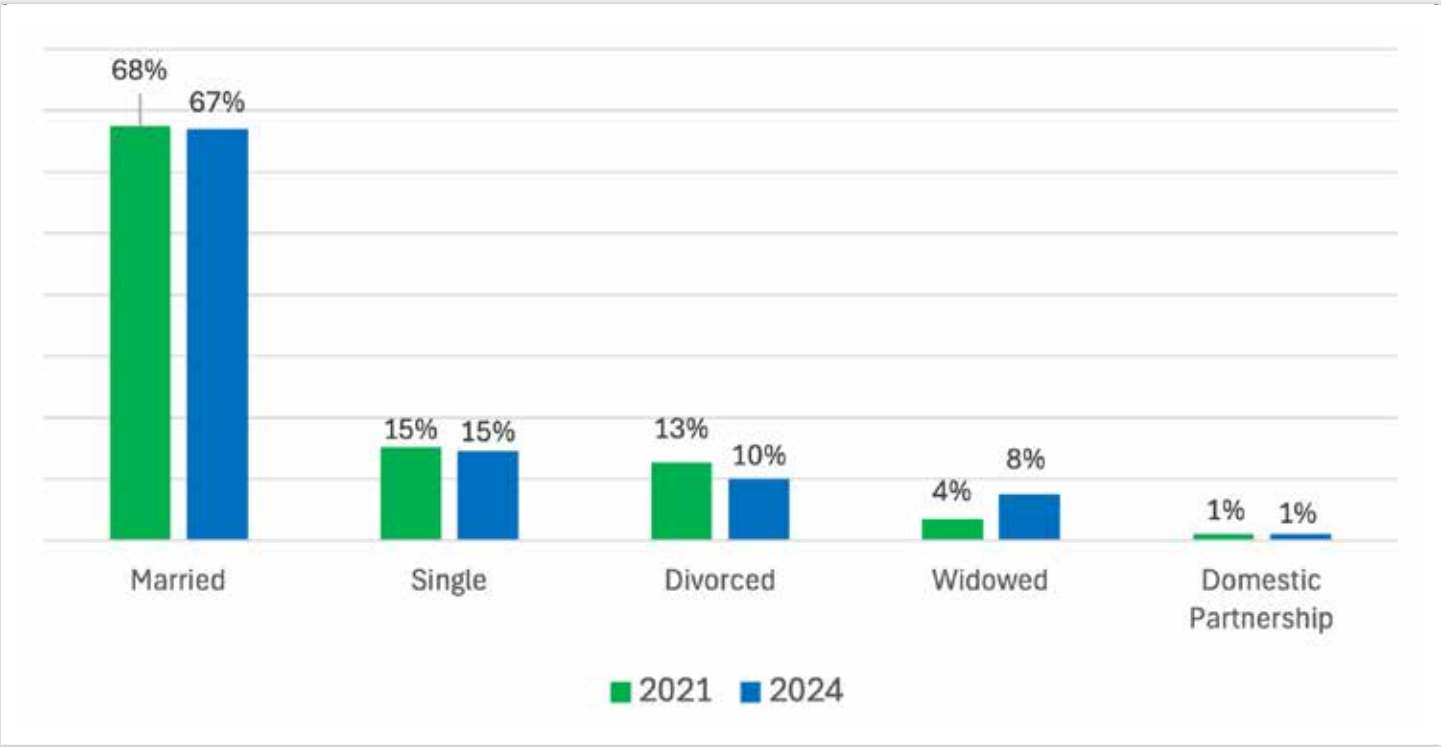
What is your gender identity?	*2021*	*2024*	*Service Area (U.S. Census)*
Female	70%	79%	51%
Male	29%	19%	49%
Prefer not to answer	N/A	2%	
Non-binary	0%	0%	
Transgender	N/A	0%	
Gender queer	N/A	0%	
Gender fluid	N/A	0%	
Other	0%	N/A	
Total Answered	835	614	
Skipped	22	151	

Table Source: US Census. American Fact Finder. Table DP05. American Community Survey 2018 – 2022 Demographic and Housing Estimates Retrieved from https://factfinder.census.gov 04/09/2024

The percentage of female respondents increased significantly from 70% in 2021 to 79% in 2024, which is above the Service Area average of 51%. In 2021, 29% of respondents identified as male. In 2024, this dropped to 19%, which is now notably lower than the 49% representation of males in the Service Area.

The introduction of new categories in 2024, including "Transgender (0%)" "Gender queer (0%)" and "Gender fluid (0%)" reflects a recognition of broader gender diversity. The sexual orientation & gender identity estimate in Virginia is 7.2% (Source: U.S. Census. Sexual Orientation and Gender Identity in the Household Plus Survey. Characteristics of the LGBTQ+ adult population. Retrieved 08/09/24, https://www.census.gov/quickfacts/).

What is your marital status?



What is your marital status?	*2021*	*2024*
Married	68%	67%
Single	15%	15%
Divorced	13%	10%
Widowed	4%	8%
Domestic Partnership	1%	1%
Total Answered	840	604
Skipped	18	161

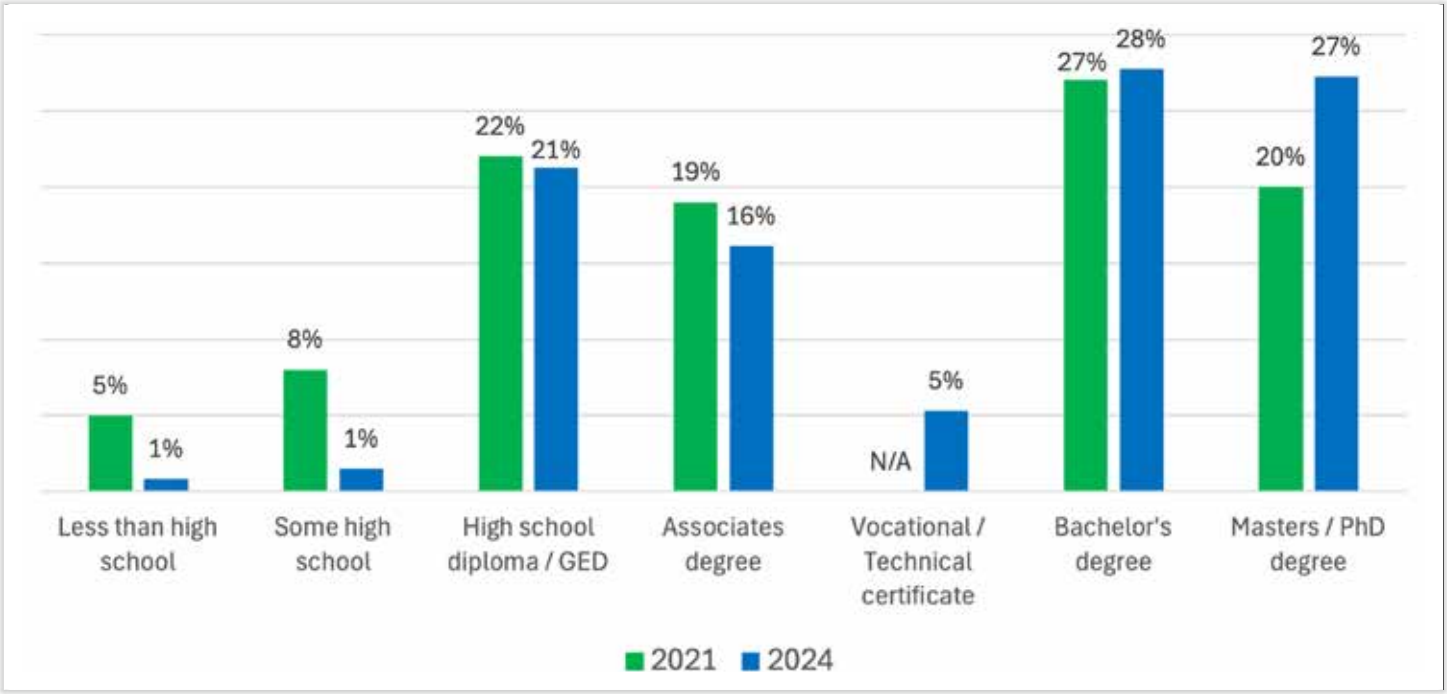
The percentage of respondents who were married in the 2024 Community Health Needs Assessment remained nearly unchanged, with a slight 1% drop from 68% in 2021. Those who identified as single stayed consistent at 15% for both years. Divorced respondents decreased from 13% in 2021 to 10% in 2024, while the number of widowed respondents doubled, rising from 4% in 2021 to 8% in 2024.

HEALTH FACTORS

Social and Economic Factors

EDUCATION

What is your highest education level completed?



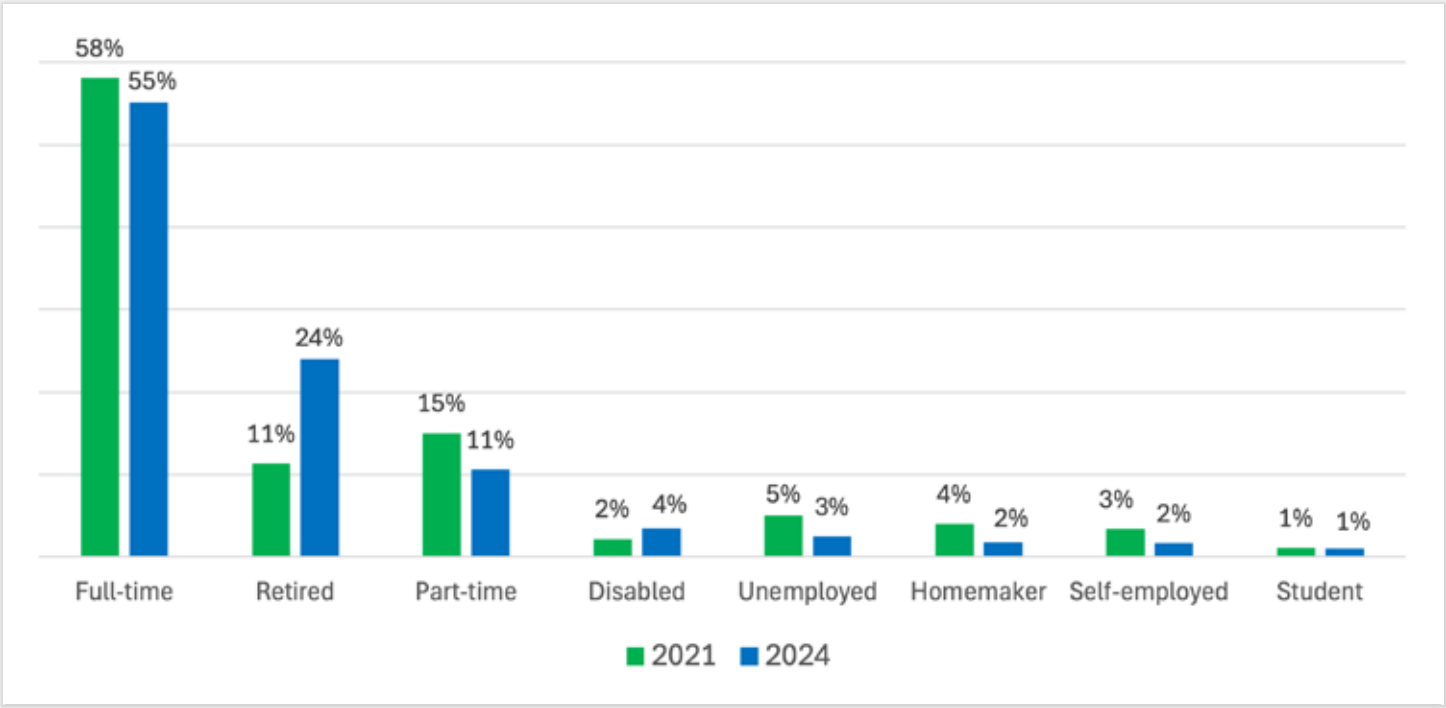
What is your highest education level completed?	*2021*	*2024*
Less than high school	5%	1%
Some high school	8%	1%
High school diploma / GED	22%	21%
Associates degree	19%	16%
Vocational / Technical certificate	N/A	5%
Bachelor's degree	27%	28%
Masters / PhD degree	20%	27%
Total Answered	833	603
Skipped	24	162

In 2024, only 1% of respondents had less than a high school diploma or GED, down from 5% in 2021. Those with some high school education dropped from 8% to 1%. Respondents with a high school diploma or GED stayed fairly stable at 21%, down slightly from 22% in 2021.

A new response option, vocational/technical certificates, was introduced in 2024, with 5% of respondents obtaining one, highlighting the growing value of non-traditional education. "Middle-skill jobs" (those requiring some education beyond high school but not a 4-year degree) make up 52% of the U.S. labor market (Source: National Skills Coalition, The Roadmap for Racial Equality, Retrieved 10/27/2024, https://nationalskillscoalition.org/wp-content/uploads/2020/12/Racial-Equity-Report_6x9_web.pdf).

Respondents with higher degrees (Associate's to Master's or PhDs) increased, with the largest rise among those with a master's or PhD, from 20% in 2021 to 27% in 2024. Meanwhile, those with an associate's degree decreased slightly from 19% to 16%.

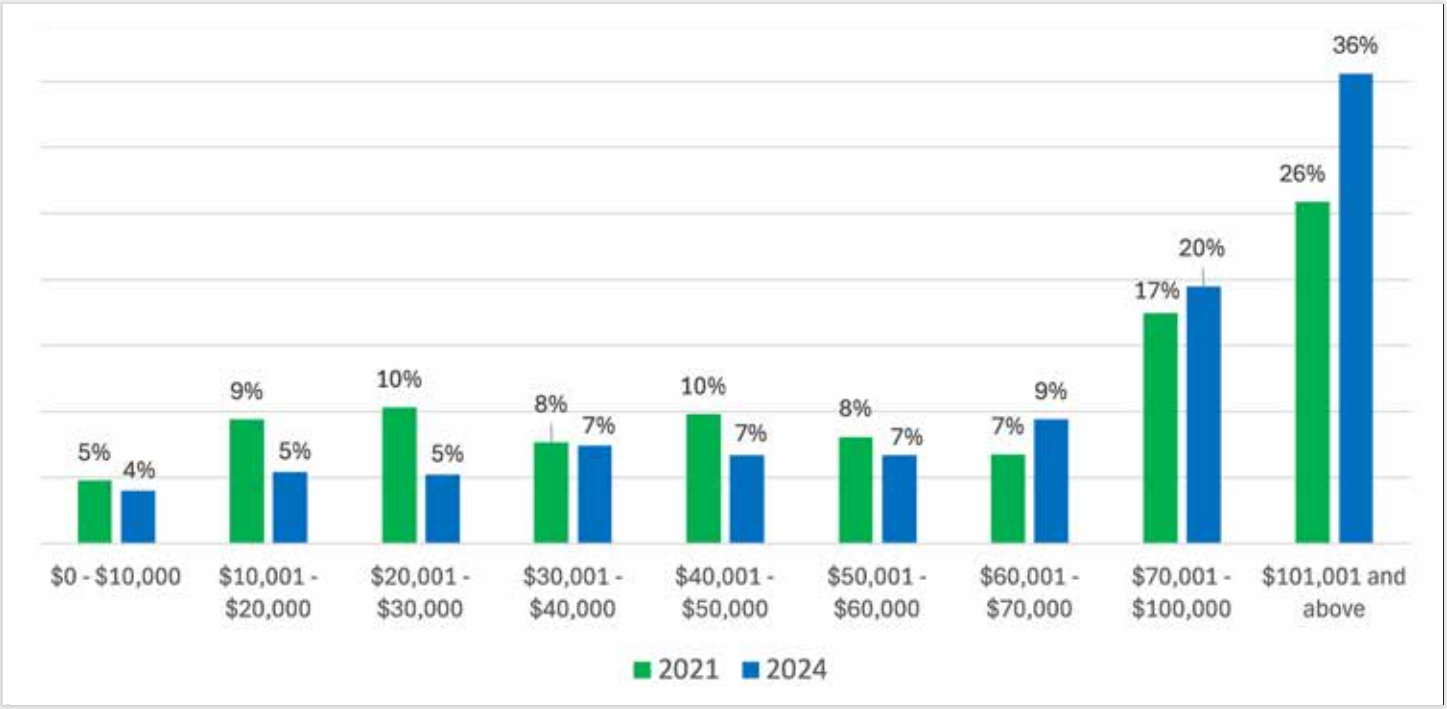
What is your current employment status?



What is your current employment status?	2021	2024
Full-time	58%	55%
Retired	11%	24%
Part-time	15%	11%
Disabled	2%	4%
Unemployed	5%	3%
Homemaker	4%	2%
Self-employed	3%	2%
Student	1%	1%
Total Answered	833	595
Skipped	24	170

2024 respondents who indicated they were employed full-time declined from those of 2021 respondents from 58% in 2021 to 55% in 2024. The number of unemployed in 2024 (3%) reduced in number compared to 2021 (5%). The number of part-time employed respondents was 11% in 2024 compared to 15% in 2021, which could indicate a shift to full-time employment or retirement. The 2024 survey reflected a significant rise in retired respondents, increasing from 11% in 2021 to 24% in 2024.

What is your yearly household income?



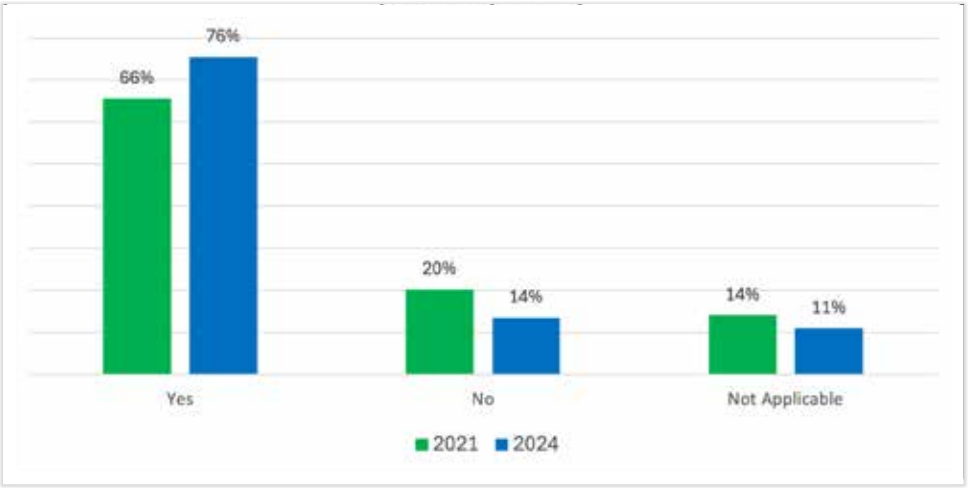
What is your yearly household income?	2021	2024
$0 - $10,000	5%	4%
$10,001 - $20,000	9%	5%
$20,001 - $30,000	10%	5%
$30,001 - $40,000	8%	7%
$40,001 - $50,000	10%	7%
$50,001 - $60,000	8%	7%
$60,001 - $70,000	7%	9%
$70,001 - $100,000	17%	20%
$101,001 and above	26%	36%
Total Answered	764	596
Skipped	96	169

In 2024, 12% of respondents reported household incomes between $20,001 and $40,000, down from 18% in 2021. Those earning between $50,001 and $60,000 stayed relatively stable, at 8% in 2021 and 7% in 2024. The proportion of respondents with incomes between $70,001 and $100,000 rose from 17% in 2021 to 20% in 2024, while those earning over $100,000 increased significantly from 26% to 36%.

AFFORDABILITY AND SAFETY

Respondents were asked about the affordability of medications, rent/mortgage, and food, as well as personal and community safety and social connectedness. In 2024, "not applicable" responses were factored into the analysis, and a new Likert scale question on social connectedness was added to the survey.

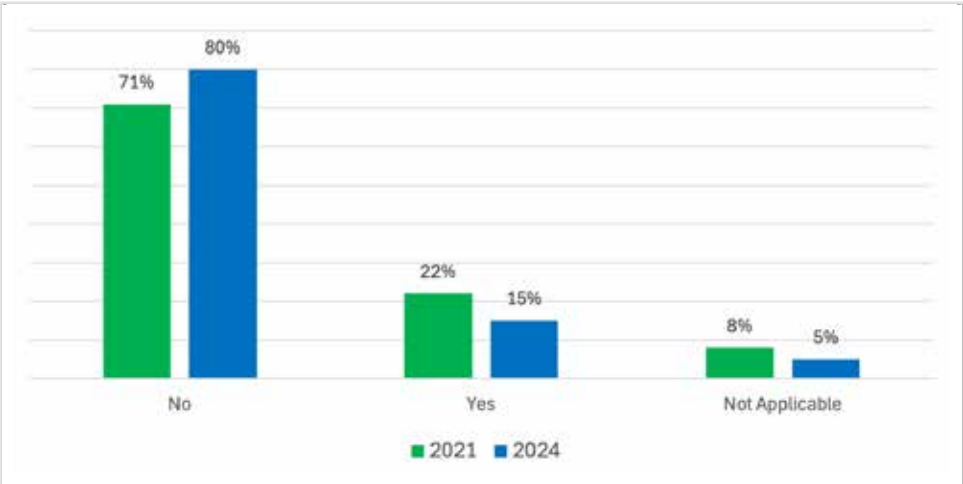
I can afford the medicine needed for my health conditions.



I can afford the medicine needed for my health conditions.	*2021*	*2024*
Yes	66%	76%
No	20%	14%
Not Applicable	14%	11%
Total Answered	835	609
Skipped	31	156

The number of respondents indicating that they can afford the medicine needed for their health conditions increased from 66% in 2021 to 76% in 2024 while those reporting "no" in 2021 was 20% and 14% in 2024.

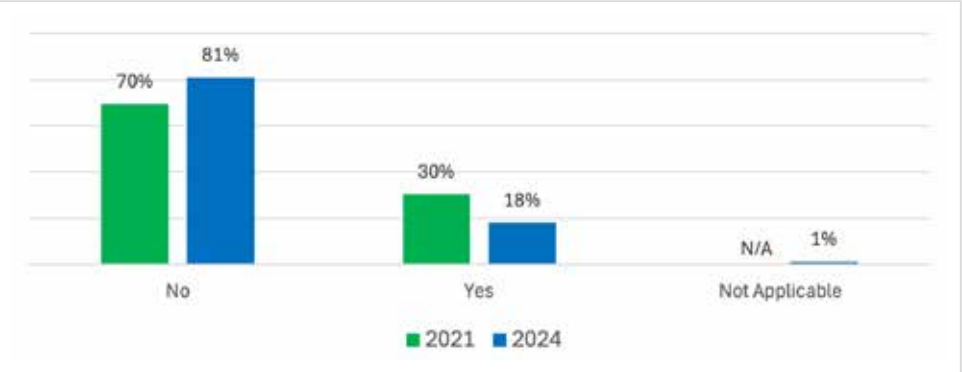
Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?



Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?	*2021*	*2024*
No	71%	80%
Yes	22%	15%
Not Applicable	8%	5%
Total Answered	840	610
Skipped	13	155

In 2024, the percentage of respondents unable to afford rent or mortgage was 15%, down from 22% in 2021. Conversely, those who reported they could afford their payments increased from 71% in 2021 to 80% in 2024.

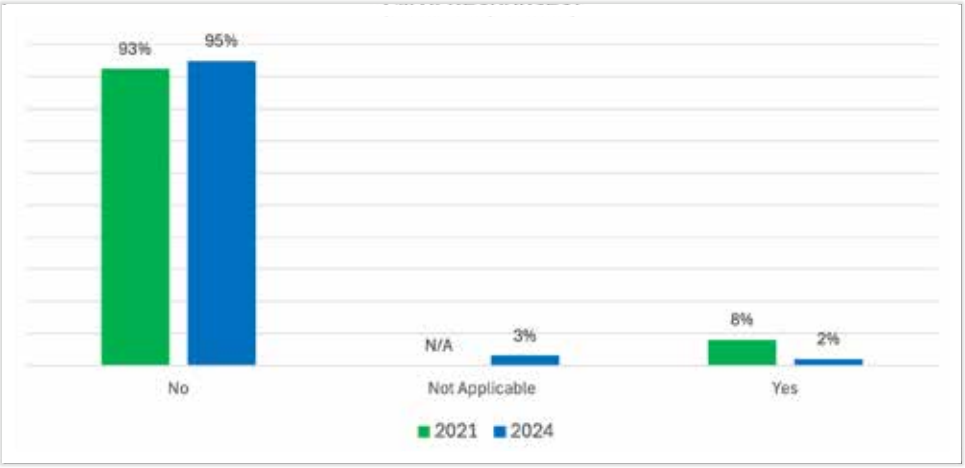
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?



Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?	*2021*	*2024*
No	70%	81%
Yes	30%	18%
Not Applicable	N/A	1%
Total Answered	838	608
Skipped	19	157

The number of respondents who indicated that there had been times when they did not have enough money to buy the food they or their family needed decreased from 2021 (30%) to 2024 (18%). Those who answered "no" increased to 81% in 2024, compared to 70% in 2021.

I have been the victim of domestic violence or abuse in the past 12 months.

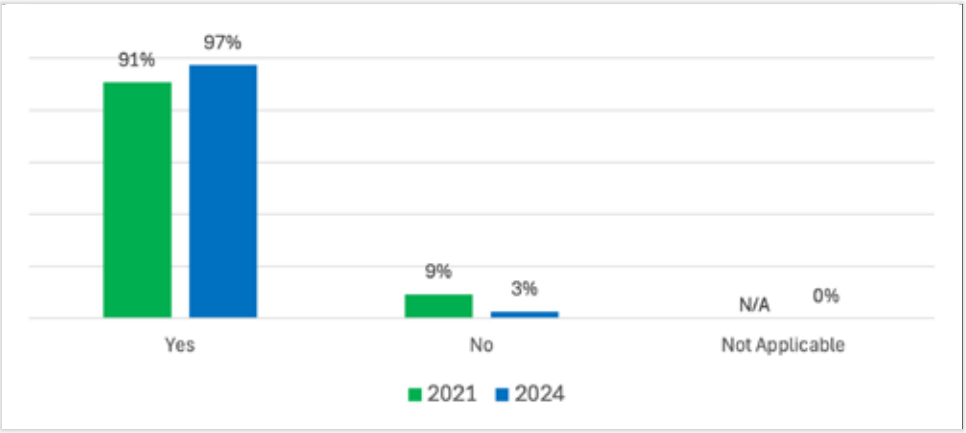


I have been a victim of domestic violence or abuse in the past 12 months.	*2021*	*2024*
No	93%	95%
Not Applicable	N/A	3%
Yes	8%	2%
Total Answered	838	606
Skipped	19	159

The percentage of respondents reporting experiences of domestic violence or abuse dropped significantly from 8% in 2021 to 2% in 2024. Additionally, those reporting no experience with domestic violence increased from 93% to 95% over the same period. While these findings suggest a positive shift in the experiences of our respondents, it's crucial to acknowledge that domestic violence remains a persistent issue in the broader community. The discrepancy between the 2021 and 2024 results may be influenced by several factors. One possible reason is the change in the demographic profile of survey respondents in 2024. Another factor could be that in 2021, the COVID-19 stay-at-home orders impacted domestic violence rates, as victims were confined with abusers without safe places to go.

There were approximately 1,370,440 domestic violence victimizations in the United States in 2022, indicating that this issue continues to affect many individuals (Source: Bureau of Justice Statistics, Criminal Victimization, 2022, Retrieved 10/27/24, https://bjs.ojp.gov/document/cv22.pdf). In Virginia, from 2021-2023 domestic violence and sexual assault hotlines experienced a high demand for assistance for those impacted including emergency temporary shelter, transitional and self-supported housing. (Source: RD841-2023 Annual Report on Domestic and Sexual Violence in Virginia, Retrieved 10/31/24, https://rga.lis.virginia.gov/Published/2023/RD841). Despite the decline in self-reported domestic violence victimization seen in our local survey data, this broader context emphasizes the ongoing need for strong support systems and resources to assist victims and address domestic violence.

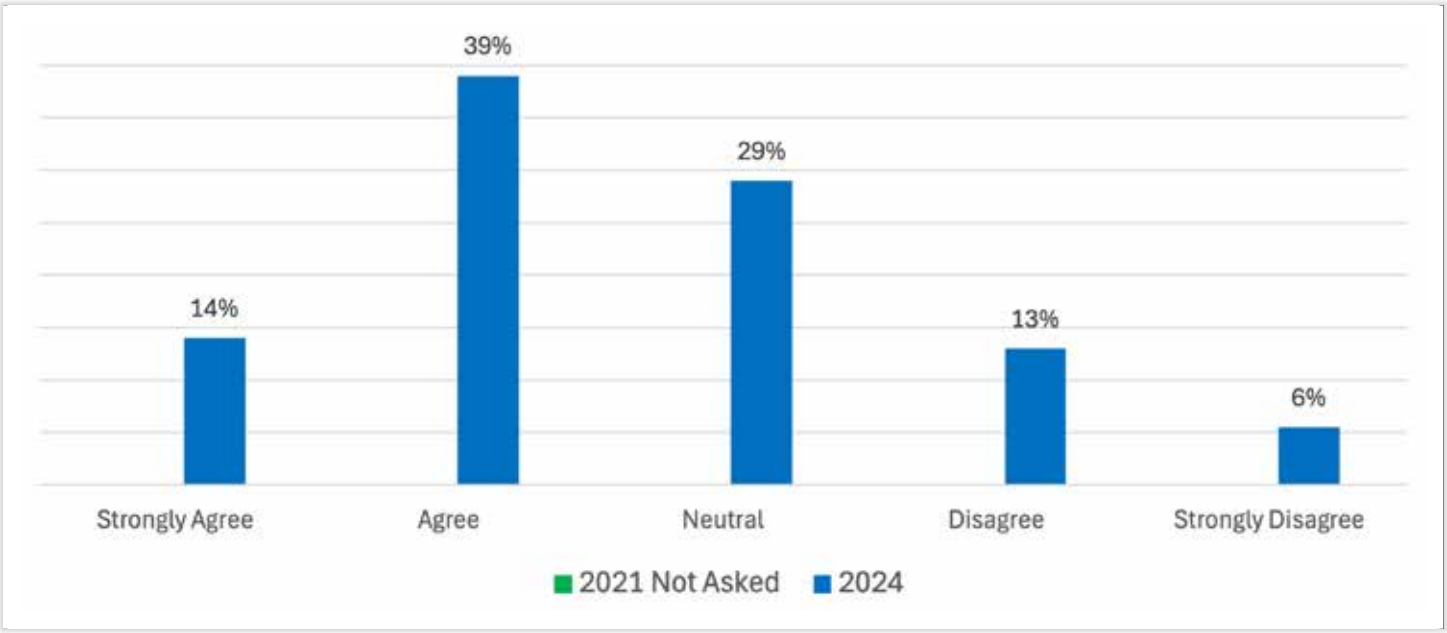
Do you feel safe where you live?



Do you feel safe where you live?	*2021*	*2024*
Yes	91%	97%
No	9%	3%
Not Applicable	N/A	0%
Total Answered	839	610
Skipped	19	155

The number of respondents who felt safe where they live increased from 2021 (91%) to 2024 (97%). Those who responded "no" declined from 9% in 2021 to 3% in 2024.

I feel socially connected to the community and those around me.



I feel socially connected to the community and those around me.	*2021 Not Asked*	*2024*
Strongly Agree		14%
Agree		39%
Neutral		29%
Disagree		13%
Strongly Disagree		6%
Total Answered		606
Skipped		159

In 2024, many respondents expressed a positive sense of social connection to the community and those around them, with 39% agreeing and 14% strongly agreeing. However, 29% of respondents remained neutral, indicating they neither agreed nor disagreed. 13% of respondents disagreed and 6% strongly disagreed with feeling socially connected.

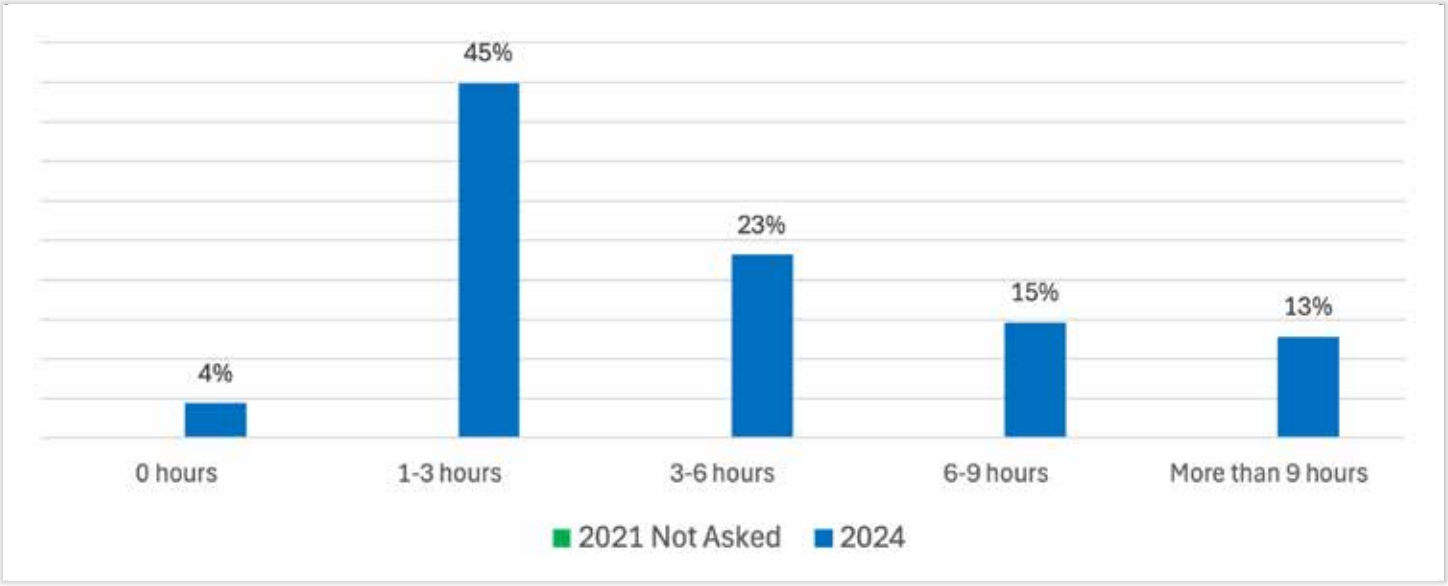
USE OF TECHNOLOGY

In the 2024 Community Health Needs Assessment, respondents were asked two new questions about their technology usage outside of school or work: overall technology use and social media use.

The rise of technology and social media has significantly impacted community health and individual well-being. As of 2024, technology is integral to daily life, influencing how people access health information and connect with services. While social media can foster support networks and promote healthy behaviors, excessive use may lead to negative outcomes, such as increased anxiety and social isolation.

Research indicates that moderate social media use can enhance social connectedness and provide valuable health information, but excessive use is linked to issues like depression and sleep disturbances (Source: Pew Research Center, Social Media Use in 2021, Retrieved 10/27/24, https://www.pewresearch.org/internet/2021/04/07/social-media-use-in-2021/).

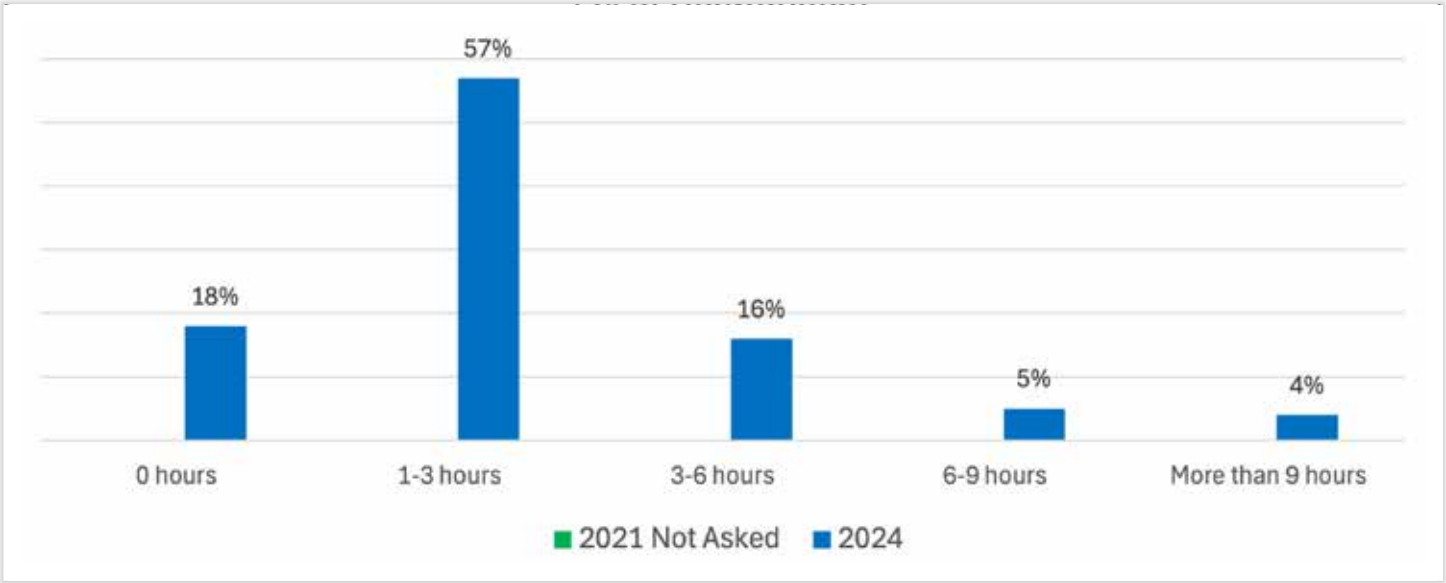
Over the past 7 days, how many hours per day do you spend using technology (smartphones, computers, tablets, gaming devices) outside of school or work?



Over the past 7 days, how many hours per day do you spend using technology (smartphones, computers, tablets, gaming devices) outside of school or work?	*2021 Not Asked*	*2024*
0 hours		4%
1-3 hours		45%
3-6 hours		23%
6-9 hours		15%
More than 9 hours		13%
Total Answered		609
Skipped		156

Only 4% of respondents reported spending no time on technology. The largest group, 45%, spent 1 to 3 hours per day, while 23% spent 3 to 6 hours. Those who used technology for 6 to 9 hours made up 15%, and 13% reported using it for more than 9 hours daily.

Over the past 7 days, how many hours per day do you spend using social media outside of school or work?



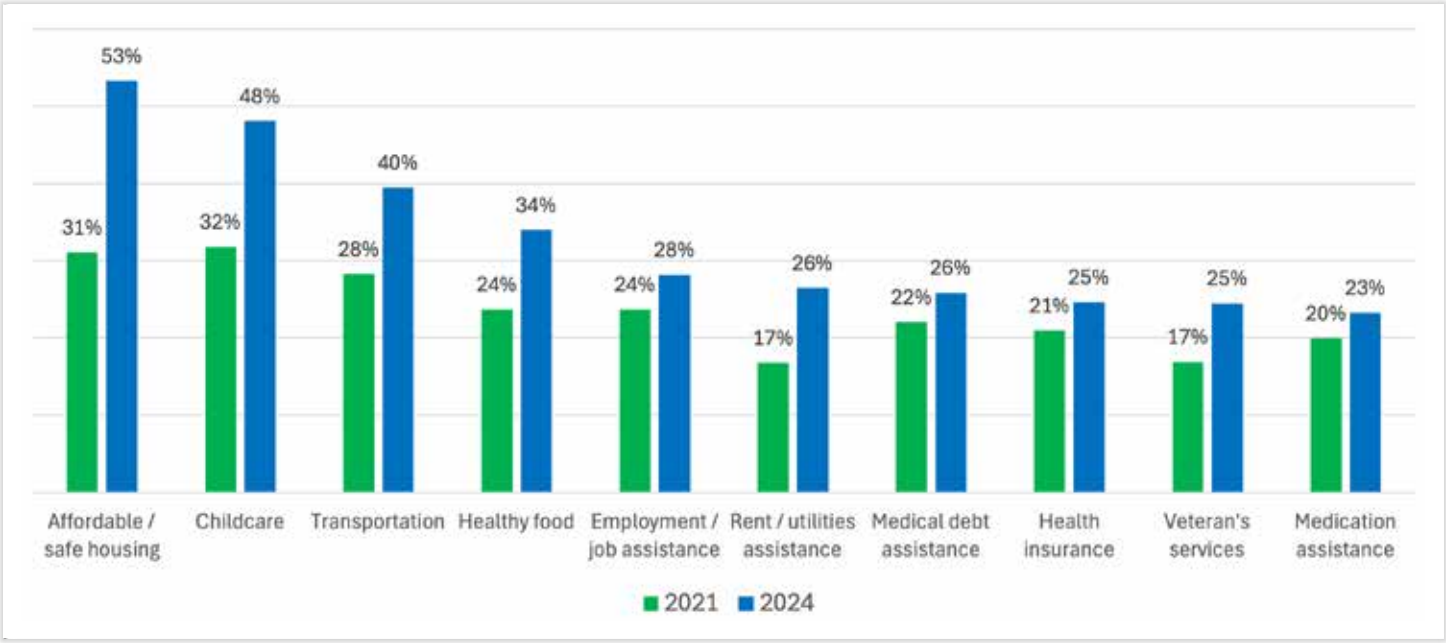
Over the past 7 days, how many hours per day do you spend using social media outside of school or work?	*2021 Not Asked*	*2024*
0 hours		18%
1-3 hours		57%
3-6 hours		16%
6-9 hours		5%
More than 9 hours		4%
Total Answered		609
Skipped		156

For social media usage, 18% of respondents reported no daily use. The majority, 57%, spent 1 to 3 hours on social media, while 16% used it for 3 to 6 hours. A smaller percentage, 5%, spent 6 to 9 hours on social media, and 4% indicated usage of more than 9 hours per day.

SOCIAL/SUPPORT RESOURCES IN THE COMMUNITY

Respondents were asked to identify which social and/or support resources are difficult to access in the community, with the option to select multiple responses. The 2024 survey refined the 2021 response options, splitting "Banking/ financial assistance" into "Financial assistance (22%)" and "Banking services (5%)" and "Education and literacy" into "Education (GED, high school, college) (7%)" and "Reading and writing support (11%)" Additionally, the 2024 survey omitted the response option "COVID-19 has made one or more of the services I selected hard to get," reflecting the easing of strict COVID-19 protocols and restrictions.

Which social/support resources are hard to get in our community? (Check all that apply) — *Top 10 responses shown*



Which social/support resources are hard to get in our community? (Check all that apply)	2021	2024
Affordable / safe housing	31%	53%
Childcare	32%	48%
Transportation	28%	40%
Healthy food	24%	34%
Employment / job assistance	24%	28%
Rent / utilities assistance	17%	26%
Medical debt assistance	22%	26%
Health insurance	21%	25%
Veteran's services	17%	25%
Medication assistance	20%	23%
Financial assistance	N/A	22%
Grief / bereavement counseling	15%	19%
Domestic violence victim assistance	18%	15%
Legal services	11%	14%
Food benefits (SNAP, WIC)	11%	13%
TANF (Temporary Assistance for Needy Families)	10%	11%
Reading and writing support	N/A	11%
Unemployment benefits	10%	8%
Education (GED / high school / college)	N/A	7%
Banking services	N/A	5%
Education and literacy	16%	N/A
Banking / financial assistance	14%	N/A
COVID-19 has made one or more of the services I selected hard to get	11%	N/A
Other	4%	N/A
Total Answered	809	653
Skipped	48	112

In 2024, the top challenges cited by the community were affordable and safe housing (53%), childcare (48%), transportation (40%), and access to healthy foods (34%). Housing concerns have surged, up from 31% in 2021, intensifying other critical needs like childcare and food security. Childcare access, now a barrier for 48% of respondents (up from 32% in 2021), especially affects working parents, limiting employment opportunities and housing stability. Additionally, a significant number of respondents (26% in 2024 compared to 17% in 2021) reported that rent and utilities assistance is hard to obtain in the community.

34% of respondents reporting limited access to healthy food, financial strain from high housing and childcare costs further limits families' ability to afford nutritious options. According to the U.S. Department of Agriculture (USDA), in 2023, 13.5% of U.S. households were food insecure at some time

Source: U.S. Department of Agriculture, Economic Research Service, Food Security Status of U.S. Households in 2023, Retrieved 10/30/24 https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/key-statistics-graphics/

Transportation challenges in rural Virginia severely limit residents' access to essential services, including healthcare, employment, and education. The Virginia Rural Health Plan 2022-2026 notes that the state's rural population faces significant transportation challenges due to extremely low population density and long travel distances, creating an environment lacking in infrastructure that would support rural public transportation.

Source: Virginia Department of Health, "Virginia Rural Health Plan 2022-2026," Retrieved on 11/4/24, https://www.vdh.virginia.gov/content/uploads/sites/76/2022/01/Virginia-Rural-Health-Plan_Book_POST_1-24-22_LR.pdf

Health Behaviors

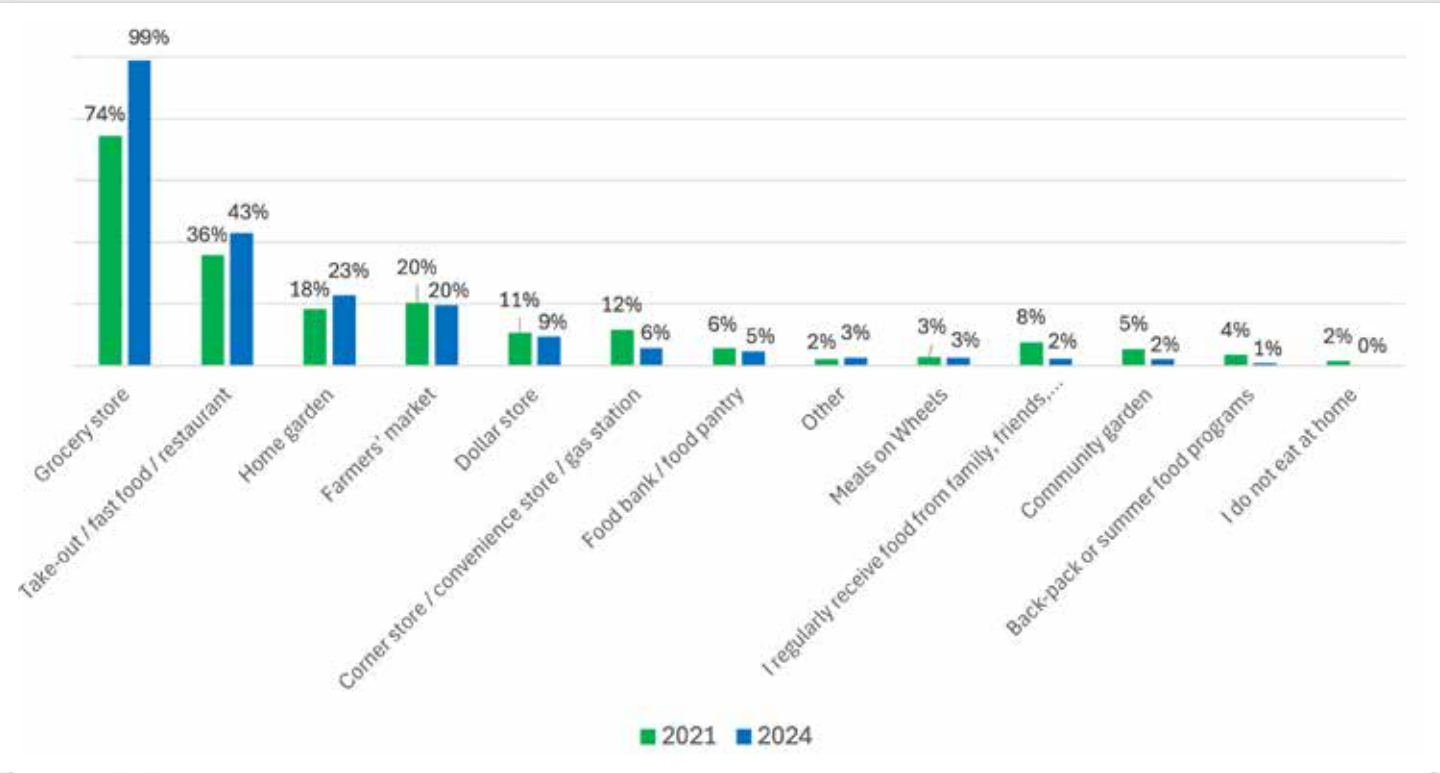
DIET AND EXERCISE

In 2024, respondents were asked a series of questions regarding food availability, fruit and vegetable consumption, family meal patterns, and physical activity. A new question was introduced, asking how often respondents walked for at least 10 minutes continuously over the past seven days.

Body Mass Indices of Respondents

Please note: As in 2018 and 2021, we asked Community Health Survey respondents to self-report their height and weight to determine their Body Mass Index (BMI). (Please refer to Questions 20 and 21 in the Survey included in the Appendix of this report.) BMI is used to determine healthy weight versus underweight or overweight/obesity status of an individual. We included the option in 2024 to report height and weight as either imperial measurements (pounds and feet/inches) or metric measurements (kilograms/centimeters). Unfortunately, there were significant discrepancies identified with the responses for these two options that led to questioning the validity of the data across all three CHNA service areas. Based on these discrepancies, it was decided not to include this data set in the 2024 Community Health Survey summaries. However, there is information presented in the Secondary Data section in this report addressing obesity levels by locality.

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

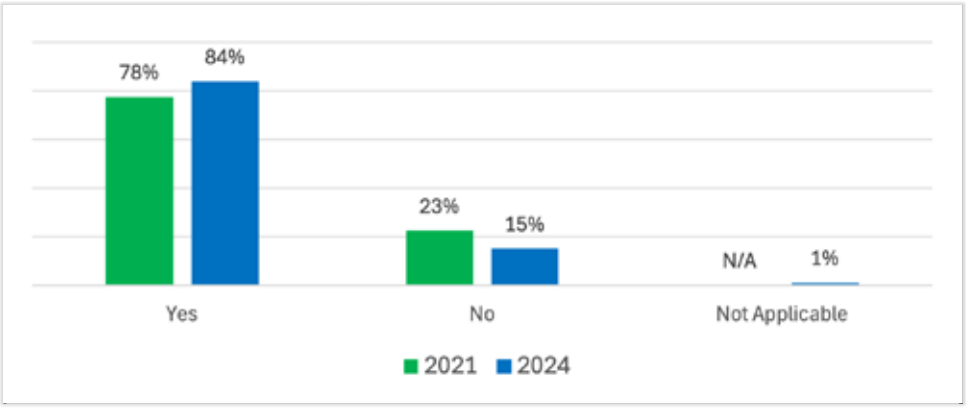


Where do you get the food that you eat at home? (Check all that apply)	*2021*	*2024*
Grocery store	74%	99%
Take-out / fast food / restaurant	36%	43%
Home garden	18%	23%
Farmers' market	20%	20%
Dollar store	11%	9%
Corner store / convenience store / gas station	12%	6%
Food bank / food pantry	6%	5%
Other	2%	3%
Meals on Wheels	3%	3%
I regularly receive food from family, friends, neighbors, or my church	8%	2%
Community garden	5%	2%
Back-pack or summer food programs	4%	1%
I do not eat at home	2%	0%
Total Answered	846	604
Skipped	11	161

In 2024, 99% of respondents reported getting food from grocery stores, up from 74% in 2021. Food sourcing from dollar stores decreased slightly from 11% to 9%. The use of community gardens dropped from 5% in 2021 to 2% in 2024, while home garden usage rose from 18% to 23%. Take-out and restaurant food consumption increased from 36% to 43%.

Fewer respondents received food from family, friends, or their church, decreasing from 8% in 2021 to 2% in 2024. Reliance on food programs also fell. The percentage of respondents sourcing food from farmers markets remained unchanged at 20% for both years. Finally, 0% of respondents reported not eating at home in 2024, down from 2% in 2021.

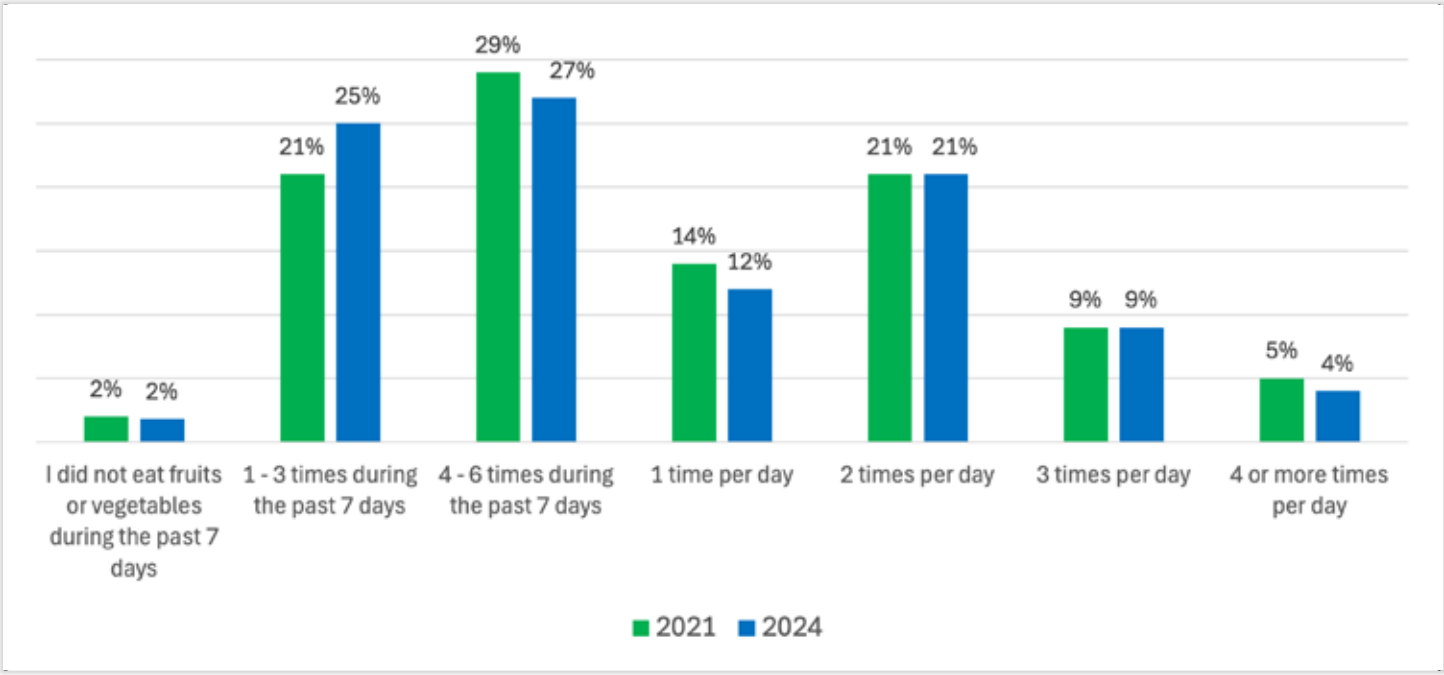
In the area where you live, is it easy to get fresh fruits and vegetables?



In the area where you live, is it easy to get fresh fruits and vegetables?	*2021*	*2024*
Yes	78%	84%
No	23%	15%
Not Applicable	N/A	1%
Total Answered	826	608
Skipped	23	157

The percentage of respondents who found it easy to access affordable fresh fruits and vegetables increased from 78% in 2021 to 84% in 2024. Consequently, those who answered "no" decreased from 23% to 15% during the same period.

During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice/supplements. (Check one)

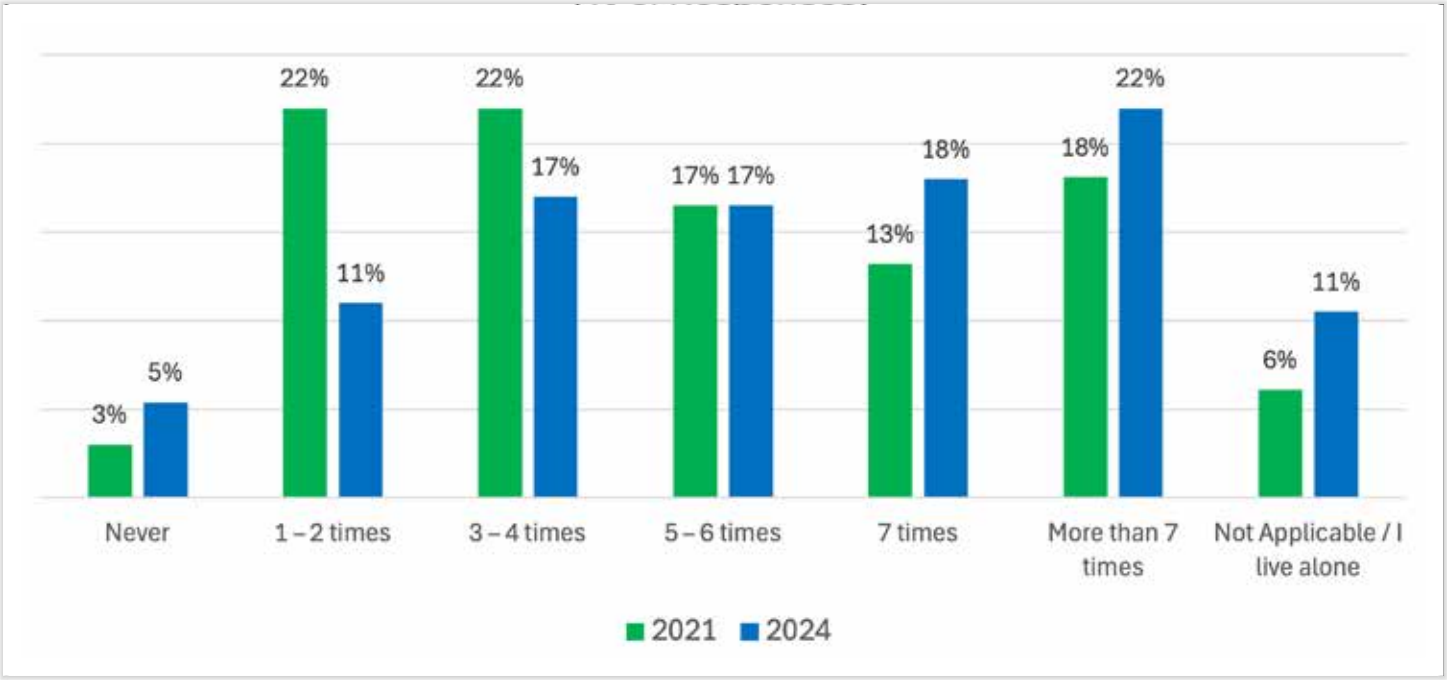


During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice/supplements. (Check one)	*2021*	*2024*
I did not eat fruits or vegetables during the past 7 days	2%	2%
1 - 3 times during the past 7 days	21%	25%
4 - 6 times during the past 7 days	29%	27%
1 time per day	14%	12%
2 times per day	21%	21%
3 times per day	9%	9%
4 or more times per day	5%	4%
Total Answered	830	611
Skipped	27	154

Between 2021 and 2024, fruit and vegetable consumption among respondents remained mostly stable. The percentage of individuals not consuming any fruits or vegetables held steady at 2%, while those eating fruits and vegetables at least twice daily remained at 21%. The proportion consuming them three times a day also stayed consistent at 9%.

Moderate consumption (four to six times per week) decreased slightly from 29% to 27%, and those eating fruits or vegetables four or more times daily fell from 5% to 4%. However, there was a positive trend for those consuming fruits or vegetables one to three times per week, which increased from 21% to 25%. This increase suggests that more respondents are incorporating fruits and vegetables into their diets, although at lower frequencies than recommended.

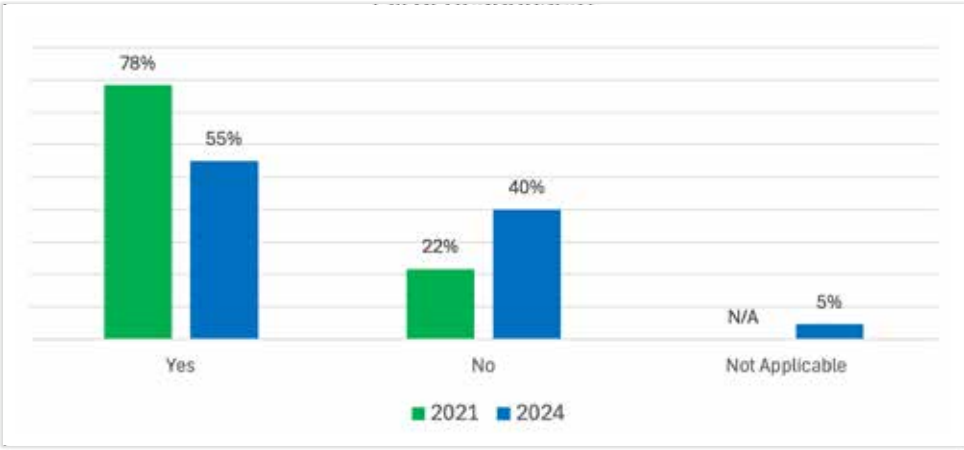
In the past 7 days, how many times did all or most of the people living in your house eat a meal together?



In the past 7 days, how many times did all or most of the people living in your house eat a meal together?	*2021*	*2024*
Never	3%	5%
1 – 2 times	22%	11%
3 – 4 times	22%	17%
5 – 6 times	17%	17%
7 times	13%	18%
More than 7 times	18%	22%
Not Applicable / I live alone	6%	11%
Total Answered	835	613
Skipped	25	152

34% of respondents had meals with their families between three and six times a week. Those eating meals together seven or more times per week in 2024 was 40% compared to 31% in 2021. Frequent family meals are linked to numerous health benefits, including improved nutrition and better family dynamics. Studies indicate that families who share meals regularly tend to consume more fruits and vegetables, contributing to healthier eating habits and lower obesity rates among children (Source: FMI, New Study Confirms Value of Family Meals, Retrieved 10/30/24, https://www.fmi.org/newsroom/news-archive/view/2020/03/10/new-study-confirms-value-of-family-meals).

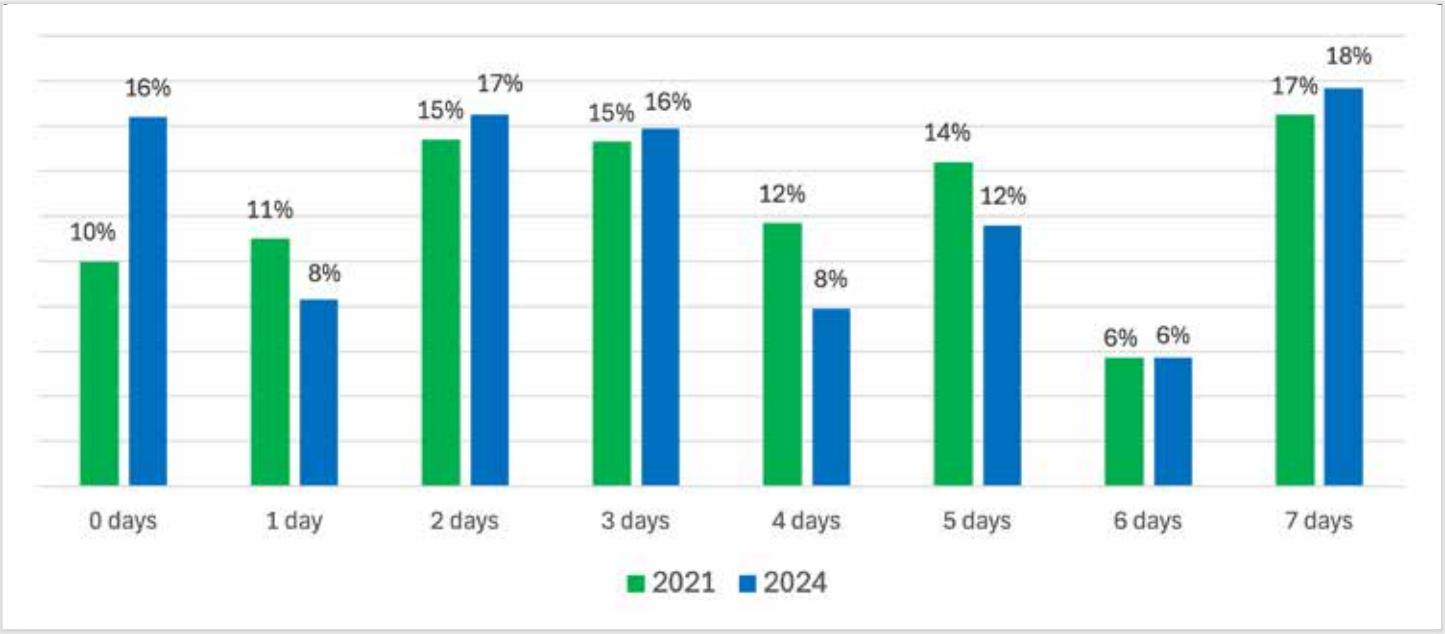
Does your community neighborhood support physical activity? (e.g. parks, sidewalks, bike lanes, etc.)



Does your community neighborhood support physical activity? (e.g., parks, sidewalks, bike lanes, etc.)	*2021*	*2024*
Yes	78%	55%
No	22%	40%
Not Applicable	N/A	5%
Total Answered	830	605
Skipped	27	160

In 2024, only 55% of respondents reported that their community neighborhood supported physical activity through amenities like parks, sidewalks, and bike lanes, a notable drop from 78% in 2021. This decline indicates a growing concern among community members about the accessibility and availability of resources for physical activity. Correspondingly, the percentage of those answering "no" to the question about community support jumped from 22% in 2021 to 40% in 2024.

Over the past 7 days, how many days were you physically active for a total of at least 30 minutes?

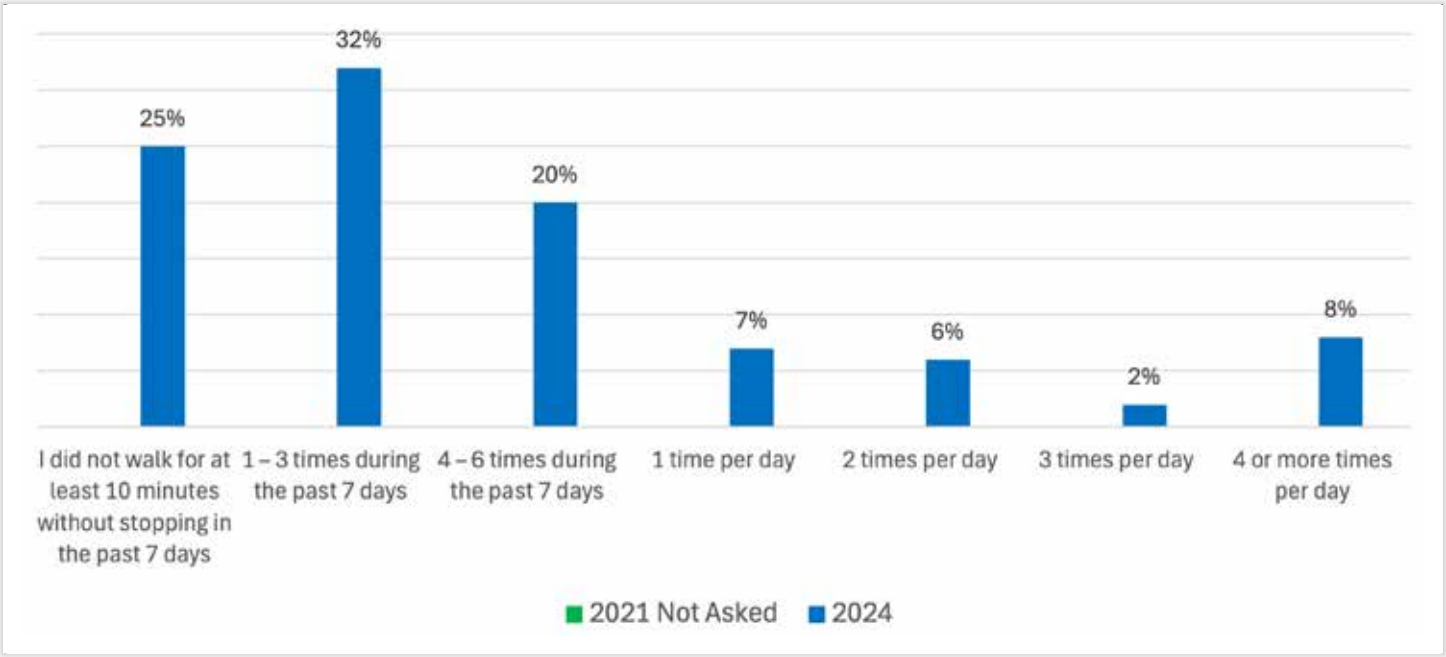


Over the past 7 days, how many days were you physically active for a total of at least 30 minutes?	*2021*	*2024*
0 days	10%	16%
1 day	11%	8%
2 days	15%	17%
3 days	15%	16%
4 days	12%	8%
5 days	14%	12%
6 days	6%	6%
7 days	17%	18%
Total Answered	838	612
Skipped	20	153

Respondents' physical activity habits from 2021 to 2024 show a mixed trend in engagement with regular exercise. The percentage of individuals active five or more days a week decreased slightly from 37% in 2021 to 36% in 2024. Similarly, those active three to four days a week declined from 27% to 24%, indicating a slight reduction in regular exercise among respondents.

Conversely, the number of respondents who reported being active only one or two days a week decreased from 26% in 2021 to 25% in 2024, suggesting a small decline in minimal physical activity. However, those reporting zero days of activity increased from 10% in 2021 to 16% in 2024, indicating a growing concern regarding inactivity among some respondents.

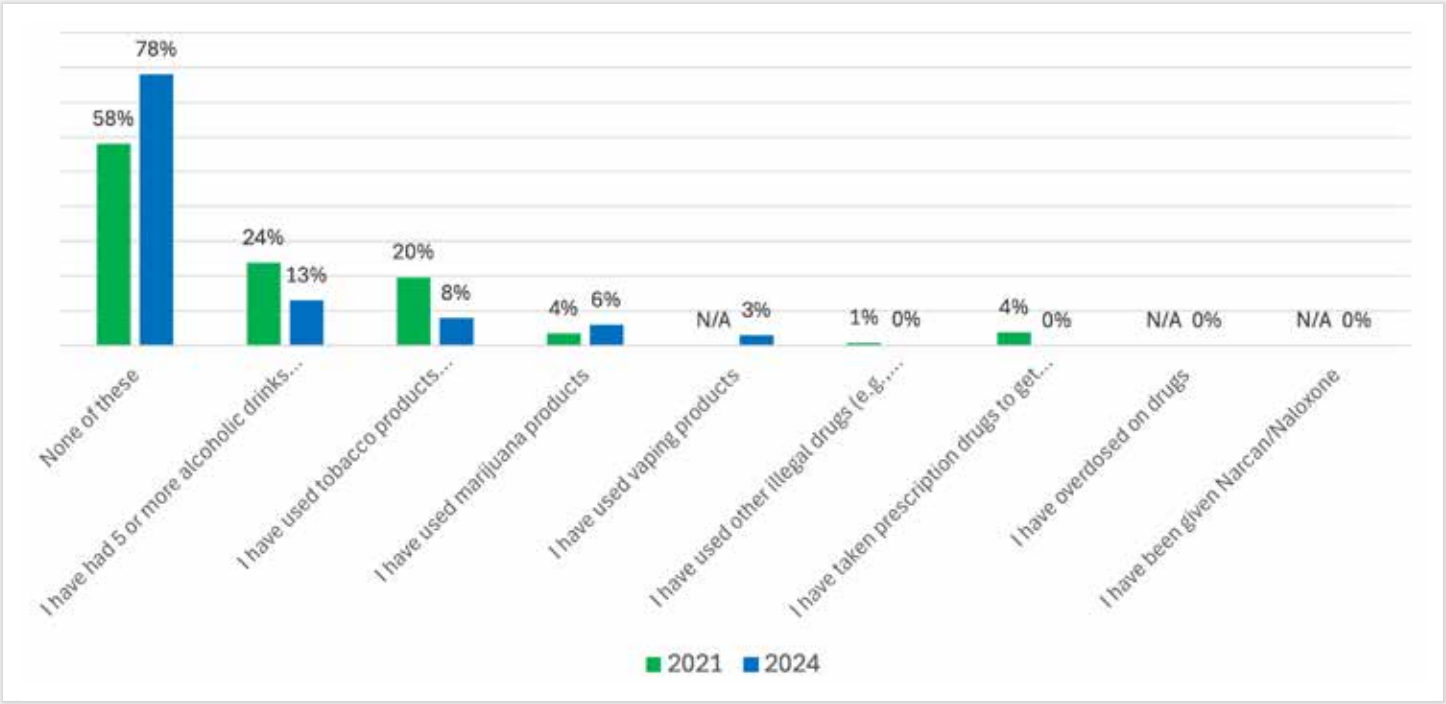
During the past 7 days, how many times did you walk for at least 10 minutes without stopping?



During the past 7 days, how many times did you walk for at least 10 minutes without stopping?	*2021 Not Asked*	*2024*
I did not walk for at least 10 minutes without stopping in the past 7 days		25%
1 – 3 times during the past 7 days		32%
4 – 6 times during the past 7 days		20%
1 time per day		7%
2 times per day		6%
3 times per day		2%
4 or more times per day		8%
Total Answered		608
Skipped		157

25% of respondents did not walk for at least 10 minutes in the past week, indicating significant inactivity. The most common response, 32%, was walking 1 to 3 times per week. About 20% walked 4 to 6 times per week. Daily walking was less frequent, with 7% walking once per day, 6% twice per day, and 2% three times per day. Additionally, 8% walked four or more times daily.

During the past 30 days: (Check all that apply)



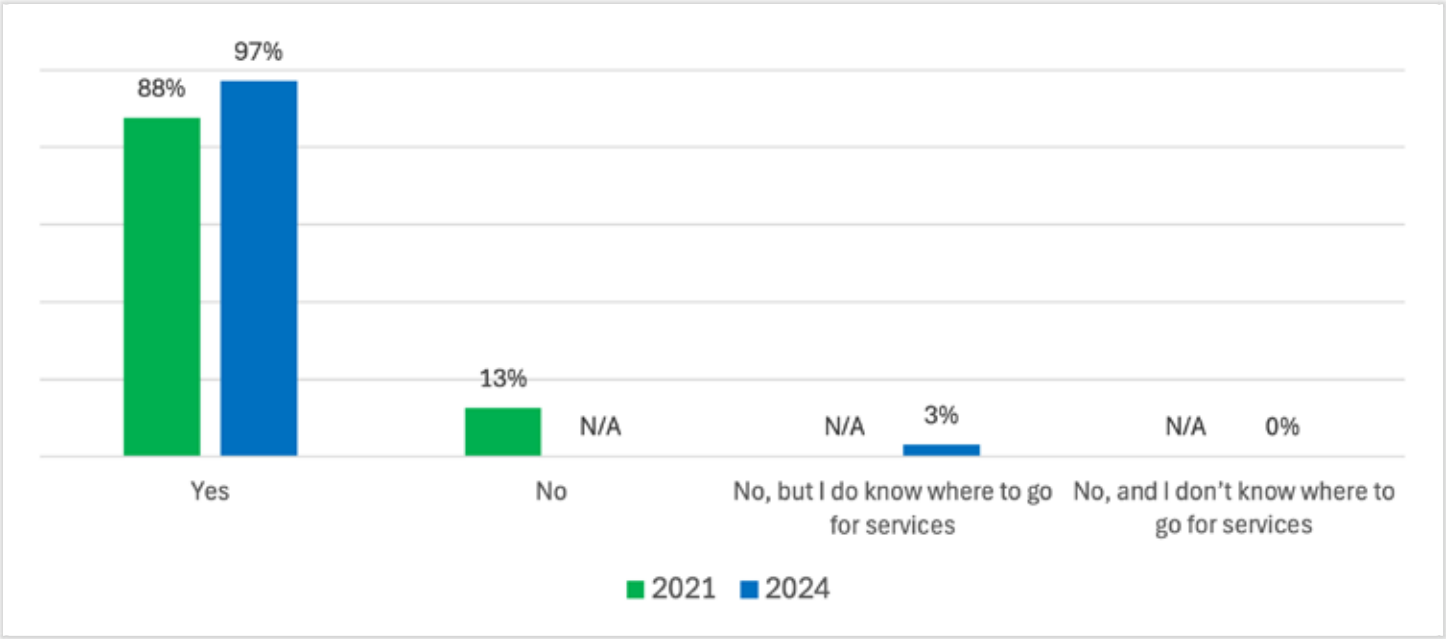
During the past 30 days: (Check all that apply)	*2021*	*2024*
None of these	58%	78%
I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion	24%	13%
I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)	20%	8%
I have used marijuana products	4%	6%
I have used vaping products	N/A	3%
I have used other illegal drugs (e.g., meth, cocaine, heroin, ecstasy, crack, LSD, etc.)	1%	0%
I have taken prescription drugs to get high	4%	0%
I have overdosed on drugs	N/A	0%
I have been given Narcan/Naloxone	N/A	0%
Total Answered	831	607
Skipped	26	158

Respondents were asked about their alcohol, tobacco, and substance use over the past 30 days, with new questions in 2024 addressing vaping, drug overdoses, and the administration of Narcan/Naloxone. 78% of respondents indicated no alcohol, tobacco, or substance use. Binge drinking declined from 2021, with 24% of respondents in 2021 reporting they had 5 or more drinks (if male) or 4 or more drinks (if female) during one occasion, compared to just 13% in 2024. There was also a decrease in the use of tobacco products, with 20% of respondents in 2021 reporting use compared to 8% in 2024. Marijuana use increased with 6% of respondents citing use. In 2024, 3% reported vaping, while 0% reported using illegal or prescription drugs to get high, experiencing overdoses, or receiving Narcan/Naloxone.

ACCESS AND UTILIZATION OF SERVICES

Survey respondents were asked about their use of medical, dental, and mental health, alcohol use, or drug use services. In the 2021 survey, respondents were asked to indicate their use of services by answering simple "yes" or "no" questions. For 2024, these questions were restructured to provide more detailed insights. Instead of merely selecting "no," respondents could specify whether they knew where to access services. This change explains the absence of a straightforward "no" option in the 2024 results, as responses were divided into more specific categories. This adjustment offers a nuanced understanding of barriers to service access.

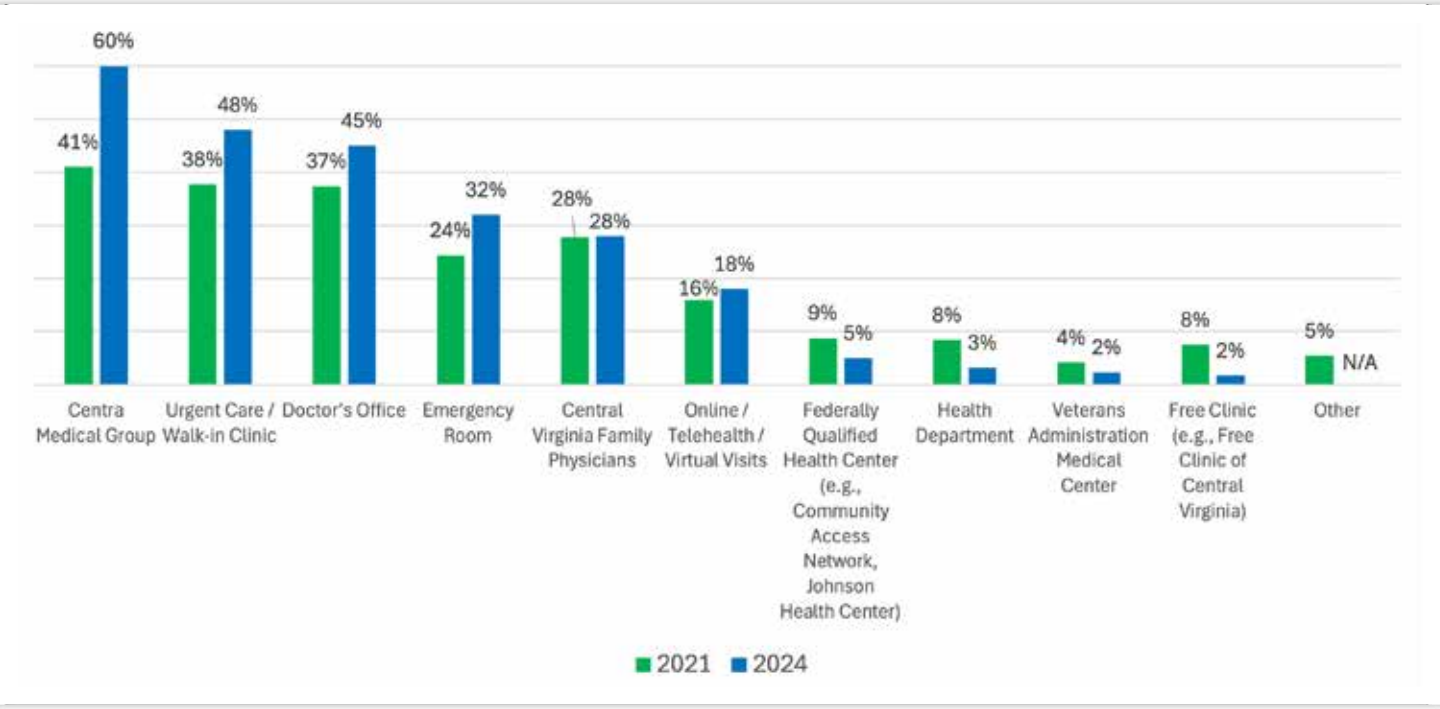
Do you use medical care services?



Do you use medical care services?	*2021*	*2024*
Yes	88%	97%
No	13%	N/A
No, but I do know where to go for services	N/A	3%
No, and I don't know where to go for services	N/A	0%
Total Answered	783	603
Skipped	74	162

The proportion of respondents using medical services grew from 88% in 2021 to 97% in 2024. In 2021, 13% had indicated they didn't use medical services. By 2024, this was broken down further: 3% knew where services were available but didn't use them, while 0% were unsure where to go for services.

Please check all the medical care services you use.

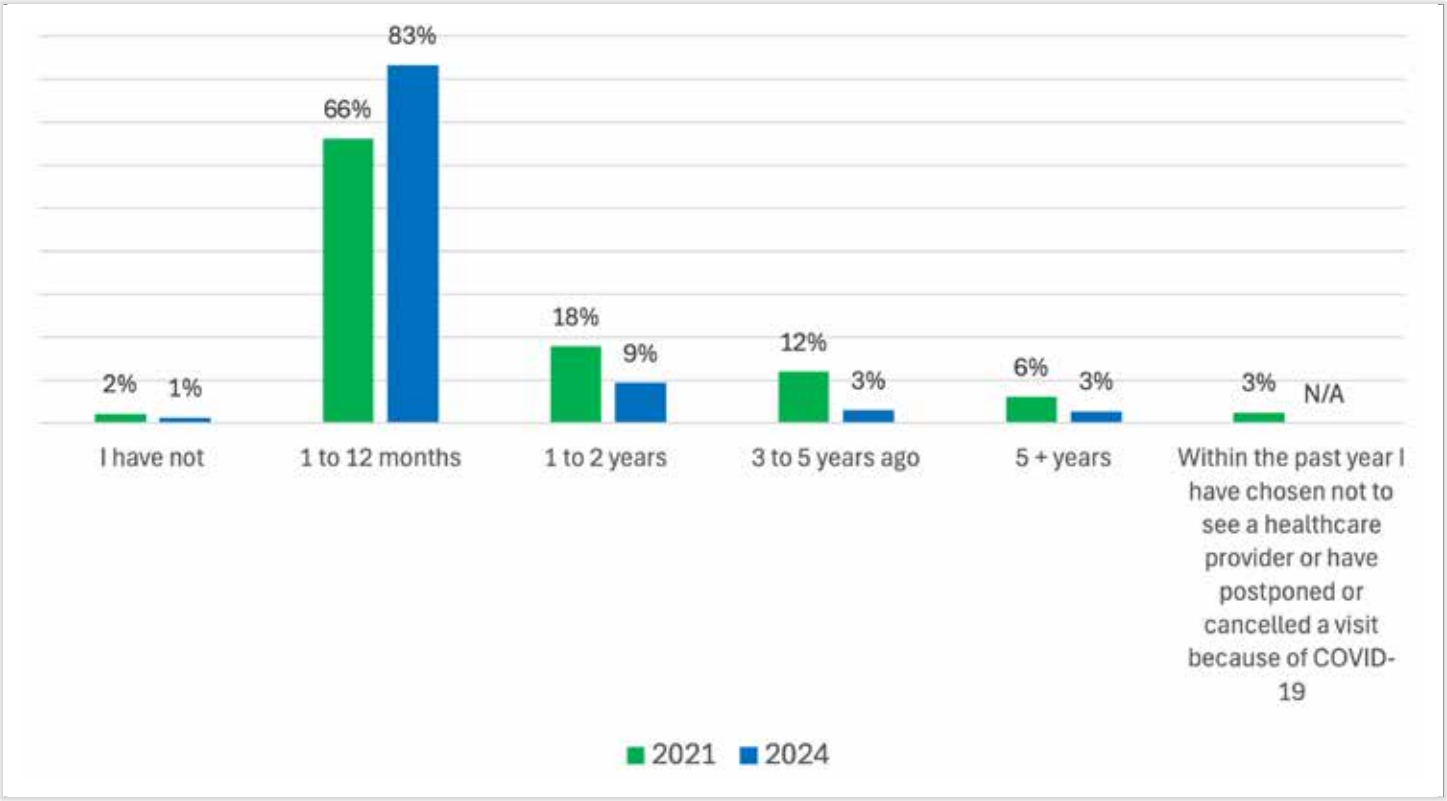


Please check all the medical care services you use.	*2021*	*2024*
Centra Medical Group	41%	60%
Urgent Care / Walk-in Clinic	38%	48%
Doctor's Office	37%	45%
Emergency Room	24%	32%
Central Virginia Family Physicians	28%	28%
Online / Telehealth / Virtual Visits	16%	18%
Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)	9%	5%
Health Department	8%	3%
Veterans Administration Medical Center	4%	2%
Free Clinic (e.g., Free Clinic of Central Virginia)	8%	2%
Other	5%	N/A
Total Answered	798	586
Skipped	59	162

In 2024, Central Medical Group emerged as the top choice for medical services, with 60% of respondents naming it as their primary provider. Urgent care and walk-in clinics saw a notable increase in usage, rising from 38% in 2021 to 48% in 2024. Despite this shift, nearly half of respondents (45%) still favored traditional doctor's offices.

Emergency room use increased significantly from 24% to 32%, which may point to barriers in accessing regular healthcare or more frequent health crises. Use of Federally Qualified Health Centers (FQHC) dropped from 9% in 2021 to 5% in 2024. Meanwhile, online and telehealth services showed only a slight rise, from 16% to 18%. Free Clinic use fell from 8% to 2%.

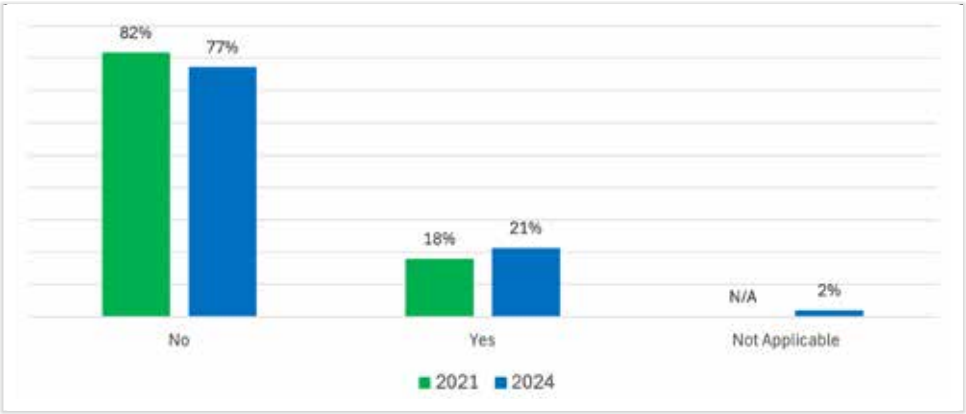
How long has it been since you last visited a doctor or other healthcare provider for a routine checkup?



How long has it been since you last visited a doctor or other healthcare provider for a routine checkup?	*2021*	*2024*
I have not visited a doctor or other healthcare provider for a checkup	2%	1%
1 to 12 months	66%	83%
1 to 2 years	18%	9%
3 to 5 years ago	12%	3%
5 + years	6%	3%
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	3%	N/A
Total Answered	851	605
Skipped	6	160

The number of respondents indicating that they last visited a healthcare provider for a routine check-up within the past year increased dramatically from 66% in 2021 to 83% in 2024. The number of respondents who had not visited a healthcare provider for a routine check-up within the past five years decreased from 6% in 2021 to 3% in 2024. The 2021 response option about postponing healthcare visits due to COVID-19, acknowledged by 3% of respondents, was not included in 2024, as pandemic-related restrictions had been largely lifted.

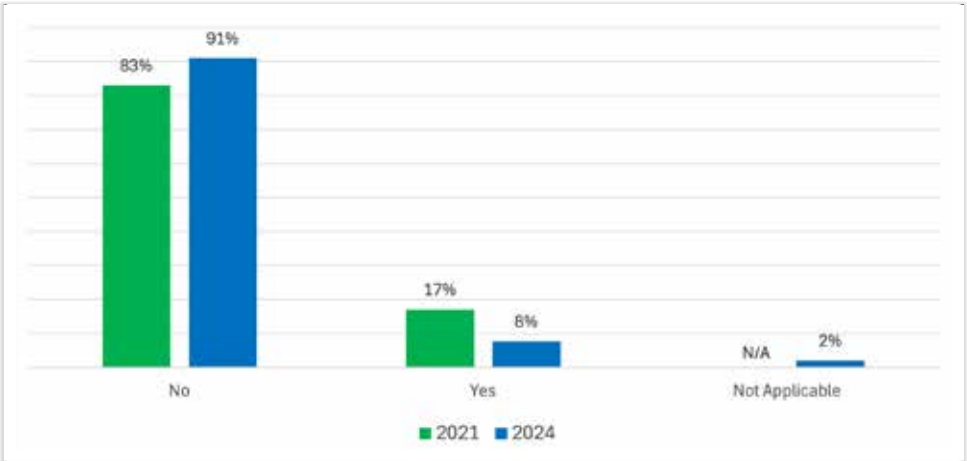
I have been to the emergency room in the past 12 months.



I have been to the emergency room in the past 12 months.	*2021*	*2024*
No	82%	77%
Yes	18%	21%
Not Applicable	N/A	2%
Total Answered	839	610
Skipped	18	154

The percentage of respondents who reported visiting the Emergency Room (ER) in the past 12 months increased from 18% in 2021 to 21% in 2024. Conversely, those who had not visited the ER dropped from 82% in 2021 to 77% in 2024.

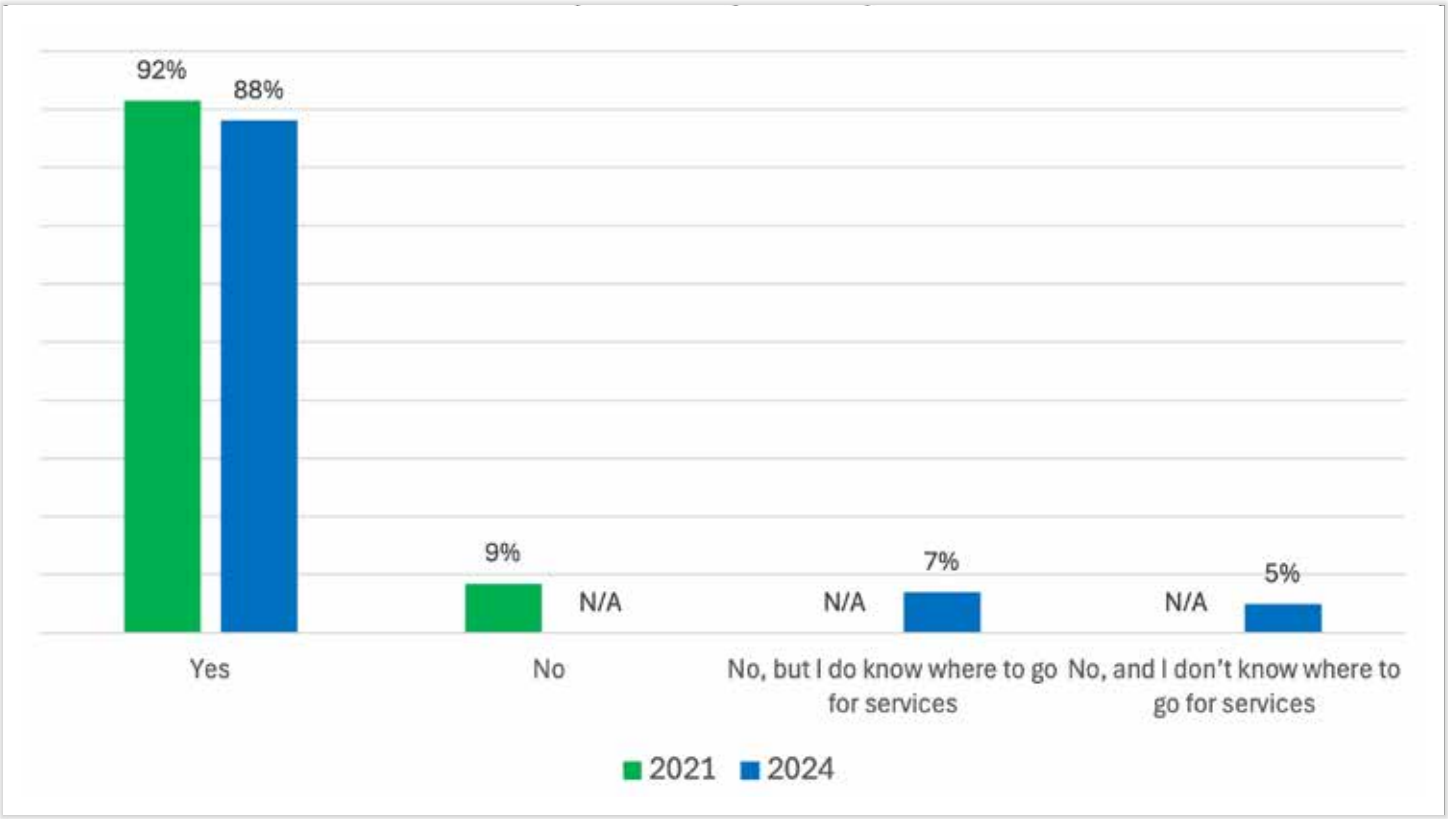
I have been to the emergency room for an injury in the past 12 months (e.g., motor vehicle crash, fall, poisoning, burn, cut, etc.).



I have been to the emergency room for an injury in the past 12 months (e.g., motor vehicle crash, fall, poisoning, burn, cut, etc.).	*2021*	*2024*
No	83%	91%
Yes	17%	8%
Not Applicable	N/A	2%
Total Answered	834	610
Skipped	23	155

In 2024, only 8% of respondents reported visiting the emergency room for an injury in the past year, down significantly from 17% in 2021. The percentage of those who indicated they had not gone to the emergency room for injuries rose from 83% in 2021 to 91% in 2024.

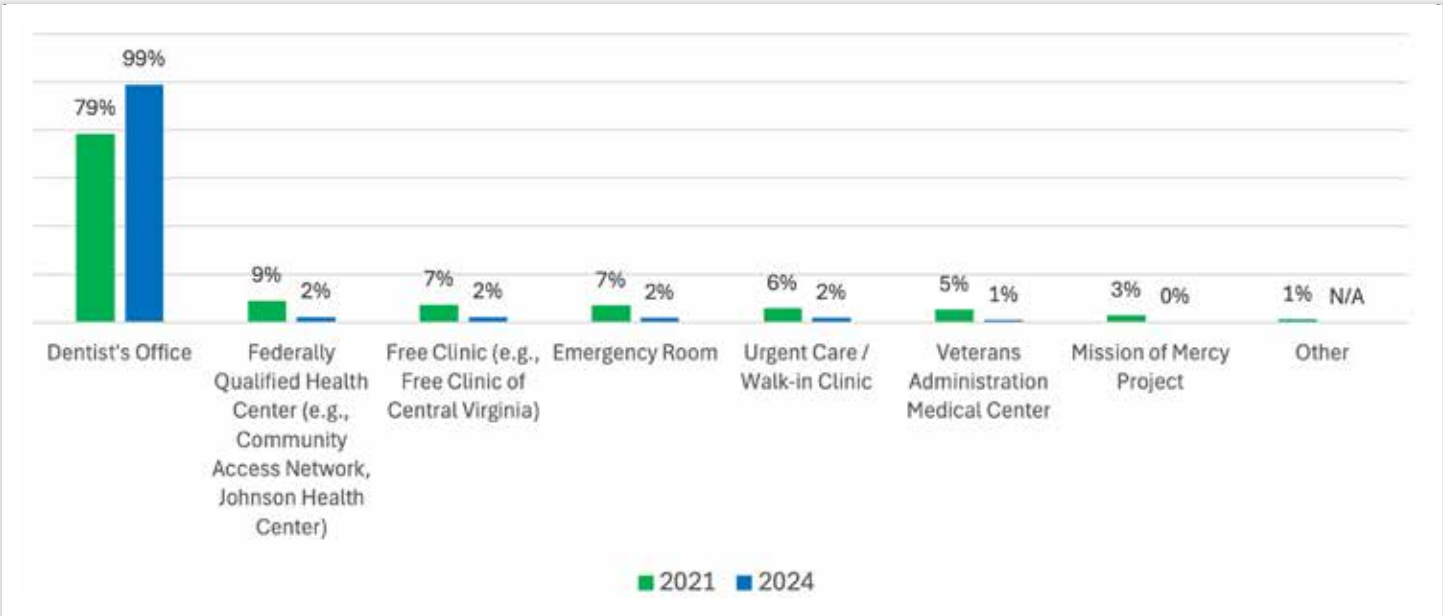
Do you use dental care services?



Do you use dental care services?	*2021*	*2024*
Yes	92%	88%
No	9%	N/A
No, but I do know where to go for services	N/A	7%
No, and I don't know where to go for services	N/A	5%
Total Answered	810	598
Skipped	47	167

The number of respondents indicating that they use dental care services decreased from 92% in 2021 to 88% in 2024. In 2021, 9% answered "no". For 2024, this was broken down further: 7% reported not using services but knowing where to go, while 5% said they did not know where to go for assistance.

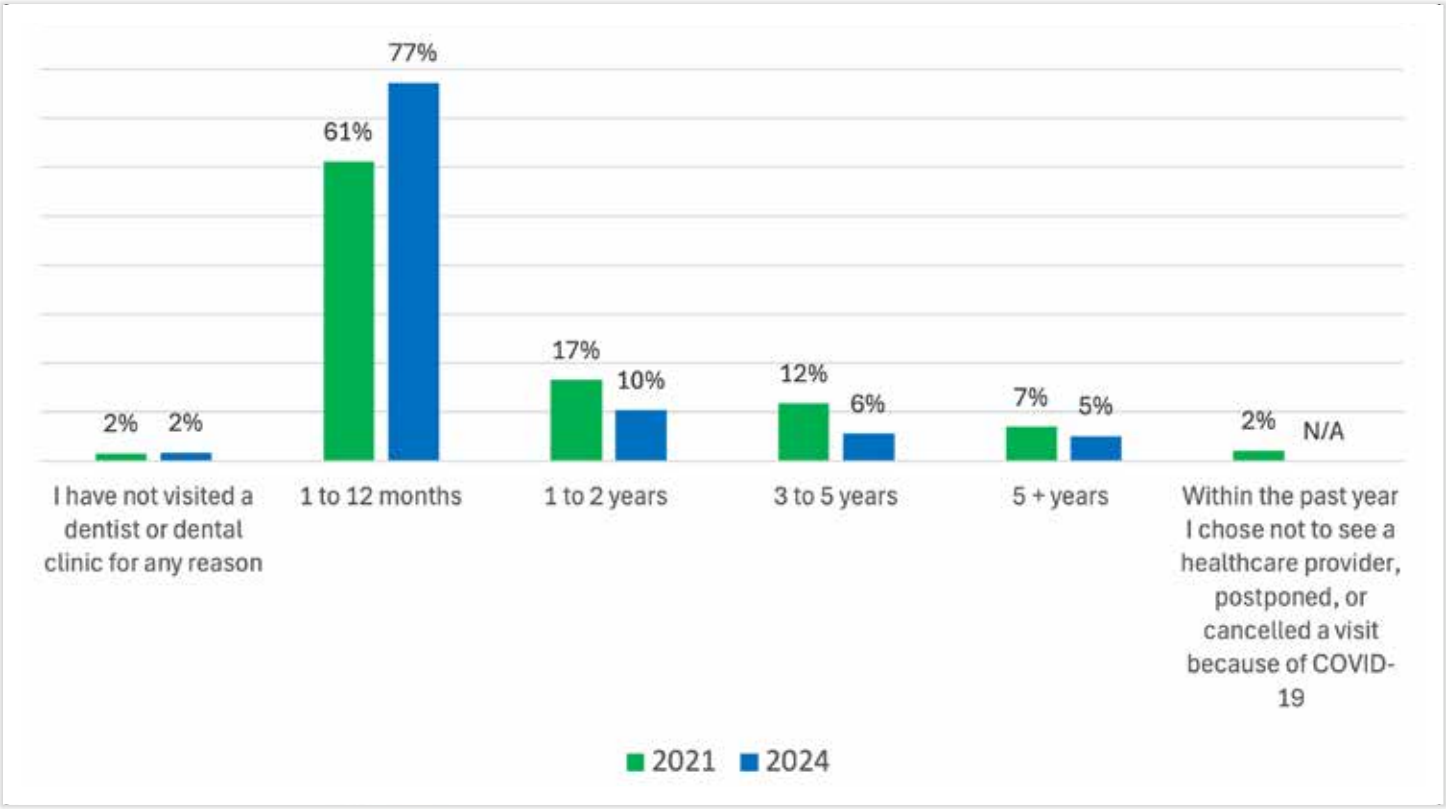
Please check all the dental care services you use.



Please check all the dental care services you use.	*2021*	*2024*
Dentist's Office	79%	99%
Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)	9%	2%
Free Clinic (e.g., Free Clinic of Central Virginia)	7%	2%
Emergency Room	7%	2%
Urgent Care / Walk-in Clinic	6%	2%
Veterans Administration Medical Center	5%	1%
Mission of Mercy Project	3%	0%
Other	1%	N/A
Total Answered	788	526
Skipped	69	167

Respondents were asked what type of dental services they use. The number of respondents selecting the generic response "Dentist's Office" rose tremendously from 79% in 2021 to 99% in 2024. The use of "Free Clinic" for dental services decreased in 2024 to 2% from 7% in 2021. Respondents using Federally Qualified Health Center's (e.g., Johnson Health Center or Community Access Network) also took a significant drop from 2021 (9%) to 2% in 2024.

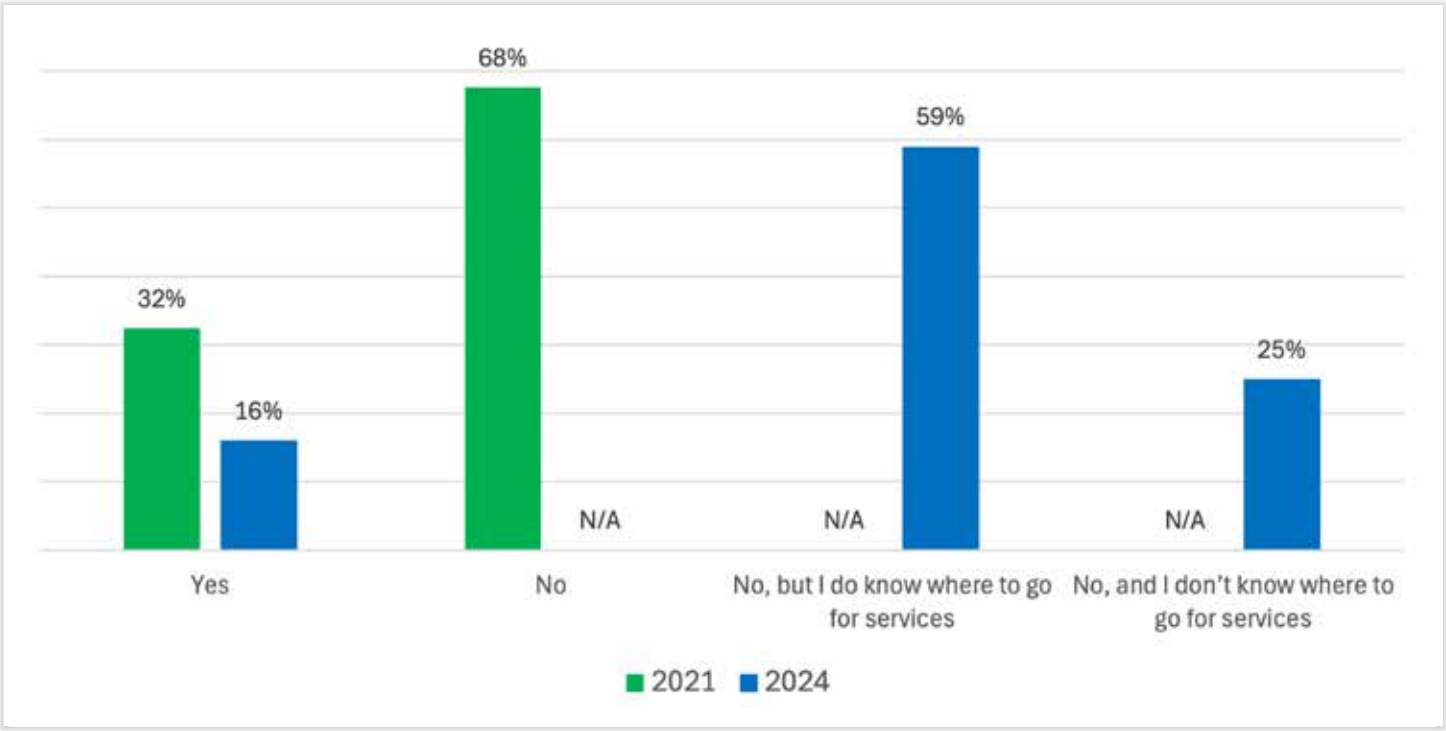
How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists (e.g., orthodontist, periodontist).



How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists (e.g., orthodontist, periodontist).	*2021*	*2024*
I have not visited a dentist or dental clinic for any reason	2%	2%
1 to 12 months	61%	77%
1 to 2 years	17%	10%
3 to 5 years	12%	6%
5 + years	7%	5%
Within the past year I chose not to see a healthcare provider, postponed, or cancelled a visit because of COVID-19	2%	N/A
Total Answered	896	606
Skipped	11	159

The number of respondents who have visited a dentist or dental clinic in the last 12 months increased from 61% in 2021 to 77% in 2024. More people reported having not visited the dentist or dental clinic within the past two years in 2021 (17%) than in 2024 (10%) as well as within the past 5 years (12% in 2021 compared to 6% in 2024). The number of respondents who had not visited a dentist or dental clinic in the past five or more years decreased from 7% in 2021 to 5% in 2024. The 2021 response option about postponing healthcare visits due to COVID-19, acknowledged by 2% of respondents, was not included in 2024, as pandemic-related restrictions had been largely lifted.

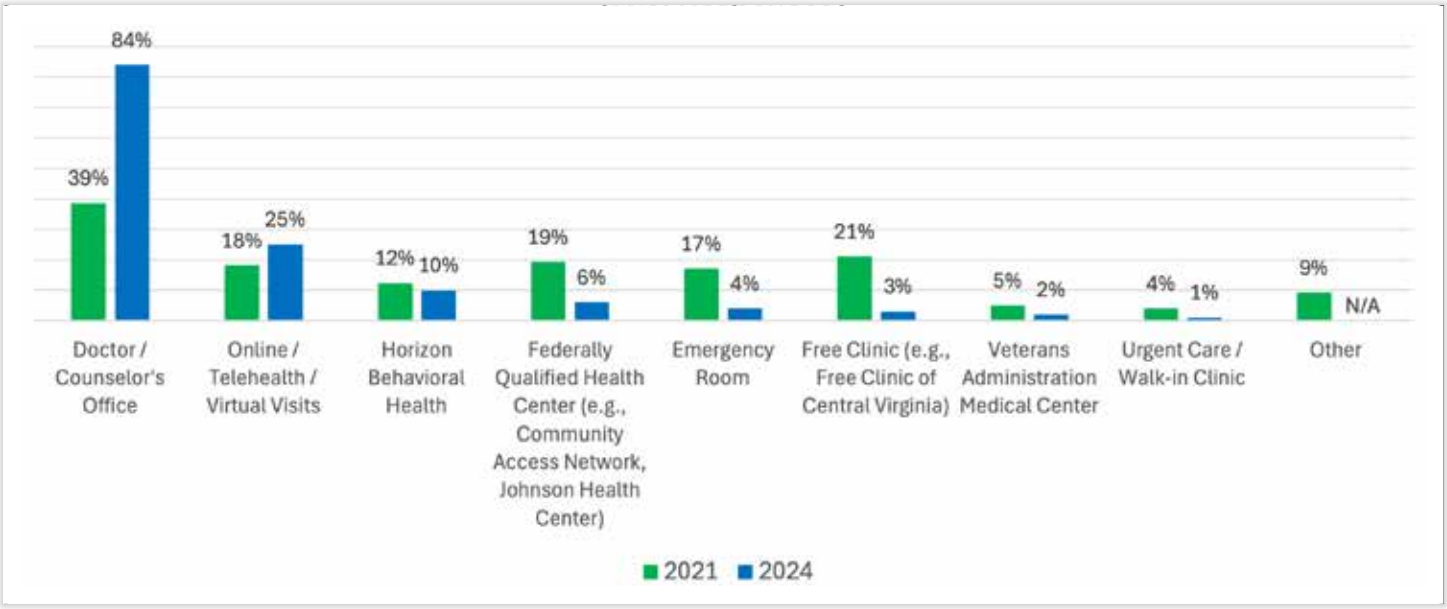
Do you use mental health, alcohol use, or drug use services?



Do you use mental health, alcohol use, or drug use services?	*2021*	*2024*
Yes	32%	16%
No	68%	N/A
No, but I do know where to go for services	N/A	59%
No, and I don't know where to go for services	N/A	25%
Total Answered	826	587
Skipped	31	178

The percentage of respondents using mental health, alcohol, or drug use services dropped significantly from 32% in 2021 to 16% in 2024. In 2021, 68% answered "no". For 2024, this was broken down further: 59% reported not using services but knowing where to go, while 25% said they did not know where to go for assistance.

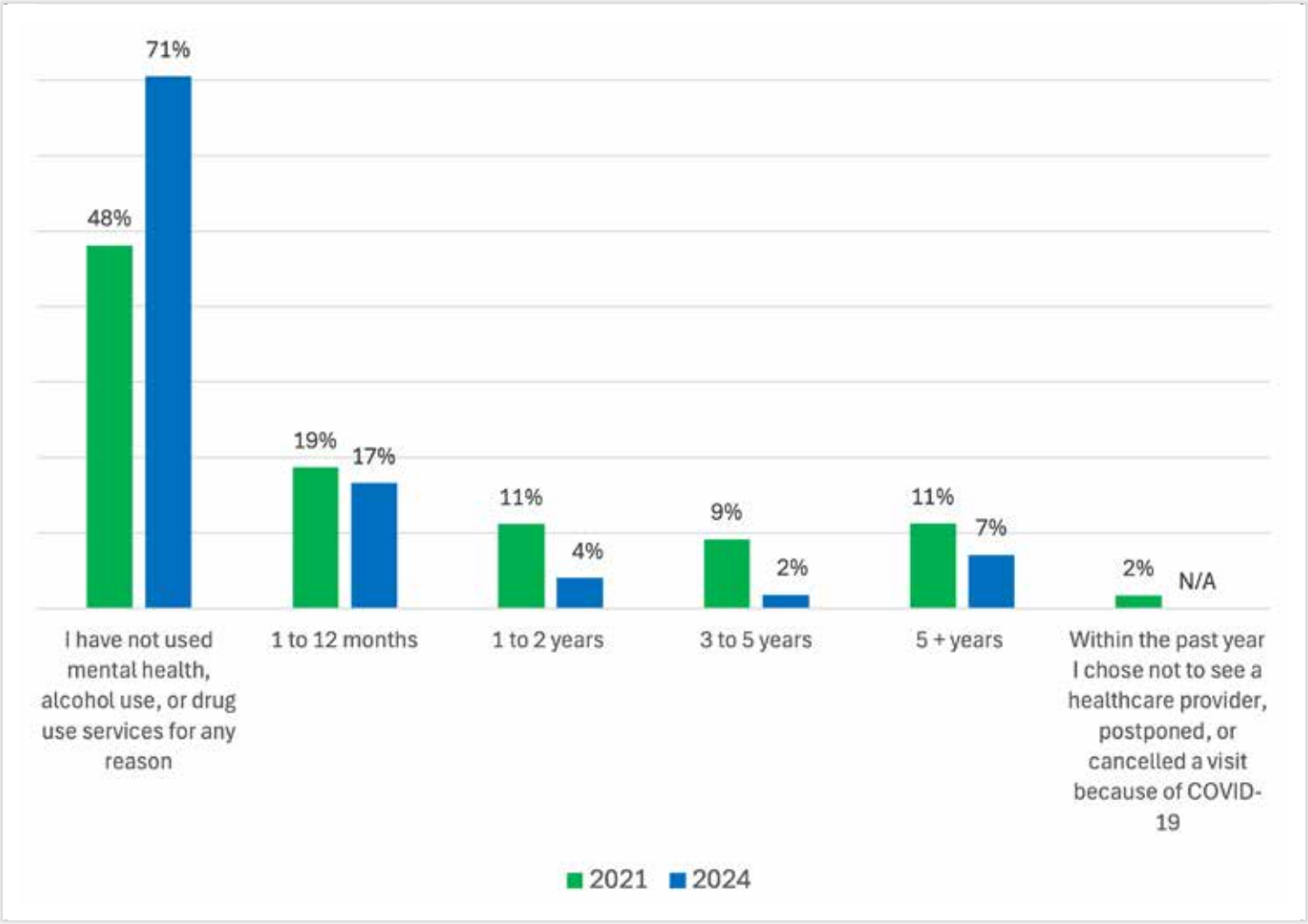
Please check all the mental health, alcohol use, or drug use services you use.



Please check all the mental health, alcohol use, or drug use services you use.	*2021*	*2024*
Doctor / Counselor's Office	39%	84%
Online / Telehealth / Virtual Visits	18%	25%
Horizon Behavioral Health	12%	10%
Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)	19%	6%
Emergency Room	17%	4%
Free Clinic (e.g., Free Clinic of Central Virginia)	21%	3%
Veterans Administration Medical Center	5%	2%
Urgent Care / Walk-in Clinic	4%	1%
Other	9%	N/A
Total Answered	347	93
Skipped	510	178

The number of respondents utilizing a "Doctor or Counselor's Office" for services saw a substantial increase, rising from 39% in 2021 to 84% in 2024. In contrast, the use of the Free Clinic and Federally Qualified Health Centers (FQHC) saw sharp declines. Respondents accessing the Free Clinic dropped from 21% in 2021 to just 3% in 2024, while those using FQHCs decreased from 19% to 6%. The use of Horizon Behavioral Health was cited by 10% of respondents. Meanwhile, emergency room use for mental health or substance services dropped significantly, from 17% in 2021 to 4% in 2024. Online/telehealth/virtual visit use increased from 2021 (18%) to 2024 (25%).

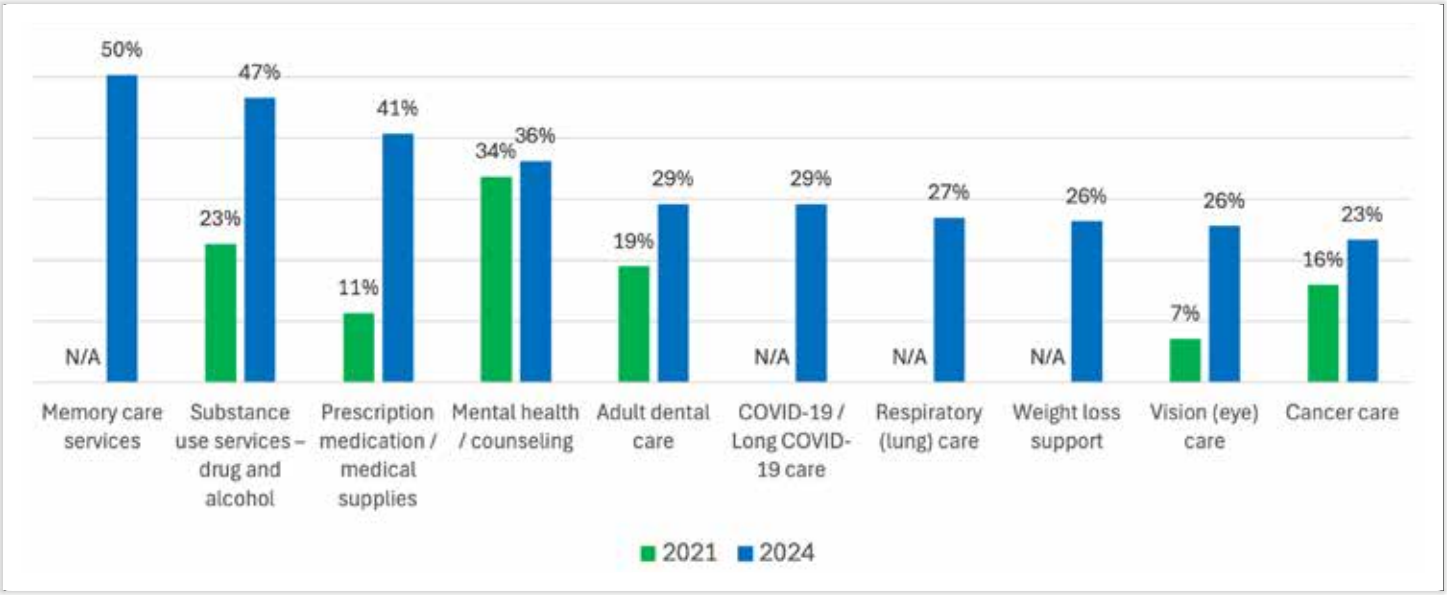
How long has it been since you last used mental health, alcohol use, or drug use services for any reason?



How long has it been since you last used mental health, alcohol use, or drug use services for any reason?	*2021*	*2024*
I have not used mental health, alcohol use, or drug use services for any reason	48%	71%
1 to 12 months	19%	17%
1 to 2 years	11%	4%
3 to 5 years	9%	2%
5 + years	11%	7%
Within the past year I chose not to see a healthcare provider, postponed, or canceled a visit because of COVID-19	2%	N/A
Total Answered	819	587
Skipped	83	178

In 2024, 71% of respondents reported not using mental health, alcohol, or drug use services, a significant increase from 48% in 2021. Short-term gaps in service use (1-12 months) remained fairly consistent, with 19% in 2021 and 17% in 2024. The percentage of respondents who hadn't used services in 1 to 2 years dropped notably, from 11% in 2021 to just 4% in 2024. The 2021 response option about postponing healthcare visits due to COVID-19, acknowledged by 2% of respondents, was not included in 2024, as pandemic-related restrictions had been largely lifted.

Which healthcare services are hard to get in our community? (Check all that apply) — *Top 10 responses shown*

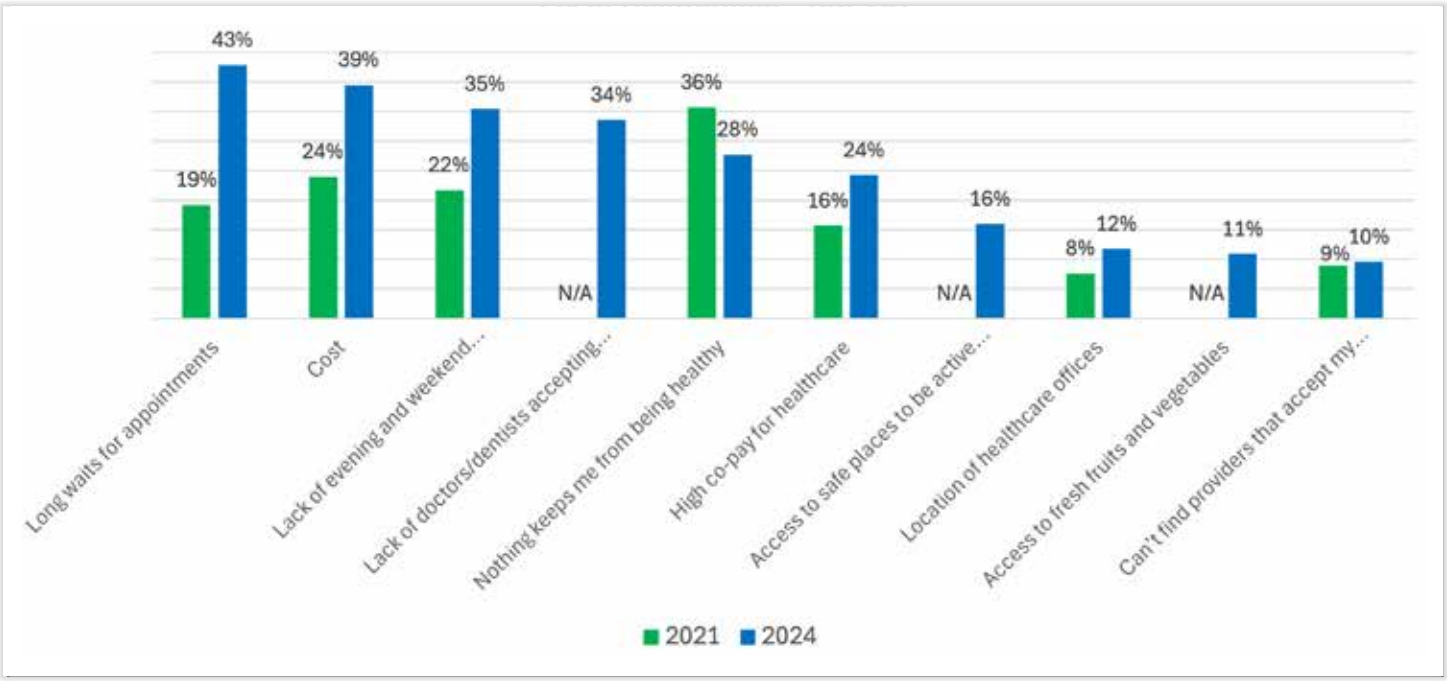


In 2024, survey respondents identified significant barriers to accessing healthcare services. Memory care services emerged as the most challenging, with 50% of respondents reporting difficulties, a response option introduced in the 2024 survey. Access to substance use services for drugs and alcohol also became more challenging, rising from 23% in 2021 to 47% in 2024. Difficulty obtaining prescription medications and medical supplies surged, doubling from 11% to 41%. Barriers to adult dental care increased from 19% to 29%, and access to mental health services saw a slight rise, from 34% to 36%.

New or revised categories introduced in 2024 included primary care provider (11%), weight loss support (26%), exercise professionals (8%), COVID-19/Long COVID care (29%), blood work (22%), and respiratory care (27%).

Which healthcare services are hard to get in our community? (Check all that apply)	*2021*	*2024*
Memory care services	N/A	50%
Substance use services – drug and alcohol	23%	47%
Prescription medication / medical supplies	11%	41%
Mental health / counseling	34%	36%
Adult dental care	19%	29%
COVID-19 / Long COVID-19 care	N/A	29%
Respiratory (lung) care	N/A	27%
Weight loss support	N/A	26%
Vision (eye) care	7%	26%
Cancer care	16%	23%
Domestic violence services	15%	22%
Blood work	N/A	22%
Chiropractic care	8%	20%
Dermatology	22%	14%
End of life / hospice / palliative care	9%	14%
Physical therapy or physical rehabilitation	6%	14%
Immunizations (vaccines)	5%	14%
X-rays / mammograms	6%	13%
Urgent care / walk-in clinic	15%	12%
Primary Care Provider	N/A	11%
Emergency department care	13%	10%
Older adult care	22%	10%
None	9%	9%
Exercise professional	N/A	8%
Alternative therapy (e.g., herbal, acupuncture, massage)	24%	8%
Programs to stop using tobacco products	13%	8%
Women's health services	16%	7%
Ambulance services	9%	6%
LGBTQIA support	13%	5%
Child dental care	15%	5%
Yearly check-ups	13%	4%
Hospital care (staying overnight)	6%	4%
Specialty care (e.g., heart doctor)	16%	N/A
COVID-19 has made one or more of the services I selected hard to get	13%	N/A
Lab work	5%	N/A
Other	4%	N/A
Total Answered	843	667
Skipped	14	98

What keeps you from being healthy? (Check all that apply) — *Top 10 responses shown*



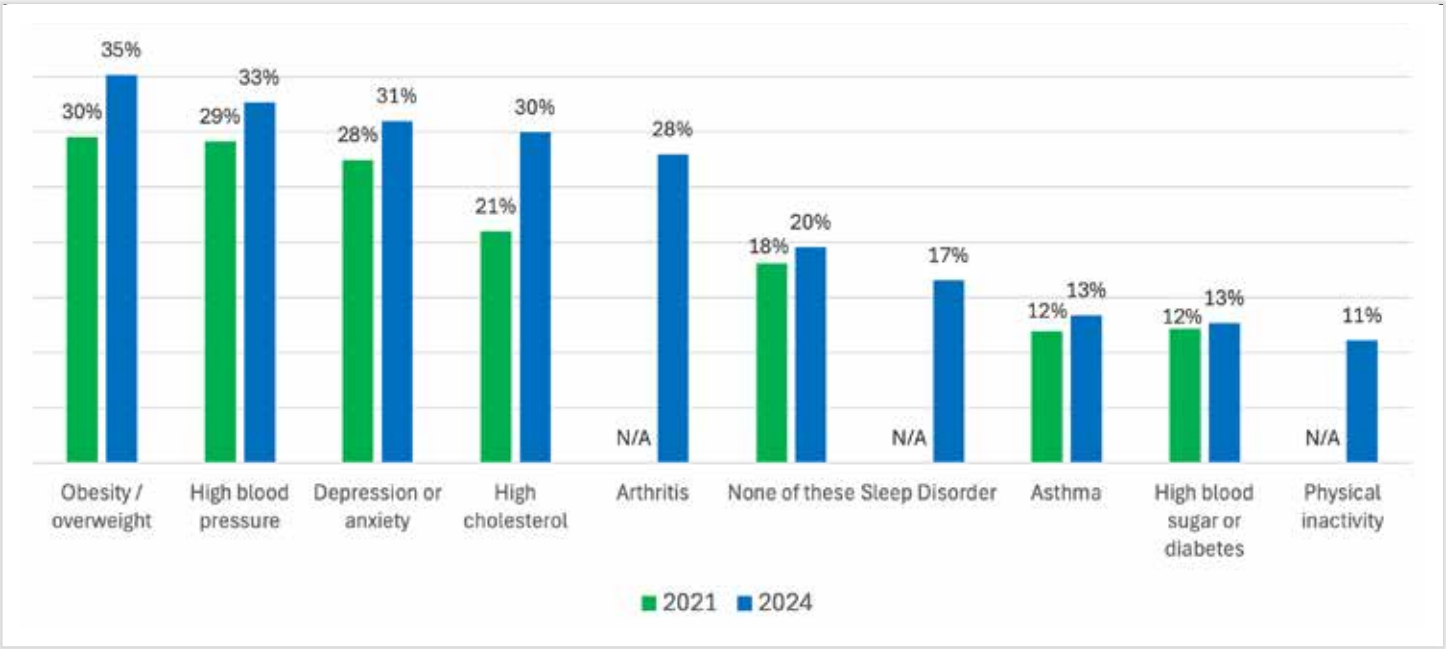
What keeps you from being healthy? (Check all that apply)	2021	2024
Long waits for appointments	19%	43%
Cost	24%	39%
Lack of evening and weekend services	22%	35%
Lack of doctors/dentists accepting new patients	N/A	34%
Nothing keeps me from being healthy	36%	28%
High co-pay for healthcare	16%	24%
Access to safe places to be active outside (parks, sidewalks)	N/A	16%
Location of healthcare offices	8%	12%
Access to fresh fruits and vegetables	N/A	11%
Can't find providers that accept my insurance	9%	10%
Childcare	6%	8%
Don't trust my insurance to help	N/A	7%
Don't trust doctors / clinics	N/A	5%
No transportation	4%	5%
Afraid to have check-ups	6%	4%
Have no regular source of healthcare	9%	4%
Don't like accepting government assistance	5%	3%
No health insurance	4%	2%
Unable to learn about medical condition because of difficulty understanding spoken or written information	N/A	1%
Language services (access to interpreter)	2%	1%
Don't know what types of services are available	11%	N/A
Don't trust doctors / clinics / my insurance	6%	N/A
Other	4%	N/A
Total Answered	833	595
Skipped	24	170

The 2024 survey data reveals notable changes in reported health barriers compared to 2021. "Long waits for appointments" saw a significant rise, doubling from 19% in 2021 to 43% in 2024, while concerns about "Cost" increased from 24% to 39%, underscoring growing issues with access and affordability. Additionally, 35% of respondents cited a "Lack of evening and weekend services," pointing to a need for more flexible healthcare options. Respondents citing that high co-pay for healthcare keeps them from being healthy increased from 16% in 2021 to 24% in 2024.

Fewer respondents reported "No regular source of healthcare" (dropping from 9% to 4%) and "No health insurance" (down from 4% to 2%). New barriers introduced in 2024 included "Lack of doctors/dentists accepting new patients" (34%), "Access to fresh fruits and vegetables" (11%), and "Access to safe places to be active outside" (16%). Meanwhile, the number of respondents who stated that nothing prevents them from being healthy dropped significantly from 36% in 2021 to 28% in 2024.

The option "Don't trust doctor/clinics/my insurance" was split in 2024 into "Don't trust my insurance to help" (7%) and "Don't trust doctors/clinics" (5%), The response option "Don't know what services are available" was removed from the 2024 survey.

Have you been told by a doctor that you have... (Check all that apply) — *Top 10 responses shown*

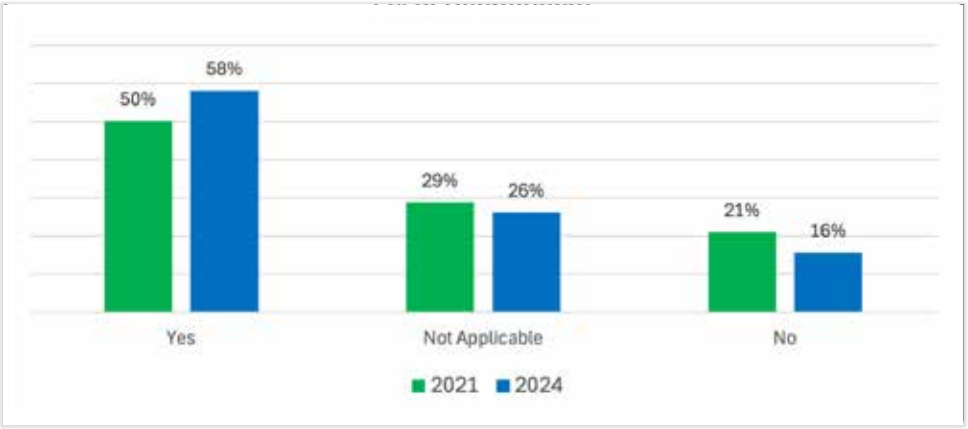


Have you been told by a doctor that you have... (Check all that apply)	*2021*	*2024*
Obesity / overweight	30%	35%
High blood pressure	29%	33%
Depression or anxiety	28%	31%
High cholesterol	21%	30%
Arthritis	N/A	28%
None of these	18%	20%
Sleep Disorder	N/A	17%
Asthma	12%	13%
High blood sugar or diabetes	12%	13%
Physical inactivity	N/A	11%
Cancer	8%	10%
Heart disease	8%	9%
Mental health problems	10%	8%
Walking or moving problems	N/A	8%
Stroke / cerebrovascular disease	4%	2%
Long COVID-19	N/A	2%
Eating disorder	N/A	2%
Drug or alcohol problems	6%	2%
Sexually transmitted infections	N/A	1%
HIV / AIDS	2%	0%
Cerebral palsy	1%	0%
Alzheimer's / Dementia	N/A	0%
Other	6%	N/A
Total Answered	830	597
Skipped	27	168

The 2024 survey highlights important shifts in diagnosed health conditions. Reports of "High blood pressure" increased from 29% to 33%, and "High cholesterol" rose from 21% to 30%. "Obesity/overweight" also saw a rise, from 30% to 35%, emphasizing growing weight-related health concerns. In contrast, "Mental health problems" dropped from 10% to 8%, and "Drug or alcohol problems" significantly decreased from 6% to 2%.

Newly added conditions like "Long COVID-19" and "Alzheimer's/Dementia" were reported by 2% and 0% of respondents, respectively. Despite some improvements, "Depression or anxiety" remained prevalent at 31%, indicating ongoing mental health challenges. Other newly reported conditions in 2024 included "Arthritis" (28%), "Sleep disorder" (17%), "Physical inactivity" (11%), "Walking or moving problems" (8%), "Eating disorder" (2%), and "Sexually transmitted infections" (1%).

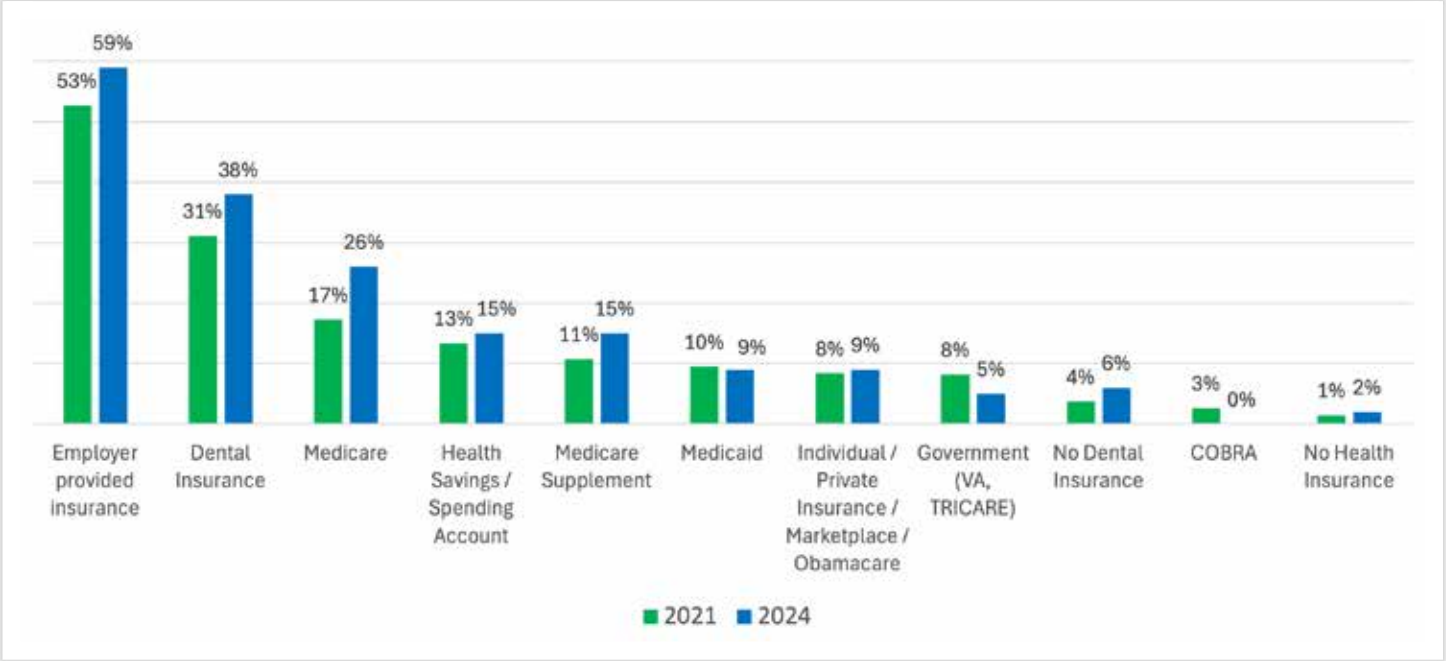
I take the medicine my doctor tells me to take to control my chronic illness.



I take the medicine my doctor tells me to take to control my chronic illness.	*2021*	*2024*
Yes	50%	58%
Not Applicable	29%	26%
No	21%	16%
Total Answered	833	607
Skipped	24	158

Respondents were asked whether they take the medicine their doctor prescribes to manage their chronic illness. In 2024, 58% reported taking their prescribed medications, up from 50% in 2021. Those who did not follow their prescribed treatment decreased from 21% in 2021 to 16% in 2024. The percentage of respondents who found the question "not applicable" decreased slightly from 29% to 26%.

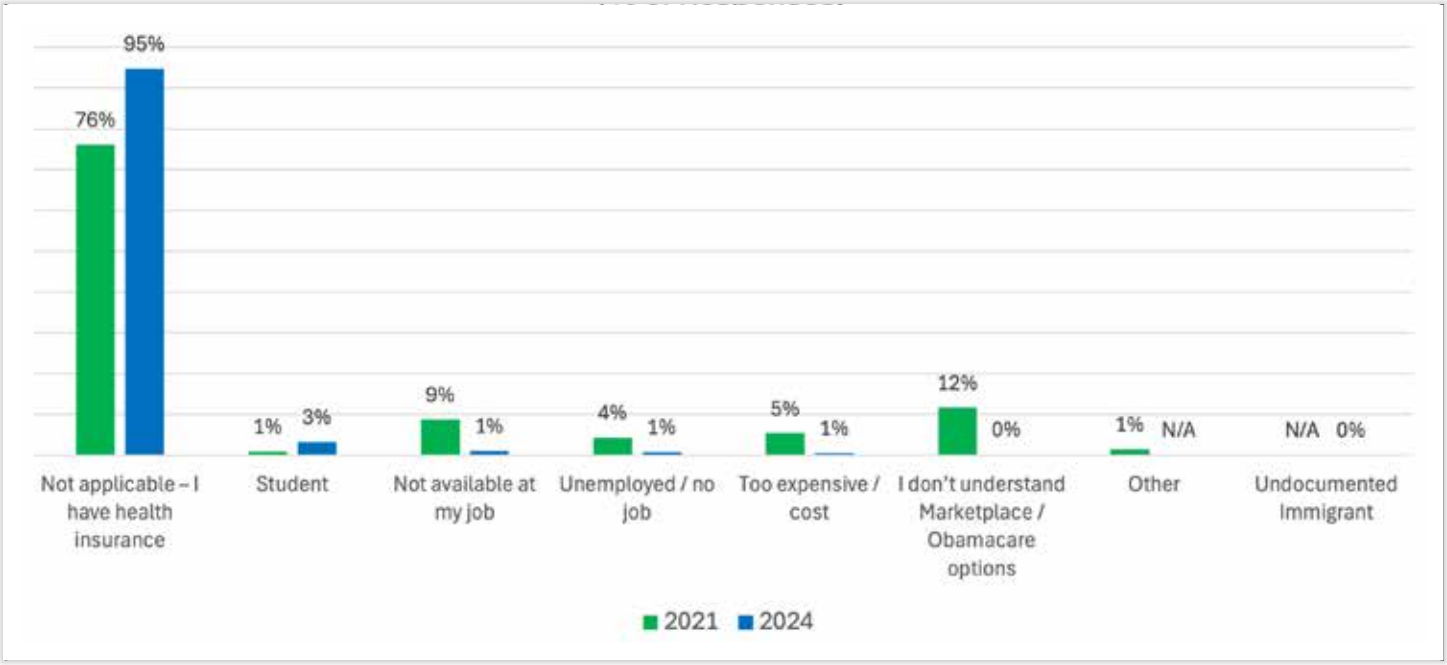
Which of the following describes your current type of health insurance? (Check all that apply)



Which of the following describes your current type of health insurance? (Check all that apply)	*2021*	*2024*
Employer provided insurance	53%	59%
Dental Insurance	31%	38%
Medicare	17%	26%
Health Savings / Spending Account	13%	15%
Medicare Supplement	11%	15%
Medicaid	10%	9%
Individual / Private Insurance / Marketplace / Obamacare	8%	9%
Government (VA, TRICARE)	8%	5%
No Dental Insurance	4%	6%
COBRA	3%	0%
No Health Insurance	1%	2%
Total Answered	845	602
Skipped	12	163

The 2024 survey shows notable changes in health insurance coverage. More respondents reported having employer-provided insurance, increasing from 53% in 2021 to 59% in 2024. Respondents citing that they have Medicare increased from 17% to 26%. Additionally, dental insurance coverage grew from 31% in 2021 to 38% in 2024.

If you have no health insurance, why don't you have insurance? (Check all that apply)

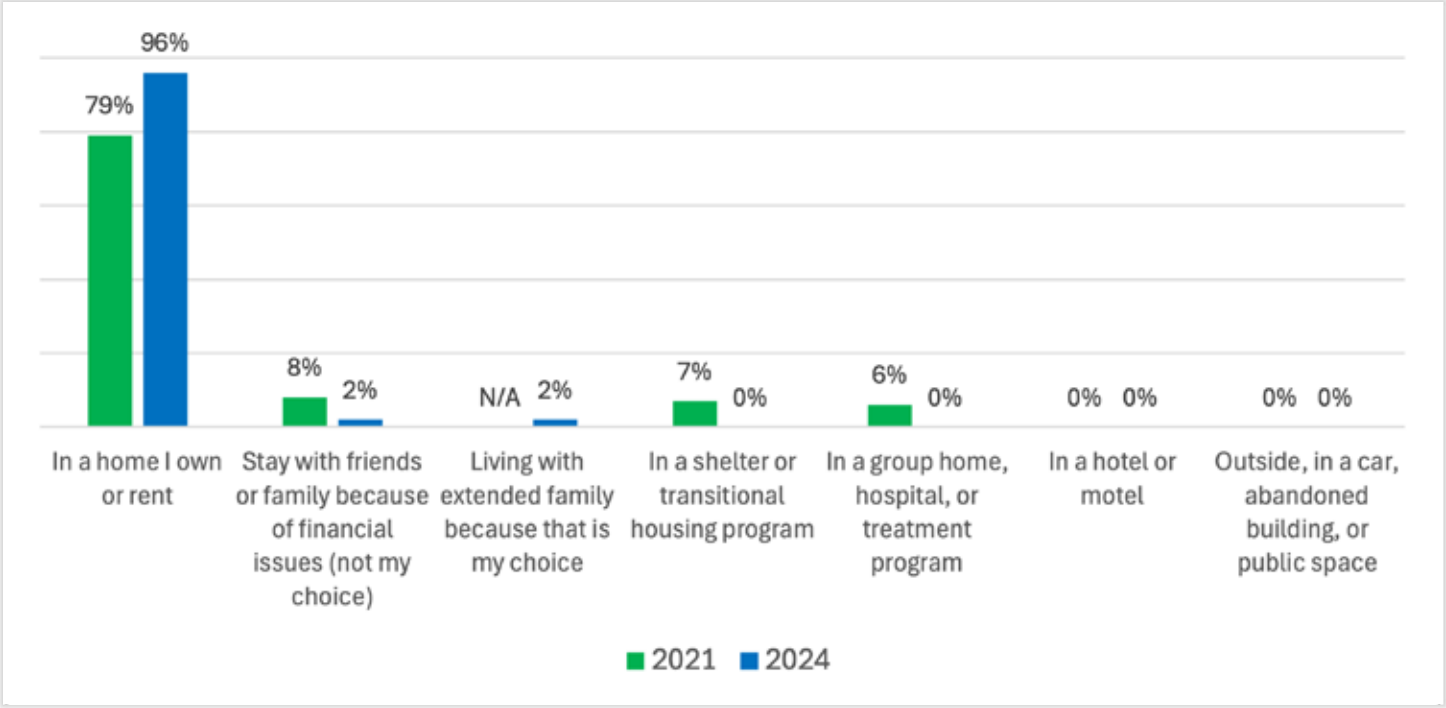


If you have no health insurance, why don't you have insurance? (Check all that apply)	*2021*	*2024*
Not applicable – I have health insurance	76%	95%
Student	1%	3%
Not available at my job	9%	1%
Unemployed / no job	4%	1%
Too expensive / cost	5%	1%
I don't understand Marketplace / Obamacare options	12%	0%
Other	1%	N/A
Undocumented Immigrant	N/A	0%
Total Answered	658	561
Skipped	199	204

The 2024 survey data reflects a positive trend in health insurance coverage, with a significant increase in respondents indicating they have insurance, as shown by the rise in "not applicable" responses from 76% in 2021 to 95% in 2024. This suggests that more people have gained access to health coverage over time. Among those without insurance, the percentage citing cost as a barrier dropped from 5% to 1%. A new response option, "undocumented immigrant," was introduced in 2024, though 0% of respondents selected this option.

HOUSING

Where do you sleep most often? (Check one)

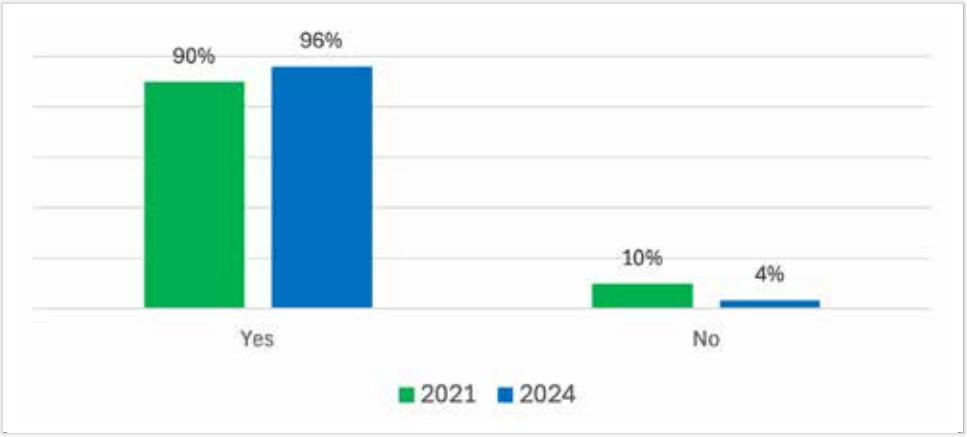


Where do you sleep most often? (Check one)	2021	2024
In a home I own or rent	79%	96%
Stay with friends or family because of financial issues (not my choice)	8%	2%
Living with extended family because that is my choice	N/A	2%
In a shelter or transitional housing program	7%	0%
In a group home, hospital, or treatment program	6%	0%
In a hotel or motel	0%	0%
Outside, in a car, abandoned building, or public space	0%	0%
Total Answered	841	615
Skipped	16	150

In 2024, 96% of participants reported sleeping in their own homes, up from 79% in 2021. Additionally, those indicating they stayed with friends or family due to financial issues decreased from 8% to 2%, and the percentage residing in shelters or transitional housing also fell significantly from 7% to 0%. Again, this is most likely related to the demographics of the respondents completing the survey in 2024.

Despite this decline in homelessness reported by respondents in 2024, housing insecurity has likely worsened overall due to escalating housing costs. The demand for affordable housing has increased dramatically in the United States, as nearly 40% of renters now find themselves cost-burdened – spending more than 30% of their income on housing (Source: U.S. Census Bureau, Retrieved 10/30/24, https://www.census.gov/newsroom/press-releases/2022/renters-burdened-by-housing-costs.html).

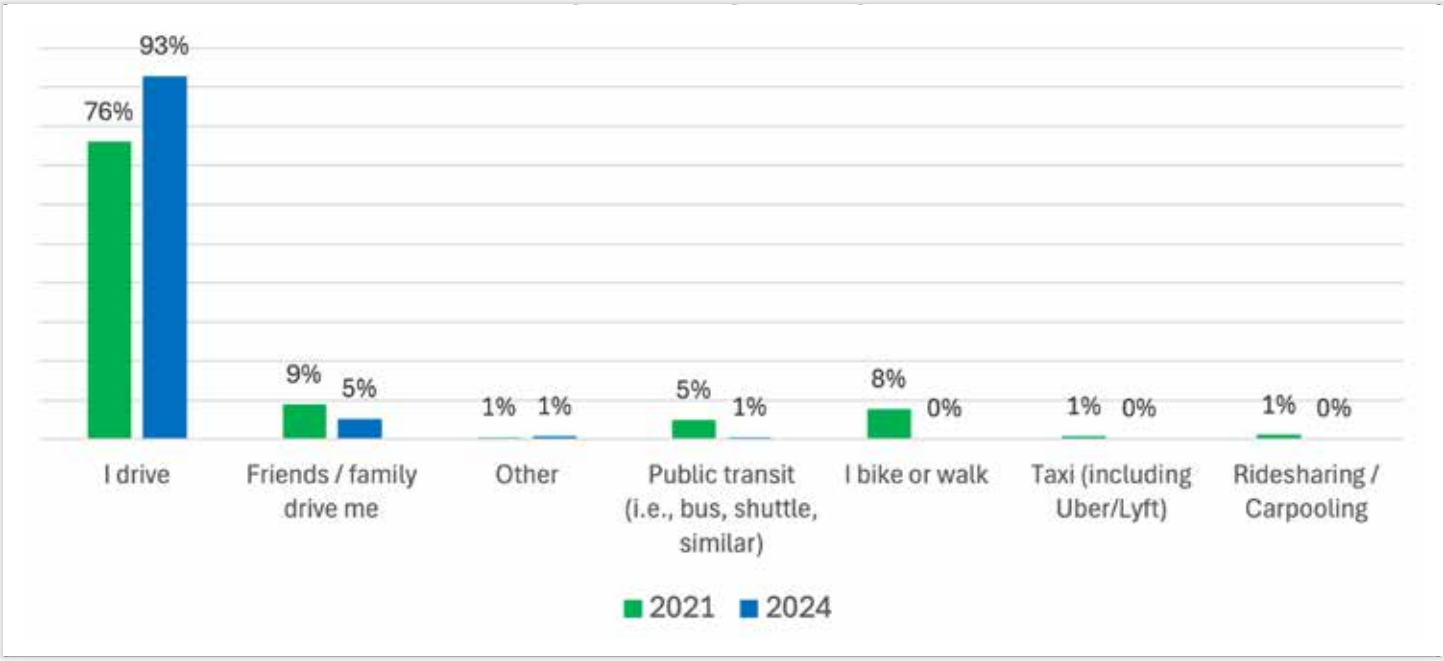
Do you have access to reliable transportation?



Do you have access to reliable transportation?	*2021*	*2024*
Yes	90%	96%
No	10%	4%
Total Answered	839	608
Skipped	19	157

In 2024, 96% reported having access to reliable transportation, an increase from 90% in 2021. Those who responded "no" decreased from 10% in 2021 to 4% in 2024.

What type of transportation do you use most often?



What type of transportation do you use most often?	2021	2024
I drive	76%	93%
Friends / family drive me	9%	5%
Other	1%	1%
Public transit (i.e., bus, shuttle, similar)	5%	1%
I bike or walk	8%	0%
Taxi (including Uber/Lyft)	1%	0%
Ridesharing / Carpooling	1%	0%
Total Answered	834	600
Skipped	23	165

In 2024, when asked about their primary mode of transportation, 93% of respondents indicated they drove, a significant increase from 76% in 2021. Conversely, the percentage of respondents who rely on family or friends for rides decreased from 9% in 2021 to 5% in 2024. Additionally, those who walked or biked also saw a decline, dropping from 8% in 2021 to 0% in 2024.

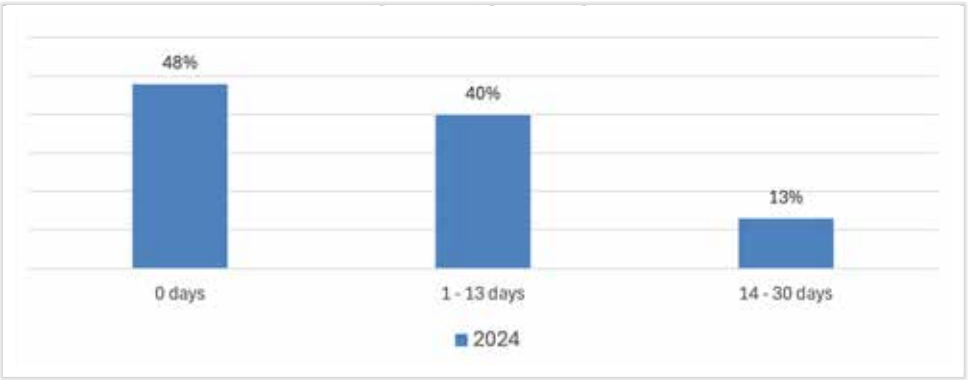
HEALTH OUTCOMES

Quality of Life

PHYSICALLY AND MENTALLY UNHEALTHY DAYS

Respondents were asked whether their physical and mental health was not good over the past 30 days. The 2024 survey revised the response options from "0 days," "1 to 2 days," and "3 to 5 days" in 2021 to "0 days," "1 to 13 days," and "14 to 30 days."

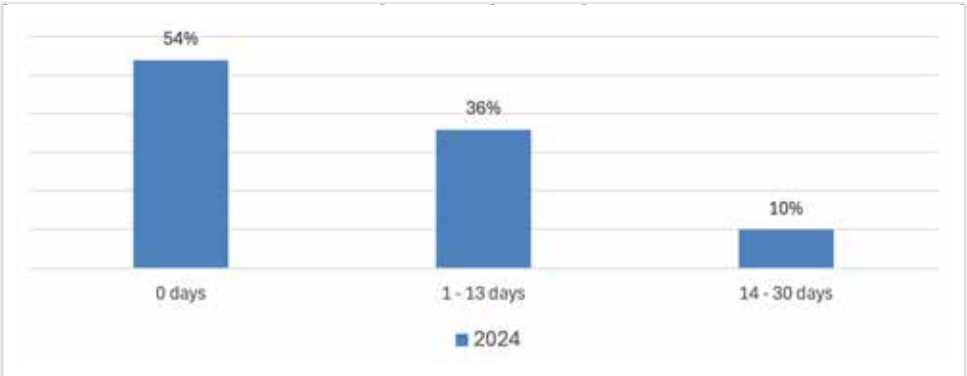
How many days during the past 30 days was your physical health not good? (Check one)



Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? (Check one)	*2024*
0 days	48%
1-13 days	40%
14-30 days	13%
Total Answered	606
Skipped	159

In 2024, 48% of respondents reported having no days of poor physical health, while 40% experienced 1 to 13 days of poor health. Only 13% indicated that their physical health was not good for 14 to 30 days.

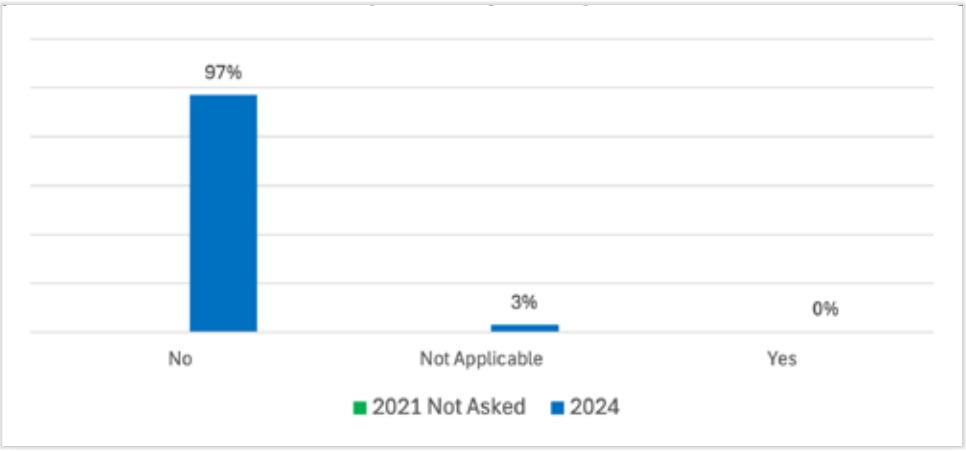
How many days during the past 30 days was your mental health not good? (Check one)



Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? (Check one)	*2024*
0 days	54%
1-13 days	36%
14-30 days	10%
Total Answered	608
Skipped	157

In 2024, 54% of respondents reported no days of poor mental health. Meanwhile, 36% experienced 1 to 13 days of poor mental health, and 10% reported more than 14 to 30 days of poor mental health.

I have attempted suicide in the past 12 months.



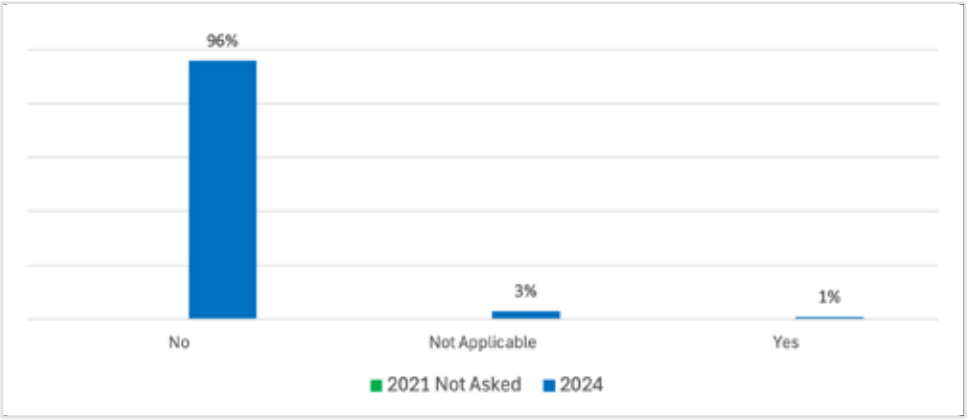
I have attempted suicide in the past 12 months.	*2021 Not Asked*	*2024*
No		97%
Not Applicable		3%
Yes		0%
Total Answered		607
Skipped		158

In 2024, respondents were asked if they had attempted suicide in the past 12 months—a question not included in the 2021 survey. Of those surveyed, 97% reported no attempts, 0% reported they had attempted suicide, and 3% selected "not applicable."

Suicide and self-harm are key indicators of community health in Virginia, reflecting broader societal, economic, and mental health challenges. Monitoring these behaviors offers insight into the state's public health and the effectiveness of prevention efforts.

Virginia's suicide rate has fluctuated in recent years. In 2022, the state recorded 1,208 suicide deaths, with a rate of 13.3 per 100,000 people—marking a 22% increase over the past two decades (Source: USA Facts, Retrieved 10/31/24, https://usafacts.org/answers/how-many-people-die-by-suicide/state/virginia/). Nationally, the age-adjusted suicide rate in 2022 was 14.3 per 100,000, placing Virginia slightly below the national average (Source: CDC National Vital Statistics System, Provisional Monthly and Quarterly Estimates of Mortality by Cause, Retrieved 10/31/24, https://www.cdc.gov/nchs/data/vsrr/vsrr034.pdf). These trends emphasize the critical need for continued mental health support and suicide prevention programs across the state.

I have attempted self-harm in the past 12 months.



I have attempted self-harm in the past 12 months.	*2021 Not Asked*	*2024*
No		96%
Not Applicable		3%
Yes		1%
Total Answered		606
Skipped		159

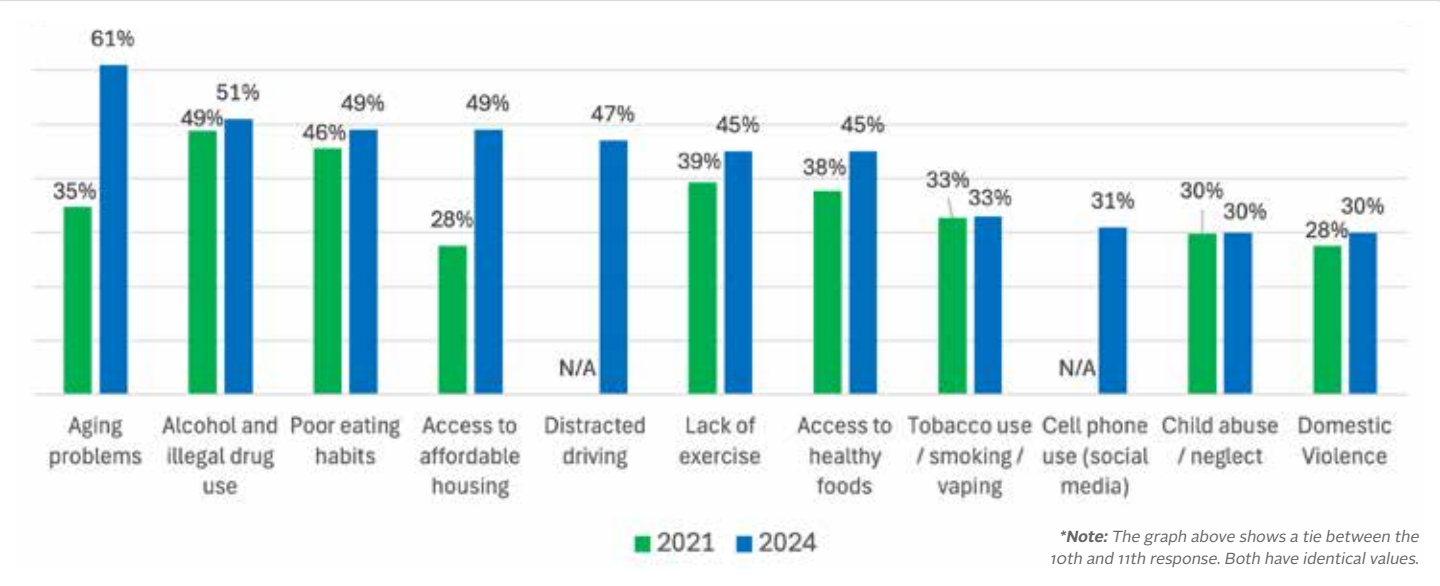
In 2024, respondents were asked if they had attempted self-harm in the past 12 months—a question not included in the 2021 survey. Of those surveyed, 96% reported no self-harm, 1% reported attempts, and 3% selected "not applicable."

In Virginia, self-harm rates have shown significant trends, particularly among youth. According to the Virginia Department of Health, from 2015 to 2021, emergency department (ED) visits for self-harm among individuals aged 9 to 18 increased sharply—from about 300 visits per 100,000 people in 2015 to over 500 per 100,000 in 2021. This rise was especially notable among females aged 13 to 15 (Source: Virginia Department of Health, Injury and Violence Data, Retrieved 10/31/24, https://www.vdh.virginia.gov/injury-and-violence-prevention/surveillance-and-data/). These trends highlight the growing concern of self-harm behavior among Virginia's youth, highlighting the need for targeted mental health interventions and support.

Community Need

In the 2024 survey, respondents were asked to identify which health factors and health conditions had the most significant impact on community health. This year's survey included several new response options to capture a broader range of health issues and their effects on the community. These new categories reflect an effort to better understand the multifaceted nature of community health, which is vital for developing targeted interventions and resource allocations.

What do you think are the most important issues that affect health in our community? Health Factors (Check all that apply) — *Top 10 responses shown*



The 2024 survey highlights significant increases in community concerns regarding "Aging problems," which surged from 35% in 2021 to 61% in 2024. Nearly 1.9 million Virginians are aged 60 or older, a number that is projected to increase to 2.2 million in 2030. Similarly, Virginia's population aged 65 and older is expected to grow from 15.9% in 2020 to 18.9% in 2030 (Source: Virginia Department for Aging and Rehabilitative Services. State Plan for Aging Services. Retrieved 11/4/24, https://www.vda.virginia.gov/downloads/State%20Plan%20for%20Aging%20Services%20FINAL%20ACCESSIBLE-Reduced.pdf). Additionally, worries about "Access to affordable housing" rose from 28% to 49%, and concerns about "Alcohol and illegal drug use" climbed from 49% to 51%. These trends underscore critical socioeconomic and support service challenges facing the community.

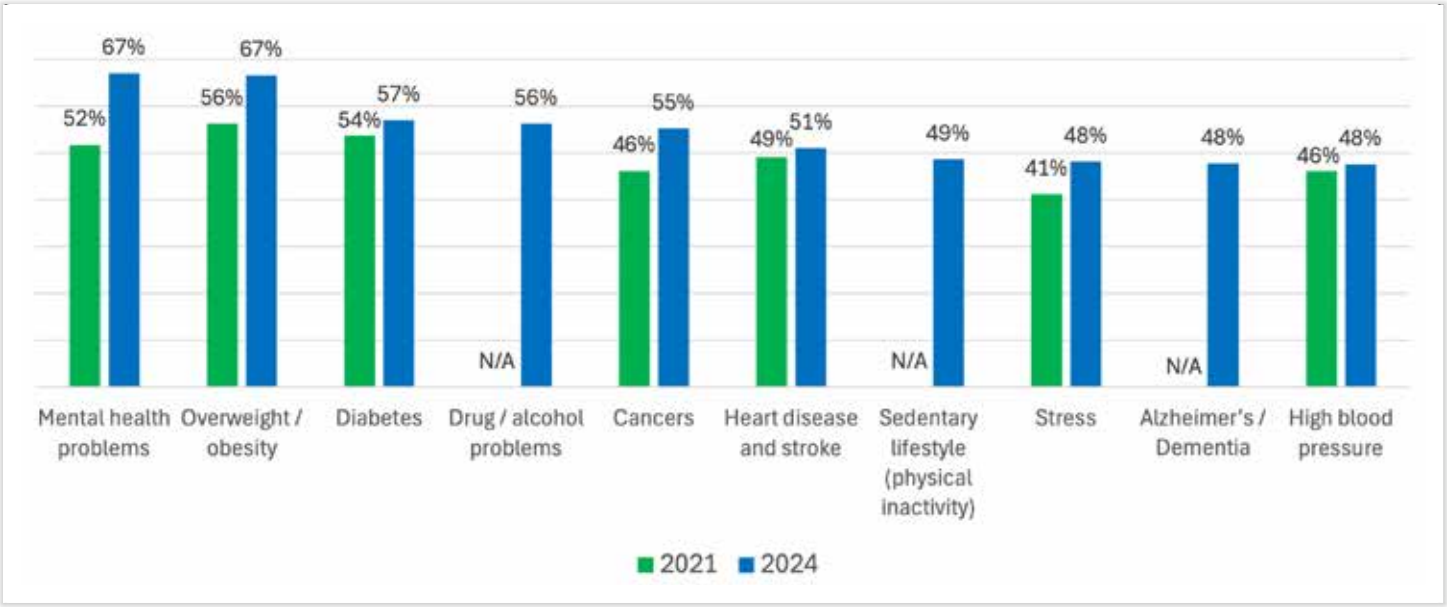
Notable health concerns in 2024 include a rise in reported "Poor eating habits" (from 46% to 49%) and "Lack of exercise" (from 39% to 45%), highlighting lifestyle factors that negatively impact health. New socioeconomic and safety issues have also emerged, with "Distracted driving" (47%) and "Homelessness" (27%) among key concerns.

The 2024 survey introduced several new response options, such as "Gun violence" (16%), "Access to safe places to exercise" (23%), and "Gender identification" (10%). Existing categories were refined for clarity—for example, "Distracted driving" (47%) and "Cell phone use (social media)" (31%) were split into distinct categories. The broader category of "Neighborhood safety" now includes sidewalks, roads, and lighting, (15%). Additional issues identified in 2024 include "Injuries" (16%), "Poor water and/or air quality" (8%), and "Gambling" (8%).

Access to affordable housing has become a pressing issue, with over half of respondents indicating concern. The shortage of affordable housing limits families' and individuals' choices about where they live, often relegating lower-income families to substandard housing in unsafe, overcrowded neighborhoods with higher rates of poverty and fewer resources for health promotion (e.g., parks, bike paths, recreation centers and activities). (Source: Robert Wood Johnson Foundation, Housing and Health, Retrieved 10/30/24, https://www.rwjf.org/en/insights/our-research/2011/05/housing-and-health.html).

What do you think are the most important issues that affect health in our community? Health Factors (Check all that apply)	*2021*	*2024*
Aging problems	35%	61%
Alcohol and illegal drug use	49%	51%
Poor eating habits	46%	49%
Access to affordable housing	28%	49%
Distracted driving	N/A	47%
Lack of exercise	39%	45%
Access to healthy foods	38%	45%
Tobacco use / smoking / vaping	33%	33%
Cell phone use (social media)	N/A	31%
Child abuse / neglect	30%	30%
Domestic Violence	28%	30%
Transportation problems	25%	30%
Social isolation	23%	29%
Homelessness	N/A	27%
Prescription drug abuse	26%	25%
Access to safe places to exercise	N/A	23%
Bullying	17%	22%
Not getting "vaccine shots" to prevent disease	N/A	20%
Housing problems (e.g., mold, bed bugs, lead paint)	16%	20%
Accidents in the home (e.g., falls, burns, cuts)	13%	18%
Gun violence	N/A	16%
Injuries (car accident, workplace injuries, home accidents)	N/A	16%
Neighborhood is not safe (sidewalks, roads, crossings, street lighting)	N/A	15%
Gang activity	8%	13%
Not using seat belts / child safety seats / helmets	11%	11%
Unsafe sex	11%	10%
Sexual assault	10%	10%
Gender identification	N/A	10%
Poor water quality and/or poor air quality	N/A	8%
Gambling (slot machines, sports betting, lottery tickets)	N/A	8%
Homicide	7%	7%
Neighborhood safety	9%	N/A
Cell phone use / texting and driving / distracted driving	32%	N/A
Environmental health (e.g., water quality, air quality, pesticides, etc.)	15%	N/A
Not getting "shots" to prevent disease	19%	N/A
Other	2%	N/A
Total Answered	848	670
Skipped	9	95

What do you think are the most important issues that affect health in our community? Health Conditions/Health Outcomes (Check all that apply) — *Top 10 responses shown*



The 2024 survey reveals a sharp increase in community concerns about health conditions. "Mental health problems" rose significantly from 52% to 67%, while concerns about "Overweight/obesity" grew from 56% to 67%. Chronic conditions like "Diabetes" saw a marked rise from 54% to 57%, and "Heart disease and stroke" increased from 49% to 51%. Newly introduced concerns for 2024 include "Drug/alcohol problems" (56%) and "Alzheimer's/Dementia" (48%). Additional new response options highlighted in the survey include "Sedentary lifestyle (49%)," "Back, hip, knee pain (35%)," "Sleep problems (23%)," "Long COVID-19 (20%)," "Kidney disease (16%)," "Sexually transmitted infections (8%)," and "Stomach disease (7%)."

Research shows that mental health issues are often intertwined with socioeconomic challenges such as poverty, housing instability, and lack of access to healthcare. These conditions can lead to increased rates of depression and anxiety, which further exacerbate health disparities within the community. For instance, the World Health Organization highlights that mental health is influenced by various structural and social determinants, including economic status and access to community resources, indicating that addressing mental health is essential for improving overall community health outcomes (Source: World Health Organization, Mental health, Retrieved 10/30/24, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response).

What do you think are the most important issues that affect health in our community? Health Conditions/Health Outcomes (Check all that apply)	*2021*	*2024*
Mental health problems	52%	67%
Overweight / obesity	56%	67%
Diabetes	54%	57%
Drug / alcohol problems	N/A	56%
Cancers	46%	55%
Heart disease and stroke	49%	51%
Sedentary lifestyle (physical inactivity)	N/A	49%
Stress	41%	48%
Alzheimer's / Dementia	N/A	48%
High blood pressure	46%	48%
Back, hip, knee pain	N/A	35%
Dental problems	24%	30%
Disability	24%	26%
Suicide	18%	24%
Sleep problems	N/A	23%
Grief	14%	21%
COVID-19 / coronavirus / Long COVID-19	N/A	20%
Kidney disease	N/A	16%
Lung Disease	17%	16%
Teenage pregnancy	10%	12%
Sexually transmitted infections	N/A	8%
Stomach disease	N/A	7%
Other	1%	5%
Infant death (less than 1 year old)	7%	4%
HIV / AIDS	7%	3%
COVID-19 / coronavirus	34%	N/A
Total Answered	845	670
Skipped	11	95

2024 BEDFORD AREA COMMUNITY HEALTH SURVEY RESPONDENTS

“Better outdoor recreation areas in Bedford would be helpful with more walking trails.”

“We are a multi-generational household. But live in an area that has a 10-mile drive to the nearest grocery. There are many aging neighbors that need help with transportation to doctors, but are above income for assistance.”

“While I have some financial resources, I am finding others in my neighborhood that are suffering either from mental health issues, domestic violence, lack of funds and the like. It’s more suffering out there than people realize.”

FOCUS GROUPS

FOCUS GROUPS

Focus groups are a cornerstone of the Community Health Needs Assessment (CHNA) process and serve as a powerful platform for diverse voices to share their perspectives and experiences. These groups foster in-depth discussions that unveil nuanced insights into the challenges and needs of the community, which would not be captured through quantitative data alone. By directly engaging with community stakeholders and target population members, focus groups help identify priority issues, root causes, and potential solutions from the community's viewpoint. This participatory approach ensures that the resulting data is rich and reflects the real-life experiences of those most affected by the issues within each service area. Ultimately, the insights gained from focus groups empower stakeholders to make more informed decisions, enabling them to develop targeted, effective interventions that address the community's specific needs. This process is crucial for community development, as it ensures that the strategies implemented are grounded in community members' actual needs and preferences, fostering more sustainable and impactful growth.

To ensure regional alignment of a collaborative and rigorous needs assessment process, Centra, the Central Virginia Health District, and University of Lynchburg Research Center led focus group efforts in 2024. A retrospective review of the 2018 and 2021 Centra CHNA focus groups format was conducted. A notable change in 2024 was that questions asked were similar for both the stakeholder and target population groups. In doing so, it is easier to compare the perspectives of those directly impacted (target population) with those involved in policymaking, funding, and service provision (stakeholders). This process helps identify gaps between perceived needs and the solutions offered.

Evidence of consistency in responses between these groups can validate the findings, making the data more reliable. Discrepancies can highlight areas where communication or understanding needs improvement. This method provides a holistic picture of the community's needs, capturing lived experiences and strategic viewpoints. It ensures that the voices of those experiencing and addressing the issues are heard and considered.

Understanding each group's perspectives fosters collaboration and ensures the data collected is aligned. This data alignment allows stakeholders to tailor their programs and initiatives better to meet the actual needs and priorities of the target population. In addition, decision-makers can use this aligned data to create more effective, targeted interventions that will likely gain community support and engagement. This confidence in the alignment of data ensures that the voices of those experiencing the issues and those addressing them are heard and considered, fostering a sense of trust and confidence in the decision-making process. This dual approach enhances the depth and breadth of the Community Health Needs Assessment, leading to more informed, inclusive, and effective community development strategies.

On Tuesday April 30, 2024, a Stakeholder Focus Group meeting was held at the Rooster House in Forest, Virginia. A total of 33 individuals attended the meeting including members of the Community Health Assessment Team and other identified cross-sector stakeholders, non-profit organizations, service providers, business leaders and local government officials. A directory of participants can be found in the Appendix.

The focus group meeting was led by the University of Lynchburg Research Center. An overview of the process included the format of the break-out session and tips and guidelines for facilitating the focus groups. Participants were randomly assigned to a table at registration. A volunteer facilitator and scribe facilitated and recorded the discussion at each table. A 40-minute break-out session occurred where participants were asked a series of questions including:

1. **What are the top 5 greatest needs in the community(s) you serve?**
    a. **Are there particular localities in the service area that have greater needs than others?**
2. **What do you see as the root cause of these needs?**
3. **What resources are available in the community to meet these needs?**
4. **What are the barriers to accessing these resources?**
5. **What is one issue/need we can work on together, to create a healthier community? How do we get started?**

Report outs from each table were presented to those present and discussion followed. Notes were taken during the break-out session on a form available at each table. These notes were transcribed and analyzed.

STAKEHOLDER FOCUS GROUP ANALYSIS

An analysis of the Stakeholder Focus Groups was conducted by the University of Lynchburg using the following process:

1. **Review all the focus group responses to understand the consistent content across the groups.**
2. **Develop a coding sheet.**
3. **Re-review the gathered data and apply the coding sheet.**
4. **Group the data and identify recurring patterns.**
5. **Note the outliers in the data.**
6. **Create a report that includes quantitative analysis ranking responses and qualitative summaries of the conversations.**
7. **Compare the greatest needs identified by stakeholders to those identified by target population participants.**

STAKEHOLDER FOCUS GROUP FINDINGS

Community Need

The Bedford Area Stakeholder Focus Group identified the following as the most critical needs within the community:

Areas of Need	*Percent of Responses*
Affordable housing	15%
Substance abuse treatment	15%
Mental health care	12%
Transportation	12%
Food insecurity	9%
Affordable childcare	9%
Elder care	9%
Access to healthcare	6%
Awareness of resources	3%
Domestic abuse	3%
Broadband access	3%

These critical areas highlight the multifaceted challenges that Bedford Area residents face daily.

Affordable housing and substance abuse treatment are the most frequently mentioned needs highlighting

a substantial concern regarding the availability and accessibility of services to address substance abuse issues and the pressing demand for affordable housing options in the community. **Mental health care services and transportation** are significant concerns. Enhancing accessibility to mental health services and investing more in current transportation options can help residents access necessary care and services more efficiently. **Food insecurity, affordable childcare, and elder care** highlight the importance of basic needs and support services for vulnerable populations, including children and older people. **Access to healthcare** concerns included the availability and accessibility of healthcare services. Enhancing **broadband access** can support education and economic opportunities, increasing **awareness of available resources** can empower residents, and addressing **domestic abuse** is vital for community safety. Addressing these needs is essential for fostering a supportive and nurturing environment for all community members.

Community(s) with Greatest Need

In the Bedford Service Area, the localities identified by stakeholders as having the greatest need are the **Town of Bedford and rural areas of Bedford County** including the communities of **Montvale, Stewartsville, Evington, Huddleston, and Big Island.** According to stakeholders, these rural communities encounter significant issues related to transportation. The lack of reliable and accessible transportation options severely impacts residents' access to essential services, including healthcare, employment, and early childhood education opportunities. The geographic barriers and limited public transit infrastructure in these areas exacerbates isolation and hinders economic mobility, making transportation a critical concern. The **Town of Bedford** faces notable challenges in childcare and poverty, especially in subsidized housing areas. The need for affordable and reliable childcare services is acute, impacting working families struggling to afford quality care for their children. This issue affects parents' ability to maintain steady employment and influences children's early development and educational readiness.

Root Causes of Community Need

The Bedford Area Stakeholder Focus Group identified the following as the top root causes that have an impact on the needs of the community.

Root Cause	*Percent of Responses*
Poverty	21%
Geography	16%
Family values	16%
Education attainment	11%
Employment	11%
Access to healthcare	5%
Local Policies	5%
Transportation	5%

The most significant root cause of need in the Bedford service area identified by stakeholders is **poverty;** a substantial portion of the community struggles with financial instability, which impacts their access to essential services. Low-income levels force families to make difficult decisions, such as choosing between buying food and paying for electricity. This financial strain exacerbates food insecurity, inadequate housing, and poor health outcomes. **Geography** is a significant root cause of community need. Bedford County, one of the top 10 largest counties by size in Virginia, is spread out and rural. The distance to urban centers where services are usually located poses a challenge for residents. Stakeholders highlighted a shift in **family values.** Many residents are on fixed incomes and often have family members living far away. This geographical separation means they lack immediate family support, which can lead to isolation and increased dependence on community services. Furthermore, family dysfunction, including issues like domestic violence and substance abuse, a lack of awareness about available resources, and the need to travel long distances for work, groceries, and other services reduces the time families can spend together.

Education attainment impacts need where limited educational opportunities can lead to lower employability and reduced ability to navigate and utilize available resources effectively. **Employment** is equally significant and impacted by geographic isolation and the lack of local job opportunities. This lack of economic opportunity perpetuates poverty and limits community growth. **Transportation** in the Bedford Area is a critical issue. Limited public transportation options along with geographic barriers make it difficult for residents to access jobs, healthcare, and other essential services.

Local policies hinder the development and accessibility of necessary services, while **access to healthcare** is still a contributor to the needs in the community including barriers to obtaining necessary medical care due to availability of services, affordability, and insurance issues.

Community Resources

The Bedford Area Stakeholder Focus Group identified the following as the top resources that impact the needs of the community.

Community Resources	*Percent of Responses*
Community agencies (i.e., state funded entities including Department of Social Service, Virginia Department of Health, Community Services Board)	36%
Healthcare organizations	18%
Religious organizations	15%
Transportation services	9%
Nonprofit organizations	6%
Community Health Workers	6%
Education organizations	3%
Eldercare organizations	3%
Crisis centers	3%

Centra Bedford Memorial Hospital and Centra Medical Group provide essential healthcare services, including emergency care, inpatient and outpatient services, and specialized treatments. **Centra Paramedicine** offers advanced care capabilities including home visiting services. The **PACE (Program of All-Inclusive Care for the Elderly)** focuses on providing comprehensive care to older adults, enabling them to maintain independence while receiving necessary medical and social services. **Horizon Behavioral Health and Agape** offer mental health services, including counseling, therapy, and support for individuals dealing with mental health issues. **Central Virginia Health District's Community Health Workers** play a crucial role in connecting residents with healthcare services, while **2-1-1 Virginia** provides information for referrals to a wide range of health and human services.

Bedford Ride offers transportation services for medical appointments and essential errands, particularly benefiting elderly and disabled residents. **The Otter Bus** provides in-town transportation, improving mobility within the community. **Lake Christian Ministries and Bedford Christian Ministries** provide emergency food assistance to individuals and families through their food pantries. **The Bedford Farmers Market, Forest Farmer's Market, and the Moneta Farmers Market's FRESH Match** programs offer nutrition incentives that double the value of SNAP (Supplemental Nutrition Assistance Program) dollars spent on fruits and vegetables.

A wide range of **nonprofits and community organizations,** such as Impact Living Services at Bedrock and Care Portal, offer support services ranging from housing assistance to family support. At the same time, the **Department of Social Services** provides a broad range of social services, including child welfare, financial aid, and support for vulnerable populations. **Local schools and churches** play a vital role in community engagement, offering programs and services that support education, family stability, and spiritual growth. The **BARC (Bedford Area Resource Council)** coordinates regional resources and addresses identified community needs through a collaboration of cross-sector stakeholders and community leaders.

Barriers to Accessing Community Resources

The Bedford Area Stakeholder Focus Group identified the following as the top barriers to accessing community resources that impact the needs of the community.

Barriers to Accessing Community Resources	*Percent of Responses*
Socioeconomic	29%
Community-based	29%
Informational	21%
Logistical	21%

Stakeholders in the Bedford service area raised numerous obstacles that hinder the community's access to essential services and resources. In an attempt to summarize these discussions, responses were broadly arranged into categories such as socioeconomic, community-based, logistical, and informational barriers.

Socioeconomic Barriers: The availability and **affordability of childcare** are significant issues, exacerbating the difficulties faced by working parents. Many families struggle to find reliable and affordable childcare, which affects their ability to work and seek necessary services. Additionally, family structure dynamics, such as single-parent households, further complicate access to support systems. **High costs** associated with healthcare, education, and basic necessities pose a substantial barrier. **Poverty** remains a prevalent issue, limiting residents' ability to afford essential services. The ALICE (Asset-limited, Income-Constrained, Employed) population particularly struggles, as they earn above the federal poverty level but still need help to afford the

essential cost of living. Concerns about **safety and the confidentiality of personal information** deter individuals from seeking help, especially in sensitive situations such as mental health care and substance abuse treatment.

Logistical Barriers: Inadequate transportation infrastructure makes it challenging for residents, especially those in rural areas, to access services and is exacerbated by the lack of public transportation options and long travel times. Additionally, many residents face time constraints due to work and family responsibilities, making attending appointments and engaging with available resources difficult. **Limited broadband access** in rural segments of the Bedford service area restricts residents' ability to utilize online resources, telehealth services, and educational opportunities. This digital divide creates significant disparities in access to information and services.

Informational Barriers: Many residents need to be made **aware of the resources available** to them, including healthcare, social services, and educational opportunities. This lack of awareness is compounded by inadequate communication strategies and the complexity of navigating available resources. **The stigma** surrounding specific issues, such as mental health and substance abuse, prevents individuals from seeking help. Furthermore, ineffective communication between service providers and the community leads to misunderstandings and underutilization of resources.

Community-Based Barriers: Local organizations and service providers often need **more support,** which strains their capacity to deliver effective services. The **dwindling volunteer base** exacerbates this issue, as many organizations rely heavily on volunteers to support their operations. The Bedford service area **needs more community stakeholders** who are actively involved in addressing local needs. Additionally, **insufficient workforce training** limits service providers' ability to meet the community's specific needs, such as cultural competence and specialized care.

Areas for Collaboration

The Bedford Area Stakeholder Focus Group identified the following as areas for collaboration to the needs of the community.

Collaboration Opportunities	*Percent of Responses*
Lobbying for economic resources	29%
Community Health Workers	29%
Mobilizing churches	14%
Policy advocacy	7%
Technical education centers	7%
Unite Virginia	7%

Stakeholders identified several key areas where collaborative efforts can significantly enhance community well-being that includes developing a comprehensive awareness campaign that targets **policy change and increases funding for health initiatives and increasing the number of Community Health Workers** serving the area. This campaign should highlight the community's pressing needs and the crucial role that Community Health Workers play in addressing these needs. Establishing a **sustainable funding stream for Community Health Workers** is crucial. A well-funded Community Health Worker program can provide consistent and reliable support to the community, addressing health disparities and improving access to care. **Churches and other community organizations** can play a pivotal role. By educating and mobilizing churches, stakeholders can tap into a network of volunteers and community leaders who are eager to help but may not know how. **Unite Virginia,** a cross-closed loop Social Determinant of Health (SDOH) referral system, can be instrumental in coordinating efforts to screen for SDOH's and connect Community Health Workers and nonprofit organizations with the resources they need to assist residents effectively. This system can streamline referrals and improve communication between various service providers, enhancing the overall efficiency of resource distribution.

Target Population Focus Groups

From April to May, four Target Population Focus Group meetings were held throughout the Bedford service area. The Central Virginia Health District identified targeted populations, recruited participants, and facilitated the focus group meetings, often using their Community Health Workers to conduct the meetings. No more than 12 participants were recruited for each meeting. All attempts were made to use groups that already meet/gather in areas and times convenient for the participants. The University of Lynchburg created a training video, "Focus Groups & Strategies for Community Engagement" for facilitation of these focus groups to ensure there was consistency in the process and cultural awareness. Meetings were audiotaped and there was a facilitator and scribe from the Health District present. Each participant was asked to complete a consent form prior to the meeting to ensure they understood the purpose and confidential nature of each meeting.

Target Population Focus Groups were on average one hour in length and participants were asked a series of questions as follows:

1. **What are the top 5 greatest needs in your community(s) around health and wellness?**
2. **What do you see as the cause of these needs?**
3. **What resources are available in the community to meet these needs?**
4. **What are the barriers to accessing these resources?**
5. **What is one issue/need we can work on together, to create a healthier community? How?**
6. **Is there anything else you would like to share? (optional depending on time)**

All notes and audio recordings were sent to the University of Lynchburg's team for analysis.

TARGET POPULATION FOCUS GROUP ANALYSIS

An analysis of the Target Population Focus Groups was conducted by the University of Lynchburg using the following process:

1. **Review all the focus group responses (audio recording and notes) to understand the content across the groups.**
2. **Audio recordings were analyzed using transcription software and listening to the recording after this transcription process to ensure that the nuances of the conversations were accurately captured.**
3. **Create a report that includes qualitative analysis of the key responses and summaries of the conversations as well as quotes from focus group participants. Unlike the Stakeholder Focus Group meeting, these responses were not ranked.**
4. **Compare the greatest needs identified by stakeholders to those identified by target population participants.**

DESCRIPTION OF TARGET POPULATION FOCUS GROUPS

In the Bedford service area, comprehensive focus group discussions were conducted with various target populations, including residents of Bedford County and the town of Bedford. A total of 19 community members participated. These discussions provided invaluable qualitative data, offering deep insights into these populations' specific challenges and needs. By engaging directly with community members, the focus groups allowed for a nuanced exploration of local issues, from healthcare accessibility and infrastructure deficits to cultural and language barriers. This analysis aims to synthesize the key findings from these discussions, highlighting unique and shared concerns across different groups and identifying potential areas for community collaboration and intervention.

A summary of the populations of focus for each group is as follows:

County/City	*Population of Focus*	*Number Attended*	*Estimated Age Range*	*Estimated Race/ Ethnicity/Gender*
Bedford, Town	Men	6	25-60	White
Bedford, Town	Families, low income	3	25-40	White, women
Bedford County	Hispanic/Latino	4	30-50	Hispanic/Latino (gender not reported)
Bedford County	Seniors	6	60+	3 White men, 2 White women, 1 Asian woman

TOWN OF BEDFORD

Site of Meeting: Bedrock Church, Bedford, Virginia

Number of Participants:
6 (Men, estimated age 25-60 years, White residents)

Community Need in the Town of Bedford

Target population focus group participants identified several community needs regarding health and wellness:

- **Affordable housing**
- **Access to healthcare**
- **Food insecurity**
- **Mental health services**
- **Substance abuse treatment**
- **Recreational spaces**
- **Transportation**

Transportation, particularly in rural areas, remains a significant issue. Although the Otter Bus has improved mobility within the town, rural residents still struggle to access healthcare and other essential services. There is a pressing need for **facilities dedicated to addiction treatment,** addressing the growing problem of drug addiction and substance use within the community. Even though residents have access to the Family Drug Court and Celebrate Recovery, residential facilities are absent. Physical activity spaces are another area of concern for target population stakeholders. They noted that the YMCA is frequently overcrowded, highlighting the need for **additional recreational spaces**. Additionally, improvements are necessary for popular walking loops to make them accessible to strollers, older adults, and individuals with disabilities.

The shortage of primary care physicians exacerbates healthcare access issues, forcing many residents to seek care outside the community. **Mental health services** are also critically needed, particularly for addressing acute trauma. **Homelessness and affordable housing** are also challenges. While shelter options are available during the cold months, the community lacks facilities to accommodate the homeless population during the hot summer months. **Food insecurity and ensuring nutritious food access** are also pressing needs for residents.

Root Causes of Community Need in the Town of Bedford

Members of the Bedrock Church target population group noted that the root causes that impact need in the community included:

- **Poverty**
- **Lack of awareness of community resources**
- **Family values**
- **Substance addiction**
- **Workforce challenges**

Poverty is a significant factor, limiting residents' access to essential services and resources. A **lack of awareness about available community resources** compounds this economic challenge and cultural factors impacting family values also affect the community's needs. There is a **promotion of negative behaviors,** such as gaming and skill gaming, which can lead to addiction. This issue is further exacerbated by a breakdown of the nuclear family, which traditionally provided support and stability. **Drug and alcohol addiction** are prevalent issues within the community, driven in part by a lack of alternative recreational activities. Without positive outlets for their time and energy, many residents turn to substance use, exacerbating the cycle of poverty and need. Additionally, **workforce challenges,** including insufficient job opportunities and training, hinder economic mobility and stability.

Community Resources in the Town of Bedford

Bedford Christian Ministries offers essential services and support to residents, while **Family Drug Court and Celebrate Recovery** provide specialized assistance for those dealing with substance abuse issues. **Horizon Impact Living Services** is notable for offering trauma counseling, addressing mental health needs within the community. Residents of the target population noted that **Centra Bedford Memorial Hospital** plays a crucial role in providing medical care. **Faith-based organizations,** such as Bedrock Church through its Care Portal and Agape, are instrumental in meeting urgent needs and offering community support. The **2-1-1 service** provides a critical connection point for residents seeking information on available resources. **Community programs,** such as the Backpack program and initiatives led by community police, enhance safety and well-being. The **Bedford Facebook** page is a valuable information hub, informing residents about local events and resources. **The Otter Bus** offers vital transportation services, particularly beneficial in rural areas where access to essential services can be challenging. Target population participants emphasized **collaboration and communication** among various agencies and organizations as key to effectively meeting community needs. They noted that improving community needs will require the involvement of multiple sectors, including non-profits, churches, and for-profit organizations like Lowe's and Walmart.

Barriers to Accessing Community Resources in the Town of Bedford

Focus group respondents note a significant issue with the **need for more awareness about available services.** Despite the 2-1-1 service providing information on community resources, many residents need to know how to access this support. This knowledge gap prevents individuals from utilizing the help they need. **Transportation** poses another substantial challenge, particularly for residents in rural areas. While the Otter Bus has been successful within town limits, there is a clear need for expanded transportation services to reach more remote areas. Specifically, improved transportation to facilities like the Agape Center, which offers extensive mentoring and support, would greatly benefit those in outlying regions. **Cultural factors** also play a role in limiting access to resources. Many individuals experience **shame in asking for help,** preventing them from seeking necessary assistance. Additionally, **a lack of trust and social connections** within the community can further isolate those in need, making it difficult for them to reach out for support.

Areas for Collaboration in the Town of Bedford

The Bedrock Church focus group identified several critical areas, including **expanding the Care Portal** which supports foster care resources and leveraging texting as a primary communication method. By centralizing and disseminating information about available services and community events through a community-wide texting thread or a dedicated newsletter, stakeholders can significantly increase awareness and accessibility.

Another collaborative effort discussed is **offering financial education** to help families make informed financial decisions. While resources like Financial Peace University and volunteer financial advisors from Bedrock Church are available, there is a need to reach lower-income individuals who might not be connected to the church. Providing financial literacy programs, primarily targeted at those most in need, can empower residents with the knowledge to improve their economic stability. The group also recognized the potential of **using video calls and online platforms to provide training and education.** During COVID-19, initiatives such as financial literacy or cooking classes were successfully implemented through these platforms. Creating a YouTube channel or using existing Facebook pages to disseminate information and resources could be an effective strategy to reach more residents. Increasing awareness of community resources and activities through virtual options can significantly improve connectivity. The stakeholders also suggested getting **for-profit organizations involved** with larger community projects.

TOWN OF BEDFORD

Site of Meeting: Bedford County Health Department, Bedford, Virginia

Number of Participants:
3 (Women, estimated age 25-40, White residents)

Community Need in the Town of Bedford

Target population focus group participants identified several community needs regarding health and wellness:

- **Access to healthcare**
- **Access to dental care**
- **Mental health and substance use issues**
- **Outdoor spaces**
- **Food insecurity**
- **Transportation**

Access to healthcare is a critical need in the Bedford Area. **The availability of dental care, especially for Medicaid recipients,** is crucial for maintaining overall health and well-being. **Mental health and substance use issues** are also prominent needs within the community. The **need for more outdoor and active opportunities** for different age groups was discussed. While parks are available, they primarily cater to children aged 2-6. Facilities and programs that engage all age groups and promote physical activity and outdoor engagement are needed. **Affordable healthy food options** are another pressing need. Participants noted that while farmers' markets offer fresh produce, the prices are often prohibitive, making it difficult for residents to incorporate healthy foods into their diets. **Transportation** is a fundamental issue affecting those in remote locations limiting access to healthcare, employment, and essential services.

Root Causes of Community Need in the Town of Bedford

Focus Group participants stated that one of the primary issues in the Bedford Service Area is the availability of resources and services. The **lack of access to essential services such as healthcare, transportation, and substance abuse treatment** creates significant barriers for residents. **Isolation and the lack of strong connections** within the community were identified as causes of need since they leave individuals vulnerable to various social and health issues. The need for more reliable **transportation options** further isolates individuals and limits their employment and community engagement opportunities. Participants noted that **poverty and financial constraints** hinder residents' ability to afford healthy food, transportation, and other necessities. Poverty has trapped individuals into a cycle where they cannot access resources that could improve their quality of life.

Community Resources Available in the Town of Bedford

The Bedford Service Area is home to various resources that support the community's diverse needs, including healthcare and transportation, addiction recovery, and recreational facilities. They include **social and community services like the Shepherd's Table, Christian Ministries, and Agape** which provide essential services such as food assistance, clothing, and other forms of support to individuals and families in need. **Horizon Behavioral Health** is vital for mental health and substance use services. **Bedrock Church** provides resources for recovering people with addiction; it offers weekly meetings that provide support not only for addiction but also for individuals dealing with various personal struggles. These meetings foster community and provide a safe space for sharing and support. **Community Health Workers** in Bedford bridge the gap between healthcare services and the community, offering education,

support, and assistance in navigating the healthcare system. **The Otter Bus** is crucial for residents who need reliable transportation within the town increasing access to medical appointments, grocery stores, and other essential services. **Bedford Ride** supports those who need transportation for healthcare appointments and other vital errands. Bedford County boasts **several excellent parks,** such as Falling Creek and Liberty Lake, which offer recreational opportunities for all age groups. **The YMCA and the Parks and Recreation Department** provide numerous activities and events, particularly for seniors, helping to promote physical activity and social engagement.

Barriers to Accessing Community Resources in the Town of Bedford

Transportation is one of the most significant barriers in the Bedford Service Area. Many residents, particularly those in remote or rural areas, struggle to access essential services such as healthcare, grocery stores, and community centers due to limited transportation options. Many **community members need to know the services and support systems** that could benefit them. Even when residents know available resources, **understanding how to access and navigate these services** can take time and effort; cognitive difficulties or lack of familiarity with the system can impede their ability to obtain support. **Supporting vulnerable populations,** such as seniors, foster children, and young mothers, is a critical need in the community. One focus group member recounted her process of accessing resources for a 17-year-old foster child with a baby who required assistance with multiple resources, including signing up for WIC, obtaining a GED, and getting a learner's permit. Ensuring these individuals are aware of and can access these resources is vital for their success and well-being.

Areas for Collaboration in the Town of Bedford

Collaboration among Bedford's focus group participants can significantly enhance awareness and access to available resources, improving overall community well-being. They agreed that one practical approach is **creating and maintaining a comprehensive resource list.** Institutions like the Health Department, churches, and the Department of Social Services (DSS) can work together to compile a list of available resources, including counseling services, housing assistance, material needs, and more. Sharing this list across various community platforms can ensure residents know where to turn for specific needs. **Community organizations, including churches and nonprofits,** play a crucial role in this collaborative effort by keeping an updated resource list and sharing it with their members; these organizations can help direct individuals to the appropriate services. **Regular meetings and information-sharing sessions** among community leaders and residents can keep everyone updated on available resources and any service changes. By fostering open lines of communication, the community can quickly adapt to new needs and resources as they arise. Residents can also work together to leverage existing networks and relationships to spread information. Informal networks, such as neighborhood groups, social clubs, and even local businesses, can be powerful channels for distributing information about available resources.

BEDFORD COUNTY

Site of Meeting: Mi Patron Restaurant, Forest, Virginia

Number of Participants: 4 (estimated age range 30-50, Hispanic/Latino Spanish-Speaking Community, gender not reported)

Community Need for the Spanish-Speaking Community in Bedford County

The greatest needs for the Spanish-speakingresidents in Bedford County, according to focus group participants, are:

- **Access to healthcare and services in Spanish**
- **Cost of medical care**
- **Awareness of community resources**

The Spanish-speaking community in Bedford faces significant challenges in **accessing healthcare information and services in their language.** Focus group participants needed clarification about where to go for different types of medical care, particularly in emergencies. There is a pressing need for clear, accessible information that explains the differences between hospitals, clinics, and urgent care centers and guides when and where to seek medical assistance. There is a **lack of basic dental and specialty care especially for children.** With this information in Spanish, navigating the healthcare system is a manageable task, especially during health crises. Another critical need in the community is **financial assistance for medical expenses.** Participants raised concerns about the **burden of high medical costs,** often compounded by a **lack of understanding of available financial aid options.** There is a need for better dissemination of information regarding programs like Medicaid and other local assistance resources that could alleviate the financial stress of healthcare. Focus group participants needed to be made aware of the processes involved or the criteria for applying to these programs, which limit their access to much-needed financial support and contribute to an overall sense of insecurity when dealing with healthcare costs. There is also a **lack of awareness of community support services** and available healthcare resources. Focus group participants noted that many Spanish-speaking residents are unaware of free clinics, income-based healthcare centers, or other services that could meet their needs more affordably and conveniently. **Language barriers exacerbate this lack of awareness,** as most healthcare materials and communication are in English, making it difficult for non-English speakers to understand and benefit from these resources. There is a lack of empathy from providers and no attempt to understand patient needs.

Root Causes of Community Need for the Spanish-Speaking Community in Bedford County

The Spanish-speaking target population in Bedford County noted that **language barriers** were a huge cause of need. Most healthcare information, including medical documents, instructions, and surveys, is available only in English. Families are using their children to interpret for medical providers. Without adequate support in their native language, Spanish-speaking residents **struggle to navigate the healthcare system effectively,** often feeling overwhelmed and excluded from essential services. Another major cause of need is the general **need for more awareness and knowledge about healthcare resources.** This confusion largely stems from insufficient outreach and a need for more information in Spanish, limiting their understanding of the different types of care available and the appropriate facilities for specific medical needs.

Community Resources for the Spanish-Speaking Community in Bedford County

Focus group participants indicated that they were **unaware of resources available** to meet these critical community needs.

Barriers to Accessing Community Resources for the Spanish-Speaking Community in Bedford County

The biggest barrier to accessing community resources for the Spanish-speaking community in Bedford is the **lack of citizenship and proper documentation,** such as Social Security numbers, which restricts eligibility for various healthcare services. Many community members need help accessing necessary resources because **they do not meet these administrative requirements, making receiving the care they need challenging.** This lack of proper documentation leaves these residents marginalized. **Language barriers** also pose a significant challenge for the Spanish-speaking community. Even when individuals know where to seek help, the **lack of translation services** makes it extremely difficult for them to navigate the healthcare system effectively. Participants expressed the **frustration of being unable to communicate** or fully understand their options due to the absence of Spanish-speaking staff or interpreters. Many community members are **uninformed and disconnected from crucial services** that could benefit them.

Areas for Collaboration for the Spanish-Speaking Community in Bedford County

The Spanish-speaking residents in Bedford discussed various areas where they could collaborate to create a healthier community, particularly **improving communication and access to resources.** One participant identified communication as a critical issue that could be addressed collectively, noting that better communication would significantly enhance community health. Having a **navigator or Community Health Worker to help guide the community through the financial assistance options for healthcare** was also suggested. Many residents avoid seeking medical care due to fears about the high costs involved. Participants agreed that collaborative efforts to improve communication, increase awareness of available financial support, and provide personalized guidance would empower the Spanish-speaking community in Bedford to meet their healthcare needs better.

BEDFORD COUNTY

Site of Meeting: Central Virginia Alliance for Community Living, Senior Nutrition Site

Number of Participants: 6 (3 Men & 3 Women, estimated age range 60+ years, 5 White & 1 Asian)

Community Need in Bedford County

The Greatest needs in Bedford County, according to focus group participants, are:

- **Access to Healthcare**
- **Community Engagement**

According to focus group participants, the Bedford Area faces a critical need for **comprehensive healthcare services,** particularly **accessible medical facilities** and **experienced professionals available during off-hours.** Participants highlighted the **need for more urgent care facilities and emergency services open evenings and weekends.** This gap in healthcare services is further compounded by a need for more adequately trained healthcare providers. One participant shared a personal experience where a young trainee at the local hospital needed help to perform a simple procedure, highlighting the need for **more experienced medical professionals.** There is a **significant need for more specialists** in the service area. Many residents are forced to travel to Lynchburg or Roanoke for specialized medical care, which is inconvenient and burdensome. The lack of local specialists means that critical health needs are not being met promptly, contributing to the overall healthcare accessibility problem in the region. Participants agreed that the **current wait times for medical appointments are excessively long,** sometimes up to five or six weeks, reflecting the shortage of medical professionals in the area.

Participants also emphasized the importance of **social engagement and community activities.** Long-time residents stressed the need for more organized gatherings to foster community and companionship. The absence of such activities has led to feelings of isolation, particularly among older residents living alone.

Root Causes of Community Need in Bedford County

Participants in the focus group identified the **high number of patients relative to the insufficient availability of doctors** as a root cause. Such delays in accessing medical care exacerbate health issues as problems worsen or become more complicated due to the lack of timely treatment. The consensus among participants is that the current system cannot meet the demand. **Transportation difficulties** impact accessing healthcare. Residents must often travel to larger hospitals in Lynchburg, highlighting the inadequacy of local facilities to conduct routine tests and procedures. The lack of regional transportation options further complicates this issue, making it challenging for residents, particularly older adults, to receive the necessary medical care. The **aging population in Bedford County faces unique challenges** that exacerbate the area's overall healthcare needs. Participants discussed how older residents often struggle with transportation and require more localized healthcare services. They recommended that Bedford's healthcare infrastructure needs to catch up with this demographic's growing needs.

Community Resources in Bedford County

In Bedford, **urgent care facilities** provide a crucial first point of contact for many healthcare needs. These facilities are complemented by individual specialties available at local hospitals, such as dermatology and orthopedic care. Participants noted that these specialties are staffed by knowledgeable professionals, ensuring a high standard of care. However, a significant issue remains

the **lack of information on how to access available resources** in the area. Bedford boasts several **safe areas for outdoor activities,** which contribute positively to community wellness. With its well-maintained trails, the town park offers residents a pleasant environment for walking and exercising. Additionally, facilities like the YMCA and various recreational activities ensure ample opportunities for residents to stay active and engaged. Bedford provides multiple **programs and resources aimed at supporting its senior population.** The **Parks and Recreation Department** also organize seniors' trips and activities, helping promote social interaction and physical activity among older residents. These programs are essential for maintaining the health and well-being of older residents, providing them with opportunities to stay active and connected within the community. **Transportation** situation is unpredictable in the Bedford Area. While a town bus service **(Otter Bus)** provides services in the Town of Bedford, its current routes only cover limited areas such as Liberty Park which hinders accessibility for some residents particularly those who rely on public transportation for their mobility.

Barriers for Accessing Community Resources in Bedford County

Transportation was consistently identified as a significant barrier to accessing essential resources in Bedford County. Participants in the discussion highlighted the difficulties residents face in reaching healthcare facilities and recreational areas due to limited transportation options. Another **significant barrier is the need for more information and awareness about available resources.** Participants noted that many residents need to be made aware of the services that exist within the community, which leads to underutilization of these resources. There is a pressing need for better dissemination of information to ensure that residents know what services are available and how to access them.

Areas for Collaboration in Bedford County

Target populations agreed that one area ripe for collaboration in the Bedford Service Area is **forming community groups** dedicated to informing residents about available resources. Participants noted the presence of new healthcare providers, such as foot doctors and dermatologists, who were not available when they first moved to the area. However, more advertising and centralized listings for these services are needed. Community groups could take the initiative to compile and disseminate information about local healthcare facilities and their services. Creating a comprehensive, easily accessible directory, possibly included in local phone books or as a standalone document, would benefit residents by making it easier to find and utilize available healthcare services. **Improving transportation services** is another opportunity for collaboration. The current public transportation in Bedford ends at 4 o'clock, which limits access for those who need to travel to healthcare appointments or other essential services after this time. Participants propose **introducing mobile healthcare services** as a creative solution to address the accessibility challenge. Having mobile doctors who travel from school to school, house to house, and development to development could significantly improve access to care for homebound individuals and those in remote areas. Although this may seem ambitious, stakeholders could explore pilot programs or partnerships with healthcare providers to make this a reality. Establishing **volunteer networks** to assist those who cannot leave their homes is another vital area for collaboration. Many residents cannot go to doctors due to mobility issues or lack of transportation. By **organizing volunteers to provide transportation or even home visits for primary medical care and support,** the community can ensure these vulnerable individuals receive the necessary care and attention.

LIFTING THE VOICE OF THE COMMUNITY- TARGET POPULATION QUOTES

"I know that there's a couple good parks around here, but I feel like being outdoors and having active opportunities, where there's not as much...could be to engage different age groups. You know parks are great for two to six year olds, but there's not a lot for all age groups."

"What we need is mobile doctors that go around from school to school, house to house, development to development."

Analysis of Similarities between Stakeholders and Target Populations' Community Needs

2024 Bedford Area Community Health Needs Assessment Focus Groups Greatest Needs in the Community	
Stakeholder Focus Group	***Target Population Focus Groups***
Access to healthcare **Affordable housing** Affordable childcare Awareness of resources Broadband access Domestic abuse Elder care **Food insecurity** **Mental health & substance abuse treatment** **Transportation**	**Access to healthcare (including cost, language barriers)** **Affordable housing** Community engagement **(includes awareness of resources)** **Food insecurity** **Mental health & substance use issues** Outdoor/ recreational spaces **Transportation**

By comparing the perspectives of the stakeholders and the target population in the 2024 Bedford Area Community Health Needs Assessment, it is possible to comprehensively understand the community's health needs. Stakeholders may have a broader or more strategic view of the issues, while the target population provides insight into residents' immediate, day-to-day challenges. This dual perspective ensures that all aspects of community well-being are considered.

In the Bedford Area, both Stakeholder and Target Population Focus Groups identified the following areas of community need:

- **Access to healthcare**
- **Affordable housing**
- **Awareness of resources**
- **Food insecurity**
- **Mental health care & drug abuse treatment**
- **Transportation**

Stakeholders also identified additional needs including:

- **Affordable childcare**
- **Broadband access**
- **Domestic abuse**
- **Elder care**

In addition to the overlaps in community needs with the Stakeholder Focus Group findings, the Target Population Focus Groups participants identified additional needs as follows:

- **Access to healthcare (details of need)**
  - **Cost & language barriers**
- **Community engagement**
- **Outdoor/recreational spaces**

Recommendations for 2027 Focus Groups

To ensure a balance between stakeholder and target population voices, the following recommendations should be considered for the future:

- **Use neutral third-party facilitators to guide the focus group discussions. This will ensure that participants are asked probing questions revealing the community's needs and that everyone feels heard and included.**
- **Consider a joint focus group session in each locality, including stakeholders and target population respondents.**
- **Record target population and stakeholder group conversations to ensure the collected data is aligned to facilitate a more cohesive analysis process.**
- **Ensure target population focus groups include diverse representations to gather a more holistic picture of the community's needs.**

SECONDARY DATA

Secondary data in this assessment includes population data for the Centra Bedford Service Area. The service area includes Bedford County and the Town of Bedford, where data is available.

Health Equity

Since 1980, Healthy People is a national initiative led by the U.S. Department of Health and Human Services that sets data-driven objectives to improve the health and well-being of Americans each decade. It builds on previous iterations of the Healthy People program, focusing on addressing health disparities, improving health equity, and fostering environments that promote good health. It is updated every 10 years. The initiative identifies key areas such as social determinants of health, health literacy, and preventive care, aiming to achieve a society where everyone can live healthier lives.

Healthy People incorporated a stronger focus on health equity beginning with Healthy People 2020, which explicitly identified the elimination of health disparities as a key objective. This effort was expanded further in Healthy People 2030, which emphasizes health equity as a foundational goal, aiming to ensure all individuals can achieve their full potential for health and well-being. Health equity is defined as the attainment of the highest level of health for all people, requiring efforts to address avoidable health disparities and social determinants of health. It includes eliminating structural barriers, addressing injustices, and ensuring equal access to health resources. The initiative focuses on reducing health disparities—differences in health outcomes that are closely linked to social, economic, or environmental disadvantages. Central themes include addressing social determinants of health such as education access, economic stability, healthcare quality, and neighborhood environments. Additionally, the initiative integrates health literacy as a crucial factor in advancing equity by ensuring individuals can access and understand health information effectively.

Source: Office of Disease Prevention and Health Promotion, Health People 2030, https://odphp.health.gov/
Data Retrieved: 11/27/2024

Since 2021, the impact of COVID-19 in Virginia has been significant, with the pandemic continuing to influence public health, economic activity, and societal behavior. In 2021, the state experienced surges related to the Delta variant, followed by Omicron in late 2021 and early 2022. The Omicron variant resulted in record-high case numbers, but relatively lower hospitalization and mortality rates compared to earlier waves due to increased vaccination coverage and prior immunity. Vaccination efforts have been central to mitigating severe outcomes. By early 2023, over 77% of Virginians had received at least one vaccine dose, with disparities in vaccine uptake observed among racial and ethnic groups.

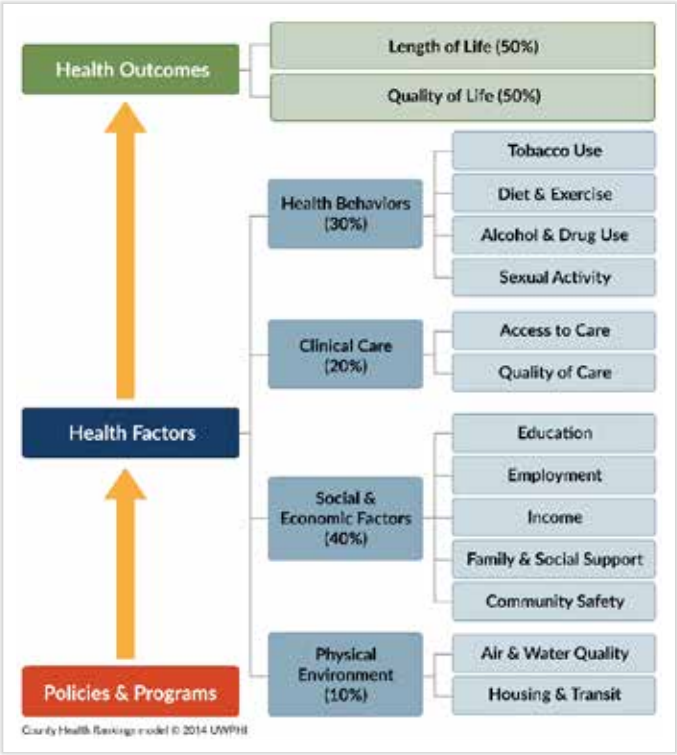
The prevalence of long COVID has become a significant health issue. Many Virginians experience lingering symptoms such as fatigue, respiratory issues, and cognitive difficulties, impacting quality of life and increasing the burden on healthcare systems. Although acute COVID-19 cases have decreased, the healthcare system continues to feel pressure from residual effects, including delayed treatments for other conditions due to prior disruptions and a surge in respiratory infections like RSV and flu. The lifting of most COVID-19 restrictions in Virginia, including mask mandates and social distancing measures, has led to a return to normalcy but also to periodic surges of infection. The end of the federal Public Health Emergency (PHE) in May 2023 resulted in changes to testing, vaccination coverage, and treatment access, particularly impacting those without insurance or in low-income communities.

Disproportionate impacts of the pandemic were particularly pronounced among minority populations, with higher rates of infection, hospitalization, and mortality early in the pandemic due to factors such as healthcare access, employment in essential industries, and socioeconomic disparities. Vulnerable groups, such as the elderly and those with pre-existing conditions, remain at higher risk. Additionally, the pandemic exacerbated mental health issues among Virginians. Increased stress, anxiety, and depression have been notable, especially among healthcare workers, students, and vulnerable populations.

While acute impacts of COVID-19 have declined, the ongoing effects on social determinants of health and healthcare access continue to shape the well-being of Virginians especially among racial and ethnic minority groups in Virginia. COVID-19 exacerbated economic disparities, especially affecting low-income families and communities of color. Job losses, inflation, and reduced financial support after the Public Health Emergency (PHE) have heightened economic stress, affecting health outcomes. Medicaid expansion in Virginia before the pandemic helped improve access to care, but the end of continuous enrollment policies during the PHE led to many losing coverage. This loss impacts preventive care and access to treatment for COVID-related complications. Prolonged school closures and disruptions have had lasting effects on children's health, including mental health challenges and learning losses. While schools have fully reopened, the pandemic's impact on educational outcomes continues to be a concern. Rising housing costs and inflation have intensified issues of housing insecurity and food access, key social determinants of health. Programs like expanded SNAP benefits during the PHE helped temporarily but post-pandemic cuts have left many families vulnerable.

Source: Virginia Department of Health, COVID-19 in Virginia, https://www.vdh.virginia.gov/coronavirus/see-the-numbers-covid-19-in-virginia/ Data Retrieved: 11/27/2024
Source: Johns Hopkins Bloomberg School of Public Health, COVID-19 in 2022, A Year-End Wrap-up, https://publichealth.jhu.edu/2022/covid-year-in-review Data Retrieved: 11/27/2024

County Health Rankings



Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. Retrieved 10/30/24 www.countyhealthrankings.org

The County Health Rankings & Roadmaps initiative, launched by the University of Wisconsin Population Health Institute with support from the Robert Wood Johnson Foundation, provides data and resources to improve health at the county level across the United States. Since its inception in 2010, the program has ranked counties based on a variety of health factors and outcomes, offering insight into disparities and actionable strategies to address them. The County Health Rankings in Virginia, up to 2023, utilize a comprehensive methodology to assess health outcomes (length and quality of life) and health factors (determinants that influence outcomes) across counties. These factors include social and economic elements, clinical care, health behaviors, and the physical environment. In Virginia, County Health Rankings were determined for 133 localities in the Commonwealth annually, with the healthiest county ranked as #1.

In 2024, the County Health Rankings & Roadmaps program introduced significant updates to its approach for evaluating county health. One of the key changes was the shift from ordinal rankings, which previously compared counties only within their respective states, to a more comparative framework that evaluates counties across state lines. This update aims to more accurately reflect regional health disparities and enable counties with similar conditions to collaborate on addressing shared health inequities. These changes have led to shifts in how counties are assessed and ranked. Previously ranked "healthy" counties may now appear less healthy due to adjustments in data presentation and evaluation criteria.

Counties are assigned composite scores for health outcomes and health factors that fall into (1 of 10) for health outcomes and or (1 of 9) for health factors, grouping localities in terms of healthiest to least healthiest counties in the country. The lower the number, the healthier the locality.

The updated framework now emphasizes factors like housing affordability, income levels, educational attainment, and access to recreational spaces. Additionally, the data incorporates more nuanced racial and ethnic groupings, better reflecting diverse community identities based on updated census information. New visualization tools also help to present data on health outcomes (like life expectancy) and health determinants more clearly, aiming to support local and national initiatives for health equity.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. www.countyhealthrankings.org
Source: Wisconsin Health News, County Health Rankings & Roadmaps takes new approach to rankings, May 26, 2024, https://wisconsinhealthnews.com/2024/03/26/county-health-rankings-roadmaps-takes-new-approach-to-rankings/
Data Retrieved: 11/27/2024

Bedford County Health Rankings

Locality	2021		2022		2023		3 YR Change	
	Health Outcomes	Health Factors	Health Outcomes	Health Factors	Health Outcomes	Health Factors	Health Outcomes	Health Factors
Bedford County	32	38	30	30	25	30	-7	-8

Table Source: 2021 – 2023 County Health Rankings, https://www.countyhealthrankings.org/health-data
Data Retrieved: 11/07/2024

WORSE
BETTER

Bedford County's health outcomes have shown consistent improvement over the three years, moving from a rank of 32 in 2021 to 25 in 2023. The overall improvement indicates positive changes in the length and quality of life for the county's population. Bedford County's health factors also showed significant improvement from 2021 to 2022, moving from a rank of 38 to 30, and maintaining this rank in 2023. This improvement over three years suggests that the factors influencing the community's health, such as health behaviors, clinical care, social and economic factors, and the physical environment, have seen positive developments.

2024 County Health Rankings

Health Outcomes Groupings		
County	Group Range Rank	Health Group Range
Bedford	8	-0.72 to -0.4

Health Outcomes Groupings		
	Group Range Rank	Group Range
Healthiest	**1**	2.02 to 2.99
	2	1.42 to 2
	3	0.95 to 1.42
	4	0.56 to 0.95
	5	0.22 to 0.56
Least Healthy	**6**	-0.1 to 0.21
	7	-0.4 to -0.11
	8	-0.72 to -0.4
	9	-1.09 to -0.72
	10	-1.76 to -1.1

Health Factors Groupings		
County	Group Range Rank	Health Group Range
Bedford	7	-0.67 to -0.44

Health Factors Groupings		
	Group Range Rank	Group Range
Healthiest	**1**	0.75 to 1.11
	2	0.47 to 0.75
	3	0.23 to 0.47
	4	0 to 0.23
	5	-0.22 to 0
Least Healthy	**6**	-0.44 to -0.22
	7	-0.67 to -0.44
	8	-0.96 to -0.67
	9	-1.62 to -0.97

The County Health Rankings for the Bedford Area for 2024 reveal distinct changes in Bedford County's scoring, ranking it unhealthy for both health outcomes and health factors as compared to similar localities nationally. With the previous methodology, the County was ranked as one of the healthiest localities in Virginia.

HEALTH OPPORTUNITY INDEX

Like the County Health Rankings, Virginia's Health Opportunity Index (HOI) is a data-driven tool that evaluates health risks among populations by considering various social determinants of health. It is designed to identify areas and communities that may face greater health challenges due to factors such as socioeconomic status, access to healthcare, and environmental conditions.

The HOI uses a range of indicators, including:

1. **Demographics:** Age, race, and ethnicity statistics to understand the diverse needs of the population.
2. **Health Access:** Data on insurance coverage, availability of healthcare providers, and access to preventive services.
3. **Socioeconomic Factors:** Information on income levels, education, employment status, and poverty rates.
4. **Health Outcomes:** Prevalence of chronic diseases, infant mortality rates, and other health indicators.

This index enables public health officials and policymakers to identify high-risk areas, allocate resources effectively, and design targeted interventions to address health disparities.

The HOI is reported at both the census tract and county/independent city level. Numeric scores are based on 134 Virginia localities with the highest scores (worst) labeled as Very Low Opportunity to the lowest scores (best) labeled as Very High Opportunity. The HOI score helps to identify localities where there are barriers to achieving the highest level of health possible. As an example, currently Arlington County is ranked number 1 in the Commonwealth of Virginia indicating that the community members have the highest opportunity to live long and healthy lives based on the Social Determinants of Health. Bedford County, in the Bedford Service Area, is currently ranked number 50, meaning their community members have a high opportunity to live long and healthy lives.

Source: https://apps.vdh.virginia.gov/omhhe/hoi/dashboards
Data Retrieved: 10/23/24

Health Opportunity Index		
Locality	*Rank*	*Rating*
Bedford County	50	High

Table Source: Virginia Department of Health. Virginia Health Opportunity Index. https://apps.vdh.virginia.gov/omhhe/hoi/dashboards/counties
Data Retrieved: 08/09/2024

Bedford Population by Age Group by Locality

Age Group	Bedford County		Virginia	
	Number	Percent	Number	Percent
Under 5 years	3,041	3.76%	494,148	5.73%
5 to 9 years	4,747	5.87%	511,965	5.94%
10 to 14 years	4,393	5.43%	545,595	6.33%
15 to 19 years	5,210	6.44%	573,642	6.65%
20 to 24 years	4,078	5.04%	580,019	6.73%
25 to 29 years	4,598	5.69%	579,897	6.72%
30 to 34 years	4,018	4.97%	590,216	6.84%
35 to 39 years	4,348	5.38%	588,506	6.82%
40 to 44 years	4,192	5.19%	556,645	6.45%
45 to 49 years	4,321	5.34%	541,770	6.28%
50 to 54 years	5,997	7.42%	561,174	6.51%
55 to 59 years	6,913	8.55%	576,469	6.68%
60 to 64 years	6,077	7.52%	543,459	6.30%
65 to 69 years	6,113	7.56%	453,677	5.26%
70 to 74 years	4,848	6.00%	365,967	4.24%
75 to 79 years	4,617	5.71%	251,265	2.91%
80 to 84 years	1,798	2.22%	158,796	1.84%
85 years and over	1,539	1.90%	151,301	1.75%
Median Age	47.6		38.7	
Total	80,848	100%	8,624,511	100%

Table Source: US Census. American Fact Finder. Table DP05. American Community Survey Demographic and Housing Estimates. 2018 – 2022. https://factfinder.census.gov
Data Retrieved: 04/04/2024

Approximately 22% of the population in Bedford County is 0 to 19 years of age, compared to 25% in Virginia. Bedford County has a higher percentage of its population 65 years of age and older (23%) compared to the state average (16%). Bedford County has a significantly higher median age (47.6) as compared to the Commonwealth (38.7). The aging population may have implications for local services, healthcare, and workforce availability in Bedford County.

Bedford Population by Sex

Locality	Male		Female	
	Number	%	Number	%
Bedford County	39,452	49.46%	40,309	50.54%
Virginia	4,159,173	49.20%	4,295,290	50.80%

Table Source: US Census. American Fact Finder. Table DP05. American Community Survey 2018 - 2022 Demographic and Housing Estimates https://factfinder.census.gov
Data Retrieved: 04/09/2024

Both Bedford and the state of Virginia have a similar gender distribution, with a slight female majority.

Sexual Orientation and Gender Identity Estimate

Locality	Population 18 and Older	LGBTQI+ Estimate
Bedford County	65,791	4,737
Virginia		7.2%

Table Source: U.S. Census. Quick Facts. Population estimates, July 1, 2023. https://www.census.gov/quickfacts/
Data Retrieved: 08/09/2024
Table Source: U.S. Census. Sexual Orientation and Gender Identity in the Household Plus Survey. Characteristics of the LGBTQ+ adult population.
https://www.census.gov/quickfacts/
Data Retrieved: 08/09/2024

Beginning in 2021, the US Census Bureau began collecting Sexual Orientation and Gender Identity (SOGI) data to advance equity for lesbian, gay, transgender, queer and intersexual (LGBTQI+) individuals. In Virginia, it is estimated that 7.2% of the population 18 years of age and older identify as LGBTQI+. Using this estimate, we can determine the Service Area data for the population 18 years of age and older who identify as LGBTQI+.

https://www.census.gov/library/stories/2021/11/census-bureau-survey-explores-sexual-orientation-and-gender-identity.html

Bedford Population by Race

Locality	White	Black	American Indian / Alaskan Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino	Total Population
Bedford County	67,554	4,837	109	1,216	0	3,175	3,957	2,226	78,622	80,848
Virginia	5,473,610	1,630,355	23,728	591,088	6,185	576,163	341,207	865,015	7,759,496	8,624,511

Table Source: US Census. American Fact Finder. Table DP05. ACS Demographic and Housing Estimates. 2018 - 2022 American Community Survey 5-Year Estimates https://factfinder.census.gov
Data Retrieved: 04/18/2024

Bedford Population by Race by Percent of Total Population

Locality	White	Black	American Indian / Alaskan Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino
Beford County	83.6%	6.0%	0.1%	1.5%	0%	3.9%	4.9%	2.8%	97.2%
Virginia	63.5%	18.9%	0.3%	6.9%	0.1%	6.7%	4.0%	10.0%	90.0%

Table Source: US Census. American Fact Finder. Table DP05. ACS Demographic and Housing Estimates. 2018 - 2022 American Community Survey 5-Year Estimates, https://factfinder.census.gov
Data Retrieved: 04/18/2024

Bedford shows less racial and ethnic diversity and is more homogenous as compared to the state overall with nearly 84% of the population White, 6% Black and 2.8% Hispanic or Latino (63.5%, 18.9%, and 10.0% respectively in Virginia).

Bedford Limited English-Speaking Households

Locality	Total			Alternate Language		
	Total Population Over Five	Speaks English Less than Very Well	Percent	Spanish	Asian and Pacific Isl.	Other
Bedford County	76,223	832	1.10%	433	244	155
Virginia	8,130,363	477,522	5.90%	246,030	118,157	113,365

Table Source: US Census, American Fact Finder. American Community Survey 5-Year Estimates 2018 - 2022.
Data Retrieved: 04/18/2024

A "limited English-speaking" household is one in which all members age 14 and older have at least some difficulty with English. The U.S. Census Bureau defines "limited English-speaking" household as one in which no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English "very well."(https://www.census.gov/topics/population/language-use/about/faqs.html Retrieved 10/23/24)

Bedford has a relatively low percentage of residents with limited English proficiency (1.10%) compared to the state average (5.9%). The primary non-English language spoken by those with limited English proficiency in both Bedford and Virginia is Spanish, followed by Asian and Pacific Island languages.

Population Projections by Locality, 2030-2050

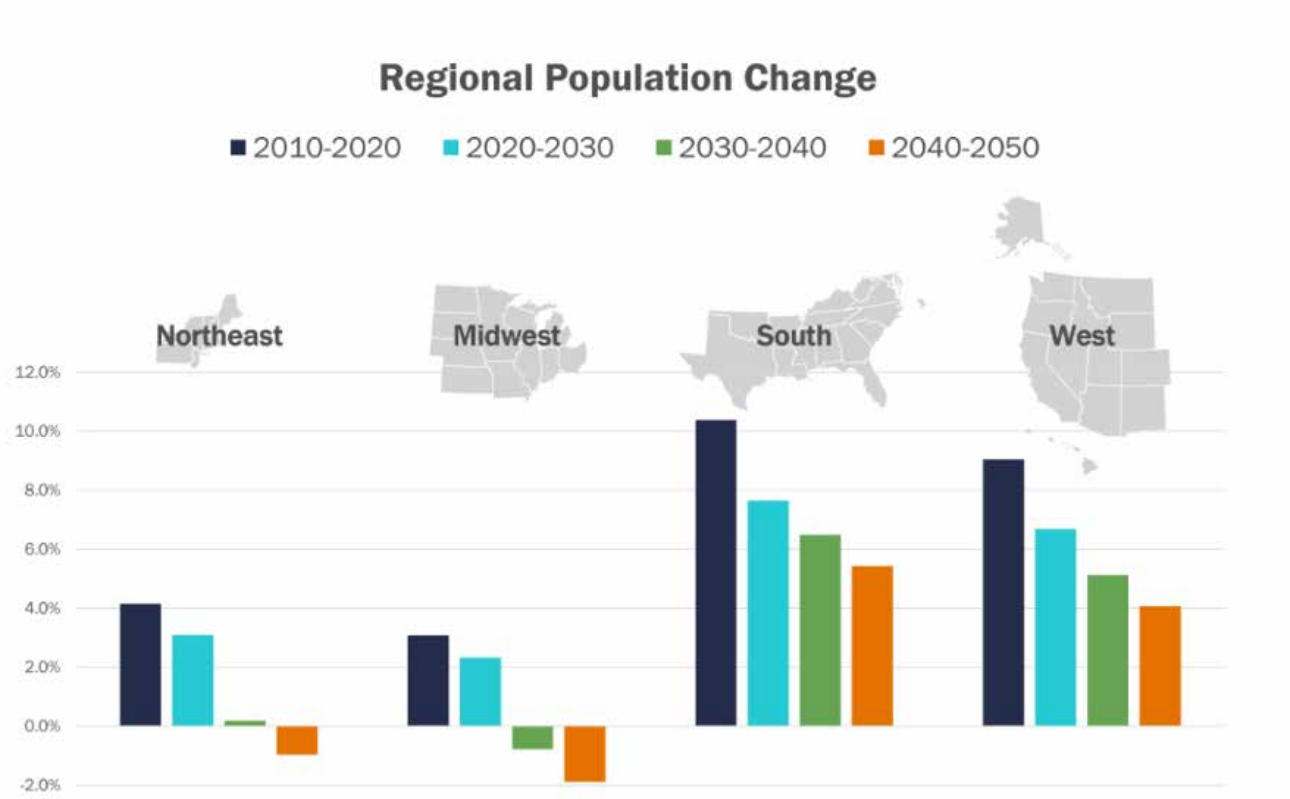
Locality	2030	2040	2050	+/-
Bedford	82,822	87,902	94,298	13.9%
Virginia	9,129,002	9,759,371	10,535,810	15%

Table Source: Weldon Cooper Center for Public Service: https://www.coopercenter.org/virginia-population-projections
Years Measured: 2030-2050. Data Retrieved: 07/16/2024

Virginia is projected to see steady population growth over the next two decades. From 2030 to 2040, the population is projected to increase by 630,369, a 6.9% increase over the 10-year period. From 2040 to 2050, the population is projected to increase by 776,439, representing an 8.0% increase over the following 10-year period. Virginia's population growth rate (15.4%) is projected to be higher than that of Bedford County (13.9%) over the 20-year period.

Between now and 2050, the overall population of the United States is expected to increase, from 331 million in 2020 to 349 million in 2030 and 371 million in 2050. In continuation of the well-established trend of slowing growth rates, we may see the national rate of growth decrease from nearly 10% in 2000-2010 to 7.4% over 2010-2020 to an anticipated 5.5% over 2020-2030. Most states will also experience similar deceleration as per the projections. This pattern can be partially attributed to the lower level of immigration as well as the accompanying lower birth rates and older age profile over the recent decades. The change in the total U.S. population is of course not uniformly distributed across all geographies. This variation can be demonstrated in multiple ways, by regions and by states. A comparison across the regions in the United States reveals that population growth over the next several decades is expected to continue to move towards the South and West, with both regions experiencing 6-8% increase in the current decade until 2030. Between 2040-2050 the Northeast is expected to see a slight population decline, whereas the Midwest is expected to shrink even earlier and see negative population change over 2030-2040.

Source: https://www.coopercenter.org/research/national-50-state-population-projections-2030-2040-2050
Data Retrieved 10/23/2024



Demographics, Town of Bedford

	Town of Bedford
Population	
Population estimates, July 1, 2023	6,777
Population estimates base, April 1, 2020	6,649
Population, percent change - April 1, 2020 to July 1, 2023	1.9%
Age and Sex	
Persons under 5 years, percent	2.9%
Persons under 18 years, percent	20.2%
Persons 65 years and over, percent	19.2%
Female persons, percent	55.4%
Race and Hispanic Origin	
White alone, percent	71.8%
Black or African American alone, percent	17.6%
American Indian and Alaska Native alone, percent	0.0%
Asian alone, percent	3.2%
Native Hawaiian and Other Pacific Islander alone, percent	0.0%
Two or More Races, percent	3.5%
Hispanic or Latino, percent	2.5%
White alone, not Hispanic or Latino, percent	71.8%
Limited English-Speaking Households	
Language other than English spoken at home, percent of persons age 5 years+, 2018-2022	6.3%
Education	
High school graduate or higher, percent of persons age 25 years+, 2018-2022	84.0%
Bachelor's degree or higher, percent of persons age 25 years+, 2018-2022	19.5%
Income & Poverty	
Median household income (in 2022 dollars), 2018-2022	$41,154.00
Per capita income in past 12 months (in 2022 dollars), 2018-2022	$26,238.00
Persons in poverty, percent	26.7%

Table Source: US Census QuickFacts, https://www.census.gov/quickfacts/
Data Retrieved: 10/15/24

Given its relatively small size, public data for the Town of Bedford is limited. According to the US Census, the Town of Bedford, Virginia, had an estimated population of 6,777 as of July 1, 2023, representing a 1.9% increase from its 2020 population of 6,649. The town's demographic profile shows a diverse age distribution, with 2.9% of residents under 5 years, 20.2% under 18 years, and 19.2% aged 65 and older. Females comprise 55.4% of the population.

The racial composition is more diverse than in that County with 71.8% who identify as White alone, 17.6% as Black or African American alone, and 3.2% as Asian alone. Hispanic or Latino residents make up 2.5%, while 6.3% of households speak a language other than English at home. Educational attainment in Bedford reveals that 84.0% of individuals aged 25 years or older have completed high school, and 19.5% hold a bachelor's degree or higher. However, economic indicators highlight challenges, with a median household income of $41,154 and a per capita income of $26,238. Poverty affects 26.7% of the population, signaling a need for targeted support and economic development in the community.

HEALTH FACTORS

The County Health Rankings measure Health Factors, which are elements influencing a community's overall health. These factors fall into four broad categories and each health factor is assigned different weights to reflect its estimated contribution to overall health outcomes.

1. **Social and Economic Factors (40%):** Social determinants of health like education level, employment rates, income inequality, family support, and community safety.
2. **Health Behaviors (30%):** Indicators such as smoking rates, physical activity levels, diet, alcohol use, and sexual activity patterns.
3. **Clinical Care (20%):** Access to and quality of healthcare services, including the number of uninsured individuals and the ratio of healthcare providers to the population.
4. **Physical Environment (10%):** Environmental conditions such as air and water quality, housing affordability, and access to transportation and healthy foods.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. www.countyhealthrankings.org,
Data Retrieved 10/23/2024.

Social and Economic Factors

Social and economic factors affect how well and how long we live. Social and economic factors include factors such as income, education, employment, community safety, and social support. The choices that are available in a community are impacted by social and economic factors. These choices include our abilities to afford medical care and housing and to manage stress. Social and economic opportunities help communities live longer and healthier lives. For example, a living wage shapes opportunities for housing, education, childcare, food and medical care. Strategies to improve these factors can have a greater impact on health than strategies that target individual behaviors. Communities that have been cut off from investments or who have experienced discrimination have fewer social and economic opportunities. These gaps disproportionately affect people of color and people living in rural areas. Children may be especially impacted.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-factors/social-economic-factors
Data Retrieved: 10/23/2024

EDUCATION

The relationship between education and health is well-documented, with numerous studies showing that higher levels of education are linked to better health outcomes. This connection stems from various factors, including access to resources, health knowledge, and social determinants of health.

People with higher levels of education are more likely to engage in healthier behaviors. They tend to have better knowledge of health practices, such as the importance of regular exercise, a balanced diet, and preventive care. Education also improves critical thinking skills, which helps individuals make informed health decisions. Research shows that higher educational attainment is associated with lower rates of smoking, obesity, and other risky behaviors. Education can play a protective role in mental health. Higher educational attainment has been linked to lower rates of depression, anxiety, and psychological distress. The cognitive and social skills acquired through education help individuals manage stress more effectively and access mental health resources when needed. Education is strongly correlated with income levels, and higher income provides better access to healthcare services, nutritious food, and healthier living environments. People with more education are more likely to secure jobs that offer health insurance, paid sick leave, and less physically taxing working conditions, all of which contribute to better health.

Sources: Cutler, D. M., Huang, W., & Lleras-Muney, A. (2021). Economic approaches to understanding and reducing health disparities. JAMA, 326 (7), 637-638; Galama, T. J., & van Kippersluis, H. (2019). A theory of socio-economic disparities in health over the life cycle. The Economic Journal, 129 (617), 338-374; Hamad, R., Penner, E. C., & Tylavsky, F. A. (2019). The effects of cumulative and intergenerational education on health in young adulthood. Social Science & Medicine, 222, 1-9; Zimmerman, E., Woolf, S. H., & Haley, A. (2020). Understanding the relationship between education and health: A review of the evidence and an examination of community perspectives. Health Affairs, 39 (6), 1019-1025.
Data Retrieved: 10/23/24

Educational Attainment by Locality for the Population Age 25 and Over

Locality	Population 25 Years and Over	Less than High School Graduate	High School Grad or Equivalent	Some College of Associate's Degree	Bachelor's Degree or Higher
Bedford	58,099	7.5%	29.4%	30.5%	32.6%
Virginia	5,919,142	9.9%	23.9%	26.3%	41.0%

Table Source: US Census. American Fact Finder. EDUCATIONAL ATTAINMENT 2018 -2022. American Community Survey 5-Year Estimates.
Data Retrieved: 05/27/2024

In Bedford County, 7.5% of the population has less than a high school diploma, 29.4% are high school graduates or equivalent, 30.5% have completed some college or an associate's degree, and 32.6% hold a bachelor's degree or higher. Comparatively, in Virginia, 9.9% have less than a high school education, 23.9% are high school graduates, 26.3% have some college or an associate's degree, and a higher percentage, 41.0%, have a bachelor's degree or higher. This data indicates that Bedford County outperforms the state in high school completion and associate-level education, though it falls short in the proportion of residents with a bachelor's degree or higher.

Poverty Rate for the Population 25 Years and Over and for Whom Poverty Status is Determined by Educational Attainment

Locality	Less than high school graduate	High school graduate	Some college, associate's degree	Bachelor's degree or higher
Bedford	31.9%	7.8%	4.1%	6.0%
Virginia	23.4%	13.0%	9.2%	3.4%

Table Source: US Census. American Fact Finder. POVERTY STATUS IN THE PAST 12 MONTHS 2018 - 2022. American Community Survey 5-Year Estimates.
Data Retrieved: 05/09/2024

The poverty rate for individuals aged 25 years and over in Bedford County reveals a strong correlation between educational attainment and economic well-being. Bedford County's poverty rates for individuals aged 25 years and over for less than high school graduate (31.9%) and Bachelor's degree or higher (6.0%) is higher than Virginia's rate (23.4% and 3.4% respectively) while the percentage for high school graduate (7.8%) and some college, associate's degree (4.1%) is lower than the state (13.0% and 9.2% respectively).

ON TIME GRADUATION AND DROP-OUT RATES

The Virginia On-Time Graduation Rate defines graduates as students who earn Advanced Studies, Standard, International Baccalaureate (IB), or Applied Studies Diplomas for students who entered the ninth grade for the first time together and were scheduled to graduate four years later. The formula also recognizes that some students with disabilities and limited English proficient (EL) students are allowed more than the standard four years to earn a diploma and counts those students as 'on-time' graduates.

Bedford County

Jefferson Forest High	*Total*	*Female*	*Male*	*White*	*Black*	*Hispanic*	*Economically Disadvantaged*	*Disability*
On Time Graduation	75.38%	77.51%	72.96%	76.14%	81.48%	70.00%	68.12%	81.48%
Drop-out Rate	4.86%	2.37%	7.55%	4.17%	0.00%	10.00%	10.14%	14.81%
Liberty High	*Total*	*Female*	*Male*	*White*	*Black*	*Hispanic*	*Economically Disadvantaged*	*Disability*
On Time Graduation	85.71%	91.76%	78.95%	85.95%	88.46%	<	75.76%	88.00%
Drop-out Rate	8.07%	3.53%	13.16%	8.26%	3.85%	<	15.15%	8.00%
Staunton River High	*Total*	*Female*	*Male*	*White*	*Black*	*Hispanic*	*Economically Disadvantaged*	*Disability*
On Time Graduation	90.91%	92.22%	90.00%	90.86%	90.00%	83.33%	88.57%	93.48%
Drop-out Rate	5.91%	5.56%	6.15%	5.91%	10.00%	8.33%	8.57%	6.52%

Note: < Indicates insufficient data from VDOE
Table Source: Virginia Department of Education. Statistics and Reports. Graduation, Completion, Dropout & Postsecondary Date. 2023.
https://p1pe.doe.virginia.gov/apex/f?p=246:1:::::p_session_id,p_application_name:14515291606537576 2,cohortgrad
Data Retrieved: 05/23/2024

For the 2023-2024 school year, the Virginia Department of Education (VDOE) published on-time graduation and dropout rates for various student demographics across the state. Key data include:

- **Total Graduation Rate:** 92.8%, with a dropout rate of around 4.5%.
- **By Gender:** Female students typically graduate at slightly higher rates than male students.
- **By Race/Ethnicity:** White students generally have higher graduation rates than Black and Hispanic students.
- **By Economic and Disability Status:** Economically disadvantaged and students with disabilities have lower graduation rates and higher dropout rates than their peers.

Source: Virginia Department of Education, https://www.doe.virginia.gov/, Graduation and Dropout Reports
Data Retrieved: 10/25/2024

FREE AND REDUCED LUNCH RATES

The Free and Reduced Lunch (FRL) rate from the Virginia Department of Education (VDOE) refers to the percentage of students in a school or school district who qualify for free or reduced-price meals under the National School Lunch Program (NSLP). This rate serves as an indicator of student economic need within schools and districts.

Eligibility for free or reduced-price meals is based on household income and family size, using federal poverty guidelines:

- **Free lunch:** Students from households with income at or below 130% of the federal poverty line.
- **Reduced-price lunch:** Students from households with income between 130% and 185% of the federal poverty line.

The FRL rate is commonly used as a socioeconomic metric in school reporting, and it can have an impact on funding, resource allocation, and the development of educational programs targeted at reducing educational inequities.

In Virginia, some districts report the same Free and Reduced Lunch (FRL) rates across all schools due to a program called the Community Eligibility Provision (CEP). Under CEP, schools or districts with a high percentage of low-income students can offer free breakfast and lunch to all students, regardless of individual eligibility. This eliminates the need for families to apply individually, which can help reduce administrative burdens and stigma associated with free meals.

CEP-eligible districts calculate a district-wide FRL rate based on the proportion of students directly certified for free meals, such as those enrolled in specific assistance programs (e.g., SNAP, TANF). The VDOE then applies this rate uniformly across all schools in the CEP district for reporting purposes, even though the actual economic need might vary slightly among individual schools.

School Division Number	*District*	*School Nutrition Program Membership (Number)*	*Total FRL Eligible (Number)*	*Total FRL Eligible (%)*
10	**Bedford County Public Schools**	9,087	5,167	56.86%
	Virginia Public School Division	1,257,975	730,844	58.1%

Table Source: Virginia Department of Education retrieved from https://www.doe.virginia.gov/programs-services/school-operations-support-services/school-nutrition/program-statistics-reports. Data for the 2023 - 2024 School Year. Data Retrieved: 05/16/2024

In Bedford County Public Schools, 56.86% of the 9,087 students are eligible for free and reduced-price lunch (FRL), based on school nutrition program data. This percentage is slightly below the Virginia state average, where 58.1% of students in public schools qualify for FRL. In the public school district, several schools have qualified for CEP based on their economically disadvantaged status. As of the 2022–2023 school year, the following schools were offering free meals to all students under CEP:

- Bedford Elementary School
- Bedford Primary School
- Big Island Elementary School
- Goodview Elementary School
- Huddleston Elementary School
- Moneta Elementary School
- Montvale Elementary School
- Stewartsville Elementary School
- Liberty Middle School
- Liberty High School
- Staunton River Middle School
- Staunton River High School

However, not all schools in the district qualified for CEP. Schools such as Otter River Elementary, Forest Elementary, Boonsboro Elementary, Thomas Jefferson Elementary, Forest Middle School, and Jefferson Forest High School did not meet the criteria and therefore continued with the regular school meals program, where students could apply for free or reduced-price meals based on individual eligibility.

Source: Virginia Department of Education retrieved from https://www.doe.virginia.gov/programs-services/school-operations-support-services/school-nutrition/program-statistics-reports. Data for the 2023 - 2024 School Year. Data Retrieved: 05/16/2024

CHRONIC ABSENTEEISM

Since the COVID-19 pandemic, Virginia has experienced a significant increase in chronic absenteeism among K-12 students. In the 2021-2022 school year, chronic absenteeism—defined as missing 10% or more of school days—reached nearly double pre-pandemic levels, with around 20% of students meeting this threshold. This surge has been linked to various pandemic-related issues, including mental health challenges, disrupted routines, and economic difficulties that impacted family stability and student engagement. Nearly all school divisions in the 2021–22 school year experienced surges in chronic absenteeism, with just three divisions experiencing a decrease. While COVID-19 quarantines contributed to increased absenteeism, school staff indicated other factors contributed as well. More students also exhibited disruptive behavior as they returned to in-person instruction, according to school staff (though quantifying the increase is difficult because of data limitations). School staff were asked to rate the seriousness of 15 issues they faced, such as teacher compensation, student academic progress, lack of respect from parents, and concerns about health during the pandemic. Student behavior problems were rated as the most serious of all 15 issues listed. Principals and teachers cited months spent out of the physical classroom as the main reason for increased student behavioral problems. (Source: Commonwealth of Virginia, Joint Legislative Audit & Review Commission, Pandemic Impact on Public K-12 Education, 2022, https://jlarc.virginia.gov/pdfs/reports/Rpt568-1.pdf)

To address this, the Virginia Department of Education (VDOE) under Governor Glenn Youngkin established the Chronic Absenteeism Task Force under its "ALL IN VA" plan. This task force works with schools and community organizations to re-engage students and support families, emphasizing the importance of consistent attendance, especially in elementary grades, where absenteeism has remained a persistent issue. (Source: Virginia Department of Education, Chronic Absenteeism Task Force, https://www.doe.virginia.gov/teaching-learning-assessment/all-in-va/attendance-matters/chronic-absenteeism-task-force)

By the 2023-2024 academic year, chronic absenteeism rates in Virginia showed some improvement, falling to 15.1% from a high of 19.3% the previous year, although rates remain above pre-pandemic averages. The VDOE has continued to focus on long-term solutions, such as mental health resources and family engagement programs, to further reduce absenteeism and support students' educational outcomes.

Division	*Chronic Absenteeism Rate 2023-2024*
Bedford County Public Schools	14.0%
Virginia	15.1%

Table Source: Virginia Department of Education, School Quality Profiles, https://schoolquality.virginia.gov/download-data
Data Retrieved: 10/27/2024

Chronic absenteeism is defined by VDOE as the number of students missing 10% or more of days enrolled. For the percentage, this number is then divided by student enrollment.

In the 2023-2024 school year, Bedford County Public Schools had lower chronic absenteeism rates as compared to the rate in Virginia.

EMPLOYMENT

Employment trends in Virginia following the COVID-19 pandemic reveal both shifts and resilience across various sectors. Virginia has benefited from a strong tech and professional services presence, which buffered the state from the worst job losses seen in other regions, especially due to its high number of remote-capable jobs. This has been particularly evident in sectors like Information Technology, which saw stable or increased demand due to Virginia's large data center industry.

Conversely, tourism, hospitality, and retail sectors were hard-hit initially. Hotels and restaurants faced significant challenges, with some establishments permanently closing. However, these sectors are rebounding, though not fully to pre-pandemic levels, as reduced business travel and a shift towards remote work diminished demand for in-person services. Additionally, there has been increased investment in automation and e-commerce, which has expanded warehouse and transportation roles to meet rising online shopping demand. However, these trends also mean that traditional retail and low-wage service positions are unlikely to return to former levels, and job growth is concentrated in higher-wage positions.

As of recent data from the Bureau of Labor Statistics, Virginia's unemployment rate has stabilized, with industries like construction, healthcare, and technology continuing to show resilience. Construction alone saw nearly a 5.4% increase year-over-year, while the manufacturing and trade sectors are growing but at a slower pace. This dynamic landscape indicates a broader trend of employment recovery, tempered by a shift towards automation and remote work.

Sources: Virginia Business, The great transformation, February 28, 2021, https://virginiabusiness.com/the-great-transformation/; McKinsey Global Institute, The future of work after COVID-19, February 18, 2021, https://www.mckinsey.com/featured-insights/future-of-work/the-future-of-work-after-covid-19; US Bureau of Labor Statistics, Economy at a glance, Virginia, https://www.bls.gov/eag/eag.va.htm
Data Retrieved: 10/27/24

UNEMPLOYMENT RATES

Unemployment is associated with adverse health effects. Prolonged unemployment increases the risk of mental health issues, including depression and anxiety, and is correlated with higher rates of substance use and mortality. Physical health can deteriorate due to factors like stress-induced health conditions and lack of access to employer-based health insurance. Research indicates that unemployed individuals may experience a 20-30% increase in mortality risk compared to those employed.

Source: Virginia Business, The great transformation, February 28, 2021, https://virginiabusiness.com/the-great-transformation/; McKinsey Global Institute, The future of work after COVID-10, February 18, 2021, https://www.mckinsey.com/featured-insights/future-of-work/the-future-of-work-after-covid-19)
Data Retrieved: 10/27/24

Unemployment Rates by Locality by Percent

Locality	*2020*	*2021*	*2022*	*2023*
Beford County	5.8	3.7	3	3.2
Virginia	6.5	3.9	2.8	2.9

Table Source: Virginia Works. Current Local Area Unemployment Statistics (LAUS). https://virginiaworks.com/Local-Area-Unemployment-Statistics-LAUS.
Data Retrieved: 06/10/2024

Both Bedford and Virginia experienced a strong recovery from the initial impact of the pandemic, with unemployment rates improving significantly in 2021 and 2022, though they saw a small increase in 2023. Bedford consistently had a lower unemployment rate compared to Virginia throughout this period.

WAGES

The nature and quality of employment also plays a crucial role in health outcomes. Jobs with high levels of stress, poor working conditions, or lack of autonomy can negatively impact health. For example, low-wage or high-stress positions often lead to burnout and physical health issues, such as cardiovascular problems. Meanwhile, secure, well-compensated jobs with good working conditions are associated with better health outcomes, as they afford employees the means and time to prioritize health.

Source: US Bureau of Labor Statistics, Economy at a glance, Virginia https://www.bls.gov/eag/eag.va.htm
Data Retrieved: 10/27/24

Annual Employment and Wage Statistics by Locality in 2023

Locality	Annual Establishments	Annual Average Employment	Total Annual Wages	Annual Average Weekly Wage	Annual Wages per Employee
Bedford	2,402	18,624	$888,772,972.00	$918.00	$47,723.00
Virginia	322,450	4,048,268	$300,603,986,144.00	$1,428.00	$74,255.00
United States	11,916,357	153,087,529	$11,076,974,138,515.00	$1,391.00	$72,357.00

Table Source: Total Covered, 10 Total, all industries, All Counties in Virginia 2023 Annual Averages, All establishment sizes Source: Quarterly Census of Employment and Wages - Bureau of Labor Statistics (bls.gov), https://data.bls.gov/cew/apps/table_maker/v4/table_maker.htm#type=2&st=51&year=2023&qtr=A&own=0&ind=10&supp=1.
Data Retrieved: 07/16/2024

Bedford County has lower annual average weekly wages and annual wages per employee compared to Virginia and the U.S.

Virginia shows higher average wages than Bedford County but lower than the national average, with a larger workforce and more establishments as compared to Bedford County.

Largest Employers by Locality

Bedford County Top 10 Employers (2024)	
1	Bedford County School Board
2	County of Bedford
3	Centra Health
4	Wal Mart
5	GP Big Island LLC
6	Food Lion
7	Sentry Equipment Erectors
8	Elwood Staffing Services Inc
9	Runk & Prat Health Care, Inc.
10	UOS, LLC

The top industries with the greatest number employed in Bedford County include "Government, Local Government, Healthcare & Social Assistance, Manufacturing, and Retail Trade".

Table Source for all localities: Virginia Works, Economic Information & Analytics, Quarterly Census of Employment and Wages (QCEW), 2nd Quarter (April, May, June) 2024, https://virginiaworks.com/community-profiles
Data Retrieved: 10/26/2024

INCOME

The link between poverty and health is a critical public health issue, as poverty has consistently been shown to negatively impact health outcomes. Poverty influences health through multiple pathways, including limited access to healthcare, poor living conditions, inadequate nutrition, and increased exposure to stress.

People living in poverty often lack access to affordable healthcare. Without health insurance or financial resources, they are less likely to receive preventive services, timely medical treatment, and necessary medications. This delay in care can lead to the progression of preventable diseases and worse health outcomes. Studies show that uninsured individuals are more likely to experience poor health and higher mortality rates. Poverty is associated with chronic stress, which negatively affects both physical and mental health and is impacted by financial insecurity, food scarcity, and unsafe living environments. Chronic stress has been linked to an increased risk of mental health issues, including depression, anxiety, and substance abuse disorders. Furthermore, long-term exposure to stress hormones can lead to the development of chronic diseases like hypertension and diabetes.

Poverty is associated with higher rates of chronic diseases such as heart disease, diabetes, and respiratory disorders. Low-income individuals often face barriers to managing these conditions, including limited access to medications, healthy food, and safe places to exercise. Additionally, poverty exacerbates the impact of these diseases because of delayed diagnosis and inadequate treatment. Recent studies show that individuals in the lowest income bracket have a significantly higher risk of developing chronic diseases compared to wealthier counterparts.

Poverty affects not just the individual but also subsequent generations. Children raised in poverty are more likely to experience poor health, educational deficits, and reduced economic opportunities as adults. This cycle of poverty and poor health continues across generations, perpetuating health disparities. Exposure to adverse childhood experiences (ACEs), which are more common in low-income households, can lead to lifelong health issues like cardiovascular disease and mental health disorders. Addressing poverty is essential for improving public health and reducing health disparities.

Sources: Boehm, J. K., & Kubzansky, L. D. (2020). The heart's content: The association between positive psychological well-being and cardiovascular health. Psychological Bulletin, 146(8), 617–644; Braveman, P., & Gottlieb, L. (2019). The social determinants of health: It's time to consider the causes of the causes. Public Health Reports, 129(1), 19-31; Fiscella, K., & Sanders, M. R. (2019). Racial and ethnic disparities in the quality of health care. Annual Review of Public Health, 37, 375-394; Garner, A. S., Forkey, H., & Szilagyi, M. (2021). Translating developmental science to address childhood adversity. Pediatrics, 147(2), e2020040282; Seligman, H. K., & Berkowitz, S. A. (2019). Aligning programs and policies to support food security and public health goals. Annual Review of Public Health, 40, 319-337. Data Retrieved: 10/23/24

Median Household Income ($) by Locality, by Race 2022

Locality	Households	White	Black	Hispanic
Bedford County	71,751	70,170	81,008	46,986
Virginia	85,873	91,924	60,526	84,525

Table Source: US Census. American Fact Finder. Median Income in the Past 12 Months. 2018-2022 American Community Survey 5-Year Estimates
Data Retrieved: 05/07/2024

The 2022 median household income data by race highlights disparities and variations in earnings across households. In Bedford County, White households had a median income of $70,170, while Black households earned significantly more at $81,008, and Hispanic households earned much less at $46,986. Comparatively in Virginia, White households earned a higher income at $91,924, whereas Black households earned less at $60,526, and Hispanic households had a median income of $84,525. This data reflects racial income disparities, with White, Black, and Hispanic households' incomes varying significantly between Bedford County and the Commonwealth.

2024 Health & Human Services (HHS) Poverty Guidelines

Persons in Family/Household	Poverty Guideline
1	$15,060
2	$20,440
3	$25,820
4	$31,200
5	$36,580
6	$41,960
7	$47,340
8	$52,720
For families/households with more than 8 persons, add $5,380 for each additional person.	

Table Source: https://aspe.hhs.gov/poverty-guidelines
Data Retrieved: 05/07/2024

The 2024 HHS Poverty Guidelines show the annual income thresholds considered to be at or below the poverty line in the United States, based on family size. The poverty guideline increases as the number of people in the household increases. For each additional person, the amount added to the guideline is $5,380, reflecting the higher cost of living for larger households. The poverty guideline shows a progressive increase as household size grows. For a single-person household, the guideline is $15,060, while for an 8-person household, it is $52,720. This difference highlights the increased financial needs of larger households. These guidelines are often used to determine eligibility for various federal programs and benefits. Households with income below these thresholds might qualify for assistance programs designed to help low-income individuals and families.

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

Locality	All People	Persons Age 65 Years and Over	Persons Under 18 Years	Families with female householder, no spouse present
Bedford	9.1%	4.7%	12.5%	20.7%
Virginia	10.0%	8.0%	12.8%	21.1%

Table Source: US Census, American Fact Finder. Selected Economic Characteristics 2018-2022 American Community Survey 5-Year Estimates. Table DP03
Data Retrieved: 01/02/2024

Living in poverty has a profound and unique impact on seniors, children, and female head of households due to their increased vulnerability and the compounded challenges they face. In Virginia, 8% of those 65 years and older live below the poverty line, however this is lower in Bedford County, (4.7%). In Virginia, 12.8% of children live below poverty while 12.5% of children in the service area live in poverty. Families with female householders, with no spouse present have a higher probability of living below poverty in Virginia (21.1%) as compared to the service area (20.7%). Overall, slightly more people (10%) live below the poverty level in Virginia as compared to Bedford County (9.1%).

Children living in households headed by single mothers without a spouse present often face various health challenges compared to those in two-parent households. Research indicates that these children are more likely to experience adverse physical and mental health outcomes, including higher rates of depression, anxiety, and stress-related disorders. They are also more vulnerable to food insecurity and unhealthy behaviors such as poor dietary habits, which can have long-term impacts on their well-being. These outcomes are often linked to socioeconomic factors, as single-mother households frequently experience higher rates of poverty, reduced access to healthcare, and limited social support. Despite these risks, some studies have highlighted protective factors, such as strong maternal engagement and community resources, which can mitigate these challenges and promote resilience in children.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. www.countyhealthrankings.org; BMJ Open, Health outcomes, healthcare use and development in children born into or growing up in single-parent households, a systemic review study protocol, https://bmjopen.bmj.com/content/11/2/e043361
Data Retrieved: 12/11/2024

Locality	Percent Population Between 100% and 200% of Poverty Level
Bedford County	15.7%
Bedford, Town	17.5%
Virginia	26.6%

Table Source: US Census, American Fact Finder. 2018 - 2022 American Community Survey 5-Year Estimates
Data Retrieved: 05/02/2024

Living between 100% and 200% of the federal poverty level means having an income that is above the official poverty line but still relatively low, often making it difficult to afford basic necessities like housing, healthcare, and food without financial strain. Although people in this range are above the poverty line, they still often struggle with "near-poverty" conditions, where they may not qualify for some government assistance programs but face financial challenges with rising living costs, such as rent, healthcare, and childcare. They are also more vulnerable to financial instability in the event of unexpected expenses or emergencies.

The percentage of the population living between 100% and 200% of the poverty level reveals economic vulnerability in Bedford County, the Town of Bedford, and Virginia overall. In Bedford County, 15.7% of the population falls within this range, while the Town of Bedford has a slightly higher percentage at 17.5%. Statewide, Virginia reports a significantly higher rate, with 26.6% of the population living within this income bracket. These figures indicate that while economic vulnerability in Bedford County and its town is present, it is less pronounced compared to the state average.

ALICE HOUSEHOLDS

An ALICE household refers to a group of individuals or families who are ***A***sset ***L***imited, ***I***ncome ***C***onstrained but ***E***mployed. These households earn above the federal poverty level but still do not make enough to cover basic living costs such as housing, food, healthcare, childcare, and transportation. ALICE families struggle financially despite working, often because their jobs pay low wages, offer limited benefits, or are unstable.

The concept of ALICE helps to shed light on the struggles of households that do not fall under traditional definitions of poverty but are still financially unstable. These families often don't qualify for public assistance but still struggle to afford everyday necessities. The ALICE population is significant in many regions, highlighting how economic challenges extend beyond just those living below the poverty line.

In 2022, 40% of Virginia households faced financial hardship, meaning they either lived in poverty or were part of the ALICE (Asset Limited, Income Constrained, Employed) population. Out of Virginia's 3.3 million households:

- 11% (359,347 households) lived below the Federal Poverty Level (FPL), struggling with extreme financial hardship.
- 29% (977,828 households) were ALICE, meaning they earned more than the FPL but not enough to cover basic living costs like housing, healthcare, childcare, and transportation.
- The remaining 60% of households were above the ALICE threshold, having enough income to meet their essential needs.

The ALICE population includes many essential workers, such as childcare providers and home health aides, who often live paycheck to paycheck despite being employed. The economic challenges for these households have been exacerbated by rising living costs and the rollback of pandemic-related financial supports.

Source: https://unitedforalice.org/virginia
Data Retrieved: 10/24/24

ALICE Households by Locality by Percent, 2022

Locality	Total Households	Poverty Households	Poverty Households %	ALICE Households	Above ALICE Households	Percent ALICE Households
Bedford County	32,510	2,926	9%	9,103	23,407	28%
Virginia			11%			29%

Table Source: United for ALICE, Research Center- Virginia, https://unitedforalice.org/virginia
Data Retrieved: 10/24/2024

The 2022 data on ALICE (Asset Limited, Income Constrained, Employed) households highlights economic challenges in Bedford County and Virginia overall. In Bedford County, 32,510 households were recorded, with 2,926 (9%) living below the poverty level and 9,103 (28%) classified as ALICE households. The remaining 23,407 households (63%) had incomes above the ALICE threshold. Across Virginia, 11% of households were below the poverty level, and 29% were classified as ALICE households.

FAMILY & SOCIAL SUPPORT

The Virginia Department of Social Services (VDSS) provides a wide range of services designed to assist residents with basic needs, promote family stability, and ensure child and adult welfare. Services include financial assistance programs (Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, Emergency Assistance Program); child and family services (Child Protective Services, Foster Care and Adoption, Childcare Subsidy Program); adult services (Adult Protective Services, Home and Community Based Services); housing and homelessness services (Housing Assistance Programs, Emergency Assistance); employment and workforce development (Virginia Initiative for Employment not Welfare, Workforce Services); health and wellness programs (Medicaid, Child Support services) and funding for Community Action Programs.

VDSS plays a crucial role in helping Virginia's most vulnerable populations by offering a comprehensive range of programs and services aimed at promoting economic stability, protecting vulnerable children and adults, and supporting healthy families.

Source: Virginia Department of Social Services https://www.dss.virginia.gov/
Data Retrieved: 10/24/24

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) provides low-income individuals and families with monthly benefits to purchase food. During the COVID-19 pandemic, the U.S. government introduced emergency SNAP EBT benefits to provide additional financial support to families struggling with food insecurity. These benefits were part of the federal response to the economic challenges created by the pandemic, ensuring that vulnerable populations had enough resources to purchase food. In Virginia, these emergency benefits ended in 2023 with the lifting of the public health emergency due to the pandemic. After the emergency allotments ended, SNAP recipients in Virginia returned to receiving the regular benefit amount based on their income, household size, and expenses, which for many meant a significant reduction in monthly benefits. The reduction in benefits has been substantial for many families, especially those who had been receiving the maximum monthly amount during the pandemic. Some households experienced a decrease of hundreds of dollars per month, making it harder to afford groceries as food prices remained high due to inflation. Since that time, community organizations, food banks, and local governments have been working to provide additional support for families in need, though the transition has been difficult for many households relying on the enhanced benefits.

SNAP Participation Report

Locality	*2020*	*2021*	*2022*	*2023*	*4 YR Change*
Bedford County	10.8%	10.9%	9.9%	8.0%	-2.8%
Virginia	13.2%	13.1%	Not available	Not available	Not available

Table Source: Virginia Department of Social Services retrieved from https://www.dss.virginia.gov/geninfo/reports/financial_assistance/snap_participation.cgi
Data Retrieved: 05/16/2024

The Supplemental Nutrition Assistance Program (SNAP) participation data for Bedford County and Virginia shows a decline over the four-year period from 2020 to 2023. In Bedford County, SNAP participation decreased from 10.8% in 2020 to 8.0% in 2023, reflecting a 4-year change of -2.8%. Statewide data for Virginia shows a slightly higher participation rate of 13.2% in 2020 and 13.1% in 2021, though data for 2022 and 2023 is not available.

There has been an uptick in the use of food pantries/food banks in the area since the reduction in SNAP benefits.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

The Temporary Assistance for Needy Families (TANF) program in Virginia provides financial assistance and supportive services to low-income families with children to help them achieve self-sufficiency. The program offers temporary cash benefits and aims to reduce dependency on government aid by promoting job preparation, work, and family stability.

TANF Participation Report - Total Persons

Locality	April 2021	April 2022	April 2023	3 YR Change
Bedford County	258	302	212	-46.00
Virginia	37,229	Not available	Not available	Not available

Table Source: https://www.dss.virginia.gov/geninfo/reports/financial_assistance/tanf.cgi
Data Retrieved: 05/16/2024

The TANF participation data for Bedford County shows a decline in the total number of participants over the three-year period from April 2021 to April 2023. In Bedford County, participation decreased from 258 individuals in 2021 to 212 individuals in 2023, reflecting a 3-year change of -46 individuals. Statewide data for Virginia in April 2021 reported 37,229 participants, but data for 2022 and 2023 is unavailable.

CHILD ABUSE AND NEGLECT

From 2021 to 2023, Virginia saw fluctuations in child abuse and neglect reports, heavily influenced by the COVID-19 pandemic and systemic challenges within the child welfare system. The number of reports of abuse and neglect decreased during the pandemic, likely due to reduced in-person interactions with mandated reporters such as educators. In Virginia, "founded cases" of child abuse and neglect refer to cases where the evidence gathered during an investigation meets the "preponderance of the evidence" standard. This means it is more likely than not that the abuse or neglect occurred. These determinations are made after a thorough review of facts by Child Protective Services (CPS). Founded cases typically lead to interventions to ensure the child's safety, which may include family services, legal actions, or other protective measures. In contrast, "unfounded" cases lack sufficient evidence to substantiate the allegation.

Source: Virginia Department of Social Services, Child Maltreatment Death Investigations in Virginia during State Fiscal Year 2021, July 2022, https://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2022/FINAL_Report_on_CDI_for_SFY21_COMBINED.pdf; Family and Children's Trust Fund, Report of the Child Abuse and neglect Advisory Committee Citizen Review Panel, May 2023, https://www.fact.virginia.gov/wp-content/uploads/2023/05/FACT.CAN_.CAPTA-2023-Final.-Report.051223.pdf
Data Retrieved: 12/11/2024

Founded Cases of Child Abuse and Neglect

Locality	2023	2022	2021
Bedford	26	31	31
Virginia	2913	3161	3360

Table Source: https://cpsaccountability.dss.virginia.gov/index-social-services.html/ Virginia Social Services CPA Reports
Data Retrieved: 10/28/2024

The data on founded cases of child abuse and neglect shows a declining trend both locally and statewide between 2021 and 2023. In the Bedford area, the number of cases decreased from 31 in 2021 and 2022 to 26 in 2023. Similarly, statewide in Virginia, cases dropped from 3,360 in 2021 to 3,161 in 2022, and further to 2,913 in 2023. This reduction may reflect improved preventative measures, increased awareness, or changes in reporting and investigation practices.

FOSTER CARE

Since 2022, the number of children in Virginia's foster care system has remained relatively stable. In April 2023, there were 4,973 children in foster care, compared to 4,948 in April 2022. Of these, more than half were placed in non-relative foster homes, indicating a persistent reliance on traditional placements over kinship care options. Virginia's implementation of the federal Family First Prevention Services Act emphasized keeping children with their families and providing in-home services. While this approach seeks to reduce reliance on foster care, concerns persist about its long-term effects on child safety and well-being, including inconsistencies in local application and the capacity of families to meet children's needs without robust support. Governor Glenn Youngkin's Safe and Sound Task Force seeks to improve housing placements for foster children. However, systemic issues such as funding limitations and lack of sufficient foster family recruitment persist.

Source: Virginia Department of Social Services, Foster Care by the Numbers, https://www.dss.virginia.gov/fosterVA/fostercare_facts.html
Source: Final Report of the Virginia Commission on Youth, Improving Virginia's Foster Care System, https://vcoy.virginia.gov/Improving%20Virginia%20Foster%20Care%20System%20-%20Final%20Report%20-%202023.pdf
Source: Family and Children's Trust Fund, Report of the Child Abuse and neglect Advisory Committee Citizen Review Panel, May 2023, https://www.fact.virginia.gov/wp-content/uploads/2023/05/FACT.CAN_.CAPTA-2023-Final.-Report.051223.pdf
Data Retrieved: 12/11/2024

Rate of Children Entering Congregate Foster Care per 1,000

Locality	3-Yr. Avg.	2023	2022	2021
Bedford	2.7	2.6	2.6	2.8
Virginia	1.5	1.6	1.5	1.5

Table Source: https://www.dss.virginia.gov/geninfo/reports/children/fc.cgi
Data Retrieved: 10/29/2024

The rate of children entering congregate foster care per 1,000 shows that Bedford County consistently exceeds the statewide average. Over the three-year period from 2021 to 2023, Bedford's three-year average rate is 2.7, compared to Virginia's lower average of 1.5. In 2023 and 2022, Bedford recorded a rate of 2.6, while the rate was slightly higher in 2021 at 2.8. Over the same years, Virginia's rate remained steady at 1.5, except for a slight increase to 1.6 in 2023.

CHILDCARE

Childcare in Virginia is a significant financial burden for families and presents challenges in terms of availability. On average, families spend $12,000 to $15,000 annually per child for childcare, which surpasses the cost of in-state tuition at many Virginia colleges. This expenditure accounts for roughly 12-15% of the median household income of married couples, which is higher than the 7% affordability benchmark set by the U.S. Department of Health and Human Services. In terms of availability, Virginia has about 5-8 childcare centers per 1,000 children under the age of five, varying by county. This measure reflects center-based childcare facilities and does not include in-home or informal care options. However, this number does not fully capture issues such as affordability, quality, or capacity, all of which significantly affect families' access to adequate childcare.

In May 2024, Virginia's General Assembly approved a biennial budget allocating over $1.1 billion to early childhood education for fiscal years 2025 and 2026. This historic investment includes state general fund contributions of $366 million for FY25 and $461 million for FY26. The funding aims to support more than 42,000 children in FY25 and 45,000 in FY26 through the Child Care Subsidy Program, with additional resources directed toward the Mixed Delivery Program and the Virginia Preschool Initiative. These investments reflect Virginia's commitment to expanding access to quality early childhood education, benefiting families across the Commonwealth.

Source: Child Care VA, Virginia Department of Education, Estimating the Cost of High-Quality Early Childhood Care and Education, https://www.childcare.virginia.gov/reports-resources/research-reports-and-resource/virginia-s-cost-estimation-model
The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. www.countyhealthrankings.org
Data Retrieved: 12/11/2024

Childcare Cost Burden- % Household Income Required for Child Care Expenses

Locality	2022 & 2023
Bedford	20
Virginia	26

Table Source: 2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources. Years Measured: 2022 & 2023. Data Retrieved: 11/12/2024

The childcare cost burden data for 2022 and 2023 shows that households in Bedford allocate 20% of their income to childcare expenses, which is notably lower than the statewide average of 26% in Virginia.

Number of Childcare Centers per 1,000 Population under 5 years old

Locality	2010 - 2022	
	Number of Child Care Centers	Childcare Centers per 1,000 Children
Bedford	26	7
Virginia	-	7

Table Source: 2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources. Years Measured: 2010-2022. Data Retrieved: 11/12/2024

In 2024, Bedford has 26 childcare centers, providing 7 childcare centers per 1,000 children under 5 years old. This matches the statewide average for Virginia, which also has 7 childcare centers per 1,000 children.

Head Start programs support children's growth from birth to age 5 through services centered around early learning and development, health, and family well-being. Head Start staff actively engage parents, recognizing family participation throughout the program as key to strong child outcomes. Head Start services are available at no cost to children from birth to 5 years of age in eligible families. Eligible participants include children whose families meet the federal low-income guidelines — that is, whose incomes are at or below the federal poverty guidelines or who receive Temporary Assistance for Needy Families, Supplemental Security Income, or Supplemental Nutrition Assistance Program public assistance services. Other eligible participants include children who are in the foster care system or experiencing homelessness. Programs may also accept a limited number of children who do not meet any of those eligibility criteria.

The federal government funds Head Start programs through the U.S. Department of Health and Human Services, Administration for Children and Families. The federal-to-local model allows local leaders to create a Head Start experience that is responsive to the unique and specific needs of their community. Many programs combine funding from federal, state, and local sources to maximize service delivery and continuity. Head Start Collaboration Offices facilitate partnerships between Head Start agencies and other state entities that provide services to benefit low-income children and their families.

Head Start preschool services work with children ages 3 to 5 and their families. Early Head Start services work with families that have children ages birth to 3, and many also serve expectant families. Many programs operate both Head Start preschool and Early Head Start services. Programs deliver child development services in center-based, home-based, or family childcare settings. Head Start programs operate in every state, many tribal nations, and several U.S. territories, including Puerto Rico. All Head Start programs continually work toward the mission for eligible children and families to receive high-quality services in safe and healthy settings that prepare children for school and life.

Source: US Department of Health & Human Services, Office of Head Start, Head Start Services, https://www.acf.hhs.gov/ohs/about/head-start
Data Retrieved: 12/11/2024

Lynchburg Community Action Group (Lyn-CAG) and HumanKind are key providers of Head Start and Early Head Start programs in the Lynchburg region, offering vital early childhood education and family support to low-income families. Lyn-CAG operates Head Start programs serving children aged three to five in multiple locations, including the city of Lynchburg, Amherst County, and Bedford County. Lyn-CAG serves over 100 children annually, with all programs adhering to state licensing standards. HumanKind provides Early Head Start programs for infants and toddlers up to age three, with its Lynchburg and Bedford centers. The program accommodates up to 48 children and offers year-round services. HumanKind also equips families with tools for at-home learning and provides affordable childcare options, including access to Virginia's Child Care Subsidy Program. These programs promote school readiness through a focus on cognitive, social, and emotional development while emphasizing parental involvement.

Source: Lyn-CAG Head Start https://lyncagkidz.org/lyn-cag-head-start
Source: HumanKind Early Head Start https://www.humankind.org/early-head-start/
Data Retrieved: 12/16/2024

DOMESTIC VIOLENCE

Domestic violence, as defined by the U.S. Department of Justice's Office on Violence Against Women, is "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner." It can include physical, sexual, emotional, economic, or psychological abuse. Domestic violence remains a critical issue in Virginia, with approximately 33.6% of women and 28.6% of men experiencing intimate partner violence, rape, and/or stalking during their lifetimes.

Domestic violence prevention programs are federal-and state-funded public or private, non-profit agencies that provide services to survivors of domestic violence and their children. Local domestic violence programs provide for the safety of battered adults and their children through the provision of emergency housing and transportation, crisis intervention, peer counseling, support, advocacy and information and referral. Funding also supports public awareness initiatives and the statewide Family Violence and sexual assault hotlines.

In Virginia, the Domestic Violence Program is administered by the Virginia Department of Social Services which identifies, mobilizes, and monitors resources for victims of domestic violence. Over 20,000 women and children are served annually across the Commonwealth.

Additionally, according to Virginia Commonwealth University:

- More than 30% of Virginia's homicides are domestic violence related.
- About 56% of domestic violence homicides involve firearms.
- About 80% of domestic violence homicides happen in people's homes.
- About 40% of domestic violence homicides happen during or after a relationship breakup.
- More than 20% of domestic violence homicides involve a homicide-suicide.
- Women make up 51% of Virginia's population but account for 63% of the people killed by firearms in intimate partner-related homicides.

Source: Office of Violence Against Women, US Department of Justice, Domestic Violence, https://www.justice.gov/ovw/domestic-violence
Source: Commonwealth of Virginia. Virginia Department of Social Services. Domestic Violence. https://www.dss.virginia.gov/family/domestic_ violence/index.cgi.
Source: World Population Review. Domestic Violence by State 2024. https://worldpopulationreview.com/state-rankings/domestic-violence-by-state
Source: Virginia Commonwealth University, Domestic Violence in Virginia: Statistics and Resources, https://onlinesocialwork.vcu.edu/blog/domestic-violence-virginia/?emci=ffe4e379-addd-ee11-85fb-002248223794&emdi=772712f0-14de-ee11-85fb-002248223794&ceid=8284860
Data Retrieved: 11/05/24

To address these challenges, Virginia offers resources such as a 24/7 statewide hotline and a network of local crisis programs which serves Bedford County. The YWCA of Central Virginia, founded in 1912, is a cornerstone in the region's fight against domestic violence and sexual assault. Serving Lynchburg and seven surrounding counties, the organization's mission is to eliminate racism, empower women, and promote peace, justice, freedom, and dignity for all. Its programs include the Domestic Violence Prevention Program (DVPP), the Sexual Assault Response Program (SARP), and the Town Center Residential Housing Program, each providing critical support and services to those in need.

The Bedford Domestic Violence Coalition is dedicated to supporting programs and services that address domestic violence within the community. Their mission is to end domestic violence by collaborating with community partners to mitigate its impact on individuals and families in Bedford County. They aim to raise awareness about domestic violence and provide resources for identification and reporting, striving for a safe environment for all residents and are members of the Bedford Area Resource Council. Bedford County's Department of Social Services provides support and education to victims, concerned family members, friends, and citizens, including access to shelter, information, referrals, and court accompaniment. All services are free of charge.

Source: YWCA Central Virginia, https://ywcacva.org/
Source: Bedford Area Resource Council, https://www.bedfordarearesourcecouncil.org/domestic-violence-coalition.html
Source: Bedford County Department of Social Services, https://www.bedfordcountyva.gov/government/departments-offices-o-z/social-services/domestic-violence-services
Data Retrieved: 12/12/2024

Bedford County Department of Social Services Annual Report 2023-2024

Bedford County Department of Social Services Annual Report 2023-2024			
Services Site	*Type of Service*	*Fiscal Year 2023-2024*	*Fiscal Year 2022-2023*
Main Office Services	Hotline Calls	415	373
	Walk In Center Clients	161	266
	Hours of Advocacy	577	539
Shelter Services	Nights in Shelter	999	2,264
	Adults Sheltered	39	52
	Children Sheltered	25	35
	Hours of Advocacy	672	1169
Court Services	Protective Order	79	116
	Adults	72	220
	Hours of Advocacy	382	365

Table Source: Bedford County Department of Social Services
Data Retrieved: 10/25/2024

The Bedford County Department of Social Services Annual Report for 2023-2024 shows changes in domestic violence program statistics compared to the previous year. Main Office Services reported an increase in hotline calls, rising from 373 in 2022-2023 to 415 in 2023-2024. However, walk-in center clients declined significantly from 266 to 161, while hours of advocacy increased slightly from 539 to 577. Shelter Services saw notable decreases, with nights in shelter dropping from 2,264 to 999, and fewer adults (39 compared to 52) and children sheltered (25 compared to 35). Hours of advocacy also decreased from 1,169 to 672. Court Services showed a reduction in protective orders, declining from 116 to 79. The number of adults assisted decreased from 220 to 72, while hours of advocacy remained relatively steady, rising slightly from 365 to 382. These statistics highlight a mixed trend, with increased hotline calls suggesting continued demand for services, but a decrease in shelter usage and protective orders.

RESIDENTIAL SEGREGATION (BLACK/WHITE)

In rural Virginia, residential segregation has contributed to health disparities by reinforcing systemic inequities in access to essential resources. Historical policies, such as redlining and discriminatory housing practices, concentrated economic disadvantages in certain rural communities, limiting access to quality healthcare, transportation, and nutritious food. These challenges are exacerbated by the rural nature of the region, which often results in fewer healthcare facilities and economic opportunities. The legacy of segregation has also influenced environmental health risks, such as inadequate infrastructure and higher exposure to pollutants, disproportionately affecting minority populations in rural areas. Efforts to address these inequities in rural Virginia focus on enhancing access to healthcare, improving transportation networks, and targeted reinvestment in underserved areas.

The index of dissimilarity is a measure used to quantify how evenly two groups are distributed across geographic areas (such as neighborhoods or census tracts). It provides values ranging from 0 to 100, where 0 indicates perfect integration (both groups are evenly distributed across all areas) and 100 represents complete segregation (the groups do not share any neighborhoods).

Source: University of Richmond's Digital Scholarship Lab & National Community Reinvestment Coalition, Not Even Past, https://dsl.richmond.edu/socialvulnerability/
Data Retrieved: 12/11/2024

Residential Segregation - Non-white/ White

Locality	2017-2021
Bedford	36
Virginia	51

Table Source: Community Health Rankings 2017-2021 from American Community Survey, 5-year estimates
Data Retrieved: 05/20/2024

The residential segregation index for non-White and White populations from 2017 to 2021 shows that Bedford has a segregation score of 36, which is lower than the statewide average for Virginia, at 51. Bedford's lower score suggests a relatively more integrated community compared to the state average.

COMMUNITY SAFETY

Injuries through accidents or violence are the third leading cause of death in the United States, and the leading cause for those between the ages of one and 44. Accidents and violence affect health and quality of life in the short and long-term, for those both directly and indirectly affected, and living in unsafe neighborhoods can impact health in a multitude of ways.

The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-factors/social-economic-factors/community-safety
Data Retrieved: 12/11/2024

Key: Community Safety Metrics

Metric	Definition	Source	Period Measured
Homicides	Number of deaths due to homicide per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	**2015-2021**
Suicides	Number of deaths due to suicide per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	**2017-2021**
Firearm Fatalities	Number of deaths due to firearms per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	**2017-2021**
Motor Vehicle Crash Deaths	Number of motor vehicle crash deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	**2015-2021**
Juvenile Arrests	Rate of delinquency cases per 1,000 juveniles.	Easy Access to State and County Juvenile Court Case Counts	**2021**

Table Source: 2024 County Health Rankings Report.https://www.countyhealthrankings.org/health-data/virginia/data-and-resources
Data Retrieved: 09/13/2024

Community Safety

Locality	Homicide Rate	Suicide Rate (Age-Adjusted)	Firearm Fatalities Rate	Motor Vehicle Mortality Rate	Juvenile Arrest Rate
Bedford	3.1	18.7	15.7	15.6	12.9
Virginia	5.5	13.4	12.9	10.2	*

Table Source: 2024 County Health Rankings Report.https://www.countyhealthrankings.org/health-data/virginia/data-and-resources
Data Retrieved: 09/13/2024

The community safety statistics highlight key differences between Bedford and Virginia in various measures of mortality and crime. Bedford's homicide rate is lower at 3.1 compared to Virginia's 5.5. However, Bedford has a significantly higher suicide rate, age-adjusted at 18.7, compared to the statewide rate of 13.4. Similarly, the firearm fatalities rate in Bedford is 15.7, exceeding the state average of 12.9. Bedford's motor vehicle mortality rate is also notably higher at 15.6 compared to Virginia's 10.2. The juvenile arrest rate in Bedford is reported at 12.9, though no state comparison is provided. These figures suggest Bedford faces challenges in areas such as mental health, firearm safety, and traffic-related incidents, despite lower homicide rates.

Health behaviors are health-related practices, such as diet and exercise, that can improve or damage the health of individuals or community members. Health behaviors are determined by the choices available in the places where people live, learn, work, and play. Not everyone has the money, access, and privilege needed to make healthy choices.

The County Health Rankings (CHR) model considers healthy behaviors to be a 30% contributor to population health. Healthy behaviors include tobacco use, diet and exercise, alcohol and drug use, and sexual activity.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors
Data Retrieved 10/23/2024

TOBACCO USE

Tobacco use is the leading cause of preventable death in the United States. It affects not only those who choose to use tobacco, but also people who live and work around tobacco. The term "tobacco" refers to commercial tobacco, not ceremonial or traditional tobacco.

Each year, smoking kills 480,000 Americans, including about 41,000 from exposure to secondhand smoke. Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease which includes emphysema and chronic bronchitis. On average, smokers die 10 years earlier than nonsmokers.

Tobacco is not only smoked. Smokeless tobacco, while less lethal than smoked tobacco, can lead to various cancers, gum and teeth problems, and nicotine addiction. Almost 6% of young adults use smokeless tobacco and half of new users are younger than 18.

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

Researchers estimate that tobacco control policies have saved at least 8 million Americans. Yet about 18% of adults still smoke. Each day, nearly 3,200 youth smoke their first cigarette, and 2,100 transition from occasional to daily smokers. Continuing to adopt and implement tobacco control policies can motivate users to quit, help youth choose not to start, and improve the quality of the air we all breathe.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/tobacco-use
Data Retrieved 10/23/2024

Percentage of Adults Who are Current Smokers (%) Age Adjusted

Locality	2019	2020	2021
Bedford	18	17	15
Virginia	14	14	13

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2019-2021. Data Retrieved: 05/30/2024

The percentage of adults who are current smokers is higher in the service area compared to the statewide average. There has been a decline in smoking rates in Bedford between 2019 and 2021 while across Virginia these rates have remained stable.

DIET AND EXERCISE

ADULT OBESITY

People who have obesity, compared to those with a healthy weight, are at an increased risk for many serious diseases and health conditions. In addition, obesity and its associated health problems have a significant economic impact on the U.S. health care system. Obesity in children and adults increases the risk for chronic conditions including heart disease; Type 2 diabetes; breathing problems, such as asthma and sleep apnea; joint problems; and gallstones and gallbladder disease. Adults with obesity have higher risks for stroke, many types of cancer, premature death, and mental illness such as clinical depression and anxiety. A healthy diet and regular exercise are a key component to managing obesity.

Body Mass Index (BMI) is a widely used measure to classify weight categories based on height and weight. It is divided into three categories:

- **Healthy Weight:** BMI 18.5- 24.9
- **Overweight:** BMI 25.0- 29.9
- **Obesity:** BMI ≥ 30.0

Source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, Reviewed July 15, 2022
Source: US Centers for Disease Control and Prevention, BMI, https://www.cdc.gov/bmi/faq/?CDC_AAref_Val=https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html
Data Retrieved: 12/11/2024

Percent of Adults with Obesity

Locality	*2019*	*2020*	*2021*
Bedford	33	32	36
Virginia	32	32	34

Table Source: 2022- 2024 County Health Rankings https://www.countyhealthrankings.org/health-data/virginia/data-and-resources
Years Measured: 2019-2021. Data Retrieved: 11/05/2024

The data presented is a measurement of the percentage of the adult population (age 20 and older) that reports a BMI greater than or equal to 30 kg/m2. For the years measured (2019-2021), slightly more adults in the service area (32-36%) reported a BMI that classifies them as obese as compared to Virginia (32-34%). These measurements increased over the three years for the most part.

FOOD INSECURITY

Food insecurity is an ongoing concern in Virginia, with recent trends showing a troubling increase, particularly among vulnerable groups like children, seniors, and minority communities. Currently, about 11.1% of Virginians (nearly 1 in 9) experience food insecurity, with rural areas in Southwest Virginia showing some of the highest rates. Food insecurity affects children at a rate of 13.6%, meaning 1 in 7 children live in households that struggle to provide consistent, nutritious food.

The impact of the COVID-19 pandemic and inflation has exacerbated this issue. For example, the expiration of pandemic-related Supplemental Nutrition Assistance Program (SNAP) emergency allotments in March 2023 has left many households struggling as their benefits were significantly reduced. Rising food prices—up by 9.5% as of early 2023—are putting additional strain on both low- and middle-income families, causing many parents to skip meals to ensure their children are fed.

Virginia has implemented several initiatives to combat this problem, including the "Produce Rx" program, which connects food access with healthcare by providing prescriptions for fresh produce to improve diet-related health outcomes. Additionally, partnerships with local farmers and the "Food is Medicine" initiative are helping provide nutritionally tailored foods through Virginia's food banks, which collectively distributed over 157 million pounds of groceries in 2023.

To address these needs, Virginia advocates are focusing on policy improvements, such as strengthening SNAP benefits, increasing access to school meal programs, and expanding community-based programs that address food security at local levels.

Source: Virginia Roadmap to End Hunger, 2024 Update, https://vplc.org/wp-content/uploads/2024/01/Roadmap-to-End-Hunger_2024-Update_Final.pdf
Food Security in Virginia, Virginia Department of Social Services, https://www.dss.virginia.gov/community/food_security/index.cgi
No Kid Hungry Virginia, Rising Food Prices & Childhood Hunger, https://state.nokidhungry.org/virginia/2023/04/11/food-insecurity-rates-on-the-rise/
Federation of Virginia Food Banks, Hunger in Virginia, https://vafoodbanks.org/about-us/hunger-in-virginia/
Data Retrieved: 10/29/24

FOOD ENVIRONMENT INDEX

The Food Environment Index is a measure that reflects access to affordable and nutritious food within a community. It typically combines data on food insecurity (the percentage of individuals who lack reliable access to sufficient food) and the proximity of households to healthy food outlets, such as grocery stores or supermarkets. A higher index score, ranging from 0 (worst) to 10 (best), indicates better access to food resources and lower levels of food insecurity. The Food Environment Index is often used to evaluate disparities in food access, inform policy decisions, and support interventions aimed at improving public health and reducing food deserts.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/diet-and-exercise/food-environment-index?year=2024
Data Retrieved 10/23/2024

Food Environment Index

Locality	*2019 & 2020*	*2019 & 2021*
Bedford	9.0	9.2
Virginia	8.9	9.0

Table Source: 2023-24 County Health Rankings Report : https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2019 & 2020, 2019 & 2021. Data Retrieved: 06/10/2024; 11/04/2024

The Food Environment in the Bedford Area is slightly higher than the statewide average with a slight increase over the years measured.

PHYSICAL INACTIVITY

Physical inactivity is linked to increased risk of health conditions such as Type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and shortened life expectancy. Physical activity is associated with improved sleep, cognitive ability, bone and musculoskeletal health, and reduced risk of dementia. Physical activity, in addition to diet, is important for the prevention of obesity.

In Virginia, physical activity data by county indicates notable disparities in access to exercise opportunities and levels of physical inactivity. According to County Health Rankings, access to exercise opportunities in Virginia varies, with some counties reporting less than 40% of residents living close to parks or recreational facilities. In contrast, certain counties, particularly in urban areas, report higher access levels, exceeding 80%. These opportunities are defined by proximity to locations like parks or gyms, within a half-mile in urban regions or up to three miles in rural areas. In addition, inactivity rates (i.e., % of adults reporting no leisure-time physical activity) tend to be higher in rural and lower-income counties, where access to exercise facilities is often limited.

These trends underline the importance of both community design and local policy support in promoting physical activity through the availability of accessible, safe, and affordable recreational spaces across all counties. The data also supports targeted interventions in underserved areas to help address these physical activity disparities.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/diet-and-exercise/physical-inactivity?year=2024
Data Retrieved 10/23/2024

% of Adults Reporting No Leisure-Time Physical Activity (Age-Adjusted)

Locality	*2019*	*2020*	*2021*
Bedford	27	19	21
Virginia	25	20	20

Table Source: County Health Rankings Report: 2022-2024 https://www.countyhealthrankings.org/health-data/virginia/data-and-resources
Years Measured: 2019-2021. Data Retrieved: 11/05/2024

The percentage of adults reporting no leisure-time physical activity, age-adjusted, shows a decline and stabilization over time for both Bedford County and Virginia. While Bedford has shown improvement compared to 2019 (27%), its 2021 rate (21%) still slightly exceeds the statewide average (20%).

ALCOHOL AND DRUG USE

Excessive alcohol consumption in Virginia has significant health and social impacts. According to the Centers for Disease Control and Prevention (CDC), excessive drinking—including binge drinking and heavy drinking—leads to numerous health problems such as liver disease, cancer, cardiovascular issues, and unintentional injuries. Excessive alcohol use is also a leading preventable cause of death in the United States, contributing to conditions like alcohol poisoning, motor vehicle crashes, and violence.

Binge drinking is defined as consuming 4 or more drinks on a single occasion for women and 5 or more drinks for men, within 2 hours. Heavy drinking is defined as drinking 8 or more drinks per week for women and 15 or more drinks per week for men. In Virginia, binge drinking rates are a concern, with economic costs resulting from health care expenses, lost productivity, and other related societal burdens. These costs, driven primarily by binge drinking, place a strain on individuals, families, and public resources. Additionally, alcohol misuse is linked to the development of alcohol use disorder (AUD), a condition that affects millions nationwide, disrupting lives and public safety. Efforts to mitigate these impacts include public health campaigns, alcohol policy enforcement, and community programs aimed at promoting awareness and responsible consumption.

Source: US Centers for Disease Control and Prevention, Alcohol Use, https://www.cdc.gov/alcohol/index.html
Source: Virginia Department of Health, https://www.vdh.virginia.gov/
Source: National Institute on Alcohol Abuse and Alcoholism, https://www.niaaa.nih.gov/
Data Retrieved: 12/12/2024

EXCESSIVE DRINKING

% of Adults Reporting Binge or Heavy Drinking (age-adjusted)

Locality	2019	2020	2021
Bedford	19	20	17
Virginia	17	17	18

Table Source: 2022-2024 County Health Rankings Reports : https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2019-2021. Data Retrieved: 05/10/2024

The percentage of adults reporting binge or heavy drinking shows fluctuations in Bedford and Virginia between 2019 and 2021. In Bedford, the rate increased from 19% in 2019 to 20% in 2020 before decreasing to 17% in 2021. In contrast, Virginia's rate remained stable at 17% in 2019 and 2020 but increased slightly to 18% in 2021.

OPIOID OVERDOSE MORTALITY RATES

Since 2021, the opioid crisis has remained a significant public health issue in Virginia, with fentanyl and its analogs being the primary drivers of opioid-related deaths. In 2022, Virginia experienced an opioid-related death rate of approximately 26 per 100,000 residents, underscoring the severity of the epidemic. The Virginia Department of Health and related agencies continue to address this issue through harm reduction strategies, including naloxone distribution and awareness campaigns.

Source: Virginia Department of Health, Overdose Deaths, https://www.vdh.virginia.gov/drug-overdose-data/overdose-deaths/
Data retrieved: 12/12/2024

Opioid Overdose Mortality Rates (per 100,000 Population)

Locality	Mortality Rate (2018)	Mortality Rate (2022)	Change
Bedford	5.1	32.6	27.5

Table Source: Virginia Department of Health - Drug Overdose Data; https://www.vdh.virginia.gov/drug-overdose-data/overdose-deaths/
Data Retrieved: 05/10/2024

Opioid overdose death rates in the Bedford service area were 32.6 per 100,000 representing a change of 27.5 per 100,000 from 2018 to 2022.

SEXUAL ACTIVITY

SEXUALLY TRANSMITTED ILLNESSES

Sexually transmitted illnesses (STIs) reflect patterns of unsafe sexual activity, prevention, and access to care within communities. High STI rates signal risky behaviors like unprotected sex or inadequate screening and highlight gaps in education and healthcare resources. STIs are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, infertility, HIV risk, and premature death. STIs also have a high economic burden on society. Monitoring STI rates helps identify areas for targeted public health interventions to promote healthier behaviors and reduce disparities. Chlamydia and Gonorrhea are two of the most common STIs in the United States and worldwide.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/sexual-activity/sexually-transmitted-infections?year=2024
Source: US Centers for Disease Control and Prevention, Sexually Transmitted Infections (STIs), https://www.cdc.gov/sti/index.html
Data Retrieved 10/23/2024

Chlamydia Diagnoses Rate per 100,000 Population

Locality	*2020*	*2021*	*2022*
Bedford	236.7	211.8	184.7
Virginia	606.3	582.1	593.1

Table Source: Virginia 2022 Annual Morbidity Report- Chlamydia; https://www.vdh.virginia.gov/content/uploads/sites/10/2023/08/Virginia-2022-Annual-Morbidity-Report-Chlamydia.pdf
Data Retrieved: 11/07/2024

The rate of Chlamydia diagnoses in Bedford has progressively declined during the years measured and is significantly lower than state averages over the same time period.

Gonorrhea Diagnoses Rate per 100,000 Population

Locality	*2020*	*2021*	*2022*
Bedford	74.7	77.7	66.1
Virginia	174.1	167.1	155.7

Table Source: Virginia 2022 Annual Morbidity Report Gonorrhea; https://www.vdh.virginia.gov/content/uploads/sites/10/2023/08/Virginia-2022-Annual-Morbidity-Report-Gonorrhea.pdf
Data Retrieved: 11/07/2024

The rate of Gonorrhea diagnoses in Bedford has progressively declined during the years measured and is significantly lower than state averages over the same time period.

HIV

As of December 31, 2023, Virginia reported 27,712 people living with HIV, including 12,150 with AIDS. This is an increase from 22,445 in 2014 and reflects advancements in treatment and care, enabling longer lives for those affected. Males accounted for 75.3% of cases, with the highest prevalence among individuals aged 45 and older. Black/African American individuals were disproportionately affected, representing 56.6% of cases with the highest rates per 100,000 population. Male-to-male sexual contact was the most common transmission risk, followed by heterosexual contact and injection drug use. The Central and Eastern regions had the highest rates. These trends highlight the ongoing need for targeted prevention and care efforts in Virginia.

Source: Virginia Department of Health, People with HIV, https://www.vdh.virginia.gov/content/uploads/sites/10/2024/09/2023-Epi-Profile_PWH.pdf
Data Retrieved: 11/11/2024

Rate of Persons Living with HIV as of December 31, 2023 per 100,000

	HIV only	AIDS	Total
Bedford	57.4	52.4	109.8
Virginia	185.0	144.6	329.6

Definitions: The rate of persons living with HIV as of December 31, 2023.
Table Source: https://www.vdh.virginia.gov/content/uploads/sites/10/2024/08/HIV-AIDS-Annual-Report-2023.pdf

Data Retrieved: 11/11/2024

As of December 31, 2023, the rate of persons living with HIV per 100,000 population in Bedford is 57.4 for HIV-only cases and 52.4 for AIDS cases, with a combined total of 109.8. In comparison, Virginia's rates are significantly higher, with 185.0 for HIV-only cases, 144.6 for AIDS cases, and a combined total of 329.6.

TEEN BIRTH RATE

In 2022, Virginia's teen birth rate for females aged 15–19 was 11.2 births per 1,000, reflecting a significant decline over recent years.

This trend aligns with national decreases in teen births, attributed to factors such as improved access to contraception and comprehensive sex education. Despite the overall decline, disparities persist among different regions and demographic groups within the state. For instance, certain localities report higher rates, and racial and ethnic differences remain evident. Ongoing efforts focus on addressing these disparities through targeted public health initiatives and education programs to further reduce teen pregnancies across all communities in Virginia.

Source: US Center for Disease Control and Prevention, National Center for Health Statistics- Virginia, https://www.cdc.gov/nchs/pressroom/states/virginia/va3.htm
Data retrieved: 12/12/2024

Number of births per 1,000 female population ages 15-19

Locality	Teen Birth Rate	Teen Birth Rate (Black)	Teen Birth Rate (Hispanic)	Teen Birth Rate (White)
Bedford	13	16		13
Virginia	13	Data not available	Data not available	Data not available

Table Source: 2024 County Health Rankings; National Center for Health Statistics; https://www.countyhealthrankings.org/health-data/county-health-rankings-measures
Years Measured: 2016-2022. Data Retrieved: 06/15/2024

The teen birth rate for Black teens in Bedford County (16 per 1,000) is higher than the overall teen birth rate for the county and Virginia as a whole (13 per 1,000). The teen birth rate for White teens in Bedford County (13 per 1,000) is equal to the overall county and state rate. There is a notable disparity between the teen birth rates for Black teens compared to White teens in Bedford County.

Clinical Care

According to County Health Rankings, clinical care accounts for 20% of the factors influencing overall health outcomes. This reflects the significant, though not sole, role of healthcare access and quality in shaping population health, which are key drivers of health outcomes. Indicators like the uninsured rate, provider availability, and preventable hospital stays highlight disparities and barriers to care. By identifying gaps in access and quality, these metrics guide targeted interventions to improve health equity and outcomes. Ensuring access to affordable, effective healthcare is essential for fostering healthier communities.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care
Data Retrieved: 12/12/2024

ACCESS TO CARE

INSURANCE STATUS

In Virginia, health insurance status significantly influences individuals' access to healthcare services. **Uninsured** adults are less likely to have a regular healthcare provider and often forgo necessary medical care due to cost concerns. This lack of insurance correlates with poorer health outcomes and increased financial strain. The Virginia Health Care Foundation reports that 7.7% of Virginians under 65 are uninsured, totaling approximately 544,000 individuals. Among children, 88,000 are uninsured, with 44.3% of them eligible for Medicaid or FAMIS, indicating that nearly half of these uninsured children could have access to coverage but are not enrolled. These statistics underscore the critical role of health insurance in facilitating access to care and highlight the need for initiatives to reduce the number of uninsured Virginians.

Source: Virginia Health Care Foundation, Data- Profile of Virginia's Uninsured, https://www.vhcf.org/data/
Data Retrieved: 12/12/2024

Percentage of Adults Under Age 65 Without Health Insurance

Locality	2019		2020		2021	
	# Uninsured	% Uninsured	# Uninsured	% Uninsured	# Uninsured	% Uninsured
Bedford	4,918	11	4,303	9	4,031	9
Virginia	555,669	11	518,054	10	481,061	9

Percentage of Children Under Age 19 Without Health Insurance

Locality	2019		2020		2021	
	# Uninsured	% Uninsured	# Uninsured	% Uninsured	# Uninsured	% Uninsured
Bedford	815	5	711	4	701	4
Virginia	93,757	5	84,392	4	84,941	4

Table Source: 2022-2024 County Health Rankings, Small Area Health Insurance Estimates, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2019-2021. Data Retrieved: 06/13/2024

The percentage of adults under age 65 and children under age 19 without health insurance in Bedford and Virginia showed improvements in coverage between 2019 and 2021. For adults under 65 in Bedford, the uninsured rate decreased from 11% in 2019 to 9% in 2020 and 2021. For children under age 19 in Bedford, the percentage of uninsured children dropped from 5% in 2019 to 4% in 2020 and 2021. These trends align with the statewide trends and rates over the same time period. These figures indicate progress in expanding health insurance coverage, likely influenced by policy changes during the pandemic's State of Public Health Emergency and/or Medicaid expansion during this period.

Uninsured by Educational Attainment by Locality

Locality	Less than High School Graduate	High School Graduate or Equivalency	Some College or Associate's Degree	Bachelor's Degree or Higher
Bedford	15.0%	9.0%	7.8%	1.8%
Virginia	20.8%	11.5%	7.3%	3.2%

Table Source: US Census, American Fact Finder. American Community Survey 5-Year Estimate, https://factfinder.census.gov
Years Measured: 2018-2022. Data Retrieved: 05/30/2024

The percentage of uninsured individuals by educational attainment in Bedford County and Virginia shows a clear relationship between higher education levels and improved health insurance coverage. In Bedford, 15.0% of those with less than a high school education are uninsured, compared to 9.0% of high school graduates, 7.8% of those with some college or an associate's degree, and just 1.8% of those with a bachelor's degree or higher. Overall, these rates are lower than the statewide averages.

Medicare coverage alone is a critical component of healthcare access in rural Virginia, where a significant portion of the population depends on it, particularly older adults and individuals with disabilities. Rural areas often have higher proportions of Medicare beneficiaries compared to urban regions, reflecting an aging population. Despite this reliance, rural residents frequently face challenges such as limited provider availability and greater travel distances for care. While Medicare ensures access to essential health services, these barriers underscore the need for targeted support and infrastructure improvements to meet the unique healthcare needs of rural Virginians.

Source: Medicare Rights Center, Health Care Access Improving in Rural Areas, Challenges Persist, November 14, 2024,
https://www.medicarerights.org/medicare-watch/2024/11/14/health-care-access-improving-in-rural-areas-challenges-persist
Data Retrieved: 12/12/2024

Population with Medicare Coverage Alone

Locality	Total	Percent of Total Population
Bedford	6105	7.7%
Virginia	446,898	5.3%

Table Source: US Census, American Fact Finder. American Community Survey 5-Year Estimate, ACS PUBLIC HEALTH INSURANCE COVERAGE BY TYPE AND SELECTED CHARACTERISTICS, https://factfinder.census.gov
Years Measured: 2018-2022. Data Retrieved: 05/30/2024

The percent of the population with Medicare coverage alone in Bedford County (7.7%) is higher than the percentage for the entire state of Virginia (5.3%) which reflects in part the aging demographic of the service area.

Between 2018 and 2022 Virginia experienced significant growth in **Medicaid** enrollment, primarily due to the state's expansion of the program in January 2019 and the continuous enrollment provision during the COVID-19 pandemic. In fiscal year 2018, approximately 12.3% of Virginia's population was enrolled in Medicaid. By fiscal year 2023, this proportion had risen to 22.2%, reflecting the combined impact of policy changes and public health measures.

This expansion improved access to healthcare for many Virginians, particularly low-income adults who became newly eligible under the expanded criteria. However, the continuous enrollment provision, which prevented disenrollment during the pandemic, concluded on March 31, 2023. As a result, a gradual decline in enrollment is anticipated as states resume regular eligibility redeterminations.

Overall, the period from 2018 to 2023 marked a substantial increase in Medicaid coverage in Virginia, enhancing healthcare access for a significant portion of the state's population.

Source: Virginia Senate Finance and Appropriations Committee, Medicaid Trends and Health & Human Resources 2025 Session Outlook, November 22, 2024
Source: Kaiser Family Foundation, Analysis of National Trends in Medicaid and CHIP Enrollment During the COVID-19 Pandemic, https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/
Data Retrieved 12/12/2024

Population with Medicaid Coverage Alone

Locality	Total	Percent of Total Population
Bedford	6731	8.5%
Virginia	882,576	10.5%

Table Source: US Census, American Fact Finder. American Community Survey 5-Year Estimate, ACS PUBLIC HEALTH INSURANCE COVERAGE BY TYPE AND SELECTED CHARACTERISTICS, https://factfinder.census.gov
Years Measured: 2018-2022. Data Retrieved: 05/30/2024

A fewer percentage of the population living in Bedford County has Medicaid coverage (8.5%) as compared to the state-level coverage rate in Virginia (10.5%).

In Virginia, **private health insurance** is the primary form of coverage, with around 60.5% of residents enrolled. Most individuals receive coverage through employer-sponsored plans, while others rely on direct-purchase policies or military-related coverage, reflecting the state's large military community. These options ensure access to healthcare for a majority of Virginians.

Source: USAFacts, https://usafacts.org/
Data Retrieved: 12/12/2024

Private Health Insurance Coverage by Type

Locality	Private Health Insurance	Private Insurance that is Employer Based	Private Insurance that is Direct Purchase	Private Insurance that is Tri-Care/Military
Bedford	75.5%	48.3%	6.1%	1.2%
Virginia	74.5%	60.0%	13.0%	7.9%

Table Source: US Census, American Fact Finder. American Community Survey 5-Year Estimate, https://factfinder.census.gov
Years Measured: 2018-2022. Data Retrieved: 05/30/2024

In Bedford County, 75.5% of individuals have private health insurance, which is slightly higher than Virginia's 74.5%. However, the breakdown reveals significant differences in the types of coverage. In Bedford County, 48.3% of individuals have employer-based insurance, compared to 60.0% statewide. Direct purchase insurance in Bedford County is lower at 6.1% compared to Virginia's 13.0%. Similarly, Tri-Care or military-based insurance is far less prevalent in Bedford County at 1.2%, compared to 7.9% statewide.

AVAILABILITY OF CLINICAL CARE

Medically Underserved Areas (MUAs) and **Medically Underserved Populations (MUPs)** are federal designations identifying regions and groups lacking sufficient access to primary healthcare services. MUAs are specific geographic areas, such as counties or urban census tracts, with shortages of primary care providers, high infant mortality rates, elevated poverty levels, or a significant elderly population. MUPs refer to specific populations within a geographic area facing economic, cultural, or linguistic barriers to healthcare, including low-income individuals, migrant farmworkers, and Native American communities. These designations assist in allocating resources and support to improve healthcare access in underserved communities.

Health Professional Shortage Areas (HPSAs) are federal designations used to identify regions, populations, or facilities experiencing shortages of healthcare providers in primary care, dental care, or mental health. HPSA designations are based on criteria such as provider-to-population ratios, poverty levels, and specific needs within the area or population. They can apply to geographic areas, such as rural counties, or to specific groups, like low-income residents or individuals in federally recognized facilities like Federally Qualified Health Centers (FQHCs) and FQHC Look-A-Likes. These designations help prioritize resources, incentivize healthcare providers to work in underserved areas, and support efforts to improve healthcare access.

Source: Us Department of Health and Human Services, Health Professional Shortage Areas and Medically Underserved Areas/Populations Shortage Designation Types, https://www.hhs.gov/guidance/document/hpsa-and-muap-shortage-designation-types
Data Retrieved: 12/12/2024

Medically Underserved Area and Medically Underserved Population Designations

Locality	MUA Designation Type	Score	Update Date
Bedford County (part – Big Island)	Medically Underserved Area	60.6	11/4/2011

Tables Source: Health Resources Services and Administration , https://data.hrsa.gov/tools/shortage-area/hpsa-find
Data Retrieved: 07/25/2024

The Big Island portion of Bedford County is designated as a Medically Underserved Area.

Primary Care

Locality	HPSA Designation Type	Score	Update Date
Bedford County	Geographic HPSA	7	4/25/2022

Dental Health

Locality	HPSA Designation Type	Score	Update Date
Bedford County	High Needs Geographic HPSA	10	9/25/2023

Mental Health

Locality	HPSA Designation Type	Score	Update Date
Bedford County*	Low Income Population	16	9/12/2021

**Bedford County is included with Amherst, Appomattox, and Campbell counties, and Lynchburg City.*
Table Source: Health Resources & Services Administration, https://data.hrsa.gov/tools/shortage-area/mua-find
Data Retrieved: 07/25/2024

Bedford County is designated as a Health Professional Shortage Area for Primary Care, Dental and Mental Health. These designations reflect persistent shortages impacting underserved populations throughout the region.

Centra Health is the largest health system serving those living in these Medically Underserved and Health Professional Shortage Areas. Additional safety net providers in the area include Federally Qualified Health Centers (Community Access Network and Johnson Health Center), a Free Clinic (Free Clinic of Central Virginia), Community Services Boards (Horizon Behavioral Health), and public health departments (Central Virginia Health District). Free Clinics in Virginia provide services at no cost or low cost to low-income uninsured and publicly insured patients. Community Services Boards are the points of entry for publicly funded mental health, substance use disorder, and developmental services for intellectual disabilities and/or developmental disabilities.

AVAILABILITY OF PROVIDERS

The provider-to-population ratio quantifies the number of healthcare providers relative to the population size, serving as a key indicator of healthcare accessibility within a community. For instance, a ratio of 2,500:1 signifies that one primary care physician is available for every 2,500 individuals in a given area. This ratio is crucial because a lower provider-to-population ratio generally correlates with better access to healthcare services, leading to improved health outcomes. Conversely, higher ratios can indicate potential shortages of healthcare providers, which may result in longer wait times, reduced access to preventive care, and overall poorer health outcomes. Monitoring the provider-to-population ratio helps identify regions that may require additional healthcare resources to ensure equitable access to care for all populations.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/primary-care-physicians
Data Retrieved: 12/12/2024

Primary Care Provider to Population Ratio

Locality	2019	2020	2021
Bedford	1274:1	1287:1	1336:1
Virginia	1310:1	1324:1	1341:1

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources
Years Measured: 2019-2021. Data Retrieved: 09/13/2024

The trend in Bedford County shows that primary care access has slightly deteriorated, with an increased ratio of the population to one provider each year.

Dental Provider to Population Ratio

Locality	2020	2021	2022
Bedford	2956:1	2862:1	2994:1
Virginia	1393:1	1351:1	1329:1

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources
Years Measured: 2020-2022. Data Retrieved: 09/13/2024

The service area's ratio is significantly higher than Virginia's statewide average, indicating that dental care is less accessible in Bedford.

Mental Health Provider to Population Ratio

Locality	2021	2022	2023
Bedford	1287:1	1041:1	879:1
Virginia	484:1	447:1	411:1

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources
Years Measured: 2021-2023. Data Retrieved: 09/13/2024

Both Bedford and Virginia statewide show a steady improvement in the mental health provider to population ratio over the 3-year period. However, the rate in the County is more than double the rate in Virginia.

QUALITY OF CARE

The preventable hospitalization rate per 100,000 among the Medicare population measures the frequency of hospital admissions for conditions that could typically be managed with effective outpatient care, known as ambulatory care-sensitive conditions. This metric serves as an indicator of the accessibility and quality of primary healthcare services; higher rates suggest potential deficiencies in outpatient care, leading to unnecessary hospitalizations.

Primary care plays a critical role in reducing preventable hospitalization rates by offering timely, effective management of ambulatory care-sensitive conditions, such as asthma, diabetes, and hypertension. Access to robust primary care enables early detection, consistent monitoring, and treatment of these conditions, reducing the likelihood of complications that necessitate hospital admissions. Research shows that communities with higher primary care provider density have significantly lower rates of preventable hospitalizations. For example, a study by the Agency for Healthcare Research and Quality (AHRQ) found that improving primary care access and continuity can reduce hospital admissions for preventable conditions by up to 20%. Conversely, areas with limited access to primary care often experience higher preventable hospitalization rates due to delayed treatment and inadequate disease management.

In Virginia, investments in primary care infrastructure have contributed to favorable trends in reducing these hospitalizations, positioning the state among the better-performing states for Medicare beneficiaries. Strengthening primary care services remains essential for improving healthcare outcomes and reducing costs associated with unnecessary hospitalizations.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/quality-of-care/preventable-hospital-stays
Source: Agency for Healthcare Research and Quality, https://www.ahrq.gov/
Data Retrieved: 12/12/2024

According to County Health Rankings, physical environment accounts for 10% of the factors influencing overall health outcomes. This component evaluates how the surroundings where individuals live, learn, work, and play impact their health. This assessment includes factors such as air and water quality, housing conditions, and transportation systems. For instance, exposure to air pollutants like fine particulate matter can lead to respiratory and cardiovascular issues, while contaminated water sources may cause various illnesses. Additionally, inadequate housing and limited access to transportation can hinder individuals from obtaining necessary healthcare services and nutritious food. By analyzing these elements, the Rankings aim to highlight environmental determinants that influence community health outcomes.

AIR AND WATER QUALITY

AIR QUALITY

Virginia's air quality has improved in recent years, with most areas meeting the National Ambient Air Quality Standards (NAAQS) for pollutants such as fine particulate matter ($PM_{2.5}$), nitrogen dioxide (NO_2), carbon monoxide (CO), and ozone as of 2022. However, in 2023, the state experienced air quality challenges due to external factors, notably the impact of forest fires from outside Virginia, including those in Canada, which affected air quality during the summer months.

The Department of Environmental Quality (DEQ) monitors air quality across the state and provides daily forecasts for regions including Richmond, Norfolk, Roanoke, Winchester, and Northern Virginia. These forecasts help residents plan activities, especially during periods when air quality may pose health risks. Overall, while Virginia has made significant strides in improving air quality, ongoing efforts are necessary to address localized pollution sources and mitigate impacts from external environmental events.

Air pollution-particulate matter, often measured as $PM_{2.5}$, represents the concentration of fine inhalable particles with diameters of 2.5 micrometers or smaller in the air. This metric captures pollution from various sources, including vehicle emissions, industrial processes, construction dust, and wildfires. $PM_{2.5}$ is significant because its small size allows it to penetrate deeply into the lungs and enter the bloodstream, contributing to health issues such as respiratory and cardiovascular diseases, premature death, and aggravated asthma. This allows for the assessment of community exposure to air quality and great health risks, especially for vulnerable populations like children, the elderly, and those with preexisting health conditions.

On February 7, 2024, the U.S. Environmental Protection Agency (EPA) strengthened the National Ambient Air Quality Standards for Particulate Matter (PM NAAQS) to protect millions of Americans from harmful and costly impacts on health. Particle or soot pollution is one of the most dangerous forms of air pollution. The EPA is setting the level of the primary (health-based) annual PM2.5 standard at 9.0 micrograms per cubic meter to provide increased public health protection. These standards are outlined under the Clean Air Act.

Source: Reports to the General Assembly, RD809- Air Quality and Air Pollution Control Policies of the Commonwealth of Virginia- December 2023 https://rga.lis.virginia.gov/Published/2023/RD809
Source: Virginia Department of Health, DEQ, Air Quality Forecasting, Public Health Preparedness Planning and Response, October 24, 2023, https://www.vdh.virginia.gov/content/uploads/sites/8/2023/10/VDEQ_AirQualityForecasting_2023Oct24_update.pdf
Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/air-and-water-quality/air-pollution-particulate-matter
Source: US Environmental Protection Agency, https://www.epa.gov/pm-pollution/national-ambient-air-quality-standards-naaqs-pm
Data Retrieved: 12/12/2024

Air Pollution- Particulate Matter

Locality	Average Daily Density of Fine Particulate Matter (micrograms/cubic meters)
Bedford	7.6
Virginia	7.3

Table Source: 2024 County Health Rankings, Environmental Public Health Tracking Network, https://www.countyhealthrankings.org/health-data/virginia?year=2024
Year Measured: 2019. Data Retrieved: 11/07/2024

In Bedford County, the average daily density of fine particulate matter ($PM_{2.5}$) is 7.6 micrograms per cubic meter, slightly higher than Virginia's statewide average of 7.3 however both are relatively low compared to national standards.

WATER QUALITY

In Virginia, drinking water violations occur when public water systems fail to meet health-based standards under the Safe Drinking Water Act, such as exceeding contaminant limits, improper treatment processes, or inadequate monitoring and reporting. These violations are overseen by the Virginia Department of Health's Office of Drinking Water to protect public health. Efforts focus on ensuring compliance and maintaining safe, clean drinking water for residents.

Source: Virginia Department of Health, Drinking Water, https://www.vdh.virginia.gov/drinking-water/office-of-drinking-water/compliance/penalties/
Data Retrieved: 12/12/2024

Drinking Water Violations

Locality	Presence of health-related drinking water violations
Bedford	No

Table Source: 2024 County Health Rankings, Safe Drinking Water Information System, https://www.countyhealthrankings.org/health-data
Year Measured: 2022. Data Retrieved: 11/07/2024

In 2022, there were no reported health-related drinking water violations in Bedford County.

Virginia Health Catalyst advocates for **community water fluoridation (CWF)** as a safe, cost-effective public health measure that reduces cavities by approximately 25% in both children and adults. By adjusting fluoride levels in public water supplies to the optimal amount of 0.7 milligrams per liter, CWF ensures equitable access to preventive dental care across communities, regardless of income or education levels. This practice not only decreases dental decay but also translates into economic benefits, with communities saving an average of $32 per person annually in dental costs. For populations of 1,000 or more, the return on investment can be as high as $20 for every $1 spent on fluoridation. Virginia Health Catalyst collaborates with the Virginia Department of Health and other partners to maintain and promote fluoridation practices, aiming to enhance oral health outcomes statewide.

Source: Virginia Health Catalyst, Community Water Fluoridation and Drinking Water, https://vahealthcatalyst.org/community-water-fluoridation/
Data Retrieved: 12/12/2024

Water Fluoride Levels

Public Water System Name	County	Population Served	Fluoridated	Fluoride Conc. (mg/l)
Harbor Ridge Homeowner's Association	Bedford	28	No	0.2
Hardy Road Trailer Park, Section 2	Bedford	187	No	0.2
Hillcrest Mobile Home Park	Bedford	51	No	0.47
Montvale Water, Inc	Bedford	654	No	0.3
Mountain View Shores	Bedford	459	No	0.1
Paradise Point Estates	Bedford	56	No	0
Ridgeview Valley	Bedford	120	No	0.2
Smith Mountain Lake Central Water System	Bedford	0	No	0.1
Stallion Run Estates	Bedford	33	No	0.2
Stewartsville Consecutive	Bedford	318	Yes	0.7
Timber Ridge Subdivision	Bedford	103	No	0.2
Twin Oaks Trailer Park	Bedford	47	No	0.2
Valley Mills Crossing	Bedford	66	No	0.03
Virginia Ridge	Bedford	169	Yes	1.84
Woodhaven Nursing Home	Bedford	70	No	0.2

Table Source: Centers for Disease Control and Prevention. My Water's Fluoride: https://nccd.cdc.gov/DOH_MWF/Default/WaterSystemDetails.aspx
Years Measured: 2022. Data Retrieved: 06/28/2024

The data on water fluoride levels in Bedford County's public water systems highlights varying concentrations of fluoride and limited fluoridation across the systems. Stewartsville Consecutive and Virginia Ridge are the only systems that are fluoridated, with fluoride concentrations of 0.7 mg/L and 1.84 mg/L, respectively. The remaining systems are not fluoridated, with fluoride concentrations ranging from 0.0 mg/L to 0.47 mg/L. Disparities in fluoridation coverage suggest a need for expanded efforts to promote water fluoridation across more communities to improve oral health outcomes.

HOUSING AND TRANSIT

Housing significantly impacts health by influencing physical, mental, and social well-being. Poor housing conditions, such as inadequate ventilation, mold, or pest infestations, can contribute to respiratory illnesses, allergies, and infectious diseases. Overcrowding increases the risk of communicable diseases, while unaffordable housing may force families to prioritize rent over essentials like food and healthcare, exacerbating chronic conditions. Stable, safe, and affordable housing improves health outcomes by reducing stress, enhancing access to healthcare, and fostering community stability. Addressing housing disparities is critical for improving public health.

The Central Virginia Continuum of Care (CVCoC) serves the city of Lynchburg and the counties of Amherst, Appomattox, Bedford and Campbell. The CVCoC addresses homelessness by fostering collaboration among nonprofits, agencies, congregations, and individuals to provide safe, stable, and affordable housing. Through a community-based approach, the CVCoC coordinates programs and activities aimed at identifying and addressing the needs of homeless individuals, particularly those who are disadvantaged, disabled, or in need of supportive services. This work is supported by HUD funding, as well as other public and private resources. A key strategy employed by the CVCoC is the annual Point-in-Time (PIT) count, a federally mandated snapshot of the homeless population on a specific night. The 2024 PIT Count identified 147 individuals experiencing homelessness, including 73 unsheltered individuals and 7 chronically homeless individuals. Since 2017, homelessness in the region has increased by 18%, with unsheltered homelessness rising by 192%. These findings guide the CVCoC's initiatives, such as housing-first programs, case management, and community outreach, which aim to reduce homelessness and promote long-term stability.

Homelessness prevention remains a priority of the CVCoC, with efforts focused on eviction prevention and strengthening partnerships across sectors. The only emergency shelters in the region are in the city of Lynchburg. Shelter capacity has been a significant challenge since 2021, following the closure of the Hand Up Lodge and the reduction of beds at the Salvation Army's Center of Hope, which resulted in a 42% decrease in available beds. Despite initiatives like Miriam's House's hotel-based emergency shelter and the opening of the 16-bed Shelter at Reset in 2022, unsheltered homelessness continues to surge. In early 2024, Roads to Recovery announced plans to close The Shelter at Reset, prompting the CVCoC to solicit a new shelter provider. The Ramp, a local church, was selected to open The Refuge on Memorial, a 50-bed low-barrier shelter for individuals and families, scheduled to open in December 2024. This development aims to address the ongoing shelter gap and provide accessible support for those experiencing homelessness.

Beginning in the winter of 2021-2022, warming shelters have provided shelter during cold temperatures in the winter at St. John's Episcopal Church, Bedrock Church, and New Life Baptist Church located in the town of Beford. Bedford Presbyterian Church has provided shelter guests a place to take a shower and wash their laundry. Main Street Methodist and St. John's participate in a food ministry for the guests. From December 22 to March 20, 2024, people were given shelter 87 times and 21 volunteers stayed overnight at the shelters for a total of 98 times. Thirteen individuals stayed overnight as guests with 10 from the Bedford Area, one from Vinton, Virginia, one from Georgia and one from an unknown location.

Source: US Center for Disease Control and Prevention, Health Topics, https://www.cdc.gov/
Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/housing-and-transit?year=2024
Source: Central Virginia Continuum of Care https://centralvirginiacoc.org/point-in-time
Data Retrieved: 12/16/2024
Source: St. John's Episcopal Church, Warming Shelter by the Numbers, emailed May 2, 2024

Severe housing cost burden measures the percentage of households spending 50% or more of their income on housing-related expenses, including rent, mortgage payments, utilities, and taxes. This metric highlights financial strain that limits resources for essentials such as food, healthcare, and education, adversely affecting health and well-being. Communities with high rates of severe housing cost burden often experience increased rates of poverty, homelessness, and poor health outcomes. Tracking this measure helps identify areas needing affordable housing solutions and economic support.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/housing-and-transit/severe-housing-cost-burden?year=2024
Source: US Department of Housing & Urban Development's Office of Policy Development & Research, HUD User, https://www.huduser.gov/portal/home.html
Data Retrieved 12/13/2024

Severe Housing Cost Burden

Locality	# Households with Severe Cost Burden	% Households with Severe Cost Burden
Bedford	2476	8%
Virginia	406,590	13%

Table Source: US Census. American Fact Finder. 2018 - 2022 American Community Survey 5-Year Estimates. Data Retrieved: 04/04/2024

In Bedford County, only 8% of households experience severe housing cost burden as compared to 13% of households statewide.

The percentage of households with housing problems measures the proportion of homes facing at least one of four key issues: overcrowding, high housing costs (spending over 30% of income on housing), lack of kitchen facilities, or lack of plumbing. This metric provides insight into housing quality and affordability, which are critical for health and well-being. Households with these problems are more likely to experience stress, poor living conditions, and barriers to health equity.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/housing-and-transit/severe-housing-problems?year=2024
Data Retrieved: 12/12/2024

Percentage of Households with Housing Problems

Locality	2014-2018	2015-2019	2016-2020
Bedford	8%	8%	8%
Virginia	14%	14%	14%

Table Source: 2022-2024 County Health Rankings, Comprehensive Housing Affordability Strategy data; https://www.countyhealthrankings.org/health-data
Years Measured: 2014-2018, 2015-2019, 2016-2020
Data Retrieved: 04/24/2024

For the years measured, the percentage of households with housing problems in Bedford County (8%) and Virginia (14%) have remained steady with more households facing housing problems in the state.

Expanding broadband access in Virginia is essential for enhancing education, healthcare, and economic development, particularly in underserved rural areas. High-speed internet enables online learning, supports telemedicine services, and fosters business growth by connecting communities to global markets. Recognizing these benefits, Virginia has invested significantly in broadband infrastructure which is crucial for bridging the digital divide and ensuring equitable access to information and opportunities across the state.

From 2021 to 2024, Virginia made significant strides in broadband expansion, aiming for universal coverage by 2028. A $2 billion initiative announced in 2021, supported by the Virginia Telecommunication Initiative (VATI), extended broadband to unserved areas. In 2024, $41 million in VATI grants targeted over 12,000 connections. Despite progress, challenges like delays in utility pole attachments and updated mapping revealing more unserved areas slowed some projects. Federal funding, including $1.48 billion from the federal Broadband Equity, Access, and Deployment (BEAD) program, is supporting ongoing efforts to bridge the digital divide and achieve reliable high-speed internet access for all Virginians.

Source: Virginia Mercury, Virginia plan projects universal broadband access by 2028, https://virginiamercury.com/2023/09/06/virginia-plan-projects-universal-broadband-access-by-2028/
Source: Virginia Department of Housing & Community Development, https://www.dhcd.virginia.gov/broadband
Source: Virginia Business, https://virginiabusiness.com/?s=broadband+expansion
Data Retrieved: 12/13/2024

Percentage of Households with Broadband Internet Connection

Locality	2017-2021	2018-2022
Bedford	83%	85%
Virginia	88%	89%

Table Source: 2023-2024 County Health Rankings, American Community Survey, 5-year estimates; Report : https://www.countyhealthrankings.org/health-data/virginia/data-and-resources. Years Measured: 2017-2021; 2018-2022. Data Retrieved: 11/08/2024

The percentage of households with broadband internet connection in Bedford increased from 83% during 2017-2021 to 85% during 2018-2022. While this shows improvement, Bedford still lags behind the statewide average in Virginia, where broadband access increased from 88% to 89% over the same periods. This gap highlights ongoing disparities in digital connectivity, which could impact access to education, employment opportunities, and other essential online services in Bedford.

Transit measures evaluate access to and use of public transportation systems, focusing on their availability and impact on community health. Access to reliable transit improves access to jobs, healthcare, and essential services, reducing transportation barriers and promoting equity. These measures help identify areas needing investment to enhance connectivity and reduce social and economic disparities.

The Bedford area offers critical transit options to support its rural communities, despite limited public transportation. The Otter Bus, launched as a pilot project in 2021 and funded by the Bedford Community Health Foundation (BCHF), provides essential connections to work, healthcare, and shopping. With funding from the Virginia Department of Rail and Public Transportation (DRPT), the Otter Bus expanded its service schedule and continues to address transportation gaps. Bedford Ride also plays a vital role, offering volunteer-based transportation for older adults and persons with disabilities residing in Bedford County and the Town of Bedford. Meanwhile, efforts to enhance regional connectivity are advancing with plans for a Bedford Amtrak stop. Supported by Norfolk Southern Railway assessments and a $1.48 million federal grant for preliminary engineering, the proposed station would link Bedford to Roanoke, Lynchburg, Washington, D.C., and the Northeast Corridor.

Source: Otter Bus, https://otterbus.com/
Source: Bedford Ride, https://bedfordride-cvacl.org/
Source: Cardinal News, Bedford gets funding for preliminary engineering on proposed Amtrak stop, https://cardinalnews.org/2024/10/28/bedford-gets-funding-for-preliminary-engineering-on-proposed-amtrak-stop-more/
Data Retrieved: 12/17/2024

The American Community Survey (ACS) measures "commuting patterns by county of residence" to analyze how residents travel to work. This includes modes of transportation (e.g., car, public transit, walking, biking), average travel time, and carpooling rates. It also identifies commuting flows, such as the number of residents working within or outside their county. These patterns provide insights into infrastructure needs, economic activity, and environmental impacts, helping policymakers improve transportation planning, reduce commute times, and enhance regional connectivity.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024. https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/housing-and-transit/severe-housing-problems?year=2024
Source: US Census Bureau, Measuring America's People, Places, and Economy, https://www.census.gov/
Data Retrieved: 12/12/2024

Commuting Patterns by County of Residence

Locality	Worked in county of residence	Worked outside county of residence
Bedford	41.6%	57.3%
Virginia	57.3%	37.0%

Table Source: U.S. Census, American Community Survey, COMMUTING CHARACTERISTICS BY SEX, Table S0801, 5 Year Estimates. https://data.census.gov/ Years Measured: 2018-2022. Data Retrieved: 06/10/2024

The commuting patterns in Bedford show a heavy reliance on external employment, with 57.3% working outside the county compared to Virginia's 37.0%. Only 41.6% of Bedford residents work locally, far below the state average of 57.3%, highlighting a lack of local job opportunities or a draw to nearby areas.

HEALTH OUTCOMES

"Health Outcomes" measure the overall health of a community by assessing key indicators of length and quality of life. Length of life is evaluated using premature death rates (deaths before age 75), while quality of life considers factors like self-reported health status, physical and mental health days, and the prevalence of low birthweight. Both length of life and quality of life impact Health Outcomes by 50%. These outcomes highlight disparities and help identify areas needing targeted public health interventions to improve community health and equity.

Length of Life

LIFE EXPECTANCY

Life expectancy measures the average number of years a person is expected to live based on current mortality rates. It reflects overall health and well-being in a population, influenced by factors like access to healthcare, socioeconomic conditions, lifestyle behaviors, and environmental factors. Tracking life expectancy helps identify health disparities and evaluate the effectiveness of public health policies and interventions.

Race and ethnicity significantly impact life expectancy due to systemic inequities in healthcare access, socioeconomic status, living conditions, and exposure to stressors. Historical and structural disparities often lead to higher rates of chronic illnesses, limited access to preventive care, and differential treatment within healthcare systems among racial and ethnic minorities. For example, in the United States, Black Americans and Native Americans generally have lower life expectancies than White Americans, while Hispanic Americans often exhibit a longer life expectancy despite facing socioeconomic disadvantages—a phenomenon known as the "Hispanic paradox." Addressing these disparities requires targeted interventions to promote equity in healthcare, education, and economic opportunities.

Source: US Center for Disease Control and Prevention, Health Topics, https://www.cdc.gov/
Source: Kaiser Family Foundation, https://www.kff.org/
Data Retrieved: 12/12/2024

Life Expectancy by Average Number of Years Lived 2022-2023 County Health Rankings Years Measured: 2018-2020

Locality	All Populations	Black	Hispanic	White
Bedford	79.1	77.3	98.9	79.0
Virginia	79.1	75.6	87.4	79.1

Life Expectancy by Average Number of Years Lived 2022-2023 County Health Rankings Years Measured: 2019-2021

Locality	All Populations	Black	Hispanic	White
Bedford	77.8	76.4	106.3	77.6
Virginia	78.1	Not available	Not available	Not available

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2018-2020; 2019-2021. Data Retrieved: 11/10/2024

The analysis of life expectancy trends between 2018–2020 and 2019–2021 shows a decline across most populations in Bedford, likely due to the COVID-19 pandemic. Life expectancy for all populations fell from 79.1 to 77.8 years, with the Black population decreasing from 77.3 to 76.4 years and the White population from 79.0 to 77.6 years. The Hispanic population saw an unusual increase from 98.9 to 106.3 years. Statewide, life expectancy for all populations declined from 79.1 to 78.1 years, though updated racial/ethnic data was not available for comparison in the 2024 report.

DEATH RATES

As of 2022, the leading causes of death in Virginia were:

1. **Heart Disease**
2. **Cancer**
3. **Accidents** (Unintentional Injuries)
4. **COVID-19**
5. **Cerebrovascular Diseases** (Stroke)

These top five causes accounted for 57% of all deaths in the state. As of this writing, this data for Virginia in 2023 is unavailable.

Nationally, in 2023, the leading causes of death were:

1. **Heart Disease**
2. **Cancer**
3. **Unintentional Injuries**
4. **Chronic Lower Respiratory Diseases**
5. **Stroke** (Cerebrovascular Diseases)

Notably, COVID-19, which was the fourth leading cause of death in 2022, became the tenth leading cause in 2023, accounting for 1.6% of all deaths.

These statistics highlight the significant impact of chronic diseases and accidents on mortality rates both in Virginia and across the United States.

Source: USAFACTS, What are the leading causes of death in Virginia?, July 19, 2024, https://usafacts.org/answers/what-are-the-leading-causes-of-death-in-the-us/state/virginia/
Source: Centers for Disease Control and Prevention, Mortality in the United States-Provisional Data, 2023, https://www.cdc.gov/mmwr/volumes/73/wr/mm7331a1.htm
Data Retrieved: 12/13/2024

Deaths per 100,000 Population Rate by Race

Locality	*2020*			
	Total	*White*	*Black*	*Other*
Bedford	12	12.1	13.4	1.4
Virginia	9.4	9.9	9.5	4.6

Table Source: Virginia Department of Health, Division of Health Statistics, https://www.vdh.virginia.gov/data/
Data Retrieved: 11/10/2024

It is important to note that this data represents the most recent figures available for 2020. Death rates in Bedford exceeded Virginia's statewide average of 9.4 per 100,000, with significant racial disparities. The White population had a rate of 12.1, and the Black population experienced an even higher rate of 13.4, both above state averages. In contrast, the Other population had a significantly lower rate of 1.4, compared to Virginia's 4.6. These trends, occurring during the COVID-19 pandemic, highlight persistent health disparities likely influenced by healthcare access and other social determinants.

Premature Age Adjusted Mortality Rates per 100,000 Population by Race 2018-2020

Locality	All Populations	Black	Hispanic	White
Bedford	329.5	417.2	Not available	332.6
Virginia	334.9	474.8	181.1	328.6

Premature Age Adjusted Mortality Rates per 100,000 Population by Race 2019-2021

Locality	All Populations	Black	Hispanic	White
Bedford	362.2	419.8	Not available	370.1
Virginia	361.9	Not available	Not available	Not available

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2018-2020; 2019-2021. Data Retrieved: 11/10/2024

Premature mortality rates in Bedford increased between 2018–2020 and 2019–2021, reflecting the impacts of the COVID-19 pandemic. Rates for all populations rose from 329.5 to 362.2 per 100,000, with the Black population seeing a slight increase from 417.2 to 419.8 and the White population rising from 332.6 to 370.1. These trends underscore persistent health disparities and the need for targeted public health efforts to address underlying social and healthcare inequities.

"Deaths due to injury" encompass fatalities resulting from both unintentional and intentional injuries. Unintentional injuries include incidents such as motor vehicle crashes, falls, drownings, and poisonings. Intentional injuries involve deliberate acts like homicide and suicide. These injuries can lead to immediate death or result in complications that cause death later. Tracking injury-related deaths helps identify public health priorities and develop prevention strategies.

In Virginia, injury-related death rates exhibit notable differences between urban and rural areas. Nationally, rural regions experience higher unintentional injury death rates compared to urban areas, a trend that is also observed within the state. Factors contributing to this disparity include limited access to trauma care, higher prevalence of high-risk occupations, and increased rates of behaviors such as impaired driving and lower seatbelt use in rural communities. Additionally, rural areas often face challenges like longer emergency response times and greater distances to healthcare facilities, which can exacerbate injury outcomes.

Source: World Health Organization, Injuries and violence, https://www.who.int/news-room/fact-sheets/detail/injuries-and-violence
Source: Rural Health Information Hub, Unintentional Injury in Rural Areas, https://www.ruralhealthinfo.org/toolkits/unintentional-injury/1/rural-issues
Data Retrieved: 12/13/2024

Number of Deaths due to Injury per 100,000 Population

Locality	2016-2020	2017-2021
Bedford	83.6	90
Virginia	67.9	71.8

Table Source: 2022-2024 County Health Rankings,
https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2016-2020; 2017-2021. Data Retrieved: 11/10/2024

Injury-related death rates in Bedford increased from 83.6 per 100,000 in 2016–2020 to 90.0 in 2017–2021, consistently exceeding Virginia's state average, which rose from 67.9 to 71.8. This trend highlights a growing concern for injury-related mortality in the locality.

Virginia has experienced fluctuations in **suicide rates,** with a general upward trend over the past few years. In 2021, the age-adjusted suicide rate was 13.3 per 100,000 people, marking a 22% increase over two decades. In Virginia, suicide rates vary significantly across demographic groups. Males are disproportionately affected, accounting for approximately 77% of suicide deaths. Individuals aged 45 and older represent 54% of suicide deaths, with notable increases among those aged 15–24 and 35–44. White, non-Hispanic individuals constitute 85% of suicide deaths, with rates over three times higher than Black, non-Hispanic individuals and twice that of Hispanic/Latinx individuals. Rural areas, particularly in the Southwest region of Virginia, experience higher suicide rates compared to urban localities. Factors contributing to elevated rates in rural areas include limited access to mental health services, greater social isolation, economic challenges, and higher prevalence of firearm ownership. Addressing these issues is crucial for effective suicide prevention in Virginia's rural communities.

Source: Virginia Department of Health, Suicide and Self-Harm in Virginia, July 2020, https://www.vdh.virginia.gov/content/uploads/sites/179/2020/08/Suicide-and-Self-Harm-in-Virginia.pdf

Number of Deaths & Rates due to Suicide per 100,000 Population (Age-adjusted)

Locality	2016-2020		2017-2021	
	Number of Deaths	Suicide Rate	Number of Deaths	Suicide Rate
Bedford	76	18.4	80	18.7
Virginia	5921	13.4	5944	13.4

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2016-2020; 2017-2021. Data Retrieved: 11/20/2024

Suicide rates in Bedford remained consistently higher than Virginia's average of 13.4 per 100,000 from 2016–2020 to 2017–2021, rising slightly from 18.4 to 18.7. The number of deaths increased from 76 to 80, underscoring the need for enhanced suicide prevention efforts in the locality.

Heart disease and **stroke** are top causes of death in Virginia. **Hypertension** is often a contributor to these chronic diseases as are certain health behaviors including poor diet, inactivity, smoking and excessive drinking.

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

Locality	2018-2020		
	Total	White	Black
Bedford	86.8	86.8	108.8
Virginia	74.1	72.7	101.8

Table Source: CDC. Interactive Atlas of Heart Disease and Stroke. https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx
Years Measured: 2018-2020. Data Retrieved: 07/11/2024

Stroke death rates among individuals aged 35+ in Bedford were higher than Virginia's average of 74.1 per 100,000 from 2018–2020, with Bedford at 86.8. Black residents experienced the highest rates at 108.8, compared to 86.8 among Whites. Statewide, Black populations also had elevated rates at 101.8.

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

Locality	2018-2020		
	Total	White	Black
Bedford	286.3	292.4	344.8
Virginia	289.7	291.5	365.6

Table Source: CDC. Interactive Atlas of Heart Disease and Stroke. https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx
Years Measured: 2018-2020. Data Retrieved: 07/11/2024

Heart disease death rates for individuals aged 35+ in Bedford between 2018–2020 were 286.3 per 100,000, slightly below Virginia's average of 289.7. The rate for White residents in Bedford was 292.4, similar to the state average of 291.5, while the Black population had a higher rate of 344.8, though still below Virginia's Black population rate of 365.6.

Hypertension Death Rate Age 35+ per 100,000, All Races/Ethnicities

Locality	2018-2020
Bedford	186.7
Virginia	193.7

Table Source: CDC. Interactive Atlas of Heart Disease and Stroke.
https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx
Years Measured: 2018-2020. Data Retrieved: 02/20/2024

The hypertension death rate for individuals aged 35+ in Bedford between 2018–2020 was 186.7 per 100,000, slightly below the Virginia average of 193.7. While Bedford's rate is lower, hypertension remains a significant health concern, highlighting the need for continued prevention and management efforts in the locality.

HEALTH STATUS

"Persons reporting being in poor or fair health by percent" measures the proportion of adults who self-rate their health as poor or fair, providing insight into general health perceptions and disparities within a population. "Physically unhealthy days reported in the past 30 days (age-adjusted)" tracks the average number of days adults experience physical health issues, while "Mentally unhealthy days reported in the past 30 days (age-adjusted)" captures days of poor mental health, reflecting overall well-being. These indicators help identify community health needs and areas for targeted intervention.

Source: The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2024.
https://www.countyhealthrankings.org/health-data/health-outcomes/quality-of-life/poor-or-fair-health?year=2024
Data Retrieved: 12/12/2024

Persons Reporting Being in Poor or Fair Health by Percent

Locality	2019	2020	2021
Bedford	16	12	14
Virginia	16	12	14

Table Source: 2022-2024 County Health Rankings,
https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2019-2021. Data Retrieved: 11/20/2024

The percentage of persons reporting being in poor or fair health in Bedford mirrored statewide trends from 2019 to 2021. Bedford's rates declined from 16% in 2019 to 12% in 2020, before rising slightly to 14% in 2021, aligning exactly with Virginia's statewide percentages during the same period. These trends reflect broader health patterns likely influenced by the COVID-19 pandemic.

The Centers for Disease Control and Prevention (CDC) utilize the **"Healthy Days"** measures to assess health-related quality of life, including the number of physically and mentally unhealthy days reported within the past 30 days. These measures provide insight into the burden of physical and mental health issues within a population. According to the CDC, individuals reporting 14 or more mentally unhealthy days in the past 30 days are considered to be experiencing frequent mental distress, indicating more severe or persistent mental health problems.

Similarly, reporting 14 or more physically unhealthy days suggests frequent physical distress, reflecting significant physical health challenges.

Source: US Centers for Disease Control and Prevention, Health Status,
https://www.cdc.gov/places/measure-definitions/health-status.html
Data Retrieved: 12/12/2024

Physically Unhealthy Days Reported in the Past 30 Days (Age-adjusted)

Locality	2019	2020	2021
Bedford	3.8	2.8	3.6
Virginia	3.7	2.7	3.2

Table Source: 2022-2024 County Health Rankings,
https://www.countyhealthrankings.org/health-data/virginia/data-and-resources.
Years Measured: 2019-2021. Data Retrieved: 11/10/2024

The average number of physically unhealthy days reported in the past 30 days in Bedford showed slight fluctuations between 2019 and 2021. Bedford's rate decreased from 3.8 days in 2019 to 2.8 in 2020 but rose to 3.6 in 2021. These trends closely mirrored Virginia's statewide averages, which dropped from 3.7 days to 2.7 in 2020 before increasing to 3.2 in 2021.

Mentally Unhealthy Days Reported in the Past 30 Days (Age-adjusted)

Locality	2019	2020	2021
Bedford	4.6	4.3	5.1
Virginia	4.2	4.1	4.9

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources. Years Measured: 2019-2021. Data Retrieved: 11/10/2024

The average number of mentally unhealthy days reported in the past 30 days in Bedford increased from 4.6 days in 2019 to 5.1 in 2021, peaking above the Virginia average of 4.9. While both Bedford and the state saw slight declines in 2020, Bedford's rates consistently remained higher, highlighting a growing need for mental health support in the locality.

Diabetes and **cancer** significantly impact health status by contributing to chronic disease burdens, reduced quality of life, and premature mortality. Diabetes increases the risk of complications such as cardiovascular disease, kidney failure, and neuropathy, leading to long-term disability and increased healthcare costs. Cancer, the second leading cause of death in the U.S., affects health through its physical toll, treatment side effects, and mental health challenges. Both conditions disproportionately impact underserved populations, exacerbating health disparities and requiring comprehensive prevention and management strategies to improve outcomes.

Source: US Centers for Disease Control & Prevention, Health Topics, https://www.cdc.gov/ Data Retrieved: 12/13/2024

DIABETES PREVALENCE

Diabetes Prevalence Percentage (%) of Adults Aged 20+, (Age-adjusted)

Locality	2019	2020	2021
Bedford	9.1	8.8	8.6
Virginia	9.8	9.8	10.2

Table Source: 2022-2024 County Health Rankings, https://www.countyhealthrankings.org/health-data/virginia/data-and-resources. Years Measured: 2019-2021. Data Retrieved: 11/11/2024

The prevalence of diabetes among adults aged 20+ in Bedford declined slightly from 9.1% in 2019 to 8.6% in 2021, remaining consistently below the Virginia average, which increased from 9.8% to 10.2% over the same period.

CANCER INCIDENCE RATES

Overall, cancer incidence rates across the Bedford area were slightly higher than the statewide rates for overall cancer types, breast cancer, and lung and bronchus cancer. For the rates by race, "all cancer types," "prostate" and "colon and rectum cancer" were highest for Black people while rates were highest for Whites for "breast" and "lung and bronchus" in the Bedford region.

All Cancer Types: Age-adjusted Incidence Cases per 100,000

Locality	Total		White		Black		Hispanic	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Bedford	432.4	2,586	424.4	2,384	432.4	168	N/A	N/A
Virginia	412	212,484	405.3	158,004	428	40,135	N/A	N/A

Table Source: Virginia Cancer Registry 1995-2021, Cancer Incidence Counts & Age-adjusted Rates (per 100,000) by Locality, Sex, and Race for Selected Cancer Sites
Years Measured: 2017-2021. Data Retrieved: 03/15/2024

Prostate Cancer: Age-adjusted Incidence Cases per 100,000

Locality	Total		White		Black		Hispanic	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Bedford Town & County	82.9	289	77.5	251	165	36	N/A	N/A
Virginia	107.1	27,987	91.4	18,422	173	7,760	N/A	N/A

Table Source: Virginia Cancer Registry 1995-2021, Cancer Incidence Counts & Age-adjusted Rates (per 100,000) by Locality, Sex, and Race for Selected Cancer Sites
Years Measured: 2017-2021. Data Retrieved: 03/15/2024Breast Cancer: Age-adjusted Incidence Cases per 100,000

Breast Cancer: Age-adjusted Incidence Cases per 100,000

Locality	Total		White		Black		Hispanic	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Bedford	137.6	407	140.5	384	89.5	18	N/A	N/A
Virginia	129.2	34,157	127.5	24,937	131.6	6,680	N/A	N/A

Table Source: Virginia Cancer Registry 1995-2021, Cancer Incidence Counts & Age-adjusted Rates (per 100,000) by Locality, Sex, and Race for Selected Cancer Sites
Years Measured: 2017-2021. Data Retrieved: 03/15/2024

Lung and Bronchus Cancer: Age-adjusted Incidence Cases per 100,000

Locality	Total		White		Black		Hispanic	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Bedford	58.2	388	59.1	366	50	21	N/A	N/A
Virginia	51.4	27,341	51.8	21,202	53.8	4,974	N/A	N/A

Table Source: Virginia Cancer Registry 1995-2021, Cancer Incidence Counts & Age-adjusted Rates (per 100,000) by Locality, Sex, and Race for Selected Cancer Sites
Years Measured: 2017-2021. Data Retrieved: 03/15/2024

Colon and Rectum Cancer: Age-adjusted Incidence Cases per 100,000

Locality	Total		White		Black		Hispanic	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Bedford Town & County	33.6	204	32.4	183	53	19	N/A	N/A
Virginia	33.9	17,031	32.5	12,345	37.7	3,420	N/A	N/A

Table Source: Virginia Cancer Registry 1995-2021, Cancer Incidence Counts & Age-adjusted Rates (per 100,000) by Locality, Sex, and Race for Selected Cancer Sites
Years Measured: 2017-2021. Data Retrieved: 03/15/2024

MATERNAL AND CHILD HEALTH INDICATORS

The United States is facing an urgent maternal and infant health crisis. Efforts to end preventable maternal health risks and death, preventable preterm birth, and close the health equity gap for every family are critical to the health of the community. Maternal and Child Health indicators like **low birthweight, prenatal care in the first trimester,** and **infant deaths** are key indicators of a community's quality of life, reflecting healthcare access, maternal health, and social determinants. High rates of low birthweight suggest challenges in maternal health and nutrition or limited access to prenatal care. Low rates of first-trimester prenatal care indicate barriers to healthcare access, such as affordability, availability, or awareness, while high infant death rates often highlight deficiencies in maternal and neonatal healthcare services and broader systemic issues like poverty and environmental hazards. Together, these measures provide a comprehensive view of the overall well-being of maternal and child health in communities.

Source: US Centers for Disease Control & Prevention, Health Topics, https://www.cdc.gov/
Source: March of Dimes, https://www.marchofdimes.org/
Data Retrieved: 12/13/2024

Prenatal Care Beginning in the First Trimester

Locality	2019	2020
Bedford	88%	89%
Virginia	78%	79%

Table Source: Kids Count Data Center- VA Kids. https://datacenter.kidscount.org/
Years Measured: 2019-2020. Data Retrieved: 03/15/2024

Bedford consistently outperformed Virginia in prenatal care initiation, with 88% in 2019 and 89% in 2020, compared to Virginia's 78% and 79%, respectively. This 10-percentage-point difference highlights Bedford's stronger access to or utilization of maternal healthcare services.

BIRTH RATE PER 1,000 POPULATION BY RACE

Virginia's birth rate per 1,000 population measures the number of live births occurring annually for every 1,000 people in the state's population. This metric provides a standard way to compare birth rates across different regions and time periods, accounting for population size. It is a key demographic indicator used to assess population growth trends, fertility levels, and the potential need for public services such as healthcare, education, and childcare.

Birth Rate Per 1,000 Population

Locality	2020 total	2021 total	2022 total
Bedford	3.97	4.10	4.27
Virginia	11.0	11.0	11.0

Table Source: Kids Count Data Center- VA Kids. https://datacenter.kidscount.org/
Years Measured: 2019-2020. Data Retrieved: 03/15/2024

The birth rates in the service area are consistently lower than the statewide rate, which remained stable at 11.0 across all three years. This is most likely due to the aging demographics of the service area.

Total Infant Deaths by Place of Residence 2020

Locality	Number of Infant Deaths				Rates per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Bedford	2	2			3.2	3.6		
Virginia	497	220	210	67	5.3	3.8	10.2	4.3

Table Source: Virginia Department of Health, Division of Health Statistics. https://www.vdh.virginia.gov/HealthStats/stats.htm; inf_1-1_2020.xls
Years Measured: 2020. Data Retrieved: 03/15/2024

Bedford's infant mortality rate is lower than the state average (3.2 vs. 5.3), while Virginia exhibits notable disparities, with Black infants experiencing the highest mortality rate.

Resident Low Weight Births by Percent of Total Live Births

Locality	2020			
	TOTAL	WHITE	BLACK	OTHER
Bedford County	6.3	6.6	5.1	
Virginia	8.3	6.6	13.5	7.6

Table Source: Virginia Department of Health, Division of Health Statistics. https://www.vdh.virginia.gov/HealthStats/stats.htm;
Years Measured: 2020. Data Retrieved: 03/15/2024

In 2020, Bedford's low-weight birth rate was 6.3%, lower than Virginia's 8.3%. Black infants in Virginia had the highest rate at 13.5%, indicating a significant racial disparity statewide.

PRIORITIZATION OF NEEDS

PRIORITIZATION OF NEEDS

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

1. **Responses from the Community Health Survey**
   - **a. Q3A:** What do you think are the most important issues that affect health in our community? (Health Factors) (n= 670 survey respondents)
   - **b. Q3B:** What do you think are the most important issues that affect health in our community? (Health Conditions or Outcomes) (n= 670 survey respondents)
   - **c. Q4:** Which healthcare services are hard to get in our community? (n= 667 respondents)
   - **d. Q5:** Which social/support resources are hard to get in our community? (n= 653 respondents)
   - **e. Q6:** What keeps you from being healthy? (n=595)
2. **Responses from the Stakeholders' & Target Population Focus Group**
   - **a. Q1. Stakeholders-** What are the top 5 greatest needs in the community(s) you serve? (n= 33 participants, 1 meeting conducted)
   - **b. Q1: Target Population-** What are the top 5 greatest needs in your community(s) around health and wellness? (n=15 participants, 3 meetings conducted)

Please note: *Analysis of the "Spanish-speaking" Target Population Focus Group meeting (4 participants) was not available in time to include in the detailed worksheet.*

To develop a list of priority needs for 2024, the top 10 responses to the five survey questions (Q3A-Q6) were sorted in an Excel workbook along with the top 11 community needs identified by the Stakeholder Focus Group and the top 7 community needs identified by the 3 Target Population Focus Groups (Q1). In addition, the top 10 Priority Areas of Need for the Bedford Service Area in 2021 were included. (It is important to note that after the 2024 primary and secondary data was presented to the CHAT at the August 23, 2024 meeting, members present agreed that the 2021 Priority Areas of Need were still relevant in 2024.) Altogether there were 18 Areas of Need. To determine how often an Area of Need was identified, an "x" was placed under one or more of the 7 survey and focus group questions to measure alignment with the Area of Need. The 18 Areas of Need and the detailed worksheet can be found in the Appendix.

An in-person CHAT meeting was held on October 4, 2024, in Bedford. There were 33 in attendance. The purpose of the meeting was to prioritize the top 10 priority needs for the 2024 Bedford Area Community Health Needs Assessment (CHNA). In addition to the detailed Area of Need worksheet, participants were provided with other supplemental information to help with their decision-making including recommendations for community collaboration to address need from Stakeholder and Target Population Focus Group participants, draft 2024 primary and secondary data, and responses from the CHAT meeting on January 26, 2024 regarding the state of our communities since 2021 and what programs/policies have had an impact on need. Those present were given time to review the materials and discuss them with others at their table.

Using Poll Everywhere, CHAT members were asked to rank the 18 Areas of Need from 1 to 18. Poll Everywhere allowed for ranking in real time and participants were given 15 minutes to complete the poll electronically. The answer choice with the most responses had the largest weight and was ranked as #1 and the answer choice with the least responses had the smallest weight and was ranked as #18. Twenty-six (26) CHAT members completed the poll. (Centra CHNA support staff did not complete the poll.)

The following table depicts the final rankings with the shaded area representing the top 10 Areas of Need:

2024 Community Health Needs Assessment
Bedford Service Area Prioritization of Needs (All)

Ranking	*Priority Area*
1	Mental Health & Substance Use Disorders & Access to Services
2	Access to Healthcare Services
3	Food Insecurity & Nutrition
4	Issues Impacting Children & their Families: Child Abuse & Neglect Childcare
5	Homelessness & Housing
6	Transportation
7	Aging and Eldercare
8	Dental Care & Dental Problems
9	Coordination of Resources & Community Outreach
10	Chronic Disease
11	Financial Stability & Assistance
12	Employment/Job Assistance
13	Domestic Violence
14	Physical Activity & Recreational Spaces
15	Cell Phone Use (Social Media)
16	Veterans Services
17	Broadband Access
18	Distracted Driving

The top 10 priority areas are reflective of the County Health Rankings' four categories for Health Factors including Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment. At Centra, we view all these health factors through the lens of equity, inclusion, and diversity.

The following table presents the final Top 10 Priority Areas of Need for 2024 as compared to the priorities in 2021. New priority areas for 2024 include:

- Food Insecurity & Nutrition
- Coordination of Resources & Outreach

These rankings will be used by Centra, the Central Virginia Health District, Bedford Area Resource Council and other community leaders and stakeholders to develop plans, collaborations and partnerships that address these needs over the next three years. Centra performs triennial Community Health Needs Assessments in three service areas (Bedford, Farmville, Lynchburg) that are served by the system's four hospitals. In 2024, the top three Priority Areas of Need for all service areas were the same.

Bedford Area Top 10 Priority Areas of Need 2021 and 2024 Compared

Ranking	2021	2024
1	Mental Health and Substance Use Disorders & Access to Services	Mental Health & Substance Use Disorders & Access to Services
2	Access to healthcare services	Access to Healthcare Services
3	Issues Impacting Children & their Families: Childcare Child abuse/neglect	Food Insecurity & Nutrition
4	Transportation	Issues Impacting Children & their Families: Childcare Child abuse/neglect
5	Aging and Eldercare	Homelessness & Housing
6	Chronic Disease	Transportation
7	Employment / Job assistance	Aging and Eldercare
8	Financial Stability	Dental Care & Dental Problems
9	Housing	Coordination of Resources & Community Outreach
10	Dental Care & Dental Problems	Chronic Disease

COMMUNITY IMPACT & RESOURCES

This evaluation of Community Impact & Resources presents the actions taken by Centra and community stakeholders across the service area to address the priority areas of need identified in the 2021 Community Health Needs Assessment.

COMMUNITY IMPACT & RESOURCES

The following section provides highlights of national, state, and local policies and programs that impacted the 2021 Bedford Area "Priority Areas of Need." It also highlights the partnerships and collaborations occurring within the region that address one or more of these priority areas.

At the conclusion of this section, a table organized by the 2021-2024 Bedford Area Priority Areas of Need outlines the efforts made by Centra and our community partners to address these needs. Most of the "Current State" and "Community Impact" sections in the table were reported by the Bedford Area Community Health Assessment Team on January 26, 2024. The "Centra Impact" section is based primarily on outcomes, services, and programs that resulted from the 2022-2025 Centra Implementation Plan.

For the 2024 Bedford Area Community Health Needs Assessment, a list of community resources that address each of the top ten Priority Areas of Need was created. This list of available resources was developed using Virginia 2-1-1 Information and Referral system (https://www.dss.virginia.gov/community/211.cgi), resources collected from Stakeholder Focus Group responses, and other web-based resource lists. This information serves to inform Centra and other community stakeholders about existing programs and resources that can support the development of Centra's Implementation Plans, the Central Virginia Health District's Community Health Improvement Plan, and other community responses to address need and improve health outcomes. **The list of resources is included in the Appendix.**

COVID-19 RELIEF: THE AMERICAN RESCUE PLAN ACT (2021)

The American Rescue Plan Act (ARPA) was signed into law by President Joe Biden in March 2021. Through the Coronavirus State and Local Fiscal Recovery Fund (SLFRF), it guaranteed direct relief to cities, towns, and villages across the United States. The purpose of this one-time funding was to assist in recovering from the public health emergency and negative economic impacts caused by the COVID-19 pandemic. Virginia was awarded $7.2 billion, with $4.3 billion allocated to the state and $2.9 billion distributed directly to localities. (https://www.wvtf.org/news/2021-05-11/how-much-is-your-community-getting-from-arpa). In the summer of 2021, Virginia's House of Delegates, Senate, and Governor agreed on how to spend $3.5 billion of the $4.3 billion in flexible federal funding for the state.

Since ARPA's enactment in 2021, the Commonwealth of Virginia has received a total of $4.29 billion as part of the American Rescue Plan Act and the Coronavirus State and Local Fiscal Recovery Fund. This funding has supported 198 projects across 42 agencies. Of the $4.29 billion, $3.85 billion has been obligated, and $2.63 billion has been spent. Virginia has effectively utilized these funds for a wide range of programs and initiatives to address the multitude of needs impacted by the COVID-19 pandemic. These initiatives have focused on efforts to strengthen health care systems, enhance unemployment benefits, expand broadband access, and provide more flexible assistance overall. (ARPA SLFRF Recovery Plan, 2024)

Source: American Rescue Plan Act SLFRF Recovery Plan. The Commonwealth of Virginia. (2024). Recovery Plan Performance Report (pdf). Retrieved from https://doa.virginia.gov/reports/AmericanRescure/Virginia-Recovery-Plan-Performance-Report-July-2024.pdf

ACCESS TO HEALTHCARE SERVICES

Medicaid (Medical and Dental Benefits)

During the COVID-19 pandemic, Medicaid enrollment in Virginia increased by 43%, growing from 1.53 million people in January 2020 to 2.1 million members by April 2023. This growth was due to federal requirements mandating that Virginia suspend normal Medicaid renewal processes and provide continuous coverage during the COVID-19 emergency. In May 2023, however, these federal requirements ended, and the state began recertifying the eligibility of all Medicaid recipients. This process, referred to as "unwinding," was conducted through the Department of Medical Assistance Services (DMAS) and the Department of Social Services (VA Free Clinics, n.d.). At the time, it was estimated that nearly 351,000 people would lose Medicaid eligibility due to these changes (VA Free Clinics, n.d.). As of September 2023, an estimated 12 million people – including 5.9 million adults and 6.1 million children – had already lost Medicaid-covered dental insurance following the end of the COVID-19 emergency (UCSF Oral Health, 2024). In Virginia alone, over 117,740 children lost dental coverage, and 90,836 children remained uninsured (UCSF Oral Health, 2024). These shifts are expected to have a significant impact on the recent progress made in improving access to dental care.

Source: Virginia Free Clinics. (n.d.). Medicaid. Virginia Free Clinics. Retrieved November 14, 2024, from https://www.vafreeclinics.org/medicaid
Source: UCSF Oral Health. (2024, November 14). Estimated 12 million children and adults lost Medicaid dental insurance after COVID-19 public health emergency. UCSF Oral Health. Retrieved November 14, 2024, from https://oralhealthsupport.ucsf.edu/news/estimated-12-million-children-and-adults-lost-medicaid-dental-insurance-after-covid-19-public

BROADBAND/INTERNET ACCESS

Between 2021 and 2024, Virginia made significant strides in improving broadband and internet access, particularly in underserved and rural areas. In 2021, the state launched the Virginia Telecommunications Initiative (VATI), a state-funded program aimed at expanding broadband infrastructure in regions with limited access (Virginia Department of Housing and Community Development, 2021). By 2024, Virginia had allocated millions of dollars in federal and state funds to support broadband expansion projects, ensuring high-speed internet was available to thousands of households, schools, and businesses in rural areas. These efforts were further bolstered by the federal American Rescue Plan Act (ARPA), which provided additional funding for broadband development across the state (Virginia Economic Development Partnership, 2023).

As of 2024, approximately 95% of Virginians have access to high-speed internet, up from about 80% in 2020 (Virginia Secretary of Technology, 2024). Key initiatives, such as partnerships between local governments and private broadband providers, helped close the digital divide. For example, the GO Virginia Region initiative focused on improving broadband access through local partnerships, using both state and federal funding to bring faster internet to rural communities (Virginia Governor's Office, 2023). Additionally, the state's expansion efforts were complemented by the Virginia Telehealth Network,

which allowed healthcare providers to offer services in remote areas, improving access to healthcare during and after the pandemic (Virginia Department of Medical Assistance Services, 2023).

These improvements have been essential for enhancing education, economic development, and healthcare in rural areas. Reliable internet access has become a critical tool for remote learning, telework, and telemedicine, helping to level the playing field for Virginians in underserved communities.

Source: Virginia Department of Housing and Community Development. (2021). Virginia Telecommunications Initiative: Expanding broadband access. Retrieved from https://www.dhcd.virginia.gov
Source: Virginia Economic Development Partnership. (2023). Broadband access in Virginia: 2021-2024 updates. Retrieved from https://www.vedp.org
Source: Virginia Secretary of Technology. (2024). Progress on broadband expansion across the Commonwealth of Virginia. Retrieved from https://www.vita.virginia.gov
Source: Virginia Governor's Office. (2023). Virginia's broadband initiatives and partnerships: A 2024 update. Retrieved from https://www.governor.virginia.gov
Source: Virginia Department of Medical Assistance Services. (2023). The role of broadband in telehealth access in Virginia. Retrieved from https://www.dmas.virginia.gov

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

In July 2021, Governor Ralph Northam proposed a $485.2 million spending package for the 2022-2024 biennial budget, designed to reduce pressure on state behavioral health facilities by pledging almost $224 million to increase support for state hospitals, community-based providers, and substance abuse prevention and treatment programs across Virginia.

In 2022, Governor Glenn Youngkin proposed an additional $230 million for behavioral health initiatives aimed at improving the capacity of Virginia's mental health system. One of the key developments was the expansion of the Crisis Intervention Team (CIT) program, which trains law enforcement officers to respond effectively to mental health crises. By 2024, over 90% of Virginia's localities had implemented CIT training, improving the handling of mental health emergencies and diverting individuals from the criminal justice system to appropriate treatment (Virginia Department of Criminal Justice Services, 2024). In addition, Youngkin's plan included increased funding and expansion of Crisis Stabilization Units (CSUs) across the state, providing alternative options to emergency rooms for individuals experiencing mental health crises (Virginia Department of Behavioral Health and Developmental Services [DBHDS], 2022). The proposal also increased funding for Mobile Crisis Teams, allowing mental health professionals to respond directly to crisis situations in the community rather than relying solely on law enforcement (DBHDS, 2022). This initiative was intended to reduce the burden on emergency departments and law enforcement while ensuring individuals receive the appropriate mental health care.

The package leveraged funds from the American Rescue Plan (ARPA) to support mental health services in schools and included funding to expand school-based mental health services. This effort focused on increasing the number of counselors, psychologists, and social workers in Virginia schools to support students' mental health needs (Virginia Department of Education, 2022). Recognizing the impact of the pandemic on children and adolescents, these efforts targeted rising rates of anxiety, depression, and behavioral issues among the student population.

In 2023, the General Assembly passed an additional $100 million in behavioral health funding to expand services for both adults and children, with a particular emphasis on telehealth services and psychiatric beds for individuals needing inpatient care (Virginia General Assembly, 2023).

By 2024, this behavioral health spending package had led to the establishment of new statewide mental health crisis centers, a marked increase in the number of individuals receiving treatment through Medicaid expansion, and progress in integrating mental health care into primary care settings. These efforts also improved access to behavioral health services for Virginians living in rural and underserved areas (Virginia Health Care Foundation, 2024).

This comprehensive spending package, supported by the General Assembly and federal funding, represented a significant step toward improving Virginia's behavioral health infrastructure, offering a more holistic and accessible approach to mental health care.

From 2021 to 2024, Virginia's behavioral and mental health initiatives focused on expanding access, integrating mental health care with other services, and addressing urgent needs through innovative, community-based models. These efforts made significant strides toward creating a more accessible and responsive mental health system.

Source: Virginia Department of Criminal Justice Services. (2024). Crisis Intervention Team (CIT) program expansion and outcomes. Retrieved from https://www.dcjs.virginia.gov
Source: Virginia Department of Behavioral Health and Developmental Services (DBHDS). (2022). Governor Northam's behavioral health spending proposal: 2022-2024 updates. Retrieved from https://www.dbhds.virginia.gov
Source: Virginia Department of Education. (2022). Mental health services in schools: Expanding support for Virginia students. Retrieved from https://www.doe.virginia.gov
Source: Virginia General Assembly. (2023). Virginia behavioral health funding and legislative updates 2023-2024. Retrieved from https://www.virginia.gov
Source: Virginia Health Care Foundation. (2024). Virginia's behavioral health initiatives: Impact of Governor Northam's funding package 2022-2024. Retrieved from https://www.vhcf.org

Regarding substance use legislation, Virginia legalized marijuana for adults on July 1, 2021, with retail sales set to begin in July 2024. Public opinion in the United States has shifted significantly since then, with 70% of Americans now supporting marijuana legalization. An article from *The New York Times* explores the evolving attitudes toward marijuana in the United States, highlighting how

it has gone from being criminalized to becoming widely accepted and legalized in various states. This shift in public opinion has been fueled by changing perceptions of marijuana's safety, medical benefits, and economic potential (Baker, 2024).

Source: Baker, P. (2024, October 24). America's embrace of marijuana: A historical perspective. The New York Times. Retrieved November 14, 2024, from https://www.nytimes.com/2024/10/24/briefing/americas-embrace-of-marijuana.html

In 2021, House Bill 2132 and Senate Bill 1303 were passed to reduce barriers to addiction treatment and recovery services. The bills enhanced access to medication-assisted treatment (MAT) for individuals with opioid use disorder and expanded access to naloxone, an opioid overdose reversal drug (Virginia General Assembly, 2021). This legislation improved access to syringe services programs and supervised consumption programs to reduce harm, minimize the spread of infectious diseases, and encourage individuals to seek treatment (Virginia Department of Health, 2022). In 2022, Senate Bill 1379 expanded telemedicine services for substance use disorder treatment, allowing individuals in rural and underserved areas to access addiction treatment remotely. However, in 2023, the Centers for Medicare & Medicaid Services (CMS) officially codified a requirement into the 2023 Physician Fee Schedule for Medicare, stating that, as of January 2025, "For behavioral health, an in-person visit is required within the first six months of an initial telehealth visit and every 12 months thereafter, with certain exceptions" (U.S.DOHHS, n.d.). This change is expected to impact access to behavioral health services in the coming years.

Source: U.S. Department of Health & Human Services. (n.d.). Medicare and Medicaid policies. Telehealth.HHS.gov. Retrieved November 14, 2024, from https://telehealth.hhs.gov/providers/telehealth-policy/medicare-and-medicaid-policies

Additionally, the Virginia Behavioral Health Recovery Fund was established, providing $50 million to support local recovery programs and initiatives aimed at reducing substance use and supporting long-term recovery (Virginia Department of Behavioral Health and Developmental Services [DBHDS], 2023). By 2024, the Drug Prevention and Recovery Act created a new task force to develop and implement a statewide addiction prevention strategy focusing on youth education, community engagement, and family-based interventions (Virginia General Assembly, 2024).

These legislative updates reflect Virginia's broader shift toward a more holistic, public health-oriented approach to substance use, prioritizing prevention, treatment, harm reduction, and recovery support services.

Source: Virginia General Assembly. (2021). HB 2132 and SB 1303: Expanding access to treatment and harm reduction for substance use disorders. Retrieved from https://lis.virginia.gov
Source: Virginia Department of Health. (2021). Virginia Harm Reduction and Syringe Exchange Programs: Legislative and public health updates. Retrieved from https://www.vdh.virginia.gov
Source: Virginia Department of Behavioral Health and Developmental Services (DBHDS). (2023). Substance use legislation and the Behavioral Health Recovery Fund: 2021-2024 updates. Retrieved from https://www.dbhds.virginia.gov
Source: Virginia General Assembly. (2024). Drug Prevention and Recovery Act of 2024: A comprehensive approach to addiction prevention. Retrieved from https://www.virginia.gov

Partnerships and Coalitions

The following partnerships and coalitions address one or more of the 2024 Priority Areas of Need:

Central Virginia Continuum of Care (CVCoC)

Addressing housing in the Lynchburg and Bedford regions https://centralvirginiacoc.org/

Since 2021, the Central Virginia Continuum of Care (CVCoC) has been advancing several key initiatives aimed at addressing homelessness in the region. Central to their efforts is the improvement of the Coordinated Entry System (CES), which enhances access to housing and services for individuals experiencing homelessness (CVCoC, 2023). The CVCoC has also worked to expand Permanent Supportive Housing (PSH) and distribute Emergency Housing Vouchers (EHVs), particularly targeting individuals with chronic homelessness and disabilities (CVCoC, 2023). Street outreach programs, such as the Point in Time Count (PIT), have been strengthened to engage people experiencing unsheltered homelessness, while racial equity remains a key focus in efforts to reduce disparities in service access (CVCoC, 2024). Additionally, the CVCoC has prioritized data collection through the Homeless Management Information System (HMIS) to track trends and improve service delivery, while expanding Rapid Rehousing (RRH) programs to increase housing stability (CVCoC, 2023). Homelessness prevention is a major priority, with initiatives focused on eviction prevention and strengthening collaborations with local agencies, nonprofits, and the private sector (CVCoC, 2024).

In late 2021, the Salvation Army renovated its Center of Hope building, reducing shelter beds from 70 to 57. In March 2022, the Lynchburg Community Action Agency closed its low-barrier, 28-bed homeless shelter, Hand Up Lodge. This closure resulted in a 42% decrease in shelter capacity for the Lynchburg area from 98 beds to 57. Throughout 2022, the Central Virginia Continuum of Care (CVCoC) worked to expand shelter capacity through a request-for-proposal process with $100,000 available in annual funding through a CVCoC grant from the Virginia Department of Housing and Community Development (DHCD). This search aimed to identify a provider to open a low-barrier shelter, as the existing shelter was often inaccessible to individuals based on intake criteria such as the requirement for a photo ID or passing a drug test. In 2022, Miriam's House, in partnership with the Lynchburg Department of Human Services, facilitated a non-congregate, hotel-based emergency shelter for those experiencing unsheltered homelessness until a more permanent shelter solution could be developed.

In December 2022, Roads to Recovery, with funding through the CVCoC, opened a 16-bed low barrier homeless shelter, The Shelter at Reset. This shelter was available to unsheltered adults in the Lynchburg area, increasing the overall shelter capacity available in the community to 73 beds. However, despite this addition, unsheltered homelessness continues to rise. In January 2024, Roads to Recovery announced plans to close The Shelter at Reset in June 2024.

In response, the Central Virginia Continuum of Care published a request for proposals to solicit a new shelter provider to replace the shelter provided by Roads to Recovery and make available the $100,000 grant from DHCD. The Ramp, a local church, applied with plans to convert its former church building into a low-barrier homeless shelter for men, women, and families with children. The CVCoC selected The Ramp's application, and efforts have been underway to assist with converting the church building into a shelter and providing technical assistance for the development of its shelter program. The Ramp plans to open its shelter, The Refuge on Memorial, in December 2024, providing 50 low-barrier shelter beds to individuals experiencing homelessness.

Source: Central Virginia CoC. (2023). 2023 Annual Report.
Source: Central Virginia CoC. (2024). Strategic Plan for Ending Homelessness.

Bright Beginnings of Central Virginia

Addressing early childhood education in the Lynchburg and Bedford region (https://unitedwaycv.org/bright-beginnings)

Since 2021, Bright Beginnings of Central Virginia (BBCV) has focused on several key initiatives to improve the quality and accessibility of childcare in the region. One of their main priorities has been enhancing the quality of early childhood education through professional development for childcare providers, including training programs and coaching aimed at improving classroom practices and helping providers achieve higher ratings through Virginia's Quality Rating and Improvement System (VQRIS) (Bright Beginnings of Central Virginia, 2023). Additionally, BBCV has worked to address workforce challenges in the sector

by offering leadership training and certification programs for early childhood educators to improve retention and address staffing shortages (Bright Beginnings of Central Virginia, 2023). The organization has also advocated for increased access to affordable, high-quality childcare by partnering with community stakeholders and local businesses to raise awareness and push for policy changes that would increase funding and resources for childcare providers (Bright Beginnings of Central Virginia, 2024). BBCV has supported family engagement efforts by providing resources to help families navigate childcare systems and better support their children's early learning (Bright Beginnings of Central Virginia, 2023).

The United Way of Central Virginia continues to secure funding for childcare through a combination of public and private partnerships, grants, and local fundraising efforts. In 2024, United Way of Central Virginia received $283,000 for a planning grant from Serve Virginia/ AmeriCorps to launch a Bright Beginning Child Care and Workforce Initiative. Centra Health is a proud supporter of this work and has recently provided a $50,000 grant to assist in these efforts. Planning is currently underway, and the Bright Beginning childcare facility has a goal to open in late 2025. It aims to provide placements for up to 300 families: 100 placements for underserved families, 100 placements for corporate partners, and 100 placements for the public. (United Way of Central Virginia, 2024). This initiative will address the critical shortage of quality and affordable childcare in Central Virginia while also creating additional jobs to help increase the workforce. The organization continues to host fundraising events and campaigns, such as the annual "Day of Caring," which mobilizes resources to provide direct support to childcare providers and families in need (United Way of Central Virginia, 2024). Through these combined efforts, the United Way of Central Virginia plays a crucial role in addressing the childcare challenges faced by local families and providers.

Bright Beginnings of Central Virginia. (2023). Early Childhood Education Workforce Initiatives. [https://unitedwaycv.org/bright-beginnings]
Bright Beginnings of Central Virginia. (2024). Advocacy and Public Awareness Campaigns. [https://unitedwaycv.org/bright-beginnings]
United Way of Central Virginia. (2023, September 12). Childcare and workforce challenges: United Way announces new initiatives to support working families. https://static1.squarespace.com/static/63c863952aca334e016f37b1/t/66f1983853d27d0560d64116/1727109176917/Press+release+September+12+Chilcare+and+Workforce%5B7%5D.pdf

Bedford Area Resource Council (BARC)

The Bedford Area Resource Council (BARC) is a network of non-profit, for profit, state and local government agencies, and citizens who serve the Town and County of Bedford. Meetings are held monthly to share ideas, information and resources. Cooperative, inter-agency efforts are planned and initiated to maximize community resources and minimize duplication of services. BARC provides a platform that results in stronger collaboration and coordination of programs to address unmet community needs, leading to a positive impact on the health and well-being of the Bedford Area. https://www.bedfordarearesourcecouncil.org/

BARC's mission is to address community need through collaboration among community partners and develop resources necessary for a sustainable community. The Bedford Area Resource Council envisions our community as a place where every person is healthy, connected, and supported. In the summer of 2021, BARC completed a 5-year strategic plan (2021-2026). With well over 100 members, many of the Bedford Area Resource Council (BARC) members also serve on Centra's triennial Community Health Assessment Team.

BARC's Action Groups include:
https://www.bedfordarearesourcecouncil.org

- Bedford Area Reentry Council
- Bedford Housing Coalition
- Domestic Violence Coalition
  www.facebook.com/BedfordDVCoalition/
  - The Coalition provides financial support for the physical safe shelter along with meeting the needs of the victims. The coalition also assists in the operation of a Transition Housing facility that provides temporary residency for those individuals leaving safe shelter and temporary safe accommodation for children who are in care of the Department of Social Services and are awaiting family, foster care, or kinship placement.
- Childcare
- Employment & Training
- Healthy Foods
- Minds Together- Mental Health/Substance use
- Transportation- 3 members

2021-2024 Community Impact

CENTRA BEDFORD MEMORIAL HOSPITAL IMPLEMENTATION PLAN

Upon completion of the 2021 CHNA, a 2022-2025 system-wide Centra implementation planning process was held. Led by the Senior Vice President - Chief Transformation Officer and Department of Community Health Director, the team was instrumental in the development of the plan and was composed of key Centra executive leaders, including Senior Vice Presidents and Chief Physician Executive, Chief Operating Officer, and Chief Clinical Officer; the Vice President of Behavioral Health, Chief Executive Officers (CEO) and Chief Nursing Officers for each Centra hospital, and others.

A series of three meetings were held with the Leadership Team on January 28, February 18, and March 25, 2022. Team members participated in the following activities:

- **Ranked the top three to five Priority Areas of Need for the service area that will be addressed by Centra**
  - Identified policies, programs, and resources already available to address the needs
  - Identified additional resources and partnerships needed to address gaps and barriers
  - Developed 3-year goals to address priority needs
  - Developed strategies to support the goals and considered whether these strategies were measurable, realistic, as well as considering organizational capacity and resources, and opportunities for community collaboration
  - Developed evaluative measures for the goals and/or strategies
- **Identified which priority needs will not be addressed by Centra and why**

The priority needs addressed by Centra Bedford Memorial Hospital included the following:

- **Access to Healthcare Services***
- **Mental Health and Substance Use Disorders & Access to Services***
- **Issues Impacting Children and their Families: Childcare; Child abuse/neglect**

Priority Areas of Need addressed across the entire Centra service region

The complete 2022-2025 Implementation Plan can be found at https://www.centrahealth.com/community-resources/community-health#chna. A Community Health Assessment Implementation Plan Leadership Team was developed and met, monthly initially and eventually quarterly, to share progress on their plan goals with members who represented the Centra hospitals and relevant service lines.

CENTRA COMMUNITY BENEFIT AND IMPACT REPORT

Centra's Community Health Services is responsible for the development and implementation of the triennial Community Health Needs Assessments and Implementation Plans, Community Grants and Sponsorships, and tracking Community Benefit activities. Community Benefit activities are programs and services provided by non-profit hospital systems like Centra, that are designed to improve health in communities and increase access to care in response to community need. Centra's Community Grants and Sponsorships fund non-profit organizations addressing the Priority Areas of Need and projects of regional importance annually. The 2021-2023 Centra Community Benefit and Impact Report can be found at https://www.centrahealth.com/sites/default/files/2024-06/Community%20Health%20Report%20Final.pdf

2021-2024 Community Impact Activities

The table below provides an evaluation of the impact made since the 2021 Bedford Area Community Health Needs Assessment (CHNA) and is delineated by the 2021 Priority Areas of Need.

2021 Priority Area of Need	*2021-2024 Community Impact & Current State*
Mental Health and Substance Use Disorders & Access to Services	**Current State:** • State Level Policy Changes- 2021 legalization of marijuana, telehealth law increased barriers to Behavioral Health Services • Increased funding to support organizations & fees associated with mental health (MH) treatment • More service providers and increased collaboration • People are not trusting prescription drugs, so they are self-medicating • Mental Health and Substance Use disorders have increased, but access continues to pose an issue • Need exceeds resources and medical paperwork delays care • Mental Health providers and recent graduates are not able to get jobs due to little experience • Increased Narcan access • Opioid abatement initiatives and substance abuse grants • Need for more creative outreach to change stigma on public assistance
	Centra Impact: • Bedford Memorial Hospital's leadership started The Bedford Mental Health Collaborative an interdisciplinary community action group- aimed at bringing together a collaborative team of individuals and community-based organizations to provide a safe and healthy community for residents experiencing mental health and substance use disorders • Centra Foundation received a $1 million anonymous gift to fund EmPATH unit (Emergency Assessment, Treatment and Healing Unit) for behavioral/mental health patients in the Lynchburg General ED- the EmPATH unit allows these patients to wait in a calming, common area where Caregivers, behavioral health experts and other patients interact and support one another throughout the patient's visit. The EmPATH unit ultimately works to reduce the need for extended Emergency Department stays or even hospitalization while ensuring that each behavioral health patient is provided care that is both equitable and excellent • Centra Health is striving to make improvements with the opioid epidemic through EmPATH unit, inpatient psychiatric units offering assessment, detox, connection and recovery support, the Pathways Treatment Center, and the Addiction Treatment Center
	Community Impact: • DePaul Community Resources- Facilitating Healing and Stability for Children and Families in the Bedford Area through DePaul's Community-Based Counseling Services project • Domestic Violence Coalition advocates for domestic violence (DV) services and operates a walk-in shelter • Horizon Behavioral Health continues to provide programs and support to individuals and families in need of mental/behavioral health services • Improved intake and crisis stabilization services (i.e., Centra's EmPATH unit, Horizon Behavioral Health Crisis Stabilization unit) • Community support from churches, with additional efforts needed (i.e., Celebrate Recovery) • Mobile crisis response through Virginia's REACH program • Bedford Area Resource Council (BARC) meets monthly to address these needs and other needs ○ Minds Together meetings for updates/education on community resources

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Access to Healthcare Services	**Current State:** • Limited primary care access • Decrease in number of providers & specialists available for appointments
	Centra Impact: • Centra Health's Bedford Memorial Hospital is working closely with pathologists and the blood bank to increase available transfusion services at their hospital • Launched system-wide closed loop referral platform, UNITE VA- a tool that assists in addressing Social Determinants of Health (SDOH) through the use of the PRAPARE screening tool to improve access to healthcare services & community resources- patients 18yrs+ are screened upon admission into the hospital for needs related to (food, housing, transportation, utilities & interpersonal safety) and referrals are sent to community partners via the UNITE VA platform or other referral methods • Remote Home Monitoring Program enhances patient care and access to healthcare services through the use of technology- patients who opt to participate receive a tablet, digital scale, blood pressure cuff, pulse oximeter and heart rate monitor which connect via Bluetooth to provide instant communication to the Centra Command Center Team for continuous patient monitoring • Centra Foundation received a $1 million anonymous gift to fund EmPATH unit (Emergency Assessment, Treatment and Healing Unit) for behavioral/mental health patients in the Lynchburg General ED- the EmPATH unit allows these patients to wait in a calming, common area where Caregivers, behavioral health experts and other patients interact and support one another throughout the patient's visit. The EmPATH unit ultimately works to reduce the need for extended Emergency Department stays or even hospitalization while ensuring that each behavioral health patient is provided care that is both equitable and excellent • Centra hosts/participates in many community events aimed at addressing Access to Healthcare Services such as a "Walk With a Doc" event, Skin cancer screening events, Breast Imaging Team's Breast Cancer prevention event, MAAM events with free mammograms provided via our MAAM van • Centra Health convened a Provider Recruitment Team with plans to hire 45 additional Providers for Primary Care 2024-2026; so far 12 have been hired
	Community Impact: • Johnson Health Center has a mobile dental unit in addition to their dental clinics • Sentara Halifax Obstetric (OB) Unit & Martinsville Unit closed, limited OB access, requiring longer travel for maternal care and delivery • Free Clinic is closing the Bedford Facility

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Issues Impacting Children and Their Families: Childcare, Child Abuse/ Neglect	**Current State:** • State funding supports the "Mixed Delivery" program and staff • Virginia's $1.1 billion investment for early childhood education access was approved in 2024 • Additional COVID funds for childcare have gone away • Lack of childcare providers and funding • Difficulty finding agencies that accept children with autism • No sick childcare services
	Centra Impact: • The Bedford National Night Out event was held to build deeper relationships and connections among law enforcement, healthcare workers, social services and the community members they serve • Centra Health supports and/or provides funding for childcare efforts such as: Teachable Moments Facility- 3-year funding, Elizabeths Early Learning Center, Bedford YMCA, Altavista YMCA, United Way of Central VA, VA Business Roundtable for Early Education and other local community nonprofit programs/efforts • Centra Health's Women and Children service line incorporated the following: ◦ A standard of practice that includes implemented services/education on: Period of Purple Crying, Safe Sleep, Life Beyond Centra, and infant falls ◦ Bereavement coordinator in place to address infant/maternal mortality needs ◦ Deployed Human Trafficking infographics for awareness and education ◦ Universal Cord Blood Screening on all Newborns ◦ Quarterly community collaborative meeting that focuses on different topics related to maternal health (current focus Maternal mental health and hypertension) ◦ Safe Haven boxes having vendors come in to review where they will or can be placed
	Community Impact: • United Way receives funding for a new Childcare Initiative, planning is underway for 2025 opening • United Way Excellence in Children's Early Language and Literacy Project is aimed at supporting successful language and literacy education • Central Virginia Health District Education enhanced access • Growing Place Preschool extended their hours • Lake Christian Ministries (LCM) held their annual fundraiser "Smith Mountain Lake Walk To End Poverty Event"- LCM provides comprehensive programs and services to families experiencing poverty to provide vital family services to Bedford community members in need • Bedford YMCA opened an Early Learning Center Childcare Program for ages 0-5 • Bowers Center for the Arts- Full Day Camps Project

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Transportation	**Current State:** • Otter Bus expansion due to grants • Working towards a program for more public transportation like Uber • Transportation access to medical services has increased • No public transportation outside of town • Medicaid rides continue to be negative – they pick-up/drop-off and leave people • Need more transportation through federal and/or state grants with full time help to enforce
	Community Impact: • Bedford Community Foundations Otter Bus provides expanded hours/ transportation services for Bedford community to access in town resources/services • Central Virginia Alliance for Community Living, Inc./Bedford Ride- Bedford Ride/Non-emergency Medical Transportation Project

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Aging and Eldercare	**Current State:** • Population has not stabilized since COVID • Eldercare has been impacted by inflation • The poverty level has increased in this population • Since COVID, social isolation continues to be an issue • There is a general lack of support for the "sandwich" generation • Continued issues with accessing wheelchairs
	Centra Impact: • Centra services address many of the needs and services required of an aging population both in the inpatient and outpatient settings.
	Community Impact: • Central VA Alliance for Community Living (CVACL) has provided groceries, meals, and social events for isolated elderly • Meals on Wheels Food Delivery and Oversight project aimed at identifying additional social needs of the populations served during food deliveries • Area Agencies on Aging provide a wide variety of services to the elderly/aging population

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Chronic Disease	**Current State:** • The prevalence of long COVID has become a significant health issue and continues to negatively impact Chronic Disease. Many Virginians experience lingering symptoms such as fatigue, respiratory issues, and cognitive difficulties, impacting quality of life and increasing the burden on healthcare systems • Chronic disease prevalence is often higher in the service area as compared to Virginia as a whole, especially those related to diet, exercise and other health behaviors (i.e., substance use) • 2023 cuts in Supplemental Nutrition Assistance Program (SNAP) benefits have increased food insecurity • Virginia Cooperative Extension helps with nutrition and budgeting education • Not enough staff for WIC to keep up with demand • Elimination of COVID-era policies at a time of high inflation, rising food costs, & increased need have a negative impact on all low to moderate income individuals
	Centra Impact: • Remote Home Monitoring Program enhances patient care and access to healthcare services through the use of technology- patients who opt to participate receive a tablet, digital scale, blood pressure cuff, pulse oximeter and heart rate monitor which connect via Bluetooth to provide instant communication to the Centra Command Center Team for continuous patient monitoring • Addressing Diabetes concerns related to increased readmission rates; working to increase community resources and health educators • Nutrition services provide Alpha Gal friendly menu options now • Centra participates in many health fairs and events to provide education and preventative screenings such as skin cancer screenings, mammograms, blood pressure screenings, STI education, Tick Born illness education, etc.
	Community Impact: • Meals on Wheels Discharge Program (Trial) aimed at lowering 30-day readmission rates by providing patients with food 45 days post-discharge • Central Virginia YMCA Chronic Disease Prevention and Management Project provides a variety of classes for diabetes, arthritis, cancer, etc., • Virginia Cooperative Extension helps with nutrition and budgeting education • Not enough resources at the health department to serve WIC (Women Infants & Children) to keep up with demand • Elimination of COVID-era policies at a time of high inflation, rising food costs, & increased need have a negative impact on all low to moderate income individuals • Continuation of the VA Tech HRSA grant to support local church support groups • Elba Butcher Shop supplies healthy foods

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Employment/ Job Assistance	**Current State:** • Department for Aging and Rehabilitative Services (DARS) coming monthly • Virginia Career Works services • Attract more businesses, jobs, and job fairs to the area **Community Impact:** • Central VA Community College (CVCC) is providing free education in the trades and high demand careers for the underprivileged community, to secure work, food, and housing • Job Corps providing hands on career technical training in high-growth industries and GED/diploma attainment assistance

2021 Priority Area of Need	2021-2024 Community Impact & Current State

Financial Stability	**Current State:**
	• Inflation and wage disparity
	  ○ It has worsened food insecurity, forcing families to buy less food
	  ○ It has caused issues with being able to access affordable childcare, eldercare, and transportation
	• There is a need for better communication/advertising of local job opportunities
	Community Impact:
	• Central VA Community College (CVCC) is providing free education in the trades and high demand careers for the underprivileged community, to secure work, food, and housing
	• HumanKind has an Economic Resource Center that helps individuals and families develop plans for achieving financial success. Through educational workshops, workforce support, and vehicle loans, clients are educated on ways to get out of debt and move toward stability
	• Freedom First Credit Union offers free financial counseling

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Housing	**Current State:** • Various Warming Shelters in Bedford • End to the eviction moratorium by the CDC in 2021 • End to the eviction moratorium for Virginia in 2021 and rental assistance programs ended in 2022 • Shortage of low-income housing in Bedford and waiting lists for housing • High demand and high cost of housing • Homelessness due to limited housing • Building restrictions in place • Building fewer affordable housing units • Elimination of COVID-era policies at a time of high inflation, rising housing costs, & increased need have a negative impact on all low to moderate income individuals

	Community Impact:
	• Warming Shelters in Bedford:
	  ○ St John's Episcopal
	  ○ Bedford Presbyterian
	  ○ Bedford Christian Ministries
	  ○ The Shepherd's Table
	  ○ Agape Center
	• No active low barrier shelters in the town of Bedford
	• The Ramp church in Lynchburg is set to open a low barrier shelter in 2025 for Central VA area
	• Miriam's House aiding in efforts to end homelessness by connecting individuals and families with stable, affordable housing and providing the skills and support that lead to self-sufficiency
	• Central Virginia Continuum of Care (CVCoC) is working to improve the Coordinated Entry System (CES), making access to housing for the homeless easier
	• CVCoC is increasing Permanent Supportive Housing (PSH) and providing additional Emergency Housing Vouchers (EHVs) for those experiencing long term homelessness and/or disabilities and prioritizing racial equity in all initiatives
	• CVCoC utilizes data collection through the Homeless Management Information System (HMIS) and Point in Time (PIT) counts to strengthen targeted efforts at addressing this need
	• The CVCoC remains focused on increasing Rapid Rehousing (RRH) programs to increase housing stability and prevent evictions
	• Coordinated Homeless Intake Access (CHIA) Hotline is available for immediate housing assistance needs
	• The Salvation Army has a homeless shelter and serves as a warming shelter in Lynchburg during the winter

2021 Priority Area of Need	2021-2024 Community Impact & Current State
Dental Care & Dental Problems	**Current State:** • Education for oral health is needed • Medicaid/Medicare doesn't reimburse at market rate
	Community Impact: • Johnson Health Center has a mobile dental unit in addition to their dental clinics • Free Clinic expanded dental services at their Lynchburg location

APPENDIX

The following documents are included as appendices:

1. 2024 Bedford Area Community Health Survey Tool (English and Spanish)
2. 2024 Bedford Area Stakeholders' Directory
3. 2024 Bedford Area Prioritization of Needs Survey and Detailed Worksheet
4. 2024 Bedford Area Community Resources

FOR OFFICE USE ONLY: Site of Collection: _____ Date: _____

Centra Health, in partnership with the Central Virginia Health District, Bedford Area Resource Council, and University of Lynchburg, would like to learn more about what you need to be healthy. Please complete the following questions with the best answer or answers. Please complete this survey only once. You must be over 18 to complete this survey. All surveys will be kept confidential. Surveys can be returned to the site of collection or mailed to Centra Department of Community Health Services, 1901 Tate Springs Rd, Lynchburg VA 24501. Thank you for taking the time to complete the survey.

BEDFORD AREA COMMUNITY HEALTH SURVEY

HEALTH OF THE COMMUNITY

1. What is your zip code? _____

2. What is your age?

❒ Under 18 ❒ 18 - 24 ❒ 25 - 34 ❒ 35 - 44 ❒ 45 - 54 ❒ 55 - 64 ❒ 65+ (years)

3. What do you think are the most important issues that affect health in our community? (Please check all that apply)

Health Factors

- ❒ Access to affordable housing
- ❒ Access to healthy foods (vegetables, lean meats, fruit)
- ❒ Access to safe places to exercise
- ❒ Accidents in the home (e.g., falls, burns, cuts)
- ❒ Aging problems (support for older adults)
- ❒ Alcohol and illegal drug use
- ❒ Bullying
- ❒ Cell phone use (social media)
- ❒ Child abuse / neglect
- ❒ Distracted Driving (Cell phone use / texting and driving)
- ❒ Domestic Violence
- ❒ Gambling (slot machines, sports betting, lottery tickets)
- ❒ Gang activity
- ❒ Gender identification
- ❒ Gun violence
- ❒ Homelessness
- ❒ Homicide (murders)
- ❒ Housing problems (e.g., mold, bed bugs, lead paint)
- ❒ Injuries (car accident, workplace injuries, home accidents)
- ❒ Lack of exercise (physical inactivity)
- ❒ Neighborhood is not safe (sidewalks, roads, crossings, street lighting)
- ❒ Not getting “vaccine shots” to prevent disease
- ❒ Not using seat belts / child safety seats / helmets
- ❒ Poor eating habits
- ❒ Poor water quality and/or poor air quality
- ❒ Prescription drug abuse
- ❒ Sexual assault
- ❒ Social isolation (loneliness)
- ❒ Tobacco use / smoking / vaping
- ❒ Transportation problems
- ❒ Unsafe sex (unprotected sex)
- ❒ Other: _____

Health Conditions or Outcomes

- ❒ Alzheimer’s / Dementia
- ❒ Back, hip, knee pain
- ❒ Cancers
- ❒ COVID-19 / coronavirus / Long COVID-19
- ❒ Dental pain/problems
- ❒ Diabetes
- ❒ Disability
- ❒ Drug / alcohol problems
- ❒ Grief (sadness)
- ❒ Heart disease and stroke
- ❒ High blood pressure
- ❒ HIV / AIDS
- ❒ Infant death (less than 1 year old)
- ❒ Kidney disease
- ❒ Lung disease
- ❒ Mental health problems
- ❒ Overweight / obesity
- ❒ Sedentary lifestyle (physical inactivity)
- ❒ Sexually transmitted infections
- ❒ Sleep problems
- ❒ Stomach disease
- ❒ Stress
- ❒ Suicide
- ❒ Teenage pregnancy
- ❒ Other: _____

4. Which healthcare services are hard to get in our community? (Please check all that apply)

- ❒ Adult dental care
- ❒ Alternative therapy (e.g., herbal, acupuncture, massage)
- ❒ Ambulance services
- ❒ Blood work
- ❒ Cancer care
- ❒ Child dental care
- ❒ Chiropractic care
- ❒ Dermatology (skin care)
- ❒ Domestic violence services
- ❒ Emergency department care
- ❒ End of life / hospice / palliative care
- ❒ Exercise professional
- ❒ Hospital care (staying overnight)
- ❒ Immunizations (vaccines)
- ❒ LGBTQIA support
- ❒ COVID-19 / Long COVID-19 care
- ❒ Memory care services
- ❒ Mental health / counseling
- ❒ Older adult care
- ❒ Physical therapy or physical rehabilitation
- ❒ Prescription medication / medical supplies
- ❒ Primary Care Provider
- ❒ Programs to stop using tobacco products
- ❒ Respiratory (lung) care
- ❒ Substance use services – drug and alcohol
- ❒ Urgent care / walk-in clinic
- ❒ Vision (eye) care
- ❒ Weight loss support
- ❒ Women’s health services
- ❒ X-rays / mammograms
- ❒ Yearly check ups
- ❒ None
- ❒ Other: _____

5. Which social / support resources are hard to get in our community? (Please check all that apply)

- ❒ Affordable / safe housing
- ❒ Banking services
- ❒ Childcare
- ❒ Domestic violence victim assistance
- ❒ Education (GED / high school / college)
- ❒ Employment / job assistance
- ❒ Financial assistance
- ❒ Food benefits (SNAP, WIC)
- ❒ Grief / bereavement counseling
- ❒ Health insurance
- ❒ Healthy food
- ❒ Legal services
- ❒ Medical debt assistance
- ❒ Medication assistance
- ❒ Reading and writing support
- ❒ Rent / utilities assistance
- ❒ TANF (Temporary Assistance for Needy Families)
- ❒ Transportation
- ❒ Unemployment benefits
- ❒ Veteran’s services
- ❒ Other: _____

GENERAL HEALTH QUESTIONS ABOUT YOU/YOUR FAMILY

6. What keeps you from being healthy? (*Please check all that apply*)

- ❒ Access to fresh fruits and vegetables
- ❒ Access to safe places to be active outside (park, sidewalks)
- ❒ Afraid to have check-ups
- ❒ Can't find providers that accept my insurance
- ❒ Childcare
- ❒ Cost (money)
- ❒ Don't like accepting government assistance
- ❒ Don't trust doctors / clinics
- ❒ Don't trust my insurance to help
- ❒ Have no regular source of healthcare
- ❒ High co-pay for healthcare
- ❒ Lack of evening and weekend services
- ❒ Lack of doctors/dentists accepting new patients
- ❒ Language services (access to interpreter)
- ❒ Location of healthcare offices
- ❒ Long waits for appointments
- ❒ No health insurance
- ❒ No transportation
- ❒ Nothing keeps me from being healthy
- ❒ Unable to learn about medical condition because of difficulty understanding spoken or written information
- ❒ Other: _____

7. Do you use medical care services?

❒ **Yes** - **Check where you go for medical care** (***check all that apply***) ❒ **No**

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Doctor's Office
- ❒ Emergency Room
- ❒ Health Department
- ❒ Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)
- ❒ Free Clinic (e.g., Free Clinic of Central Virginia)
- ❒ Online / Telehealth / Virtual Visit
- ❒ Urgent Care / Walk-in Clinic
- ❒ Veterans Administration Medical Center
- ❒ Other: _____

If no, do you know where to go for medical care in your community? ❒ **Yes** ❒ **No**

8. How long has it been since you last visited a doctor or other healthcare provider for a routine checkup? (*Please check one*)

- ❒ I have not visited a doctor or other healthcare provider for a routine checkup
- ❒ 1 to 12 months
- ❒ 1 to 2 years
- ❒ 3-5 years
- ❒ 5+ years

9. Do you use dental care services?

❒ **Yes** – **Check where you go for dental care** (***check all that apply***) ❒ **No**

- ❒ Dentist's office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)
- ❒ Free Clinic (e.g., Free Clinic of Central Virginia)
- ❒ Mission of Mercy Project
- ❒ Urgent Care / Walk-in Clinic
- ❒ Veterans Administration Medical Center
- ❒ Other: _____

If no, do you know where to go for dental care in your community? ❒ **Yes** ❒ **No**

10. How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists (e.g., orthodontist, periodontist). (*Please check one*)

- ❒ I have not visited a dentist or dental clinic for any reason
- ❒ 1 to 12 months
- ❒ 1 to 2 years
- ❒ 3-5 years
- ❒ 5+ years

11. Do you use mental health, alcohol use, or drug use services?

❒ **Yes** – **Check where you go for services** (***check all that apply***) ❒ **No**

- ❒ Doctor / Counselor's office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)
- ❒ Free Clinic (e.g., Free Clinic of Central Virginia)
- ❒ Horizon Behavioral Health
- ❒ Online / Telehealth / Virtual Visits
- ❒ Urgent Care / Walk-in Clinic
- ❒ Veterans Administration Medical Center
- ❒ Other: _____

If no, do you know where to go for mental health, substance use, and/or alcohol use services in your community? ❒ **Yes** ❒ **No**

12. How long has it been since you last used mental health, alcohol use, or drug use services for any reason? (*Please check one*)

- ❒ I have not used mental health, alcohol use, or drug use services for any reason
- ❒ 1 to 12 months
- ❒ 1 to 2 years
- ❒ 3-5 years
- ❒ 5+ years

13. Have you been told by a doctor that you have… (*Please check all that apply*)

- ❒ Alzheimer's / Dementia
- ❒ Arthritis
- ❒ Asthma
- ❒ Cancer
- ❒ Cerebral palsy
- ❒ Depression or anxiety
- ❒ Drug or alcohol problems
- ❒ Eating disorder
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High blood sugar or diabetes
- ❒ High cholesterol
- ❒ HIV / AIDS
- ❒ Long COVID-19
- ❒ Mental health problems
- ❒ Obesity / overweight
- ❒ Physical inactivity
- ❒ Sexually transmitted infections
- ❒ Sleep disorder
- ❒ Stroke / cerebrovascular disease
- ❒ Walking or moving problems
- ❒ Not applicable
- ❒ Other: _____

14. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? (Please check one)

❒ 0 ❒ 1 – 13 ❒ 14 – 30 (Days)

15. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? (Please check one)

❒ 0 ❒ 1 – 13 ❒ 14 – 30 (Days)

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

❒ I have used marijuana products
❒ I have used illegal drugs (e.g., meth, cocaine, heroin, ecstasy, crack, LSD, etc.)
❒ I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion
❒ I have used tobacco products (cigarettes, chewing tobacco, cigars, etc.)
❒ I have used vaping products (e-cigarettes)
❒ I have taken prescription drugs to get high
❒ I have overdosed on drugs
❒ I have been given Narcan/Naloxone
❒ None of these

17. Please check one of the following for each statement:

	Yes	No	Not Applicable
I have been to the emergency room in the past 12 months.	❒	❒	
I have been to the emergency room for an injury in the past 12 months (e.g., motor vehicle crash, fall, poisoning, burn, cut, etc.).	❒	❒	
I have attempted suicide in the past 12 months.	❒	❒	
I have attempted self-harm in the past 12 months.	❒	❒	
I have been a victim of domestic violence or abuse in the past 12 months.	❒	❒	
I take the medicine my doctor tells me to take to control my chronic illness.	❒	❒	❒
I can afford the medicine needed for my health conditions.	❒	❒	❒
Does your community neighborhood support physical activity? (e.g., parks, sidewalks, bike lanes, etc.)	❒	❒	
In the area where you live, is it easy to get fresh fruits and vegetables?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?	❒	❒	❒
Do you feel safe where you live?	❒	❒	

18. Over the past 7 days, how many days did you spend at least 30 minutes per day being physically active (walking, running, bicycling, yard work, physical labor)

❒ 7 days ❒ 6 days ❒ 5 days ❒ 4 days ❒ 3 days ❒ 2 days ❒ 1 day ❒ 0 days

19. During the past 7 days, how many times did you walk for at least 10 minutes without stopping?

❒ I did not walk for at least 10 minutes without stopping in the past 7 days
❒ 1 – 3 times during the past 7 days
❒ 4 – 6 times during the past 7 days
❒ 1 time per day
❒ 2 times per day
❒ 3 times per day
❒ 4 or more times per day

20. What is your height? _____feet_____inches
_____centimeters

21. What is your weight? _____pounds
_____kilograms

22. Over the past 7 days, how many hours per day do you spend using technology (smartphones, computers, tablets, gaming devices) outside of school or work?

❒ 0 hours ❒ 1 – 3 hours ❒ 3 – 6 hours ❒ 6 – 9 hours ❒ More than 9 hours

23. Over the past 7 days, how many hours per day do you spend using social media outside of school or work?

❒ 0 hours ❒ 1 – 3 hours ❒ 3 – 6 hours ❒ 6 – 9 hours ❒ More than 9 hours

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

❒ Backpack or summer food programs
❒ Community garden
❒ Corner store / convenience store / gas station
❒ Dollar store
❒ Farmers' market
❒ Food bank / food pantry
❒ Grocery store
❒ Home garden
❒ I do not cook / eat at home
❒ I regularly receive food from family, friends, neighbors, or my church
❒ Meals on Wheels
❒ Take-out / fast food / restaurant
❒ Other: _____

25. During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice, or fruit or vegetable supplements. (*Please check one*)

❒ I did not eat fruits or vegetables during the past 7 days
❒ 1 – 3 times during the past 7 days
❒ 4 – 6 times during the past 7 days
❒ 1 time per day
❒ 2 times per day
❒ 3 times per day
❒ 4 or more times per day

26. In the past 7 days, how many times did all or most of the people living in your house eat a meal together?

❒ Never ❒ 3 – 4 times ❒ 7 times ❒ Not Applicable / I live alone
❒ 1 – 2 times ❒ 5 – 6 times ❒ More than 7 times

27. How socially connected do you feel with the community and those around you?	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
I feel socially connected.	❒	❒	❒	❒	❒

28. Where do you sleep most often? (*Please check <u>one</u>*)

❒ In a group home, hospital, or treatment program
❒ In a home I own or rent
❒ In a hotel or motel
❒ In a shelter or transitional housing program
❒ Living with extended family because that is my choice
❒ Outside, in a car, abandoned building, or public space
❒ Stay with friends or family because of financial issues (not my choice)

29. Do you have access to reliable transportation? ❒ Yes ❒ No

30. What type of transportation do you use most often?

❒ Friends / family drive me
❒ I bike or walk
❒ I drive
❒ Other transit service (name): _____
❒ Public transit (i.e., bus, shuttle, similar)
❒ Ridesharing / Carpooling
❒ Taxi (including Uber / Lyft)
❒ Other: _____

DEMOGRAPHIC INFORMATION AND HEALTH INSURANCE

31. Which of the following describes your current type of health insurance? (*Please check <u>all</u> that apply*)

❒ COBRA
❒ Dental Insurance
❒ Employer provided insurance
❒ Government (VA, TRICARE)
❒ Health Savings / Spending Account
❒ Individual / Private Insurance / Marketplace / Obamacare
❒ Medicaid
❒ Medicare
❒ Medicare Supplement
❒ No Dental Insurance
❒ No Health Insurance

32. If you have no health insurance, why don't you have insurance? (*Please check <u>all</u> that apply*)

❒ Not applicable – I have health insurance
❒ I don't understand Marketplace / Obamacare
❒ Not available at my job
❒ Student
❒ Too expensive / cost
❒ Unemployed / no job
❒ Undocumented immigrant
❒ Other: _____

33. What is your gender identity?

❒ Male ❒ Non-binary ❒ Gender queer ❒ Prefer not to answer
❒ Female ❒ Transgender ❒ Gender fluid

34. What is your highest education level completed?

❒ Less than high school ❒ High school diploma / GED ❒ Associate degree ❒ Masters / PhD degree
❒ Some high school ❒ Vocational / Technical certificate ❒ Bachelor's degree

35. What race/ethnicity do you identify with? (*Please check <u>all</u> that apply*)

❒ Native Hawaiian / Pacific Islander
❒ American Indian / Alaskan Native
❒ Asian
❒ Hispanic / Latino
❒ Black / African American
❒ White
❒ More than one race
❒ Decline to answer
❒ Other: _____

36. What is your marital status?

❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partnership

37. How many people live in your home (including yourself)?

Number of children (0 – 17 years) _____ Number of adults (18 – 64 years) _____ Number of adults (65+ years) _____

38. What is your yearly household income?

❒ $0 - $10,000 ❒ $20,001 - $30,000 ❒ $40,001 - $50,000 ❒ $60,001 - $70,000 ❒ $101,001 and above
❒ $10,001 - $20,000 ❒ $30,001 - $40,000 ❒ $50,001 - $60,000 ❒ $70,001 - $100,000

39. What is your current employment status?

❒ Full-time ❒ Unemployed ❒ Retired ❒ Student
❒ Part-time ❒ Self-employed ❒ Homemaker ❒ Disabled

40. Is there anything else we should know about your (or someone living in your home) needs to stay healthy?

_____

_____

Thank you for helping make the greater Bedford Area a healthier place to live, work, and play!

PARA USO EXCLUSIVO EN LA CONSULTA: Centro de recogida: _____ Fecha: _____

Centra Health, en colaboración con el Distrito Central de Virginia Health, el Consejo de Recursos del Área de Bedford y la Universidad de Lynchburg, desearía obtener más información sobre lo que necesita para estar sano. Responda a las siguientes preguntas con la mejor respuesta o las mejores respuestas. Complete esta encuesta solo una vez. Debe tener más de 18 años para completar esta encuesta. Todas las encuestas se mantendrán confidenciales. Las encuestas se pueden enviar al centro de recolección o enviar por correo postal al Department of Community Health, 1901 Tate Springs Rd, Lynchburg VA 24501. Gracias por dedicar su tiempo a completar esta encuesta.

ENCUESTA DE SALUD COMUNITARIA DEL ÁREA DE BEDFORD

SALUD DE LA COMUNIDAD

1. ¿Cuál es su código postal? _____

2. ¿Cuál es su edad?

❒ Menos de 18 años ❒ De 18 a 24 ❒ De 25 a 34 ❒ De 35 a 44 ❒ De 45 a 54 ❒ De 55 a 64 ❒ Más de 65 años

3. ¿Cuáles cree que son los problemas más importantes que afectan a la salud de nuestra comunidad? (Marque todas las que correspondan)

Factores de salud

- ❒ Acceso a una vivienda accesible
- ❒ Acceso a alimentos saludables (verduras, carnes magras, fruta)
- ❒ Acceso a lugares seguros para hacer ejercicio
- ❒ Accidentes en el hogar (p. ej., caídas, quemaduras, cortes)
- ❒ Problemas de envejecimiento (apoyo para adultos de edad avanzada)
- ❒ Consumo de alcohol y drogas ilegales
- ❒ Acoso
- ❒ Uso del teléfono móvil (redes sociales)
- ❒ Abuso/descuido infantil
- ❒ Conducción distraída (uso del teléfono móvil/mensajes de texto y conducción)
- ❒ Violencia doméstica
- ❒ Juegos (máquinas de juego, apuestas deportivas, billetes de lotería)
- ❒ Actividad de pandillas
- ❒ Identidad de género
- ❒ Violencia con armas
- ❒ Sin vivienda
- ❒ Homicidio (asesinatos)
- ❒ Problemas de vivienda (p. ej., moho, chinches, pintura de plomo)
- ❒ Lesiones (accidente de tráfico, lesiones en el lugar de trabajo, accidentes domésticos)
- ❒ Falta de ejercicio (inactividad física)
- ❒ El vecindario no es seguro (veredas, carreteras, cruces, iluminación)
- ❒ No recibir “inyecciones” para prevenir enfermedades
- ❒ No usar cinturones de seguridad/sillas de seguridad para niños/cascos
- ❒ Malos hábitos alimenticios
- ❒ Mala calidad del agua y/o mala calidad del aire
- ❒ Abuso de fármacos con receta
- ❒ Agresión sexual
- ❒ Aislamiento social (soledad)
- ❒ Tabaquismo/fumar/vapear
- ❒ Problemas de transporte
- ❒ Prácticas sexuales poco seguras (relaciones sexuales sin protección)
- ❒ Otro: _____

Afecciones o consecuencias médicas

- ❒ Alzheimer/demencia
- ❒ Dolor de espalda, cadera, rodilla
- ❒ Tipos de cáncer
- ❒ COVID-19/coronavirus/COVID-19 prolongada
- ❒ Dolor/problemas odontológicos
- ❒ Diabetes
- ❒ Discapacidad
- ❒ Problemas con drogas o alcohol
- ❒ Pena (tristeza)
- ❒ Cardiopatía y accidente cerebrovascular
- ❒ Presión arterial alta
- ❒ VIH/SIDA
- ❒ Muerte infantil (menores de 1 año)
- ❒ Nefropatía
- ❒ Enfermedad pulmonar
- ❒ Problemas de salud mental
- ❒ Sobrepeso/obesidad
- ❒ Estilo de vida sedentario (inactividad física)
- ❒ Infecciones de transmisión sexual
- ❒ Problemas para dormir
- ❒ Enfermedad estomacal
- ❒ Estrés
- ❒ Suicidio
- ❒ Embarazo en la adolescencia
- ❒ Otro: _____

4. ¿Qué servicios de atención médica son difíciles de obtener en nuestra comunidad? (Marque todas las que correspondan)

- ❒ Cuidado dental en adultos
- ❒ Terapia alternativa (p. ej., a base de hierbas, acupuntura, masaje)
- ❒ Servicios de ambulancia
- ❒ Análisis de sangre
- ❒ Atención oncológica
- ❒ Cuidado dental infantil
- ❒ Atención quiropráctica
- ❒ Dermatología (cuidado de la piel)
- ❒ Servicios de violencia doméstica
- ❒ Atención en el departamento de emergencias
- ❒ Final de la vida/cuidados paliativos
- ❒ Profesional del ejercicio
- ❒ Atención hospitalaria (permanecer durante la noche)
- ❒ Inmunizaciones (vacunas)
- ❒ Apoyo a personas LGBTQIA
- ❒ Coronavirus/Cuidado prolongado de COVID-19
- ❒ Servicios de atención de la memoria
- ❒ Salud mental/orientación
- ❒ Atención de adultos de edad avanzada
- ❒ Fisioterapia o rehabilitación física
- ❒ Medicamentos con receta/suministros médicos
- ❒ Proveedor de atención primaria
- ❒ Programas para dejar de usar productos de tabaco
- ❒ Atención respiratoria (pulmón)
- ❒ Servicios de consumo de sustancias: drogas y alcohol
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Atención oftalmológica (ojos)
- ❒ Apoyo para la pérdida de peso
- ❒ Servicios médicos para mujeres
- ❒ Radiografías/mamografías
- ❒ Revisiones anuales
- ❒ Ninguno
- ❒ Otro: _____

5. ¿Qué recursos sociales/de apoyo son difíciles de obtener en nuestra comunidad? (Marque todas las que correspondan)

- ❒ Vivienda accesible/segura
- ❒ Servicios bancarios
- ❒ Guardería
- ❒ Asistencia a víctimas de violencia doméstica
- ❒ Educación (GED/secundario/universidad)
- ❒ Empleo/asistencia laboral
- ❒ Asistencia financiera
- ❒ Beneficios alimentarios (SNAP, WIC)
- ❒ Asesoramiento sobre duelo/sentimiento de pérdida
- ❒ Seguro médico
- ❒ Alimentos saludables
- ❒ Servicios jurídicos
- ❒ Asistencia en deudas médicas
- ❒ Asistencia con medicamentos
- ❒ Apoyo para la lectura y escritura
- ❒ Asistencia con el alquiler/servicios públicos
- ❒ Asistencia temporal para familias con necesidades (Temporary Assistance for Needy Families, TANF)
- ❒ Transporte
- ❒ Beneficios de desempleo
- ❒ Servicios para veteranos
- ❒ Otro: _____

PREGUNTAS GENERALES SOBRE SU SALUD O LA DE SU FAMILIA

6. ¿Qué le impide estar sano? *(Marque <u>todas</u> las que correspondan)*

- ❒ Acceso a frutas y verduras frescas
- ❒ Acceso a lugares seguros para estar activo en el exterior (aparcamiento, aceras)
- ❒ Temo tener revisiones
- ❒ No puedo encontrar proveedores que acepten mi seguro
- ❒ Guardería
- ❒ Costo (dinero)
- ❒ No me gusta aceptar asistencia gubernamental
- ❒ Falta de confianza en los médicos/las clínicas
- ❒ Falta de confianza en mi seguro para ayudar
- ❒ No tengo una fuente regular de atención de la salud
- ❒ Copago alto por la atención de la salud
- ❒ Falta de servicios nocturnos y de fin de semana
- ❒ Falta de médicos/dentistas que acepten pacientes nuevos
- ❒ Servicios lingüísticos (acceso a un intérprete)
- ❒ Ubicación de las oficinas de atención de la salud
- ❒ Largos períodos de espera para las citas
- ❒ Sin seguro médico
- ❒ Sin transporte
- ❒ Nada me impide estar sano
- ❒ Incapacidad para aprender sobre la afección médica debido a la dificultad para comprender información verbal o escrita
- ❒ Otro: _____

7. Utiliza servicios de atención médica?

❒ **Sí - Marque el lugar adonde acudir para recibir atención médica** ❒ **<u>No</u>**
(*marque <u>todas las respuestas</u> que correspondan*)

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Consultorio del médico
- ❒ Servicio de urgencias
- ❒ Departamento de Salud
- ❒ Centro de salud con calificación federal (p. ej., Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita (p. ej., clínica gratuita de Virginia Central)
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Veterans Administration Medical Center
- ❒ Otro: _____

Si la respuesta es <u>no</u>, ¿sabe dónde acudir para recibir atención médica en su comunidad? ❒ **<u>Sí</u>** ❒ **<u>No</u>**

8. ¿Cuánto tiempo ha pasado desde que visitó por última vez a un médico u otro proveedor de atención médica para una revisión de rutina? *(Marque <u>una</u> opción)*

- ❒ No he acudido a un médico u otro profesional de atención de la salud para una revisión rutinaria
- ❒ De 1 a 12 meses
- ❒ De 1 a 2 años
- ❒ De 3 a 5 años
- ❒ Más de 5 años

9. Utiliza servicios de cuidado dental?

❒ **Sí - Marque el lugar adonde acudir para recibir atención** ❒ **<u>No</u>**

- ❒ Consultorio del dentista
- ❒ Servicio de urgencias
- ❒ Centro de salud con calificación federal (p. ej., Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita (p. ej., clínica gratuita de Virginia Central)
- ❒ Misión del proyecto Mercy
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Veterans Administration Medical Center
- ❒ Otro: _____

Si la respuesta es <u>no</u>, ¿sabe dónde acudir para recibir atención odontológica en su comunidad? ❒ **<u>Sí</u>** ❒ **<u>No</u>**

10. ¿Cuánto tiempo ha pasado desde que visitó por última vez un dentista o clínica dental por cualquier motivo? Incluya visitas a especialistas odontológicos (como ortodoncistas, periodontista). *(Marque <u>una</u> opción)*

- ❒ Nunca he visitado a un dentista o una clínica odontológica por ningún motivo.
- ❒ De 1 a 12 meses
- ❒ De 1 a 2 años
- ❒ De 3 a 5 años
- ❒ Más de 5 años

11. Utiliza servicios de salud mental, o para el consumo de alcohol o drogas?

❒ **Sí - Marque el lugar adonde acudir para recibir estos servicios** ❒ **No**

- ❒ Consultorio del médico/orientador
- ❒ Servicio de urgencias
- ❒ Centro de salud con calificación federal (p. ej., Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita (p. ej., clínica gratuita de Virginia Central)
- ❒ Horizon Behavioral Health
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Veterans Administration Medical Center
- ❒ Otro: _____

Si la respuesta es no, ¿sabe dónde acudir para obtener servicios de salud mental, consumo de sustancias y/o consumo de alcohol en su comunidad? ❒ **Sí** ❒ **No**

12. ¿Cuánto tiempo ha pasado desde que utilizó por última vez servicios de salud mental, para el consumo de alcohol o de drogas por cualquier motivo? *(Marque una opción)*

- ❒ No he utilizado servicios de salud mental, para consumo de alcohol o de drogas por ningún motivo
- ❒ De 1 a 12 meses
- ❒ De 1 a 2 años
- ❒ De 3 a 5 años
- ❒ Más de 5 años

13. ¿Le ha dicho un médico que tiene...? (*Marque todas las que correspondan*)

- ❒ Alzheimer/demencia
- ❒ Artritis
- ❒ Asma
- ❒ Cáncer
- ❒ Parálisis cerebral
- ❒ Depresión o ansiedad
- ❒ Problemas con las drogas o el alcohol
- ❒ Trastorno de la alimentación
- ❒ Cardiopatía
- ❒ Presión arterial alta
- ❒ Nivel alto de azúcar en sangre o diabetes
- ❒ Colesterol alto
- ❒ VIH/SIDA
- ❒ COVID-19 prolongada
- ❒ Problemas de salud mental
- ❒ Obesidad/sobrepeso
- ❒ Inactividad física
- ❒ Infecciones de transmisión sexual
- ❒ Trastorno del sueño
- ❒ Accidente/enfermedad cerebrovascular
- ❒ Problemas para caminar o moverse
- ❒ No corresponde
- ❒ Otro: _____

14. Pensando en su salud física, que incluye enfermedad física y lesión, ¿durante cuántos días de los últimos 30 días su salud física no fue buena? (Marque una opción)

❒ 0 ❒ De 1 a 13 ❒ De 14 a 30 (días)

15. Pensando en su salud mental, que incluye estrés, depresión y problemas emocionales, ¿durante cuántos días de los últimos 30 días su salud mental no fue buena? (Marque una opción)

❒ 0 ❒ De 1 a 13 ❒ De 14 a 30 (días)

16. Durante los últimos 30 días: *(Marque todas las opciones que correspondan)*

- ❒ He consumido productos de marihuana
- ❒ He consumido otras drogas ilegales (p. ej., metanfetaminas, cocaína, heroína, éxtasis, crac, LSD, etc.)
- ❒ He tomado 5 o más bebidas alcohólicas (si es hombre) o 4 o más bebidas alcohólicas (si es mujer) durante una ocasión
- ❒ He utilizado productos de tabaco (cigarrillos, tabaco de mascar, cigarros, etc.)
- ❒ He utilizado productos de vapeo (cigarrillos electrónicos)
- ❒ He tomado medicamentos con receta para drogarme
- ❒ He tenido sobre dosis por consumo de drogas
- ❒ Me han administrado Narcan/Naloxone
- ❒ Ninguno de estas

17. Marque una de las siguientes opciones para cada

	Sí	**No**	**No corresponde**
He acudido a urgencias en los últimos 12 meses.	❒	❒	
He estado en urgencias por una lesión en los últimos 12 meses (p. ej., accidente de un vehículo de motor, choque, caída, intoxicación, quemadura, corte, etc.).	❒	❒	
He intentado suicidarme en los últimos 12 meses.	❒	❒	
He intentado autolesionarme en los últimos 12 meses.	❒	❒	
He sido víctima de violencia o abuso doméstico en los últimos 12 meses.	❒	❒	
Tomo el medicamento que mi médico me dice que tome para controlar mi enfermedad crónica.	❒	❒	❒
Puedo pagar los medicamentos necesarios para mis afecciones médicas.	❒	❒	❒
¿Su comunidad apoya la actividad física? (p. ej., parques, aceras, carriles para bicicletas, etc.)	❒	❒	
En la zona donde vive, ¿es fácil obtener frutas y verduras frescas?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía suficiente dinero para comprar la comida que usted o su familia necesitaban?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía dinero suficiente para pagar su alquiler o hipoteca?	❒	❒	❒
¿Se siente seguro donde vive?	❒	❒	

18. En los últimos 7 días, ¿cuántos días ha pasado al menos 30 minutos al día realizando actividades físicas (caminar, correr, montar en bicicleta, jardinería, trabajo físico)?

❒ 7 días ❒ 6 días ❒ 5 días ❒ 4 días ❒ 3 días ❒ 2 días ❒ 1 día ❒ 0 días

19. Durante los últimos 7 días, ¿cuántas veces ha caminado durante al menos 10 minutos sin parar?

❒ No he caminado durante al menos 10 minutos sin parar en los últimos 7 días.
❒ 1 a 3 veces durante los últimos 7 días
❒ De 4 a 6 veces durante los últimos 7 días
❒ 1 vez por día
❒ 2 veces por día
❒ 3 veces por día
❒ 4 o más veces por día

20. ¿Cuál es su estatura? _____pies _____pulgadas
_____centímetros

21. ¿Cuál es su peso? _____libras
_____kilogramos

22. En los últimos 7 días, ¿cuántas horas al día dedica a utilizar la tecnología (teléfonos inteligentes, computadoras, tabletas, dispositivos de juegos) fuera de la escuela o del trabajo?

❒ 0 horas ❒ De 1 a 3 horas ❒ De 3 a 6 horas ❒ De 6 a 9 horas ❒ Más de 9 horas

23. En los últimos 7 días, ¿cuántas horas al día dedica a utilizar las redes sociales fuera de la escuela o del trabajo?

❒ 0 horas ❒ De 1 a 3 horas ❒ De 3 a 6 horas ❒ De 6 a 9 horas ❒ Más de 9 horas

24. Dónde consigue la comida que come en su hogar? ***(Marque <u>todas</u> las opciones que correspondan)***

❒ Programas de comida de mochila o de verano
❒ Jardín comunitario
❒ Tienda de conveniencia/estación de servicio
❒ Tienda todo por 1 dólar
❒ Mercado
❒ Banco de alimentos/despensa de alimentos
❒ Supermercado
❒ Huerta familiar
❒ No cocino/como en casa
❒ Habitualmente recibo comida de mi familia, amigos, vecinos o de mi iglesia
❒ Programa Meals on Wheels
❒ Comida para llevar/comida rápida/restaurante
❒ Otro: _____

25. Durante los últimos 7 días, ¿cuántas veces ha comido frutas y verduras? No cuente los zumos de frutas o verduras, ni los suplementos de frutas o verduras. ***(Marque <u>una</u> opción)***

❒ No he comido frutas ni verduras durante los últimos 7 días
❒ 1 a 3 veces durante los últimos 7 días
❒ De 4 a 6 veces durante los últimos 7 días
❒ 1 vez por día
❒ 2 veces por día
❒ 3 veces por día
❒ 4 o más veces por día

26. En los últimos 7 días, ¿cuántas veces comieron juntos todos o la mayoría de los miembros de su familia que viven en su casa?

❒ Nunca ❒ 1 a 2 veces ❒ 3 a 4 veces ❒ 5 a 6 veces ❒ 7 veces ❒ Más de 7 veces ❒ No corresponde/Vivo solo

27. ¿En qué medida se siente socialmente conectado con la comunidad y las personas que le rodean?	**Totalmente en desacuerdo**	**En desacuerdo**	**Neutral**	**De acuerdo**	**Totalmente de acuerdo**
Me siento socialmente conectado.	❒	❒	❒	❒	❒

28. ¿Dónde duerme con más frecuencia? ***(Marque <u>una</u> opción)***

❒ En un hogar de grupo, hospital o programa de tratamiento
❒ En una casa que poseo o alquilo
❒ En un hotel o motel
❒ En un refugio o en un programa de vivienda de transición
❒ Vivo con mi familia extendida porque esa es mi decisión.
❒ Fuera, en un coche, en un edificio abandonado o en un espacio público
❒ Me quedo con amigos o familiares debido a problemas económicos (no es mi decisión).

29. Tiene acceso a un transporte fiable? ❒ Sí ❒ No

30. Qué tipo de transporte utiliza con más frecuencia?

❒ Mis amigos/familiares me llevan
❒ Ando en bicicleta o camino
❒ Conduzco
❒ Otro servicio de transporte (nombre): _____
❒ Transporte público (es decir, autobús, servicio de enlaces, similar)
❒ Uso compartido de vehículos
❒ Taxi (incluido Uber/Lyft)
❒ Otro: _____

INFORMACIÓN DEMOGRÁFICA Y SEGURO MÉDICO

31. ¿Cuál de las siguientes opciones describe su tipo actual de seguro médico? *(Marque <u>todas</u> las que correspondan)*

- ❒ COBRA
- ❒ Seguro dental
- ❒ Seguro proporcionado por el empleador
- ❒ Gobierno (VA, TRICARE)
- ❒ Cuenta de ahorros/gastos médica
- ❒ Seguro individual/privado/Marketplace/Obamacare
- ❒ Medicaid
- ❒ Medicare
- ❒ Complemento de Medicare
- ❒ Sin seguro dental
- ❒ Sin seguro médico

32. Si no tiene seguro médico, ¿por qué no tiene seguro? *(Marque <u>todas</u> las que correspondan)*

- ❒ No corresponde; tengo seguro médico
- ❒ No entiendo las opciones de Marketplace/Obamacare
- ❒ No disponible en mi trabajo
- ❒ Estudiante
- ❒ Demasiado caro/costo
- ❒ Desempleado/sin trabajo
- ❒ Inmigrante no documentado
- ❒ Otro: _____

33. Cuál es su identidad de género? ❒ Hombre ❒ Mujer ❒ No binario ❒ Transgénero ❒ Género *queer* ❒ Género fluido ❒ Prefiero no responder

34. Cuál es su nivel de educación completo más alto?

- ❒ Menos que la escuela secundaria
- ❒ Algo de la escuela secundaria
- ❒ Título de escuela secundaria/GED
- ❒ Certificado vocacional/técnico
- ❒ Técnico superior
- ❒ Licenciatura
- ❒ Máster/doctorado

35. ¿Con qué raza/origen étnico se identifica? *(Marque <u>todas</u> las que correspondan)*

- ❒ Nativo de Hawái/islas del Pacífico
- ❒ Nativo estadounidense/Nativo de Alaska
- ❒ Asiático
- ❒ Hispano/Latino
- ❒ Negro/Afroestadounidense
- ❒ Blanco
- ❒ Más de una raza
- ❒ Rehúso responder
- ❒ Otro: _____

36. Cuál es su estado civil?

❒ Casado/a ❒ Soltero/a ❒ Divorciado/a ❒ Viudo/a ❒ En pareja

37. Cuántas personas viven en su casa (incluido usted)?

Cantidad de niños (de 0 a 17 años) _____ Cantidad de adultos (de 18 a 64 años) _____ Cantidad de adultos (de más de 65 años) _____

38. Cuáles son los ingresos anuales de su familia?

- ❒ $0 - $10,000
- ❒ $10,001 - $20,000
- ❒ $20,001 - $30,000
- ❒ $30,001 - $40,000
- ❒ $40,001 - $50,000
- ❒ $50,001 - $60,000
- ❒ $60,001 - $70,000
- ❒ $70,001 - $100,000
- ❒ $101 001 y más

39. Cuál es su situación laboral actual?

- ❒ A tiempo completo
- ❒ A tiempo parcial
- ❒ Desempleado
- ❒ Autónomo
- ❒ Jubilado
- ❒ Tareas domésticas
- ❒ Estudiante
- ❒ Discapacitado/a

40. Hay algo más que deberíamos saber sobre sus necesidades (o las de alguien que vive en su hogar) para mantenerse sano?

_____

_____

_____

_____

Gracias por ayudar a convertir el área metropolitana de Bedford en un lugar más saludable para vivir, trabajar y jugar!

Bedford Stakeholder Focus Group Directory Date: April 30, 2024		
Last Name	**First Name**	**Organization**
Blankenship	Janet	Bedford County Fire & Rescue
Boone	Mary Jo	Bedford YMCA
Brake	Linda	Bedford Ride
Broocks	Carter	Centra - Marketing
Brown	Wilson	St John's Episcopal Church
Bunting	Melinda	Centra - Community Health Services
Carey	Laura	Bedford Department of Social Services
Crawford	Andy	Bedford Department of Social Services
Davis	Jaylin	Centra - Community Health Services
Dillon	Jeff	Centra - Process Engineering
Dooley	Heather	Lynchburg Area Center for Independent Living
Foster	Kim	Central Virginia Health District
Hitchcock	Carolyn	Centra
Hogue	Pat	Prayer Outreach Ministries
Horacek	Madison	Central Virginia Health District
Huff	Denny	Bedford Community Health Foundation
Jack	Alex	Centra - Community Health Services
Jacks	Brian	AARP
Kirby	Mary	Centra
Lewis	Ghislaine	University of Lynchburg
Pavao	Adam	Impact Living Services
Rioux	Jade	Centra - Community Health Services
Rowden	Wendy	Bedford Get Together
Saunders	Tim	Virginia Career Works
Smith	Jeanell	Virginia Cooperative Extension
Smith	Sophie	Central Virginia Health District
Stanley	Scott	Community Volunteer
Stephens	Amy	Centra - Process Engineering
Thorn	Nicole	FIVE18 Family Services
Turner	Tomi	Bedford Department of Social Services
Vaught	Stacey	Centra - BMH Hospital President
Young	Pat	Centra - VP Community Health Services
Zirkle	Mary	Town of Bedford - Economic Development Coordinator

2024 Bedford Area Prioritization of Needs Worksheet
Instructions: Rank the following "Areas of Need" from 1 to 18
(1 is the greatest need)

1 - 18	Area of Need
	Access to Healthcare Services
	Aging and Eldercare
	Broadband Access
	Cell phone use (Social Media)
	Chronic Disease
	Coordination of Resources & Community Outreach
	Dental Care & Dental Problems
	Distracted Driving
	Domestic Violence
	Employment/Job Assistance
	Financial Stability & Assistance
	Food Insecurity & Nutrition
	Homelessness & Housing
	Issues Impacting children & their Families: Childcare; Child Abuse/Neglect
	Mental Health & Substance Use Disorders & Access to Services
	Physical Activity & Recreational Spaces
	Transportation
	Veterans Services

2024 Bedford Area Prioritization of Needs Worksheet
Instructions: Rank the following "Areas of Need" from 1 to 18
(1 is the greatest need)

		2024 Community Health Survey					Stakeholder Focus Group	Target Population Focus Groups
1 - 18	Area of Need	What do you think are the most important issues that affect health in our community? Health Factors	What do you think are the most important issues that affect health in our community? Health Conditions	Which health care services are hard to get in our community?	Which social/support resources are hard to get in our community?	What keeps you from being healthy?	What are the top 5 greatest needs in the community(s) you serve?	What are the top 5 greatest needs in your community(s) around health and wellness?
	Access to Healthcare Services			x	x	x	x	x
	Aging and Eldercare	x	x	x			x	
	Broadband Access						x	
	Cell phone use (Social Media)	x						
	Chronic Disease		x					
	Coordination of Resources & Community Outreach						x	x
	Dental Care & Dental Problems			x		x		
	Distracted Driving	x						
	Domestic Violence						x	
	Employment/Job Assistance				x			
	Financial Stability & Assistance				x			
	Food Insecurity & Nutrition	x		x	x	x	x	x
	Homelessness & Housing	x			x		x	x
	Issues Impacting children & their Families: Childcare; Child Abuse/Neglect	x			x		x	
	Mental Health & Substance Use Disorders & Access to Services	x	x	x			x	x
	Physical Activity & Recreational Spaces	x	x			x		x
	Transportation				x		x	x
	Veterans Services				x			

2024 Bedford Priority Area of Needs and Community Resources		
Ranking	**2024 Priority Area of Need**	**Resources Available**
1	Mental Health & Substance Use Disorders & Access to Services	**Mental Health & Substance Abuse Treatment Services** Avenues to Wellness Horizon Behavioral Health Celebrate Recovery Pathways Treatment Center Centra – EmPATH Unit, Bridges Treatment Center, Centra Medical Group Mount Regis Center Oxford Houses The Haven UP Foundation Impact Living Services Roads to Recovery Addiction Allies Johnson Health Center Community Access Network – Hope Initiative BrightView Anderson Counseling Services Dogwood Counseling Center Acute Psychiatric Inpatient – Virginia Baptist Hospital Thriveworks Minds Together The Madeline Centre Focus Psychiatry and Wellness **Crisis Intervention Prevention** Bedford Domestic Violence Services YWCA Central VA - Sexual Assault Response Program Horizon Behavioral Health Embrace Healthy Solutions Agape Center RAINN Hotline for Sexual Violence National Suicide Prevention Line
2	Access to Healthcare Services	**Medical Services** Bedford Community Health Center Free Clinic of Central Virginia Centra Health & Centra Medical Group Centra Bedford Memorial Hospital Community Access Network Virginia Department of Medical Assistance Services VA Medical Center Carilion Clinic **Prescription Assistance** FamilyWize Discount Card Free Clinic of Central Virginia – MedsHelp Virginia Medication Assistance Program (VA MAP) GoodRx *continued on next page...*

Ranking	2024 Priority Area of Need	Resources Available
		Virginia Department of Health Central Virginia Health District *Bedford County Health Department* *Lynchburg Health Department*
3	Food Insecurity & Nutrition	**Food / Food Pantries** Agape Center Bedford Christian Ministries Bedford Church of God Bonsack Baptist Church Churches of Urban Ministry Lake Christian Ministries Lynchburg Daily Bread Salvation Army Shepherds Table Virginia Cooperative Extension Blue Ridge Area Food Bank Interfaith Outreach Ministries Bedford County Department of Social Services Park View Community Mission Society of St. Andrew Bedford Community Christmas Station Lynchburg Grows Central Virginia Alliance for Community Living Meals on Wheels Farmers' Market – Bedford, Forest, & Moneta SML Good Neighbors
4	Issues Impacting Children & their Families: Childcare, Child Abuse/Neglect	**Childcare – Financial Assistance** Lynchburg Community Action Group Bedford County Department of Social Services Bedford Area Family YMCA Bright Beginnings Central Virginia Mary Bethune Academy **Childcare – Resources and Referrals** HumanKind 2-1-1 Virginia Bright Beginnings Central Virginia Bedford Area Family YMCA **Child/Infant Car Seats** Lynchburg Police Department Bedford County Sheriff's Office Central Virginia Health District *Bedford County Health Department* *Lynchburg Health Department* Bedford County Department of Social Services *continued on next page...*

Ranking	2024 Priority Area of Need	Resources Available
		Child Protective Services CASA of Central Virginia Bedford County Department of Social Services Childhelp National Child Abuse Hotline Children's Advocacy Center of Bedford **Children & Family Recreation** Bedford County Parks & Recreation Department Bedford Area Family YMCA Virginia Cooperative Extension Girls on the Run Central Virginia & Blue Ridge Claytor Nature Center Girl Scouts of Virginia Skyline Council Boy Scouts of America, Blue Ridge Mountains Council Camp Kum Ba Yah **Parenting Skills & Family Support** HumanKind FIVE18 Family Services Impact Living Services The Madeline Centre
5	Homelessness & Housing	**Housing** College Hill Apartments James Crossing Apartments Raintree Village Apartments Lynchburg Covenant Fellowship Mill Woods Apartments Pinecrest Apartments Peaks Crossing Apartments Liberty Manor Apartments Salem Court Apartments Powder Horn Apartments Hillcrest Apartments (Seniors) John Early Apartments (Seniors) Meadows Apartments (Disabled) McGurk House (Seniors) RUSH Homes (Disabled) Joseph's Dream Apartments (Seniors) USDA Rural Development Bedford Redevelopment & Housing Authority **Shelters & Transitional Housing** Coordinated Homeless Intake and Access (CHIA) Bedford Domestic Violence Services Homes of Hope Lighthouse Community Center *continued on next page...*

Ranking	2024 Priority Area of Need	Resources Available
		Shelters & Transitional Housing (cont.) Salvation Army Miriam's House YWCA Domestic Violence Shelter YWCA Residential Program Oxford Houses Central Virginia Continuum of Care (CVCoC) **Housing Weatherization & Rehabilitation** Central Virginia Alliance for Community Living (Senior Services) Lynchburg Community Action Group Interfaith Outreach Association Southeast Rural Community Assistance Project (SERCAP)
6	Transportation	**Transportation** Bedford Ride Otter Bus ModivCare (Medicaid Transportation) Johnson Health Center – Appointment Transportation Dial-A-Ride / New Freedom
7	Aging & Eldercare	**Senior Services** Bedford County Parks and Recreation Bedford Ride Bedford Get Together Central Virginia Alliance for Community Living Generation Solutions Home Instead Meals on Wheels Bedford Adult Day Center Raspberry Hill Adult Daytime Center Bedford County Department of Social Services AARP Virginia Alzheimer's Association Centra PACE Virginia Department for Aging & Rehabilitative Services **Veterans** Lynchburg Area Veterans Council Virginia Department of Veterans Services **Disability Services & Rehabilitation** The ARC of Central Virginia Lynchburg Area Center for Independent Living (LACIL) Achieve of Central Virginia RUSH Homes Virginia Department for Aging & Rehabilitative Services Harmony Day Support The Hive Day Services Special Olympics

Ranking	2024 Priority Area of Need	Resources Available
8	Dental Care & Dental Problems	**Dental Services** Free Clinic of Central Virginia Community Access Network Bedford Community Health Center Bedford County Health Department VA Medical Center
9	Coordination of Resources & Community Outreach	**Community Partnerships & Coalitions** Blue Ridge Re-Entry Council Bedford Area Resource Council (BARC) Central Virginia Continuum of Care (CVCoC) Bedford Community Coalition Bedford Domestic Violence Coalition Bedford Area Chamber of Commerce Bedford NAACP Bedford Get Together Rotary Club of Bedford **Community Philanthropic Organizations** Centra – Community Health Bedford Community Health Foundation United Way of Central Virginia Virginia Early Childhood Foundation **Financial & Job Assistance** Virginia Career Works Lynchburg Community Action Group Virginia Employment Commission Interfaith Outreach Association Bedford Christian Ministries **Legal Assistance** Virginia Legal Aid Society **Public Safety & Disaster Relief** American Red Cross – Blue Ridge Bedford Police Department Gleaning for the World Bedford County Sheriff's Department / Emergency Services Virginia State Police
10	Chronic Disease	**Health Education** Centra Health Community Access Network Johnson Health Center Carilion Clinic Virginia Cooperative Extension American Cancer Society American Diabetes Association Alzheimer's Association