CENTRA

2021–2024 | Town of Bedford and Bedford County

Bedford Area Community Health Needs Assessment

Centra Bedford Memorial Hospital

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ACKNOWLEDGEMENTS

The 2021 Bedford Area Community Health Needs Assessment 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 2021 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 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 because of the assessment process. The Community Health Needs Assessment and Prioritization of Needs was approved by the Centra Community Benefit Committee on November 19, 2021, the Centra Bedford Memorial Hospital Board of Directors on November 30, 2021 and the Centra Board of Directors on December 6, 2021.

The Partnership for Healthy Communities is a planning initiative led by Centra, the Community Access Network, the Central Virginia, Piedmont, and Pittsylvania/Danville Health Districts, the Bedford Community Health Foundation, Greater Lynchburg Community Foundation, Johnson Health Center and United Way of Central Virginia. The partners are committed to regional alignment of a collaborative and rigorous needs assessment process that will result in action-oriented solutions to improve the health of the communities they serve. A Community Health Assessment Team composed of over 40 individuals with a broad representation of community leaders and cross-sector stakeholders acted to oversee, advise, and support the CHNA activities.

The 2021 Bedford Area Community Health Needs Assessment focused on lifting the voice of the community through the collection of 857 Community Health Surveys as well as conducting a stakeholder focus group/survey. In addition, over 65 sources of publicly available secondary data were collected.

KEY FINDINGS

The data for the Community Health Needs Assessment is reported using the framework for the County Health Rankings from the University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation. These rankings, released annually, measure the health of a community, and rank them against all other counties within a state. In Virginia, there are 133 localities that are ranked annually. The County Health Rankings for the Bedford service area for 2019-2021 are in the 1st to 2nd quartile for "Health Outcomes", which is a measure of morbidity and mortality and how healthy a locality is today. "Health Factors," represents factors that influence health of a community in the future.

County Health Rankings

Locality	*2019*		*2020*		*2021*	
	Health Outcomes	*Health Factors*	*Health Outcomes*	*Health Factors*	*Health Outcomes*	*Health Factors*
Bedford	33	36	35	44	32	38

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).

HEALTH FACTORS

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

Demographics, Social and Economic Status

According to the U.S. Census, the total population for the service area is 78,376 in Bedford County and 6562 in the town of Bedford. In the county, 49.1% of the population is male and 50.9% is female and in the town 47.10% of the population is male and 52.9% is female. The median age for Bedford County is 46.3 years and for the town of Bedford 34.5 years. The median age in Virginia is 38.2. Approximately 20% of the population is 65 years of age or older which is slightly higher than those living in Virginia as a whole (15.1%). In Bedford County and the town of Bedford, 89.4% and 76.3% respectively are White, 6.9% and 20.3% are Black, and 2.0% are Hispanic or Latino (Bedford County only).

The median household income in the County is $64,199 and in the town is $36,364 as compared to $74,222 in Virginia with whites and Hispanics having higher median household incomes than blacks. Approximately 23.8% of county residents and 45.7% of town residents live at or below 200% of the Federal Poverty Level as compared to 24.8% in Virginia. Approximately 36% of the 31,206 households in the service area are classified as ALICE (Asset Limited, Income Constrained, Employed) as compared to 29% of households in Virginia. ALICE is a way of defining and understanding the struggles of households that earn above the Federal Poverty Level, but not enough to afford basic household needs (i.e., cost of living outpaces what they earn).

Of the public school-aged children in the service area, 40% (3,873) are eligible for free and reduced lunches as compared to 45.6% of children in the Commonwealth. Most notably, 97% of students at Bedford Primary Thomas Jefferson Elementary and Bedford Alternative Education Center are eligible for free and reduced lunches. Approximately 29% of children in Bedford County live at or below 200% of Federal Poverty (4,659 children) compared to 33% in Virginia. This statistic was not available for children living in the town of Bedford.

Although unemployment rates were decreasing in 2018 and 2019 across the Commonwealth, there was an almost doubling of these rates in 2020 as a result of the COVID-19 pandemic. The unemployment rate for Bedford County was 5.7% and 6.2% in Virginia. In the service area, of the population age 25 and over, educational attainment for the town of Bedford and the county of Bedford (respectively) is 19.1% and 10% for less than high school graduate; 31.2% and 30.2% for high school graduate or equivalency; 32.1% and 30.6% for some college or Associate's Degree; and 17.6 and 29.2% for Bachelor's Degree or Higher.

Most Community Health Survey respondents (96.8%) lived in the Bedford Area with a median age of 45 years. In 2021, we saw a significant increase in the number of male respondents (29.2%) while 70.4% were female and 0.4 % identified as non-binary. Slightly fewer survey respondents were White (71.3%) or Black/African American (8.8%) as compared to 2018 respondents. However, there was a significant increase in the number who reported being Hispanic/Latino (5.0%) or either Asian, American Indian/Alaska Native or Native Hawaiian/Pacific Islander (12.4% collectively).

Significantly fewer survey respondents in 2021 reported an annual income of $20,000 or less as compared to 2018 (14.2% versus 28% respectively). However, there was an increase in the number of respondents who reported incomes of $20,001 to $40,000 (18%). This may reflect those who are ALICE (Asset Limited, Income Constrained, Employed). Those reporting household incomes of over $100,000 per year in 2021 (25.9%) was slightly higher compared to 2018 (20.1%). An estimated 33.6% of respondents lived no greater than 200% of the Federal Poverty Level (FPL) of which an estimated 11.2% lived below 100% of FPL. Survey respondents had higher education attainment rates than the population as a whole. Over half were employed full-time and 5% were unemployed. Approximately 22% of respondents reported not having enough money in the past 12 months to pay for rent or mortgage, while 30% reported not having enough money in the past 12 months to buy food. Approximately 20% could not afford to pay for their medications.

Almost 8% of respondents reported being a victim of domestic violence or abuse in the past 12 months more than double those in 2018 (2.8%) while 9% of respondents did not feel safe where they lived. When asked which social/support resources are hard to get in the community, the top 5 responses included (1) childcare; (2) affordable/safe housing; (3) transportation; (4) healthy food; and (5) employment/job assistance.

Health Behaviors

The obesity rate for Bedford County is 34.6% and 30.5% for Virginia. Approximately 18% of Community Health Survey respondents self-reported being overweight while 32% reported being obese. According to data from County Health Rankings, 21% of those living in Bedford County report no-leisure time physical activity as compared to 22% of adults in the Commonwealth. About 37% of Bedford Area Community Health Survey respondents met physical activity guidelines of 150 minutes of aerobic activity weekly in 2021.

In 2021, approximately 22% of Community Health Survey respondents reported that their neighborhoods don't support physical activity and that it is not easy to get affordable fresh fruits and vegetables in their neighborhoods. There was an increase in respondents who reported getting the food they eat from food banks/ food pantries, back-pack or summer food programs, and Meals on Wheels. Additionally, less than half of respondents met the minimum requirements for daily fruit and vegetable consumption.

Data for Bedford County reveals that 18.7% of adults binge or drink heavily (17.7% in Virginia) while 19% are current tobacco smokers (15% in Virginia). Approximately 20% of Community Health Survey respondents reported using tobacco products and 24% reported binge drinking during one occasion in the past month. Those who reported taking prescription drugs to get high (4%) increased from 2018 (0.8%) while 3.5% used marijuana and 0.8% used other illicit drugs in the past month.

In 2018, the mortality rate (per 100,000) for overdose from any opioid use was 5.1 in Bedford County and 12.4 in Virginia. In 2020, overdose deaths in the United States reached a record 93,000 eclipsing the high of 72,000 deaths the year before (29% increase). The pandemic exacerbated this "overdose pandemic" which is being driven by fentanyl contaminated opioids and amphetamines. Service area opioid overdose data for 2019 and 2020 was unavailable for this assessment.

Clinical Care

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

Over 87% of Community Health Survey respondents reported using medical services. Of those who use medical services, 41% reported Centra Medical Group as their top choice for care while there was a dramatic increase in the use of Urgent Care (38%) in 2021 as compared to 2018 (26%). Nearly 25% used the Emergency Room and 16% reported using online/telehealth/virtual visits. Three percent (3%) reported not seeing, postponing, or cancelling visits with their healthcare providers due to COVID-19.

There was an increase in the number of respondents who reported using dental services in 2021 (92%) compared to 2018 (77%) while there was a slight decrease in the number who reported having a dental exam within the past 12 months. The use of a Free Clinic, Urgent Care or Walk-in Clinic, Federally Qualified Health Center or the Emergency Room for dental services increased in 2021. Additionally, 5% of respondents delayed their care due to COVID-19.

The number of respondents indicating that they use mental health, alcohol or drug abuse services increased dramatically from 13% in 2018 to 32% in 2021. Eighteen percent (18%) used online, telehealth, or virtual visits for their care and the use of FQHC's and Free Clinics increased significantly while the use of the area Community Services Board decreased in 2021. Almost 2% delayed their care due to COVID-19.

The number of respondents indicating that they had no health insurance fell dramatically from 10% in 2018 to just 1.4% in 2021. Respondents with Medicare coverage increased to 28% while slightly fewer respondents reported having Medicaid (9.5%) as compared to 2018. With Medicaid Expansion in Virginia beginning in 2019, an estimated 400,000 people were expected to become eligible for coverage under the expanded guidelines, but that number is higher now that the COVID pandemic has caused widespread job losses. By early 2020, about 375,000 people had gained coverage under the expanded eligibility guidelines. By December 2020, however, that number had grown to more than 494,000 people. When the job market rebounds after the pandemic recedes, some of those individuals will transition away from Medicaid.

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

Physical Environment

The physical environment can impact a wide range of health and quality-of-life outcomes and include such factors as the natural environment, transportation, the built environment, housing, exposure to toxic substances, and physical barriers especially for those living with disabilities. Data for Bedford County reveals that 8.6% of households have severe housing problems compared to 14.6% in Virginia. Housing problems include overcrowding, high housing costs, or lack of kitchen or plumbing facilities. Additionally, residential segregation (the degree to which two or more groups live separately from one another in a geographic area) is 28 in Bedford County as compared to 41 in Virginia. (This housing and segregation data was not available for the town of Bedford.)

Community Health Survey respondents were asked where they sleep most often. In 2021, 79% of respondents slept most often in their own homes. The additional respondents who reported either sleeping at a friend's or family's home, in a shelter or transitional housing, or in a group home, hospital, or treatment program was 21.1%.

Approximately 90% of respondents indicated that they had access to reliable transportation. When asked what type of transportation they use most often, 76% indicated that they drove; 8% biked or walked; 9% relied on others to drive them, and 5% relied on public transit.

During the pandemic shutdown, the lack of broadband access especially in the more rural areas, made it difficult for adults to work remotely, prevented children from attending school virtually, and decreased access to telehealth services. In Bedford County, the percentage of households with Broadband Internet access is 76% as compared to 84% in Virginia as a whole.

HEALTH OUTCOMES

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

Length of Life

In Bedford County, the life expectancy by average number of years lived is comparable to life expectancy in Virginia (79.5 years). The premature death rate for Bedford County is 339.4 as compared to 320.3 in Virginia. Three-year average death rates are higher in Bedford County as are rates for deaths due to injury; stroke; heart disease and hypertension. Service area death rates for heart disease and stroke are higher for blacks compared to whites. Cancer incidence rates are higher for all cancer types including lung, colon and rectal cancers as compared to rates in Virginia. Incidence rates were higher for blacks as compared to whites in the service area for colon, rectal, and prostate cancers.

Suicide rates in Bedford County (19.56) are higher than the overall state rate (13.20).

Quality of Life

From 2017-2019, average low birth weights per total live births were slightly lower in Bedford County as compared to the Commonwealth. However, racial disparities existed in the service area for black and "other" races where low birth weights are significantly higher than for whites. These disparities are also evident for teen birth rates in Bedford County however overall teen birth rates are lower than rates in Virginia as a whole.

In 2021, 84% of survey respondents reported that their physical health was not good for 0 to 5 days and 91.7% of persons felt their mental health was not good for 0-15 days in the past month, an increase from 2018 (78% and 85.7% respectively). The impact of COVID-19 should be considered as a contributor to these changes. Secondary data for the service area revealed that persons reporting physically unhealthy days in the past month, and those reporting average number of poor mental health days in the past 12 months, was slightly higher for Bedford County as compared to rates in Virginia.

Survey respondents diagnosed with a chronic condition had obesity/overweight, high blood pressure, depression or anxiety, high cholesterol, and high blood sugar or diabetes most frequently.

COVID-19

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

COMMUNITY NEED

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

	Health Factors	
1	**Alcohol and illegal drug use**	48.8%
2	**Poor eating habits**	45.6%
3	**Lack of exercise**	39.3%
4	**Access to healthy foods**	37.7%
5	**Aging problems**	34.7%
6	**Tobacco use / smoking / vaping**	32.8%
7	**Cell phone use / texting and driving / distracted driving**	31.8%
8	**Child abuse / neglect**	29.8%
9	**Domestic Violence**	27.6%
	Access to affordable housing	27.5%

	Health Conditions or Outcomes	
1	**Overweight / obesity**	56.3%
2	**Diabetes**	53.8%
3	**Mental health problems**	51.8%
4	**Heart disease and stroke**	49.1%
5	**Cancers**	46.2%
6	**High blood pressure**	46.2%
7	**Stress**	41.2%
8	**COVID-19 / coronavirus**	33.7%
9	**Dental problems**	24.4%
	Disability	23.6%

A Focus Group meeting was held with 37 cross-sector stakeholders, non-profit organizations, service providers, business leaders, and local government officials. Keeping the impact of the COVID-19 pandemic in mind, they were asked questions regarding the needs of those they serve, resources available in the community to address those needs (including any gaps in resources), and how we can work together to create healthier communities. In the Bedford Area, the top 5 needs identified by these stakeholders were (1) mental health; (2) transportation; (3) childcare; (4) substance use; and (5) housing.

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.

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

1. Responses from the Community Health Survey

a. Q2A: What do you think are the most important issues that affect health in our community? (Health Factors) (n= 848 survey responses)

b. Q2B: What do you think are the most important issues that affect health in our community? (Health Conditions or Outcomes) (n= 845 survey responses)

c. Q3: Which health care services are hard to get in our community? (n= 843 responses)

d. Q4. Which social/support resources are hard to get in our community? (n= 809 responses)

2. Responses from the Stakeholders' Focus Group/Survey

a. Q1. What are the top 5 greatest needs in the community(s) you serve? (n= 86 responses)

CHAT members were asked to rank the top five priority areas of need (out of the 41 identified) with 1 being the greatest need and 5 being the 5th greatest need.

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

1. Mental Health and Substance Use Disorders & Access to Services
2. Access to Healthcare Services
3. Issues Impacting Children and their Families
   a. Childcare
   b. Child Abuse/Neglect
4. Transportation
5. Aging and Eldercare
6. Chronic Disease
7. Employment/Job Assistance
8. Financial Stability
9. Housing
10. Dental Care & Dental Problems

PROJECT BACKGROUND

This section highlights Centra's services and programs, a project overview, and description of the service area, target population and methodology for the 2021 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 8,100 employees, 500 employed providers and physicians, and a medical staff of nearly 800 providing care in 50 locations, Centra serves over 500,000 people as the dominant provider of critical medical services in central and southern Virginia. Over the last five years, the system's net revenues grew from $930 million in 2015 to $1.2 billion in 2020.

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

Centra Bedford Memorial Hospital (CBMH) is a full-service medical facility with 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 60,000 residents. CBMH is a licensed 50 bed acute care facility with an attached licensed 111 bed long-term care facility (formally owned by Centra). CBMH has an estimated 1,800 admissions and 18,000 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, the Institute offers specialty care for patients with a wide range of heart and blood vessel disorders like arrythmias, peripheral artery disease, heart failure, aortic stenosis and varicose veins. They offer advanced cardiac imaging and other diagnostic tests. HVI has locations throughout the Centra footprint including Lynchburg, Farmville, Danville, Gretna, Moneta, and Bedford.

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

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

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

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

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

SCOPE AND PURPOSE OF COMMUNITY HEALTH NEEDS ASSESSMENT

The scope of this Community Health Needs Assessment pertains to Centra 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". In 2021-2022, Centra is undergoing a strategic planning process and the CHNA will help inform the design and implementation of new services, programs, and partnerships in response to identified unmet community health needs. In addition, the CHNA and Implementation Plan is used to guide the actions of Centra's Board of Directors' Community Benefit Committee, which provides community-based grant and sponsorship funding to area non-profit organizations addressing prioritized needs identified through the CHNA. Lastly, the completion of both the triennial Community Health Needs Assessment and successful execution of the associated Implementation Plan ensures compliance with the Patient Protection and Affordable Care Act of 2010 which is promulgated in regulation by the Internal Revenue Service as documented annually in Centra's Form 990- Schedule H.

PROJECT OVERVIEW

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

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

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

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

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

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

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

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

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

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

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

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

For more than 30 years the ***Bedford Community Health Foundation (BCHF)*** has been supporting area organizations that provide health related services to the citizens of Bedford County. The foundation works to identify and address community health issues by leading initiatives and providing funding. In that time, BCHF has provided more than $6 million in grants and scholarships to Bedford residents. The ***Greater Lynchburg Community Foundation*** is committed to enhancing the lives of central Virginians through the provision of grants and scholarships to nonprofits and students in the city and the four surrounding counties. These totaled over $1.9 million in this fiscal year and benefitted 175 different nonprofits and thousands of people. The ***United Way of Central Virginia's (UWCV)*** mission is to mobilize the compassionate power of our community to improve the quality of lives in Central Virginia. In the past year, UWCV funded 38 programs through its partner agencies, investing $1.5 million in the community impacting over 60,500 people living in the counties of Amherst, Appomattox, Bedford, and Campbell and the city of Lynchburg.

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

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

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

A ***Community Health Assessment Team (CHAT)*** with more than 40 individuals and a broad representation of community leaders and cross-sector stakeholders in the service area was developed. The role of the CHAT is to oversee, advise and assist in CHNA data collection activities, prioritize needs, and participate in the development of the Implementation Plan as appropriate. A list of these individuals is presented in the "Acknowledgements" section of this report.

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

2021-2022 Bedford Area CHNA & IP Activities	*Date*
Data Collection: Primary & Secondary Data	March- August 2021
CHAT: Launch of CHNA activities	April 14, 2021
Stakeholder Focus Group Meeting	May 12, 2021
CHAT: Presentation of Primary & Secondary Data	August 27, 2021
CHAT: Prioritization of Needs	September 24, 2021
Presentation to Centra Executive Leadership	November 17, 2021
Approval by Community Benefit Committee	November 19, 2021
Approval by Centra Bedford Memorial Hospital Board of Directors	November 30, 2021
Approval by Centra Board of Directors	December 6, 2021
Implementation Planning	December 2021 – April 2022
Centra Board Approval of Implementation Plan	By May 15, 2022

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

The 2021 Bedford Area Community Health Needs Assessment (CHNA) and Prioritization of Needs (PON) was approved by the Centra Community Benefit Committee on November 19, 2021. This committee includes members of both the Centra Board of Directors and the Centra Foundation Board of Directors and provides oversight of the health system's community benefit activities. Final approval of the 2021 CHNA and PON by the Centra Bedford Memorial Hospital Board of Directors occurred on November 30, 2021 and by the Centra Board of Directors on December 6, 2021. The Community Health Needs Assessment was made publicly available on the Centra website the week of December 6, 2021 and was widely shared with the Community Health Assessment Team and other key community stakeholders and leaders.

SERVICE AREA

The service area for the 2021 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 2019 calendar year (Source: Cerner, January 2021).

The findings revealed:

Discharge Summary By Zip Codes Representing 80% Of Discharges

Row Labels	*# of Discharges*	*% of Total Discharges*
BEDFORD (CITY)	10060	50.78
BEDFORD	4832	24.39
***LYNCHBURG (CITY)**	1182	5.97
	16074	***81.13***
Other Zip Codes	***3738***	***18.87***

*Lynchburg City will be included in the 2021 Centra Lynchburg Area Community Health Needs Assessment.

Bedford County, part of the Lynchburg Metropolitan Statistical Area, is one of the fastest-growing counties in Virginia. Part of the Piedmont Region, the county is seated comfortably at the foothills of the Blue Ridge Mountains, with rolling, hilly terrain and popular destinations like Smith Mountain Lake and the Appalachian Trail, it abounds with natural beauty and outdoor recreational opportunities. (www.visitbeford.com). Historically, Bedford County was an agricultural economy, and while agriculture is still an important factor, the county now has a wide range of industries from nuclear energy to wireless communications. The county has been designated one of Virginia's Technology Zones, and the Town of Bedford is a Virginia Enterprise Zone. Hotels and restaurants provide appealing accommodations to visitors. (www.insidelynchburgregion.com)

The town of Bedford is centrally located between the metropolitan areas of Roanoke and Lynchburg (25 miles from each) and is only 178 miles from Washington D.C. Centra Bedford Memorial Hospital is located there. Resting at the foot of the Peaks of Otter in the heart of Virginia's Blue Ridge Mountains, and only 9 miles from the Blue Ridge Parkway, the town of Bedford is surrounded by some of the most beautiful scenery in Central Virginia as well as several historic landmarks, including the National D-Day Memorial, the Elks National Home, Thomas Jefferson's Poplar Forest, and the Avenel Plantation. The town was also home to some of the brave soldiers that fought at the D-Day Invasion during World War II. Known as the "Bedford Boys," these men served with Company A, 116th Infantry, and lost the most soldiers of any town during the invasion. Their sacrifice was immortalized in the 2008 film "The Town They Left Behind."

TARGET POPULATION

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

METHODOLOGY

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

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

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

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

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

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

All of the data collected for the Community Health Needs Assessment was used to prioritize needs for the 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" and is a key driver in the development of prioritized needs for each of Centra's service regions. In 2021, a Community Health Survey and Stakeholder Focus Group meeting provided primary data that was used for identification and prioritization of needs.

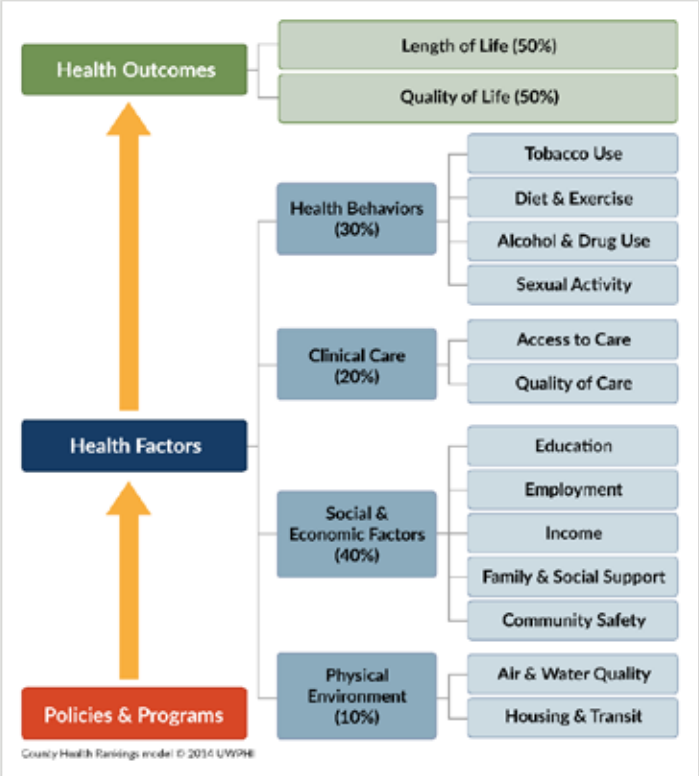
Community Health Survey

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

The Community Health Survey was administered both electronically through a publicly available link via Survey Monkey and through paper surveys (which were in turn entered into Survey Monkey). Paper surveys were available in both English and Spanish. A total of 857 surveys were collected. All survey respondents were offered the opportunity to enter a raffle to win a $25 gift card if they completed the survey.

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

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



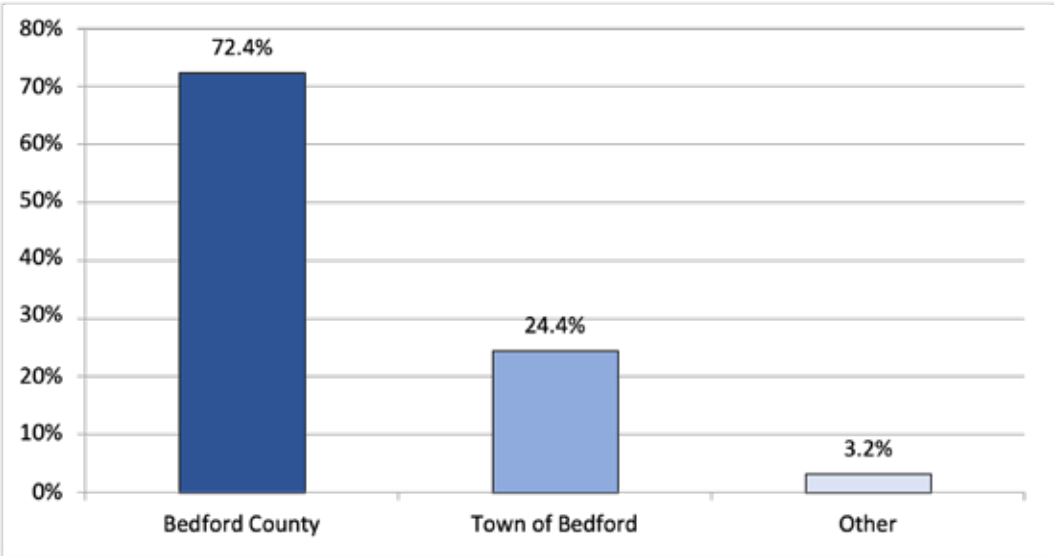
Source: County Health Rankings & Roadmaps. Accessed November 2, 2021. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model.

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

DEMOGRAPHIC PROFILE OF RESPONDENTS

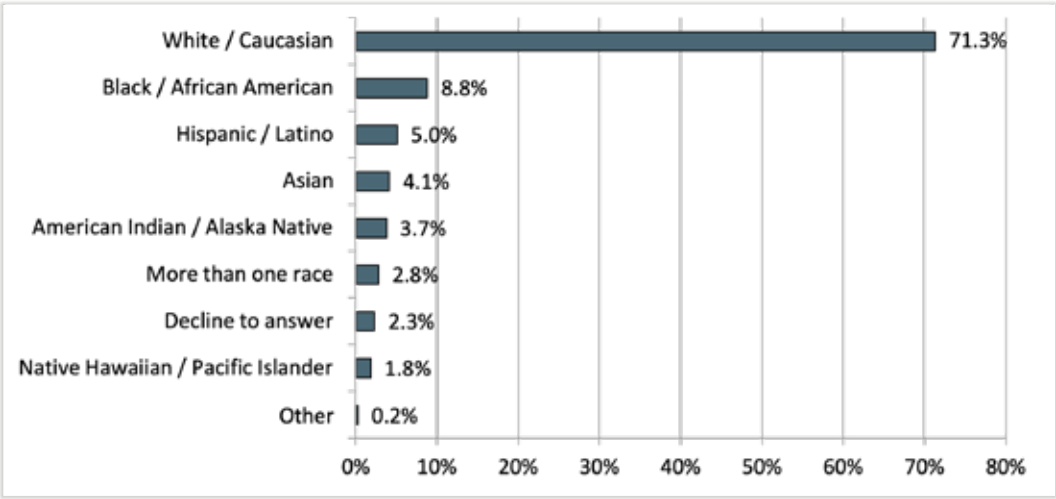
The majority of respondents lived in the service area.

Where do you live?



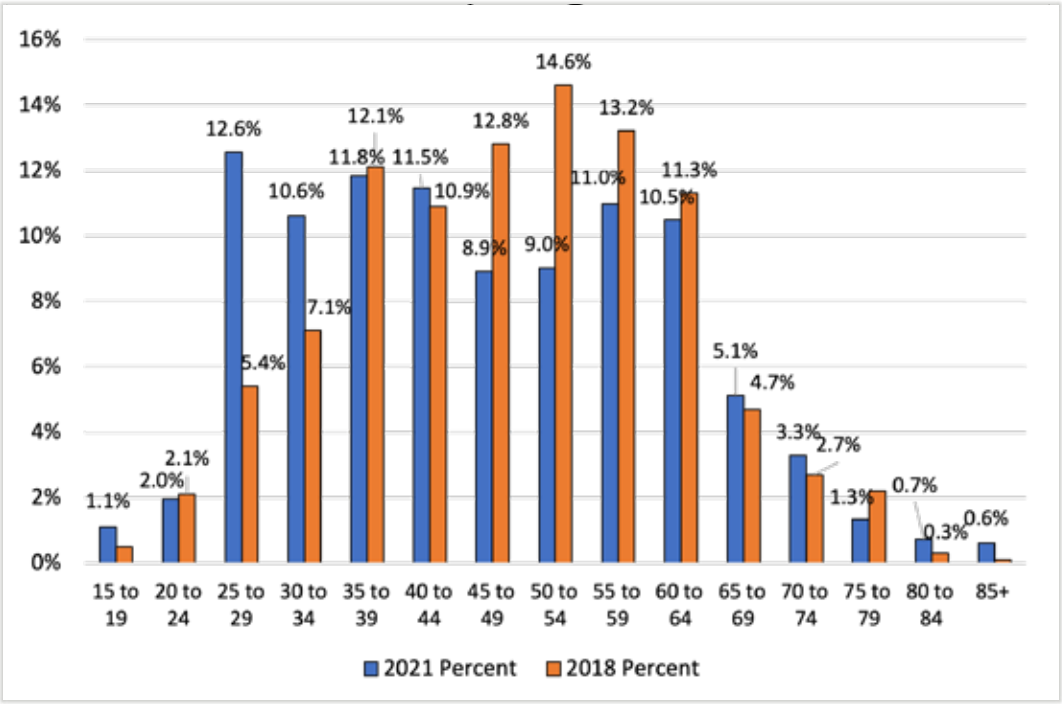
The number of White respondents decreased from 86.3% in 2018 to 71.3% in 2021. This number is lower than the overall percentage of the White population in the service area – 89.4% in Bedford County and 76.3% in the Town of Bedford (U.S. Census). The number of respondents indicating they are Black or African-American fell slightly from 2018 (9.3%) to 2021(8.8%). In the service area, 6.9% of Blacks live in Bedford County and 20.3% live in the Town of Bedford (U.S. Census). The service area percentage of Hispanics or Latino is 2.2% (U.S. Census). The number of Hispanic or Latino respondents in 2021 was 5%, increasing from just 0.7% in 2018. In addition, there was an increase in the respondents who reported being Asian (4.1% in 2021 compared to 0.3% in 2018); American Indian/Alaska Native (3.7% in 2021 compared to 1.1% in 2018); and Native Hawaiian/Pacific Islander (1.8% in 2021 compared to 0.2% in 2018). According to the U.S. Census, service area percentages for Asians is 1.2% in the County and 0.5% in the Town; for American Indian/Alaska Native is 0.1% in the County and 0% in the Town; and 0% for Native Hawaiian or Pacific Islander in both localities.

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



The percentage of respondents age 20 to 65 in 2021 was 87.8% in 2021 and 89.5% in 2018. The rate of respondents age 65 and older was 11% in 2021 and 10% in 2018. The average and median age in 2021 (46 and 45 years) was slightly lower than in 2018 (48.6 and 49.0 years). With a few exceptions, the percent of respondents in each age category remained consistent between assessments.

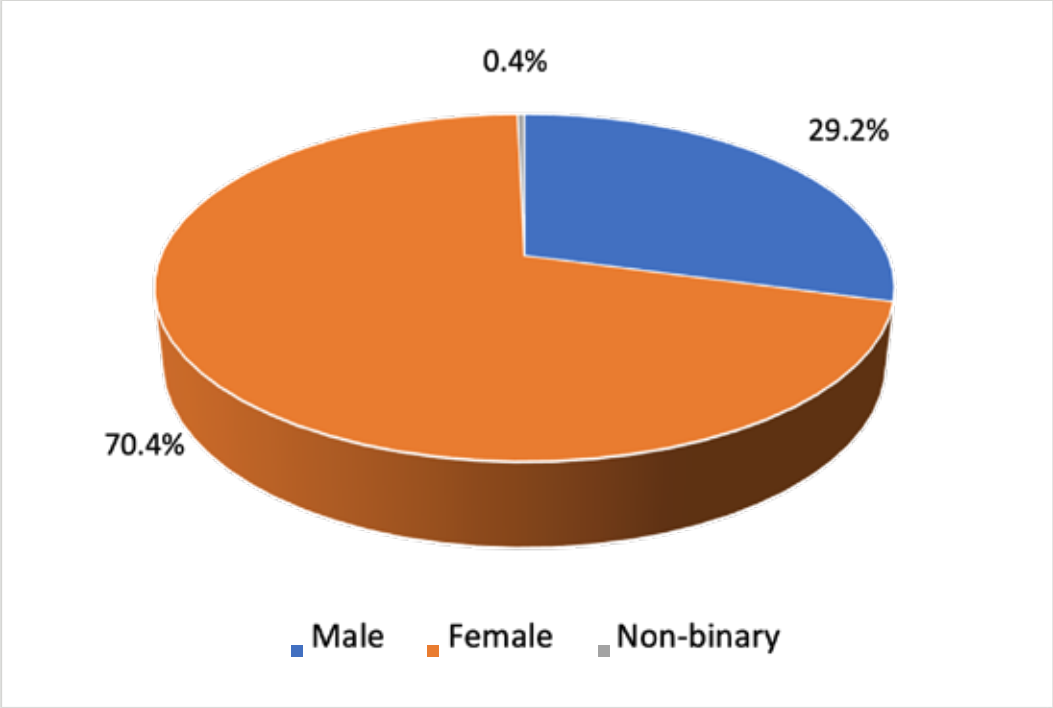
What is your age?



Median Age	46
Mean Age	45
Age Range	16–87

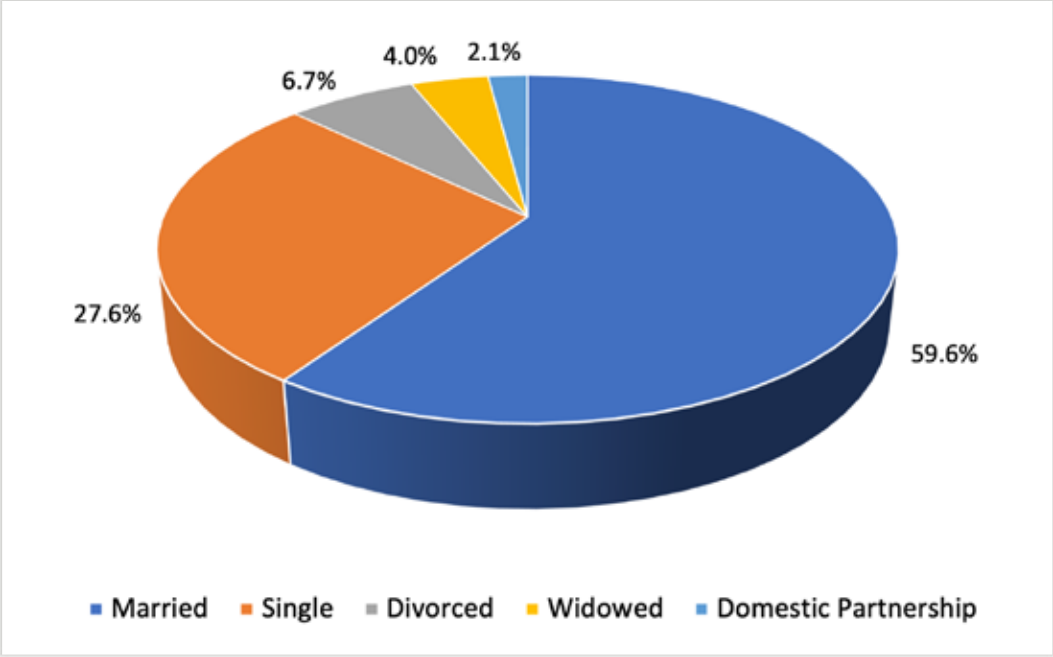
The number of male respondents increased from 17.3% in 2018 to 29% in 2021. Males represent 47% of the service area's population (U.S. Census). "Non-binary" was added as a response to this question in 2021.

What is your gender identity?



The percentage of persons responding that they were married in the 2021 assessment increased 4.3% over the 2018 response (63.2%). The percentage of widowed respondents decreased from 5.7% in 2018 to 3.5% in 2021. Other marital statuses were consistent when comparing 2018 and 2021 assessments.

What is your marital status?

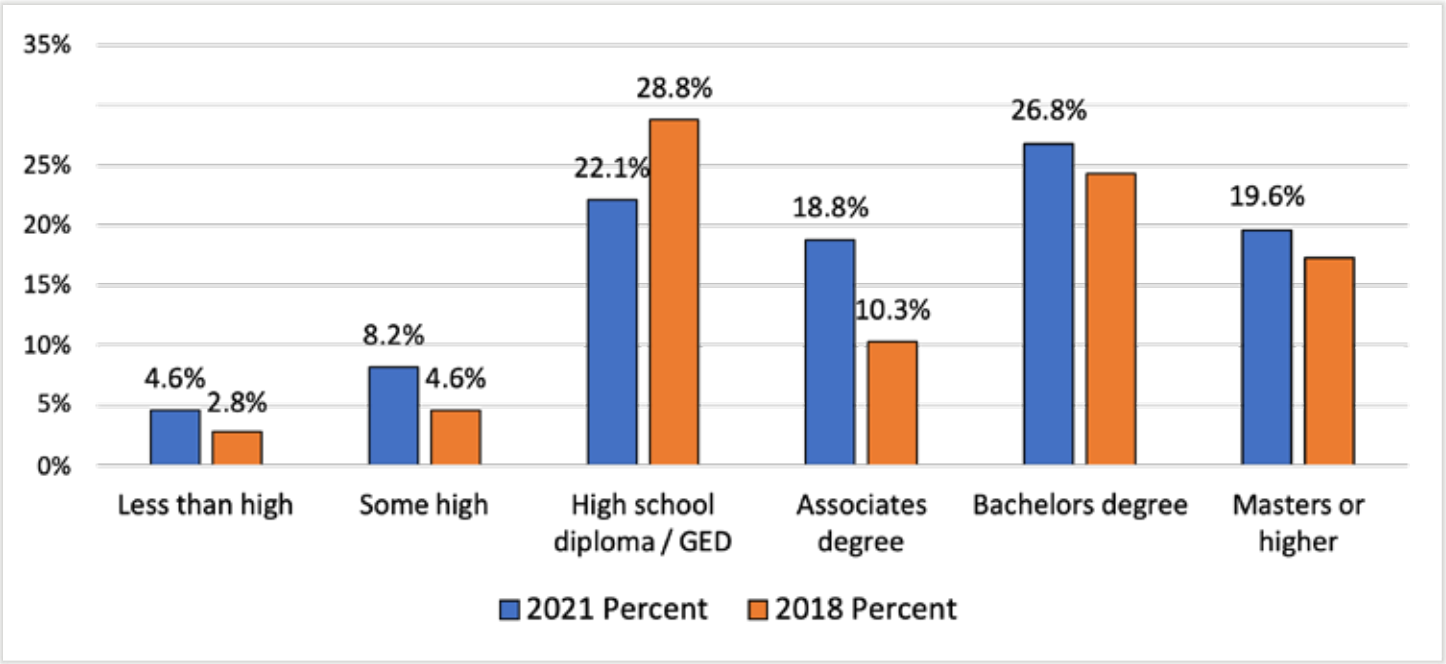


SOCIAL AND ECONOMIC FACTORS

Education

The number of respondents indicating that they had a degree (Associates – Masters or higher) was 65.2% in 2021. This is a 13.3% increase over 2018 due mainly to the difference among respondents with an Associates degree (18.8% in 2021 compared to 10.3% in 2018). The percent of 2018 respondents indicating that they had less than a high school diploma or GED was 7.4% compared to 12.8% in 2021. For persons age 25 and over residing in the Bedford Area, 10% had less than a high school education or equivalence in Bedford County compared to 19.1% in the town of Bedford (U.S. Census). Those who had graduated from high school or equivalency was 30.2% in the County and 31.2% in the Town of Bedford (U.S. Census), higher than the 2021 respondent rate. The percentage of persons in the service area with a Bachelor's Degree or higher was 29.2% in Bedford County and 17.6% in the Town of Bedford (U.S. Census), significantly lower than the 2021 respondent percentage of 46.4%. Respondents with an Associate's degree were not compared to area statistics as the U.S. Census includes Associate's Degree attainment in a category with "Some College" (U.S. Census, Table S1501).

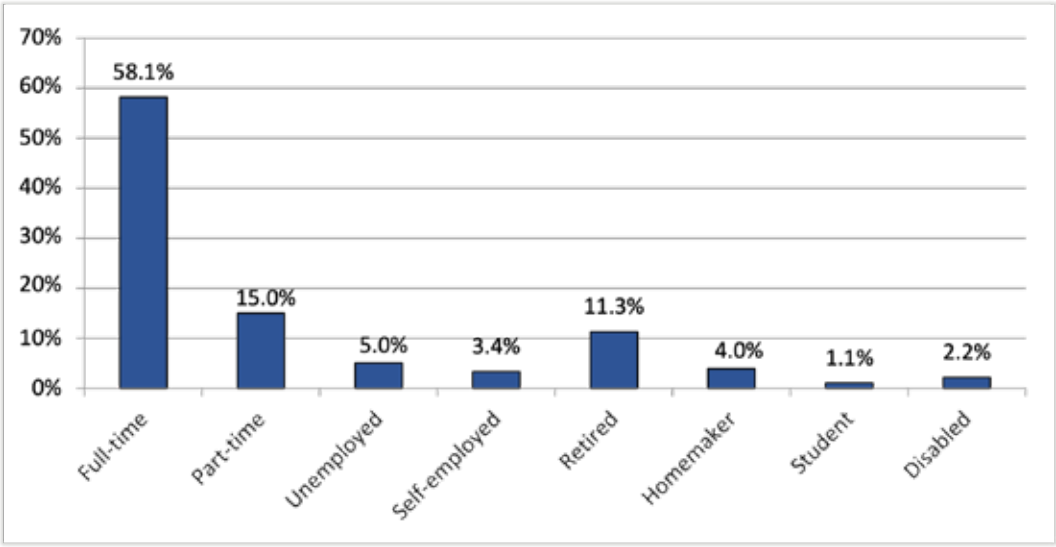
What is your highest education level completed?



Employment

The rate of 2021 respondents employed full-time was consistent with 2018 respondents for this status (58% compared to 60%). The number of unemployed was more than double among 2018 respondents than 2021 respondents (12.8% compared to 5%). The reader should consider this disparity in context with the number of 2018 respondents with household incomes less than $20,000 was 28% compared to 14.5% in 2021. Other employment status responses were consistent when comparing 2018 and 2021 assessments.

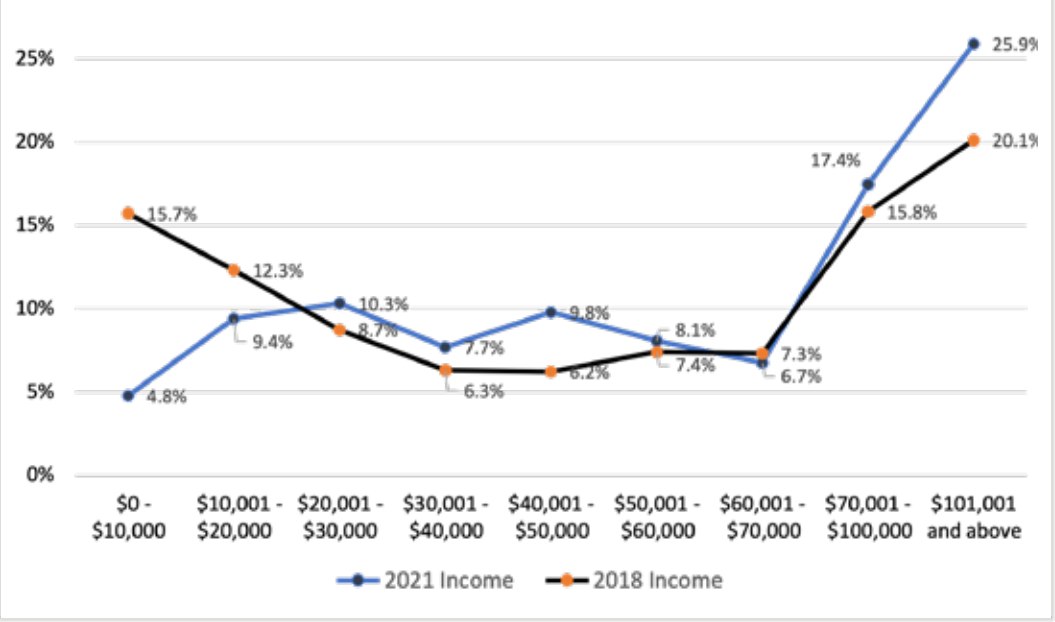
What is your current employment status?



Income

Respondents in 2021 reflected a large variance from the lowest household income categories (at or below $20,000) which was 14.2% in 2021 and 28% in 2018. The number of respondents with household incomes of over $100,000 was slightly higher in 2021 (25.9%) than that of 2018 respondents (20.1%).

What is your yearly household income?



Poverty Status

Analysis of Poverty Status Among Survey Respondents

House-hold Size	Number	Self-Reported Household Income Category							<100% FPL	<200% FPL
		0-10,000	10,001-20,000	20,001-30,000	30,001-40,000	40,001-50,000	50,001-60,000	60,001-70,000		
1	90	8	10						8.9%	20.0%
2	239	17	18	24					7.1%	24.7%
3	103	2	12	10	6				13.6%	29.1%
4	158	4	14	26	11	19			11.4%	46.8%
5	96	2	7	6	16	9	13		15.6%	55.2%
6	56	1	10	8	7	5	6	4	33.9%	73.2%
7	14	1	0	0	1	2	0	0	14.3%	28.6%
8	1	0	0	0	0	0	0	0	0.0%	0.0%
Total	***757***	***35***	***71***	***74***	***41***	***35***	***19***	***4***	***11.2%***	***33.6%***

Although survey income categories do not align with the Federal Poverty Level guidelines (FPL), respondent poverty status can still be estimated at levels below 100% and 200% of the FPL. Based on the FPL, the number of respondents in each household size noted above in yellow would fall below 100% of the FPL. The number of responses in blue would fall below 200% of the FPL. Combining these values represent respondents whose household income falls below 200% of the FPL. A respondent's household income will often fall between FPL category minimum and maximum limits. For example, a respondent's household income that is $11,500 would still be below 100% of the federal poverty level but would be placed in the survey's $10,001 to $20,000 income category because it cannot be determined that the respondent's household income is, in fact, below 100% of the poverty level, between 100% and 150% of the FPL, or at some point over 150% FPL. However, it can be determined that this income is still below 200% of the FPL. In 2021, a minimum of 11.2% of respondents represented in the table above had incomes below 100% of the FPL and 33.6% had incomes below 200% FPL. The total number of households in the table above represent 99% of all income respondents.

Federal Poverty Level Guideline Table

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

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

Affordability and Safety

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

Regarding affordability, the number of respondents indicating that they can afford the medicine needed for their health conditions increased 10.4% from 55.2% in 2018 to 65.6% in 2021 while those reporting "no" was at 20.2%. The percentage of respondents who did not have enough money in the past 12 months to pay rent or mortgage changed little from 2018 (22.5%) to 2021 (21.5%). The number of respondents who indicated that there had been times when they did not have enough money to buy the food they or their family eat remained essentially the same from 2018 (29.4%) to 2021 (30.4%).

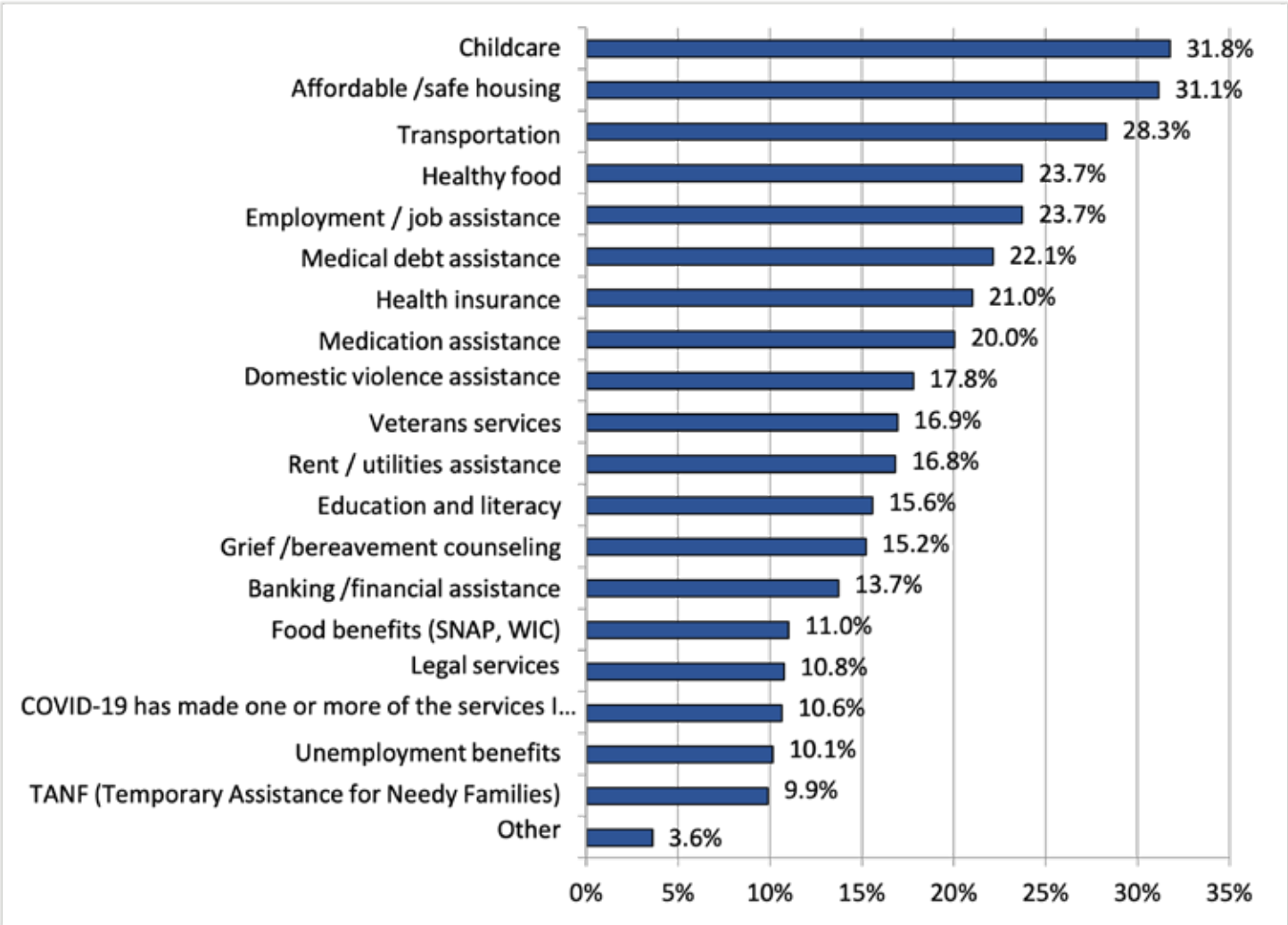
Regarding safety, the number of respondents who reported that they had been victims of domestic violence in the last 12 months more than doubled from 2018 (2.8%) to 2021 (7.5%). The number of respondents who felt safe where they live decreased slightly from 94% in 2018 to 91% in 2021. The percentage of respondents who felt somewhat connected to the community and those around them increased slightly from 58.3% in 2018 to 59.6% in 2021. The number of respondents who felt very connected remained steady from 26.1% in 2018 to 26.5% in 2021. The number of respondents who felt not connected decreased to 14% in 2021 from 15.6% in 2018.

I cannot afford my medications (%)	20.2	
In the past 12 months- I could not afford rent/mortgage (%)	21.5	
In the past 12 months- I could not afford food (%)	30.4	
I have been a victim of domestic violence or abuse in the past 12 months (%)	7.5	
Do not feel safe where you live (%)	9.3	
Feel connected with the community and those around you (%)	*Very*	26.5
	Somewhat	59.6
	Not connected	13.9

Social/Support Resources in the Community

Respondents were asked which social/support resources are hard to get in our community and could check more than one response. Childcare and affordable and safe housing were cited by 2021 respondents as the most difficult services to get in the community. Affordable and safe housing also ranked high in the 2018 assessment at 30%. The percentage of responses that cited transportation as a hard-to-get service remained consistent from 2018 (28.4%) to 2021 (28.3%).

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



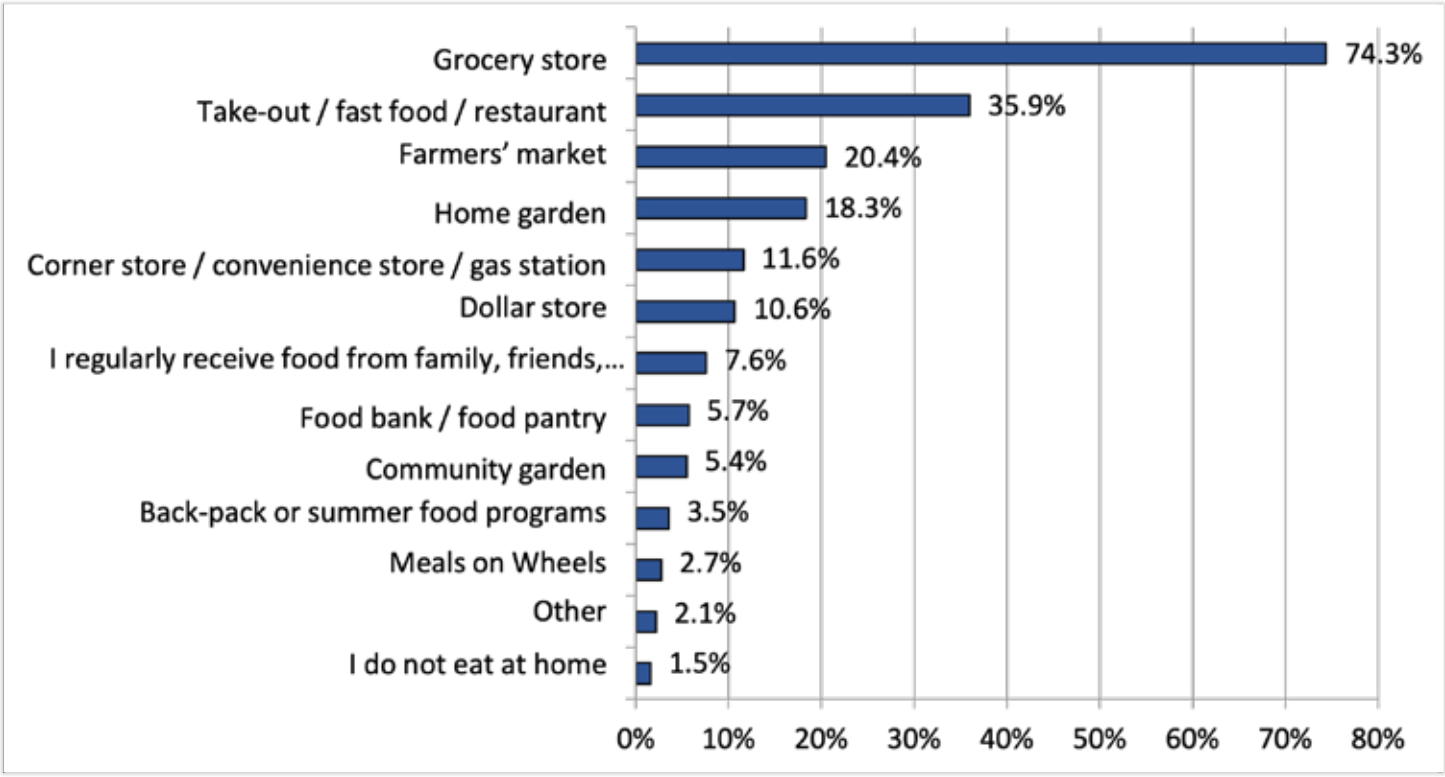
HEALTH BEHAVIORS

Diet and Exercise

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

Fewer respondents reported using the grocery store, take-out/fast food, farmer's market or home garden to get food in 2021 (74,3%, 35.9%, 20.4% and 18.3 % respectively) compared to 2018 (96.4%; 46.9%; 27.2%; 24.9% respectively). The percent of respondents getting food from dollar stores in 2021 was less than half of those in 2018 (10.6% compared to 22.7%). In addition, the percent of 2018 respondents getting food from food banks or food pantries was almost triple the rate in 2021 (16.4% compared to 5.7% respectively). There was an uptick in those reporting getting the food they eat at home from back-pack or summer food programs in 2021 (3.5%) compared to 2018 (2.8%) and from Meals on Wheels (2.7% in 2021, 0.6% in 2018).

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



The number of respondents indicating that it was easy to get affordable fresh fruits and vegetables increased from 70.4% in 2018 to 77.5% in 2021. Approximately 48% of respondents ate fruit and vegetables on a daily basis. This is consistent with the response rate from the 2018 assessment, where 49% of respondents indicated that they ate fruits and vegetables daily. In the Bedford Area, 38.3% of respondents ate together between three and six times a week. Those eating meals together seven or more times per week in 2021 was 31.3% compared to 35.2% in 2018. Frequent family meals are associated with decreased risk factors in youth.

Regarding physical activity, there was a significant increase in the number of respondents (78.3%) who said their community supported physical activity compared to 45.5% in 2018. Access to physical activity "spaces" is important as regular exercise reduces the number of risk factors (such as obesity) associated with many health conditions. The number of respondents who were physically active five or more days per week increased from 33.6% in 2018 to 36.6% in 2021. The number of respondents who were active three to four days per week fell slightly from 28.5% in 2018 to 27% in 2021. The number of respondents who were active one or two days per week increased slightly from 25.7% in 2018 to 26.4% in 2021.

In the area that you live, it is easy to get affordable fresh fruits and vegetables? (%)	**77.5**
During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice. (Please check one) Respondents who ate fruits and vegetables one time per day or greater (%)	**48.2**
In the past 7 days, how many times did all or most of your family living in your house eat a meal together? (%) Respondents who ate with their families 7 or more times per week (%)	**31.3**
The community supports physical activity? (e.g., parks, sidewalks, bike lanes, etc.) (%)	**78.3**
In the past 7 days, how many days were you physically active for a total of at least 30 minutes? Respondents who met physical activity guidelines of 150 minutes of aerobic activity weekly(%)	**36.6**

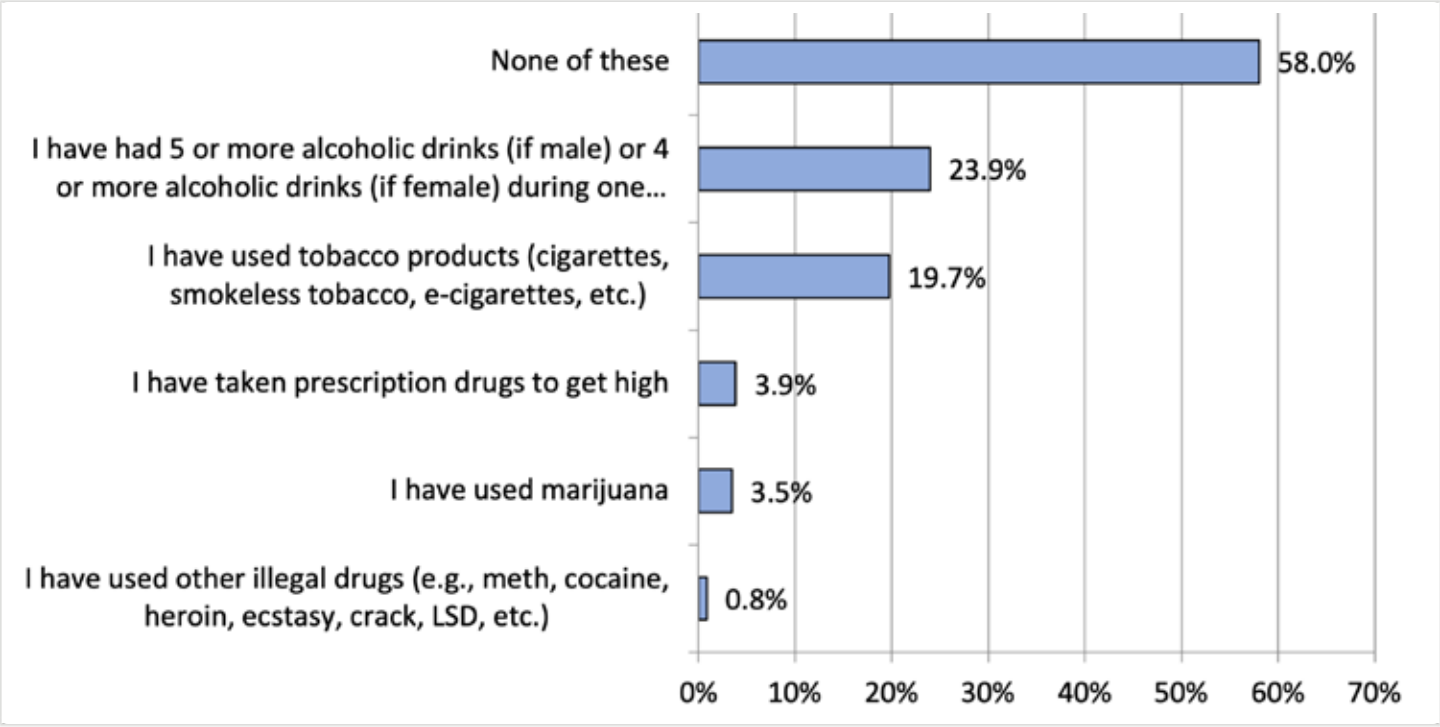
Alcohol, Tobacco, and Other Substance Use

Respondents were asked about their alcohol, tobacco, and substance use over the past 30 days.

There was a decrease in the number of respondents who indicated that they used tobacco products from 2018 (54%) to 2021 (19.7%). There was also a decrease in the number of persons who reported binge drinking (i.e., having five or more alcoholic drinks for males or four or more for females) in the past 30 days (37.4% for 2018 respondents and 24% for 2021 respondents). More 2021 respondents indicated that they have taken prescription drugs to get high – approximately 4% in 2021 compared to just 0.8% in 2018.

Those who used other illegal drugs (including marijuana) was 2.9% in 2018. In 2021, illegal drug use excluded marijuana with 0.8% of respondents reporting illegal drug use and 3.5% reporting having used marijuana. On July 1, 2021, recreational use of marijuana became legal in Virginia although retail sales will not begin until 2024.

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



CLINICAL CARE

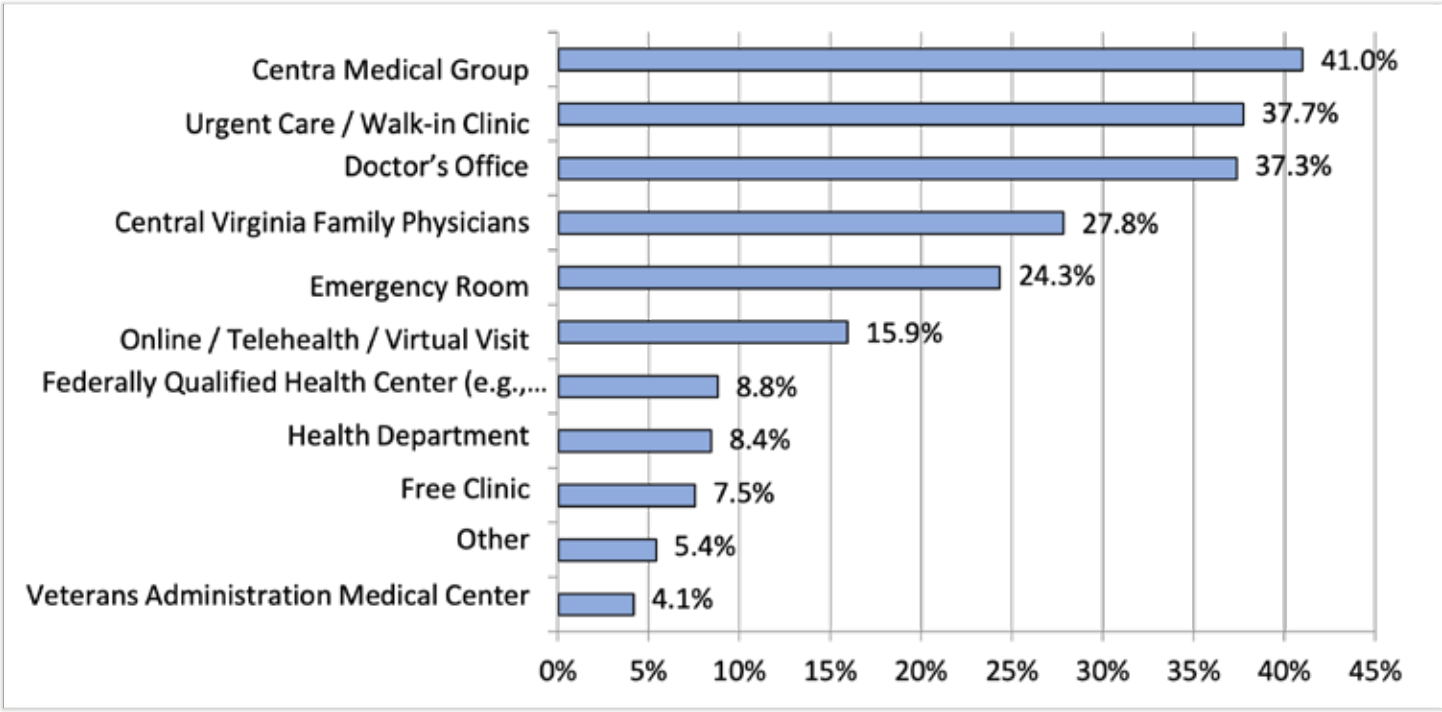
Access and Utilization of Services

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

The number of respondents who indicated that they use medical services increased from 2018 (78.6% in 2018) to 87.5% in 2021. The number of respondents who indicated that they had been to the Emergency Room in the past 12 months decreased from 23.6% in 2018 to 18.2% in 2021. The number of respondents indicating that they had used the emergency room for an injury in the last 12 months doubled in 2021 (17%) compared to 2018 (8.2%).

When asked what type of medical services they use, the generic "Doctor's Office" was the top response in 2018 (68.5%). The percent of respondents who chose this option in 2021 was 37%. Respondents selecting Centra Medical Group increased to 41% in 2021 from 27% in 2018, a 14% increase. Respondents indicating that they used the Emergency Room decreased slightly from 28% in 2018 to 24% in 2021. Urgent Care or Walk-in Clinic showed a large increase from 26% in 2018 to 38% in 2021. The use of the region's Federally Qualified Health Centers increased from 3.8% in 2018 to 8.8% in 2021. Those who used online/telehealth/virtual visits in 2021 was 15.9%. The online/telehealth/virtual visit was not an option for this question in the 2018 assessment.

Please check all the medical care services you use:



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

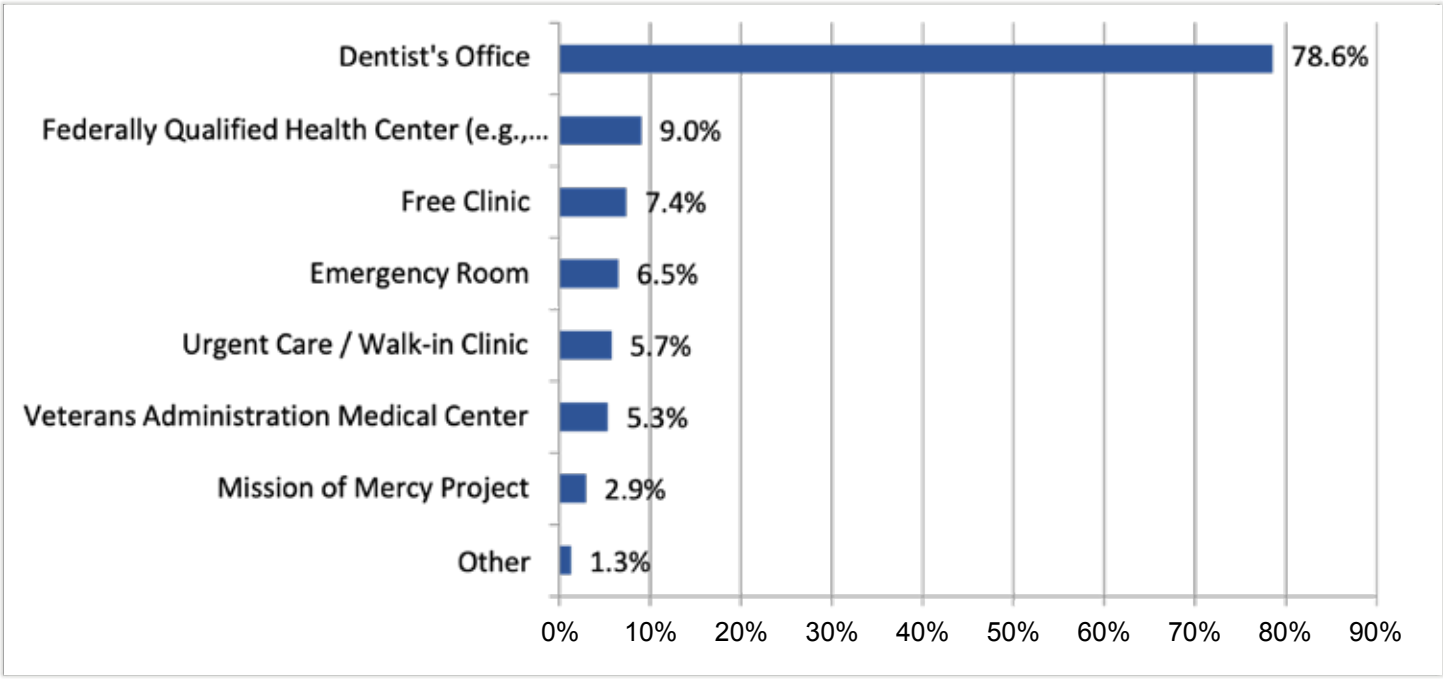
How long has it been since you last visited a doctor or other healthcare provider for a routine checkup?

Within the past year (1 to 12 months)	66.2%
Within the past 2 years (1 to 2 years ago)	17.9%
Within the past 5 years (2 to 5 years ago)	12.0%
5 or more years ago	6.1%
I have never visited a doctor or other healthcare provider for a routine checkup	2.2%
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	2.5%

The number of respondents indicating that they use dental care services increased 14.7% from 2018 (76.8%) to 2021 (91.5%).

Respondents were asked what type of dental services they use. The number of respondents selecting the generic response "Dentist's Office" had a small increase from 2018 (76%) to 78.6% in 2021. The use of "Free Clinic" for dental services increased 5.6% in 2021 to 7.4% from 1.8% in 2018. Respondents using "Urgent Care or Walk-in Clinic" increased 5% to 5.7% in 2021 from 0.7% in 2018. Respondents using a Federally Qualified Health Center more than doubled in 2021 (4% in 2018 to 9% in 2021). Respondents using "Mission of Mercy Project" for dental services was 0.1% in 2018 to almost 3% in 2021. Use of the Emergency Room for dental services increased almost three-fold from 2.2% in 2018 to 6.5% in 2021. The number of respondents who reported having dental insurance in 2021 (31.1%) decreased from 2018 (39.2%).

Please check all the dental care services you use:



The number of respondents who have visited a dentist or dental clinic in the last 12 months fell from 67% in 2018 to 61% in 2021. More people reported having visited the dentist or dental clinic within the past two years (16.5%) than in 2018 (10%). The number of respondents who had visited a dentist or dental clinic in the past five years increased in 2021 to 11.7% compared to 8.2% in 2018. In the past year, 2.1% of respondents chose not to see a provider or postponed or cancelled a visit because of COVID-19.

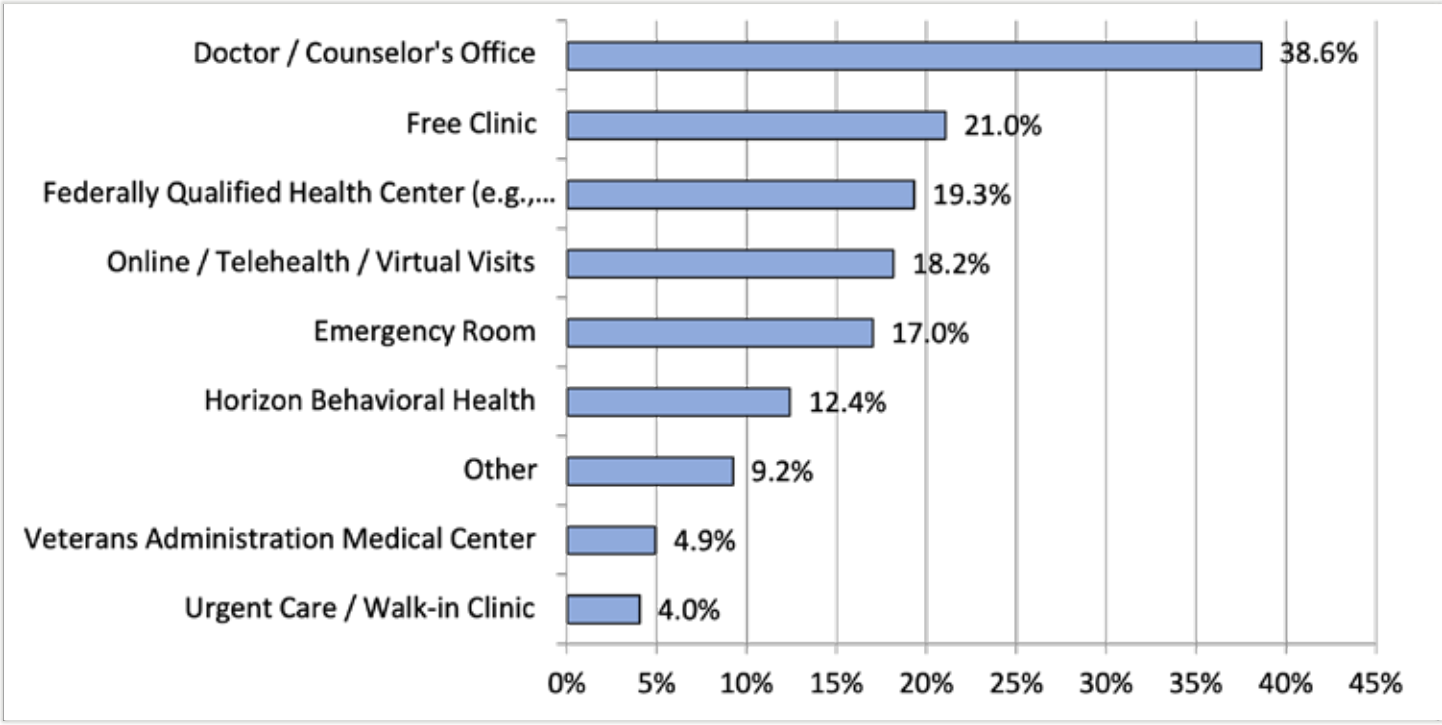
How long has it been since you last visited a dentist or dental clinic for any reason?

Within the past year (1 to 12 months)	61.2%
Within the past 2 years (1 to 2 years ago)	16.5%
Within the past 5 years (2 to 5 years ago)	11.7%
5 or more years ago	6.9%
I have never visited a dentist or dental clinic for any reason	1.6%
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	2.1%

The number of respondents indicating that they use mental health, alcohol or drug use services increased dramatically from 13% in 2018 to 32% in 2021.

Respondents were asked what type of mental health, alcohol or drug use services they use. The generic response, "Doctor or Counselor's Office," was combined from two separate responses from 2018 – "Doctor's Office" and "Counselor's Office." These two responses in 2018 were approximately 18% and 32%, while combined for 2021, the percentage of responses was 38%. The number of respondents who used Horizon Behavioral Health for services fell from 38.5% in 2018 to 12.4% in 2021. Online, telehealth, or virtual visits were not an option for respondents in 2018 however, close to 1 out of 5 respondents using mental health, alcohol use, or drug use services indicated such a visit. The number of respondents using the Free Clinic or a Federally Qualified Health Center (FQHC) both increased significantly from 2018 (1.1% Free Clinic; 3.4% FQHC) to 2021 (Free Clinic 21%; FQHC 19.3%). The use of the Emergency Room increased significantly from 4% in 2018 to 17% in 2021.

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



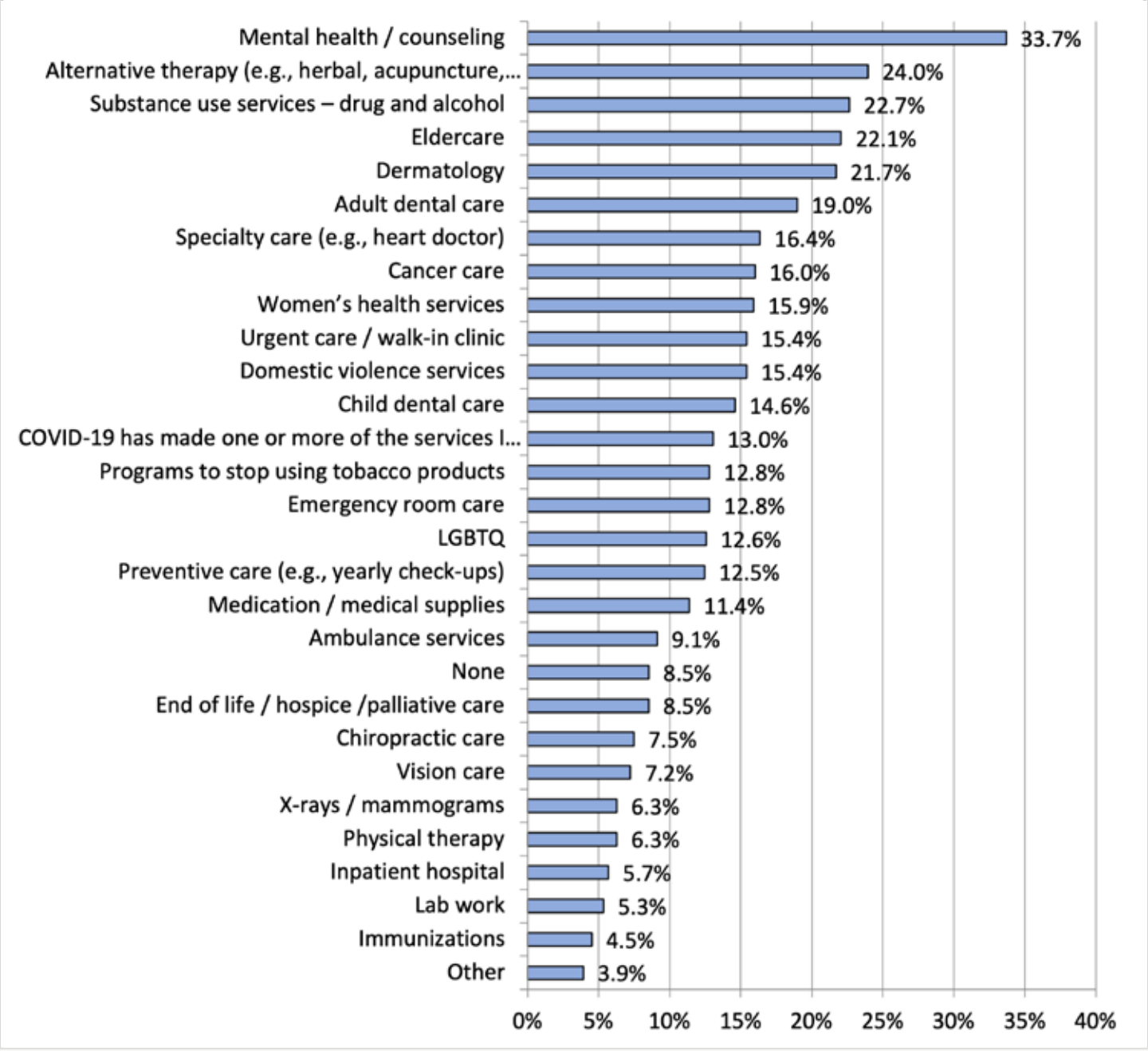
Within the past year, 18.7% of respondents used mental health, alcohol use, or drug use services. An additional 1.7% of respondents did not seek services due to COVID-19. This question was not included in the previous 2018 Community Health Survey.

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

I have never used mental health, alcohol use, or drug use services for any reason	48.1%
Within the past year (1 to 12 months)	18.7%
Within the past 2 years (1 to 2 years ago)	11.1%
Within the past 5 years (2 to 5 years ago)	9.2%
5 or more years ago	11.2%
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	1.7%

Survey respondents were asked what health care services are hard to get in the community. In 2021, the number of respondents indicated mental health and counseling services were the hardest to get. This number increased close to 6% from 2018 (28%) to 2021 (33.7%). Alternative therapies were in the top five in both assessment years, 24.8% in 2018, and 24% in 2021. Eldercare was consistent from 2018 (22.3%) to 2021 (22.1%). Adult dental care ranked high in both assessments (26% in 2018 and 19% in 2021). It is important to note that beginning July 1, 2021, Virginia Medicaid started providing comprehensive adult dental services to Medicaid beneficiaries for the first time.

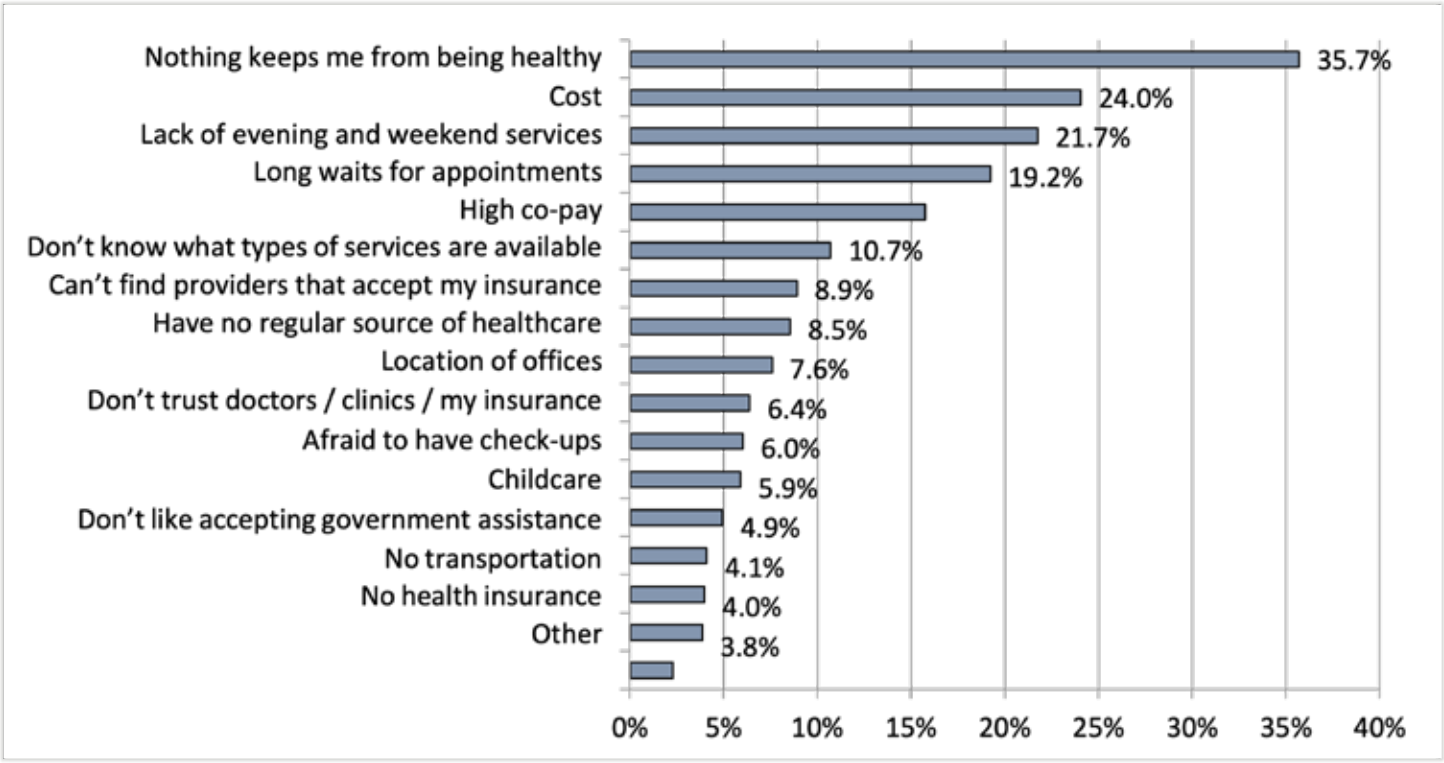
Which health care services are hard to get in our community? (Respondents could check more than one)



Health Status

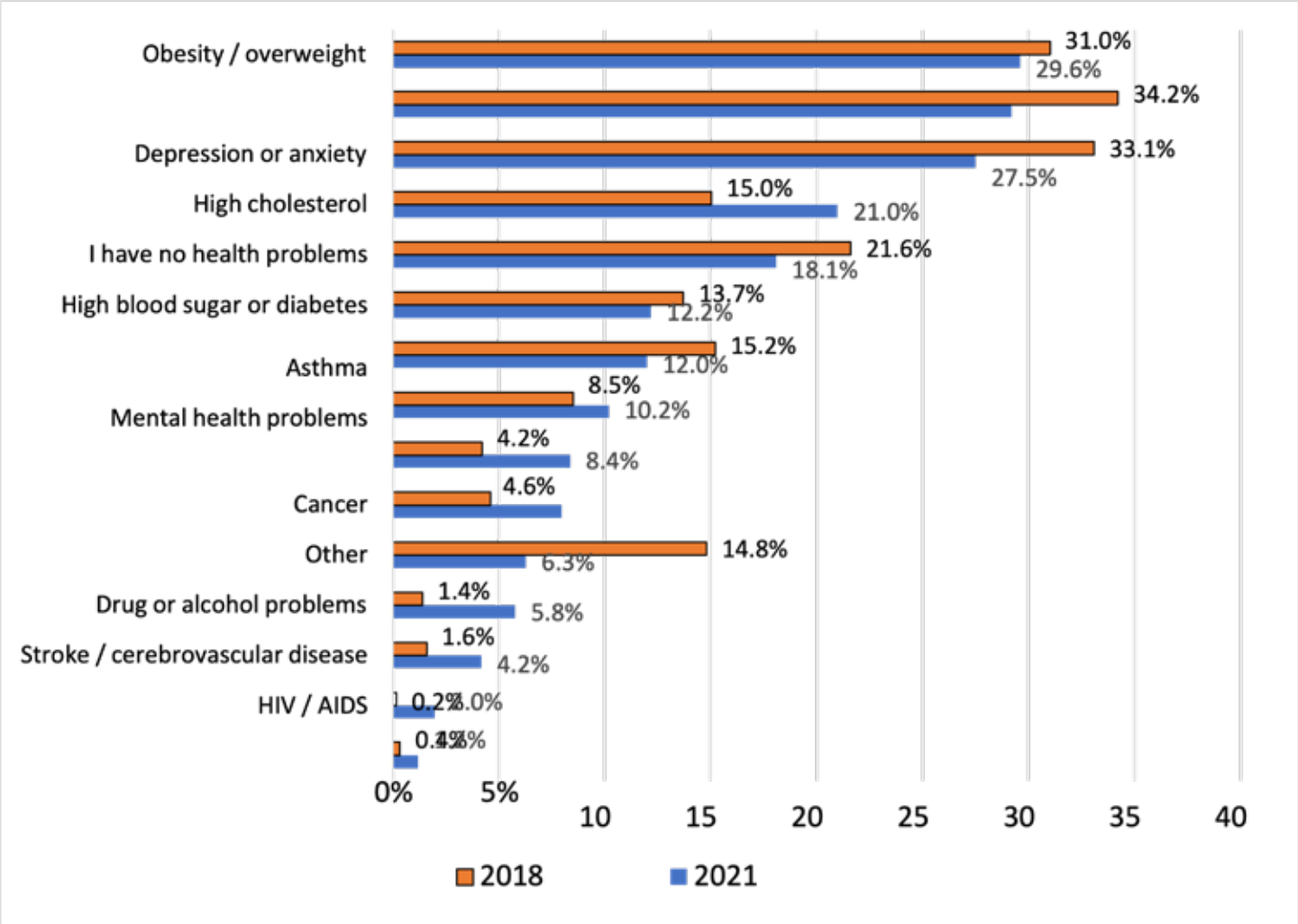
Respondents were asked, "What Keeps you from being healthy?". In 2018, the response "Nothing keeps me from being healthy" was not an option and the question was phrased differently. In 2018, the question was, "What do you feel prevents you from getting the services you need? In 2021, the top five reasons respondents felt kept them from being healthy were identical to the top five reasons respondents felt were obstacles to getting the services they needed in 2018. Cost was 24% in 2021 and 47% in 2018. High co-pays were 27.3% in 2018 and 15.7% in 2021. Lack of evening and weekend services decreased slightly in 2021 to 21.7% from 24.3% in 2018. Long waits for appointments remained consistent at 19.2% in 2021 compared to 20.5% in 2018. No health insurance dropped as a reason from 12.2% in 2018 to 4% in 2021.

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



Respondents were asked if they had been told by a doctor if they have a certain medical condition. The trend among disorders is largely consistent between 2018 and 2021. More respondents to the 2021 survey were told that they have high cholesterol than in 2018 (21% in 2021 compared to 15% in 2018). Of particular note is the decrease in depression or anxiety (approximately 6%) from 2021 to 2018 although there was an uptick in those reporting they have mental health problems (10.2% in 2021, 8.5% in 2018) and/or drug or alcohol problems (5.8% in 2021, 1.38% in 2018).

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

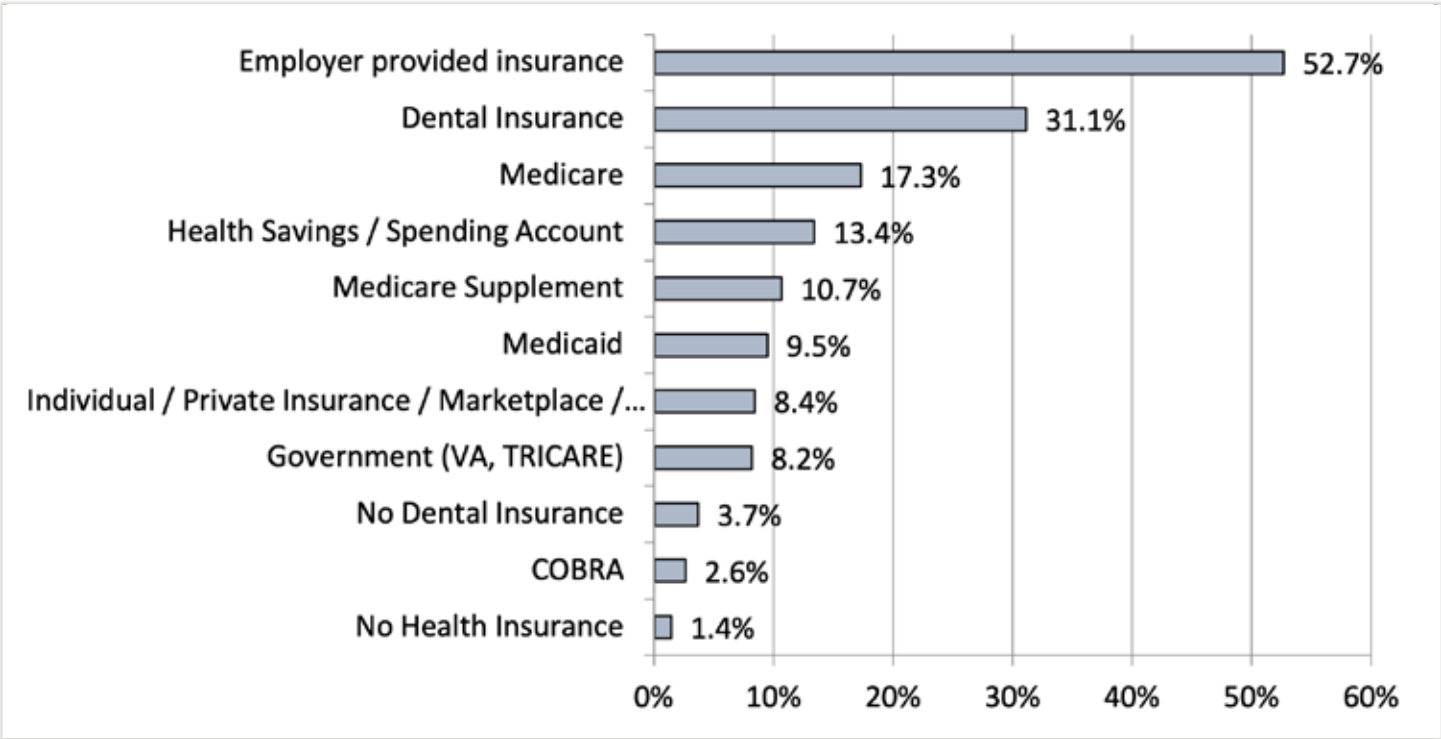


Health Insurance Status

When asked about their health insurance status, more respondents in 2018 indicated that they had employer provided insurance than in 2021 (59% in 2018 compared to 53% in 2021). The number of respondents indicating that they had no insurance fell dramatically from 10% in 2018 to just 1.4% in 2021. The number of respondents indicating that they had a health savings or spending account remained the same at 13.4%. Respondents in 2021 indicating that they had either Medicare and a Medicare supplement increased to 28% from 19.3% in 2018. Fewer respondents reported having Medicaid in 2021 (9.5%) as compared to 2018 (12.9%); no dental insurance (3.7% in 2021 compared to 12.3% in 2018); or no health insurance (1.4% in 2021 compared to 9.9% in 2018).

For those who did not have health insurance, the number of respondents indicating that health insurance was too expensive in 2018 was over double the number in 2021 (13.6% compared to 5.3% in 2021). The number of unemployed/no job respondents in 2018 was also more than double the percentage of responses in 2021 (9% compared to 4.3%). More 2021 respondents indicated that health insurance was not available at their job (8.7%) than 2018 respondents (3%) and exponentially more reported not understanding the Marketplace/Obamacare in 2021 (11.6%) compared to 2018 (1.1%).

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

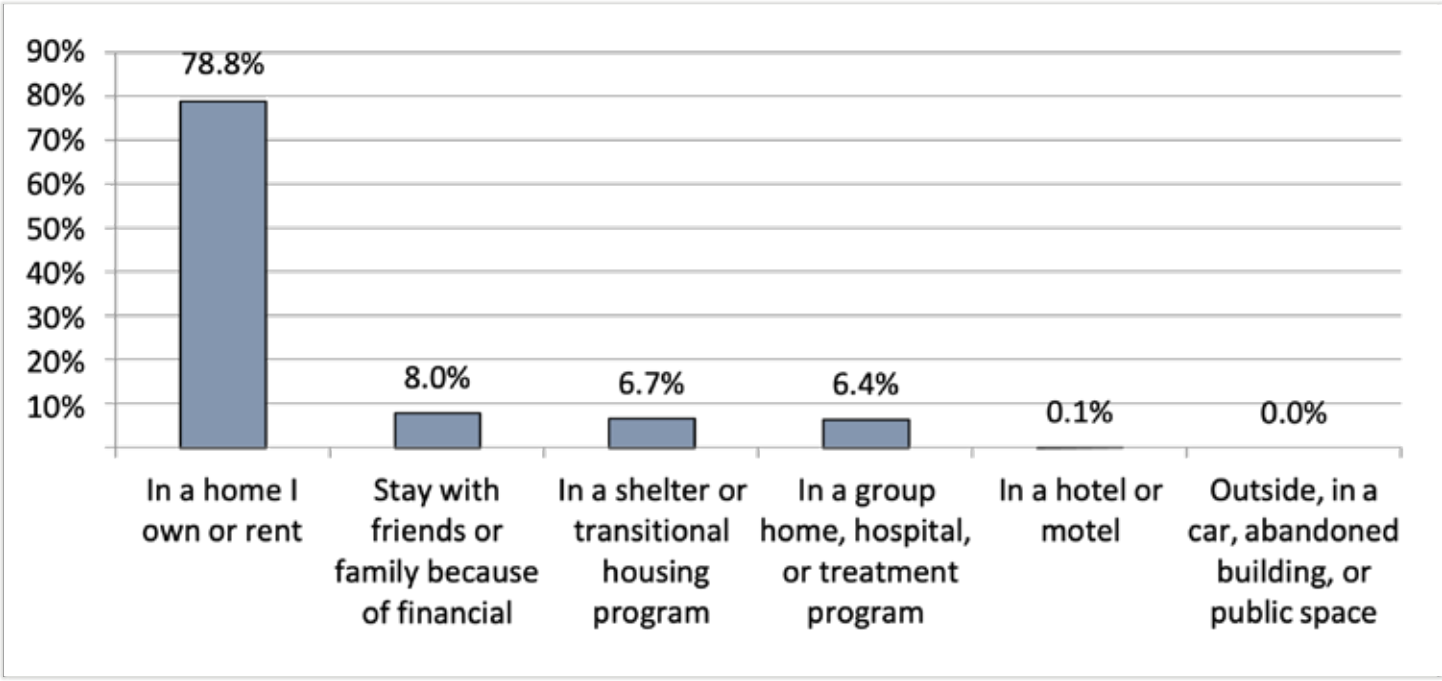


PHYSICAL ENVIRONMENT

Housing

To determine housing insecurity, respondents were asked where they sleep most often. In 2021, 79% of respondents slept most often in their own homes. The additional respondents who reported either sleeping at a friend's or family's home, in a shelter or transitional housing, or in a group home, hospital, or treatment program was 21.1%.

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

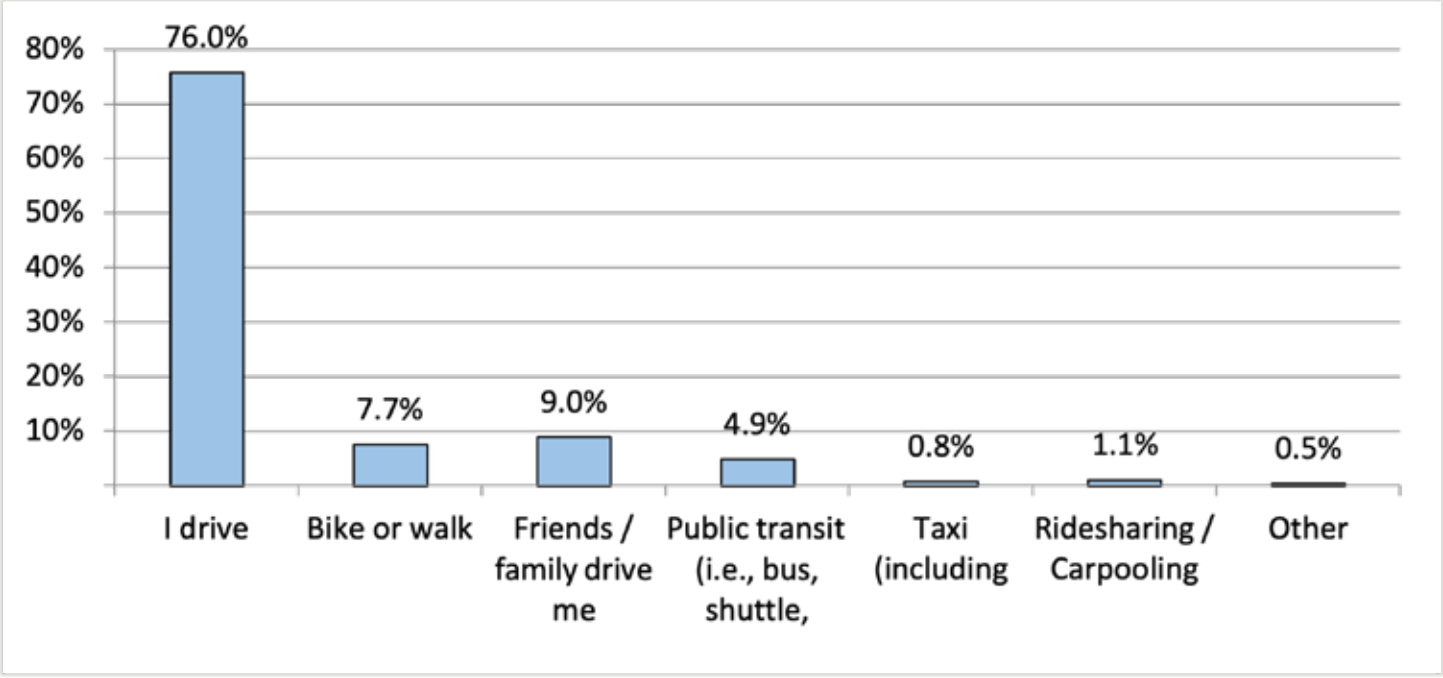


Transportation

Survey respondents were asked if they had reliable transportation. Approximately 90% of respondents indicated that they had access to reliable transportation. This question was not a question on the 2018 assessment. However, the 2018 assessment included how many vehicles were owned, leased, or available for regular use by the respondent and those in their household. The percentage indicating zero (0) was 5.6%.

When asked what type of transportation they use most often, in 2021, 76% indicated that they drove. In 2018, 91.2% indicated that the mode of transportation that that they "typically used" was a car. In 2018 respondents were able to select multiple answers. This makes comparisons between the assessment years difficult. However, the number of 2021 respondents who indicated that they use public transportation increased to 5% from 1% in 2018.

What type of transportation do you use most often?



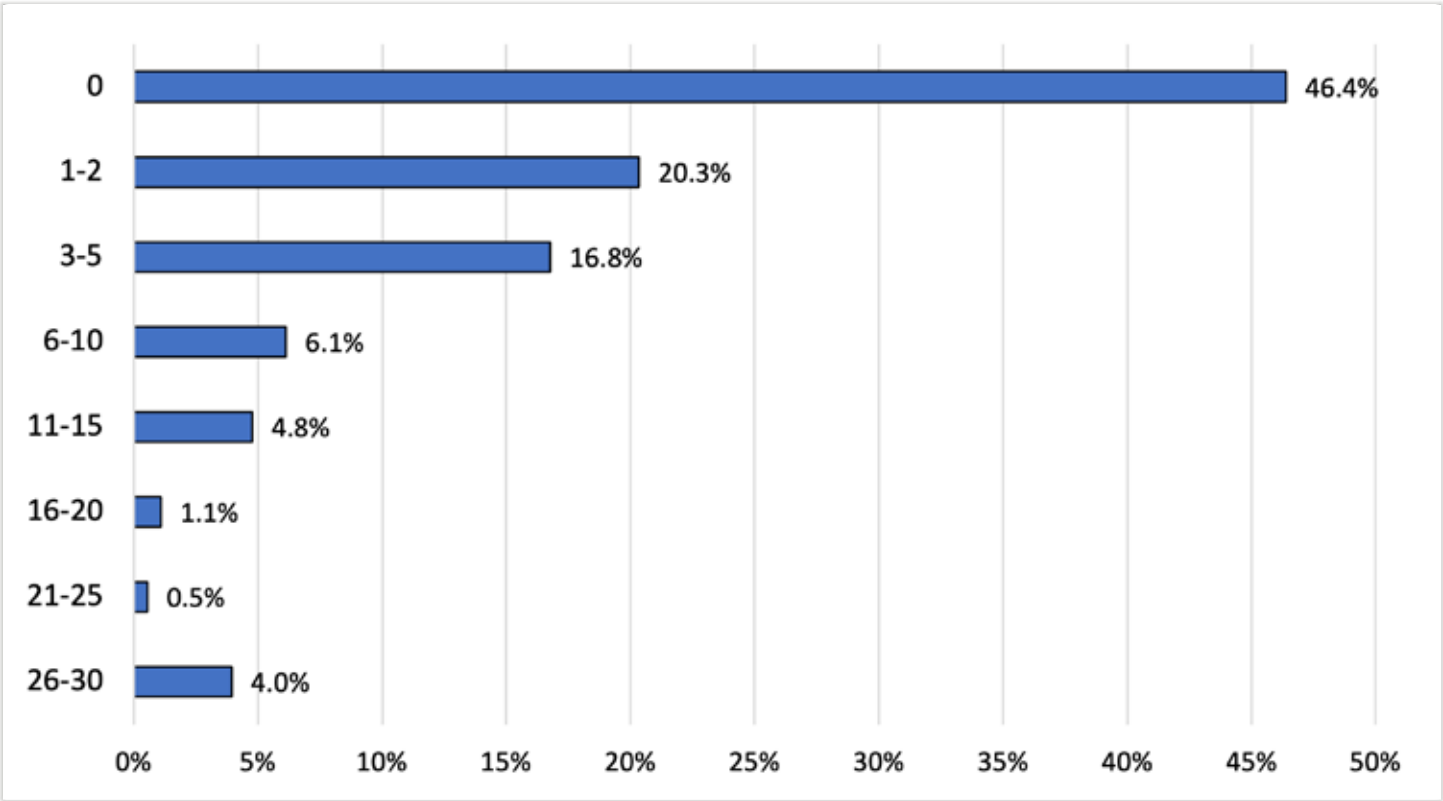
QUALITY OF LIFE

Physically and Mentally Unhealthy Days

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

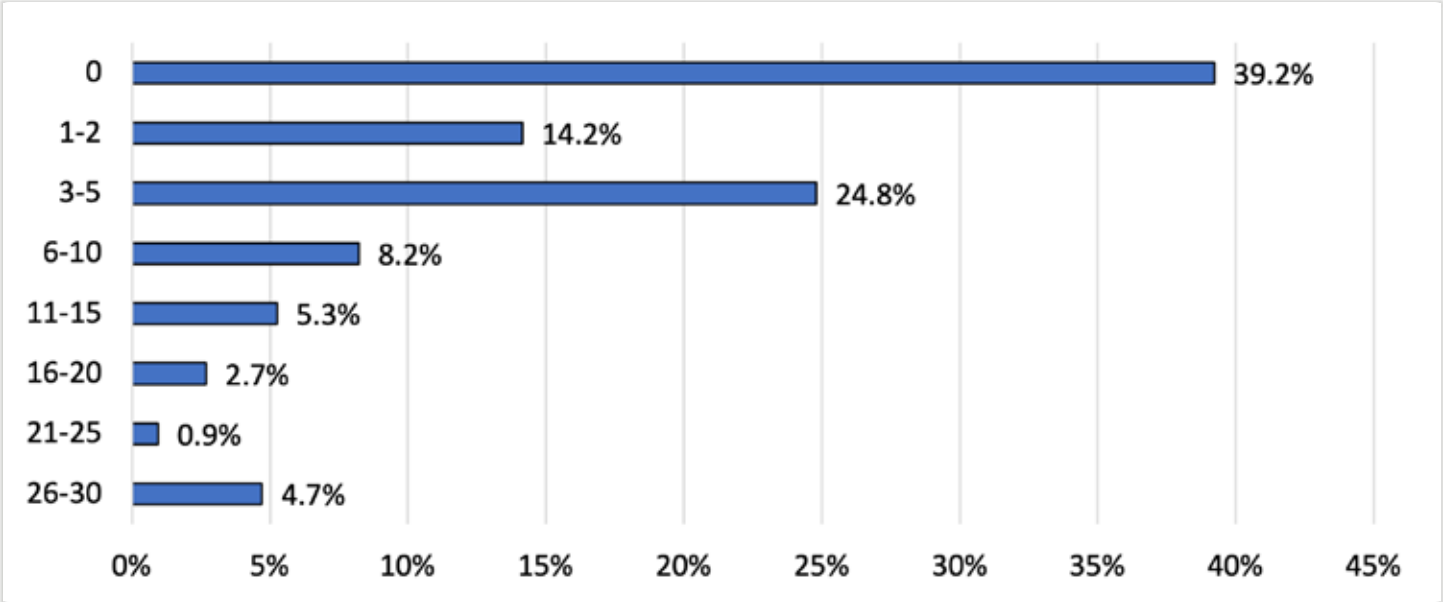
The 2021 assessment breaks out 2018's assessment from 0-5 days to 0 days, 1 to 2 days, and 3 to 5 days. Combined the number of persons who reported that their health was not good from 0 to 5 days was 78% in 2018 compared to 84% in 2021. The percentage of respondents indicating that their physical health was not good for 6 to 15 days decreased slightly in 2021 (10.9% in 2021 versus 12% in 2018); as did those reporting their health was not good 16 to 20 days (2.5% in 2018 and 1.1% in 2021) and 26 to 30 days (6.7% in 2018 to 4% in 2021). There was only a 0.5% change from the 2018 assessment to the 2021 assessment among respondents answering 21 to 25 days (0.5% in 2021 compared to 1% in 2018). Those reporting 26-30 days decreased in 2021 as compared to 2018 (4.0% and 6.7% respectively).

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



The percentage of 2021 respondents who felt their mental health was not good for 0-5 days (78.2%) and for 6-15 days (13.5%) increased slightly from 2018 (74.2% and 11.5% respectively). The impact of COVID-19 should be considered as a contributor to this increase. There were fewer respondents reporting their mental health was not good more than 15 days in the last 30 days in 2021 (8.3%) as compared to 2018 (14.3%).

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

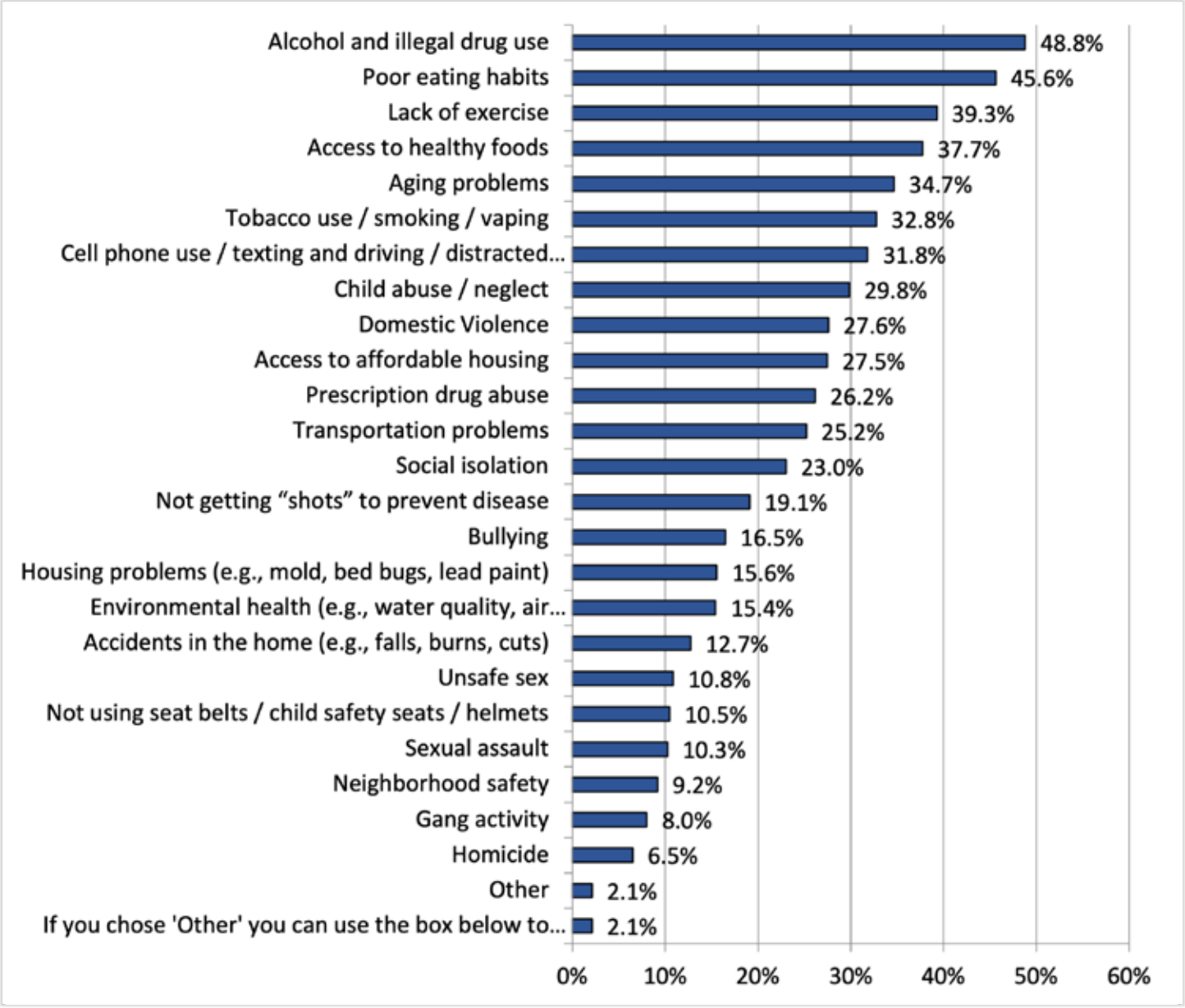


COMMUNITY NEED

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

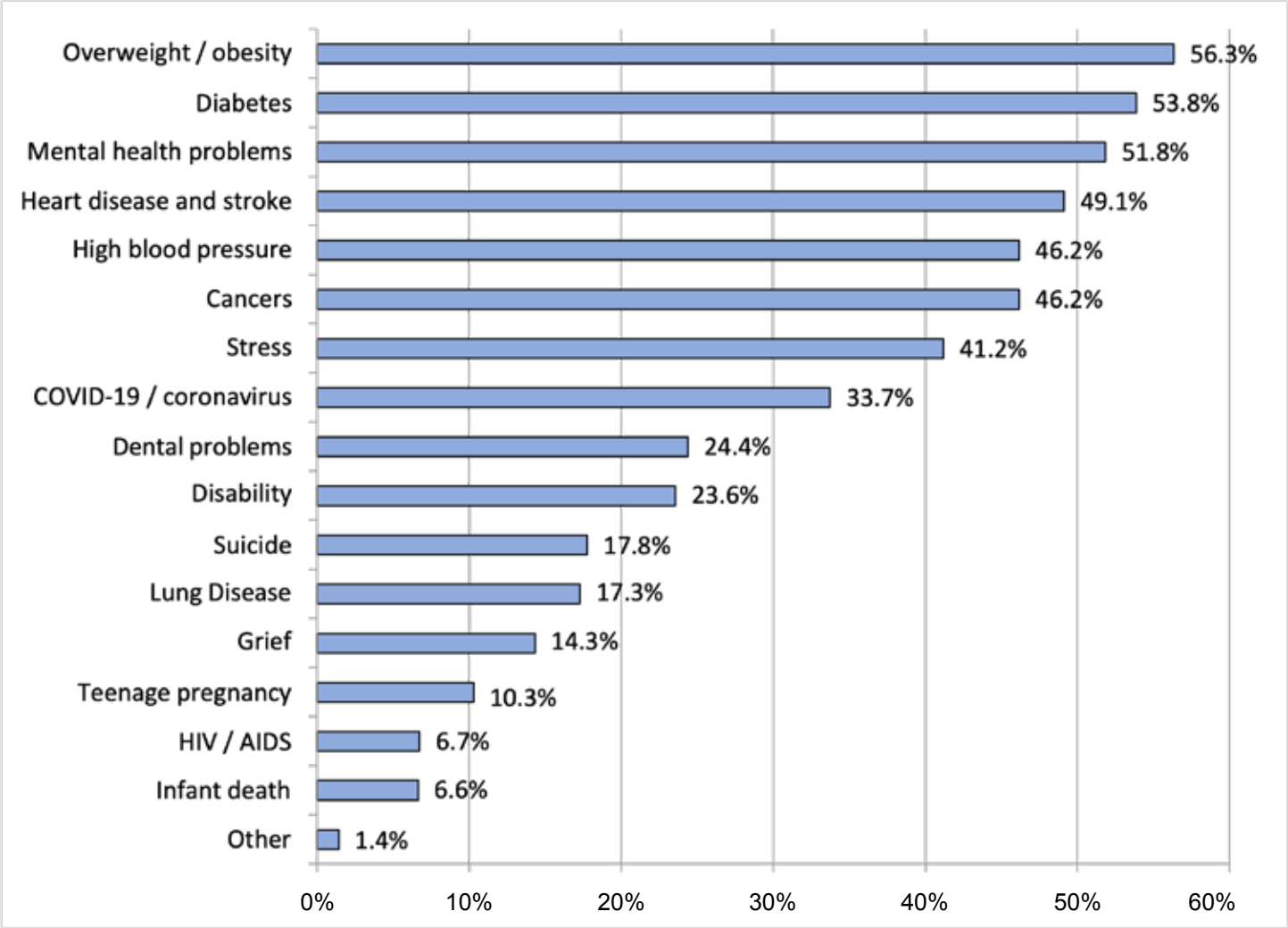
In 2021 respondents ranked alcohol and illegal drug as the most important health factor. This was a 14% increase over the 2018 rate (48.8% compared to 34.2%). Poor eating habits increased significantly from the 2018 assessment (16.7%) to 45.6% in 2021. Lack of exercise increased approximately 23% from 2018 (16.4%) to 39.3% in 2021 as did access to healthy foods (25.2% in 2018 and 37.7% in 2021). It is important for the reader to note that "health conditions" were separated from "health factors" in the 2021 assessment. This makes comparisons between 2018 and 2021 difficult.

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



Respondents ranked health conditions or outcome issues that directly address diabetes or are significant risk factors for other chronic diseases (obesity, high blood pressure, and stress) highly. Of particular note, in 2018, 26% of respondents selected mental health problems and in 2021 that number increased to 52%. This increase may be impacted by COVID-19 and the fact that health care "factors" and health care "issues" were broken into separate questions in 2021. This makes comparisons between 2018 and 2021 difficult.

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



STAKEHOLDERS SUMMARY

Stakeholder Focus Group and Survey

To further understand the needs of the target populations in the Bedford Area and the factors that impact the health of these residents, a Stakeholder Focus Group meeting was held on May 12, 2021 via Microsoft Teams. A total of 37 individuals attended the meeting including members of the Community Health Assessment Team and other identified cross-sector stakeholders, non-profit organizations, service providers, business leaders, and local government officials. A directory of participants can be found in the Appendix.

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

After the Focus Group meeting, a Stakeholder Survey was administered and included the same questions that were asked in the Focus Group meeting. An additional question asking about the impact of the COVID-19 pandemic on the needs in the community was included in the survey. The survey was available via Survey Monkey from May 12 to May 26, 2021 for individuals and/or organizations who were unable to attend the Focus Group meeting. All total, 4 surveys were completed for the Bedford Area. An example of the survey can be found in the Appendix.

Stakeholder Focus Group questions included:

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

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

Bedford Area Stakeholder Summary Tables

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

Area of Need	*Number of Responses*	*% of Responses*	*Comments*
Mental health	**15**	**17.4**	Overcoming mental health stigma; More options for mental health supports; Mental health of our children
Transportation	**15**	**17.4**	Lack of transportation in rural areas; Transportation to medical appointments; Public transportation
Childcare	**13**	**15.1**	
Substance use	**9**	**10.5**	Lack of detox and inpatient treatment
Housing	**6**	**7.0**	Affordable housing
Workforce	**4**	**4.7**	Finding workers; Job training; quality employment
Food insecurity and nutrition	**3**	**3.5**	Access to healthy and affordable food
Community outreach	**3**	**3.5**	More outreach to let public know about all resources available; More community involvement activities
Health care access	**3**	**3.5**	Affordable health care; Distance to medical and developmental services; ER that does not have a wait time that lasts hours
Coordination of resources	**2**	**2.3**	Streamlining resources; Limited willingness of local government to invest in community resources
Families	**2**	**2.3**	Marriage counseling; More children interactions
Health promotion and disease prevention	**2**	**2.3**	There is a lack of education around healthy living; The increase/impact of chronic disease
Vaccination hesitancy	**2**	**2.3**	COVID-19
Poverty	**2**	**2.3**	
Education attainment	**1**	**1.2**	Lack of motivation for higher education
Financial stability	**1**	**1.2**	
Isolation	**1**	**1.2**	
Health literacy	**1**	**1.2**	
Criminal justice	**1**	**1.2**	Stricter justice system
Total	**86**	**100%**	

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

Needs Impacted by COVID-19	*Number of Responses*	*Comments*
Socialization	**2**	• Instead of getting outside, exercising, eating healthy, and living a healthier life to build immune system - we were afraid and locked up in our homes without any socialization; By not allowing people to hold (an event with) more than a certain amount of people.
Mental health & substance use	**1**	• Further driving people to substance abuse and negatively effecting mental health
Wait times	**1**	• Made wait times worse for any provider

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

Area of Need	*Number of Responses*	*% of Responses*	*Comments*
Community resources & outreach	**5**	**20.0**	Improve visibility of resources already established; Resources to know where to go to find help; Talking about different topics with interactions in the community; Understanding why people don't use the resources we already have- cultural issues
Poverty	**4**	**16.0**	
Mental health	**3**	**12.0**	Free access to mental health; Continuity of care; Reforming mental health system
Health literacy	**2**	**8.0**	
Inclusion	**2**	**8.0**	We need people who need the help at the table; Meeting directly with our citizens to hear their needs
Transportation	**2**	**8.0**	Public transportation
Childcare	**1**	**3.8**	
Economic development	**1**	**3.8**	
Education	**1**	**3.8**	
Financial stability	**1**	**3.8**	
Food insecurity and nutrition	**1**	**3.8**	Food security; educate our community on available resources
Patient-provider relationship	**1**	**3.8**	Find doctors that don't judge a patient's ideas or don't just push pills
Substance use	**1**	**3.8**	Getting people off drugs
Total	**25**	**100%**	

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

One Issue	Number of Responses	% of Responses	Comments
Coordination of resources	**5**	**19.2**	Centralizing resource information; Collaborate to share resources; Reduce duplication of resources where there is overlap; Phone app to access resources
Community outreach	**4**	**15.4**	Involve policymakers; Events, ways to get resources education to the public; Work together to launch outreach initiative to meet or speak with the public; Set a date for an interest meeting or other idea to bring to one another; Community forums, finding ways to understand why, not just developing more of the same
Bedford area resource council (BARC)	**3**	**11.5**	Keep using BARC and talking with real outcomes; BARC is an awesome collaboration effort to not duplicate efforts. Continue with this and advertise this program more.
Community referral system	**3**	**11.5**	
Funding	**3**	**11.5**	Action and financing; Seek grant funding; Prioritize where we need more grant funding
Advocacy	**2**	**7.7**	Political advocacy; Involve policymakers
Access to services	**1**	**3.8**	Make accessing services easier; Phone app to access resources
Centra leadership	**1**	**3.8**	
Education	**1**	**3.8**	Develop a massive campaign in support of education
Faith community	**1**	**3.8**	Involve faith community
Mental health	**1**	**3.8**	Reform mental health assessments and/or treatments and the Emergency Custody Order/Temporary Detention Order processes and educate health care providers on issues/laws/protocols.
Workforce	**1**	**3.8**	Involve employers where possible
Total	**26**	**100%**	

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

Vulnerable Populations or Localities	*Number of Responses*	*% of Responses*	*Comments*
Rural areas	**5**	**15.6**	Those in isolated areas; Rural parts of Bedford
Low income	**4**	**12.5**	Pockets of poverty in the subsidized housing; Poor people in rural communities; Families with young children in poverty
Lack of internet access	**4**	**12.5**	Those without easy access to the internet; Rural residents with no reliable internet; Those without internet access
Town of Bedford	**3**	**9.4**	Census Tracts south of Washington St in Town of Bedford; Town of Bedford, South and West of Town are the needy areas
Bedford county & town	**2**	**6.3**	
Children & youth	**2**	**6.3**	Young adults transitioning to adulthood; Children
Isolation	**2**	**6.3**	People who are isolated and do not have social or human capital; Those socially isolated
Parents/guardians	**2**	**6.3**	Single mothers; Grandparents raising children
Childcare	**1**	**3.1**	Families with childcare access barriers
Criminal justice	**1**	**3.1**	Convicted felons
Disabilities	**1**	**3.1**	Adults living with intellectual/ developmental disabilities
Huddleston	**1**	**3.1**	
Seniors	**1**	**3.1**	Especially elderly in rural areas
Substance use	**1**	**3.1**	Those with substance addictions
Thaxton	**1**	**3.1**	
Transportation	**1**	**3.1**	Those without transportation
Total	**32**	**100%**	

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

Resources	*Number of Responses*	*% of Responses*	*Comments*
Faith communities	**5**	**12.8**	Lake and Bedford Christian Ministries; Churches; Agape; Church buses
Non-profits	**4**	**10.3**	Non-profits with outreach mission; Non-profits whose mission it is to positively impact health; Community Centers
Department of social services	**4**	**10.3**	
Bedford area resource council (BARC)	**2**	**5.1**	BARC partners
Bedford ride	**2**	**5.1**	
Centra	**2**	**5.1**	
Central Virginia alliance for community living for seniors	**2**	**5.1**	
Collaboration	**2**	**5.1**	We have the collaborative spirit; Ability to write grants, network of connected citizens
Horizon CSB	**2**	**5.1**	
Libraries	**2**	**5.1**	
YMCA	**2**	**5.1**	
Care portal	**1**	**2.6**	
Child health investment partnership (CHIP)	**1**	**2.6**	For families in poverty
Employers	**1**	**2.6**	Employers have lots of jobs available as well as training! This will help on many fronts
Johnson health center	**1**	**2.6**	
Lynchburg area center for independent living	**1**	**2.6**	
Meals on wheels	**1**	**2.6**	
Ruritans	**1**	**2.6**	
School systems	**1**	**2.6**	
SML good neighbors	**1**	**2.6**	
Technology	**1**	**2.6**	Online access having the information at certain locations in town or county
Total	**39**	**100%**	

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

Gaps	Number of Responses	% of Responses	Comments
Transportation	**7**	**29.2**	Limitations on destinations for Bedford ride; Gas
Funding	**3**	**12.5**	
Community outreach		**8.3**	Considering issues and concerns from the community; Creative ways to reach those without internet
Coordination of resources	**1**	**8.3**	Coordination of resources; Need to be able to go to one place and be able to get a direct line to resources; Knowledge of resources; Local resources hotline
Access to services		**4.2**	Central point of access
Case management	**2**	**4.2**	
Childcare	**1**	**4.2**	Cost and lack of childcare providers
Elderly	**1**	**4.2**	Closure of senior "Meal Centers"
Internet	**1**	**4.2**	Getting internet to everyone and utilizing digital platforms to reach more people; Creative ways to reach those without internet
Staffing	**1**	**4.2**	Lack of staffing
Volunteers	**1**	**4.2**	There is an overreliance on volunteers
Voter apathy	**1**	**4.2**	
Total	**24**	**100%**	

SECONDARY DATA

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

Bedford Population by Age Group by Locality

Age Group	Bedford County		Bedford Town		Virginia	
	Number	Percent	Number	Percent	Number	Percent
Under 5 years	3,709	4.70%	441	6.70%	508,399	6.00%
5 to 9 years	4,532	5.80%	586	8.90%	515,885	6.10%
10 to 14 years	4,482	5.70%	358	5.50%	525,704	6.20%
15 to 19 years	4,684	6.00%	361	5.50%	551,262	6.50%
20 to 24 years	4,278	5.50%	433	6.60%	576,327	6.80%
25 to 34 years	7,714	9.80%	1,152	17.60%	1,174,091	13.90%
35 to 44 years	8,391	10.70%	371	5.70%	1,100,460	13.00%
45 to 54 years	11,500	14.70%	648	9.90%	1,139,236	13.50%
55 to 59 years	6,220	7.90%	525	8.00%	571,821	6.80%
60 to 64 years	6,523	8.30%	443	6.80%	519,332	6.10%
65 to 74 years	9,773	12.50%	392	6.00%	756,712	9.00%
75 to 84 years	4,876	6.20%	597	9.10%	368,997	4.40%
85 years and over	1,694	2.20%	255	3.90%	146,237	1.70%
Median Age	**46.3**		**34.5**		**38.2**	
Total	**78,376**	**100%**	**6,562**	**100%**	**8,454,463**	**100%**

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

Population by Sex

Locality	Male		Female	
	Number	Percent	Number	Percent
Bedford County	38,462	49.10%	39,914	50.90%
Bedford Town	2,329	47.10%	2,613	52.90%
Virginia	**4,159,173**	**49.20%**	**4,295,290**	**50.80%**

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

Bedford Population by Race

Locality	White	Black	American Indian / Alaskan Native	Asian	Native Hawaiian or Pacific Isl	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino
Bedford County	70,090	5,384	42	943	10	283	1,624	1,720	76,656
Bedford Town	5,007	1,335	0	34	0	0	186	2	6,560
Service Area	**75,097**	**6,719**	**42**	**977**	**10**	**283**	**1,810**	**1,722**	**83,216**

Bedford Population by Race by Percent of Total Population

Locality	White	Black	American Indian / Alaskan Native	Asian	Native Hawaiian or Pacific Isl	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino
Bedford County	89.4%	6.9%	0.1%	1.2%	0.0%	0.4%	2.1%	2.2%	97.8%
Bedford Town	76.3%	20.3%	0.0%	0.5%	0.0%	0.0%	2.8%	0.0%	100.0%
Virginia	**67.6%**	**19.2%**	**0.3%**	**6.4%**	**0.1%**	**2.6%**	**3.8%**	**9.4%**	**90.6%**
United States	**72.5%**	**12.7%**	**0.8%**	**5.5%**	**0.2%**	**4.9%**	**3.3%**	**18.0%**	**82.0%**

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

Limited English-Speaking Households

Locality	Total			Limited English Speaking by Language	
	Total Population	Limited English	Percent Limited English	Spanish	Asian Pacific Isl.
Bedford County	31,317	168	0.50%	71	52
Bedford Town	2,658	19	0.70%	0	19
Virginia	**3,151,045**	**84,373**	**2.70%**	**41,500**	**24,490**

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

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

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

Population Projections

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

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

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

Population Projections by Locality, 1990 - 2010

Locality	1990	2000	2010	+/-
Bedford County	45,656	60,371	74,898	64.0%
Virginia	**6,187,358**	**7,078,515**	**8,001,024**	**29.3%**

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

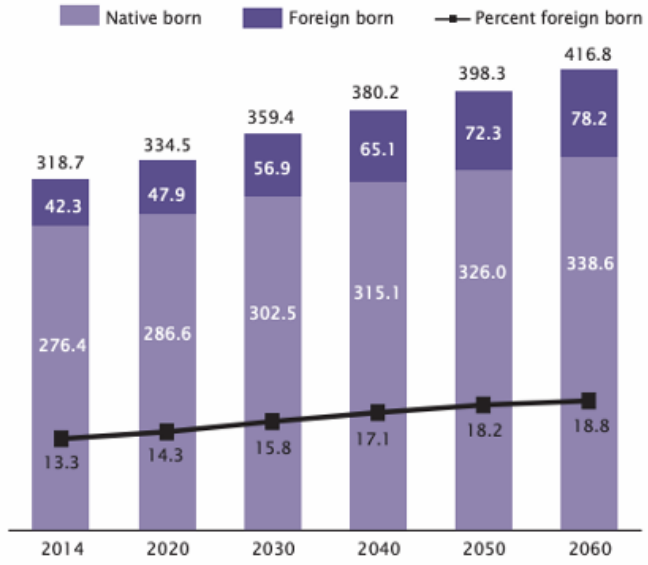
Population Projections by Locality, 2020-2040

Locality	2020	2030	2040	+/-
Bedford County	79,241	84,604	88,794	12.1%
Virginia	**8,655,021**	**9,331,666**	**9,876,728**	**14.1%**

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

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

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



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

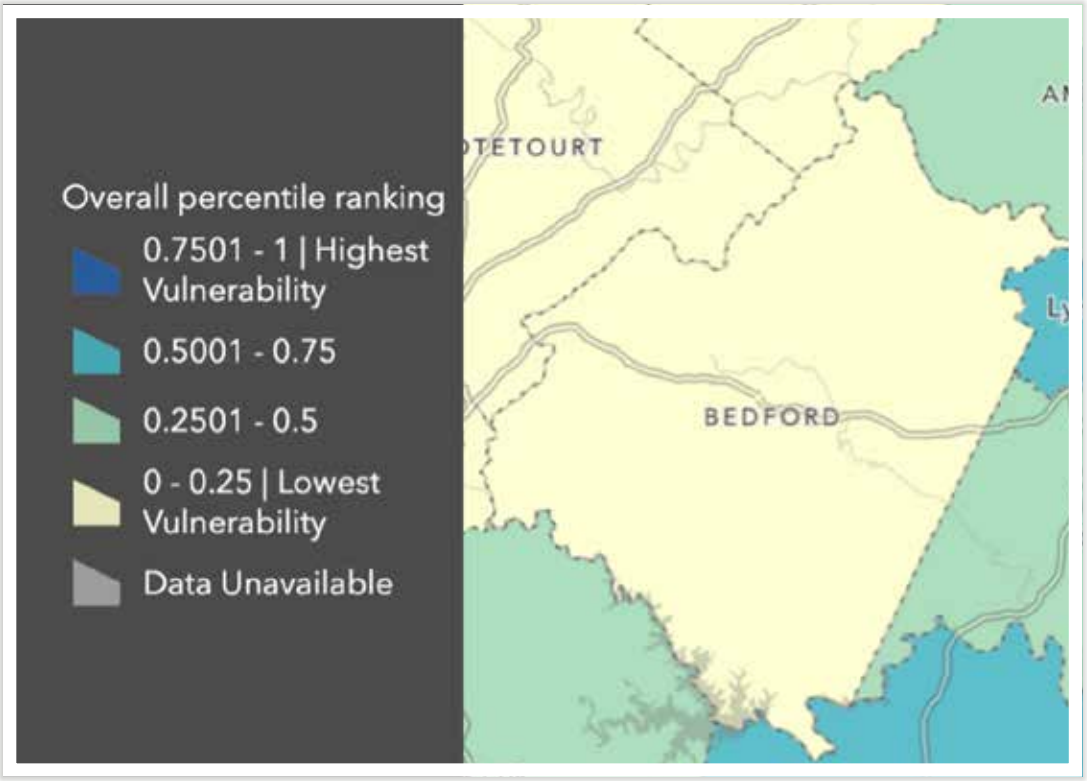
SOCIAL VULNERABILITY INDEX

"What is social vulnerability?

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

What is CDC Social Vulnerability Index?

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



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

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

***Bedford County*:** A score of **0.0984** indicates a low level of vulnerability.

***Bedford Town*:** A score of **0.6296** indicates a moderate to high level of vulnerability.

EDUCATION

The Link Between Education and Health

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

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

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

Poverty Status and Educational Attainment

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

Locality	*Less than High School Graduate*	*High School Graduate*	*Some College, Associate's Degree*	*Bachelor's Degree or Higher*
Bedford County	21.8%	9.4%	5.9%	3.3%
Bedford Town	38.7%	27.9%	1.4%	4.1%
Virginia	**21.6%**	**11.8%**	**7.8%**	**3.2%**

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

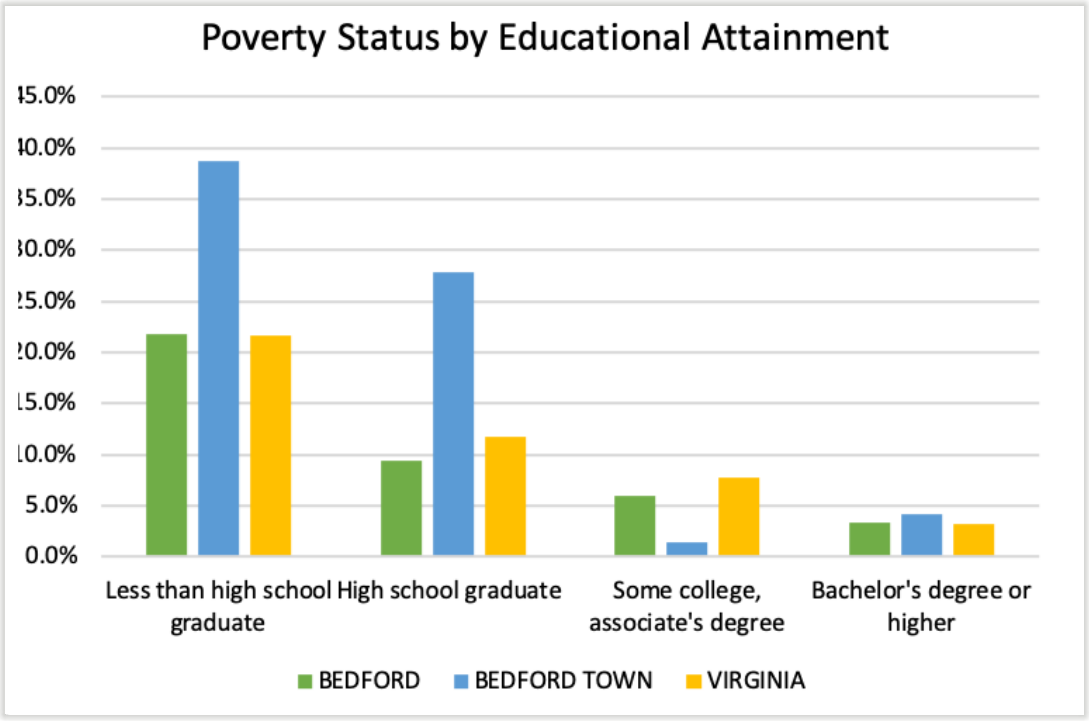


Table Source: U.S. Census, Poverty Status in the past 12 months. Table S1701. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

Among the service area localities, roughly 22% of Bedford County residents living in poverty have less than a high school education. In the town of Bedford, that is almost doubled, at 38% of those living in poverty with less than a high school education. Poverty rates by academic attainment were higher for the town of Bedford as compared to the same rates in Bedford County and the state of Virginia. Across localities, the service area, and overall state rate, the largest difference is between those who have less than a high school education and those who have a high school education or equivalent – a stark representation of the value of achieving, at a minimum, a high school or equivalent education. The chart above provides a visual representation of the difference in poverty status based on educational attainment with a clear indication of the gulf between less than a high school education and those with a high school education.

Educational Attainment by Locality for the Population Age 25 and Over

Locality	*Population 25 Years and Over*	*Less than High School Graduate*	*High School Grad or Equivalent*	*Some College or Associate's Degree*	*Bachelor's Degree or Higher*
Bedford Town	4,383	19.1%	31.2%	32.1%	17.6%
Bedford County	56,691	10.0%	30.2%	30.6%	29.2%
Virginia	**5,776,886**	**10.3%**	**24.0%**	**26.9%**	**38.8%**

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

There is a striking difference between the overall state rate across attainment categories and localities that comprise the service area rates. The rates for less than high school graduation in the town of Bedford is almost double the rate for Bedford County and the state of Virginia. For both localities in the service area, there are more residents with a high school or equivalent degree and those with some college or Associate's degree as compared to the rates for Virginia. However, we start to see a lowering of these rates for those in the service region with a bachelor's degree or higher as compared to statewide averages.

Graduation and Drop Out Rates

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

Division Name	Race	Gender	Economically Disadvantaged	2018		2019		2020	
				Graduation	Dropout	Graduation	Dropout	Graduation	Dropout
Bedford County	Black	F	N	80.00%	10.00%	100%	0%	100.00%	0.00%
	Black	M	N	100.00%	0.00%	<	<	<	<
	White	F	N	96.21%	2.37%	95.94%	1.48%	97.22%	1.85%
	White	M	N	95.20%	3.06%	91.77%	4.53%	94.71%	0.88%
	Black	F	Y	95.83%	4.17%	82.35%	0.00%	80.00%	20.00%
	Black	M	Y	88.89%	11.11%	90.91%	0.00%	95.83%	0.00%
	White	F	Y	87.72%	7.02%	82.61%	10.87%	90.12%	3.70%
	White	M	Y	83.05%	11.02%	80.22%	13.19%	85.42%	6.25%

Note: '<' indicates insufficient data from VDOE

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

Bedford County

Jefferson Forest High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	94.01%	93.42%	94.51%	95.56%	90.00%	75.00%	82.69%	88.24%
Drop-out Rate	2.99%	3.29%	2.75%	1.85%	10.00%	12.50%	9.62%	0.00%

Liberty High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	91.84%	93.94%	89.69%	94.00%	86.36%	70.00%	89.13%	76.00%
Drop-out Rate	5.10%	5.05%	5.15%	3.33%	4.55%	30.00%	7.61%	16.00%

Staunton River High	Total	Female	Male	White	Black	Hispanic	Economically Disadvantaged	Disability
On Time Graduation	89.58%	95.73%	2.56%	90.50%	90.91%	76.47%	86.11%	80.65%
Drop-out Rate	4.17%	2.56%	5.69%	2.50%	9.09%	17.65%	6.48%	12.90%

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

Chronic Absenteeism

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

Common health conditions that have been associated with school absenteeism include influenza infection, group A streptococcal pharyngitis, gastroenteritis, fractures, poorly controlled asthma, type 1 diabetes mellitus,

chronic fatigue, chronic pain (including headaches and abdominal pain), seizures, poor oral health, dental pain, and obesity.

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

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

Chronic Absenteeism by Percent

Locality	2014 - 2015	2015 - 2016	2016 - 2017	2018 - 2019
Bedford County	8.3	13.8	7.5	7.5
Virginia	**10.7**	**10.6**	**10.4**	**10.1**

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

The chronic absenteeism rate in the service area is lower than the overall state rate in more recent years; however, there was a spike in the 2017 school year in Bedford.

Free and Reduced Lunch Data

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

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

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

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

In 2014, some Virginia school districts began participating in the Community Eligibility Option (CEP), a federal program that allows school districts to provide free or reduced-price meals to all students at high poverty or 'high need' schools without determining the exact number of eligible students. As a result, it is possible that an undetermined number of students who would not otherwise qualify for FARMs eligibility are now counted in this group and FARMs eligibility data after 2014 may no longer be an accurate indicator of student poverty or comparable to data from 2013 and before. Comparing across years for any CEP school is not advised. The free eligible for the school districts participating in CEP is a VDOE calculated number based on USDA guidance."

Source: Annie E. Casey Foundation, Kids Count Data Center, "Students approved for free or reduced price school lunch in Virginia", Accessed September 14, 2021. Retrieved from: https://datacenter.kidscount.org/data/tables/3239-students-approved-for-free-or-reduced-price-school-lunch#detailed/2/any/false/1577,1565,1380,1232,1123,1031,923,920,919,918/any/12923,6682

Bedford County:
Free and Reduced Lunch by Locality & School

School Name	School Type	SNAP Member	FREE Eligible	FREE Percent	Reduced Eligible	Reduced Percent	TOTAL Eligible	TOTAL Percent
Big Island Elem	Elementary	153	64	41.83%	10	6.54%	74	48.37%
Boonsboro Elem	Elementary	350	56	16.00%	21	6.00%	77	22.00%
Montvale Elem	Elementary	272	133	48.90%	30	11.03%	163	59.93%
Bedford Elem	Elementary	455	256	56.26%	24	5.27%	280	61.54%
Forest Elem	Elementary	347	34	9.80%	13	3.75%	47	13.54%
New London Academy Elem	Elementary	318	41	12.89%	17	5.35%	58	18.24%
Stewartsville Elem	Elementary	347	175	50.43%	48	13.83%	223	64.27%
Moneta Elem	Elementary	210	102	48.57%	19	9.05%	121	57.62%
Huddleston Elem	Elementary	268	126	47.01%	13	4.85%	139	51.87%
Otter River Elem	Elementary	238	76	31.93%	10	4.20%	86	36.13%
Bedford Primary	Elementary	298	290	97.32%	0	0.00%	290	97.32%
Thomas Jefferson Elem	Elementary	578	98	16.96%	27	4.67%	125	21.63%
Goodview Elem	Elementary	505	196	38.81%	53	10.50%	249	49.31%
Liberty Middle	Middle	589	261	44.31%	40	6.79%	301	51.10%
Staunton River Middle	Middle	674	296	43.92%	62	9.20%	358	53.12%
Forest Middle	Middle	927	148	15.97%	33	3.56%	181	19.53%
Jefferson Forest High	High	1,382	180	13.02%	54	3.91%	234	16.93%
Staunton River High	High	938	384	40.94%	76	8.10%	460	49.04%
Liberty High	High	750	314	41.87%	51	6.80%	365	48.67%
Bedford Alt Ed Ctr		43	42	97.67%	0	0.00%	42	97.67%
TOTALS		**9,642**	**3,272**	**33.93%**	**601**	**6.23%**	**3,873**	**40.17%**

Virginia Total:
Free and Reduced Lunch by Locality & School

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

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

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

EMPLOYMENT

Unemployment and Wages

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

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

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

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

Unemployment Rates by Locality

Locality	2018	2019	2020
Bedford County	3	2.7	5.7
Virginia	2.9	2.7	6.2
United States	3.9	3.7	8.1

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

Annual Employment and Wage Statistics by Locality in 2020

Locality	Annual Establishments	Annual Average Employment	Annual Average Weekly Wage	Annual Wages per Employee
Bedford County	2,260	18,131	$776	$40,337
Virginia	283,780	3,744,370	$1,253	$65,146

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

It is important to understand these unemployment wages in the context of the COVID-19 Pandemic, where many U.S. Citizens found themselves unable to, or out of, work. State wages are impacted by areas within the commonwealth that have higher costs of living and therefore have higher wages such as Northern Virginia. Despite this fact, there are localities within the service area where wages are low relative to the costs of insurance, food and other commodities that impact health. However, in Bedford, the annual wages per employee is roughly $25,000 less than both the US and VA averages.

Largest Employers

Bedford: Top 10 Largest Employers in Q4 2020	
Employer Name	***Size***
Bedford County School Board	1000 and over employees
County of Bedford	500 to 999 employees
Centra Health	500 to 999 employees
Elwood Staffing Services Inc	250 to 499 employees
Wal Mart	250 to 499 employees
GP Big Island LLC	250 to 499 employees
Mail America Communications	250 to 499 employees
Food Lion	250 to 499 employees
Sentry Equipment Erectors	100 to 249 employees
Sam Moore Furniture LLC	100 to 249 employees

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

INCOME

Poverty

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

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

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

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

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

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

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

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

Locality	50 percent of poverty level	125 percent of poverty level	200 percent of poverty level
Bedford Town	713	1,940	2,894
Bedford County	3,409	9,691	18,523
Virginia	**414,408**	**1,143,890**	**2,030,587**

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

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

Locality	50 percent of poverty level	125 percent of poverty level	200 percent of poverty level
Bedford Town	11.3%	30.7%	45.7%
Bedford County	4.3%	12.5%	23.8%
Virginia	**5.1%**	**13.9%**	**24.8%**

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

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

Locality	Households	White	Black	Hispanic
Bedford Town	36,364	40,721	25,720	<
Bedford County	64,199	65,865	48,000	72,917
Virginia	**74,222**	**79,578**	**51,654**	**68,772**

Note: '<' indicates insufficient data from VDOE

Table Source: Census_ACS Table S1903. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

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

ALICE Households

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

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

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

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

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

ALICE Households by Locality by Percent, 2018

Locality	Household	Poverty Household	ALICE Household	Above ALICE Household	Percent ALICE Households
Bedford	31206	2992	11335	16879	36%

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

ALICE household data is available for Bedford County which has a higher percentage of ALICE households as compared to Virginia as a whole.

Impact of Poverty on Physical Health of Children

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

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

Children that are Economically Disadvantaged (Below 200% FPL)

Locality	Number Below 200% FPL	Percent below 200% FPL
Bedford County	4,659	29%
Virginia	**620,201**	**33%**

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

Children and adults between 200% and 300% of poverty are often economically vulnerable and may live "pay check-to-pay check". This reality suggests that more than 29% of the children residing in Bedford County are subject to the impact of living in or near poverty as described in the American Association of Pediatrics brief cited above and are at risk for poor health and issues associated with poverty.

Poverty and Seniors

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

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

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

Person Age 65+ Years: Below Poverty

Locality	Persons	Percent
Bedford Town	113	10.20%
Bedford County	1,045	6.50%
Virginia	**92,951**	**7.50%**

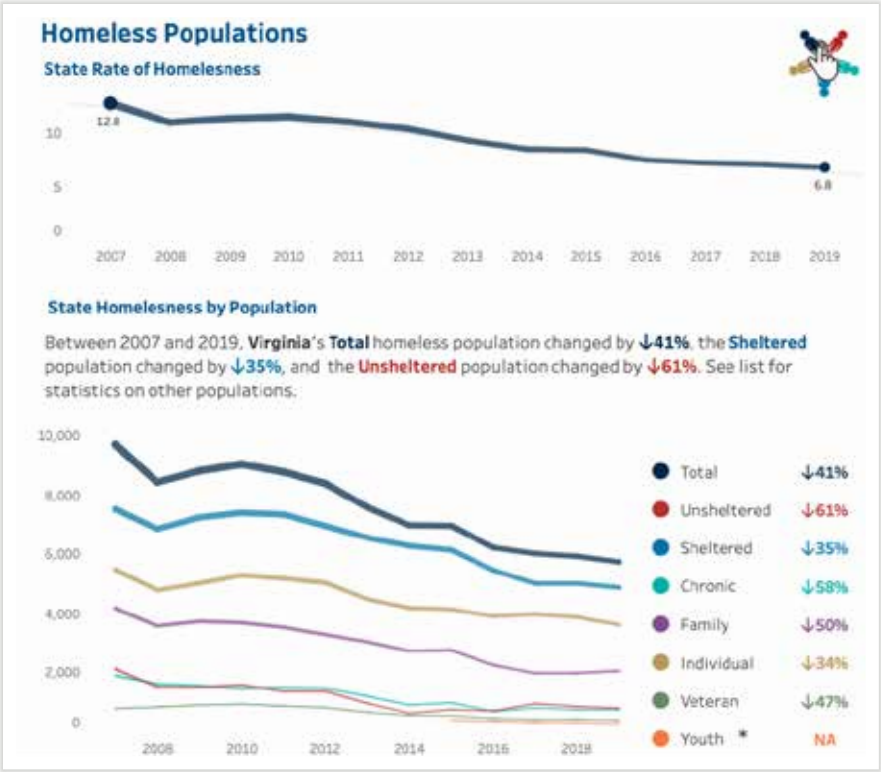
Table Source: Census_ACS_Table S1701. Date of Table: 2019. Year(s) Measured: 5 Year Estimates. Retrieved from https://data.census.gov/

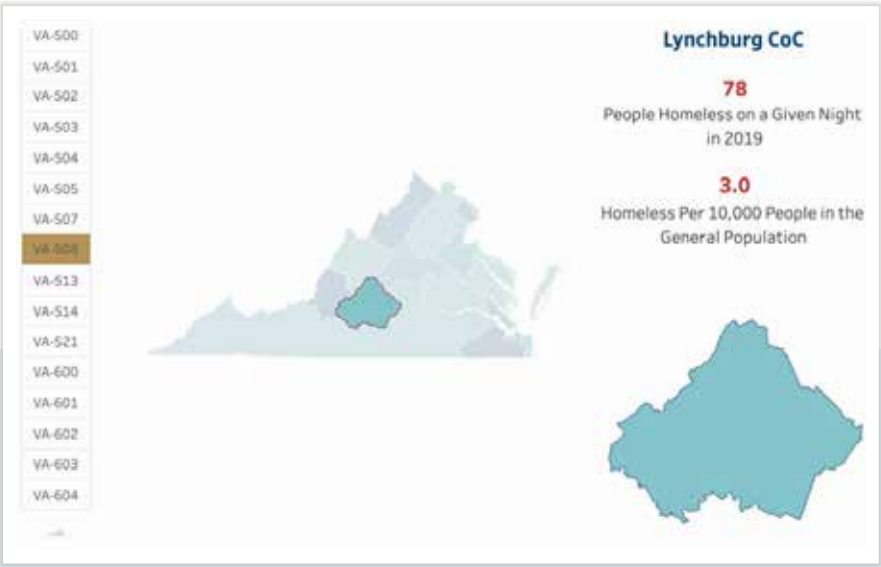
Percentage of Families and People Whose Income in the Past 12 Months is Below the Poverty Level

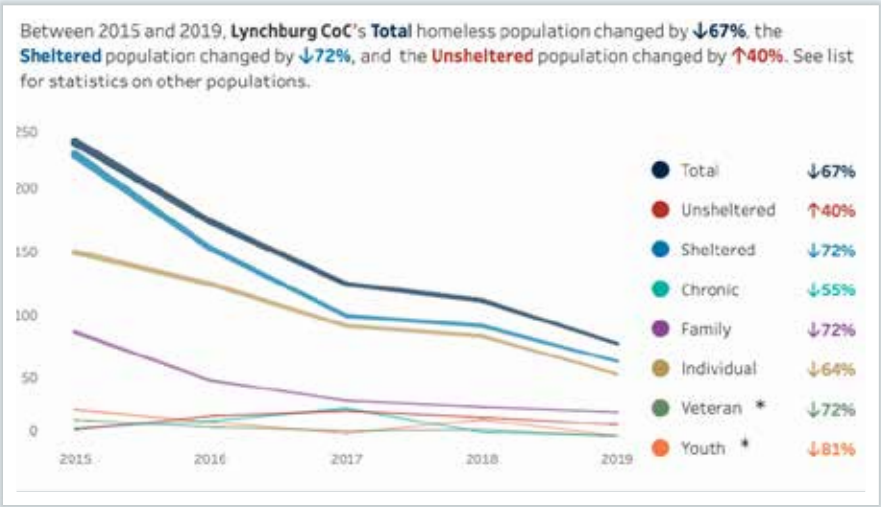
Locality	All families	Married couple families	Families with female householder, no spouse present
Bedford Town	19.40%	6.30%	33.00%
Bedford County	5.80%	3.50%	16.30%
Virginia	**7.10%**	**3.20%**	**22.70%**

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

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







HOMELESSNESS

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

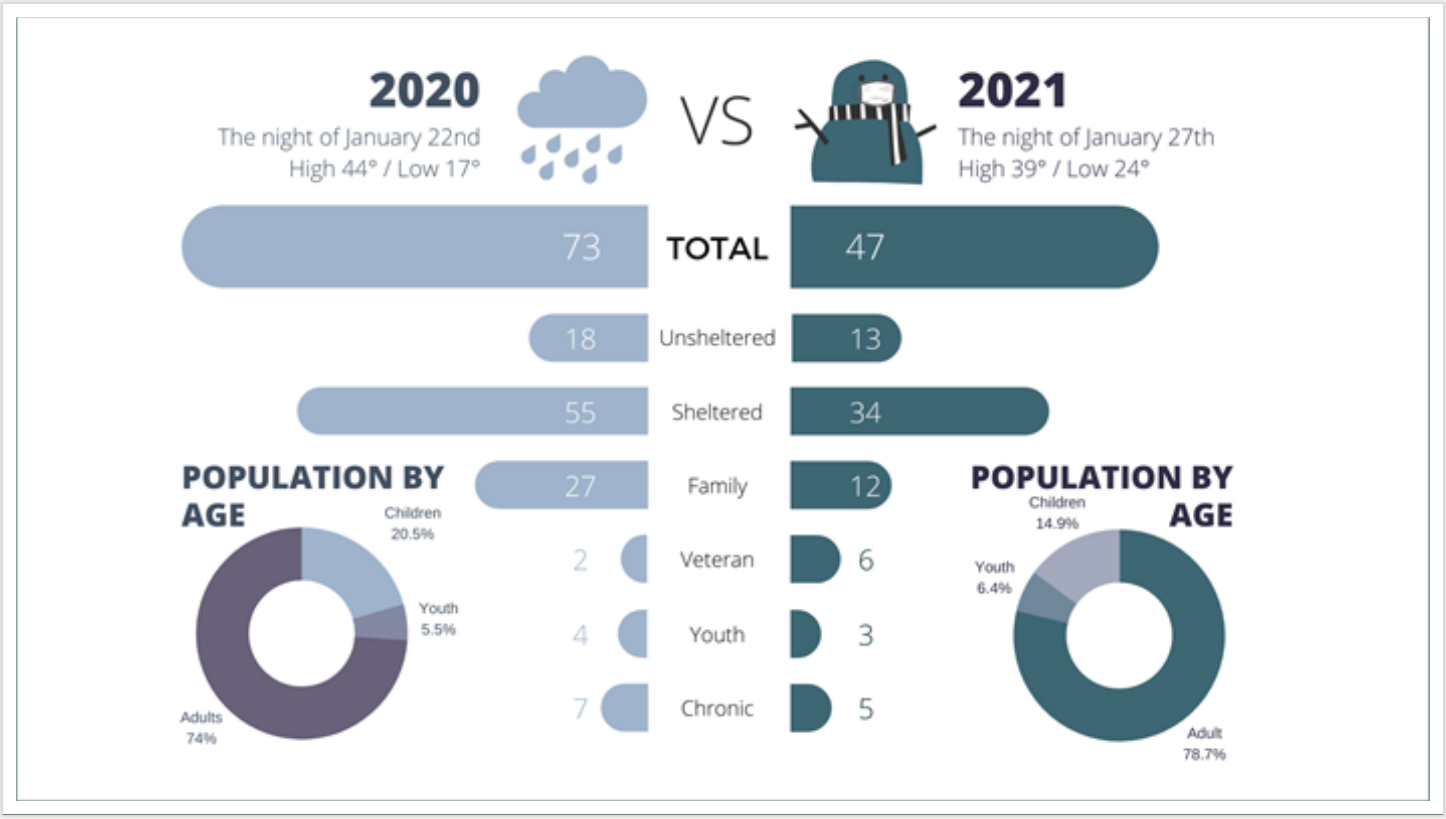
Treatment and preventive care can be difficult to access for people who are experiencing homelessness. This is often because they lack insurance or have difficulty engaging health care providers in the community.

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

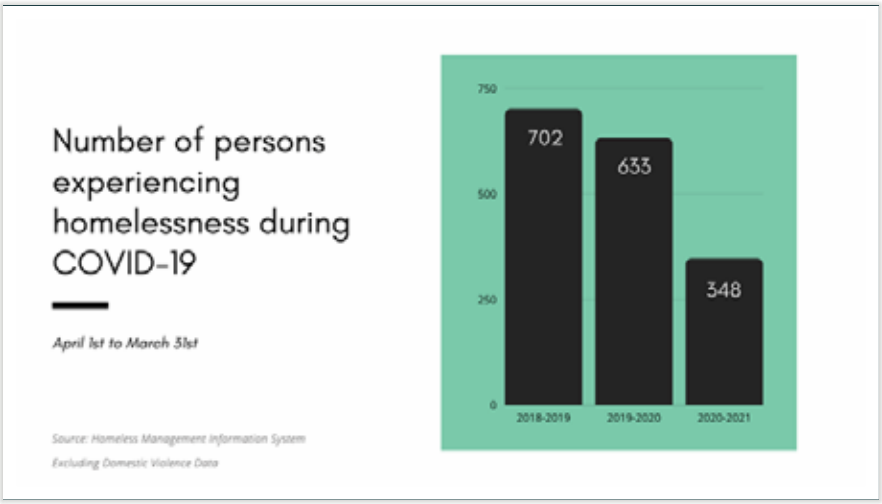
Source: National Alliance to End Homelessness. Health and Homelessness. Website Last Updated 2020. Accessed July 9th, 2021. Retrieved from: https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/

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

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



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



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

FAMILY SUPPORT

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

Food Insecurity

SNAP Participation Report

Locality	2018	2019	2020	2021	4 YR Change
Bedford County	10.5%	10.7%	10.8%	10.9%	0.4%
Virginia	**13.9%**	**14.0%**	**13.2%**	**13.1%**	**-0.8%**

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

Data available for Bedford county reveals consistency in SNAP participation, even in 2020 and the first half of 2021 during the COVID-19 pandemic with rates lower than Virginia as a whole. "The far-reaching health and economic effects of COVID-19 and widespread business closures to limit its spread have made it even more difficult for many low-income households to afford food and other needs. Data have shown a sharp increase in the number of families reporting difficulties affording adequate food and other basic needs, which have remained high throughout the pandemic compared to pre-pandemic levels, despite recent declines. SNAP is essential to helping these families put food on the table."

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

Food Insecurity Among Child Population under 18

Locality	2017	2018	2019	3 YR Change
Bedford County	13.1%	12.9%	12.8%	-0.3%
Virginia	**13.3%**	**13.2%**	**12.5%**	**-0.8%**

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

In Bedford County, food insecurity rates in children and youth under 18 years of age is consistent with the rates in Virginia as a whole.

TANF Participation Report - Total Persons

Locality	2019	2020	2021	3 YR Change
Bedford County	229	269	258	12.7%
Virginia	**36336**	**36723**	**37229**	**2.5%**

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

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

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

Foster Care

Rate of Children Entering Foster Care per 1,000 Population

Locality	3-Yr. Avg.	2017	2016	2015
Bedford County	2.3	1.8	2.1	3.1
Virginia	**2.5**	**1.5**	**1.5**	**1.5**

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

In the "Foster Care Children Demographic" report for August 2021 (as of September 1, 2021) for Bedford County, 83 children were in foster care representing 1.5% of the total children in foster care across the state (5359).

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

Child Abuse and Neglect

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

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

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

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

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

Child Abuse Case Responses by Localities | 2018-2020

Locality	Cases Received			Cases Accepted			Investigations		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Bedford County	1,091	1,065	918	623	536	473	117	90	114
Virginia	**88,124**	**90,492**	**75,758**	**39,404**	**39,970**	**35,704**	**11,102**	**11,201**	**9,423**

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

Childcare

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

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

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

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

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

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

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

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

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

in leadership roles, including having a say in program operations.

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

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

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

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

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

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

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

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

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

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

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

ACCESS

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

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

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

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

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

Insurance Coverage and its Impact on Health

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

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

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

Uninsured Adults and Children

Uninsured Adults by Year

Locality	2016		2017		2018	
	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured
Bedford County	4926	10.6	5383	11.6	5588	12.0
Virginia	**606611**	**11.8**	**620551**	**12.1**	**618552**	**12.0**

Uninsured Children by Year

Locality	2016		2017		2018	
	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured	Number Uninsured	Percent Uninsured
Bedford County	766	5	841	5	839	5
Virginia	**94398**	**5**	**97657**	**5**	**95977**	**5**

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

Privately Insured

Persons with Private Insurance by Type

Locality	Total Private	Private Employer-based	Private Direct-purchase	Private Tricare/Military
Bedford Town	49.70%	44.30%	3.5%	2.0%
Bedford County	58.70%	50.70%	6.80%	1.20%
Virginia	**60.00%**	**49.60%**	**6.60%**	**3.70%**

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

Fewer persons living in the town of Bedford are privately insured and more than double the number of persons have Medicaid coverage as compared to the county and state. In Bedford County more of the population has Medicare coverage alone as compared to the town of Bedford and Virginia. (See tables below)

Population with Medicaid Coverage Alone

Locality	Total	Percent of Total Population
Bedford Town	1,243	19.6%
Bedford County	5,700	7.3%
Virginia	**719,551**	**8.7%**

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

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

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

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

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

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

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

Population with Medicare Coverage Alone

Locality	Total	Percent of Total Population
Bedford Town	322	5.1%
Bedford County	5,887	7.5%
Virginia	**375,643**	**4.6%**

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

AVAILABILITY

Medically Underserved Areas

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

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

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

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

Some examples include:

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

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

Medically Underserved Area / Population Designation Status

Locality	*Designation Status*	*Service Area Name*	*MUA Index Score 1 (highest need) – 100 (lowest need)*
Bedford County	Yes	Big Island	60.8

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

HPSAs – Primary Care, Dental & Mental Health

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

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

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

Geographic Area

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

Population Groups

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

Facilities

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

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

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

HPSA: Mental Health

Locality	HPSA Designation Type	Score
Bedford County	High Needs Geographic HPSA	13

HPSA: Dental Care

Locality	HPSA Designation Type	Score
Bedford County	Geographic HPSA	12

HPSA: Primary Care

Locality	HPSA Designation Type	Score
Bedford County	Low Income Population HPSA	16

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

Provider Availability: PCP, Dental and Mental Health Providers

Primary Care Provider to Population Ratio

Locality	2018	2019	2020
Bedford County	1417:1	1418:1	1382:1
Virginia	**1310:1**	**1319:1**	**1325:1**

Dental Provider to Population Ratio

Locality	2018	2019	2020
Bedford County	3899:1	3750:1	3292:1
Virginia	**1473:1**	**1457:1**	**1409:1**

Mental Health Provider to Population Ratio

Locality	2018	2019	2020
Bedford County	2689:1	2187:1	1837:1
Virginia	**628:1**	**572:1**	**531:1**

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

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

Organization	Facility Type	Localities Served	Website
Johnson Health Center: Bedford Community Health Center; Bedford Community Dental Center	FQHC	Bedford	https://www.jhcvirginia.org/
Community Access Network	FQHC LAL, Free Clinic	Bedford	www.jhcvirginia.org/
Free Clinic of Central Virginia: Bedford Clinic	Free Clinic	Adults who reside in the region	https://www.communityaccessnetwork.org/
Horizon Behavioral Health	CSB	Bedford	https://www.horizonbh.org/

OVERALL HEALTH RANKINGS

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

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

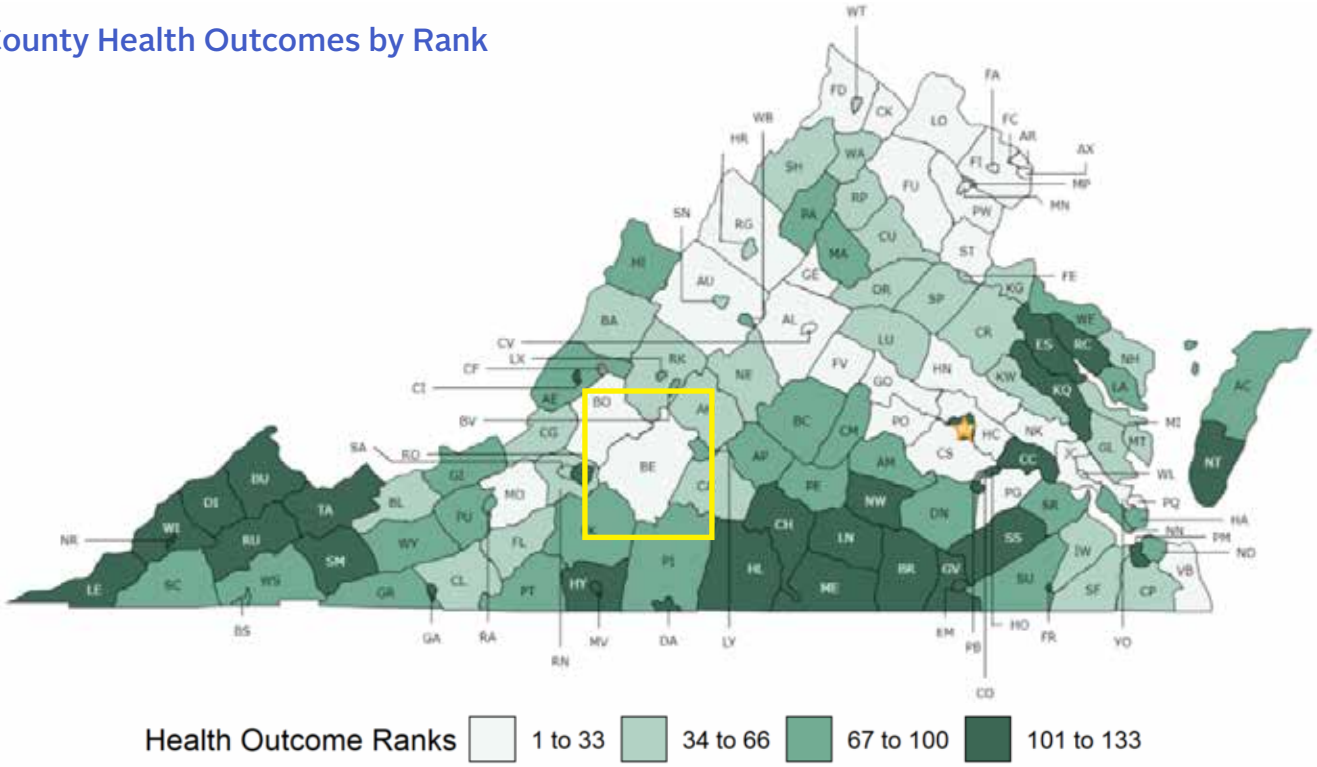
County Health Rankings

Locality	2019		2020		2021	
	Health Outcomes	Health Factors	Health Outcomes	Health Factors	Health Outcomes	Health Factors
Bedford	33	36	35	44	32	38

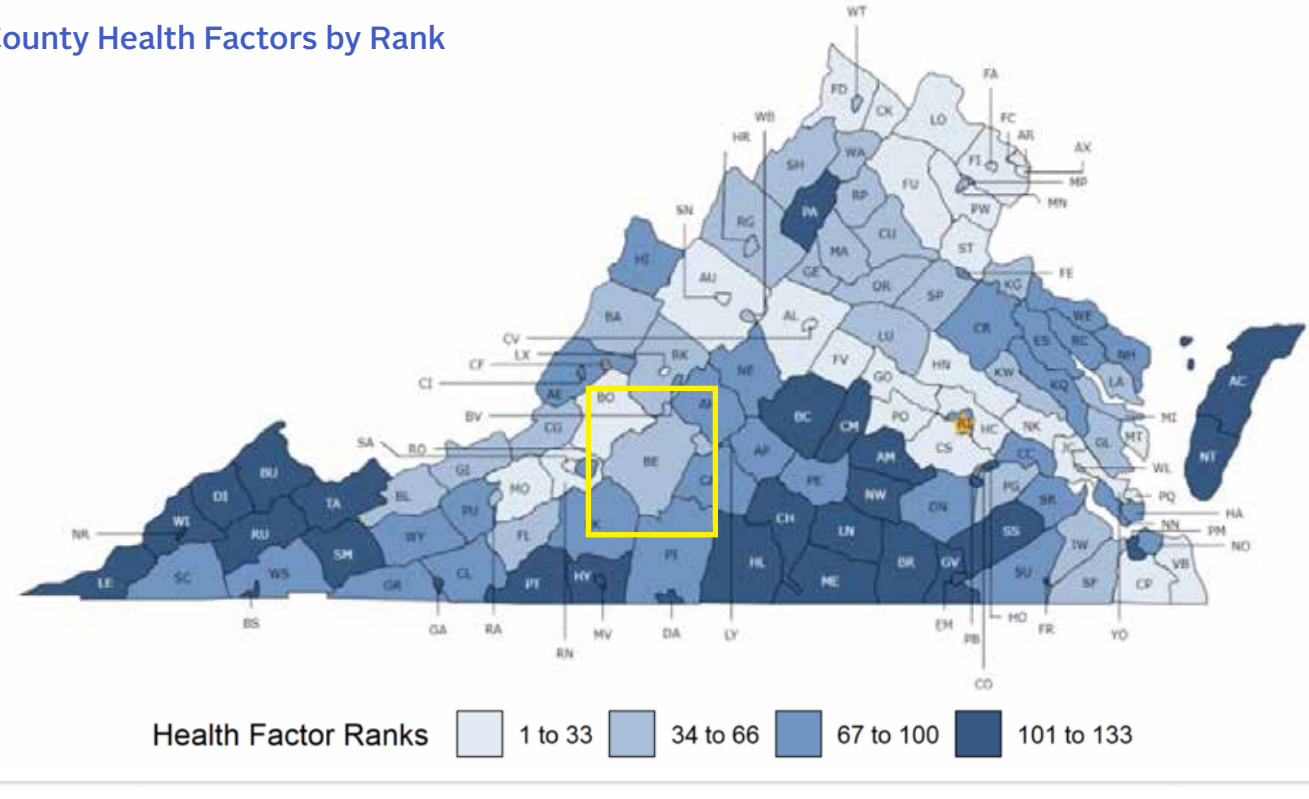
Note: "1" equals best; "133" equals worst. Change: 'minus (-)' equals improving; 'plus (+)' equals worsening

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

County Health Outcomes by Rank



County Health Factors by Rank



Of the localities served by the Central Virginia Health District (including the counties of Amherst, Appomattox, Bedford and Campbell and the city of Lynchburg) Bedford County has remained in the lower two quartiles for health outcomes and health factors for the past three years.

Obesity and Physical Activity

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

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

Percent of Adults with Obesity

Locality	2015	2016	2017
Bedford County	31.9	34.2	34.6
Virginia	**28.8**	**29.8**	**30.5**

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

Note: Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.

Obesity rates in Bedford County are higher than those in Virginia as a whole.

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

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

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

Locality	2015	2016	2017
Bedford County	24	27	21
Virginia	**22**	**23**	**22**

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

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

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

Percentage of Population with Access to Exercise Opportunities

Locality	2010 & 2019
Bedford County	53
Virginia	**82**

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

Access to Healthy Foods

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

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

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

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

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

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

Food Environment Index

Locality	2015 & 2018
Bedford County	8.9
Virginia	**8.8**

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

Alcohol Consumption

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

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

Percentage of Adults Reporting Binge or Heavy Drinking

Locality	2016	2017	2018
Bedford County	17.6	17.5	18.7
Virginia	**17.4**	**17.4**	**17.7**

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

Drug and Tobacco Use

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

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

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

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

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

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

Percentage of Adults Who are Current Smokers

Locality	2016	2017	2018
Bedford County	15	15	19
Virginia	**15**	**16**	**15**

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

Opioid Use

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

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

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

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

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

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

Locality	Mortality Rate
Bedford County	5.1
Virginia	**12.4**

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

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

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

Sexually Transmitted Infections

Chlamydia Incidence Rate Per 100,000 Population

Locality	2016	2017	2018
Bedford County	174.7	175.7	203.9
Virginia	**471.4**	**500.3**	**507.3**

Gonorrhea Incidence Rate Per 100,000 Population

Locality	2016	2017	2018
Bedford County	50.1	34.6	41
Virginia	**131.7**	**148.7**	**139.0**

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

Health Status

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

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

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

Persons Reporting Being in Poor or Fair Health by Percent

Locality	2016	2017	2018
Bedford County	13	14	15
Virginia	**16**	**16**	**17**

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

Persons Reporting Physically Unhealthy Days in the Past Month

Locality	2016	2017	2018
Bedford County	3.3	3.3	3.7
Virginia	**3.5**	**3.5**	**3.5**

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

Average Number of Poor Mental Health Days in Past 12 Months

Locality	2016	2017	2018
Bedford	3.4	3.5	4.3
Virginia	**3.5**	**3.8**	**4.0**

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

INCIDENCE RATES

All Cancer Types:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Bedford City & County	434.9	-0.5	438.3	-0.4	409.5	-1.4	341.7	-0.5
Virginia	**416.1**	**-1.5**	**421.1**	**-1.5**	**438.9**	**-1.5**	**265.1**	**-2.1**

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

Breast Cancer:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Bedford City & County	126.0	-0.4	131.1	6.1	89.4	-3.3	*	*
Virginia	**416.1**	**-1.5**	**421.1**	**-1.5**	**438.9**	**-1.5**	**265.1**	**-2.1**

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

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

Lung & Bronchus Cancer:

Age Adjusted Incidence Cases per 100,000 Population

Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Bedford City & County	59.8	-1.1	60.1	-1.0	55.8	-3.2	*	*
Virginia	**56.4**	**-2.2**	**58.2**	**-2.1**	**60.0**	**-1.6**	**24.2**	**-2.6**

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

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

Colon - Rectum Cancer:

Age Adjusted Incidence Cases per 100,000 Population								
Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Bedford City & County	38.9	0.8	36.0	-2.7	75.4	-0.7	*	*
Virginia	**35.2**	**-1.5**	**34.7**	**-1.1**	**40.9**	**-3.3**	**24.0**	**-2.9**

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

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

Prostate Cancer:

Age Adjusted Incidence Cases per 100,000 Population								
Locality	Total		White		Black		Hispanic	
	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend	Rate	5 Year Trend
Bedford City & County	72.4	1.1	67.2	1.1	124.5	-3.5	*	*
Virginia	**99.6**	**-0.9**	**82.3**	**-2.2**	**167.6**	**-1.3**	**67.6**	**2.0**

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

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

LIFE EXPECTANCY & DEATH RATES

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

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

Life Expectancy by Average Number of Years Lived

Locality	2015-2017	2016-2018	2017-2019
Bedford County	78.5	78.4	79.0
Virginia	**79.4**	**79.5**	**79.5**

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

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

Deaths per 1,000 Population Rate

Locality	2017	2018	2019	3 YR AVG
Bedford County	11.0	10.6	9.2	10.3
Virginia	**8.1**	**8.1**	**8.2**	**8.1**

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

As a general health indicator, Bedford County has a higher death rate among 1,000 residents than the overall state rate; however, it has decreased over the last three years. This could be a positive indicator towards improved health outcomes in the area.

Death Rates by Race

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

Deaths per 1,000 Population Rate by Race

Locality	2017				2018				2019			
	Total	White	Black	Other	Total	White	Black	Other	Total	White	Black	Other
Bedford County	11.0	11.3	9.8	0.7	10.6	10.7	10.7	2.9	9.2	9.5	6.6	4.3
Virginia	**8.1**	**8.8**	**7.8**	**2.8**	**8.1**	**8.8**	**7.8**	**2.8**	**8.2**	**8.9**	**7.9**	**3.5**

3yr Average Death Rate, 2017 - 2019

Locality	Total	White	Black	Other
Bedford County	10.3	10.5	9.0	2.6
Virginia	**8.1**	**8.8**	**7.8**	**3.0**

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

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

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

Premature and Injury Death Rates

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

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

Locality	2015 - 2017	2016 - 2018	2017 - 2019	AVG	YoY Change
Bedford County	342.8	344.3	331.2	339.4	-3.51%
Virginia	**319.7**	**321.1**	**320.0**	**320.3**	**0.10%**

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

Number of Deaths due to Injury per 100,000 Population

Locality	2013 - 2017	2014 - 2018	2015 - 2019	AVG	YoY Change
Bedford County	*	78.9	82.8	80.9	*
Virginia	**60.2**	**62.8**	**64.7**	**62.6**	**6.88%**

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

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

Suicide Death Rates

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

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

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

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

Locality	Number of Deaths	Suicide Rate (Age-Adjusted)
Bedford County	80	19.56
Virginia	**5836**	**13.20**

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

Stroke and Heart Disease Death Rates

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

Locality	Total	White	Black	Hispanic
Bedford County	93.6	94.4	101.1	*
Virginia	**74.1**	**71.4**	**97.1**	**41.2**

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

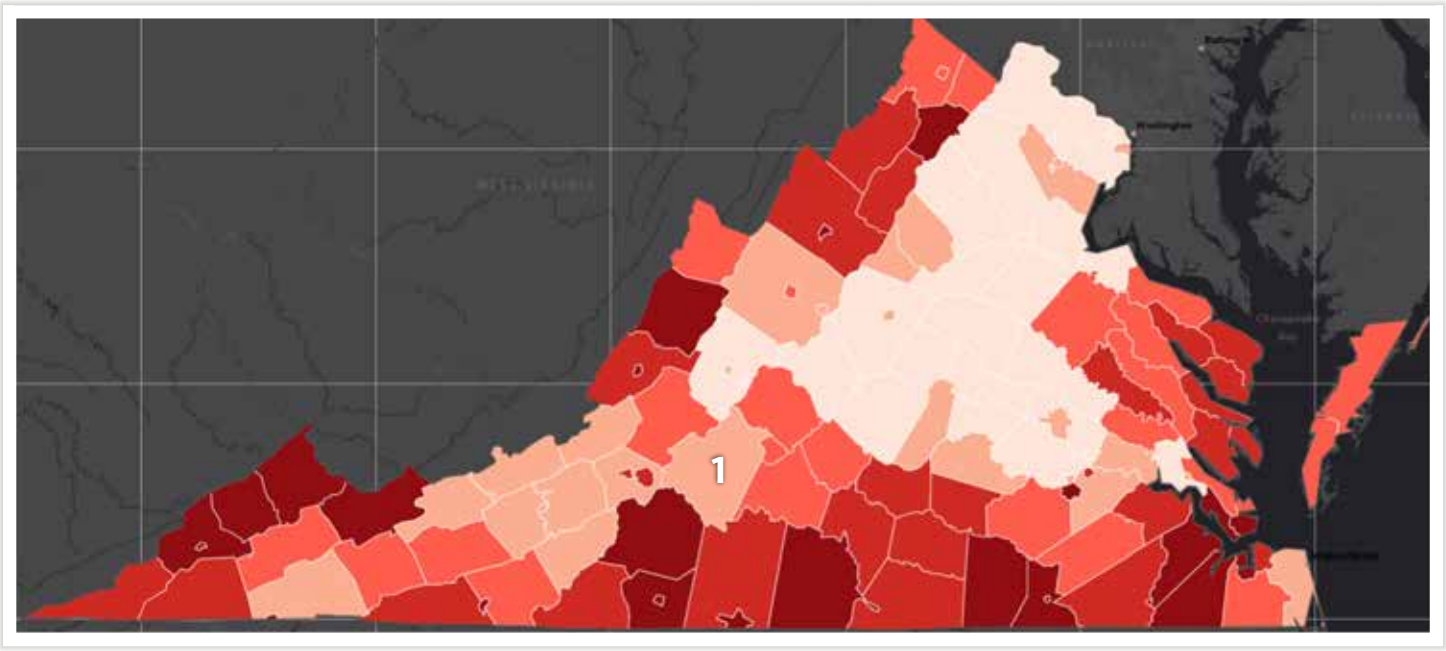
Table Source(s): CDC. Date of Table: 2018. Year(s) Measured: 2016 - 2018. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx

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

Locality	Total	White	Black	Hispanic
Bedford County	301.9	302.2	388.8	*
Virginia	**292.3**	**294.0**	**364.6**	**123.1**

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

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

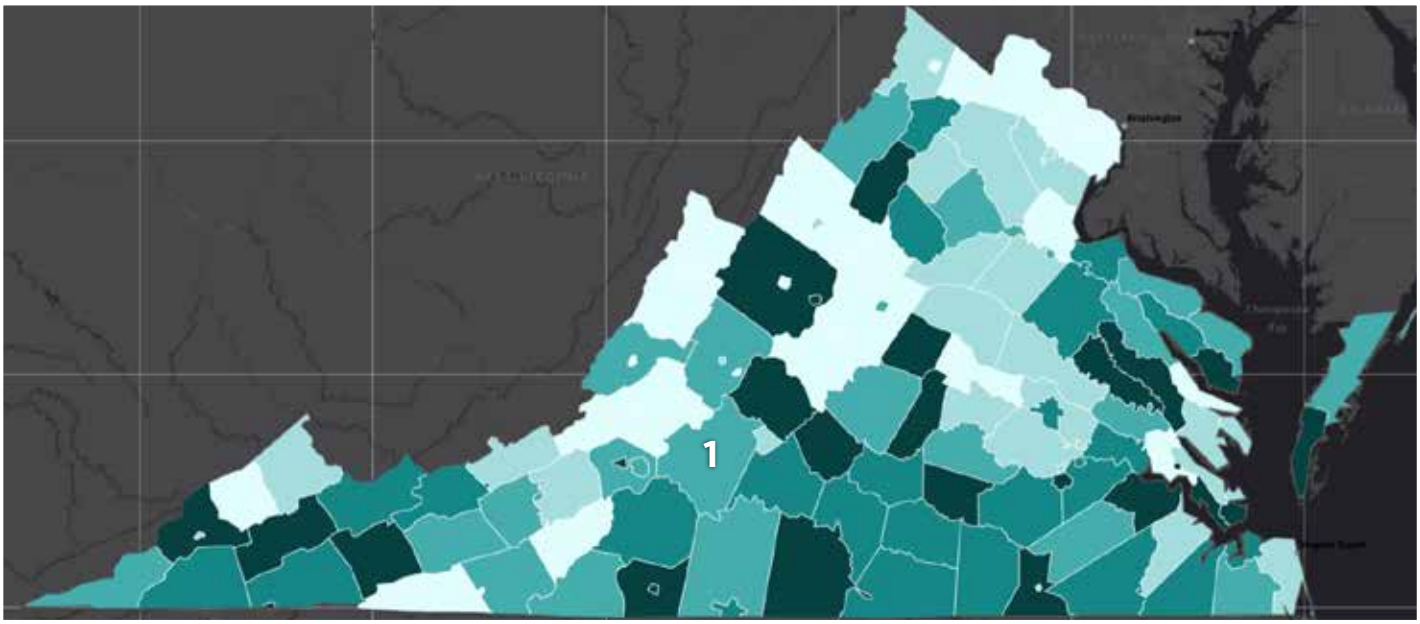


Hypertension Death Rate per 100,000 Population: Age 35+, 2017-2019

Locality	*Rate*
1. Bedford County	179.8
Virginia	**172.8**

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

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



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

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

Locality	*Percentage*
1. Bedford County	11.9
Virginia	**11.0**

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

MATERNAL AND CHILD HEALTH INDICATORS

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

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

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

Prenatal Care Beginning in the First Trimester

Locality	2016	2017	2018
Bedford County	87.3%	85.0%	84.9%
Virginia	**84%**	**80%**	**78%**

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

Mortality and Birth Rates

Total Infant Deaths by Place of Residence 2017

Locality	Number of Infant Deaths				Rates per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Bedford County	5	5	*	*	7.5	8.3	*	*
Virginia	**524**	**270**	**202**	**52**	**5.3**	**4.4**	**9.6**	**3.0**

Total Infant Deaths by Place of Residence 2018

Locality	Number of Infant Deaths				Rates per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Bedford County	1	1	*	*	1.5	1.6	*	*
Virginia	**558**	**301**	**204**	**53**	**5.6**	**4.9**	**9.7**	**3.1**

Total Infant Deaths by Place of Residence 2019

Locality	Number of Infant Deaths				Rates per 1,000 Live Births			
	Total	White	Black	Other	Total	White	Black	Other
Bedford County	1	1	*	*	1.5	1.7	*	*
Virginia	**570**	**280**	**226**	**64**	**5.9**	**4.7**	**10.6**	**4.0**

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

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

Locality	Teen Birth Rate	Black	Hispanic	White
Bedford County	14.95	24.14	*	14.68
Virginia	**16.27**	**23.40**	**31.16**	**12.20**

Note: '*' indicates insufficient data

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

Birth Rate Per 1,000 Population by Race

Locality	2017				2018				2019			
	Total	White	Black	Other	Total	White	Black	Other	Total	White	Black	Other
Bedford County	8.7	8.7	8.3	12.4	8.4	8.5	6.4	10.8	8.2	8.2	7.9	7.9
Virginia	11.8	10.1	12	25.6	11.7	10.2	11.8	24.4	11.4	9.9	12	22.9

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

Resident Low Weight Births by Percent of Total Live Births

Locality	2017				2018				2019			
	Total	White	Black	Other	Total	White	Black	Other	Total	White	Black	Other
Bedford County	8.8	8.3	14.3	12.5	7.7	7.7	10.5		6.8	6.5	10.4	9.1
Virginia	8.4	6.7	13.5	8	8.2	6.7	13.7	7.2	8.4	6.7	13.5	7.9

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

PHYSICAL ENVIRONMENT

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

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

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

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

Water Quality

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

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

Public Water System Name	County	Population Served	Fluoridated	Fluoride Conc. Mg/L
FOREST CENTRAL WATER SYSTEM	Bedford County	18205	Yes	0.7
HARBOR RIDGE HOMEOWNERS ASSOCATION, INC.	Bedford County	28	No	0.2
HARDY ROAD TRAILER PARK, SECTION 2	Bedford County	189	No	0.2
HILLCREST MOBILE HOME PARK	Bedford County	51	No	0.47
MARINERS LANDING	Bedford County	284	No	0.2
MONTVALE WATER, INC.	Bedford County	660	No	0.3
MOUNTAIN VIEW SHORES	Bedford County	463	No	0.1
PARADISE POINT ESTATES	Bedford County	57	No	0
RIDGEVIEW VILLAGE	Bedford County	121	No	0.2
SMITH MOUNTAIN LAKE CENTRAL WATER SYSTEM	Bedford County	0	No	0.1
STALLION RUN ESTATES	Bedford County	33	No	0.2
STEWARTSVILLE CONSECUTIVE	Bedford County	321	Yes	0.7
TIMBER RIDGE SUBDIVISION	Bedford County	104	No	0.2
TWIN OAKS TRAILER PARK	Bedford County	47	No	0.2
VALLEY MILLS CROSSING	Bedford County	66	No	0.03
WOODHAVEN NURSING HOME	Bedford County	71	No	0.2
BEDFORD CENTRAL WATER TREATMENT PLANT	Bedford City	5714	No	0

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

Housing Problems

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

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

Percentage of Households with Severe Problems

Locality	*2011-2015*	*2012-2016*	*2013-2017*
Bedford County	10.7	10.0	8.6
Virginia	**15.2**	**14.9**	**14.6**

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

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

Residential Segregation

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

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

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

Residential Segregation Index, 2016–2018

Locality	*Segregation Index*
Bedford County	28
Virginia	**41**

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

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

Safety

Violent Crime Reported Offenses Rate per 100,000 Population

Locality	2014 & 2016
Bedford County	83
Virginia	207

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

Domestic Violence

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

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

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

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

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

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

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

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

In the Bedford region, Bedford Domestic Violence Services provides support and education to victims of domestic violence and is housed within the Bedford Department of Social Services. They provide access to shelter, information and referral, and court accompaniment all free of charge. They reported the following statistics for fiscal years 2018-2020:

Bedford Domestic Violence Services 2018-2020

Bedford	*Hotline Calls*	*Walk-in Center Clients*	*Nights in Shelter (Total)*	*Adults in Shelter annually*	*Children in Shelter Annually*	*Court Protective orders*
2018-19	2294	182	2716	76	83	67
2019-20	1318	174	1898	50	110	102
2020-21	823	198	1003	40	23	108

In 2018-2019, the method used to count hotline calls was changed to avoid duplication which makes it difficult to compare the number of calls received that year to the number of calls received in 2019-2020 and 2020-2021. As anticipated, the number of adults and children in shelter decreased during the pandemic however the number of Court Protective orders has shown a steady increase throughout this three-year period.

Source: Bedford Department of Social Services. Annual Reports 2018-2021. Data provided by Bedford DSS on October 4, 2021. Website: https://www.bedfordcountyva.gov/departments/social-services/bedford-domestic-violence-services

In addition, residents of the Bedford region are served by the YWCA of Central Virginia's Domestic Violence Prevention Program. The primary feature of this program is two Virginia Sexual and Domestic Violence Action Alliance (VSDVAA) certified shelters as well as a hotline, referrals, and advocacy services. The shelters are in private, secure, and confidential places in both the City of Lynchburg and the Town of Altavista (Campbell County). YWCA Central Virginia serves the counties of Amherst, Appomattox, Bedford, Campbell, and Nelson and the city of Lynchburg. They reported the following statistics for 2018-2020:

YWCA of Centra Virginia Domestic Violence Prevention Center 2018-2020

		2018	*2019*	*2020*
Hotline	Arranged Emergency Transportation	223	71	72
	Counseling/Support	5058	4779	6370
	Criminal Justice Information Support	4333	3816	3476
	Crisis Intervention	2932	3269	3769
	Information & Referral	6005	5546	6900
	Safety Planning, including Legal Protections	5865	5393	6091
Shelter Services	Total All Shelter Provided	6144	5014	3748

continued on following page...

Advocacy Service for Adults	Total Number of Adult Family Violence Victims Served	898	984	768
	Race/Ethnicity of Victim/Survivor (Victims may identify with more than one race)			
	African American/Black	294	308	183
	Asian/Pacific Islander	5	10	5
	Caucasian	565	631	558
	Hispanic/Latino	30	25	12
	Native American/Alaskan	0	4	5
	Other	5	16	11
	Primary Concerns for Victim on Initial Contact			
	1. Safety (feeling unsafe, threatened, or in danger of physical or emotional harm)	790	824	579
	2. Physical well-being (activity level, stress level, health issues/symptoms, sleep and eating patterns)	442	537	477
	3. Support/relationships (trust, relationships, within the community, family & friends)	262	402	279
	Advocacy Services Provided			
	Crisis Intervention	431	599	472
	Safety Planning Other	412	227	240
	Services to Address Basic Needs	646	667	483
	Transportation	87	66	91
	Legal Advocacy Services			
	Accompaniment Services -Civil	517	472	274
	Accompaniment Services -Criminal	103	121	176
	Accompaniment Services -Forensic Exam	13	7	1
	Assistance Filing a Family Abuse EPO/PPO (Juvenile and Domestic Court)	376	394	223
	Family Abuse EPO/PPO Petition Awarded	378	381	220
	Family Abuse EPO/PPO Petition Denied	5	6	13
Advocacy Service for Children	Total Number of Child Family Violence Victims Served	112	147	121
	Race/Ethnicity of Victim/Survivor (Victims may identify with more than one race)			
	African American/Black	56	45	26
	Asian/Pacific Islander	0	0	0
	Caucasian	40	73	86
	Hispanic/Latino	4	8	1
	Native American/Alaskan	0	2	0
	Other	12	21	11
	Advocacy Services Provided			
	Child Care	86	68	21
	Counseling/Support	92	128	111
	Crisis Intervention	35	53	58
	Safety Planning Other	80	67	32
	Services to Address Basic Needs	89	119	78

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

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

Household Internet Access

Percentage of Households with Broadband Internet Connection, 2015 - 2019

Locality	*Percent Broadband Access*
Bedford County	76
Virginia	**84**

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

Commuting Patterns

Commuting Patterns by County of Residence

Locality	*Worked in county of residence*	*Worked outside county of residence*
Bedford County	37.5%	61.3%
Bedford Town	61.6%	38.4%
Virginia	**48.5%**	**42.8%**

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

COVID-19

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

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

Cases, Hospitalizations and Death Rates

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

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

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

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

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

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

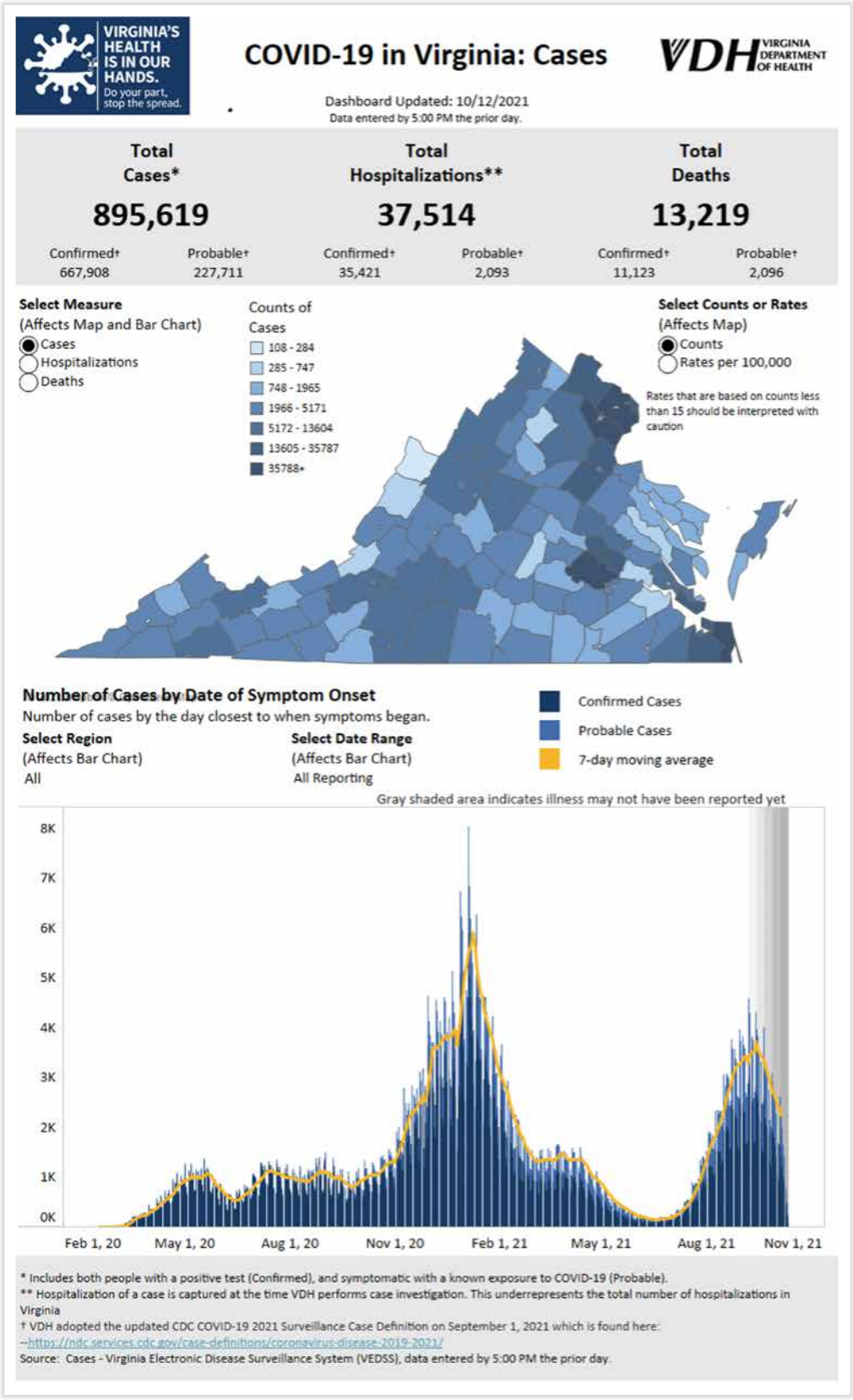
The Center for Disease Control and Prevention (CDC) Nowcast projections for the week ending October 2, 2021, estimate the national proportion of the Delta variant to be greater than 99%. Nowcast estimates indicate that Delta will continue to be the predominant variant circulating in all 10 U.S. Department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

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

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

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

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



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

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

Locality	Cases		Hospitalizations		Deaths	
	Total Count	Rate per 100,000	Total Count	Rate per 100,000	Total Count	Rate per 100,000
Bedford County	9,311	11,824	363	461	132	168
Bedford, Town	N/A	N/A	N/A	N/A	N/A	N/A
Virginia	**877,090**	**10,338**	**36,913**	***-**	**12,908**	**152**

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

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

In Bedford County there have been a reported 9,311 cases (1.1% of Virginia cases) since the start of the pandemic. Bedford's case rate is higher than the rate in Virginia as a whole. In the region there have been 363 hospitalizations (1% of Virginia hospitalizations). The region has experienced 132 total deaths due to COVID-19 with the regional death rate higher than the rate in the Commonwealth as a whole.

Racial and Ethnic Disparities

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

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

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

Updated Sept. 9, 2021 Print

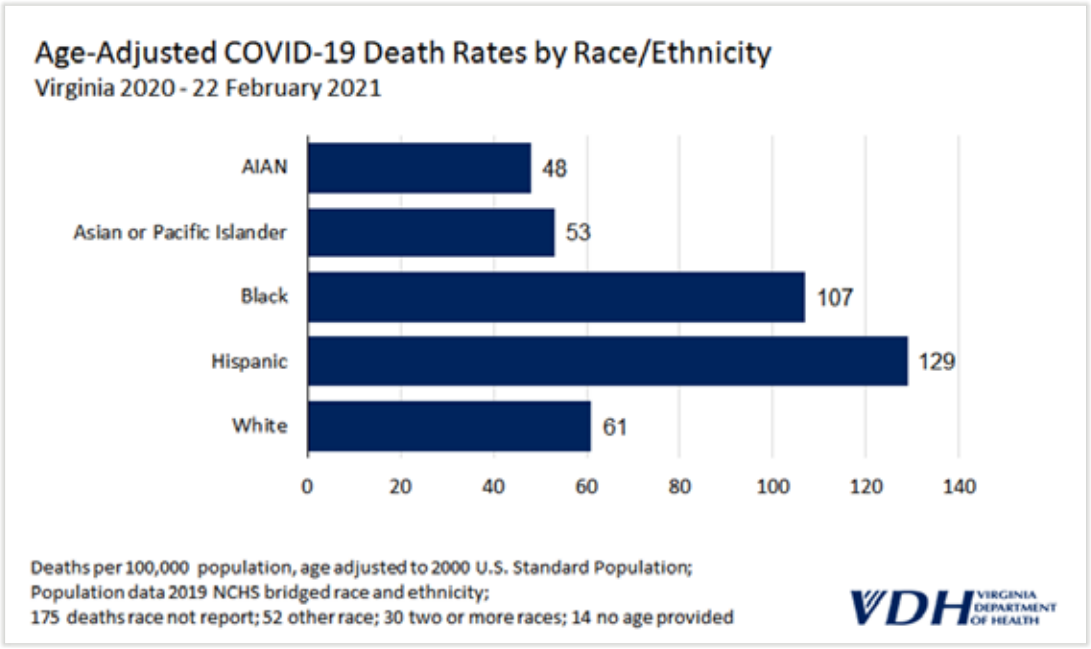
Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	1.7x	0.7x	1.1x	1.9x
Hospitalization[2]	3.5x	1.0x	2.8x	2.8x
Death[3]	2.4x	1.0x	2.0x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

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

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

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

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



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

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

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

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

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

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

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

Community Transmission Rates

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

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

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

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

COVID-19 Community Transmission Rates

Locality	*Transmission Level*	*Rate of new cases per 100,000*	*% of PCR tests that are positive*	*Week of Report Date*
Bedford County	High	330.4	17.7%	9/26/21-10/2/21
Virginia Total	**High**	**262.9**	**8.6%**	**9/26/21-10/2/21**

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

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

Vaccinations

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

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

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

COVID-19 Vaccination Rates As of October 7, 2021

Locality	*% Fully Vaccinated*	*Vaccination Rate (per 100,000)*
Bedford County	46%	46,028
Virginia	**60.7%**	**Not available**

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

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

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

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

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

Centra's Response

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

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

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

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

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

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

PRIORITIZATION OF NEEDS

Prioritization of Needs

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

1. **Responses from the Community Health Survey**
    a. Q2A: What do you think are the most important issues that affect health in our community? (Health Factors) (n= 848 survey responses)
    b. Q2B: What do you think are the most important issues that affect health in our community? (Health Conditions or Outcomes) (n= 845 survey responses)
    c. Q3: Which health care services are hard to get in our community? (n= 843 responses)
    d. Q1. What are the top 5 greatest needs in the community(s) you serve? (n= 809 responses)

2. 2. **Responses from the Stakeholders' Focus Group/ Survey**
    a. Q1. What are the top 5 greatest needs in the community(s) you serve? (n= 86 responses)

These responses were sorted in an Excel workbook and clustered together by "Area of Need" categories. Relevant responses to each question and how they were ranked (% of responses) were listed under the corresponding "Area of Need" categories. Altogether, there were 34 main priority areas of need identified. The detailed worksheet and list of 34 priority areas can be found in the Appendix.

On August 27, 2021, a virtual meeting was held to present a summary of the primary and secondary data to the CHAT members. Additionally, members received final drafts of the Community Health Survey, Stakeholders Focus Group/Survey, and Secondary Data prior to the meeting. After that meeting, from September 14, 2021 to September 24, 2021, CHAT members were asked to rank the top five priority areas of need (out of the 34 identified) in Survey Monkey, with 1 being the greatest need and 5 being the 5th greatest need. CHAT members were asked to use the data presented on August 27 and the detailed Prioritization of Needs Worksheet to help with their decision-making. The survey link and instructions on how to complete the prioritization of needs exercise were emailed to CHAT members. Twenty-three (23) CHAT members completed the prioritization of need survey for a 47% response rate.

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

On September 24, 2021, the final CHAT meeting was held to present the 2021 Bedford Area Prioritization of Needs. The rankings and weighted scores for all 34 priority areas are presented in the following table. The shaded area in the table represents the top 10 rankings.

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

Ranking	Priority Area of Need	Score	Ranking	Priority Area of Need	Score
1	Mental Health and Substance Use Disorders & Access to Services	32.28	**18**	Accidents in the Home	21.43
2	Access to Healthcare Services	31.82	**19**	Education and Literacy	20.67
3	Childcare	29.94	**20**	Families	19
4	Transportation	27.65	**21**	Social Isolation	19
5	Child abuse/neglect	27	**22**	Overweight/Obesity	18.6
6	Aging and Eldercare	26.27	**23**	Health Promotion and Disease Prevention	18.13
7	Chronic Disease	25.44	**24**	Poverty & Economic Assistance	18.13
8	Employment / Job assistance	24.9	**25**	Environmental Health	15.71
9	Financial Stability	24.4	**26**	Safety and Violent Crime	15.67
10	Housing	23.58	**27**	Legal Services	13
11	Dental Care & Dental Problems	22.9	**28**	Veterans Services	12.8
12	Coordination of Resources	22.86	**29**	End of Life Care and Services	11.71
13	Community Outreach	22.7	**30**	Maternal/Child Health	10.71
14	Disability	22.13	**31**	Physical Activity	10.29
15	Domestic Violence	22	**32**	Sexual Health	8.63
16	COVID-19 Pandemic	21.63	**33**	Vision Care	7.13
17	Food Insecurity and Nutrition	21.5	**34**	Unsafe Driving Practices	4.71
	Total Responses	**23**			

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

- "Childcare" and "Child Abuse/Neglect" were grouped together under the title "Issues Impacting Children and their Families".
    - This grouping shifted "Dental Care & Dental Problems" into the top 10.
- "Financial Stability" will include addressing banking and financial assistance in this priority area.

Priority areas are reflective of the County Health Rankings' four categories for Health Factors including Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment. All these health factors are viewed through the lens of equity, inclusion, and diversity.

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

- Issues Impacting Children and their Families
  - o Childcare
  - o Child Abuse/Neglect
- Aging and Eldercare
- Employment/Job Assistance
- Financial Stability
- Dental Care & Dental Problems

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

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

Ranking	*2018*	*2021*
1	Access to Affordable Health Care	Mental Health and Substance Use Disorders & Access to Services
2	Access to mental health services & mental health problems	Access to Healthcare Services
3	Substance use and alcohol & illegal drug use	Issues Impacting Children and their Families: • Childcare • Child Abuse/Neglect
4	Diabetes	Transportation
5	Overweight/Obesity	Aging and Eldercare
6	Poor eating habits	Chronic Disease
7	Transportation	Employment / Job assistance
8	Access to healthy foods	Financial Stability
9	Access to affordable housing	Housing
10	High blood pressure	Dental Care & Dental Problems

COMMUNITY RESOURCES

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

Community Resources

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

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

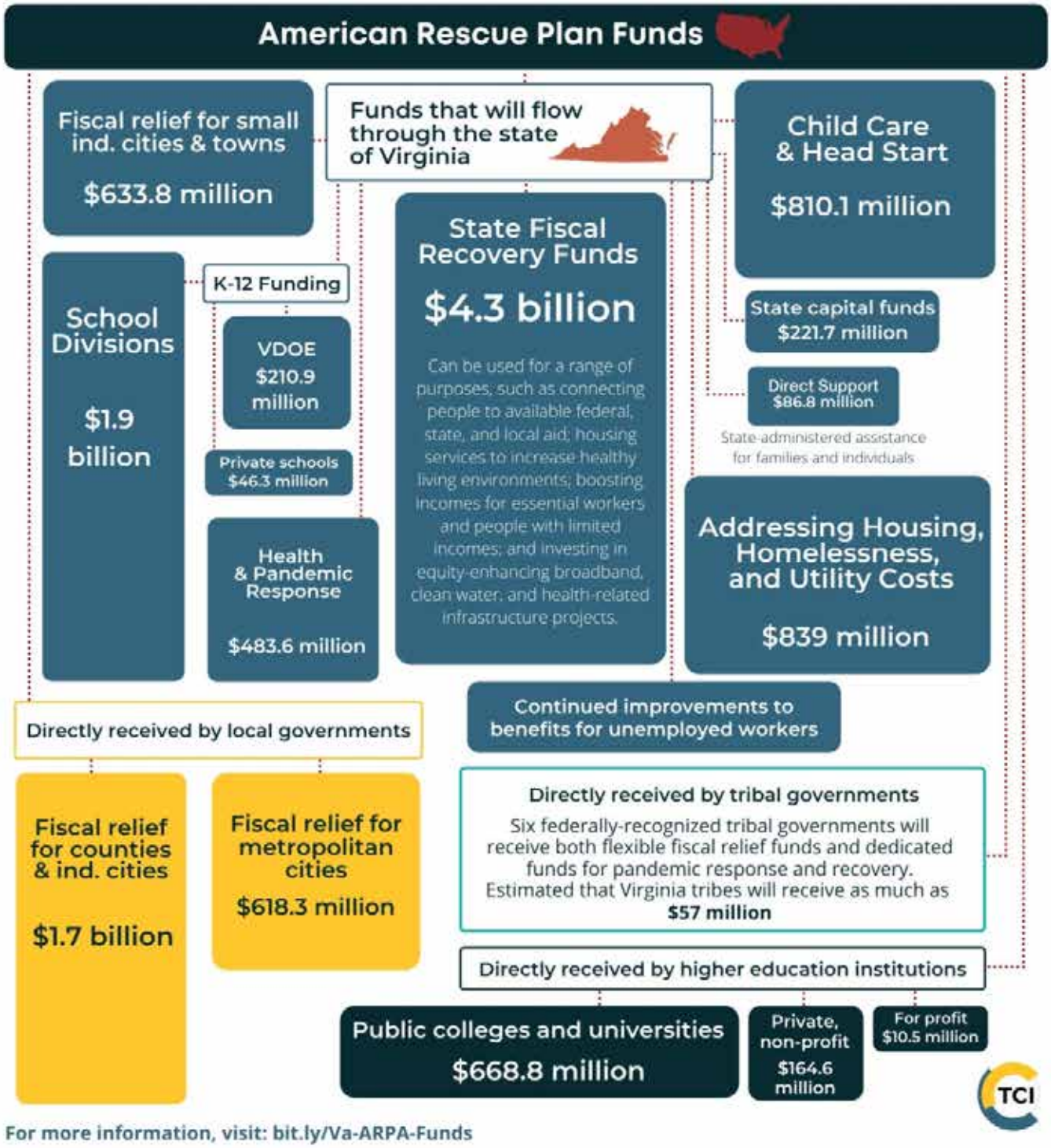
The American Rescue Plan Act (2021)

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

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

How ARPA Funds Will Flow to Virginia Communities

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



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

Access to Healthcare Services

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

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

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

Medicaid Expansion (Medical and Dental Benefits)

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

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

Broadband/Internet Access

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

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

Mental Health and Substance Use Disorders

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

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

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

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

Partnerships and Coalitions:

The Bedford Area Resource Council (BARC) ***(https://www.bedfordarearesourcecouncil.org/)*** is a network of non-profit, for profit, medical, faith organizations, and state and local government agencies who serve the Town and County of Bedford. Participation is open to agencies, organizations, and businesses with community service functions within the Bedford Area, and any citizen of the Bedford Area. Meetings are held monthly to hear committee reports; share ideas, information and resources. Cooperative, inter-agency efforts are planned and initiated in an attempt to maximize community resources and minimize duplication of services. This collaborative community engagement provides a platform to share information and build awareness of current community unmet needs, as well as services and resources available, thus allowing for a better coordination in planning and designing for extension of services and resources for the community.

BARC's mission is to facilitate collaboration among community partners (non-profits, business, faith community, schools, government, civic organizations, and healthcare) and to develop resources necessary for a sustainable community. BARC envisions our community as a place where every person is healthy, engaged and self-sufficient. In the summer of 2021, BARC completed a 5-year strategic plan (2021-2026).

The Bedford Area Resource Council partners closely with the Partnership for Healthy Communities described throughout this assessment. In addition, many of the BARC members serve on Centra's triennial Community Health Assessment Team.

In addition to the Partnership for Healthy Communities, BARC's key partners include:

- Bedford Area Reentry Council ***(https://www.bedfordarearesourcecouncil.org/bedford-area-reentry-council.html)***
- Bedford Get Together ***(http://www.bedfordgettogether.com/)***
- Crime Prevention Council ***(https://www.bedfordarearesourcecouncil.org/crime-prevention-council.html)***
- Domestic Violence Coalition ***(https://www.facebook.com/BedfordDVCoalition/)***
- Minds Together Coalition ***(https://www.bedfordarearesourcecouncil.org/mental-healthsubstance-use-coalition-minds-together.html)***
- Smart Beginnings Central Virginia ***(https://unitedwaycv.org/smart-beginnings/)***

Currently, BARC has six subcommittees that work to plan and implement their agreed upon goals and actions for the following areas of need:

- Employment and Education
- Mental Health/Substance Use (Minds Together Coalition)
- Housing (Bedford Housing Coalition)
- Transportation Committee
- Childcare (Bedford Early Childhood Coalition)
- Healthy Foods Committee
- Transportation has been identified as a community need in both the 2018 and 2021 Centra Community Health Needs Assessments.

In 2021, a collaboration between the Bedford Community Health Foundation and the Town of Bedford to provide public transportation (bus) in the town was the result of work by the BARC Transportation Committee. The "Otter Bus" has routes with 16 stops that offer access to major resources and areas of the town three days per week (Wednesday, Friday and Saturday) from 10 a.m. to 4 p.m. Because of a $50,000 grant from the Bedford Community Health Foundation, there is currently no fee to ride the Otter Bus. Transportation has been identified as a community need in both the 2018 and 2021 Centra Community Health Needs Assessments.

EVALUATION OF IMPACT

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

Evaluation of Impact

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

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

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

Priority Area: **Access to affordable healthcare**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategy 1: Reduce the stigma of substance use disorders

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX

The following documents are included as appendices:

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

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

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

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

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

  OR

- ***Scan the QR code***

  OR

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

YOU WILL GET THE CHANCE TO WIN A $25 Walmart GIFT CARD.
To thank you for filling out the survey, you can enter a drawing to receive a $25.00 gift certificate to Walmart. There will be four chances to win. If you would like to enter the drawing, please complete the information below. Your contact information will not be linked to your survey answers. The drawing will take place in July of 2021 and winners will be contacted.

Thank you very much for your help,

Centra Department of Community Health

Please complete the information below if you would like to be entered into a drawing for a $25.00 Gift Certificate to Walmart. Winners will be contacted in July of 2021.

Name: _____

Address: _____

_____

Phone: _____

Email: _____

FOR OFFICE USE ONLY: Site of Collection: _____ Date: _____

Centra Health, in partnership with the Partnership for Healthy Communities and the Central Virginia Health District, is working with community leaders to learn more about what you need to be healthy. Please answer the following questions with the best answer or answers. All surveys will be kept confidential. Thank you for taking the time to complete this survey. Surveys can be mailed to Centra Department of Community Health, 1901 Tate Springs Rd, Lynchburg VA 24501. You must be over 18 to complete this survey. Please complete this survey only once.

BEDFORD AREA COMMUNITY HEALTH SURVEY

HEALTH OF THE COMMUNITY

1. Where do you live?

❒ Bedford Co. ❒ Town of Bedford ❒ Other: _____

2. What do you think are the most important issues that affect health in our community? (*Please check all that apply*)

Health Factors

- ❒ Access to affordable housing
- ❒ Access to healthy foods
- ❒ Accidents in the home (e.g., falls, burns, cuts)
- ❒ Alcohol and illegal drug use
- ❒ Aging problems
- ❒ Bullying
- ❒ Cell phone use / texting and driving / distracted driving
- ❒ Child abuse / neglect
- ❒ Domestic Violence
- ❒ Environmental health (e.g., water quality, air quality, pesticides, etc.)
- ❒ Gang activity
- ❒ Homicide
- ❒ Housing problems (e.g., mold, bed bugs, lead paint)
- ❒ Injuries
- ❒ Lack of exercise
- ❒ Neighborhood safety
- ❒ Not getting "shots" to prevent disease
- ❒ Not using seat belts / child safety seats / helmets
- ❒ Poor eating habits
- ❒ Prescription drug abuse
- ❒ Sexual assault
- ❒ Social isolation
- ❒ Transportation problems
- ❒ Tobacco use / smoking / vaping
- ❒ Unsafe sex
- ❒ Other: _____

Health Conditions or Outcomes

- ❒ Cancers
- ❒ COVID-19 / coronavirus
- ❒ Dental problems
- ❒ Diabetes
- ❒ Disability
- ❒ Grief
- ❒ Heart disease and stroke
- ❒ High blood pressure
- ❒ HIV / AIDS
- ❒ Infant death
- ❒ Lung disease
- ❒ Mental health problems
- ❒ Overweight / obesity
- ❒ Stress
- ❒ Suicide
- ❒ Teenage pregnancy
- ❒ Other: _____

3. Which health care services are hard to get in our community? *(Please check all that apply)*

- ❒ Adult dental care
- ❒ Alternative therapy (e.g., herbal, acupuncture, massage)
- ❒ Ambulance services
- ❒ Cancer care
- ❒ Child dental care
- ❒ Chiropractic care
- ❒ Dermatology
- ❒ Domestic violence services
- ❒ Eldercare
- ❒ Emergency room care
- ❒ End of life / hospice / palliative care
- ❒ Family doctor
- ❒ Immunizations
- ❒ Inpatient hospital
- ❒ Lab work
- ❒ LGBTQ
- ❒ Medication / medical supplies
- ❒ Mental health / counseling
- ❒ Physical therapy
- ❒ Preventive care (e.g., yearly check-ups)
- ❒ Programs to stop using tobacco products
- ❒ Specialty care (e.g., heart doctor)
- ❒ Substance use services – drug and alcohol
- ❒ Urgent care / walk-in clinic
- ❒ Vision care
- ❒ Women's health services
- ❒ X-rays / mammograms
- ❒ None
- ❒ Other:_____
- ❒ COVID-19 has made one or more of the services I selected hard to get

4. Which social / support resources are hard to get in our community? *(Please check all that apply)*

- ❒ Affordable / safe housing
- ❒ Banking / financial assistance
- ❒ Childcare
- ❒ Domestic violence assistance
- ❒ Education and literacy
- ❒ Employment / job assistance
- ❒ Food benefits (SNAP, WIC)
- ❒ Grief / bereavement counseling
- ❒ Health insurance
- ❒ Healthy food
- ❒ Legal services
- ❒ Medication assistance
- ❒ Medical debt assistance
- ❒ Rent / utilities assistance
- ❒ TANF (Temporary Assistance for Needy Families)
- ❒ Transportation
- ❒ Unemployment benefits
- ❒ Veterans services
- ❒ Other: _____
- ❒ COVID-19 has made one or more of the services I selected hard to get

GENERAL HEALTH QUESTIONS

5. What keeps you from being healthy? (*Please check <u>all</u> that apply*)

- ❒ Afraid to have check-ups
- ❒ Can't find providers that accept my insurance
- ❒ Childcare
- ❒ Cost
- ❒ Don't know what types of services are available
- ❒ Don't like accepting government assistance
- ❒ Don't trust doctors / clinics / my insurance
- ❒ Have no regular source of healthcare
- ❒ High co-pay
- ❒ Lack of evening and weekend services
- ❒ Language services
- ❒ Location of offices
- ❒ Long waits for appointments
- ❒ No health insurance
- ❒ No transportation
- ❒ Nothing keeps me from being healthy
- ❒ Other:_____

6. Do you use medical care services?

❒ **<u>Yes</u> - Check where you go for medical care** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Doctor's Office
- ❒ Emergency Room
- ❒ Urgent Care / Walk-in Clinic
- ❒ Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Health Department
- ❒ Veterans Administration Medical Center
- ❒ Online / Telehealth / Virtual Visit
- ❒ Other:_____

7. How long has it been since you last visited a doctor or other healthcare provider for a routine checkup? (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never visited a doctor or other healthcare provider for a routine checkup
- ❒ Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19

8. Do you use dental care services?

❒ **<u>Yes</u> – Check where you go for dental care** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Dentist's Office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Veterans Administration Medical Center
- ❒ Urgent Care / Walk-in Clinic
- ❒ Mission of Mercy Project
- ❒ Other:_____

9. How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists such as orthodontists. (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never visited a dentist or dental clinic for any reason.
- ❒ Within the past year I have chosen not to see a dentist or dental specialist or have postponed or cancelled a visit because of COVID-19

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

❒ **<u>Yes</u> – check where you go for services** (***check <u>all</u> that apply***) ❒ **<u>No</u>**

- ❒ Horizon Behavioral Health
- ❒ Doctor / Counselor's office
- ❒ Emergency Room
- ❒ Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)
- ❒ Free Clinic
- ❒ Online / Telehealth / Virtual Visits
- ❒ Veterans Administration Medical Center
- ❒ Urgent Care / Walk-in Clinic
- ❒ Other:_____

11. How long has it been since you last used mental health, alcohol use, or drug use services for any reason? (*Please check <u>one</u>*)

- ❒ Within the past year (1 to 12 months)
- ❒ Within the past 2 years (1 to 2 years ago)
- ❒ Within the past 5 years (2 to 5 years ago)
- ❒ 5 or more years ago
- ❒ I have never used mental health, alcohol use, or drug use services for any reason
- ❒ Within the past year I have chosen not to see a mental health or substance use provider or counselor or have postponed or cancelled a visit because of COVID-19

12. Have you been told by a doctor that you have… (*Please check all that apply*)

- ❒ Asthma
- ❒ Cancer
- ❒ Depression or anxiety
- ❒ Drug or alcohol problems
- ❒ Heart disease
- ❒ High blood pressure
- ❒ High blood sugar or diabetes
- ❒ Cerebral palsy
- ❒ High cholesterol
- ❒ HIV / AIDS
- ❒ Mental health problems
- ❒ Obesity / overweight
- ❒ Stroke / cerebrovascular disease
- ❒ I have no health problems
- ❒ Other:_____

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

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

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

- ❒ I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion
- ❒ I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)
- ❒ I have taken prescription drugs to get high
- ❒ I have used marijuana
- ❒ I have used other illegal drugs (e.g., meth, cocaine, heroin, ecstasy, crack, LSD, etc.)
- ❒ None of these

16. Please check one of the following for each statement	**Yes**	**No**	**Not Applicable**
I have been to the emergency room in the past 12 months.	❒	❒	
I have been to the emergency room for an injury in the past 12 months (e.g., motor vehicle crash, fall, poisoning, burn, cut, etc.).	❒	❒	
I have been a victim of domestic violence or abuse in the past 12 months.	❒	❒	
I take the medicine my doctor tells me to take to control my chronic illness.	❒	❒	❒
I can afford medicine needed for my health conditions.	❒	❒	❒
Does your community support physical activity? (e.g., parks, sidewalks, bike lanes, etc.)	❒	❒	
In the area that you live, is it easy to get affordable fresh fruits and vegetables?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?	❒	❒	
Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?	❒	❒	❒
Do you feel safe where you live?	❒	❒	

17. In the past 7 days, how many days were you physically active for a total of at least 30 minutes? (Add up all the time you spend in any kind of physical activity that increased your heart rate and made you breathe hard for some of the time.)

❒ 0 days ❒ 1 day ❒ 2 days ❒ 3 days ❒ 4 days ❒ 5 days ❒ 6 days ❒ 7 days

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

- ❒ Back-pack or summer food programs
- ❒ Community garden
- ❒ Corner store / convenience store / gas station
- ❒ Dollar store
- ❒ Farmers' market
- ❒ Food bank / food pantry
- ❒ Grocery store
- ❒ Home garden
- ❒ I do not eat at home
- ❒ I regularly receive food from family, friends, neighbors, or my church
- ❒ Meals on Wheels
- ❒ Take-out / fast food / restaurant
- ❒ Other:_____

19. During the past 7 days, how many times did you eat fruit and vegetables? Do not count fruit or vegetable juice. (*Please check one*)

- ❒ I did not eat fruits or vegetables during the past 7 days
- ❒ 1 – 3 times during the past 7 days
- ❒ 4 - 6 times during the past 7 days
- ❒ 1 time per day
- ❒ 2 times per day
- ❒ 3 times per day
- ❒ 4 or more times per day

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

- ❒ Never
- ❒ 1 – 2 times
- ❒ 3 – 4 times
- ❒ 5 – 6 times
- ❒ 7 times
- ❒ More than 7 times
- ❒ Not Applicable / I live alone

21. How connected do you feel with the community and those around you?

❒ Very connected ❒ Somewhat connected ❒ Not connected

22. Where do you sleep most often? (*Please check <u>one</u>*)

❒ In a home I own or rent
❒ Stay with friends or family because of financial issues
❒ In a shelter or transitional housing program
❒ In a group home, hospital, or treatment program
❒ In a hotel or motel
❒ Outside, in a car, abandoned building, or public space

23. Do you have access to reliable transportation? ❒ Yes ❒ No

24. What type of transportation do you use most often?

❒ I drive
❒ Bike or walk
❒ Friends / family drive me
❒ Public transit (i.e., bus, shuttle, similar)
❒ Other transit service (name):_____
❒ Taxi (including Uber / Lyft)
❒ Ridesharing / Carpooling
❒ Other:_____

DEMOGRAPHIC INFORMATION AND HEALTH INSURANCE

25. Which of the following describes your current type of health insurance? (*Please check <u>all</u> that apply*)

❒ COBRA
❒ Dental Insurance
❒ Employer provided insurance
❒ Government (VA, TRICARE)
❒ Health Savings / Spending Account
❒ Individual / Private Insurance / Marketplace / Obamacare
❒ Medicaid
❒ Medicare
❒ Medicare Supplement
❒ No Dental Insurance
❒ No Health Insurance

26. If you have no health insurance, why don't you have insurance? (*Please check <u>all</u> that apply*)

❒ Not applicable – I have health insurance
❒ I don't understand Marketplace / Obamacare options
❒ Not available at my job
❒ Student
❒ Too expensive / cost
❒ Unemployed / no job
❒ Other:_____

27. What is your Zip Code? _____ **28. What is your age?** _____

29. What is your gender identity? ❒ Male ❒ Female ❒ Non-binary ❒ Other:_____

30. What is your height? _____feet_____inches **31. What is your weight?** _____pounds

32. How many people live in your home (including yourself)?

Number of children (0 - 17 years of age) _____ Number of adults age 18 - 64_____ Number of adults age 65 or older_____

33. What is your highest education level completed?

❒ Less than high school
❒ Some high school
❒ High school diploma / GED
❒ Associates degree
❒ Bachelors degree
❒ Masters / PhD degree

34. What race/ethnicity do you identify with? (*Please check <u>one</u>*)

❒ Native Hawaiian / Pacific Islander
❒ American Indian / Alaskan Native
❒ Asian
❒ Hispanic / Latino
❒ Black / African American
❒ White
❒ More than one race
❒ Decline to answer
❒ Other: _____

35. What is your marital status?

❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partnership

36. What is your yearly household income?

❒ $0 - $10,000
❒ $10,001 - $20,000
❒ $20,001 - $30,000
❒ $30,001 - $40,000
❒ $40,001 - $50,000
❒ $50,001 - $60,000
❒ $60,001 - $70,000
❒ $70,001 - $100,000
❒ $101,001 and above

37. What is your current employment status?

❒ Full-time
❒ Part-time
❒ Unemployed
❒ Self-employed
❒ Retired
❒ Homemaker
❒ Student
❒ Disabled

38. Is there anything else we should know about your (or someone living in your home) needs to stay healthy?

_____

_____

_____

Thank you for helping make the greater Bedford Area a healthier place to live, work, and play!

QUEREMOS CREAR UNA REGIÓN DE BEDFORD MÁS SALUDABLE PARA TODOS LOS QUE VIVEN, TRABAJAN Y JUEGAN AQUÍ.

¡DÍGANOS QUÉ NECESITA PARA VIVIR UNA VIDA MÁS SALUDABLE!

<u>COMPLETE NUESTRA ENCUESTA.</u> TODA LA INFORMACIÓN SE MANTENDRÁ CONFIDENCIAL.

- ***Complete la encuesta en línea en*** **centerhealth.com/CHNA**

  O

- ***escanee el código QR***

  O

- ***complete la encuesta en papel adjunta.***

TENDRÁ LA OPORTUNIDAD DE GANAR UNA TARJETA REGALO DE Walmart DE $25. *Para agradecerle que haya completado la encuesta, puede participar en un sorteo para recibir un certificado de regalo de $25.00 para Walmart. Habrá cuatro oportunidades de ganar. Si desea ingresar al sorteo, complete la información a continuación. Su información de contacto no estará vinculada a sus respuestas a la encuesta. El sorteo tendrá lugar en julio de 2021 y los ganadores serán contactados.*

Muchas gracias por su ayuda,

Centra Department of Community Health

Complete la información a continuación si desea que le incluyan en un sorteo para un certificado de regalo de $25.00 para Walmart. Los ganadores serán contactados en julio de 2021.

Nombre: _____

Dirección: _____

_____

Teléfono: _____

Correo electrónico: _____

PARA USO EXCLUSIVO EN LA CONSULTA: Centro de recogida: _____ Fecha: _____

Centra Health, en sociedad con Partnership for Healthy Communities y el Central Virginia Health District, está trabajando con líderes de la comunidad para saber más sobre lo que necesita para estar sano. Responda a las siguientes preguntas con la mejor respuesta o las mejores respuestas. Todas las encuestas se mantendrán confidenciales. Gracias por dedicar su tiempo a completar esta encuesta. Las encuestas se pueden enviar por correo postal al Department of Community Health, 1901 Tate Springs Rd, Lynchburg VA 24501. Debe tener más de 18 años para completar esta encuesta. Complete esta encuesta solo una vez.

ENCUESTA DE SALUD COMUNITARIA DEL ÁREA DE BEDFORD

SALUD DE LA COMUNIDAD

1. ¿Dónde vive?

❒ Condado de Bedford ❒ Ciudad de Bedford ❒ Otro: _____

2. ¿Cuáles cree que son los problemas más importantes que afectan a la salud de nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

<u>Factores de salud</u>

- ❒ Acceso a una vivienda accesible
- ❒ Acceso a alimentos saludables
- ❒ Accidentes en el hogar (p. ej., caídas, quemaduras, cortes)
- ❒ Consumo de alcohol y drogas ilegales
- ❒ Problemas de envejecimiento
- ❒ Acoso
- ❒ Uso del teléfono móvil/mensajes de texto y conducción/conducción distraída
- ❒ Abuso/descuido infantil
- ❒ Violencia doméstica
- ❒ Salud ambiental (p. ej., calidad del agua, calidad del aire, pesticidas, etc.)
- ❒ Actividad de pandillas
- ❒ Homicidio
- ❒ Problemas de vivienda (p. ej., moho, chinches, pintura de plomo)
- ❒ Lesiones
- ❒ Falta de ejercicio
- ❒ Seguridad del vecindario
- ❒ No recibir “inyecciones” para prevenir enfermedades
- ❒ No usar cinturones de seguridad/sillas de seguridad para niños/cascos
- ❒ Malos hábitos alimenticios
- ❒ Abuso de fármacos con receta
- ❒ Agresión sexual
- ❒ Aislamiento social
- ❒ Problemas de transporte
- ❒ Tabaquismo/fumar/vapear
- ❒ Sexo sin protección
- ❒ Otro: _____

<u>Afecciones o consecuencias médicas</u>

- ❒ Tipos de cáncer
- ❒ COVID-19/coronavirus
- ❒ Problemas dentales
- ❒ Diabetes
- ❒ Discapacidad
- ❒ Aflicción
- ❒ Cardiopatía y accidente cerebrovascular
- ❒ Presión arterial alta
- ❒ VIH/SIDA
- ❒ Muerte en menores de 1 año
- ❒ Enfermedad pulmonar
- ❒ Problemas de salud mental
- ❒ Sobrepeso/obesidad
- ❒ Estrés
- ❒ Suicidio
- ❒ Embarazo en la adolescencia
- ❒ Otro: _____

3. ¿Qué servicios de atención médica son difíciles de obtener en nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

- ❒ Cuidado dental en adultos
- ❒ Terapia alternativa (p. ej., a base de hierbas, acupuntura, masaje)
- ❒ Servicios de ambulancia
- ❒ Atención oncológica
- ❒ Cuidado dental infantil
- ❒ Atención quiropráctica
- ❒ Dermatología
- ❒ Servicios de violencia doméstica
- ❒ Cuidado de personas mayores
- ❒ Atención en urgencias
- ❒ Final de la vida/cuidados paliativos
- ❒ Médico de cabecera
- ❒ Inmunizaciones
- ❒ Hospitalización
- ❒ Análisis de laboratorio
- ❒ LGBTQ
- ❒ Medicamentos/suministros médicos
- ❒ Salud mental/orientación
- ❒ Fisioterapia
- ❒ Atención preventiva (p. ej., revisiones anuales)
- ❒ Programas para dejar de usar productos de tabaco
- ❒ Atención especializada (p. ej., cardiólogo)
- ❒ Servicios de consumo de sustancias: drogas y alcohol
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Cuidado de la vista
- ❒ Servicios médicos para mujeres
- ❒ Radiografías/mamografías
- ❒ Ninguno
- ❒ Otro: _____
- ❒ La COVID-19 ha hecho que uno o más de los servicios que he seleccionado sean difíciles de obtener

4. ¿Qué recursos sociales/de apoyo son difíciles de obtener en nuestra comunidad? *(Marque <u>todas</u> las que correspondan)*

- ❒ Vivienda accesible/segura
- ❒ Asistencia bancaria/financiera
- ❒ Guardería
- ❒ Asistencia para la violencia doméstica
- ❒ Educación y alfabetización
- ❒ Empleo/asistencia laboral
- ❒ Beneficios alimentarios (SNAP, WIC)
- ❒ Asesoramiento sobre duelo/sentimiento de pérdida
- ❒ Seguro médico
- ❒ Alimentos saludables
- ❒ Servicios jurídicos
- ❒ Asistencia con medicamentos
- ❒ Asistencia en deudas médicas
- ❒ Asistencia con el alquiler/servicios públicos
- ❒ Asistencia temporal para familias con necesidades (Temporary Assistance for Needy Families, TANF)
- ❒ Transporte
- ❒ Beneficios de desempleo
- ❒ Servicios para veteranos
- ❒ Otro: _____
- ❒ La COVID-19 ha hecho que uno o más de los servicios que he seleccionado sean difíciles de obtener

PREGUNTAS DE SALUD GENERAL

5. ¿Qué le impide estar sano? *(Marque <u>todas</u> las que correspondan)*

- ❒ Temo tener revisiones
- ❒ No puedo encontrar proveedores que acepten mi seguro
- ❒ Guardería
- ❒ Costo
- ❒ No sé qué tipos de servicios están disponibles
- ❒ No me gusta aceptar asistencia gubernamental
- ❒ No confío en los médicos/clínicas/mi seguro
- ❒ No tengo una fuente regular de atención médico
- ❒ Copago alto
- ❒ Falta de servicios nocturnos y de fin de semana
- ❒ Servicios de idiomas
- ❒ Ubicación de las oficinas
- ❒ Largos períodos de espera para las citas
- ❒ Sin seguro médico
- ❒ Sin transporte
- ❒ Nada me impide estar sano
- ❒ Otro: _____

6. ¿Utiliza servicios de atención médica?

❒ **<u>Sí</u> - Marque dónde acude para recibir atención médica** (***marque <u>todas</u> las que correspondan***) ❒ **<u>No</u>**

- ❒ Centra Medical Group
- ❒ Central Virginia Family Physicians
- ❒ Consultorio del médico
- ❒ Servicio de urgencias
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Centro de salud con calificación federal (p. ej., Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Departamento de Salud
- ❒ Veterans Administration Medical Center
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Otro: _____

7. ¿Cuánto tiempo ha pasado desde que visitó por última vez a un médico u otro proveedor de atención médica para una revisión de rutina? *(Marque <u>una</u> opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he acudido a un médico ni a otro proveedor de atención médica para una revisión de rutina
- ❒ En el último año, he decidido no ver a un proveedor de atención médica o he pospuesto o cancelado una visita debido a la COVID-19

8. ¿Utiliza servicios de cuidado dental?

❒ **<u>Sí</u> - Marque dónde acude para recibir atención dental** (***marque <u>todas las</u> que correspondan***) ❒ **<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
- ❒ Veterans Administration Medical Center
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Misión del proyecto Mercy
- ❒ Otro: _____

9. ¿Cuánto tiempo ha pasado desde que visitó por última vez un dentista o clínica dental por cualquier motivo? Incluya visitas a especialistas dentales como ortodoncistas. *(Marque <u>una</u> opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he visitado a un dentista o clínica dental por ningún motivo.
- ❒ En el último año, he decidido no ver a un dentista o especialista dental o he pospuesto o cancelado una visita debido a la COVID-19

10. ¿Utiliza servicios de salud mental, o para el consumo de alcohol o drogas?

❒ **Sí - Marque dónde acude para recibir los servicios (*marque todas las que correspondan*)**

- ❒ Horizon Behavioral Health
- ❒ Consultorio del médico/orientador
- ❒ Servicio de urgencias
- ❒ Centro de salud con calificación federal (p. ej., Community Access Network, Johnson Health Center)
- ❒ Clínica gratuita
- ❒ Visitas en línea/de telesalud/virtuales
- ❒ Veterans Administration Medical Center
- ❒ Atención de urgencias/Puesto de asistencia sanitaria básica
- ❒ Otro: _____

❒ **No**

11. ¿Cuánto tiempo ha pasado desde que utilizó por última vez servicios de salud mental, para el consumo de alcohol o de drogas por cualquier motivo? *(Marque una opción)*

- ❒ En el último año (de 1 a 12 meses)
- ❒ En los últimos 2 años (de 1 a 2 años atrás)
- ❒ En los últimos 5 años (de 2 a 5 años atrás)
- ❒ Hace 5 años o más
- ❒ Nunca he utilizado servicios de salud mental, para consumo de alcohol o de drogas por ningún motivo
- ❒ En el último año, he decidido no ver a un proveedor de salud mental o de consumo de sustancias u orientador o he pospuesto o cancelado una visita debido a la COVID-19

12. ¿Le ha dicho un médico que tiene...? (*Marque todas las que correspondan*)

- ❒ Asma
- ❒ Cáncer
- ❒ Depresión o ansiedad
- ❒ Problemas con las drogas o el alcohol
- ❒ Cardiopatía
- ❒ Presión arterial alta
- ❒ Nivel alto de azúcar en sangre o diabetes
- ❒ Parálisis cerebral
- ❒ Colesterol alto
- ❒ VIH/SIDA
- ❒ Problemas de salud mental
- ❒ Obesidad/sobrepeso
- ❒ Accidente/enfermedad cerebrovascular
- ❒ No tengo problemas de salud
- ❒ Otro: _____

13. Pensando en su salud física, que incluye enfermedad física y lesión, ¿durante cuántos días de los últimos 30 días su salud física no fue buena? _____ días

14. Pensando en su salud mental, que incluye estrés, depresión y problemas emocionales, ¿durante cuántos días de los últimos 30 días su salud mental no fue buena? _____ días

15. Durante los últimos 30 días: *(Marque todas las que correspondan)*

- ❒ He tomado 5 o más bebidas alcohólicas (si es hombre) o 4 o más bebidas alcohólicas (si es mujer) durante una ocasión
- ❒ He utilizado productos de tabaco (cigarrillos, tabaco sin humo, cigarrillos electrónicos, etc.)
- ❒ He tomado medicamentos con receta para drogarme
- ❒ He consumido marihuana
- ❒ He consumido otras drogas ilegales (p. ej., metanfetaminas, cocaína, heroína, éxtasis, crac, LSD, etc.)
- ❒ Ninguno de estas

16. Marque una de las siguientes opciones para cada afirmación	**Sí**	**No**	**No corresponde**
He acudido a urgencias en los últimos 12 meses.	❒	❒	
He estado en urgencias por una lesión en los últimos 12 meses (p. ej., accidente de un vehículo de motor, choque, caída, intoxicación, quemadura, corte, etc.).	❒	❒	
He sido víctima de violencia o abuso doméstico en los últimos 12 meses.	❒	❒	
Tomo el medicamento que mi médico me dice que tome para controlar mi enfermedad crónica.	❒	❒	❒
Puedo pagar los medicamentos necesarios para mis afecciones médicas.	❒	❒	❒
¿Su comunidad apoya la actividad física? (p. ej., parques, aceras, carriles para bicicletas, etc.)	❒	❒	
En la zona donde vive, ¿es fácil obtener frutas y verduras frescas accesibles?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía suficiente dinero para comprar la comida que usted o su familia necesitaban?	❒	❒	
¿Ha habido momentos en los últimos 12 meses en que no tenía dinero suficiente para pagar su alquiler o hipoteca?	❒	❒	❒
¿Se siente seguro donde vive?	❒	❒	

17. En los últimos 7 días, ¿cuántos días practicó actividad física durante un total de al menos 30 minutos? (Sume todo el tiempo que dedique a cualquier tipo de actividad física que aumente su frecuencia cardíaca y le haga respirar con dificultad durante parte del tiempo).

❒ 0 días ❒ 1 día ❒ 2 días ❒ 3 días ❒ 4 días ❒ 5 días ❒ 6 días ❒ 7 días

18. ¿Dónde consigue la comida que come en su hogar? *(Marque <u>todas</u> las que correspondan)*

❒ Programas de comida de mochila o de verano
❒ Jardín comunitario
❒ Tienda de conveniencia/estación de servicio
❒ Tienda todo por 1 dólar
❒ Mercado
❒ Banco de alimentos/despensa de alimentos
❒ Supermercado
❒ Huerta familiar
❒ No como en casa
❒ Habitualmente recibo comida de mi familia, amigos, vecinos o de mi iglesia
❒ Programa Meals on Wheels
❒ Comida para llevar/comida rápida/restaurante
❒ Otro: _____

19. Durante los últimos 7 días, ¿cuántas veces ha comido frutas y verduras? No cuente jugo de frutas ni de verduras. *(Marque <u>una</u> opción)*

❒ No he comido frutas ni verduras durante los últimos 7 días
❒ 1 a 3 veces durante los últimos 7 días
❒ 4 a 6 veces durante los últimos 7 días
❒ 1 vez por día
❒ 2 veces por día
❒ 3 veces por día
❒ 4 o más veces por día

20. En los últimos 7 días, ¿cuántas veces comieron juntos todos o la mayoría de los miembros de su familia que viven en su casa?

❒ Nunca ❒ 1 a 2 veces ❒ 3 a 4 veces ❒ 5 a 6 veces ❒ 7 veces ❒ Más de 7 veces ❒ No corresponde/Vivo solo

21. ¿En qué medida se siente conectado con la comunidad y las personas que le rodean?

❒ Muy conectado ❒ Algo conectado ❒ No conectado

22. ¿Dónde duerme con más frecuencia? *(Marque <u>una</u> opción)*

❒ En una casa que poseo o alquilo
❒ Con amigos o familiares debido a problemas económicos
❒ En un refugio o en un programa de vivienda de transición
❒ En un hogar de grupo, hospital o programa de tratamiento
❒ En un hotel o motel
❒ Fuera, en un coche, en un edificio abandonado o en un espacio público

23. ¿Tiene acceso a un transporte fiable? ❒ Sí ❒ No

24. ¿Qué tipo de transporte utiliza con más frecuencia?

❒ Conduzco
❒ Bicicleta o andando
❒ Mis amigos/familiares me llevan
❒ Transporte público (es decir, autobús, servicio de enlaces, similar)
❒ Otro servicio de transporte (nombre): _____
❒ Taxi (incluido Uber/Lyft)
❒ Uso compartido de vehículos
❒ Otro: _____

INFORMACIÓN DEMOGRÁFICA Y SEGURO MÉDICO

25. ¿Cuál de las siguientes opciones describe su tipo actual de seguro médico? *(Marque <u>todas</u> las que correspondan)*

❒ COBRA
❒ Seguro dental
❒ Seguro proporcionado por el empleador
❒ Gobierno (VA, TRICARE)
❒ Cuenta de ahorros/gastos médica
❒ Seguro individual/privado/Marketplace /Obamacare
❒ Medicaid
❒ Medicare
❒ Complemento de Medicare
❒ Sin seguro dental
❒ Sin seguro médico

26. Si no tiene seguro médico, ¿por qué no tiene seguro? *(Marque <u>todas</u> las que correspondan)*

❒ No corresponde; tengo seguro médico
❒ No entiendo las opciones de Marketplace/Obamacare
❒ No disponible en mi trabajo
❒ Estudiante
❒ Demasiado caro/costo
❒ Desempleado/sin trabajo
❒ Otro: _____

27. ¿Cuál es su código postal? _____ **28. ¿Cuál es su edad?** _____

29. ¿Cuál es su identidad de género? ❒ Hombre ❒ Mujer ❒ No binario ❒ Otro: _____

30. ¿Cuál es su estatura? _____pies _____pulgadas **31. ¿Cuál es su peso?** _____libras

32. ¿Cuántas personas viven en su casa (incluido usted)?

Cantidad de niños (de 0 a 17 años de edad) _____ Cantidad de adultos de 18 a 64 años _____ Cantidad de adultos de 65 años o más _____

33. ¿Cuál es su nivel de educación completo más alto?

- ❒ Menos que la escuela secundaria
- ❒ Algo de la escuela secundaria
- ❒ Título de escuela secundaria/GED
- ❒ Técnico superior
- ❒ Licenciatura
- ❒ Máster/doctorado

34. ¿Con qué raza/origen étnico se identifica? *(Marque <u>una</u> opción)*

- ❒ Nativo de Hawái/islas del Pacífico
- ❒ Nativo estadounidense/Nativo de Alaska
- ❒ Asiático
- ❒ Hispano/Latino
- ❒ Negro/Afroestadounidense
- ❒ Blanco
- ❒ Más de una raza
- ❒ Rehúso responder
- ❒ Otro: _____

35. ¿Cuál es su estado civil?

❒ Casado/a ❒ Soltero/a ❒ Divorciado/a ❒ Viudo/a ❒ En pareja

36. ¿Cuáles son los ingresos anuales de su familia?

- ❒ $0 a $10 000
- ❒ $10 001 a $20 000
- ❒ $20 001 a $30 000
- ❒ $30 001 a $40 000
- ❒ $40 001 a $50 000
- ❒ $50 001 a $60 000
- ❒ $60 001 a $70 000
- ❒ $70 001 a $100 000
- ❒ $101 001 y más

37. ¿Cuál es su situación laboral actual?

- ❒ A tiempo completo
- ❒ A tiempo parcial
- ❒ Desempleado
- ❒ Autónomo
- ❒ Jubilado
- ❒ Tareas domésticas
- ❒ Estudiante
- ❒ Discapacitado/a

38. ¿Hay algo más que deberíamos saber sobre sus necesidades (o las de alguien que vive en su hogar) para mantenerse sano?

_____

_____

_____

¡Gracias por ayudar a convertir el área metropolitana de Bedford en un lugar más saludable para vivir, trabajar y jugar!

2021 Centra Community Health Needs Assessment- Bedford Area

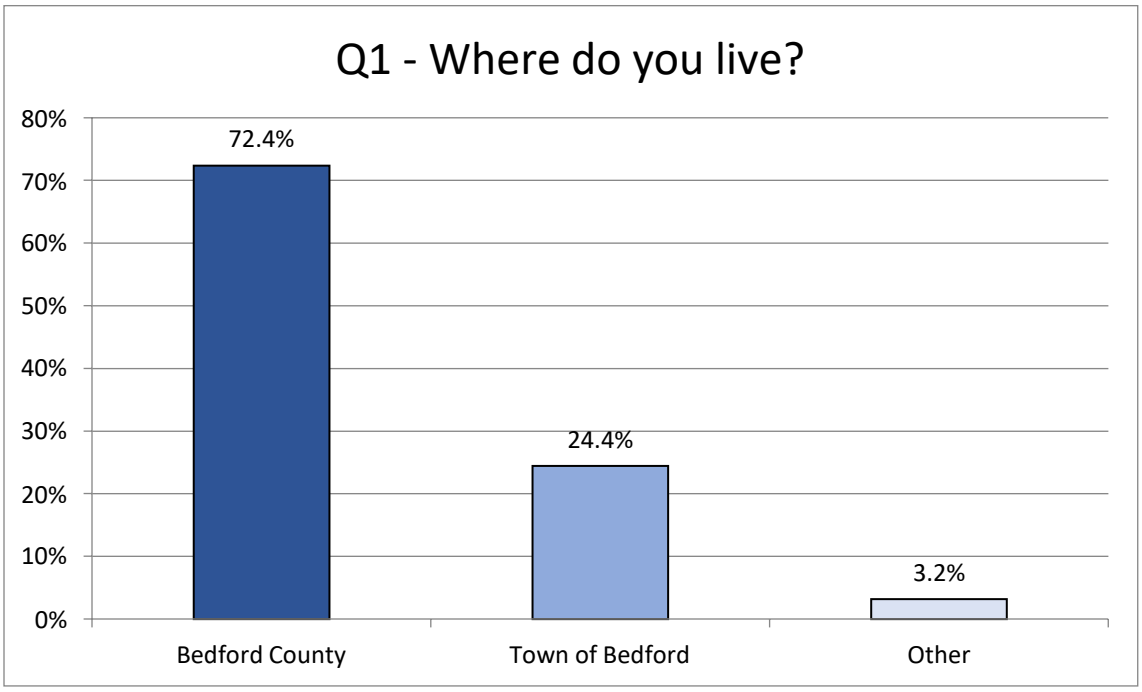
Community Health Surveys
FINAL

Prepared by: **Christopher Nye, Consultant**
Health Access Strategies, Stuarts Draft, Virginia

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

The Community Health Survey was administered both electronically through a publicly available link via Survey Monkey and through paper surveys (which were in turn entered into Survey Monkey). Paper surveys were available in both English and Spanish. A total of 857 surveys were collected. All survey respondents were offered the opportunity to enter a raffle to win a $25 gift card if they completed the survey.

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

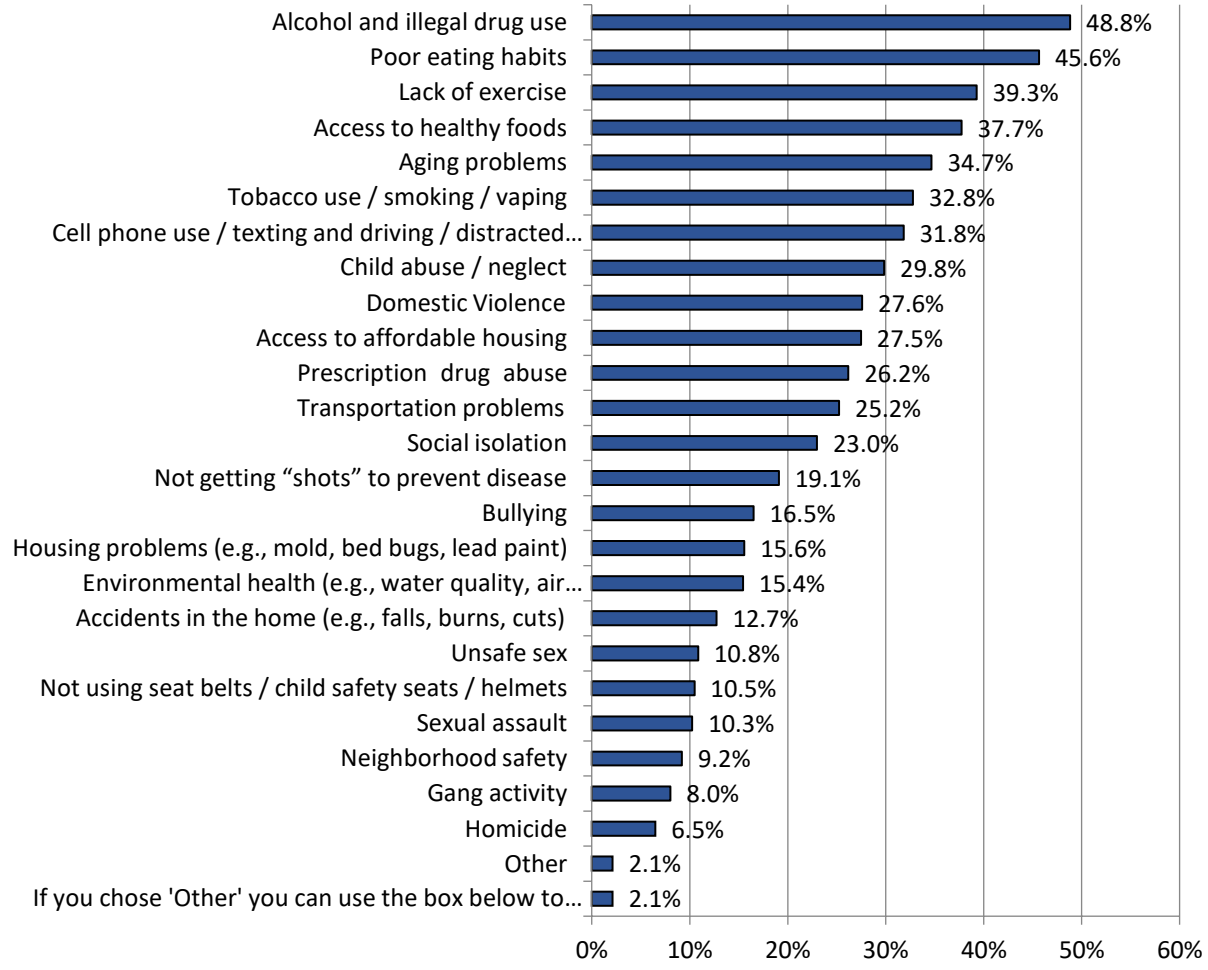


	Percent	Responses
Bedford County	72.4%	616
Town of Bedford	24.4%	208
Other	3.2%	27
	Answered	**851**
	Skipped	**5**

Q1. Other responses Where do you live?		
Code	**Responses**	**Percent**
Bedford county	13	46%
Lynchburg city	6	21%
Campbell county	2	7%
Roanoke county	2	7%
Amherst county	1	4%
Botetourt county	1	4%
Prince Edward county	1	4%
Pittsylvania county	1	4%
Roanoke city	1	4%
Total	**28**	**100%**

In the Bedford region, 28 respondents chose "other" for their selection. Of these "other" responses, 13 or 46% indicated that they were Bedford county residents; 6 or 21% indicated that they were residents of Lynchburg city. The remaining 9 responses or 33% were made up of various surrounding cities and counties.

Q2A - What do you think are the most important health factor issues that affect health in our community? (Respondents could check more than one)

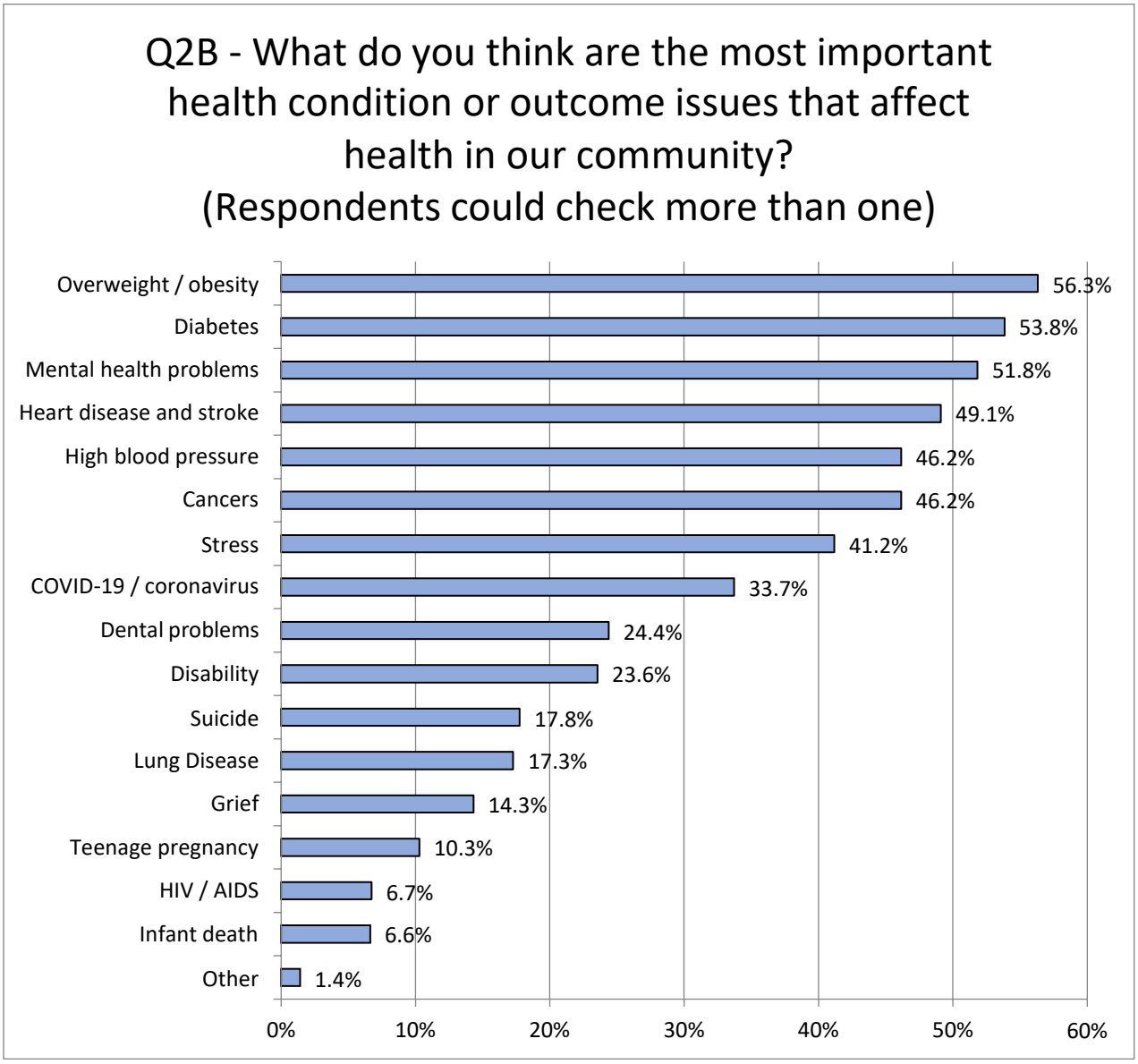


	Percent	Responses
Alcohol and illegal drug use	48.8%	414
Poor eating habits	45.6%	387
Lack of exercise	39.3%	333
Access to healthy foods	37.7%	320
Aging problems	34.7%	294
Tobacco use / smoking / vaping	32.8%	278
Cell phone use / texting and driving / distracted driving	31.8%	270
Child abuse / neglect	29.8%	253
Domestic Violence	27.6%	234
Access to affordable housing	27.5%	233
Prescription drug abuse	26.2%	222
Transportation problems	25.2%	214
Social isolation	23.0%	195
Not getting “shots” to prevent disease	19.1%	162
Bullying	16.5%	140
Housing problems (e.g., mold, bed bugs, lead paint)	15.6%	132
Environmental health (e.g., water quality, air quality, pesticides, etc.)	15.4%	131
Accidents in the home (e.g., falls, burns, cuts)	12.7%	108
Unsafe sex	10.8%	92
Not using seat belts / child safety seats / helmets	10.5%	89
Sexual assault	10.3%	87
Neighborhood safety	9.2%	78
Gang activity	8.0%	68
Homicide	6.5%	55
If you chose 'Other' you can use the box below to specify	2.1%	18
Other	2.1%	18
	Answered	**848**
	Skipped	**9**

In 2021 respondents ranked alcohol and illegal drug as the most important health factor. This was a 14% increase over the 2018 rate (48.8% compared to 34.2%). Poor eating habits increased significantly from the 2018 assessment (16.7%) to 45.6% in 2021. Lack of exercise increased approximately 23% from 2018 (16.4%) to 39.3% in 2021 as did access to healthy foods (25.2% in 2018 and 37.7% in 2021). It is important for the reader to note that “health conditions” were separated from “health factors” in the 2021 assessment. This makes comparisons between 2018 and 2021 difficult.

Q2a. Other responses What do you think are the most important issues that affect health in our community? Health Factors:		
Code	**Responses**	**Percent**
Injuries	4	22%
Access to mental health services	3	17%
Racism/Discrimination	2	11%
Access to childcare	1	6%
Affordability of medication	1	6%
Affordable dental Care	1	6%
Education on vaccination	1	6%
Generational poverty	1	6%
Religious/Spiritual Support	1	6%
Tick-Borne Illness	1	6%
Mental health	1	6%
N/A	1	6%
Total	**18**	**100%**

In the Bedford region, 18 respondents chose "other" for their selection. Of these "other" responses, 4 or 22% indicated that they felt injuries was the most important health factor that affects our community; 3 (17%) indicated that access to mental health services was the most important health factor that affects the community, while 2 responses (11%) said racism/discrimination most influenced community health. Additional issues are listed in the table above.


Q2B - What do you think are the most important health condition or outcome issues that affect health in our community? (Respondents could check more than one)
Overweight / obesity 56.3%
Diabetes 53.8%
Mental health problems 51.8%
Heart disease and stroke 49.1%
High blood pressure 46.2%
Cancers 46.2%
Stress 41.2%
COVID-19 / coronavirus 33.7%
Dental problems 24.4%
Disability 23.6%
Suicide 17.8%
Lung Disease 17.3%
Grief 14.3%
Teenage pregnancy 10.3%
HIV / AIDS 6.7%
Infant death 6.6%
Other 1.4%
0% 10% 20% 30% 40% 50% 60%

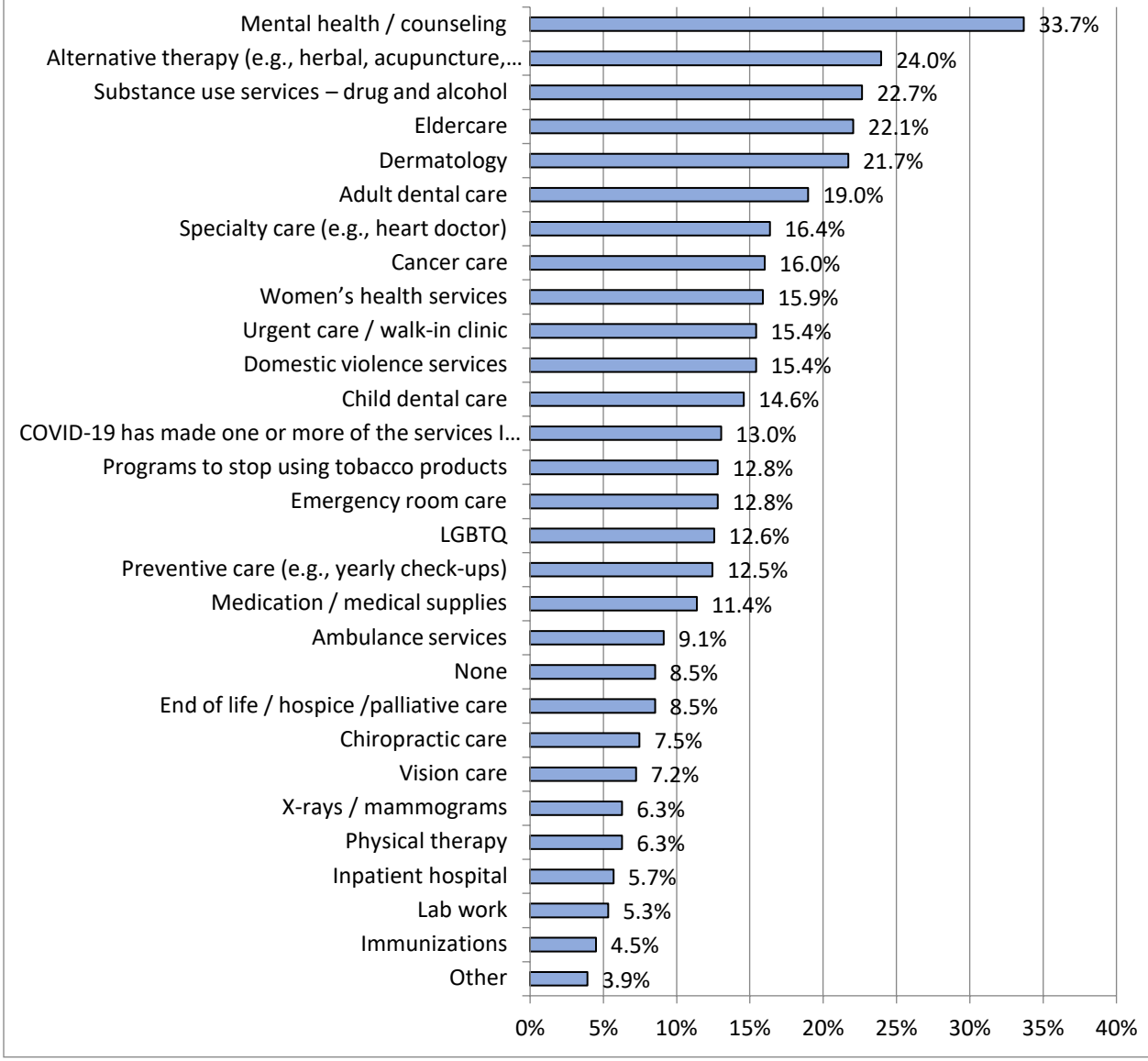
	Percent	Responses	
Overweight / obesity	56.3%	476	
Diabetes	53.8%	455	
Mental health problems	51.8%	438	
Heart disease and stroke	49.1%	415	
Cancers	46.2%	390	
High blood pressure	46.2%	390	
Stress	41.2%	348	
COVID-19 / coronavirus	33.7%	285	
Dental problems	24.4%	206	
Disability	23.6%	199	
Suicide	17.8%	150	
Lung Disease	17.3%	146	
Grief	14.3%	121	
Teenage pregnancy	10.3%	87	
HIV / AIDS	6.7%	57	
Infant death	6.6%	56	
Other	1.4%	12	
	Answered	**845**	
	Skipped	**11**	

Respondents ranked health conditions or outcome issues that directly address diabetes or are significant risk factors for other chronic diseases (obesity, high blood pressure, and stress) highly. Of particular note, in 2018, respondents indicated that mental health problems were 26% of respondents' five selections, and in 2021 that number increased to 52%. This increase may be impacted by COVID-19 and the fact that health care “factors" and health care "issues" were broken into separate questions in 2021. This makes comparisons between 2018 and 2021 difficult.

Q2b. Other responses What do you think are the most important issues that affect health in our community? Conditions/Outcomes:		
Code	**Responses**	**Percent**
Addiction	2	22%
Mental Health	2	22%
Alzheimer's/dementia	1	11%
Crohns/colitis	1	11%
Politics	1	11%
Racism	1	11%
Spreading of false information	1	11%
Total	**9**	**100%**

In the Bedford region, 9 respondents chose "other" for their selection. Of these "other" responses, 2 or 22% said they felt that the most important condition/outcome that influenced community health was addiction and mental health. Additional responses are shown in the table above.

Q3 - Which health care services are hard to get in our community? (Respondents could check more than one)



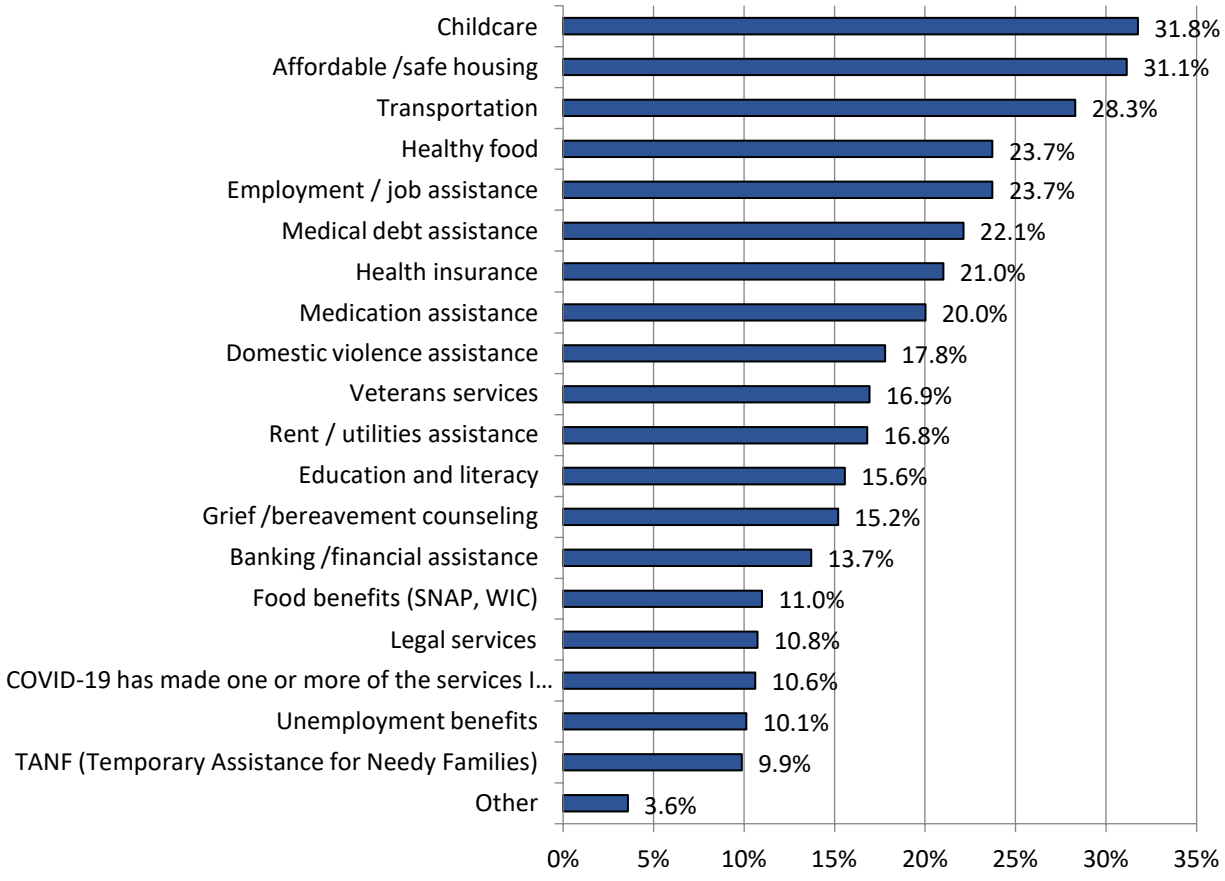
	Percent	Responses
Mental health / counseling	33.7%	284
Alternative therapy (e.g., herbal, acupuncture, massage)	24.0%	202
Substance use services – drug and alcohol	22.7%	191
Eldercare	22.1%	186
Dermatology	21.7%	183
Adult dental care	19.0%	160
Specialty care (e.g., heart doctor)	16.4%	138
Cancer care	16.0%	135
Women's health services	15.9%	134
Domestic violence services	15.4%	130
Urgent care / walk-in clinic	15.4%	130
Child dental care	14.6%	123
COVID-19 has made one or more of the services I selected hard to get	13.0%	110
Emergency room care	12.8%	108
Programs to stop using tobacco products	12.8%	108
LGBTQ	12.6%	106
Preventive care (e.g., yearly check-ups)	12.5%	105
Medication / medical supplies	11.4%	96
Ambulance services	9.1%	77
End of life / hospice /palliative care	8.5%	72
None	8.5%	72
Chiropractic care	7.5%	63
Vision care	7.2%	61
Physical therapy	6.3%	53
X-rays / mammograms	6.3%	53
Inpatient hospital	5.7%	48
Lab work	5.3%	45
Immunizations	4.5%	38
Other	3.9%	33
	Answered	**843**
	Skipped	**14**

In 2021, the number of respondents indicated mental health and counseling services were the hardest to get. This number increased close to 6% from 2018 (28%) to 2021 (33.7%). Alternative therapies were in the top five in both assessment years, 24.8% in 2018, and 24% in 2021. Eldercare was consistent from 2018 (22.3%) to 2021 (22.1%). Adult dental care ranked high in both assessments (26% in 2018 and 19% in 2021). It is important to note that beginning July 1, 2021, Virginia Medicaid started providing comprehensive adult dental services to Medicaid beneficiaries forthe first time.

Q3. Other responses What health care services are hard to get in our community?		
Code	**Responses**	**Percent**
Family doctor	8	23%
Pediatric Care	3	9%
Adult dental care	2	6%
Affordable eldercare	2	6%
Appointments-long waits	2	6%
Cost of services	2	6%
Psychiatric care- pediatric	2	6%
Access to affordable care for under-insured	1	3%
Affordable nursing home facilities	1	3%
Neurology	1	3%
Diabetes care	1	3%
Health literacy/health education	1	3%
Home health- aids	1	3%
Occupational therapy	1	3%
Programs for depression- pediatric	1	3%
Psychiatric care- adults	1	3%
Sitters or care for Alzheimer's/Dementia patients	1	3%
Speech therapy	1	3%
Transportation	1	3%
Veteran Care	1	3%
Psychiatric Therapy- Ketamine Infusion	1	3%
Total	**35**	100%

In the Bedford region, 35 respondents chose "other" for their selection. Of these "other" responses, 8 or 23% said they felt that the service that is hardest to get in the community is a Family doctor; 3 or 9% said they felt the hardest service to get was pediatric care. Various other issues were identified and are listed in the table above.

Q4 - Which social / support resources are hard to get in our community? (Respondents could check more than one)

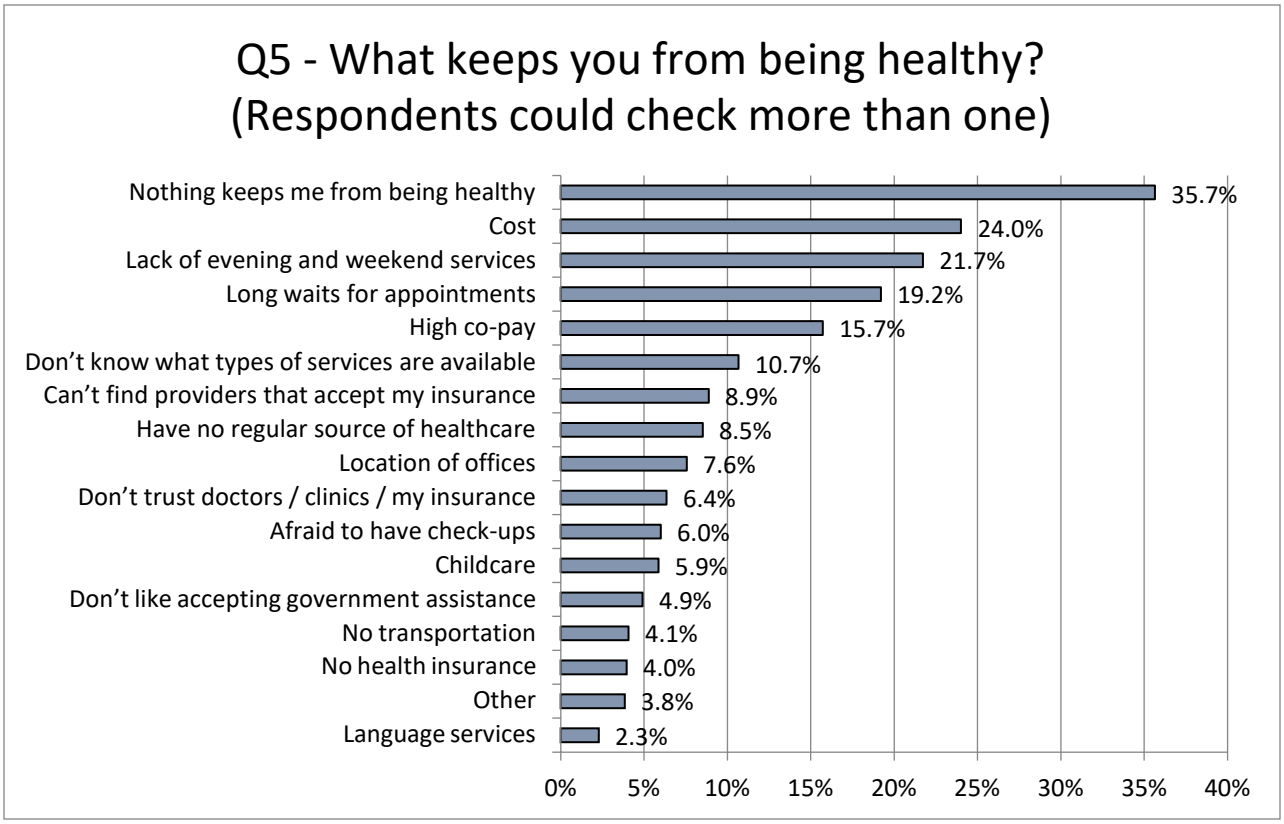


	Percent	Responses
Childcare	31.8%	257
Affordable /safe housing	31.1%	252
Transportation	28.3%	229
Employment / job assistance	23.7%	192
Healthy food	23.7%	192
Medical debt assistance	22.1%	179
Health insurance	21.0%	170
Medication assistance	20.0%	162
Domestic violence assistance	17.8%	144
Veterans services	16.9%	137
Rent / utilities assistance	16.8%	136
Education and literacy	15.6%	126
Grief /bereavement counseling	15.2%	123
Banking /financial assistance	13.7%	111
Food benefits (SNAP, WIC)	11.0%	89
Legal services	10.8%	87
COVID-19 has made one or more of the services I selected hard to get	10.6%	86
Unemployment benefits	10.1%	82
TANF (Temporary Assistance for Needy Families)	9.9%	80
Other	3.6%	29
	Answered	**809**
	Skipped	**48**

Childcare and affordable and safe housing were cited by 2021 respondents as the most difficult service to get in the community. Affordable and safe housing also ranked high in the 2018 assessment at 30%. The percentage of responses that cited transportation as a hard-to-get service remained consistent from 2018 (28.4%) to 2021 (28.3%).

Q4. Other responses Which Social /Support Services resources are hard to get in our community?		
Code	**Responses**	**Percent**
Alzheimer's/dementia- affordability/resources	3	16%
Eldercare	2	11%
Physical activity resources	1	5%
Childcare-affordability	1	5%
Childcare- on site	1	5%
Home repair & maintenance	1	5%
Health literacy/health education	1	5%
Affordable home health services	1	5%
Mental health & substance use services	1	5%
Nurse retention	1	5%
Nursing homes that accept Medicaid	1	5%
Entertainment (movie theater, comedy club) for stress reduction & socialization	1	5%
SSI	1	5%
N/A	3	16%
Total	**19**	**100%**

In the Bedford region, 19 respondents chose "other" for their selection. Of these "other" responses, 3 or 16% said they felt that the social/support services hardest to get in the community were affordable resources for Alzheimer's/dementia patients. Following closely behind with 2 responses (or 11%), eldercare was the second most challenging social/support service to get in the community. Various other issues were mentioned and are listed above in the table.

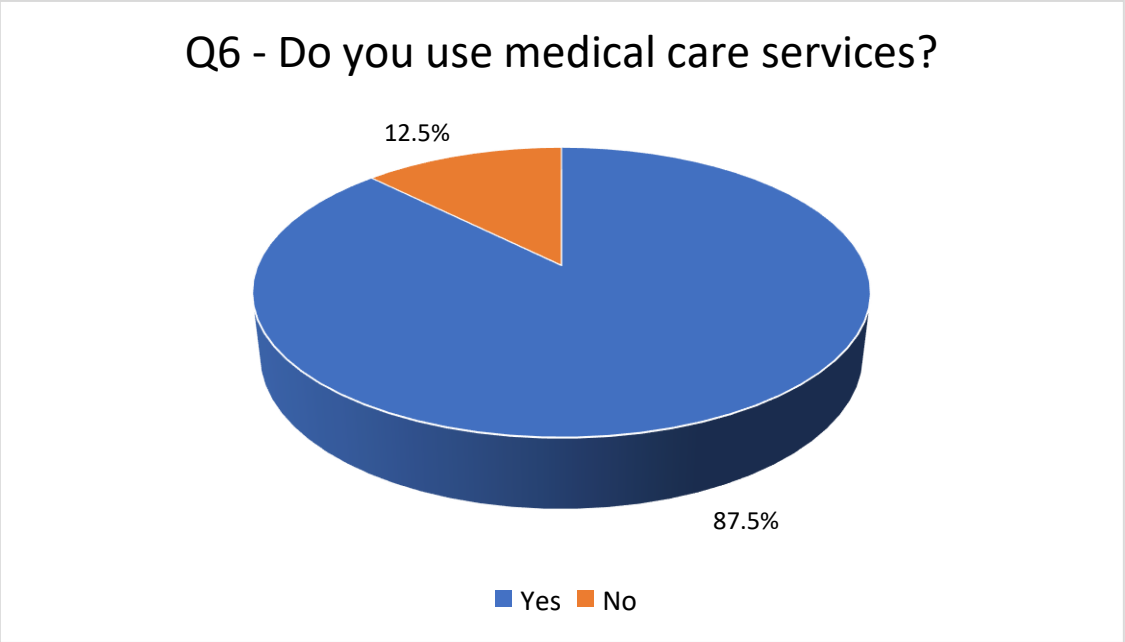


	Percent	Responses
Nothing keeps me from being healthy	35.7%	297
Cost	24.0%	200
Lack of evening and weekend services	21.7%	181
Long waits for appointments	19.2%	160
High co-pay	15.7%	131
Don't know what types of services are available	10.7%	89
Can't find providers that accept my insurance	8.9%	74
Have no regular source of healthcare	8.5%	71
Location of offices	7.6%	63
Don't trust doctors / clinics / my insurance	6.4%	53
Afraid to have check-ups	6.0%	50
Childcare	5.9%	49
Don't like accepting government assistance	4.9%	41
No transportation	4.1%	34
No health insurance	4.0%	33
Other	3.8%	32
Language services	2.3%	19
	Answered	**833**
	Skipped	**24**

In 2018, the response "Nothing keeps me from being healthy" was not an option and the question was phrased differently. In 2018, the question was, "What do you feel prevents you from getting the services you need? In 2021, the top five reasons respondents felt kept them from being healthy were identical to the top five reasons respondents felt were obstacles to getting the services they needed in 2018. Cost was 24% in 2021 and 47% in 2018. High co-pays were 27.3% in 2018 and 15.7% in 2021. Lack of evening and weekend services decreased slightly in 2021 to 21.7% from 24.3% in 2018. Long waits for appointments remained consistent at 19.2% in 2021 compared to 20.5% in 2018. No health insurance dropped as a reason from 12.2% in 2018 to 4% in 2021.

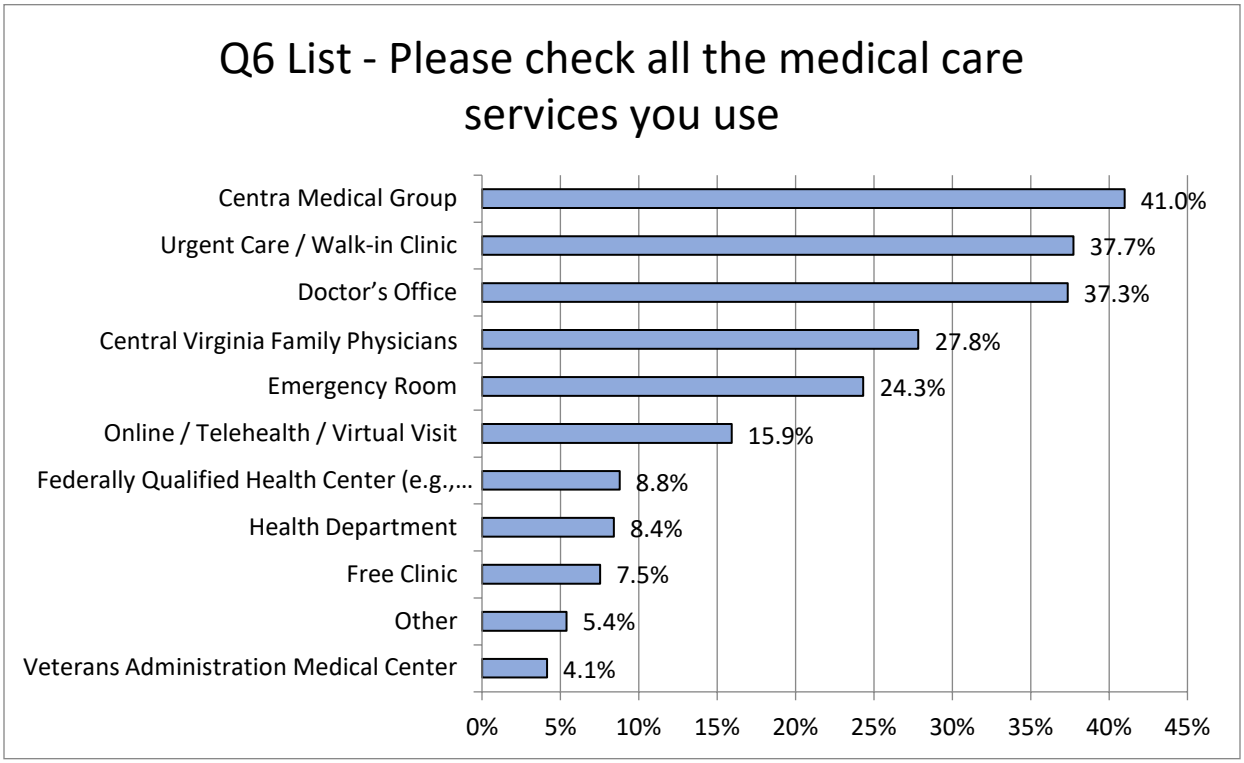
Q5. Other responses What Keeps you from being Healthy?		
Code	**Responses**	**Percent**
Lack of motivation, willpower	5	13%
Work related challenges	5	13%
Cost of care	3	8%
Don't trust doctors/clinics/insurance	3	8%
Stress	3	8%
Access to diabetic care	1	3%
Access to primary care	1	3%
Affordable health insurance	1	3%
Lack of time- job related	1	3%
Difficulty getting appointments	1	3%
Lack of exercise	1	3%
Lack of time	1	3%
Medical challenges	1	3%
Overeating	1	3%
Provider shortage	1	3%
Time management	1	3%
Transportation	1	3%
Cost of care- non-VA services	1	3%
Lack of access to Physician vs Advanced Practice Provider	1	3%
N/A	6	15%
Total	**39**	**100%**

In the Bedford region, 39 respondents chose "other" for their selection. Of these "other" responses, 5 or 13% said the main thing that stopped them from being healthy was lack of motivation and willpower, and work-related challenges. Tied for second with 8% of responses was cost of care, lack of trust in doctors/clinics/insurance and stress. A multitude of other responses were provided and are listed above.



	Percent	Responses
Yes	87.5%	685
No	12.5%	98
	Answered	**783**
	Skipped	**74**

The number of respondents who indicated that they use medical services increased from 2018 (78.6%) to 87.5% in 2021.

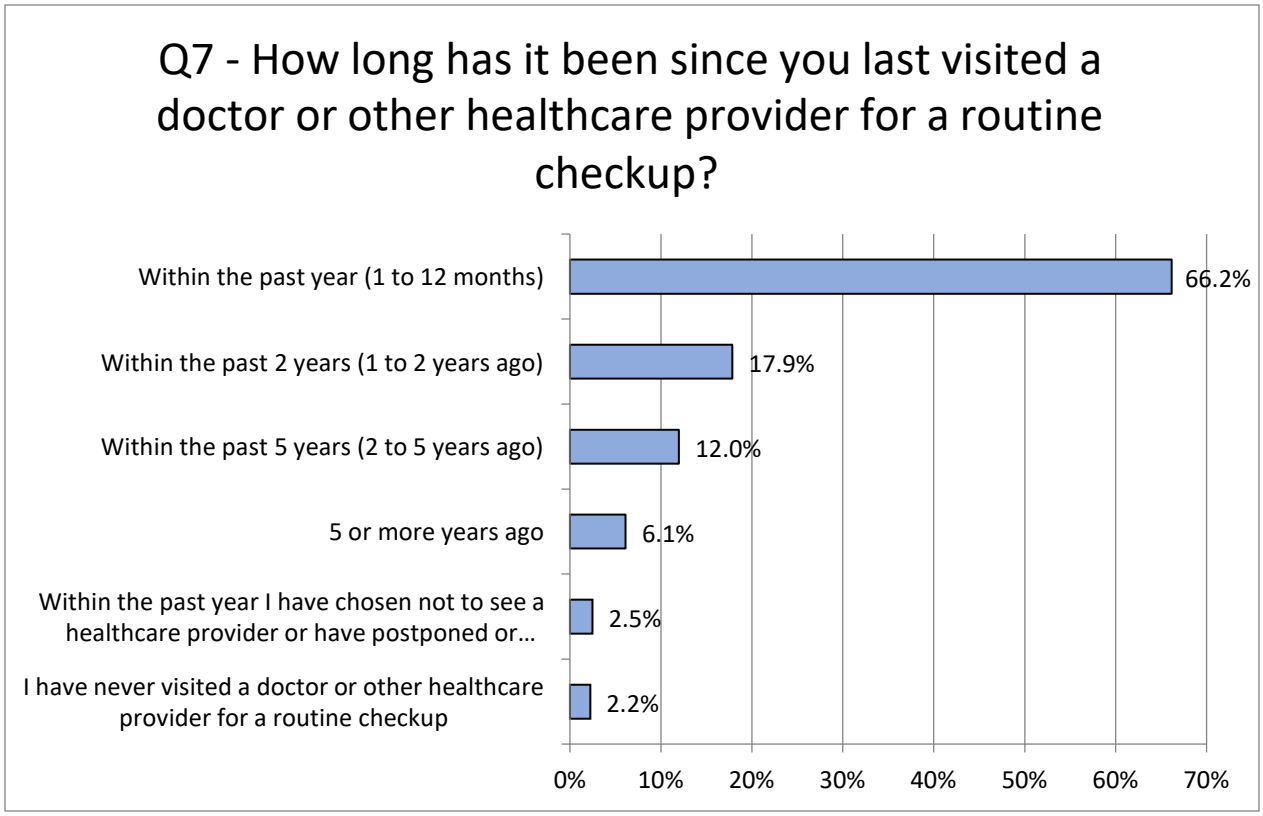


	Percent	Responses
Centra Medical Group	41.0%	327
Urgent Care / Walk-in Clinic	37.7%	301
Doctor's Office	37.3%	298
Central Virginia Family Physicians	27.8%	222
Emergency Room	24.3%	194
Online / Telehealth / Virtual Visit	15.9%	127
Health Department	8.4%	67
Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)	8.8%	70
Free Clinic	7.5%	60
Other	5.4%	43
Veterans Administration Medical Center	4.1%	33
	Answered	**798**
	Skipped	**59**

The generic "Doctor's Office" was the top response in 2018 (68.5%). The percent of respondents who chose this option in 2021 was 37%. Respondents selecting Centra Medical Group increased to 41% in 2021 from 27% in 2018, a 14% increase. Respondents indicating that they used the Emergency Room decreased slightly from 28% in 2018 to 24% in 2021. Urgent Care or Walk-in Clinic showed a large increase from 26% in 2018 to 38% in 2021. The use of the region's Federally Qualified Health Centers increased from 3.8% in 2018 to 8.8% in 2021. The online/telehealth/virtual visit was not an option for this question in the 2018 assessment.

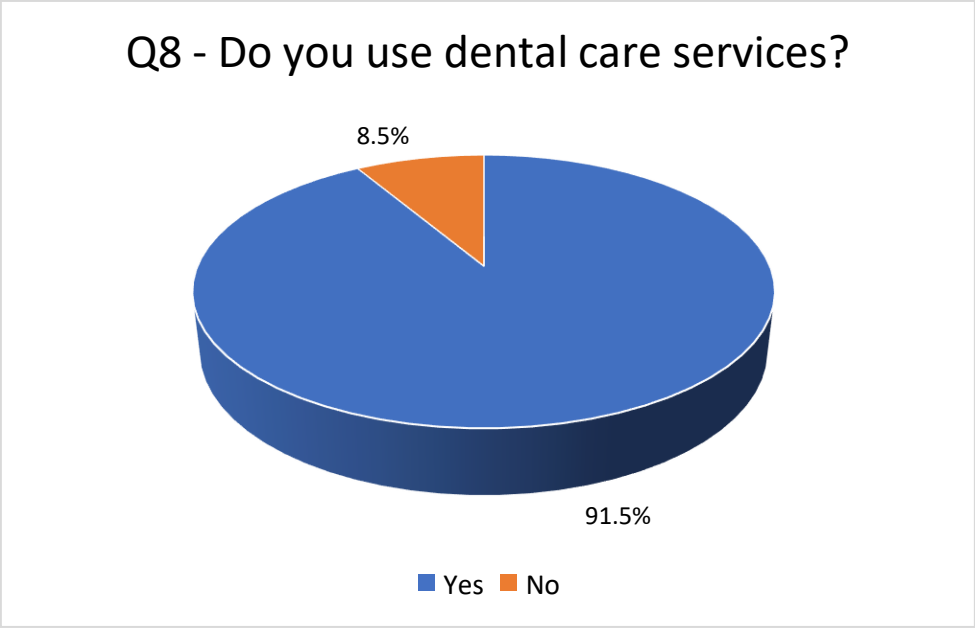
Q6. Other responses If Yes, Where do you go for medical care?		
Code	**Responses**	**Percent**
UVA health	7	14%
Dentist	5	10%
Ortho Virginia	4	8%
Carilion	3	6%
Johnson Health Center	3	6%
Specialty Care	3	6%
Women's Health of Central VA	3	6%
Doctors' office	2	4%
LewisGale Physicians	2	4%
Optometrist/ophthalmologist	2	4%
Community Based Outpatient Clinic	1	2%
CVS minute clinic	1	2%
Duke clinic	1	2%
Famers Market	1	2%
Message Therapy	1	2%
Telehealth- pediatric mental health services	1	2%
Out of State	1	2%
Physical Therapist	1	2%
Piedmont eye	1	2%
VA health services- geographic barriers	1	2%
Seven Hills Dermatology	1	2%
VelocityCare	1	2%
Unknown	1	2%
Free Clinic services needed	1	2%
Chiropractor	1	2%
Psychiatry-Pediatric	0	0%
Total	**49**	**100%**

In the Bedford region, 49 respondents chose "other" for their selection. Of these "other" responses, 7 or 14% said they utilize UVA Health for medical care; while 5 or 10% said they go to the dentist for medical care and 4 people or 8% said Ortho Virginia. Additional responses were provided and are also listed in the table.



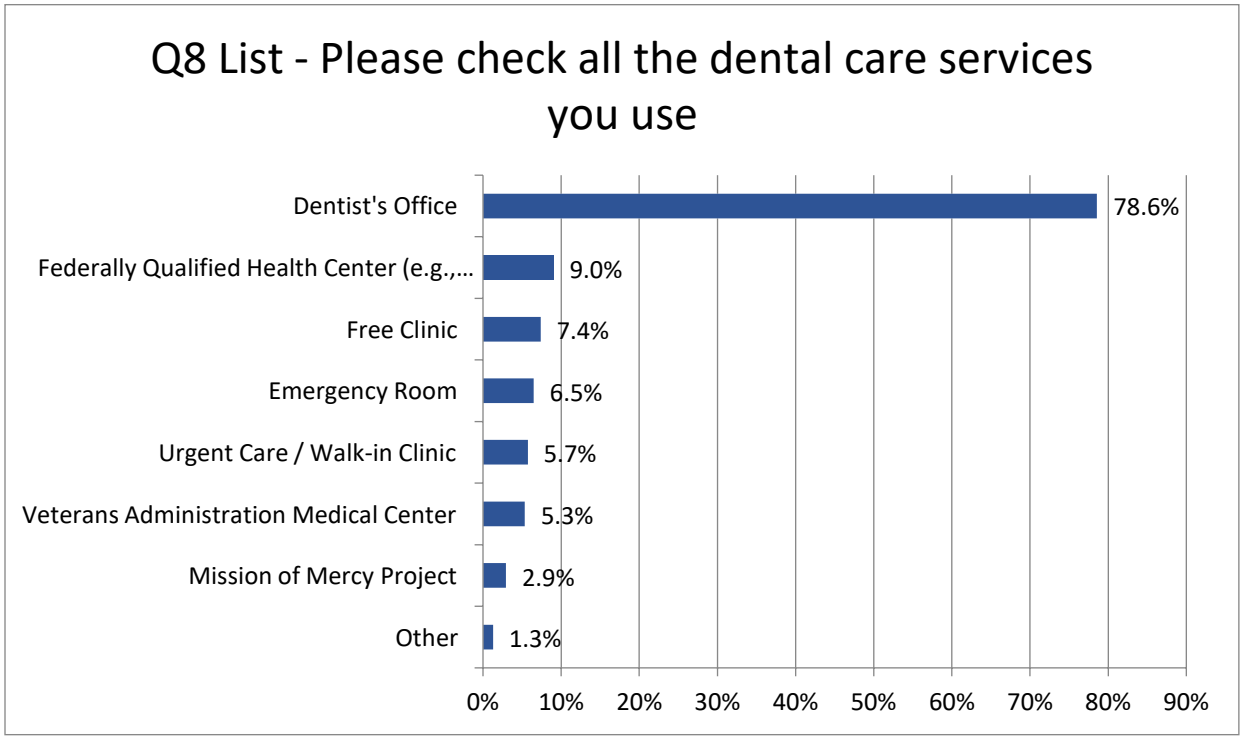
	Percent	Responses
Within the past year (1 to 12 months)	66.2%	563
Within the past 2 years (1 to 2 years ago)	17.9%	152
Within the past 5 years (2 to 5 years ago)	12.0%	102
5 or more years ago	6.1%	52
I have never visited a doctor or other healthcare provider for a routine checkup	2.2%	19
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	2.5%	21
	Answered	**851**
	Skipped	**6**

The number of respondents indicating that they last visited a healthcare provider for a routine check-up essentially decreased from 2018 (78%) to 2021 (66%) in the past year. The number of respondents who had visited a healthcare provider for a routine check-up within the past five years declined from 14.2% in2018 to 12.0% in 2021 and 2.5% reported not seeing, postponing, or cancelling visits with their healthcare providers due to COVID-19.



	Percent	Responses
Yes	91.5%	741
No	8.5%	69
	Answered	**810**
	Skipped	**47**

The number of respondents indicating that they use dental care services increased 14.7% from 2018 (76.8%) to 2021 (91.5%).

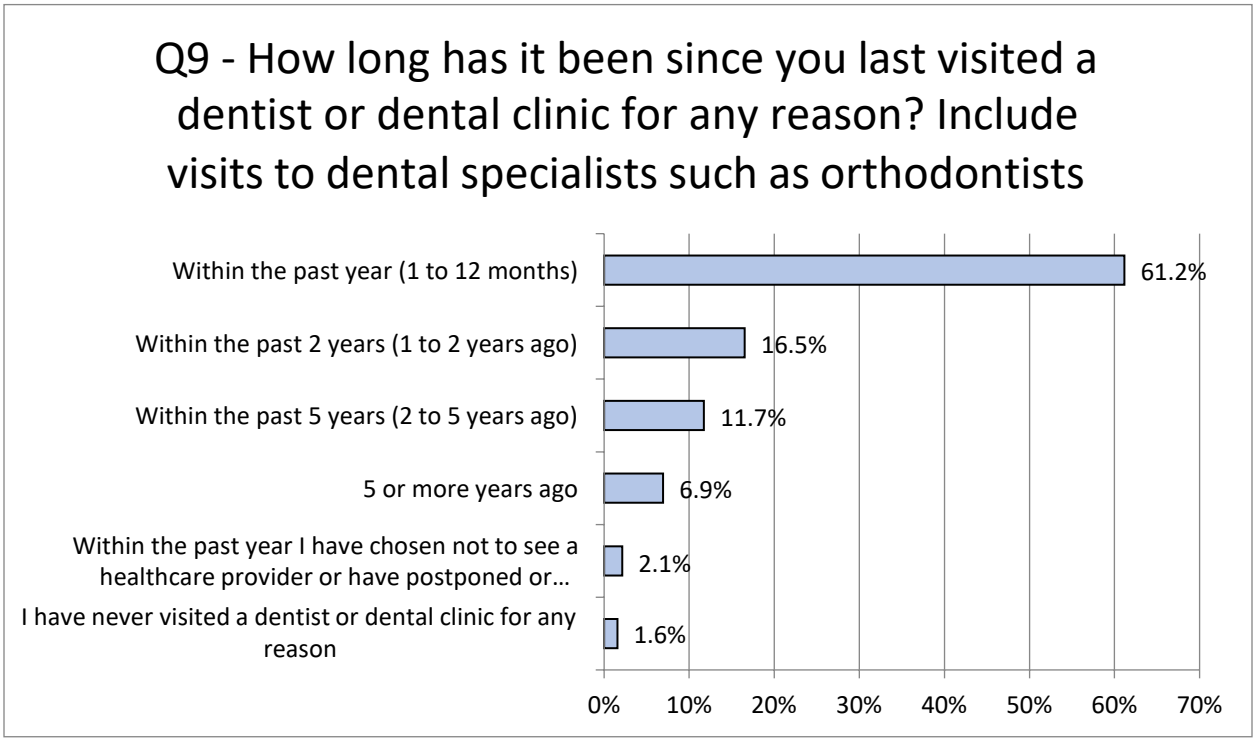


	Percent	Responses
Dentist's Office	78.6%	619
Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)	9.0%	71
Free Clinic	7.4%	58
Emergency Room	6.5%	51
Urgent Care / Walk-in Clinic	5.7%	45
Veterans Administration Medical Center	5.3%	42
Mission of Mercy Project	2.9%	23
Other	1.3%	10
	Answered	**788**
	Skipped	**69**

The number of respondents selecting the generic response "Dentist's Office" had a small increase from 2018 (76%) to 78.6% in 2021. The use of "Free Clinic" for dental services increased 5.6% in 2021 to 7.4% from 1.8% in 2018. Respondents using "Urgent Care or Walk-in Clinic" increased 5% to 5.7% in 2021 from 0.7% in 2018. Respondents using a Federally Qualified Health Center more than doubled in 2021 (4% in 2018 to9% in 2021). Respondents using "Mission of Mercy Project" for dental services was 0.1% in 2018 toalmost 3% in 2021. Use of the Emergency Room for dental services increased almost three-fold from 2.2% in 2018 to 6.5% in 2021. The number of respondents who reported having dental insurance in 2021 (31.1%) decreased from 2018 (39.2%).

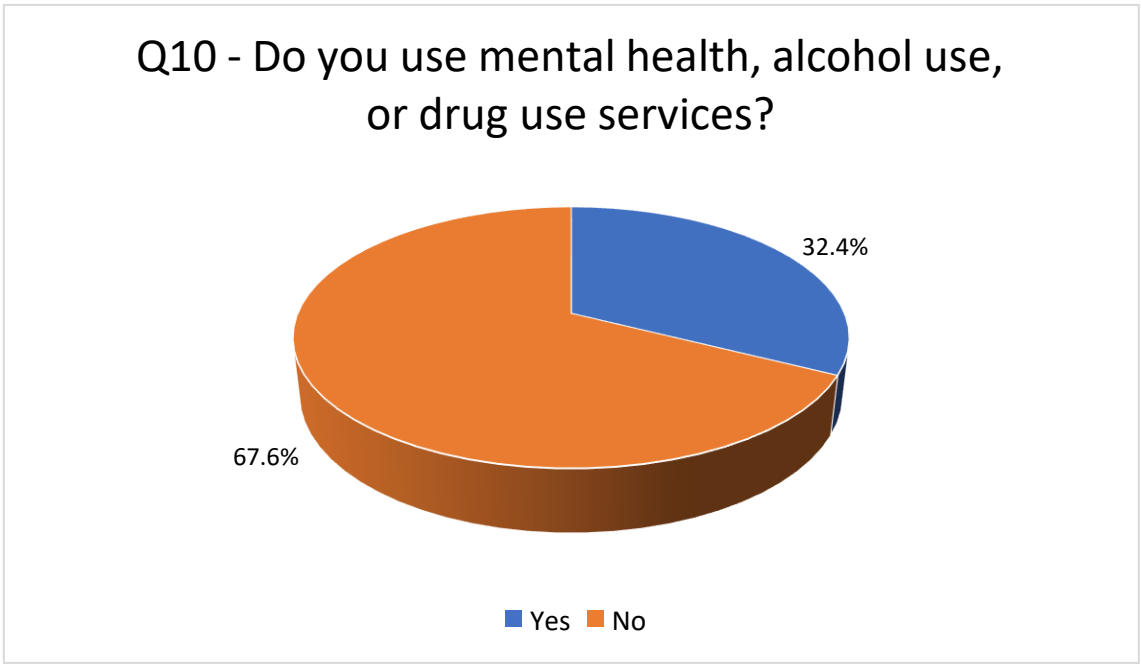
Q8. Other responses Check all Dental Services that you use:		
Code	**Responses**	**Percent**
I don't go	2	22%
Affordable dentures	1	11%
Dentist office-Roanoke	1	11%
Difficulties getting appointment- obesity	1	11%
Dr. Coots	1	11%
Out of state	1	11%
Free care	1	11%
N/A	1	11%
Total	**9**	**100%**

In the Bedford region, 9 respondents chose "other" for their selection. Of these "other" responses, 2 or 22% said they do not go to the dentist at all. The remaining respondents identified services that are listed in the table above.



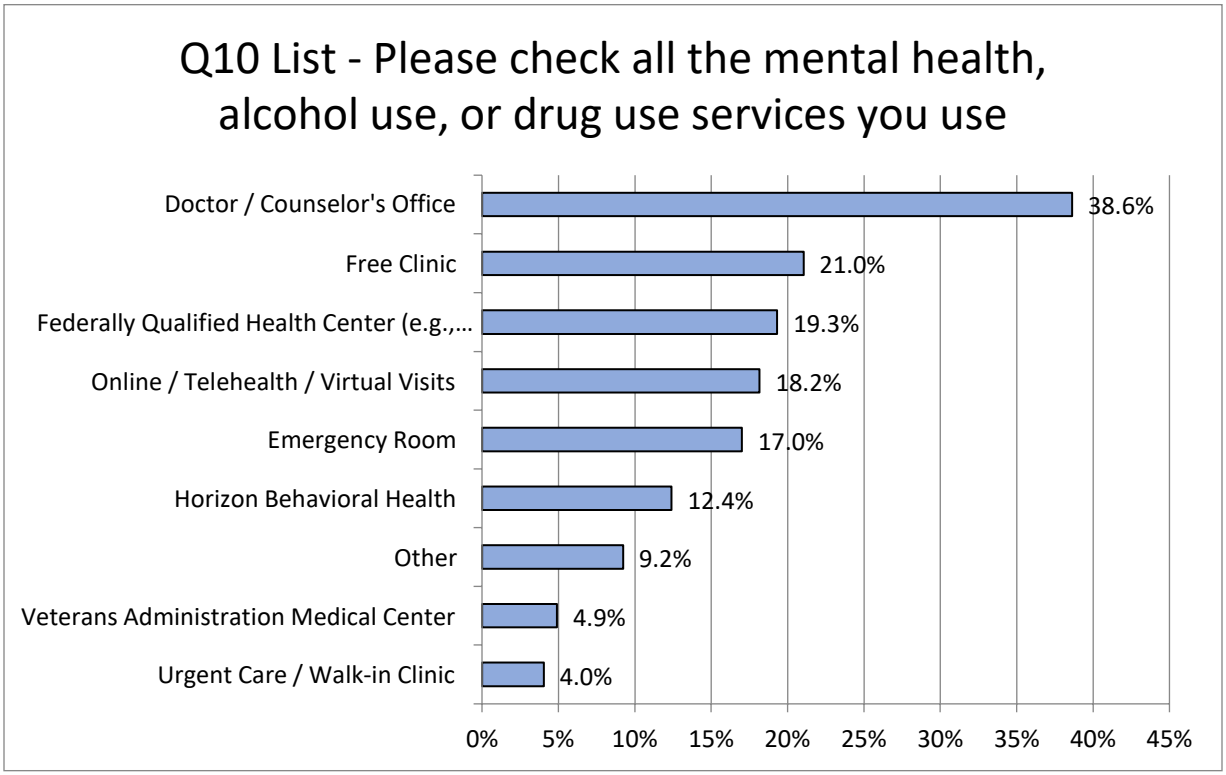
	Percent	Responses
Within the past year (1 to 12 months)	61.2%	548
Within the past 2 years (1 to 2 years ago)	16.5%	148
Within the past 5 years (2 to 5 years ago)	11.7%	105
5 or more years ago	6.9%	62
I have never visited a dentist or dental clinic for any reason	1.6%	14
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	2.1%	19
	Answered	**896**
	Skipped	**11**

The number of respondents who have visited a dentist or dental clinic in the last 12 months fell from 67% in 2018 to 61% in 2021. More people reported having visited the dentist or dental clinic within the past two years (16.5%) than in 2018 (10%). The number of respondents who had visited a dentist or dental clinic in the past five years increased in 2021 to 11.7% compared to 8.2% in 2018.



	Percent	Responses
Yes	32.4%	268
No	67.6%	558
	Answered	**826**
	Skipped	**31**

The number of respondents indicating that they use mental health, alcohol or drug use services increased dramatically from 13% in 2018 to 32% in 2021.



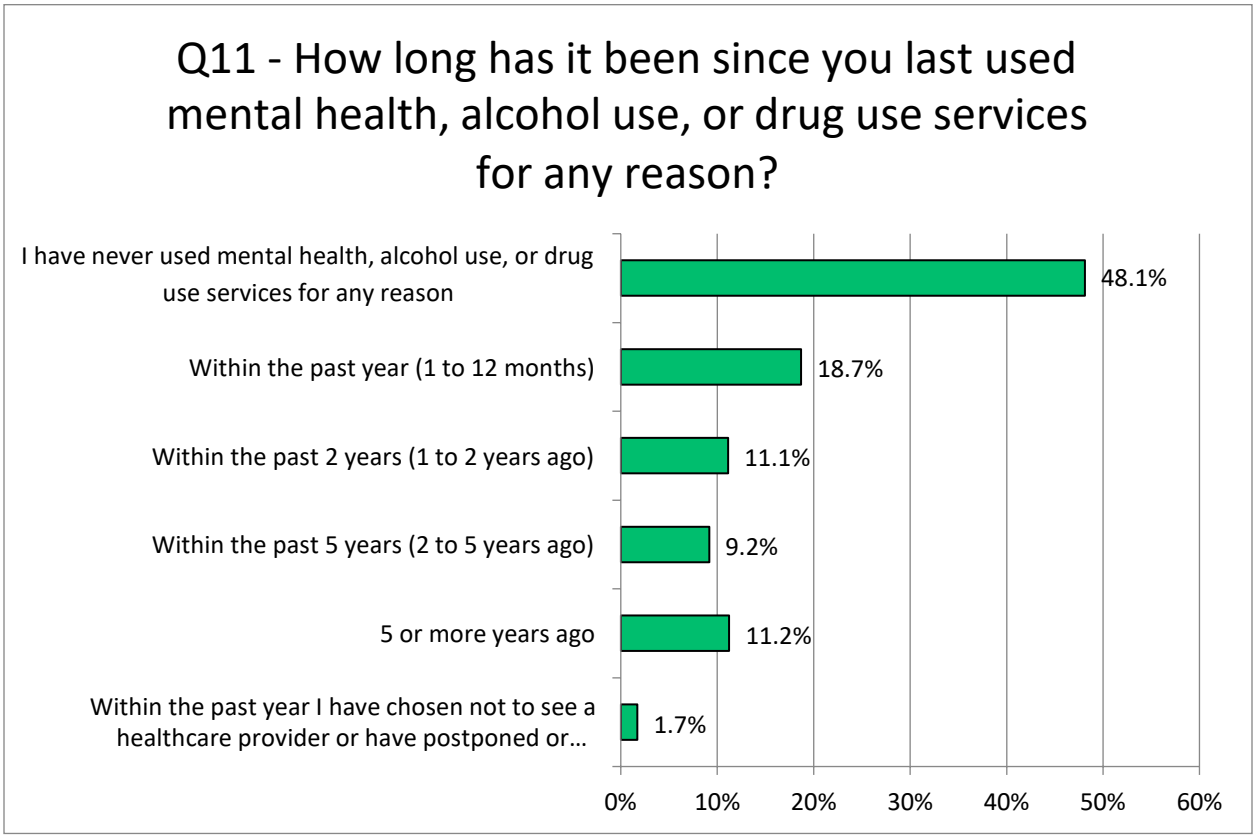
	Percent	Responses
Doctor / Counselor's Office	38.6%	134
Free Clinic	21.0%	73
Federally Qualified Health Center (e.g., Community Access Network, Johnson Health Center)	19.3%	67
Online / Telehealth / Virtual Visits	18.2%	63
Emergency Room	17.0%	59
Horizon Behavioral Health	12.4%	43
Other	9.2%	32
Veterans Administration Medical Center	4.9%	17
Urgent Care / Walk-in Clinic	4.0%	14
	Answered	**347**
	Skipped	**510**

The generic response, "Doctor or Counselor's Office," was combined from two separate responses from 2018 – "Doctor's Office" and "Counselor's Office." These two responses in 2018 were approximately 18% and 32%, while combined for 2021, the percentage of responses was 38%. The number of respondents who used Horizon Behavioral Health for services fell from 38.5% in 2018 to 12.4% in 2021. Online, telehealth, or virtual visits were not an option for respondents in 2018 however, close to 1 out of 5 respondents using mental health, alcohol use, or drug use services indicated such a visit. The number of respondents using the Free Clinic or a Federally Qualified Health Center (FQHC) both increased significantly from 2018 (1.1% Free Clinic; 3.4% FQHC) to 2021 (Free

Clinic 21%; FQHC 19.3%). The use of theEmergency Room increased significantly from 4% in 2018 to 17% in 2021.

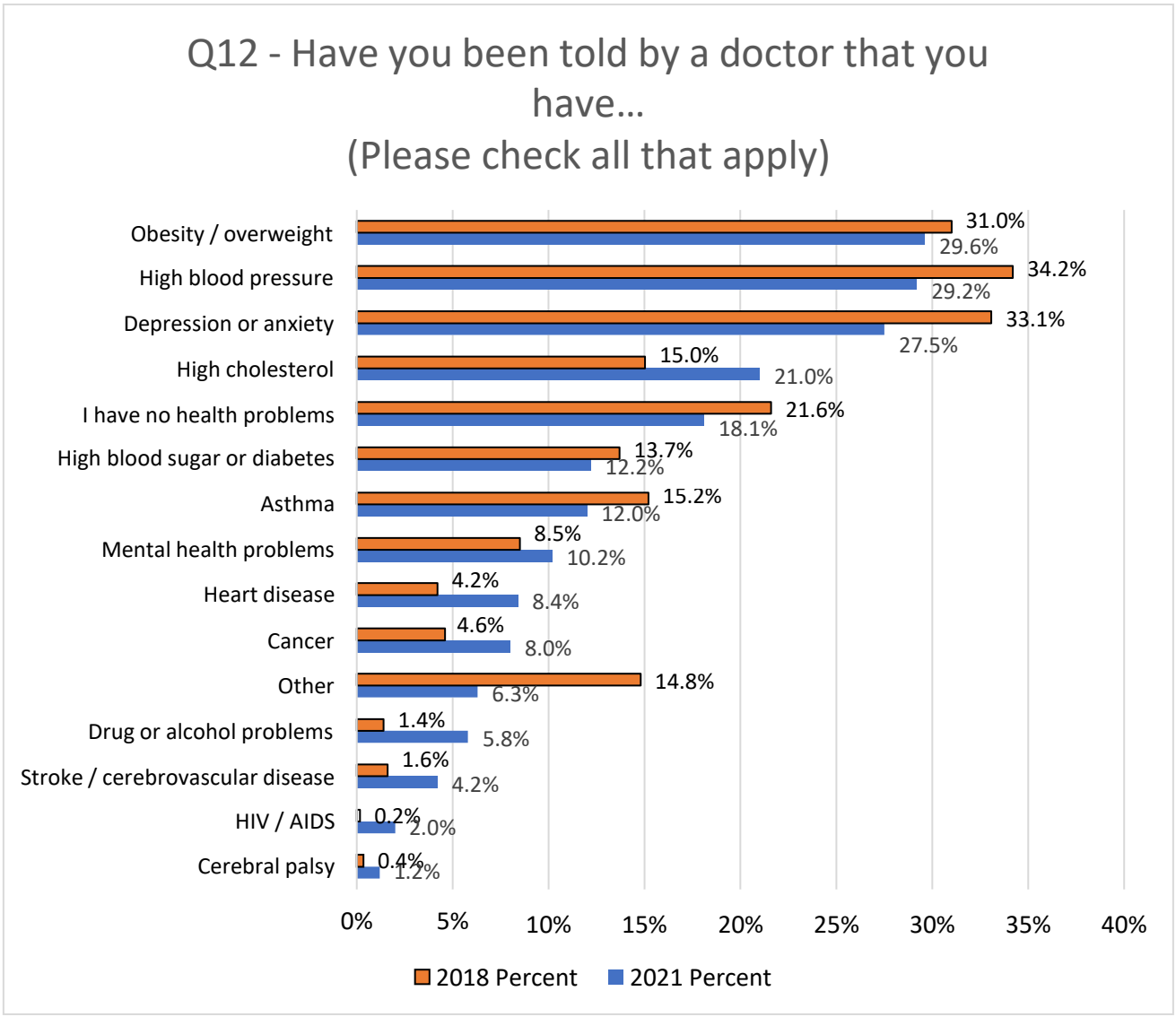
Q10. Other responses If yes, which mental health services do you use?		
Code	**Responses**	**Percent**
CMG Piedmont Psychiatry	4	14%
Doctor/counselors office	2	7%
Carilion	1	3%
Christian Counseling Services	1	3%
Employee Assistance Program	1	3%
Johnson Health Center	1	3%
Ortho Virginia	1	3%
Thrive works	1	3%
N/A	17	59%
Total	**29**	**100%**

In the Bedford region, 29 respondents chose "other" for their selection. Of these "other" responses, 4 or 14% said they used CMG Piedmont Psychiatry for mental health services, while 2 or 7% said they utilized a doctor or counselors office. A multitude of other responses were given and listed above.



	Percent	Responses
I have never used mental health, alcohol use, or drug use services for any reason	48.1%	394
Within the past year (1 to 12 months)	18.7%	153
Within the past 2 years (1 to 2 years ago)	11.1%	91
Within the past 5 years (2 to 5 years ago)	9.2%	75
5 or more years ago	11.2%	92
Within the past year I have chosen not to see a healthcare provider or have postponed or cancelled a visit because of COVID-19	1.7%	14
	Answered	**819**
	Skipped	**83**

Within the past year, 18.7% of respondents used mental health, alcohol use, or drug use services. An additional 1.7% of respondents did not seek services due to COVID-19. This question was not included in the previous 2018 Community Health Survey. The Substance Abuse & Mental Health Data Archive cites 18.6% of Virginians (age 18 or older) had "Any Mental Illness in 2018-19." (SAMHDA. Interactive NSDUH State Estimates. Substance Abuse & Mental Health Data Archive. Accessed July 14, 2021 at https://pdas.samhsa.gov/saes/state)


Q12 - Have you been told by a doctor that you have…
(Please check all that apply)
Obesity / overweight
High blood pressure
Depression or anxiety
High cholesterol
I have no health problems
High blood sugar or diabetes
Asthma
Mental health problems
Heart disease
Cancer
Other
Drug or alcohol problems
Stroke / cerebrovascular disease
HIV / AIDS
Cerebral palsy
31.0%
29.6%
34.2%
29.2%
33.1%
27.5%
15.0%
21.0%
21.6%
18.1%
13.7%
12.2%
15.2%
12.0%
8.5%
10.2%
4.2%
8.4%
4.6%
8.0%
14.8%
6.3%
1.4%
5.8%
1.6%
4.2%
0.2%
2.0%
0.4%
1.2%
0%
5%
10%
15%
20%
25%
30%
35%
40%
2018 Percent
2021 Percent

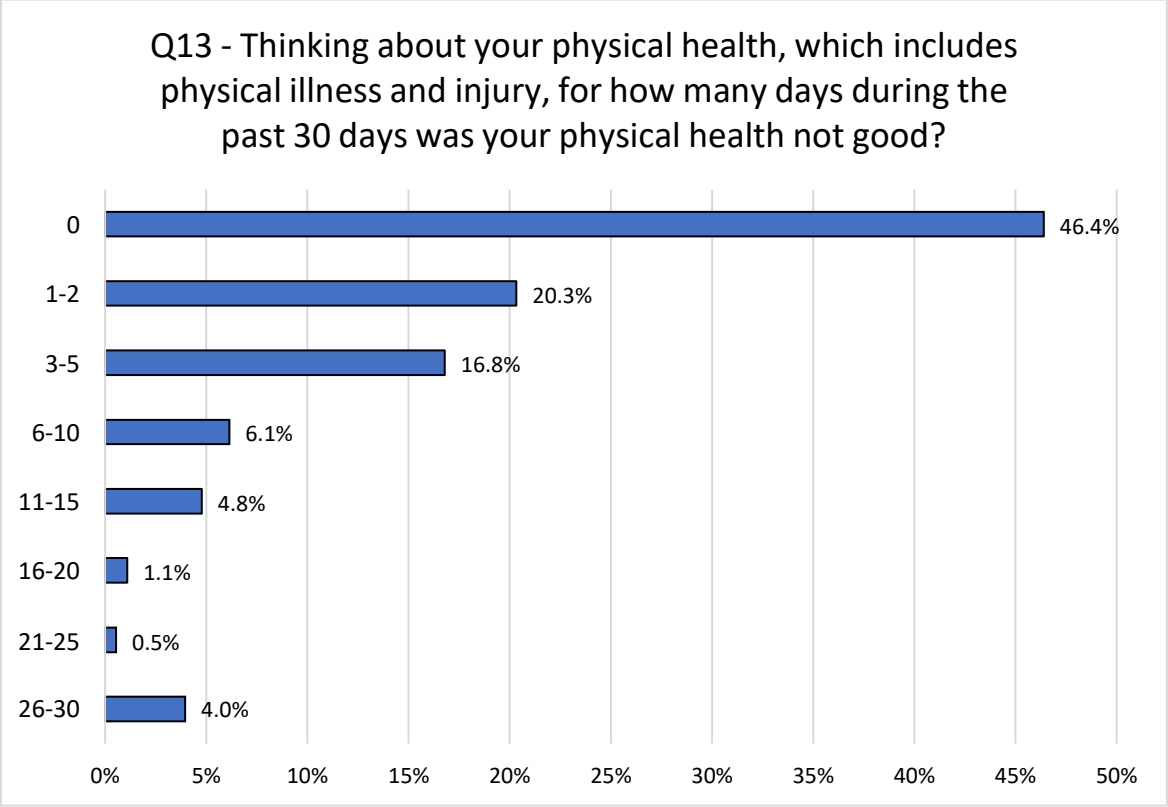
	2021 Percent	Responses
Obesity / overweight	29.6%	246
High blood pressure	29.2%	242
Depression or anxiety	27.5%	228
High cholesterol	21.0%	174
I have no health problems	18.1%	150
High blood sugar or diabetes	12.2%	101
Asthma	12.0%	100
Mental health problems	10.2%	85
Heart disease	8.4%	70
Cancer	8.0%	66
Other	6.3%	52
Drug or alcohol problems	5.8%	48
Stroke / cerebrovascular disease	4.2%	35
HIV / AIDS	2.0%	17
Cerebral palsy	1.2%	10
	Answered	**830**
	Skipped	**27**

When looking at the chart of responses regarding whether or not the respondent has been told by a doctor that they have a certain condition, the trend among disorders is largely consistent between 2018 and 2021. More respondents to the 2021 survey have been told that they have high cholesterol than in 2018 (21% in 2021 compared to 15% in 2018). Of particular note is the decreasein depression or anxiety (approximately 6%) from 2021 to 2018 although there was an uptick in those reporting they have mental health problems (10.2% in 2021, 8.5% in 2018) and/or drug or alcohol problems (5.8% in 2021, 1.38% in 2018).

Q12. Other responses Have Been Told by a Doctor that you have:		
Code	**Responses**	**Percent**
Arthritis	9	15%
Migraines	4	6%
Epilepsy/seizure disorder	3	5%
Osteoporosis	3	5%
Thyroid disorder/disease	3	5%
Autoimmune disease	2	3%
Diabetes	2	3%
Fibromyalgia	2	3%
Lupus	2	3%
Abnormal blood protein	1	2%
Attention Deficit Hyperactivity Disorder (ADHD)	1	2%
Allergies	1	2%
Angina	1	2%
Barrett's esophagus	1	2%
Blood pressure issues	1	2%
Cardiac/heart issues	1	2%
Chronic fatigue	1	2%
Chronic Obstructive Pulmonary Disease	1	2%
Chronic pain	1	2%
Crohn's Disease	1	2%
Endometriosis	1	2%
Gastroesophageal Reflux Disease	1	2%
Glaucoma	1	2%
Hashimoto's Thyroiditis	1	2%
Hypothyroidism	1	2%
Iron deficiency	1	2%
Kidney stones	1	2%
Multiple sclerosis	1	2%
Nerve damage	1	2%
Peripheral vertigo	1	2%
Reflux/indigestion	1	2%
Renal disease/disorder	1	2%
Sarcoidosis	1	2%
Scoliosis	1	2%
Sleep disorder	1	2%
Stroke	1	2%
Temporomandibular Joint (TMJ) disorder	1	2%
Tick-borne illness	1	2%
Vision impairment	1	2%

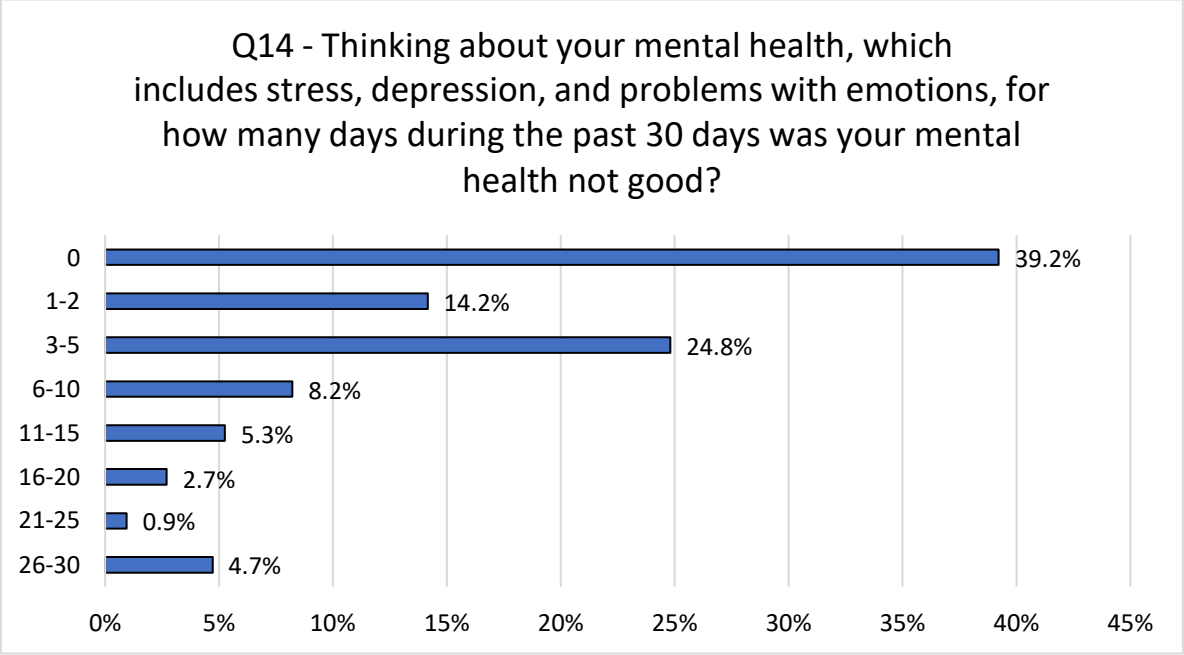
N/A	2	3%
Total	**62**	**100%**

In the Bedford regions, 62 respondents chose "other" for their selection. Of these "other" responses, 9 or 15% said they had been diagnosed with arthritis; while 4 or 6% said they have been diagnosed with migraines. Tied with 3 responses each or 5% are epilepsy/seizure disorder, osteoporosis, and thyroid disorder/disease. Many other items were listed and are shown in the table above.



Days	Percent	Responses
0	46.4%	340
1-2	20.3%	149
3-5	16.8%	123
6-10	6.1%	45
11-15	4.8%	35
16-20	1.1%	8
21-25	0.5%	4
26-30	4.0%	29
	Responses	**733**
	Skipped	**95**

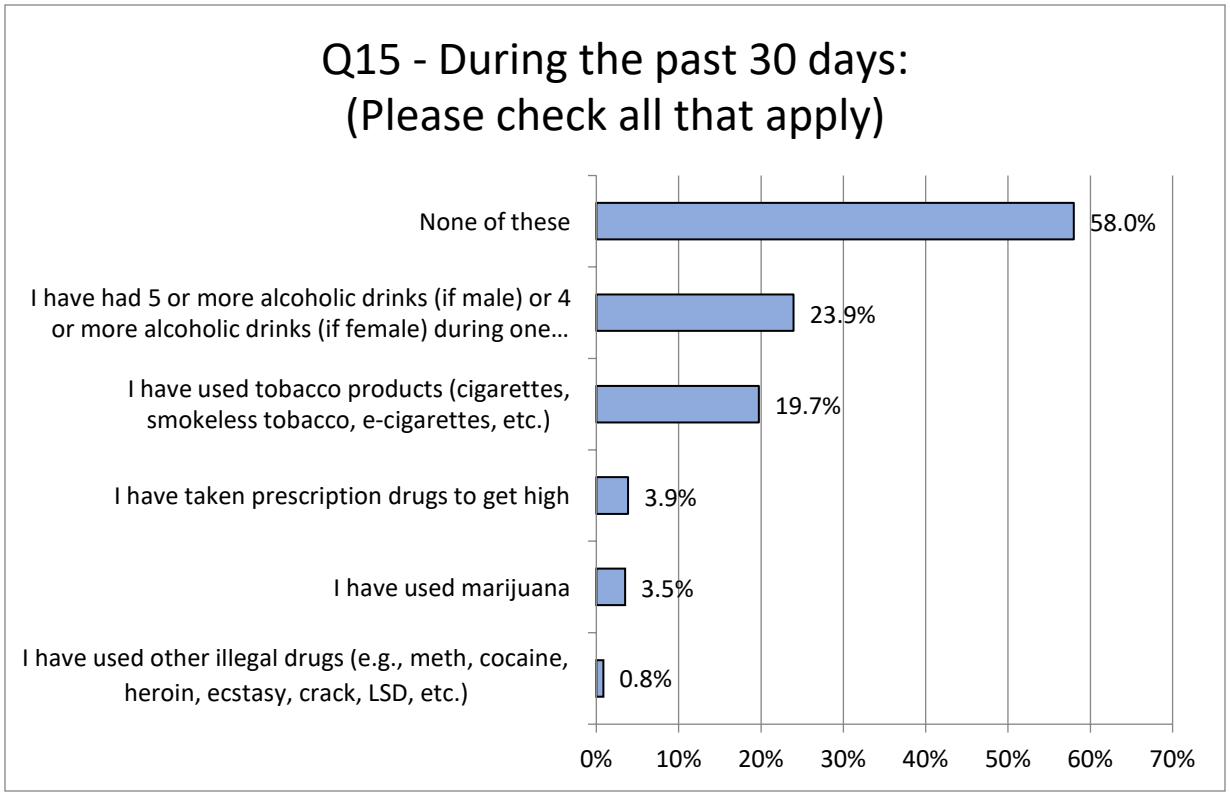
The 2021 assessment breaks out 2018's assessment from 0-5 days to 0 days, 1 to 2 days, and 3 to 5 days. Combined the number of persons who reported that their health was not good from 0 to 5 days was 78% in 2018 compared to 84% in 2021. The percentage of respondents indicating that their physical health was not good for 6 to 15 days decreased slightly in 2021 (10.9% in 2021 versus 12% in 2018); as did those reporting their health was not good 16 to 20 days (2.5% in 2018 and 1.1% in 2021) and 26 to 30 days (6.7% in 2018 to 4% in 2021). There was only a 0.5% change from the 2018 assessment to the 2021 assessment among respondents answering 21 to 25 days (0.5% in 2021 compared to 1% in 2018). Those reporting 26-30 days decreased in 2021 as compared to 2018 (4.0% and 6.7% respectively).



Days	Percent	Responses
0	39.2%	291
1-2	14.2%	105
3-5	24.8%	184
6-10	8.2%	61
11-15	5.3%	39
16-20	2.7%	20
21-25	0.9%	7
26-30	4.7%	35
	Responses	**742**
	Skipped	**98**

The percentage of 2021 respondents who felt their mental health was not good for 0-5 days (78.2%) and for 6-15 days (13.5%) increased slightly from 2018 (74.2% and 11.5% respectively). The impact of COVID-19 should be considered as a contributor to this increase. There were fewer respondents

reporting their mental health was not good more than 15 days in the last 30 days in 2021 (8.3%) as compared to 2018 (14.3%).

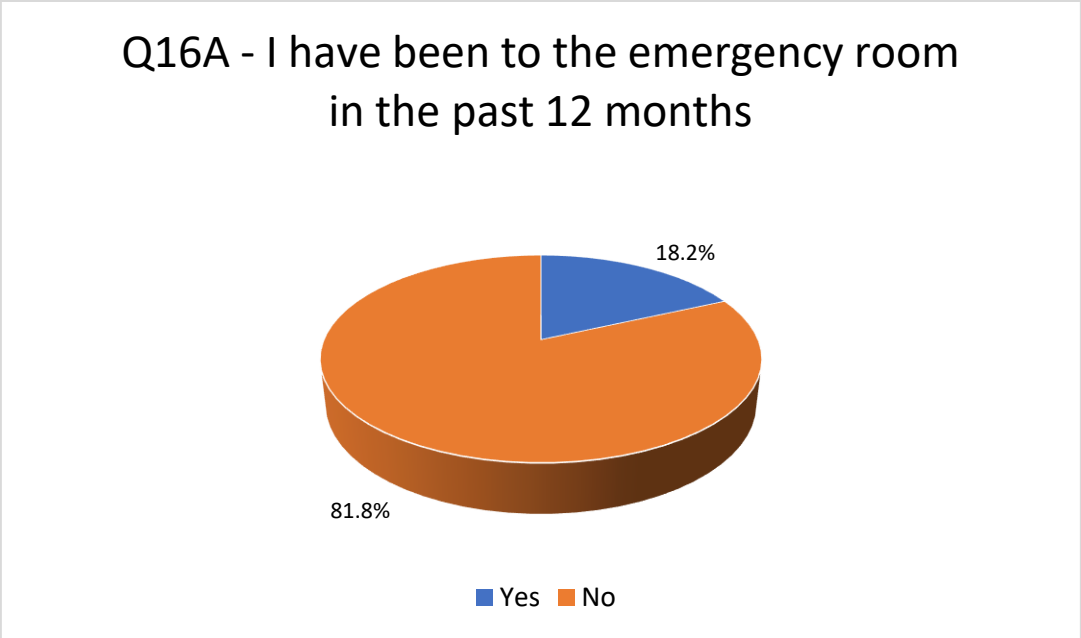


	Percent	Responses
None of these	58.0%	482
I have had 5 or more alcoholic drinks (if male) or 4 or more alcoholic drinks (if female) during one occasion	23.9%	199
I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)	19.7%	164
I have taken prescription drugs to get high	3.9%	32
I have used marijuana	3.5%	29
I have used other illegal drugs (e.g., meth, cocaine, heroin, ecstasy, crack, LSD, etc.)	0.8%	7
	Answered	**831**
	Skipped	**26**

There was a decrease in the number of respondents who indicated that they used tobacco products from 2018 (54%) to 2021 (19.7%). There was also a decrease in the number of persons who had had five or more alcoholic drinks for males or four or more for females during one occasion in the past 30 days (37.4% for 2018 respondents and 24% for 2021 respondents). More 2021 respondents indicated that they have taken prescription drugs to get high – approximately 4% in 2021 compared to just .8% in 2018.

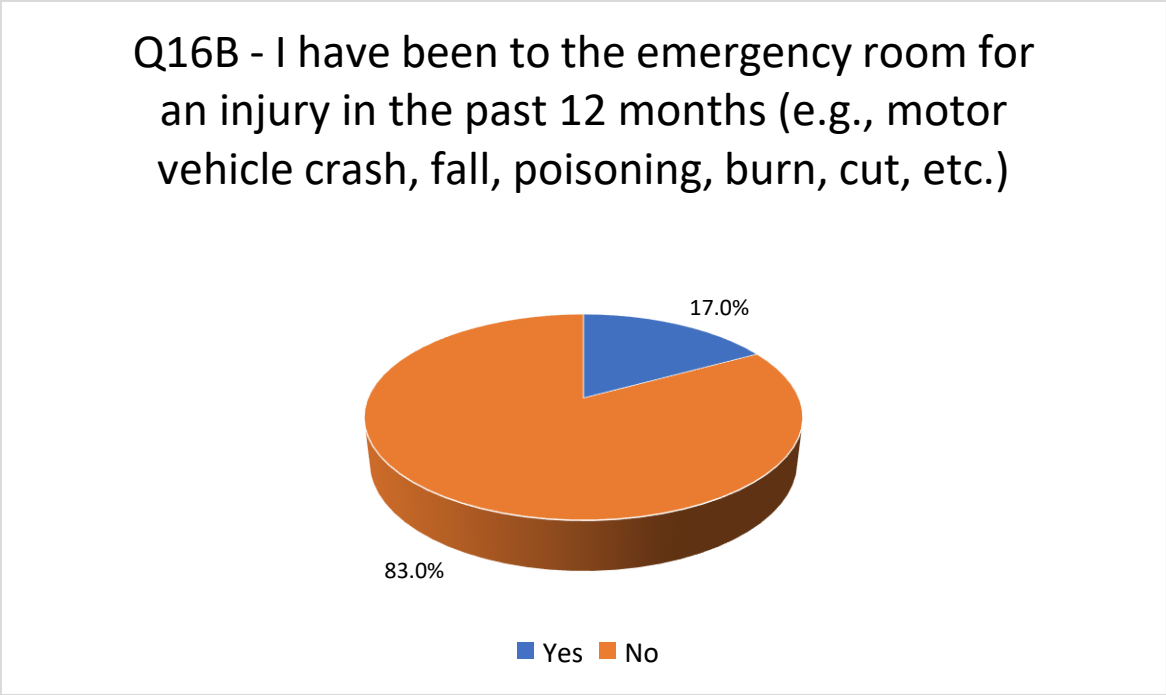
Those who used other illegal drugs (including marijuana) was 2.9% in 2018. In 2021, illegal drug use excluded marijuana with 0.8% of respondents reporting illegal drug use and 3.5% reporting having used marijuana. On July 1, 2021, recreational use of marijuana became legal in Virginia although retail sales will not begin until 2024.

Alcohol use disorder among Virginians 18 or older was 5.4% in 2018-2019 and illicit drug use other than marijuana in the past 30 days (2015 onward) among Virginians 18 and older was 2.9%. (SAMHDA. Interactive NSDUH State Estimates. Substance Abuse & Mental Health Data Archive. Accessed July 14, 2021 at https://pdas.samhsa.gov/saes/state)



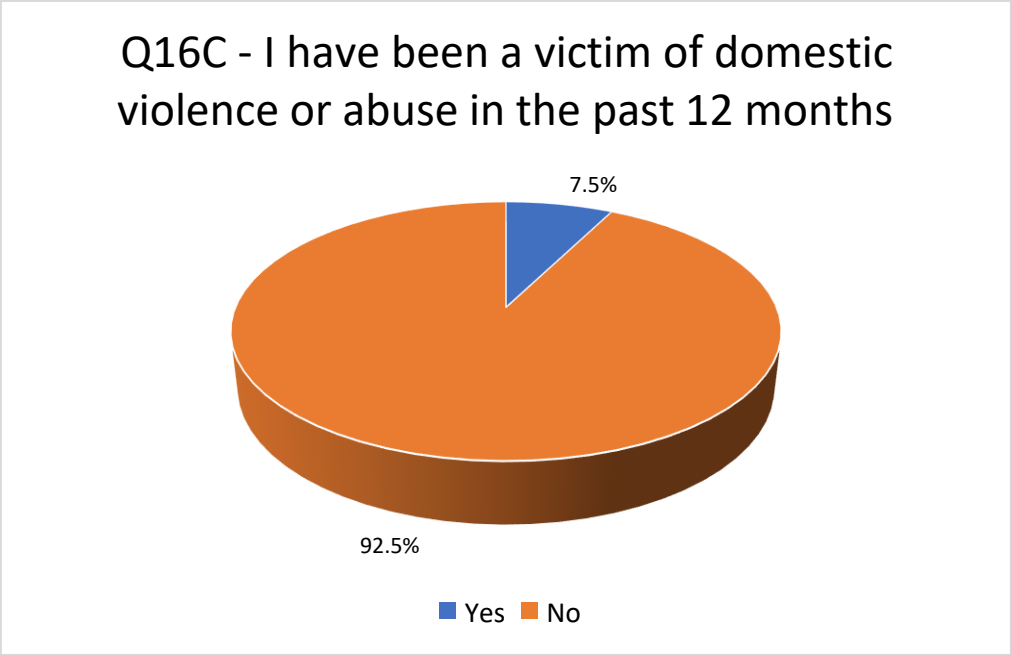
	Percent	Responses
Yes	18.2%	153
No	81.8%	686
	Answered	**839**
	Skipped	**18**

The number of respondents who indicated that they had been to the Emergency Room in the past 12 months decreased from 23.6% in 2018 to 18.2% in 2021. In 2019, approximately 22% of adults aged 18 and over had visited the ED in the past 12 months (Centers for Disease Control and Prevention. National Health Statistics. Emergency Department Visit Rates by Selected Characteristics: United States, 2018. Accessed July 19, 2021 at https://www.cdc.gov/nchs/products/databriefs/db401.htm).



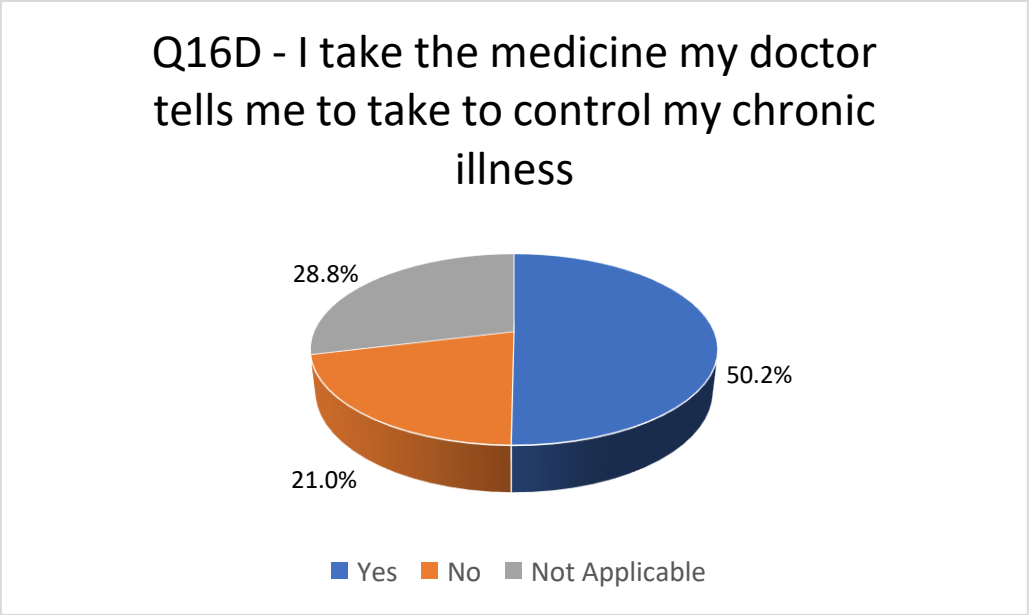
	Percent	Responses
Yes	17.0%	142
No	83.0%	692
	Answered	**834**
	Skipped	**23**

The number of respondents indicating that they had used the emergency room for an injury in the last 12 months doubled in 2021 (17%) than in 2018 (8.2%).



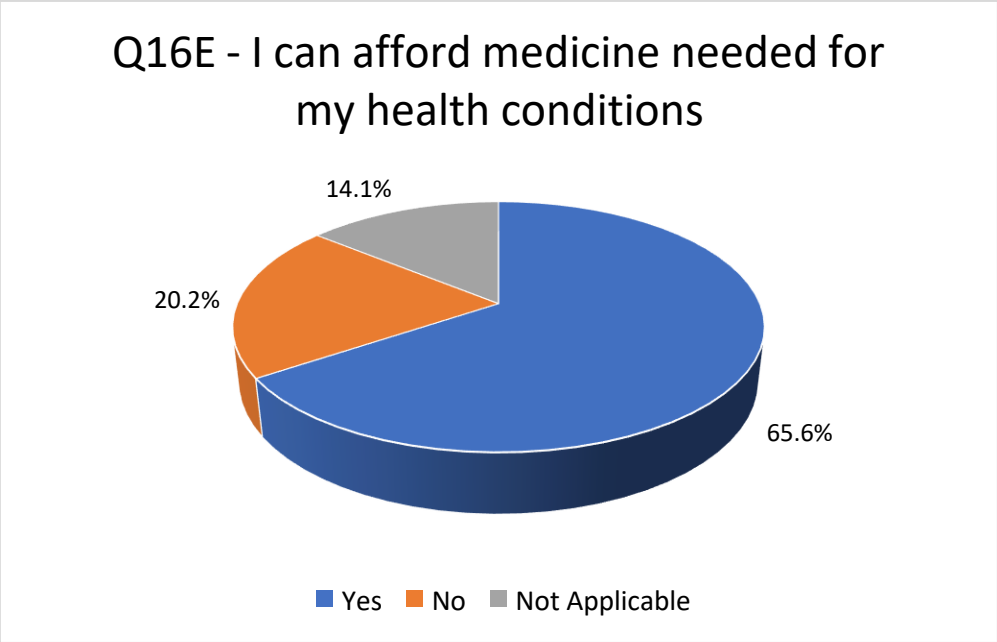
	Percent	Responses
Yes	7.5%	63
No	92.5%	775
	Answered	**838**
	Skipped	**19**

The number of respondents who reported that they had been victims of domestic violence in the last 12 months more than doubled from 2018 (2.8%) to 2021 (7.5%). These responses are likely under-reported. According to the World Population Review, domestic violence against women in Virginia is 33.6% and 28.6% against men (National Coalition Against Domestic Violence (2019). *Domestic violence in Virginia*. Accessed July 13, 2021, from www.ncadv.org/files/Virginia.pdf).



	Percent	Responses
Yes	50.2%	418
No	21.0%	175
Not Applicable	28.8%	240
	Answered	**833**
	Skipped	**24**

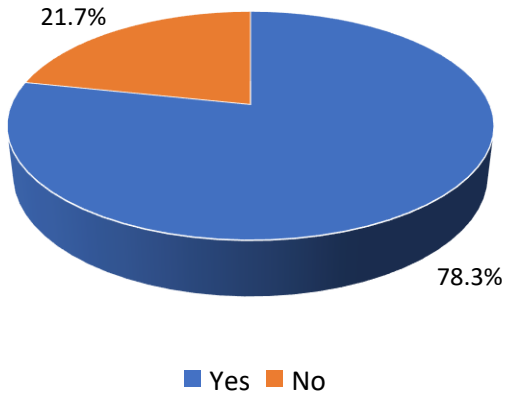
The number of respondents indicating that they take the medicine that their doctor tells them to take increased 14.6% from 36.4% in 2018 to 50.2% in 2021.



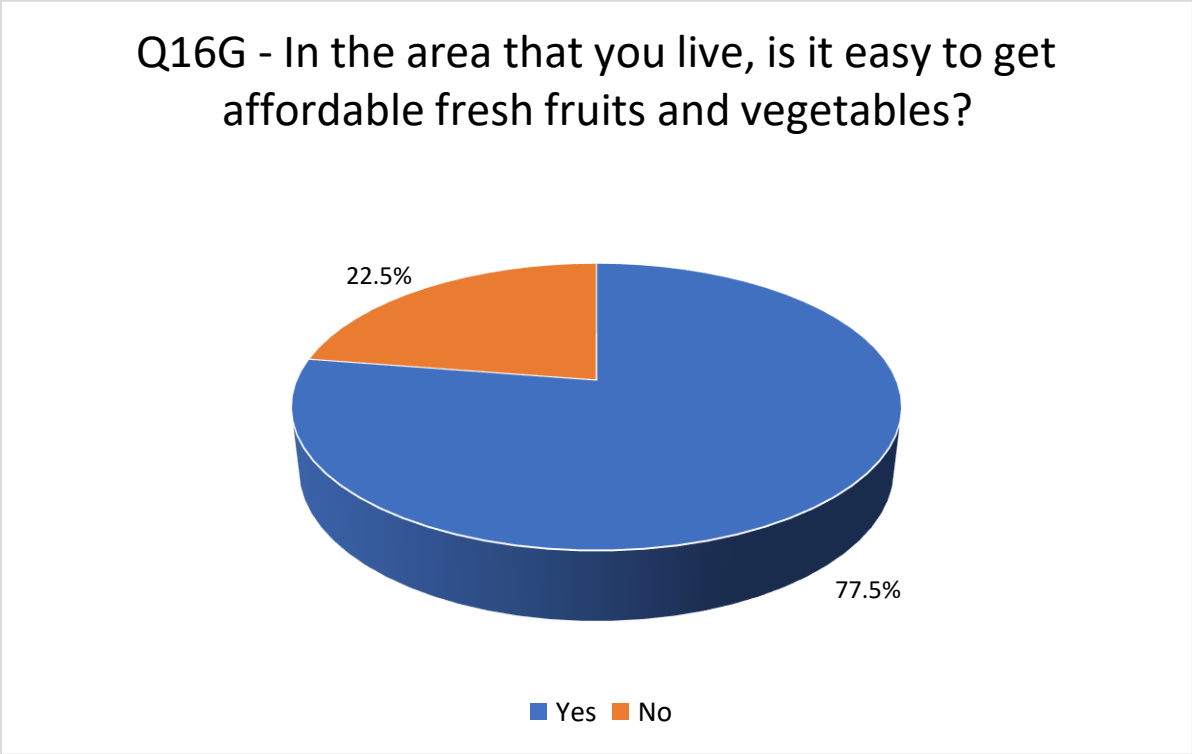
	Percent	Responses
Yes	65.6%	548
No	20.2%	169
Not Applicable	14.1%	118
	Answered	**835**
	Skipped	**31**

The number of respondents indicating that they can afford the medicine needed for their health conditions increased 10.4% from 55.2% in 2018 to 65.6% in 2021.

Q16F - Does your community support physical activity? (e.g., parks, sidewalks, bike lanes, etc.)

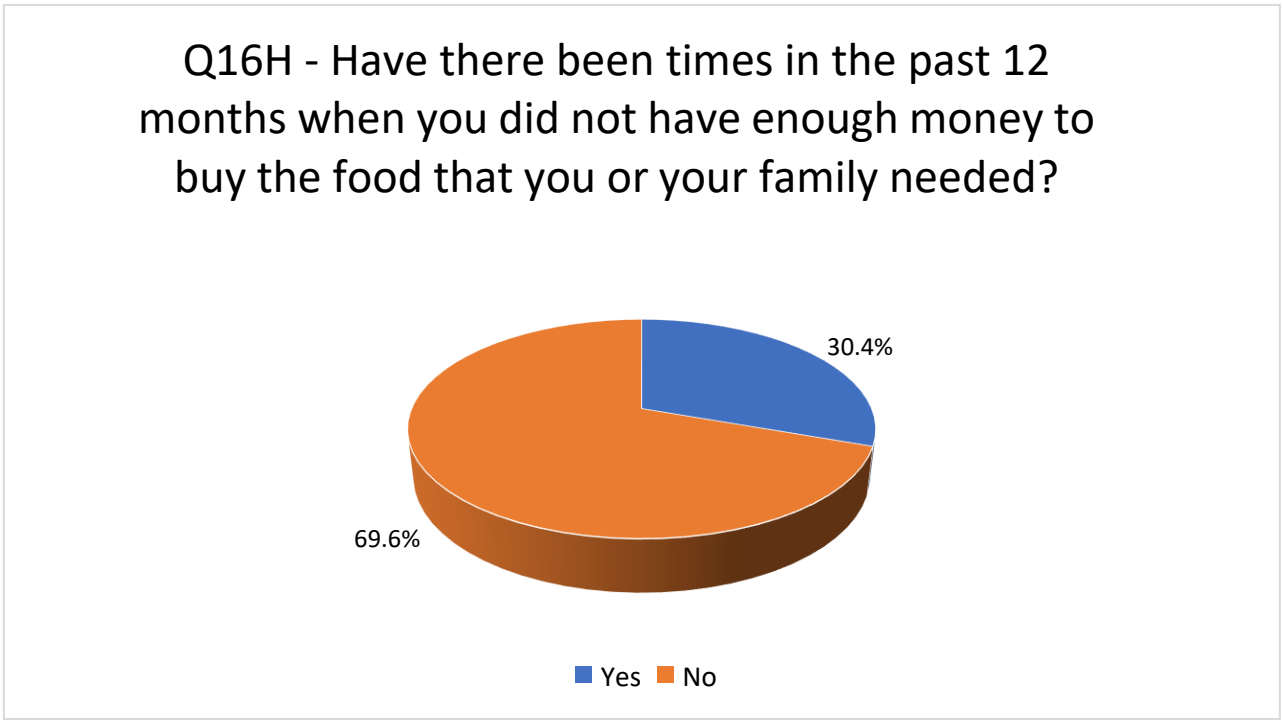


	Percent	Responses
Yes	78.3%	650
No	21.7%	180
	Answered	**830**
	Skipped	**27**



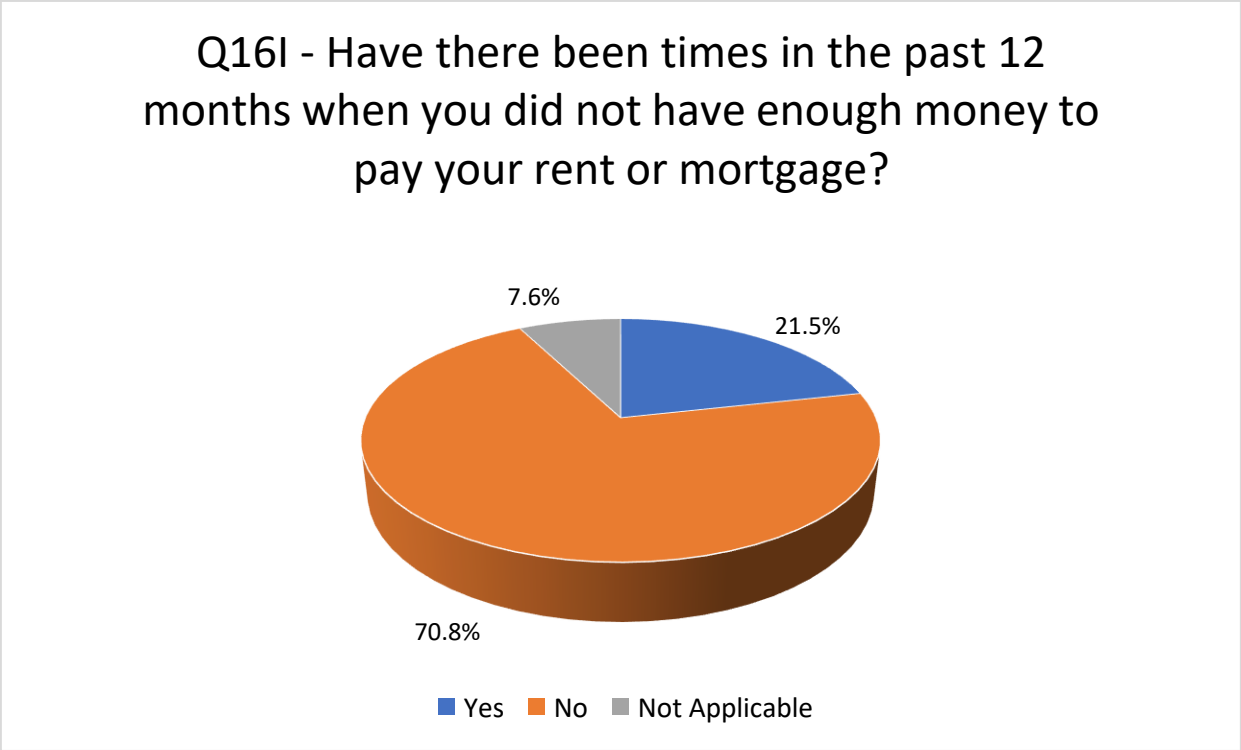
	Percent	Responses
Yes	77.5%	640
No	22.5%	186
	Answered	**826**
	Skipped	**23**

The number of respondents indicating that it was easy to get affordable fresh fruits and vegetables increased from 70.4% in 2018 to 77.5% in 2021. "According to the 2015—2020 Dietary Guidelines for Americans, healthy eating patterns include a variety of vegetables; fruits, especially whole fruits; grains, at least half of which are whole grains; fat-free or low-fat dairy; protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), unsalted nuts and seeds, and soy products; and oils. Some research has shown that increased access to healthy foods corresponds with healthier dietary practices." (U.S. Department of Health and Human Services, Office of Disease Prevention and Promotion. (January 2020). Access to Foods that Support Healthy Eating Patterns. Healthy People 2030. Accessed July 13, 2021, at https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/access-foods-support-healthy-eating-patterns).



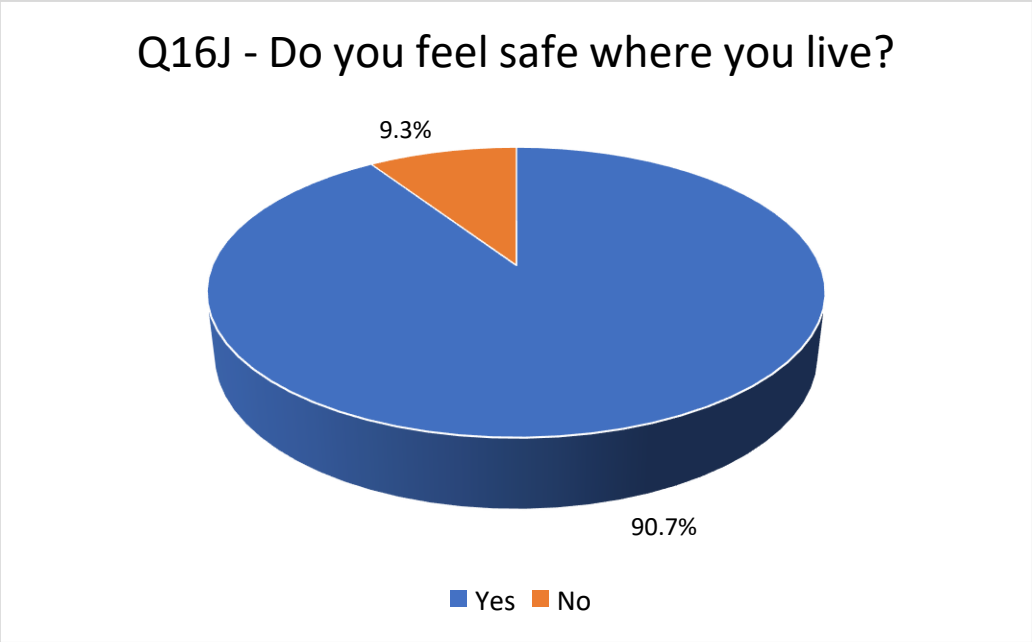
	Percent	Responses
Yes	30.4%	255
No	69.6%	583
	Answered	**838**
	Skipped	**19**

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 remained essentially the same from 2018 (29.4%) to 2021 (30.4%).



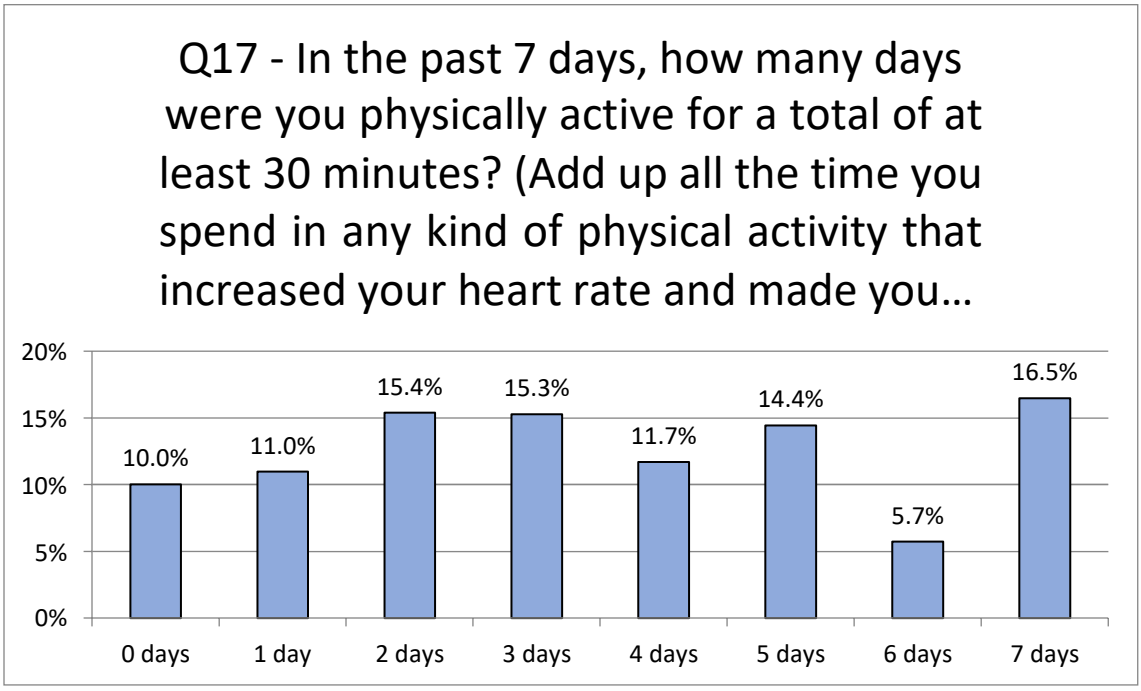
	Percent	Responses
Yes	21.5%	181
No	70.8%	595
Not Applicable	7.6%	64
	Answered	**840**
	Skipped	**13**

The percentage of respondents who did not have enough money in the past 12 months to pay rent or mortgage changed little from 2018 (22.5%) to 2021 (21.5%).



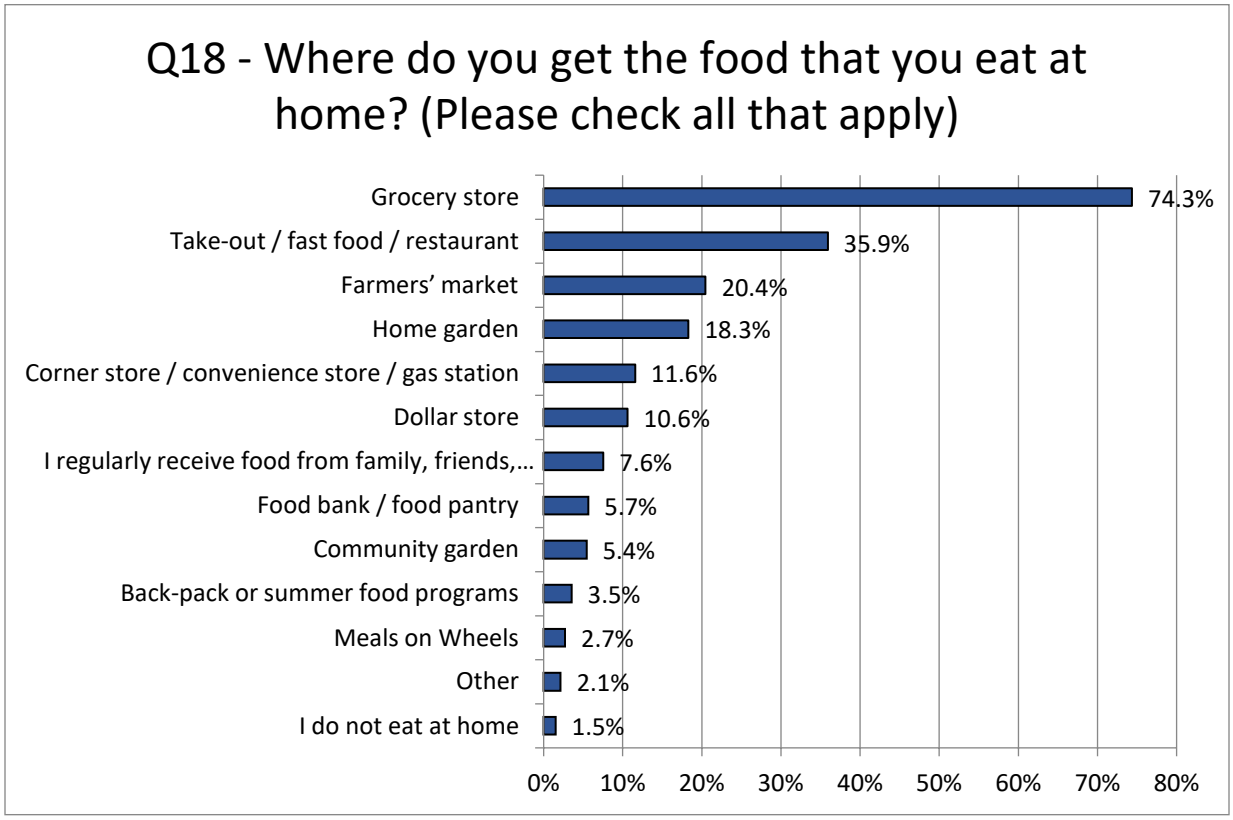
	Percent	Responses
Yes	90.7%	761
No	9.3%	78
	Answered	**839**
	Skipped	**19**

The number of respondents who felt safe where they live decreased slightly from 94% in 2018 to 91% in 2021.



	Percent	Responses
0 days	10.0%	84
1 day	11.0%	92
2 days	15.4%	129
3 days	15.3%	128
4 days	11.7%	98
5 days	14.4%	121
6 days	5.7%	48
7 days	16.5%	138
	Answered	**838**
	Skipped	**20**

The number of respondents who were physically active five or more days per week increased from 33.6% in 2018 to 36.6% in 2021. The number of respondents who were active three to four days per week fell slightly from 28.5% in 2018 to 27% in 2021. The number of respondents who were active one or two days per week increased slightly from 25.7% in 2018 to 26.4% in 2021.



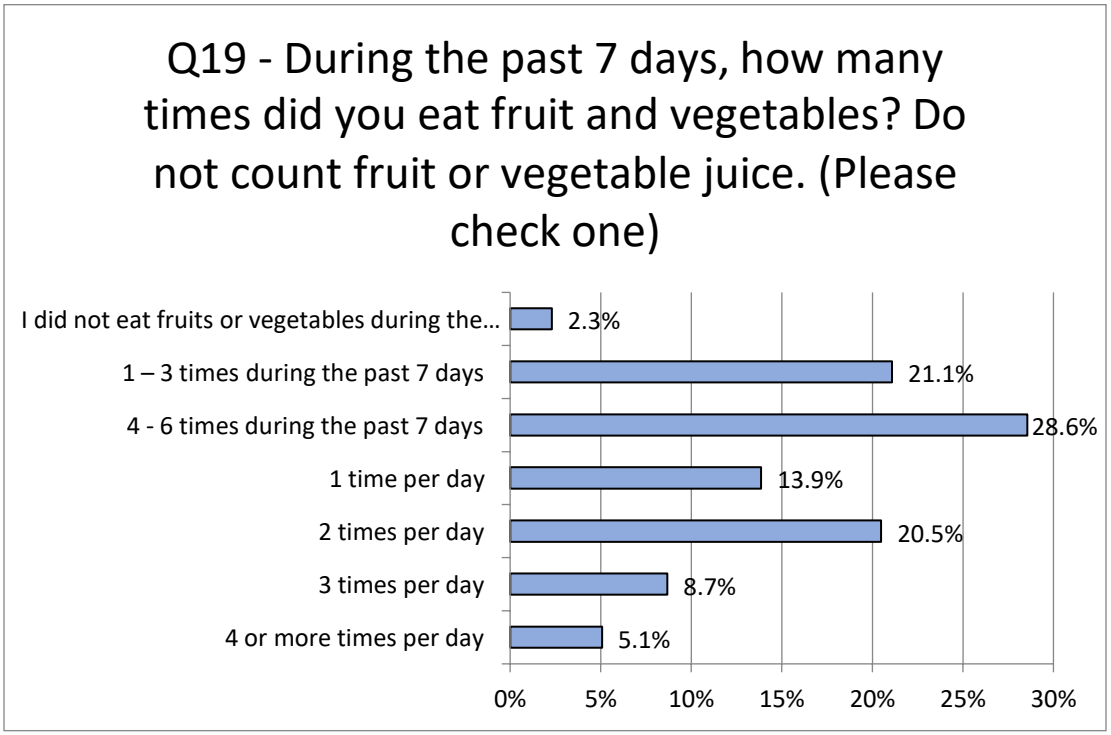
	Percent	Responses
Grocery store	74.3%	629
Take-out / fast food / restaurant	35.9%	304
Farmers' market	20.4%	173
Home garden	18.3%	155
Corner store / convenience store / gas station	11.6%	98
Dollar store	10.6%	90
I regularly receive food from family, friends, neighbors, or my church	7.6%	64
Food bank / food pantry	5.7%	48
Community garden	5.4%	46
Back-pack or summer food programs	3.5%	30
Meals on Wheels	2.7%	23
Other	2.1%	18
I do not eat at home	1.5%	13
If you chose 'Other' you can use the box below to specify		17
	Answered	**846**
	Skipped	**11**

Fewer respondents reported using the grocery store, take-out/fast food, farmer's market or home garden to get food in 2021 (74,3%, 35.9%, 20.4% and 18.3 % respectively) compared to 2018 (96.4%; 46.9%; 27.2%; 24.9% respectively). The percent of respondents getting food from dollar

stores in 2021 was less than half of those in 2018 (10.6% compared to 22.7%). In addition, the percent of 2018 respondents getting food from food banks or food pantries was almost triple the rate in 2021 (5.7% compared to 16.4%). There was an uptick in those reporting getting the food they eat at home from back-pack or summer food programs in 2021 (3.5%) compared to 2018 (2.8%) and from Meals on Wheels (2.7% in 2021, 0.6% in 2018).

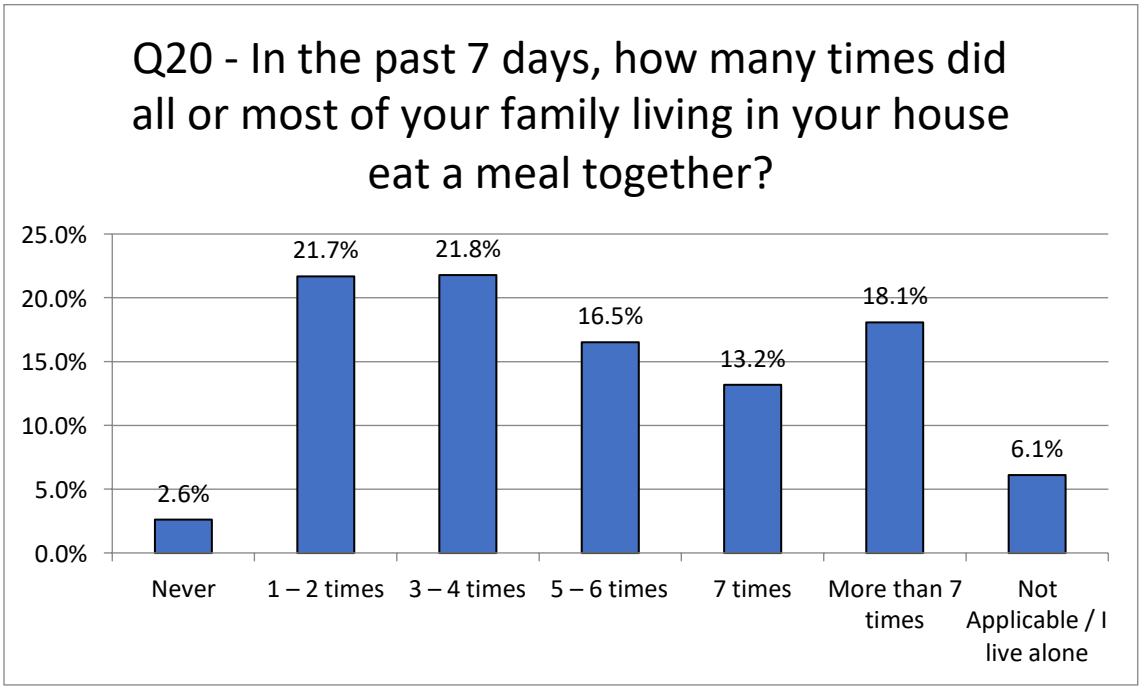
Q18. Other responses **Where do you get the food that you eat at home?**		
Code	**Responses**	**Percent**
Lake Christian ministries	7	41%
Food subscription/delivery service	4	24%
Grocery Store	2	12%
Flea market	1	6%
Dollar Store	1	6%
Personal farm	1	6%
Local farmer	1	6%
Total	**17**	**100%**

In the Bedford region, 17 respondents chose "other" for their selection. Of these "other" responses, 7 or 41% said they get their food from Lake Christian Ministries; 4 people or 24% said they get their food from a food subscription or delivery service; while 2 people or 16% said they got their food from the grocery store. Additional responses are shown above.



	Percent	Responses
I did not eat fruits or vegetables during the past 7 days	2.3%	19
1 – 3 times during the past 7 days	21.1%	175
4 - 6 times during the past 7 days	28.6%	237
1 time per day	13.9%	115
2 times per day	20.5%	170
3 times per day	8.7%	72
4 or more times per day	5.1%	42
	Answered	**830**
	Skipped	**27**

Approximately 48% of respondents ate fruit and vegetables on a daily basis. This is consistent with the response rate from the 2018 assessment, where 49% of respondents indicated that they ate fruits and vegetables daily. The federal fruit and vegetable recommendations vary by age and sex. Adult women need at least 1½ cups of fruit and 2½ cups of vegetables each day and adult men need at least 2 cups of fruit and 3½ cups of vegetables each day (Centers for Disease Control and Prevention. *Only 1 in 10 Adults Get enough Fruits and Vegetables*. Retrieved July 27, 2021 from https://www.cdc.gov/nccdphp/dnpao/division-information/media-tools/adults-fruits-vegetables.html). The CDC recommends learning more from the U.S. Department of Agriculture (USDA). The U.S. Department of Agriculture has created an online food plan recommendation based on a person's age, sex, and physical activity. The reader can access the food plan resource at https://www.myplate.gov/myplate-plan.

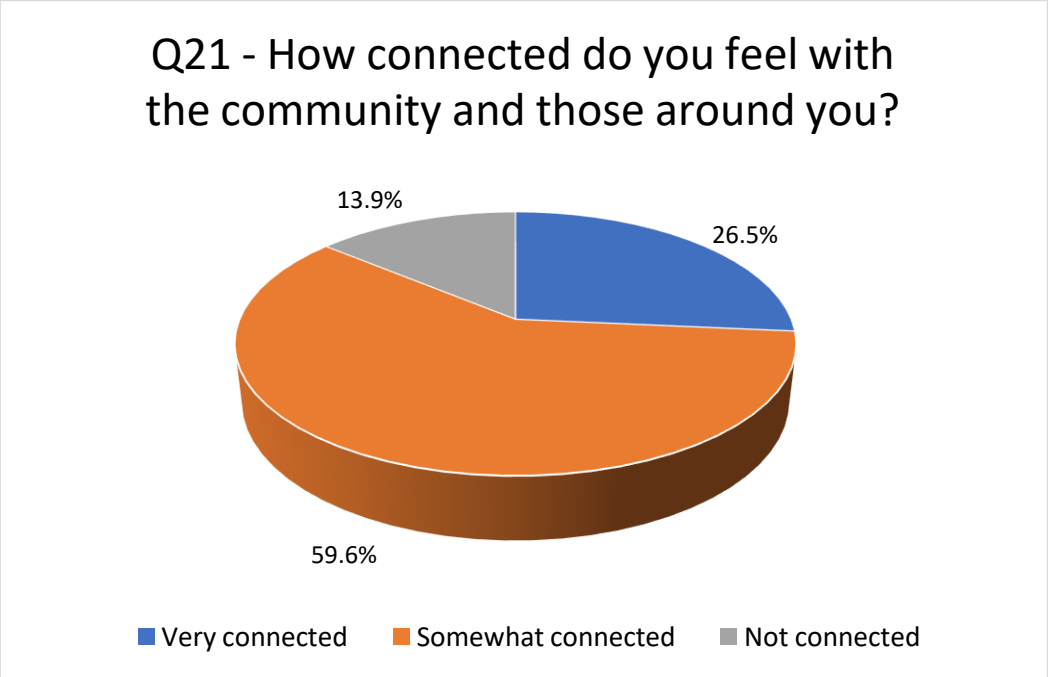


	Responses	Responses
Never	2.6%	22
1 – 2 times	21.7%	181
3 – 4 times	21.8%	182
5 – 6 times	16.5%	138
7 times	13.2%	110
More than 7 times	18.1%	151
Not Applicable / I live alone	6.1%	51
	Answered	**835**
	Skipped	**25**

In the Bedford Area, 38.3% of respondents ate together between three and six times a week. Those eating meals together seven or more times per week in 2021 was 31.3% compared to 35.2% in 2018.

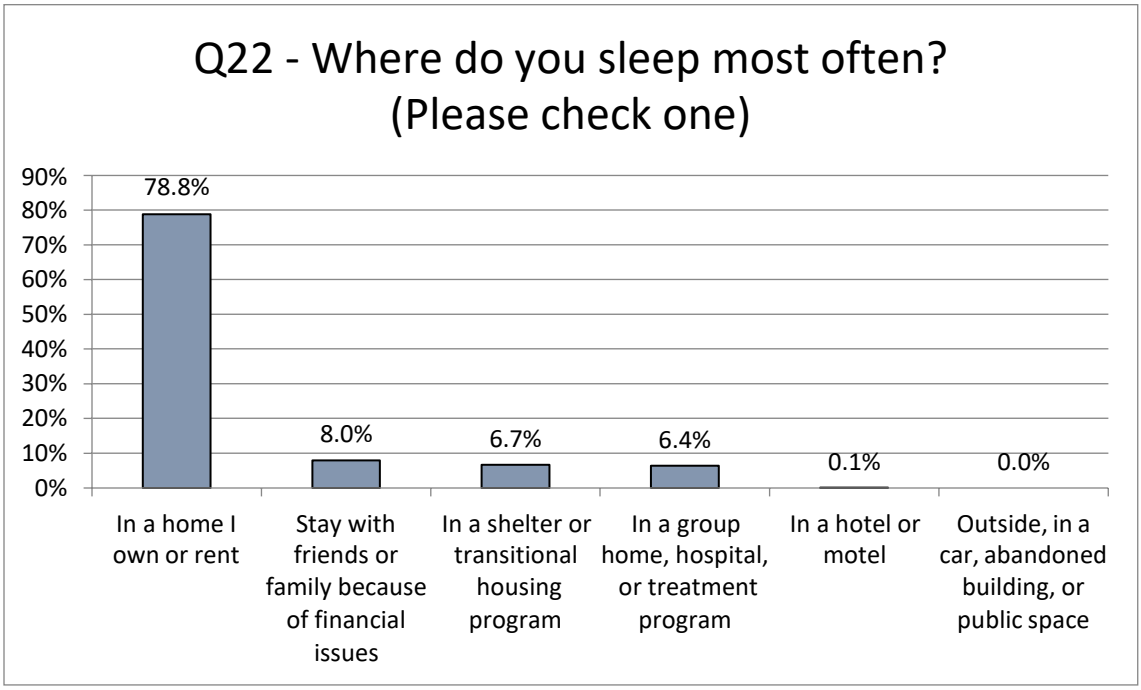
"Over the past three decades, family time at the dinner table and family conversation, in general, has declined by more than 30%. Families with children under age 18 report having family dinners three to four times per week. One third (33%) of families with 11 to 18-year-olds only eat one or two meals a week together. Only one fourth (25%) eat seven or more family meals per week. The experience at the meal table has also declined in quality with the increase in distractions, such as television watching, text messaging, phone conversations and social media. Barriers to family meals cited by parents include: too little time, child and adult schedule challenges, and food preparation. Most parents, however, say they place a high value on family meals, ranking them above every other activity (including vacations, playing together and religious services) in helping them connect with their families and children. Most wish they had more family dinners (American College of Pediatricians. *The Benefits of the Family Table.* (February 2021). Retrieved July 27, 2021 from https://acpeds.org/position-statements/the-benefits-of-the-family-table).

"Regular family dinners are associated with lower rates of depression, and anxiety, and substance abuse, and eating disorders, and tobacco use, and early teenage pregnancy, and higher rates of resilience and higher self-esteem. Kids who grow up having family dinners, when they're on their own tend to eat more healthily and to have lower rates of obesity." "Although it's interesting in affluent families, the numbers have gone up, and in low-income families they've gone down, which I think speaks to the extra stressors of having to work extra jobs, having unpredictable schedules, not having as much access to healthy food." Anderson, J. (Host) (2021, April 1). [Audio podcast transcription]. Harvard EdCast: The Benefit of Family Mealtime: Anne Fishel, Executive Director of the Family Dinner Project, helps families find fun, creative, and easy ways to make meals a reality. https://www.gse.harvard.edu/news/20/04/harvard-edcast-benefit-family-mealtime.



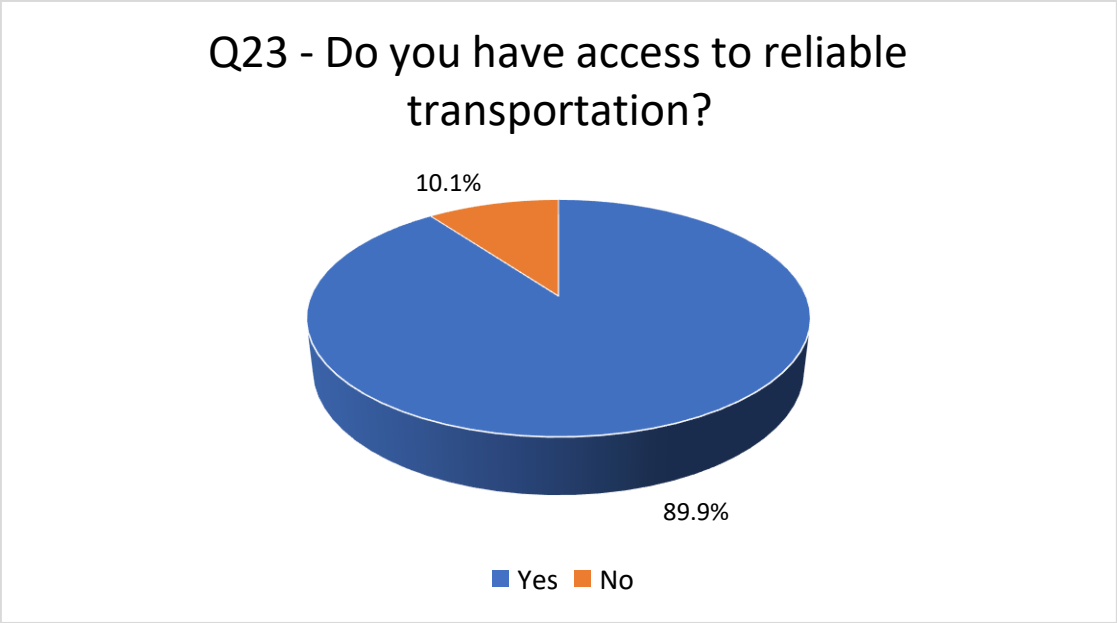
	Percent	Responses
Very connected	26.5%	222
Somewhat connected	59.6%	500
Not connected	13.9%	117
	Answered	**839**
	Skipped	**18**

The percentage of respondents who felt somewhat connected to the community and those around them increased slightly from 58.3% in 2018 to 59.6% in 2021. The number of respondents who felt very connected remained steady from 26.1% in 2018 to 26.5% in 2021. The number of respondents who felt not connected decreased to 14% in 2021 from 15.6% in 2021.



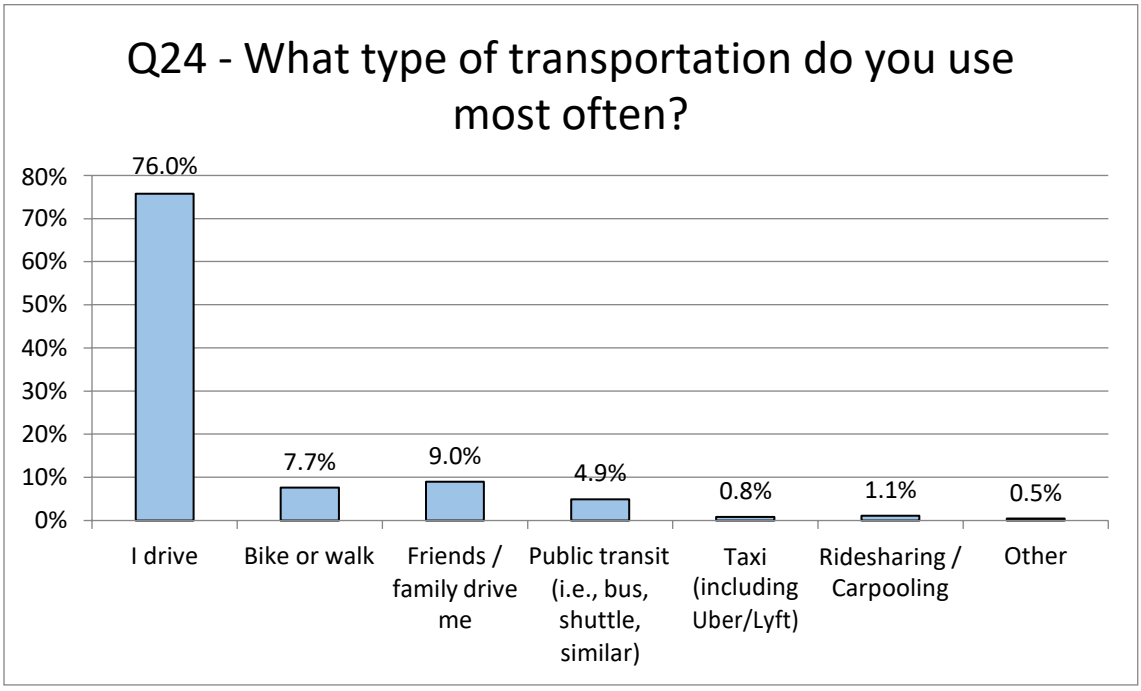
	Percent	Responses
In a home I own or rent	78.8%	663
Stay with friends or family because of financial issues	8.0%	67
In a shelter or transitional housing program	6.7%	56
In a group home, hospital, or treatment program	6.4%	54
In a hotel or motel	0.1%	1
Outside, in a car, abandoned building, or public space	0.0%	0
	Answered	**841**
	Skipped	**16**

In 2021, 79% of respondents slept most often in their own homes. The combined percentage of respondents that did not sleep in their own home and were not in a group home, hospital, or treatment program was 14.8%. "As of January 2020, Virginia had an estimated 5,957 experiencing homelessness on any given day, as reported by Continuums of Care to the U.S. Department of Housing and Urban Development (HUD)." As a percent, the rate of total homelessness in Virginia is 1.1%. (United States Interagency Council on Homelessness. (2021). *Virginia Homelessness Statistics.* Accessed July 13, 2021, at https://www.usich.gov/homelessness-statistics/va/)



	Percent	Responses
Yes	89.9%	754
No	10.1%	85
	Answered	**839**
	Skipped	**19**

Approximately 90% of respondents indicated that they had access to reliable transportation. This question was not a question on the 2018 assessment. However, the 2018 assessment included how many vehicles were owned, leased, or available for regular use by the respondent and those in their household. The percentage indicating zero (0) was 5.6%.

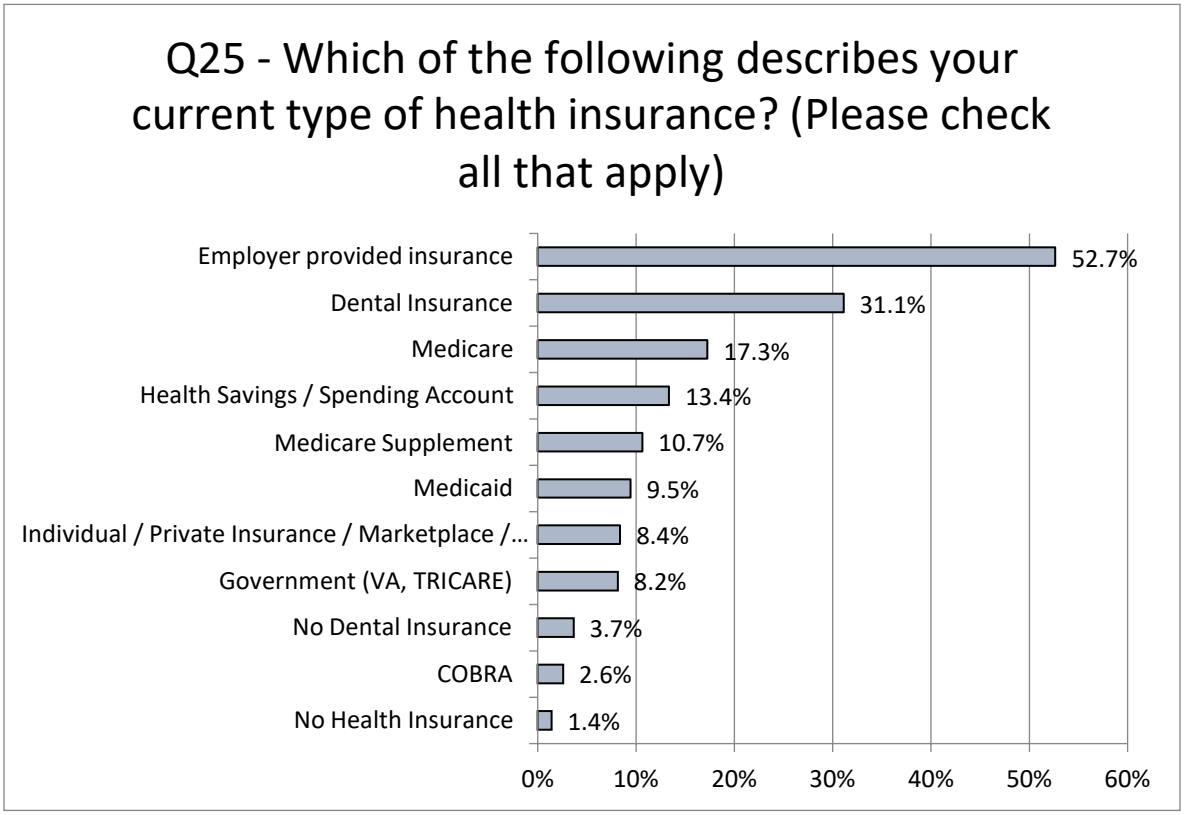


	Percent	Responses
I drive	76.0%	634
Bike or walk	7.7%	64
Friends / family drive me	9.0%	75
Public transit (i.e., bus, shuttle, similar)	4.9%	41
Taxi (including Uber/Lyft)	0.8%	7
Ridesharing / Carpooling	1.1%	9
Other	0.5%	4
	Answered	**834**
	Skipped	**23**

In 2021, 76% indicated that they drove. In 2018, 91.2% indicated that the mode of transportation that that they "typically used" was a car. In 2018 respondents were able to select multiple answers. This makes comparisons between the assessment years difficult. However, the number of 2021 respondents who indicated that they use public transportation increased to 5% from 1% in 2018.

Q24. Other responses What type of transportation do you use most often?		
Code	**Responses**	**Percent**
Health system- transport service	1	50%
Bedford Ride	1	50%
Total	**2**	**100%**

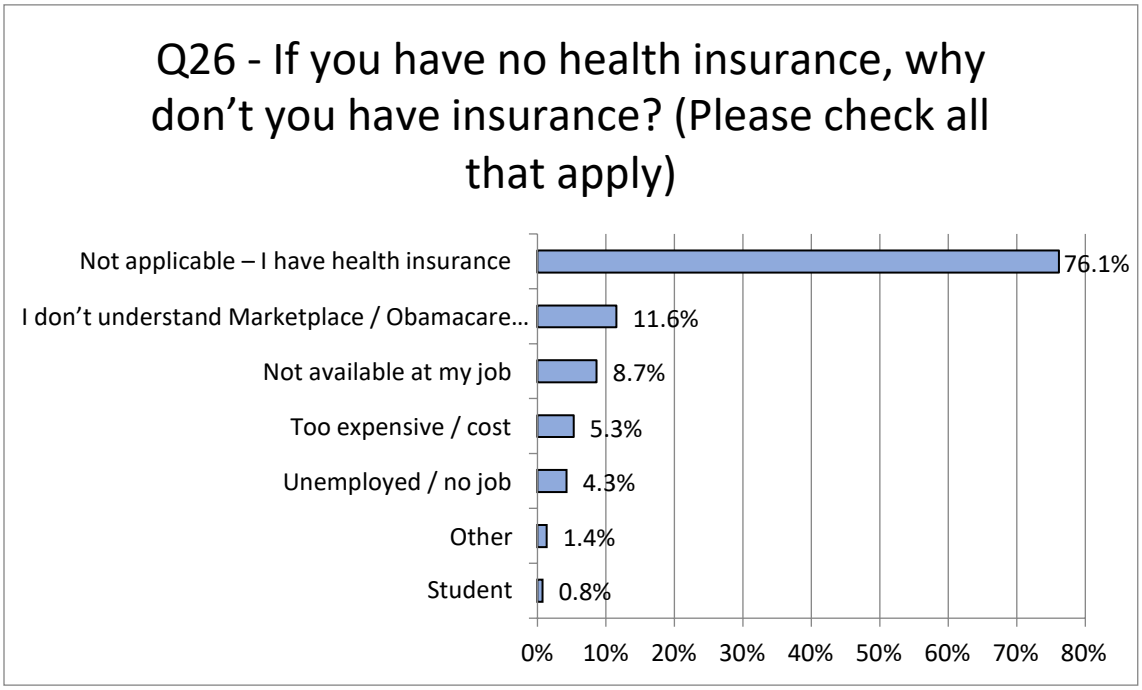
In the Bedford region, 2 respondents chose "other" for their selection. Of these "other" responses, 50% listed health system-transport service as their main source of transportation while the other 50% said the Bedford Ride program.



	Percent	Responses
Employer provided insurance	52.7%	445
Dental Insurance	31.1%	263
Medicare	17.3%	146
Health Savings / Spending Account	13.4%	113
Medicare Supplement	10.7%	90
Medicaid	9.5%	80
Government (VA, TRICARE)	8.2%	69
Individual / Private Insurance / Marketplace / Obamacare	8.4%	71
No Dental Insurance	3.7%	31
COBRA	2.6%	22
No Health Insurance	1.4%	12
	Answered	**845**
	Skipped	**12**

More respondents in 2018 indicated that they had employer provided insurance than in 2021 (59% in 2018 compared to 53% in 2021). The number of respondents indicating that they had no

insurance fell dramatically from 10% in 2018 to just 1.4% in 2021. The number of respondents indicating that they had a health savings or spending account remained the same at 13.4%. Respondents in 2021 indicating that they had either Medicare and a Medicare supplement increased to 28% from 19.3% in 2018. Fewer respondents reported having Medicaid in 2021 (9.5%) as compared to 2018 (12.9%); no dental insurance (3.7% in 2021 compared to 12.3% in 2018); or no health insurance (1.4% in 2021 compared to 9.9% in 2018).

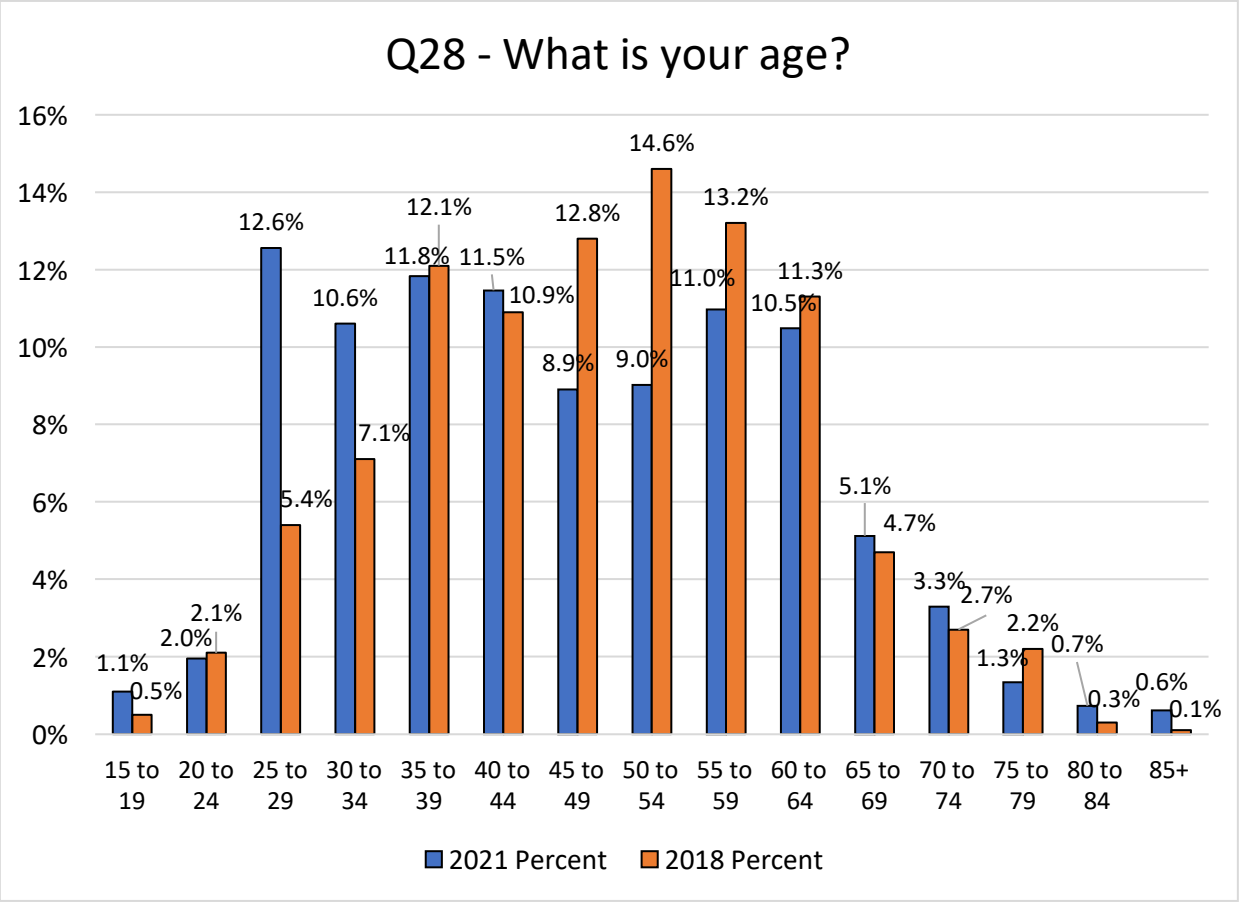


	Percent	Responses
Not applicable – I have health insurance	76.1%	501
I don't understand Marketplace / Obamacare options	11.6%	76
Not available at my job	8.7%	57
Student	0.8%	5
Too expensive / cost	5.3%	35
Unemployed / no job	4.3%	28
Other	1.4%	9
	Answered	**658**
	Skipped	**199**

The number of respondents indicating that health insurance was too expensive in 2018 was over double the number in 2021 (13.6% compared to 5.3% in 2021). The number of unemployed/no job respondents in 2018 was also more than double the percentage of responses in 2021 (9% compared to 4.3%). More 2021 respondents indicated that health insurance was not available at their job (8.7%) than 2018 respondents (3%) and exponentially more reported not understanding the Marketplace/Obamacare in 2021 (11.6%) compared to 2018 (1.1%).

Q26. Other responses If you have no health insurance, why don't you?		
Code	**Responses**	**Percent**
Shared plan	1	25%
N/A	3	75%
Total	**4**	**100%**

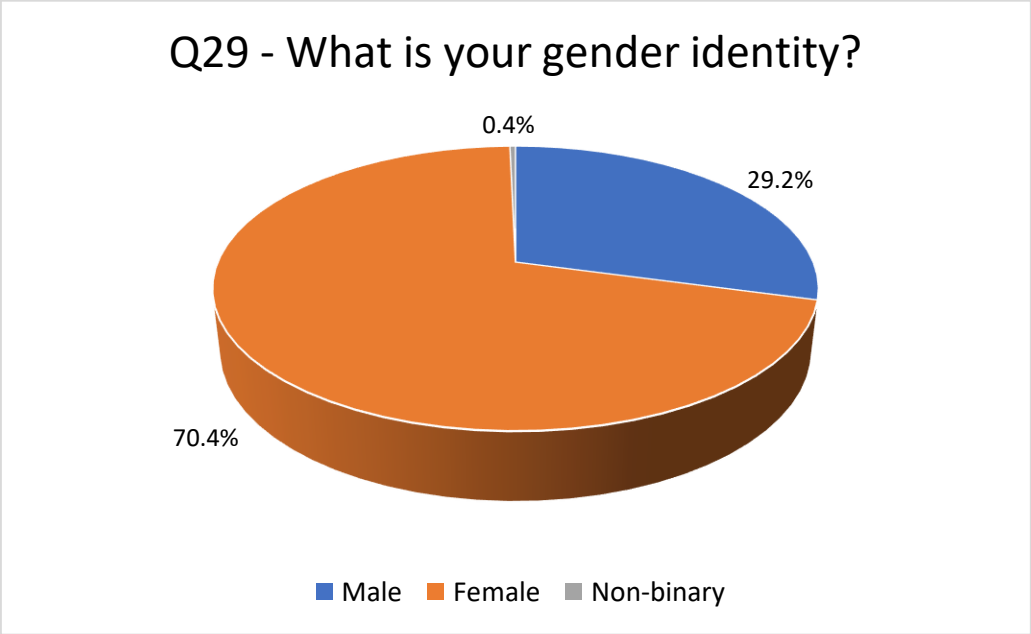
In the Bedford region, 4 respondents chose "other" for their selection. Of these "other" responses, 25% said they didn't have health insurance because they were on a shared plan.


Q28 - What is your age?
16%
14%
12%
10%
8%
6%
4%
2%
0%
1.1%
0.5%
2.0%
2.1%
12.6%
5.4%
10.6%
7.1%
11.8%
12.1%
11.5%
10.9%
8.9%
12.8%
9.0%
14.6%
11.0%
13.2%
10.5%
11.3%
5.1%
4.7%
3.3%
2.7%
1.3%
2.2%
0.7%
0.3%
0.6%
0.1%
15 to 19
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50 to 54
55 to 59
60 to 64
65 to 69
70 to 74
75 to 79
80 to 84
85+
2021 Percent
2018 Percent

Age	2021 Percent	2018 Percent
15 to 19	1.1%	0.5%
20 to 24	2.0%	2.1%
25 to 29	12.6%	5.4%
30 to 34	10.6%	7.1%
35 to 39	11.8%	12.1%
40 to 44	11.5%	10.9%
45 to 49	8.9%	12.8%
50 to 54	9.0%	14.6%
55 to 59	11.0%	13.2%
60 to 64	10.5%	11.3%
65 to 69	5.1%	4.7%
70 to 74	3.3%	2.7%
75 to 79	1.3%	2.2%
80 to 84	0.7%	0.3%
85+	0.6%	0.1%
Answered	**820**	
Skipped	**35**	

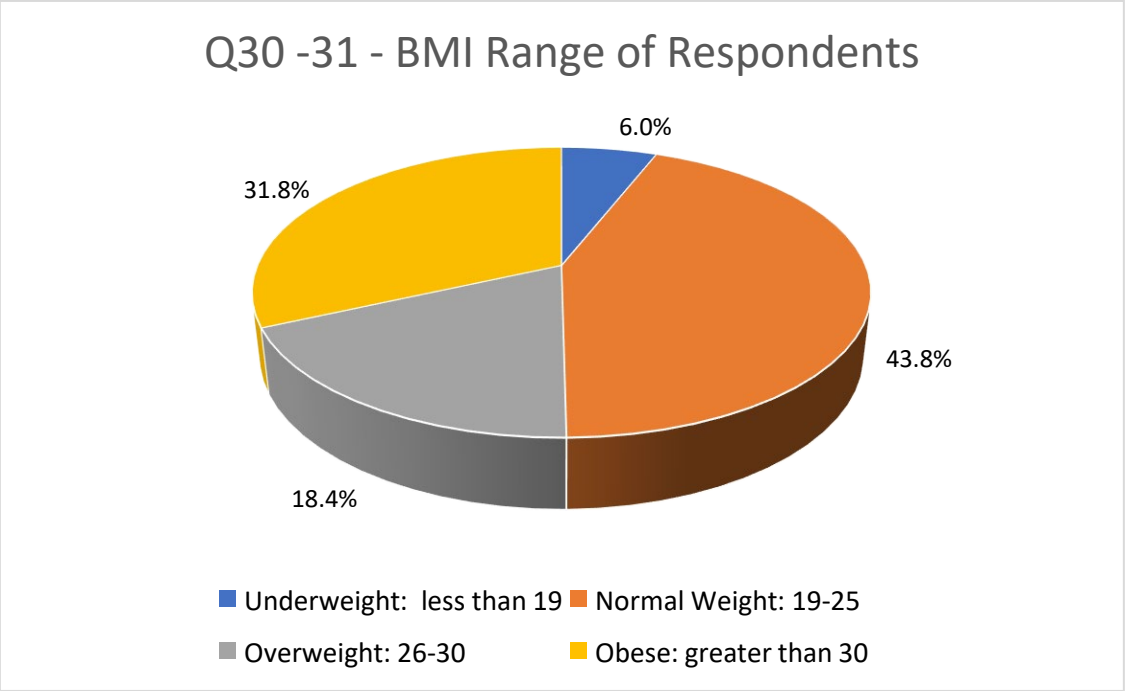
Mean Age	46
Median Age	45
Age Range	16 - 87

The percentage of respondents age 20 to 65 in 2021 was 87.8% in 2021 and 89.5% in 2018. The rate of respondents age 65 and older was 11% in 2021 and 10% in 2018. The average and median age in 2021 (46 and 45 years) was slightly lower than in 2018 (48.6 and 49.0 years). With a few exceptions, the percent of respondents in each age category remained consistent between assessments.



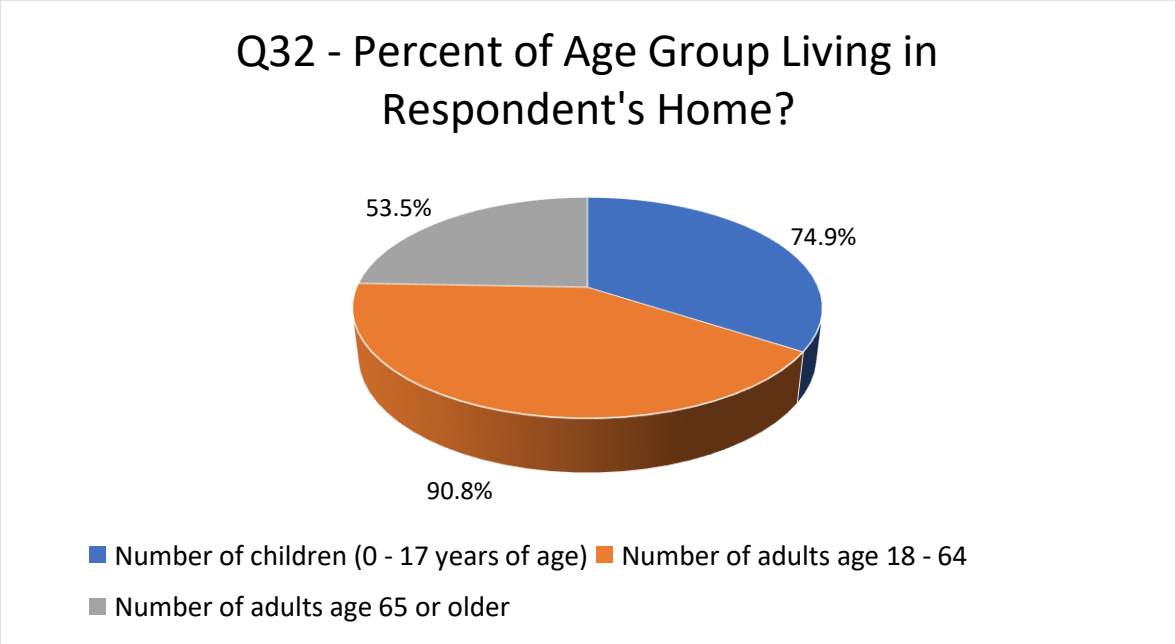
	Percent	Responses
Male	29.2%	244
Female	70.4%	588
Non-binary	0.4%	3
Other	0.0%	0
	Answered	**835**
	Skipped	**22**

The number of male respondents increased from 17.3% in 2018 to 29% in 2021. Males represent 47% of the service area's population. Virginia's male population is 49.2% of the overall population.



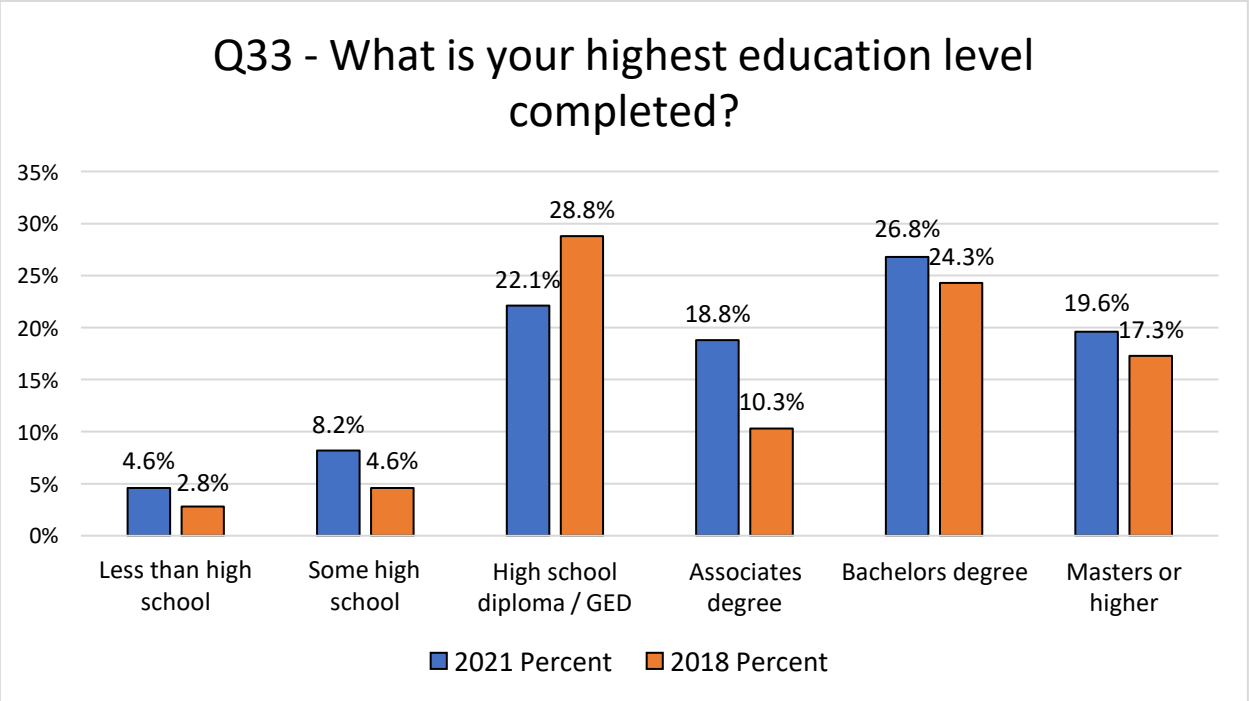
BMI Range	Percent	Frequency
Underweight: less than 19	6.0%	42
Normal Weight: 19-25	43.8%	309
Overweight: 26-30	18.4%	130
Obese: greater than 30	31.8%	224
	100.0%	**705**

The number of respondents whose BMI fell into the obese range decreased from 43% in 2018 to 31.8% in 2021. The number of Virginians that are obese was 31.9% in 2019 (United Health Foundation. America's Health Rankings. Annual Report. Accessed July 15, 2021, at https://www.americashealthrankings.org/explore/annual/measure/Obesity/state/VA). The respondents who are overweight remained stable. The decrease in obesity among respondents may be due to the higher percentage of male respondents. In Virginia, the female obesity rate in 2019 was 34.2%, while the male obesity rate was 29.6% (United Health Foundation). The number of respondents who were overweight in 2018 was 24% compared to 18.4% in 2021. Respondents with a normal BMI range in 2021 was approximately 44% compared to 28% in 2018. Please note that the respondents self-reported their height and weights.



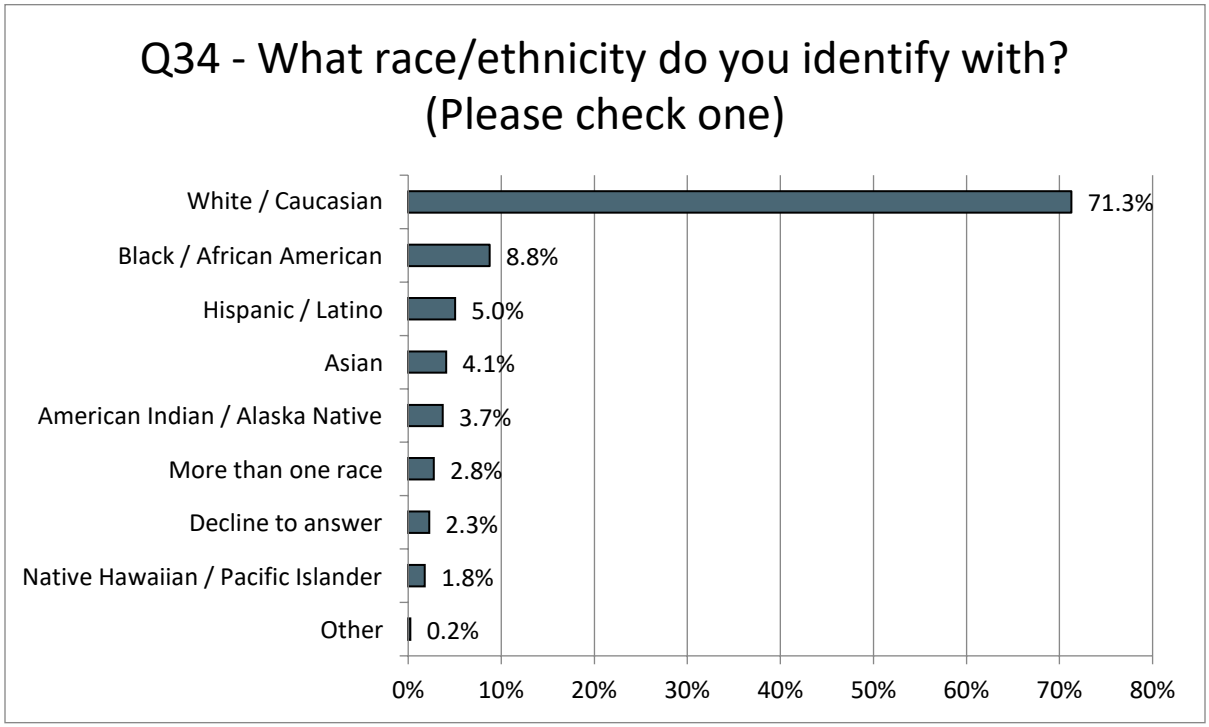
	Percent	Responses	Avg. Number in Home
Number of children (0 - 17 years of age)	74.9%	613	3.3
Number of adults age 18 - 64	90.8%	743	
Number of adults age 65 or older	53.5%	438	
	Answered	**818**	
	Skipped	**28**	

There was some mild variation from 2018 to 2021 in response percentage for the number of people living in the respondent's home by age group. The number of respondents who had one or more children age 0 to 17 was 67% in 2018 compared to 75% in 2021. The number of adults living in the respondents' homes remained consistent (91.5% in 2018 and 90.8% in 2021). The number of adults age 65 or older increased in 2021 to 53.5% from 36.3% in 2018. The average number in the home was 3.3, while the service area average household size was 2.5 (U.S Census. American Community Survey, 2019: ACS 5-Year Estimates Subject Tables. Households and Families. Table S1101. Accessed July 15, 2021, at https://data.census.gov/).



	Percent	Responses
Less than high school	4.6%	38
Some high school	8.2%	68
High school diploma / GED	22.1%	184
Associates degree	18.8%	157
Bachelor's degree	26.8%	223
Masters or higher	19.6%	163
	Answered	**833**
	Skipped	**24**

The number of respondents indicating that they had a degree (Associates – Masters or higher) was 65.2% in 2021. This is a 13.3% increase over 2018 due mainly to the difference among respondents with an Associates degree (18.8% in 2021 compared to 10.3% in 2018). The percent of 2018 respondents indicating that they had less than a high school diploma or GED was 7.4% compared to 12.8% in 2021. For persons age 25 and over residing in the Bedford Area, 10% had less than a high school education or equivalence in Bedford County compared to 19.1% in the town of Bedford (U.S. Census). Those who had graduated from high school or equivalency was 30.2% in the County and 31.2% in the Town of Bedford (U.S. Census), higher than the 2021 respondent rate. The percentage of persons in the service area with a Bachelor's Degree or higher was 29.2% in Bedford County and 17.6% in the Town of Bedford (U.S. Census), significantly lower than the 2021 respondent percentage of 46.4%. Respondents with an Associate's degree were not compared to area statistics as the U.S. Census includes Associate's Degree attainment in a category with "Some College" (U.S. Census, Table S1501).



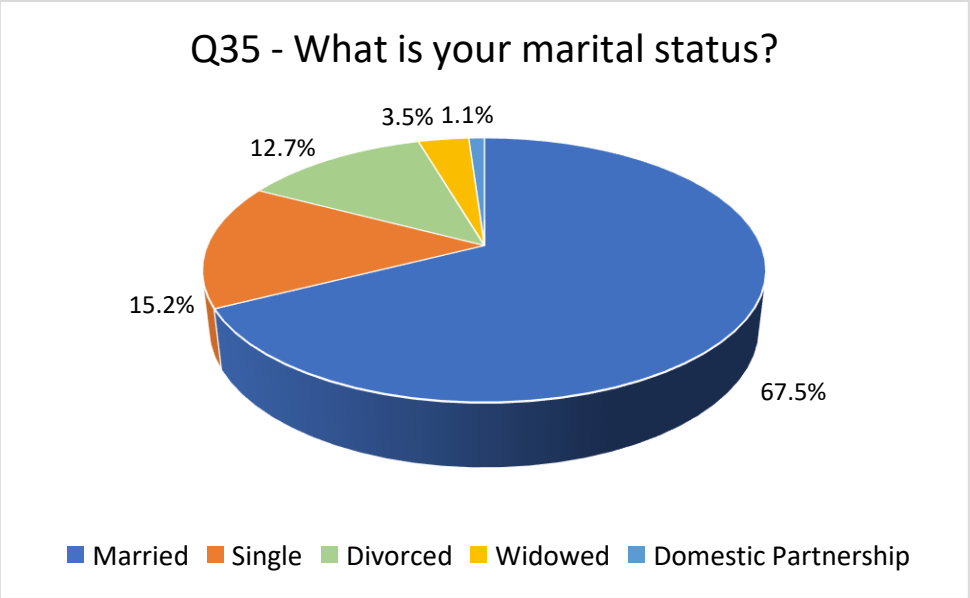
	Percent	Responses
White / Caucasian	71.3%	593
Black / African American	8.8%	73
Hispanic / Latino	5.0%	42
Asian	4.1%	34
American Indian / Alaska Native	3.7%	31
More than one race	2.8%	23
Decline to answer	2.3%	19
Native Hawaiian / Pacific Islander	1.8%	15
Other	0.2%	2
	Answered	**832**
	Skipped	**19**

The number of White respondents decreased from 86.3% in 2018 to 71.3% in 2021. This number is lower than the overall percentage of the White population in the service area – 89.4% in Bedford County and 76.3% in the Town of Bedford (U.S. Census). The number of respondents indicating they are Black or African-American fell slightly from 2018 (9.3%) to 2021(8.8%). In the service area, 6.9% of Blacks live in Bedford County and 20.3% live in the Town of Bedford (U.S. Census). The service area percentage of Hispanics or Latino is 2.2% (U.S. Census). The number of Hispanic or Latino respondents in 2021 was 5%, increasing from just 0.7% in 2018. In addition, there was an increase in the respondents who reported being Asian (4.1% in 2021 compared to 0.3% in 2018); American Indian/Alaska Native (3.7% in 2021 compared to 1.1% in 2018); and Native Hawaiian/Pacific Islander (1.8% in 2021 compared to 0.2% in 2018). According to the U.S. Census, service area percentages for Asians is 1.2% in the County and 0.5% in the Town; for American

Indian/Alaska Native is 0.1% in the County and 0% in the Town; and 0% for Native Hawaiian or Pacific Islander in both localities.

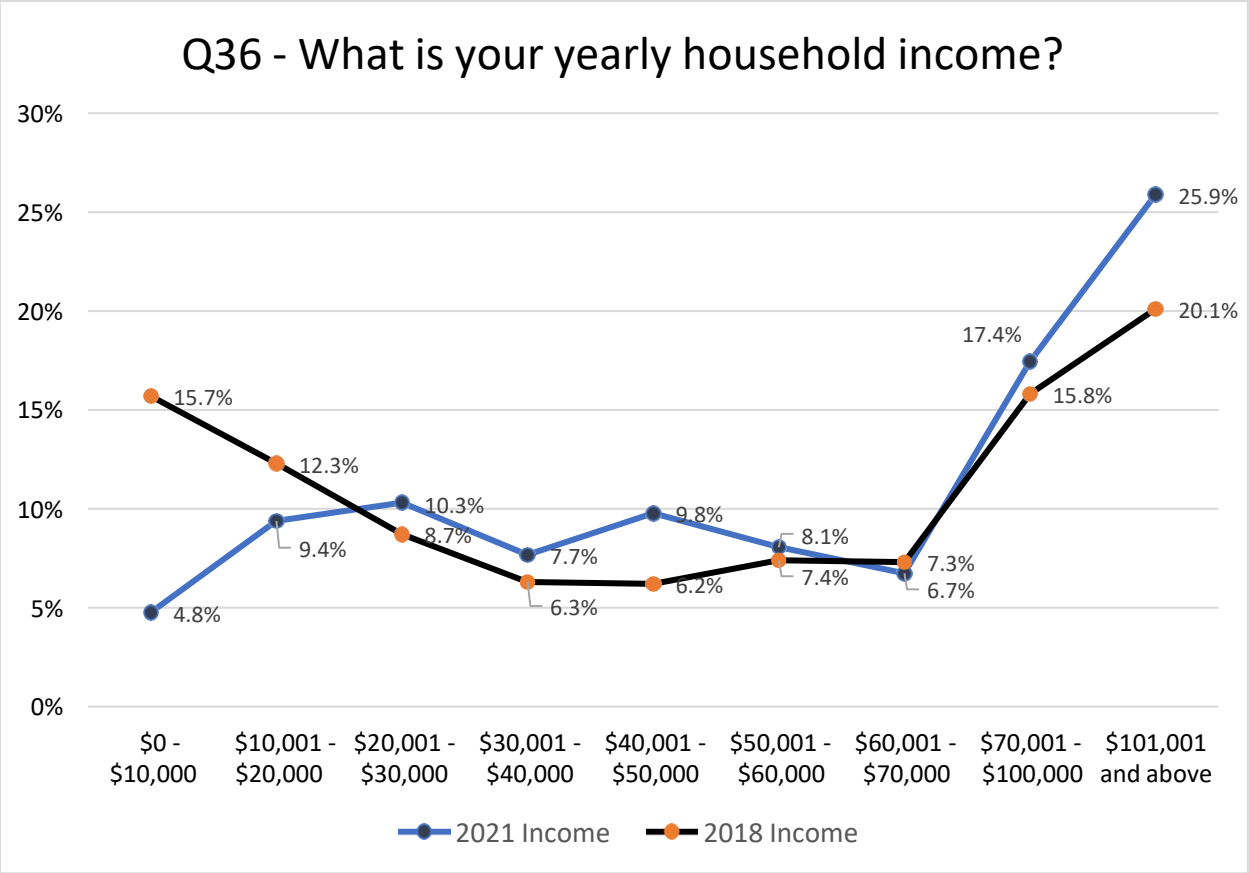
Q34. Other responses What Race/ethnicity do you Identity with?		
Code	**Responses**	**Percent**
Italian	1	25%
Romanian	1	25%
N/A	2	50%
Total	**4**	**100%**

In the Bedford regions, 4 respondents chose "other" for their selection. Of these "other" responses, 25% listed Italian as their race/ethnicity while 25% listed Romanian.



	Percent	Responses
Married	67.5%	567
Single	15.2%	128
Divorced	12.7%	107
Widowed	3.5%	29
Domestic Partnership	1.1%	9
	Answered	**840**
	Skipped	**18**

The percentage of persons responding that they were married in the 2021 assessment increased 4.3% over the 2018 response (63.2%). The percentage of widowed respondents decreased from 5.7% in 2018 to 3.5% in 2021. Other marital statuses were consistent when comparing 2018 and 2021 assessments.



	2021 Income	2018 Income
$0 - $10,000	4.8%	15.7%
$10,001 - $20,000	9.4%	12.3%
$20,001 - $30,000	10.3%	8.7%
$30,001 - $40,000	7.7%	6.3%
$40,001 - $50,000	9.8%	6.2%
$50,001 - $60,000	8.1%	7.4%
$60,001 - $70,000	6.7%	7.3%
$70,001 - $100,000	17.4%	15.8%
$101,001 and above	25.9%	20.1%

Respondents in 2021 reflected a large variance from the lowest household income categories (at or below $20,000) which was 14.2% in 2021 and 28% in 2018. The number of respondents with household incomes of over $100,000 was slightly higher in 2021 (25.9%) than that of 2018 respondents (20.1%).

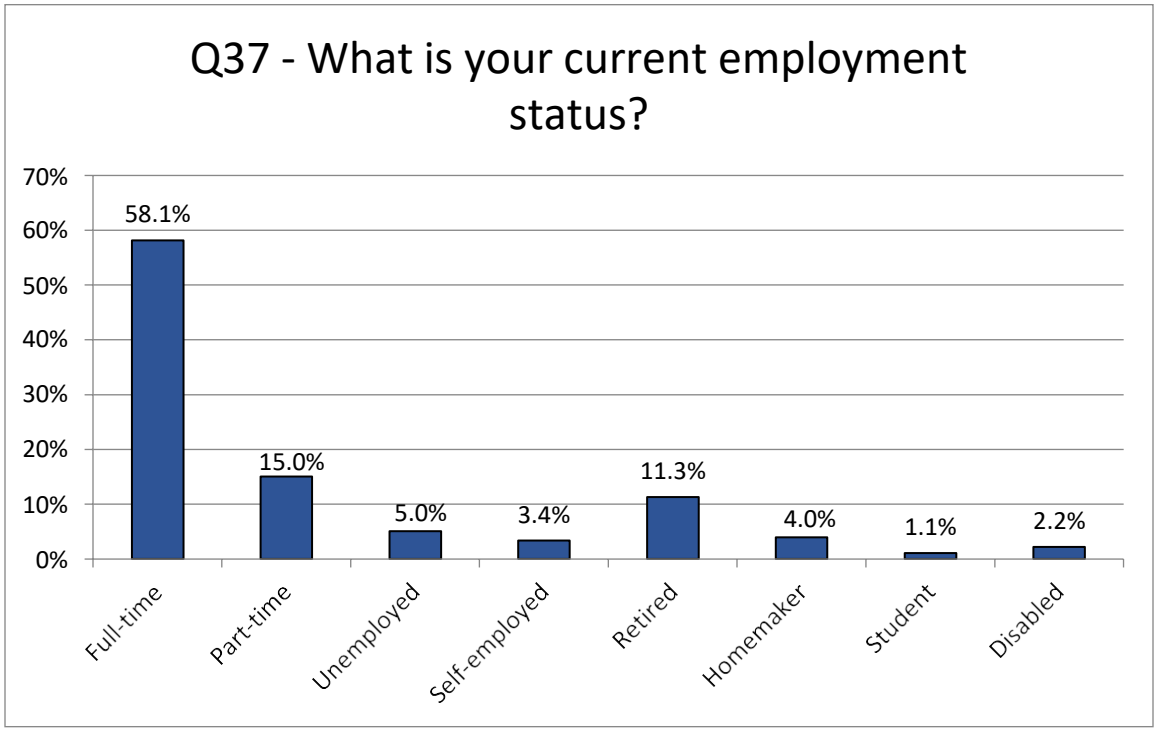
Analysis of Poverty Status Among Survey Respondents

Household Size	Number	Self-Reported Household Income Category							<100% FPL	<200% FPL
		0-10,000	10,001-20,000	20,001-30,000	30,001-40,000	40,001-50,000	50,001-60,000	60,001-70,000		
1	90	8	10						8.9%	20.0%
2	239	17	18	24					7.1%	24.7%
3	103	2	12	10	6				13.6%	29.1%
4	158	4	14	26	11	19			11.4%	46.8%
5	96	2	7	6	16	9	13		15.6%	55.2%
6	56	1	10	8	7	5	6	4	33.9%	73.2%
7	14	1	0	0	1	2	0	0	14.3%	28.6%
8	1	0	0	0	0	0	0	0	0.0%	0.0%
Total	**757**	**35**	**71**	**74**	**41**	**35**	**19**	**4**	**11.2%**	**33.6%**

Although survey income categories do not align with the Federal Poverty Level guidelines (FPL), respondent poverty status can still be estimated at levels below 100% and 200% of the FPL. Based on the FPL, the number of respondents in each household size noted above in yellow would fall below 100% of the FPL. The number of responses in blue would fall below 200% of the FPL. Combining these values represent respondents whose household income falls below 200% of the FPL. A respondent's household income will often fall between FPL category minimum and maximum limits. For example, a respondent's household income that is $11,500 would still be below 100% of the federal poverty level but would be placed in the survey's $10,001 to $20,000 income category because it cannot be determined that the respondent's household income is, in fact, below 100% of the poverty level, between 100% and 150% of the FPL, or at some point over 150% FPL. However, it can be determined that this income is still below 200% of the FPL. In 2021, a minimum of 11.2% of respondents represented in the table above had incomes below 100% of the FPL and 33.6% had incomes below 200% FPL. The total number of households in the table above represent 99% of all income respondents.

Federal Poverty Level Guideline Table

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



	Percent	Responses
Full-time	58.1%	484
Part-time	15.0%	125
Unemployed	5.0%	42
Self-employed	3.4%	28
Retired	11.3%	94
Homemaker	4.0%	33
Student	1.1%	9
Disabled	2.2%	18
	Answered	**833**
	Skipped	**24**

The rate of 2021 respondents employed full-time was consistent with 2018 respondents for this status (58% compared to 60%). The number of unemployed was more than double among 2018 respondents than 2021 respondents (12.8% compared to 5%). The reader should consider this disparity in context with the number of 2018 respondents with household incomes less than $20,000 was 28% compared to 14.5% in 2021. Other employment status responses were consistent comparing 2018 and 2021 assessments.

Bedford Stakeholder Focus Group Directory

Date: 5/12/2021

Last Name, First Name	Organization
Bailey, Lisa	Bedford Domestic Violence Services
Bailey, Pam	Bedford Director of Economic Development
Bartz, Noah	Johnson Health Center
Bass, Bill	Centra Bedford Memorial Hospital
Brake, Linda	Bedford Ride
Brown, Susan	Centra
Buchanan, Mary	Bedford Memorial Hospital
Craig, Katy	St. John's
Crawford, Andy	Bedford County Department of Social Services
Davis, Cori	Bedford Domestic Violence Services
Deets, Ben	Virginia Department of Corrections
Dooley, Heather	LACIL
Duis, Mac	Bedford County Public Schools
Fedor, John	Bedford Department of Corrections
Fletcher, Claudia	Patrick Henry Family Services
Foreman, Todd	Bedford Police Department
Foster, Kim	Virginia Health Department
Gaylor, Wende	Chamber of Commerce
Haldiman, Robin	CHIP
Hemke, Jennifer	Centra
Hitchcock, Carolyn	Centra
Hopkins, Stacey	Centra
Horan, Leah	Community Health Solutions
Huff, Denny	Bedford Community Health Foundation
Jones, Jack	Bedford County Fire and Rescue
Jones, Jenny	Centra
Kaufman, Amanda	Bedford County Administrator
Laine, Terry	Community Health Solutions
Layne, Holly	Smart Beginnings of Central Virginia
Lucy, Christy	Community Access Network
Luth, Janice	Centra Medical Group
Miller, Mike	Bedford County Sherriff's Office
Morris, Harry	Centra
Onafowokan, Dammy	Horizon
Pollard, Sherry	Johnson Health Center
Robey, Jeffery	Central Virginia Alliance for Community Living
Temple, Mary	BARC
Woody, Wyatt	Bedford Parks and Recreation

Young, Pat	Centra
Zirkle, Mary	Town of Bedford Economic Development

CENTRA

2021 Stakeholders Focus Group Survey

Please complete the following questions:

What are the greatest issues/needs in the community(s) you serve? (List up to 5) 1. 2. 3. 4. 5.
How has the COVID-19 pandemic impacted these needs?
Of the needs listed, what is one issue/need we can work on together to create a healthier community?
What are one or two ways we can work together on this issue/need?
Are there localities or populations that are especially vulnerable to this issue/need?
What resources are available in the community to address this issue/need?
Are there gaps in these resources that we need to address?

2021 Bedford Area Prioritization of Needs Worksheet

Rank the Top 5 Greatest Needs

Instructions: Rank the following "Areas of Need" from 1 to 5

(1 is the greatest need)

Ranking	Area of Need
	Access to healthcare services
	Accidents in the home
	Aging and Eldercare
	Child abuse/neglect
	Childcare
	Chronic Disease
	Community Outreach
	Coordination of Resources
	COVID-19 Pandemic
	Dental Care & Dental Problems
	Disability
	Domestic Violence
	Education and Literacy
	Employment / Job assistance
	End of Life Care and Services
	Environmental Health
	Families
	Financial Stability
	Food Insecurity and Nutrition
	Health Promotion and Disease Prevention
	Housing
	Legal Services
	Maternal/Child Health
	Mental Health and Substance Use Disorders & Access to Services
	Overweight/Obesity
	Physical Activity
	Poverty & Economic Assistance
	Safety and Violent Crime
	Sexual Health
	Social Isolation
	Transportation
	Unsafe Driving Practices
	Veterans Services
	Vision Care

2021 Bedford Area Prioritization of Needs Worksheet
Rank the Top 5 Greatest Needs
Instructions: Rank the following "Areas of Need" from 1 to 5
(1 is the greatest need)

	CHS 2021 (n= 848)	CHS 2021 (n= 845)	CHS 2021 (n=843)	CHS 2021 (n=809)	Stakeholder Focus Group (n=86)
Area of Need	**What do you think are the most important issues that affect health in our community? (Check all that apply) Health Factors % Responses**	**What do you think are the most important issues that affect health in our community? (Check all that apply) % Responses Health Conditions**	**Which health care services are hard to get in our community? % Responses**	**Which social/support resources are hard to get in our community? % Responses**	**What are the top 5 greatest needs in the community(s) you serve? % Responses**
Access to healthcare services	x		x	x	x
Alternative therapy (e.g., herbal, acupuncture, massage)			24.0%		
Ambulance services			9.1%		
Cancer care			16.0%		
Chiropractic care			7.5%		
Dermatology			21.7%		
Emergency room care			12.8%		
Health care access					3.5%
Health insurance				21.0%	
Immunizations			4.5%		
Inpatient hospital			5.7%		
Lab work			5.3%		
Medication / medical supplies			11.4%		
Medication assistance				20.0%	
Not getting "shots" to prevent disease	19.1%				
Physical therapy			6.3%		
Preventive care (e.g., yearly check-ups)			12.5%		
Specialty care (e.g., heart doctor)			16.4%		
Urgent care / walk-in clinic			15.4%		
Women's health services			15.9%		
X-rays / mammograms			6.3%		
Accidents in the home	x				
Accidents in the home (e.g., falls, burns, cuts)	12.7%				
Aging and Eldercare	x		x		
Aging problems	34.7%				
Eldercare			22.1%		
Child abuse/neglect	x				
Child abuse / neglect	29.8%				

Childcare				x	x
Childcare				31.8%	
Childcare					15.1%
Chronic Disease		x			
Cancers		46.2%			
Diabetes		53.8%			
Heart disease and stroke		49.1%			
High blood pressure		46.2%			
HIV / AIDS		6.7%			
Lung Disease		17.3%			
Community Outreach					x
Community Outreach					3.5%
Coordination of Resources					x
Coordination of resources					2.3%
COVID-19 Pandemic		x	x	x	x
COVID-19 / coronavirus		33.7%			
COVID-19 has made one or more of the services I selected hard to get			13.0%		
COVID-19 has made one or more of the services I selected hard to get				10.6%	
Vaccination hesitancy					2.3%
Dental Care & Dental Problems		x	x		
Adult dental care			19.0%		
Child dental care			14.6%		
Dental problems		24.4%			
Disability		x			
Disability		23.6%			
Domestic Violence	x		x	x	
Domestic Violence	27.6%				
Domestic violence assistance				17.8%	
Domestic violence services			15.4%		
Sexual assault	10.3%				
Education and Literacy				x	x
Education attainment					1.2%
Education and literacy				15.6%	
Employment / Job assistance				x	x
Employment / job assistance				23.7%	
Unemployment benefits				10.1%	
Workforce					4.7%
End of Life Care and Services		x	x	x	
End of life / hospice /palliative care			8.5%		
Grief		14.3%			
Grief /bereavement counseling				15.2%	
Environmental Health	x				
Environmental health (e.g., water quality, air quality, pesticides, etc.)	15.4%				
Families					x
Families					2.3%
Financial Stability				x	x
Banking /financial assistance				13.7%	
Financial Stability					1.2%

Food Insecurity and Nutrition	x			x	x
Access to healthy foods	37.7%				
Food benefits (SNAP, WIC)				11.0%	
Food Insecurity and Nutrition					3.5%
Healthy food				23.7%	
Poor eating habits	45.6%				
Health Promotion and Disease Prevention					x
Health Promotion and Disease Prevention					2.3%
Housing	x				x
Access to affordable housing	27.5%				
Affordable /safe housing	31.1%				
Housing					7.0%
Housing problems (e.g., mold, bed bugs, lead paint)	15.6%				
Rent / utilities assistance	16.8%				
Legal Services				x	
Legal services				10.8%	
Maternal/Child Health		x			
Infant death		6.6%			
Teenage pregnancy		10.3%			
Mental Health and Substance Use Disorders & Access to Services	x	x	x		x
Alcohol and illegal drug use	48.8%				
Mental Health					17.4%
Mental health / counseling			33.7%		
Mental health problems		51.8%			
Prescription drug abuse	26.2%				
Stress		41.2%			
Substance use					10.5%
Substance use services – drug and alcohol			22.7%		
Suicide		17.8%			
Programs to stop using tobacco products			12.8%		
Tobacco use / smoking / vaping	32.8%				
Overweight/Obesity		x			
Overweight / obesity		56.3%			
Physical Activity	x				
Lack of exercise	39.3%				
Poverty & Economic Assistance				x	x
Medical debt assistance				22.1%	
Poverty					2.3%
TANF (Temporary Assistance for Needy Families)				9.9%	

Safety and Violent Crime	x				
Bullying	16.5%				
Gang activity	8.0%				
Homicide	6.5%				
Neighborhood safety	9.2%				
Sexual Health	x		x		
LGBTQ			12.6%		
Unsafe sex	10.8%				
Social Isolation	x				
Social isolation	23.0%				
Transportation	x			x	x
Transportation				28.3%	
Transportation					17.4%
Transportation problems	25.2%				
Unsafe Driving Practices	x				
Cell phone use / texting and driving / distracted driving	31.8%				
Not using seat belts / child safety seats / helmets	10.5%				
Veterans Services				x	
Veterans services				16.9%	
Vision Care					
Vision care			7.2%		

Bedford Area Community Resources 2021	
Adult Protective Services Bedford Social Services	**Housing** College Hill Apartments Hillcrest Apartments (Seniors) James Crossing Apartments Jericho Outreach Ministries John Early Apartments Raintree Village Apartments Lynchburg Covenant Fellowship Lynchburg Redevelopment and Housing Authority Meadows Apartments (Disabled) Millwood's Apartments McGurk House (Seniors) Pinecrest Apartments RUSH Homes (Disabled) STEP Inc (Section 8) USDA Rural Development Peaks Crossing Apartments Liberty Manor Josephs Dream Salem Court Apartments Powder Horn Apartments Bedford VA Housing Authority
Budget & Credit Counseling Money Management International Clearpoint Credit Counseling Solutions	**Housing Weatherization/Rehabilitation** Central Virginia Alliance for Community Living (Senior) Lynchburg Community Action Group Interfaith Rebuilds
Child Care Financial Assistance Lynchburg Community Action Group Bedford Social Services Bedford YMCA Smart Beginnings of Central VA	**Job Counseling, Training, & Placement** Goodwill Industries of the Valleys (Roanoke) Job Corps Virginia Jubilee Family Center Lynchburg Community Action Group Virginia Department of Rehabilitative Services Virginia Employment Commission Career Support Systems Central VA Community College HumanKind Lynchburg Sheltered Industries Virginia Career Works Region 2000 Workforce Investment Board Bedford County Human Resources Govt Office Simple Solutions Career and Support Center
Child Care Resources & Referrals Human Kind/Presbyterian Homes 2-1-1 Virginia Smart Beginnings of Central VA Bedford YMCA	**Legal Assistance** Virginia Lawyer Referral Virginia Legal Aid Society
Child/Infant Car Seats Lynchburg Police Department Bedford County Health Department Bedford County Sheriff's Office	**Local Government/Tourist Information** Bedford Area Chamber of Commerce Bedford County Government Office Bedford Area Welcome Center

	Altavista Area Chamber of Commerce
Child Protective Services CASA of Central VA– Lynchburg Child Protective Services-DSS	**Medical/Dental Assistance** Bedford Christian Free Clinic Bedford Community Health Center Bedford Community Dental Center Centra Community Access Network FAMIS Free Clinic of Central Virginia James River Dental Clinic Johnson Health Center Bedford Health Department VA Medical Center
Children & Family Recreation Bedford Parks & Recreation Department YMCA	**Parenting Skills/Family Support/Mental Health** Anderson Counseling Bedford Counseling Center Bridges Residential Treatment Center Community Access Network Couples and Kids Family Preservation Services Horizon Behavioral Health HumanKind Patrick Henry Family Services Mental Health America of Virginia Hope for Tomorrow Counseling Minds Together Kinship Navigator Madeline Centre Focus Psychiatry and Wellness North Bridge Counseling Peaks View Counseling Bedford Community Health Center Johnson Health Center Bedford Christian Free Clinic
Clothing Bedford Christian Ministries Lake Christian Ministries Lighthouse Community Center Salvation Army	

Commonwealth's Attorney Bedford Commonwealth Attorney VA legal Aid	**Prescription Assistance** FamilyWize Discount Card Free Clinic of Central Virginia/MedsHelp Bedford Christian Ministries Johnson Health Center- Medication Assistance Program (MAP) GoodRx
Community Partnerships & Coalitions Bridges of Central Virginia Blue Ridge Re-entry Council Bedford Area Resource Council (BARC) Central Virginia Continuum of Care The Partnership for Healthy Communities Bedford Community Coalition Bedford Domestic Violence Coalition Central VA Business Coalition Bedford NAACP Hate-Free Schools Coalition	**Public Safety/Disaster Relief** American Red Cross – Blue Ridge Bedford Police Department Bedford County Sheriff's Department Emergency Management
Community Foundations Centra Foundation Centra Community Health Bedford Community Health Foundation United Way VA Early Childhood Foundation	**Re-entry/Returning Citizens** Hope Aglow Ministries Lynchburg Community Action Group, Inc. Interfaith Outreach Association Virginia Career Works Blue Ridge Re-entry Council Virginia Dept of Corrections Virginia Cares
Crisis Bedford YWCA Domestic Violence Services Bedford YWCA Sexual Assault Response Program Suicide Hotline Family Violence & Sexual Assault Hotline RAIIN Hotline for sexual violence National Suicide Prevention Line	**Senior Services** Adult Care Center of Central Virginia Bedford County Parks and Recreation Bedford Ride Bedford GetTogether Central Virginia Alliance for Community Living/ADRC Generation Solutions Home Instead Senior Care Meals on Wheels Simple Solutions Dept. of Aging & Rehabilitative Services
Disability Services/Rehabilitation ARC of Central Virginia Lynchburg Area Center for Independent Living (LACIL) Lynchburg Sheltered Industries RUSH Homes VA Department of Rehabilitative Services ADRC-Aging and Disability Resource Center Special Olympics	**Shelters/Transitional Housing** Bedford Domestic Violence Shelter Homeless Intake (CHIA) Salvation Army Hand Up Lodge Miriam's House The Gateway-LYNCAG YWCA Domestic Violence Shelter YWCA Residential Housing Frannie's House
Economic/Neighborhood Development Bedford Bedford Main Street, Inc Bedford Area Chamber of Commerce Lynchburg Small Business Development Lynchburg Regional Business Alliance	**Social Services (SNAP, TANF, Medicaid) Assistance** Bedford Department of Social Services Community Access Network Johnson Health Center

USDA Rural Development SCORE	
Education ACE of Central Virginia Bedford County Schools Bedford County Library Laurel Regional School Rivermont School Smart Beginnings of Central VA **Special Needs** Bedford Public Schools Infant & Toddler Connection Rivermont School Special Olympics	**Substance Abuse Treatment/Transitional Housing** Avenues to Recovery Horizon Behavioral Health Celebrate Recovery Courtland Center Pathways The Gateway Elim Home Mount Regis Oxford House Our Father's House The Haven UP Foundation Celebrate Recovery Roads to Recovery Alive RVA support line Addiction Allies Lynchburg Comprehensive Treatment Center Johnson Health Center Community Access Network- Hope Initiative March of Dimes Pathways Lodge-Centra
Emergency Financial Assistance Agape Center Bedford Christian Ministries Bedford Social Services Interfaith Outreach Association Lake Christian Ministries Lynchburg Community Action Group Salvation Army - Lynchburg United Way of Central Virginia Bedford Social/Human Services	**Transportation** Bedford Ride Logisticare Johnson Health Center- Appointment Transportation
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 The Shepherds Table Virginia Cooperative Extension Blue Ridge Area Food Bank Interfaith Outreach Ministries	**Unemployment Assistance** Virginia Employment Commission Virginia Career Works Career Support Systems Goodwill Job & Employment Center

Health Department **Central Virginia Health District** Bedford County Health Department Lynchburg Health Department	**Veterans** Lynchburg Area Veterans Council Virginia Dept of Veterans Services