2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Staunton, Waynesboro & Augusta County, Virginia

Sponsored by

Augusta Health

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Prepared by PRC

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2016 and 2019, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the Total Area, the service area of Augusta Health. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Augusta Health by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

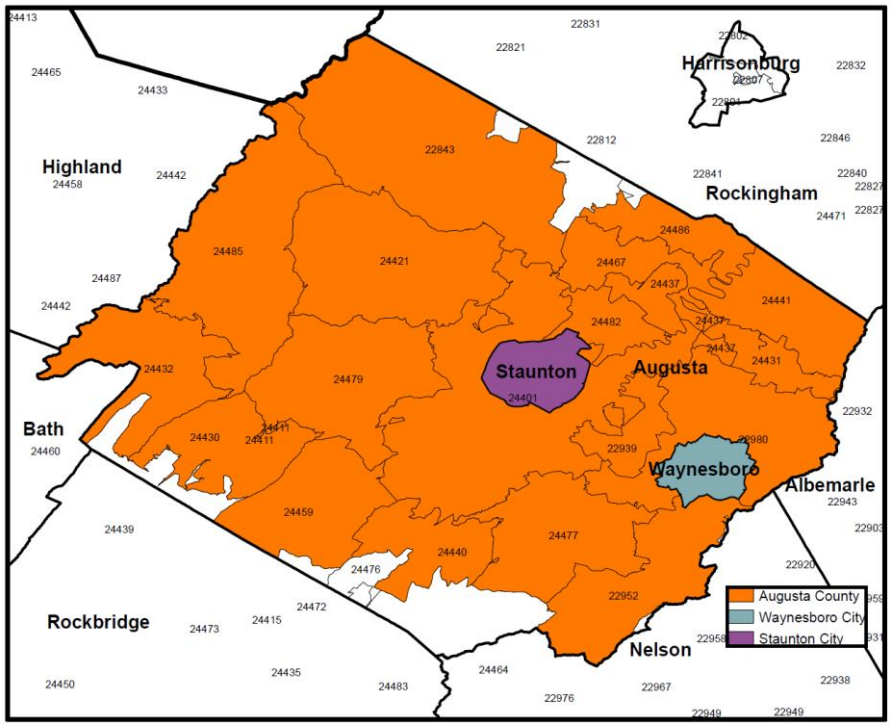
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Augusta Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Total Area" in this report) is defined as each of the residential ZIP Codes comprising Augusta County and the independent cities of Staunton and Waynesboro in Virginia. This community definition, determined based on the ZIP Codes of residence of recent patients of Augusta Health, is illustrated in the following map.

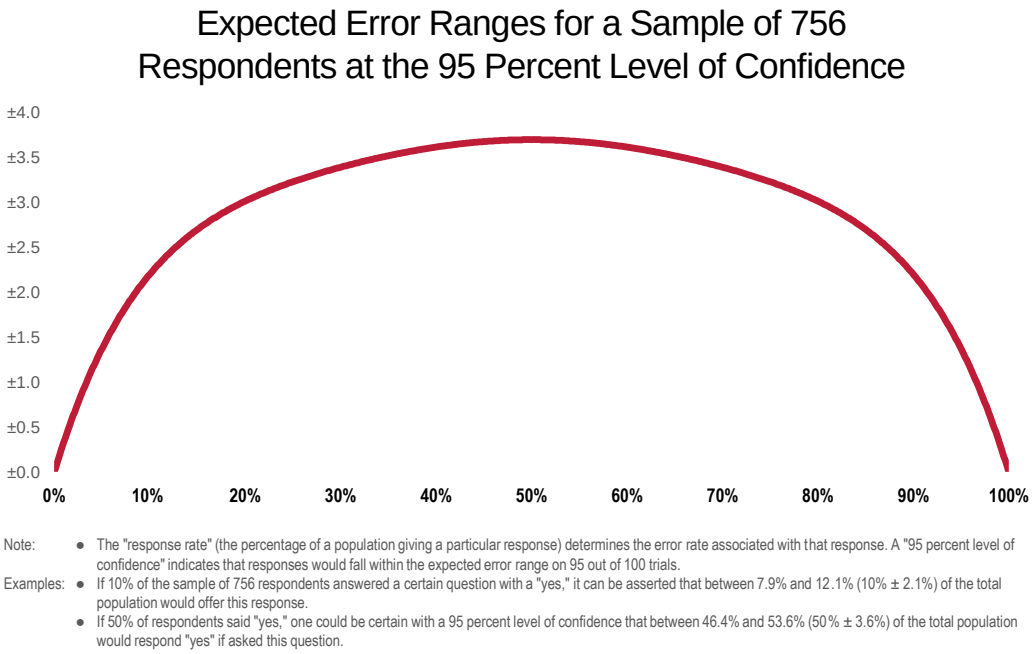


Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a sample of 756 individuals age 18 and older in the Total Area (600 reached through a phone survey, and another 156 achieved through an online survey link promoted by Augusta Health). In all, the final sample included 185 residents in Staunton, 170 in Waynesboro, and 401 in Augusta County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 756 respondents is ±3.6% at the 95 percent confidence level.



Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

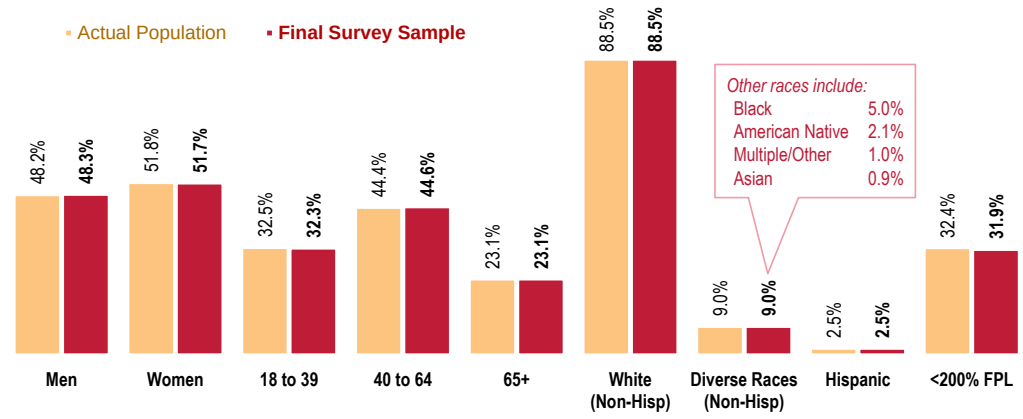
Examples:
- If 10% of the sample of 756 respondents answered a certain question with a "yes," it can be asserted that between 7.9% and 12.1% (10% ± 2.1%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.4% and 53.6% (50% ± 3.6%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Total Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(Total Area, 2022)



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2022 PRC Community Health Survey, PRC, Inc.

Notes:
- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► "White" reflects non-Hispanic White respondents; "communities of color" includes Hispanics and non-White race groups. While the survey data are representative of the racial and ethnic makeup of the population, the samples for Hispanic and non-White race groups were not of sufficient size for independent analysis.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Augusta Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 175 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	15
Public Health Representatives	6
Other Health Providers	58
Social Services Providers	43
Other Community Leaders	53

Final participation included representatives of the organizations outlined below.

- Adagio House
- Allegheny Mountain Institute
- Allen Chapel
- American Cancer Society
- ARROW Project
- Augusta County Schools
- Augusta County
- Augusta Free Press
- Augusta Health
- Augusta Health Boards and Committees
- Augusta Health Home Health
- Augusta Health Hospice
- Augusta Health Patient Advisory Council
- Augusta Health/Augusta Care Partners
- Augusta Health/Sodexo
- Augusta Medical Group
- Augusta Nursing and Rehab
- Augusta Regional Dental Clinic
- Blue Ridge Area Food Bank
- Blue Ridge CASA
- Blue Ridge Community College
- Blue Ridge Court Services
- Brain Injury Connections
- BRCC Educational Foundation
- Bridge Christian Church
- Central Shenandoah Planning District
- City of Staunton
- City of Waynesboro
- Commonwealth Center for Children
- Community Action Partnership of Staunton, Augusta, and Waynesboro
- Community Foundation for the Central Blue Ridge
- Covenant Presbyterian
- Creative Works Farm
- Disciples Kitchen
- Dixie Gas and Oil/Quarles
- Ebenezer Baptist Church, Staunton
- Graphic Packaging International
- Greater Augusta Regional Chamber of Commerce
- Gypsy Hill House
- Houff Corporation
- Jones Garden
- Latinx Health Council
- LEARN
- LIFEworks
- Love INC
- Lyndhurst United Methodist Church
- Mental Health of America-Augusta
- Murphy Deming College of Health Sciences
- National Alliance of Mental Illness
- Office on Youth
- Plaza Apartments
- Renewing Homes
- Shenandoah LGBTQ Center
- Shenandoah Valley Airport
- Shenandoah Valley Partnership
- Shenandoah Valley Social Services
- Sin Barreras
- St. John Catholic Church
- Staunton-Augusta Rescue Squad
- Staunton Schools
- United Way
- Valley Career and Technical Center
- Valley Children's Advocacy Center

- Valley Community Services Board
- Valley Hope Counseling Center
- Valley Mission
- Valley Program for Aging Services
- Valley Supportive Housing
- Virginia Department of Health
- WARM Shelter
- Waynesboro Housing Authority
- Waynesboro Schools
- Waynesboro YMCA

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Total Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics
- Virginia Department of Health

Benchmark Data

Trending

Similar surveys were administered in the Total Area in 2016 and 2019 by PRC on behalf of Augusta Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Virginia Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — although included, might not be identifiable or might be represented in numbers too small for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Augusta Health made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Augusta Health had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Augusta Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	38
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	206
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	15
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	17
Part V Section B Line 3h The process for consulting with persons representing the community's interests	9
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	214

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Inconvenient Office Hours – Cost of Prescriptions – Appointment Availability – Finding a Physician – Culture/Language ▪ Routine Medical Care (Adults) ▪ Emergency Room Utilization ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Cancer Deaths – Including Colorectal Cancer Deaths
DIABETES	▪ Diabetes Deaths ▪ Prevalence of Borderline/Pre-Diabetes ▪ Blood Sugar Testing [Non-Diabetics] ▪ Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Overall Cardiovascular Risk
HOUSING	▪ Homelessness
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths
INJURY & VIOLENCE	▪ Intimate Partner Violence

— continued on the following page —

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Stress ▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Fruit/Vegetable Consumption ▪ Leisure-Time Physical Activity ▪ Meeting Physical Activity Guidelines ▪ Children's Physical Activity ▪ Overweight & Obesity [Adults] ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
ORAL HEALTH	▪ Regular Dental Care [Adults & Children]
POTENTIALLY DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ High-Impact Chronic Pain ▪ Alzheimer's Disease Deaths ▪ Family Member Diagnosed with Alzheimer's/Dementia ▪ Caregiving
RESPIRATORY DISEASE	▪ Lung Disease Deaths
SUBSTANCE ABUSE	▪ Cirrhosis/Liver Disease Deaths ▪ Excessive Drinking ▪ Unintentional Drug-Related Deaths ▪ Illicit Drug Use ▪ Sought Help for Alcohol/Drug Issues ▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

On July 27, 2022, Augusta Health convened an online meeting with 95 community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), an online voting platform was used in which each participant was able to register his/her ratings using a web browser. The participants were asked to evaluate each health issue along two criteria:

- SCOPE & SEVERITY — The first rating was to gauge the magnitude of the problem in consideration of the following:
    - *How many people are affected?*
    - *How does the local community data compare to state or national levels, or Healthy People 2030 targets?*
    - *To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?*

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- ABILITY TO IMPACT — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Mental Health
2. Access to Health Care Services
3. Nutrition, Physical Activity & Weight
4. Diabetes
5. Substance Abuse
6. Heart Disease & Stroke
7. Cancer
8. Housing
9. Infant Health & Family Planning
10. Tobacco Use
11. Oral Health
12. Injury & Violence
13. Potentially Disabling Conditions
14. Respiratory Disease

Hospital Implementation Strategy

Augusta Health will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, Total Area results are shown in the larger, gray column.

The columns to the left of the Total Area column provide comparisons among the county and independent cities, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the combined opposing areas.

The columns to the right of the Total Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Total Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2016.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

SOCIAL DETERMINANTS	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	1.0	1.4	0.6	0.9	2.8	4.3		
Population in Poverty (Percent)	11.1	16.8	8.7	10.7	10.6	13.4	8.0	
Children in Poverty (Percent)	11.0	27.4	11.8	14.9	13.9	18.5	8.0	
No High School Diploma (Age 25+, Percent)	10.3	13.9	12.6	12.4	10.3	12.0		
% Unable to Pay Cash for a $400 Emergency Expense	20.0	22.4	16.3	18.4		24.6		21.3
% Worry/Stress Over Rent/Mortgage in Past Year	19.6	27.1	21.3	22.1		32.2		26.7
% Displaced From Housing in Past 2 Years	9.5	8.6	6.4	7.6				5.0
% Homeless in Past 2 Years	7.0	7.1	1.3	3.8				0.0
% Unhealthy/Unsafe Housing Conditions	11.8	10.8	8.1	9.5		12.2		9.9
Population With Low Food Access (Percent)	2.2	16.6	29.3	21.7	20.4	22.2		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SOCIAL DETERMINANTS (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Food Insecure	22.6	25.9	18.3	20.8		34.1		9.3
% Low Health Literacy	18.2	21.8	12.9	15.9		27.7		17.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	19.9	19.7	15.8	17.6	13.0	12.6		18.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	8.0	7.4	8.0	7.9	13.8	8.7	7.9	11.2
% Difficulty Accessing Health Care in Past Year (Composite)	41.4	50.4	45.9	45.8		35.0		36.9

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Cost Prevented Physician Visit in Past Year	10.9	13.9	10.2	11.1	12.0	12.9		8.1
% Cost Prevented Getting Prescription in Past Year	12.5	11.4	10.8	11.3		12.8		7.6
% Difficulty Getting Appointment in Past Year	27.6	36.9	23.9	27.4		14.5		14.4
% Inconvenient Hrs Prevented Dr Visit in Past Year	10.3	20.6	13.8	14.4		12.5		9.9
% Difficulty Finding Physician in Past Year	15.2	19.8	15.0	16.0		9.4		3.4
% Transportation Hindered Dr Visit in Past Year	9.8	8.9	2.9	5.7		8.9		9.6
% Language/Culture Prevented Care in Past Year	0.5	5.5	1.6	2.2		2.8		0.1
% Skipped Prescription Doses to Save Costs	12.7	14.7	12.0	12.7		12.7		11.4
% Difficulty Getting Child's Health Care in Past Year				5.5		8.0		2.3
Primary Care Doctors per 100,000	139.8	76.6	78.7	90.9	97.2	102.3		
% Have a Specific Source of Ongoing Care	72.1	77.3	78.7	76.9		74.2	84.0	77.7

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS			TOTAL AREA vs. BENCHMARKS				
	Staunton	Waynesboro	Augusta County	Total Area	vs. VA	vs. US	vs. HP2030	TREND
% Have Had Routine Checkup in Past Year	66.4	74.9	63.2	66.3	71.9	70.5		79.5
% Child Has Had Checkup in Past Year				83.8		77.4		87.2
% Two or More ER Visits in Past Year	12.3	17.0	9.1	11.4		10.1		4.3
% Eye Exam in Past 2 Years	59.3	68.3	62.6	63.1		61.0	61.1	66.1
% Rate Local Health Care "Fair/Poor"	14.7	16.8	9.4	12.2		8.0		7.1
% "Extremely/Very Likely" to Use Telemedicine	34.0	35.9	39.3	37.4				

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CANCER	DISPARITY AMONG SUBAREAS			TOTAL AREA vs. BENCHMARKS				
	Staunton	Waynesboro	Augusta County	Total Area	vs. VA	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)	185.9	216.2	130.8	156.2	146.9	146.5	122.7	181.3
Lung Cancer (Age-Adjusted Death Rate)				36.5	33.9	33.4	25.1	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CANCER (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Prostate Cancer (Age-Adjusted Death Rate)				**14.8**	19.7	18.5	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)				**19.6**	20.1	19.4	15.3	
Colorectal Cancer (Age-Adjusted Death Rate)				**16.0**	13.3	13.1	8.9	
Cancer Incidence Rate (All Sites)	580.9	616.0	436.6	**495.7**	411.0	448.6		
Female Breast Cancer Incidence Rate	168.7	171.0	124.2	**141.6**	126.4	126.8		
Prostate Cancer Incidence Rate	120.1	137.8	92.0	**104.1**	98.0	106.2		
Lung Cancer Incidence Rate	71.9	91.1	50.4	**61.2**	54.8	57.3		
Colorectal Cancer Incidence Rate	48.3	56.2	38.8	**43.6**	35.0	38.0		
% Cancer	13.4	13.5	12.1	**12.7**	12.0	10.0		
% [Women 50-74] Mammogram in Past 2 Years				**76.7**	79.5	76.1	77.1	75.0

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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CANCER (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% [Women 21-65] Cervical Cancer Screening	65.9	84.4	77.3	76.0	79.8	73.8	84.3	67.6
% [Age 50-75] Colorectal Cancer Screening	82.1	89.1	77.5	80.8	73.8	77.4	74.4	77.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CORONAVIRUS DISEASE/COVID-19	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
COVID-19 (Age-Adjusted Death Rate)	84.8		39.8	50.0	56.3	85.0		
% Using Alcohol More Often Since Pandemic Began	17.1	10.9	13.8	14.1				
% Smoking/Vaping More Often Since Pandemic Began				26.8				
% Exercising Less Often Since Pandemic Began	30.6	24.8	26.4	27.0				
% Eating Unhealthy/Overeating Since Pandemic Began	23.8	23.5	24.8	24.3				
% Mental Health Has Gotten Worse Since Pandemic Began	25.9	24.8	25.0	25.1				

CORONAVIRUS DISEASE/COVID-19 (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Vaccinated for COVID-19	79.6	80.4	77.3	78.5				
% [Vaccinated] Have Received COVID-19 Booster	79.4	70.9	65.3	69.8				
% Financially Impacted by the Pandemic	21.3	16.3	19.1	19.0				
% Avoided Medical Care Due to the Pandemic	22.9	24.0	16.8	19.6				

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DIABETES	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)	30.5	32.7	18.7	23.6	23.5	22.6		16.7
% Diabetes/High Blood Sugar	13.0	16.2	15.2	14.9	11.1	13.8		13.9
% Borderline/Pre-Diabetes	8.7	7.3	10.4	9.4		9.7		5.7
% [Diabetics] Taking Action to Control Diabetes				89.0				87.7
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	42.6	43.3	47.1	45.3		43.3		56.4

HEART DISEASE & STROKE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	199.7	205.7	141.5	164.0	149.7	164.4	127.4	166.5
% Heart Disease (Heart Attack, Angina, Coronary Disease)	5.9	7.0	7.1	6.8	5.8	6.1		6.7
Stroke (Age-Adjusted Death Rate)	43.6	36.1	32.4	35.8	39.0	37.6	33.4	37.6
% Stroke	3.0	2.5	3.8	3.3	2.8	4.3		3.0
% Told Have High Blood Pressure	34.9	36.6	43.3	40.1	33.5	36.9	27.7	42.7
% Told Have High Cholesterol	34.6	28.7	34.1	33.1		32.7		36.0
% 1+ Cardiovascular Risk Factor	86.9	88.1	89.2	88.4		84.6		84.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Low Birthweight Births (Percent)	9.1	9.0	6.0	7.6	8.1	8.2		
Infant Death Rate				6.1	5.7	5.5	5.0	4.6
Births to Adolescents Age 15 to 19 (Rate per 1,000)	26.0	41.6	17.0	23.3	16.3	20.9		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INJURY & VIOLENCE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)	54.5	47.5	50.8	50.3	46.7	51.6	43.2	46.5
Motor Vehicle Crashes (Age-Adjusted Death Rate)				13.3	10.0	11.4	10.1	
[65+] Falls (Age-Adjusted Death Rate)				78.8	68.4	67.0	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)				14.6	12.3	12.5	10.7	
Homicide (Age-Adjusted Death Rate)				3.1	4.9	5.9	5.5	

INJURY & VIOLENCE (continued)	DISPARITY AMONG SUBAREAS			TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County	Total Area	vs. VA	vs. US	vs. HP2030	TREND
Violent Crime Rate	170.1	198.9	110.7	138.6	207.8	416.0		
% Victim of Intimate Partner Violence	18.6	14.9	13.9	15.1		13.7		9.7

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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KIDNEY DISEASE	DISPARITY AMONG SUBAREAS			TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County	Total Area	vs. VA	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)	21.0		11.5	14.0	16.1	12.8		16.1
% Kidney Disease	6.7	2.8	6.8	5.9	2.7	5.0		7.0

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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MENTAL HEALTH	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	23.4	21.3	20.9	21.5		13.4		8.7
% Diagnosed Depression	31.0	31.5	26.5	28.6	17.2	20.6		14.9
% Symptoms of Chronic Depression (2+ Years)	40.1	43.3	39.6	40.5		30.3		21.8
% Typical Day Is "Extremely/Very" Stressful	16.7	12.4	14.4	14.5		16.1		10.5
Suicide (Age-Adjusted Death Rate)		38.4	22.5	22.7	13.4	13.9	12.8	18.7
Mental Health Providers per 100,000	108.7	31.5	45.2	55.8	64.2	124.9		
% Taking Rx/Receiving Mental Health Trtmt	17.4	26.9	23.5	22.9		16.8		14.9
% Unable to Get Mental Health Svcs in Past Yr	10.4	9.7	6.9	8.2		7.8		2.5
% Child [Age 5-17] "Fair/Poor" Mental Health				7.4		9.7		5.8
% Child [Age 5-17] Needed Mental Health Svcs in the Past Yr				11.7		17.1		14.1

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	21.9	23.1	23.0	22.7		21.1		19.1
% 5+ Servings of Fruits/Vegetables per Day	28.9	36.9	31.2	31.8		32.7		39.2
% Child [Age 2-17] 5+ Servings of Fruits/Vegetables per Day				43.7		36.9		50.8
% No Leisure-Time Physical Activity	31.3	34.5	40.7	37.3	20.9	31.3	21.2	27.8
% Meeting Physical Activity Guidelines	14.4	16.1	13.8	14.4	22.7	21.4	28.4	15.6
% Child [Age 2-17] Physically Active 1+ Hours per Day				43.4		33.0		66.8
Recreation/Fitness Facilities per 100,000	29.5	19.0	6.8	13.5	13.8	12.2		
% Healthy Weight (BMI 18.5-24.9)	31.9	29.7	22.9	26.4	32.2	34.5		31.3
% Overweight (BMI 25+)	67.3	69.1	74.6	71.8	67.3	61.0		61.9
% Obese (BMI 30+)	34.8	35.5	45.3	40.9	32.2	31.3	36.0	32.4

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Children [Age 5-17] Healthy Weight				54.3		47.6		40.7
% Children [Age 5-17] Overweight (85th Percentile)				34.3		32.3		58.0
% Children [Age 5-17] Obese (95th Percentile)				21.9		16.0	15.5	37.8

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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ORAL HEALTH	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Have Dental Insurance	73.2	75.7	70.4	72.1		68.7	59.8	51.1
% [Age 18+] Dental Visit in Past Year	64.7	62.4	60.6	61.9	70.0	62.0	45.0	69.9
% Child [Age 2-17] Dental Visit in Past Year				74.9		72.1	45.0	88.0

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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POTENTIALLY DISABLING CONDITIONS	DISPARITY AMONG SUBAREAS			TOTAL AREA vs. BENCHMARKS				
	Staunton	Waynesboro	Augusta County	Total Area	vs. VA	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	38.1	35.4	44.7	41.3		32.5		48.5
% Activity Limitations	30.9	26.7	26.1	27.3		24.0		25.6
% With High-Impact Chronic Pain	20.8	16.1	18.2	18.4		14.1	7.0	
Alzheimer's Disease (Age-Adjusted Death Rate)	56.1	37.9	29.4	36.6	27.6	30.9		31.3
% Family Member Diagnosed with Alzheimer's/Dementia	35.6	29.9	34.5	33.8				28.2
% Caregiver to a Friend/Family Member	30.4	27.8	26.6	27.7		22.6		20.0

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

RESPIRATORY DISEASE	DISPARITY AMONG SUBAREAS			TOTAL AREA vs. BENCHMARKS				
	Staunton	Waynesboro	Augusta County	Total Area	vs. VA	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)	57.0	61.5	41.5	47.8	34.4	38.1		42.8
Pneumonia/Influenza (Age-Adjusted Death Rate)	18.0		10.1	12.4	11.9	13.4		18.6

RESPIRATORY DISEASE (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% [Age 65+] Flu Vaccine in Past Year	82.5	75.3	79.8	79.5	65.5	71.0		60.2
% [Adult] Asthma	11.8	14.1	11.8	12.3	8.6	12.9		9.1
% [Child 0-17] Asthma				4.2		7.8		9.3
% COPD (Lung Disease)	6.8	8.9	6.6	7.2	5.8	6.4		10.9

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SEPTICEMIA	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Septicemia (Age-Adjusted Death Rate)				9.3	10.5	9.8		9.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SEXUAL HEALTH	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
HIV Prevalence Rate	192.5	177.4	112.9	140.3	321.7	372.8		
Chlamydia Incidence Rate	481.1	622.6	270.2	377.1	507.3	539.9		
Gonorrhea Incidence Rate	203.8	201.5	83.8	129.5	139.0	179.1		

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SUBSTANCE ABUSE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)				14.5	10.4	11.9	10.9	12.4
% Excessive Drinker	18.6	16.0	19.2	18.4	16.1	27.2		9.2
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)				14.8	19.0	21.0		11.4
% Illicit Drug Use in Past Month	3.3	4.2	2.6	3.1		2.0	12.0	0.5
% Used a Prescription Opioid in Past Year	14.6	16.6	16.0	15.8		12.9		17.7

SUBSTANCE ABUSE (continued)	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Ever Sought Help for Alcohol or Drug Problem	5.3	6.8	2.0	3.7		5.4		8.0
% Personally Impacted by Substance Abuse	40.4	44.0	37.4	39.5		35.8		36.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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TOBACCO USE	DISPARITY AMONG SUBAREAS			Total Area	TOTAL AREA vs. BENCHMARKS			
	Staunton	Waynesboro	Augusta County		vs. VA	vs. US	vs. HP2030	TREND
% Current Smoker	19.4	15.4	18.3	18.0	13.6	17.4	5.0	17.2
% Someone Smokes at Home	14.4	17.8	10.4	12.8		14.6		17.2
% [Household With Children] Someone Smokes in the Home				13.9		17.4		6.5
% [Smokers] Have Quit Smoking 1+ Days in Past Year				46.6	56.9	42.8	65.7	25.7
% Currently Use Vaping Products	7.5	11.1	7.8	8.4	5.2	8.9		0.3
% Use Smokeless Tobacco	3.5	3.8	6.8	5.5				3.2

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The Total Area (Staunton, Waynesboro, and surrounding Augusta County), the focus of this Community Health Needs Assessment, encompasses 1,001.96 square miles and houses a total population of 121,651 residents, according to latest census estimates.

Total Population
(Estimated Population 2015-2019)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Staunton City	24,432	19.92	1,226
Waynesboro City	22,140	14.97	1,479
Augusta County	75,079	967.07	78
Total Area	121,651	1,001.96	121
Virginia	8,454,463	39,481.77	214
United States	324,697,795	3,532,068.58	92

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Population Change 2010-2020

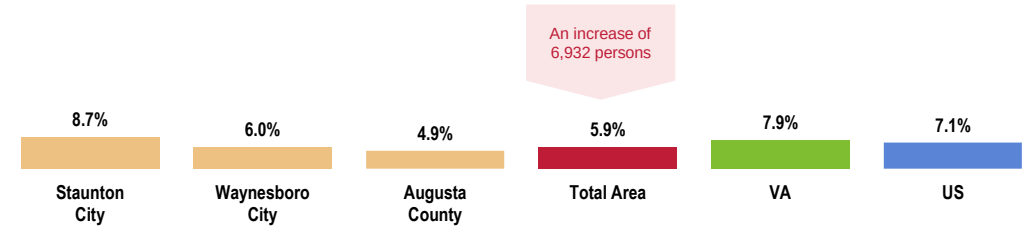
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2010 and 2020 US Censuses, the population of the Total Area increased by 6,932 persons, or 5.9%.

BENCHMARK ► Lower than state and US increases.

DISPARITY ► The highest percentage increase was recorded in Staunton.

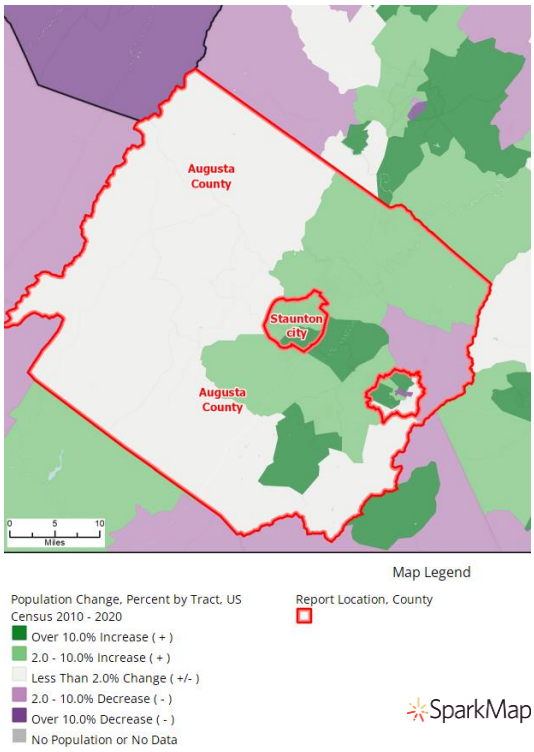
Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

This map shows the areas of greatest increase or decrease in population between 2010 and 2020.



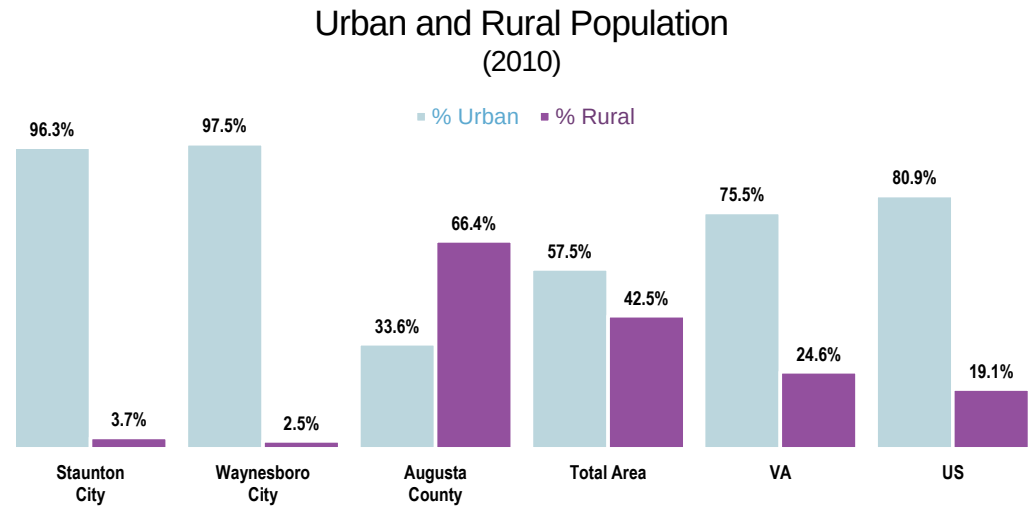
Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

More than half of the Total Area population (57.5%) lives in areas designated as urban.

BENCHMARK ► The Total Area is less urban than the state of Virginia and the US.

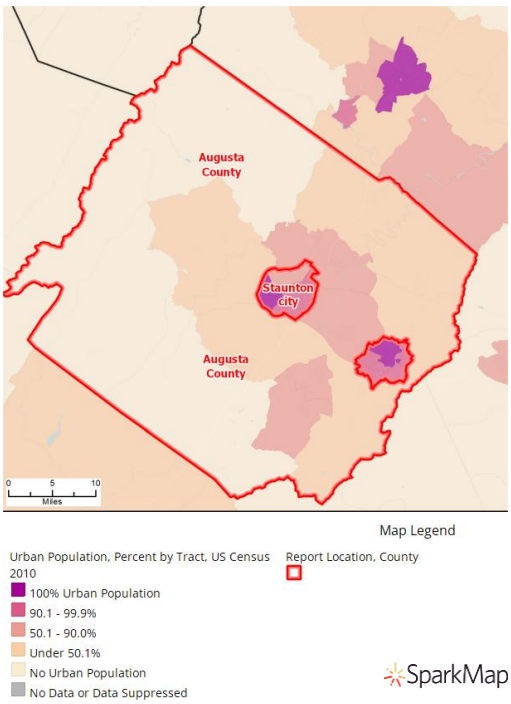
DISPARITY ► While Staunton and Waynesboro are predominantly urban, Augusta County is more rural than urban.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Note the following map, outlining the urban population in the Total Area.



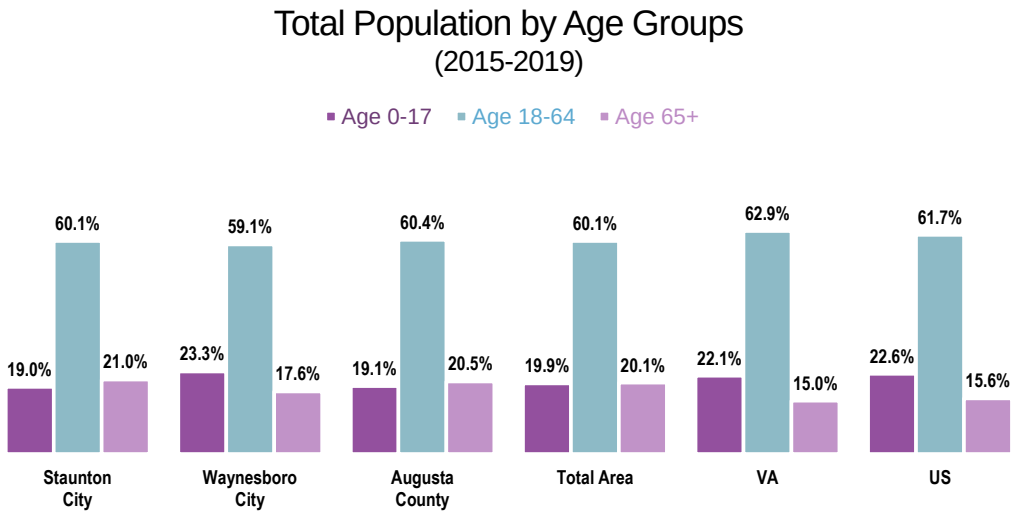
Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

In the Total Area, 19.9% of the population are children age 0-17; another 60.1% are age 18 to 64, while 20.1% are age 65 and older.

BENCHMARK ► Similar to statewide and national proportions.

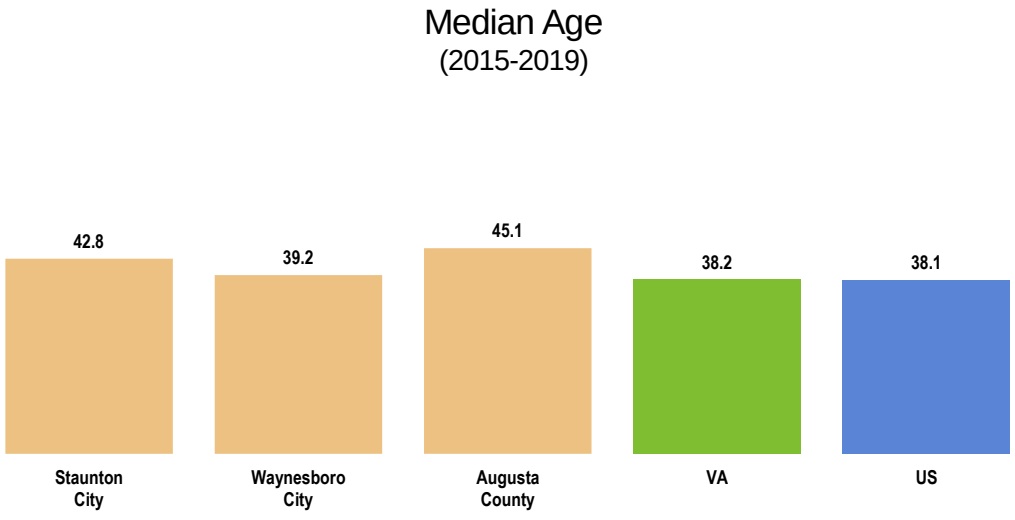
DISPARITY ► Waynesboro has a higher proportion of children than Staunton or Augusta County.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

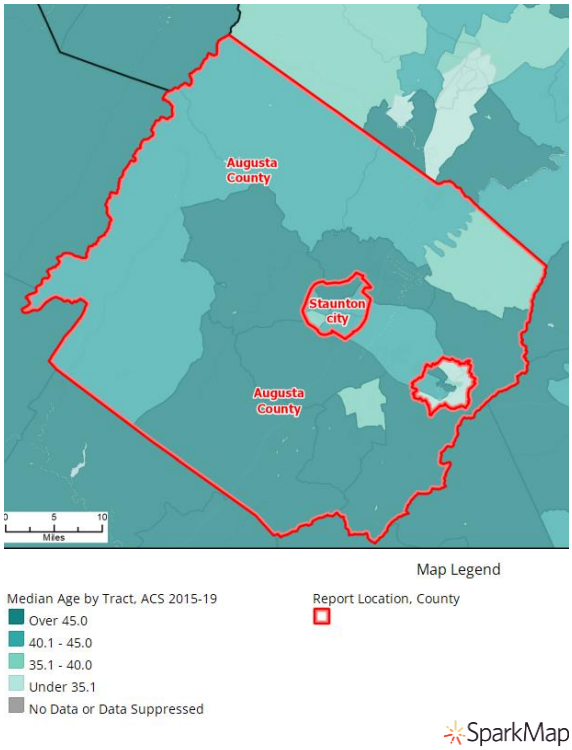
Median Age

Staunton, Waynesboro, and Augusta County are "older" than the state and the nation in that their median ages are higher.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age in the Total Area.



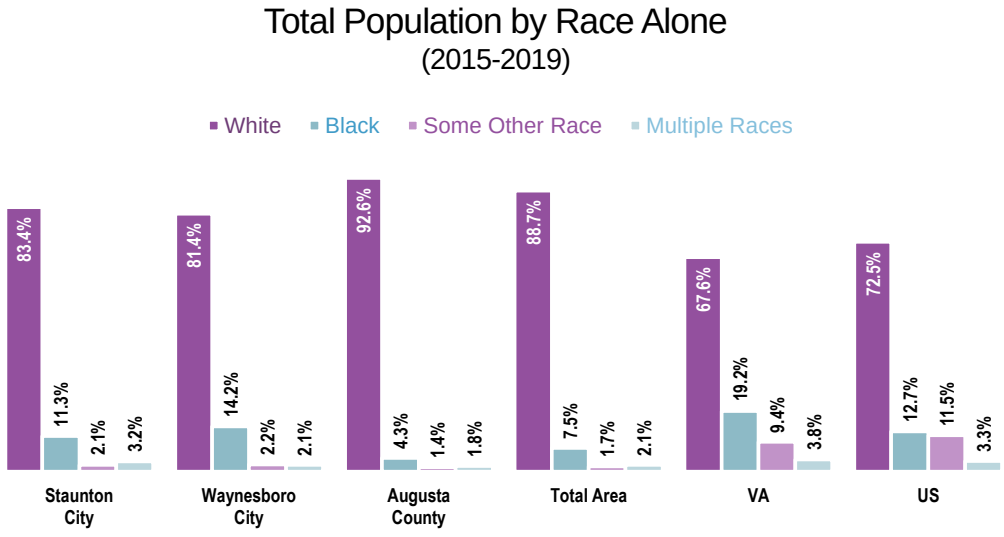
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 88.7% of Total Area residents are White and 7.5% are Black.

BENCHMARK ► Less diverse than the state and nation.

DISPARITY ► Augusta County is less diverse than either Staunton or Waynesboro.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

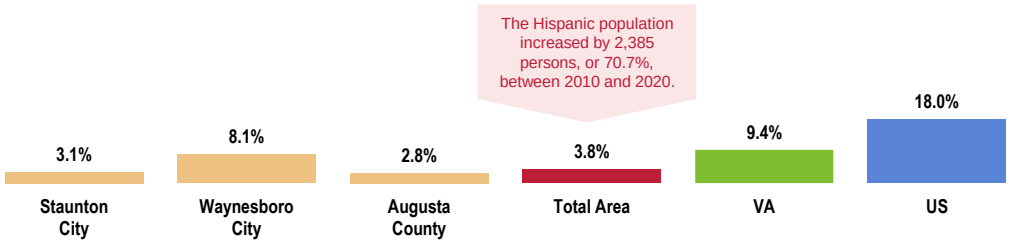
Ethnicity

A total of 3.8% of Total Area residents are Hispanic or Latino.

BENCHMARK ► Lower than statewide and especially national proportions.

DISPARITY ► Waynesboro has a higher proportion of Hispanic residents.

Hispanic Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

A total of 0.9% of the Total Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

BENCHMARK ► Much lower than found across Virginia and the US.

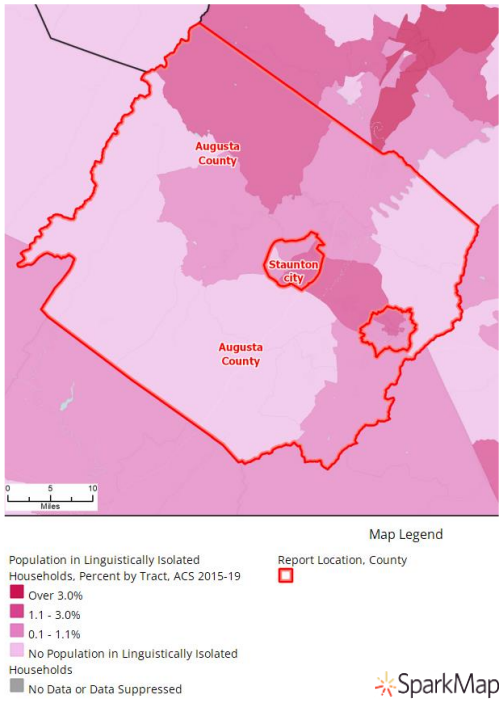
DISPARITY ► Highest in the area in Waynesboro.

Linguistically Isolated Population
(2015-2019)

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."

Note the following map illustrating linguistic isolation throughout the Total Area.



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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

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

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

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

- Healthy People 2030 (https://health.gov/healthypeople)

Poverty

The latest census estimate shows 10.7% of the Total Area population living below the federal poverty level.

BENCHMARK ► Better overall than the US finding. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Particularly high in Waynesboro.

Among just children (ages 0 to 17), this percentage in the Total Area is 14.9% (representing an estimated 3,515 children).

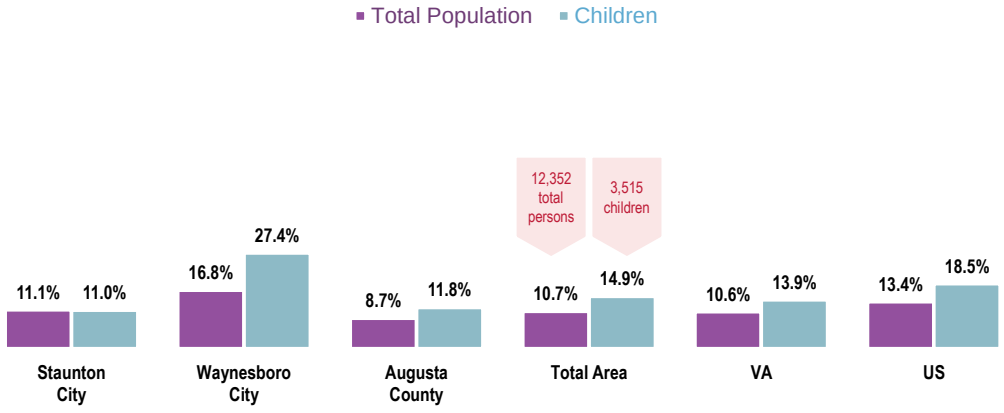
BENCHMARK ► Better overall than the US finding. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Particularly high in Waynesboro.

Population in Poverty

(Populations Living Below the Poverty Level; 2015-2019)

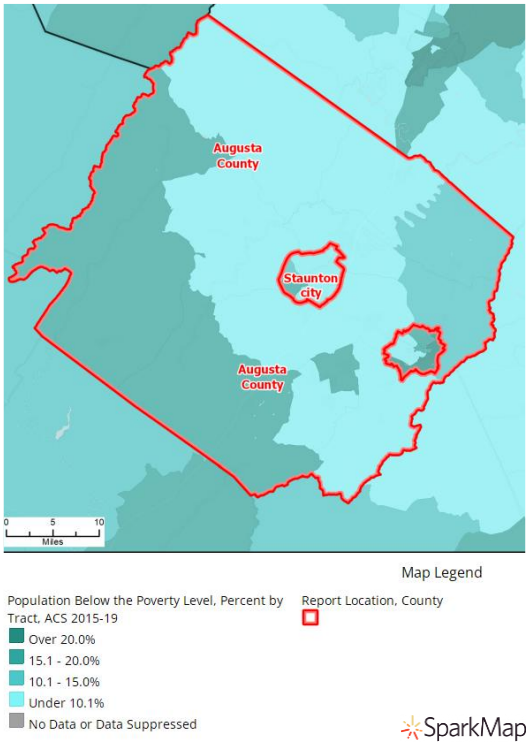
Healthy People 2030 = 8.0% or Lower

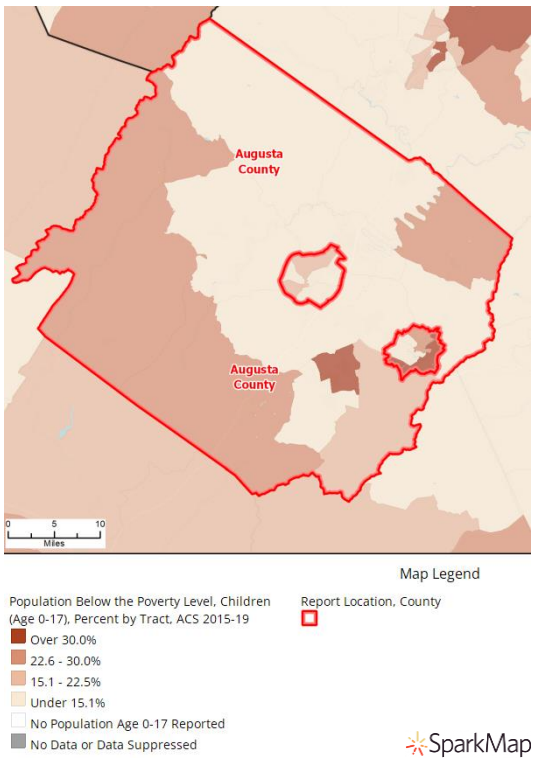


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

The following maps highlight concentrations of persons living below the federal poverty level.





Education

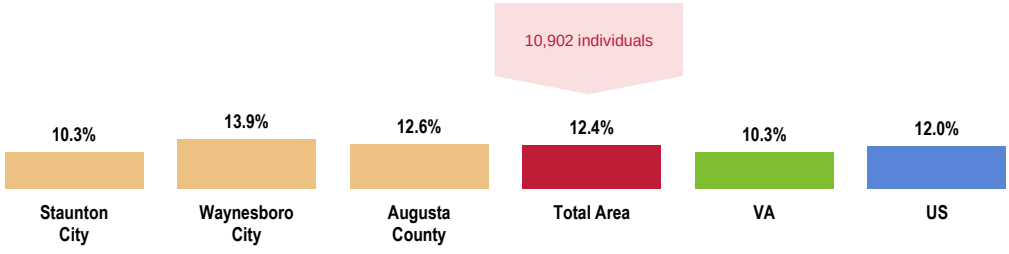
Among the Total Area population age 25 and older, an estimated 12.4% (nearly 11,000 people) do not have a high school education.

BENCHMARK ► Less favorable than found across Virginia.

DISPARITY ► Lowest in Staunton.

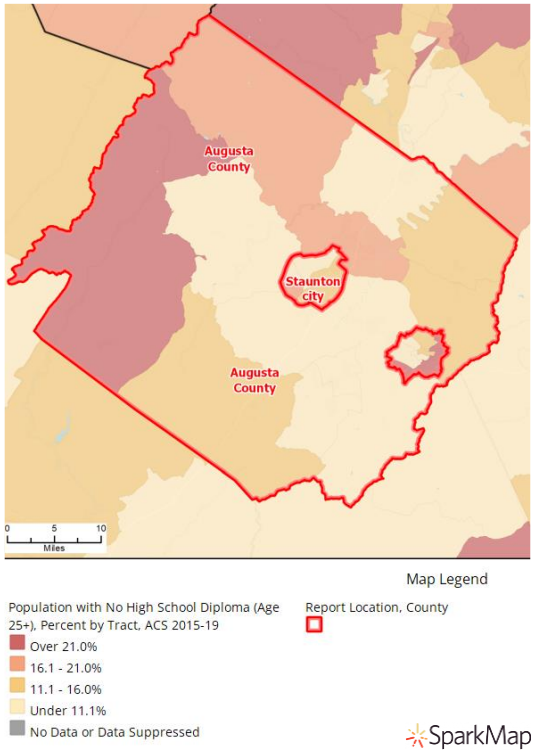
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.



Financial Resilience

A total of 18.4% of Total Area residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.

BENCHMARK ► More favorable than the national percentage.

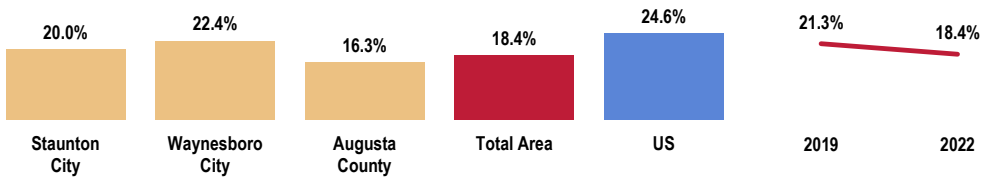
DISCREPANCY ► More often reported among women, adults younger than 65, and (especially) those with lower incomes.

Respondents were asked: "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

Total Area



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

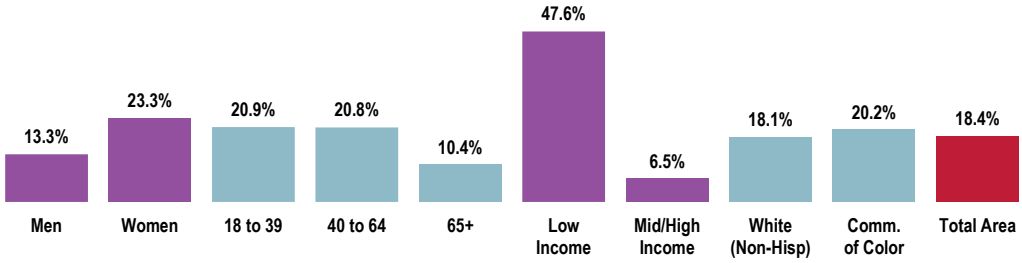
Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by sex, age groupings, income (based on poverty status), and race/ethnicity.

Here, "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to households living on incomes which are twice or more (≥200% of) the federal poverty level.

In addition, all Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Total Area, 2022)



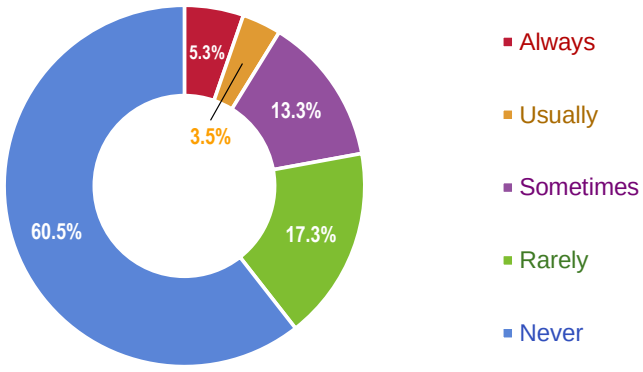
Sources: 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
Notes: Asked of all respondents.
Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Housing

Housing Insecurity

Most surveyed adults rarely, if ever, worry about the cost of housing.

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(Total Area, 2022)



Sources: 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: Asked of all respondents.

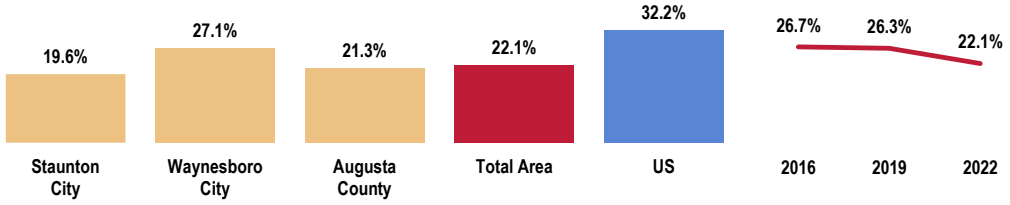
However, a considerable share (22.1%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

BENCHMARK ► Better than the US finding.

DISPARITY ► More often reported among adults younger than 65, and especially among lower-income residents and renters.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year

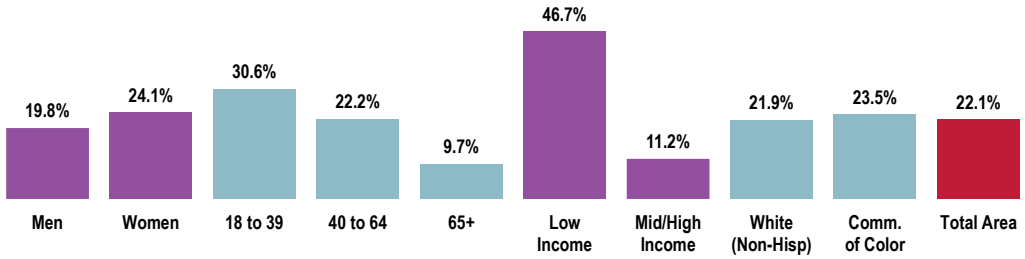
Total Area



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(Total Area, 2022)

Among homeowners	15.1%
Among renters	41.5%



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

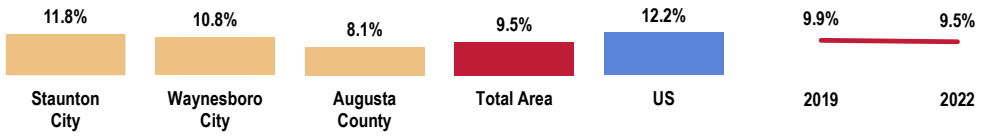
A total of 9.5% of Total Area residents report living in unhealthy or unsafe housing conditions during the past year.

Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

DISPARITY ► More often reported among lower-income respondents, renters, and younger adults.

Unhealthy or Unsafe Housing Conditions in the Past Year

Total Area



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Total Area, 2022)

Among homeowners	7.7%
Among renters	20.2%

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

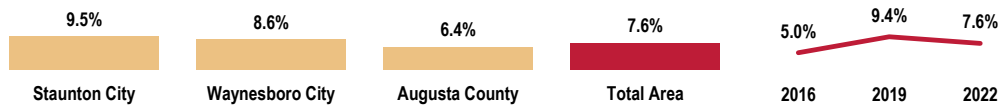
Housing Displacement

A total of 7.6% of survey respondents report that they have had to go live with a friend of relative at some point in the past two years, even if only temporarily, because of an emergency.

DISPARITY ► More often reported among younger adults and lower-income respondents.

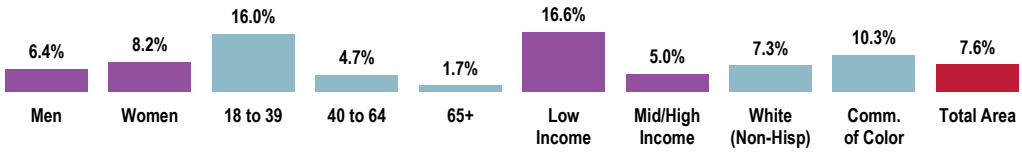
Had to Live With a Friend/Relative in the Past Two Years Due to an Emergency (Even if Only Temporarily)

Total Area



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

Had to Live With a Friend/Relative in the Past Two Years Due to an Emergency (Even if Only Temporarily)
(Total Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

Homelessness

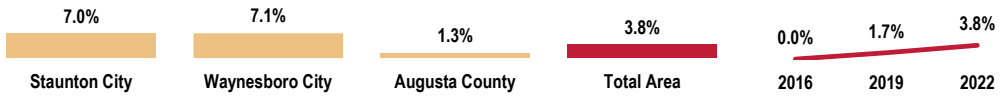
A total of 3.8% of Total Area adults reported there was a time in the past two years when they lived on the street, in a car, or in a temporary shelter.

TREND ► Marks a significant increase over time.

DISPARITY ► Higher in Staunton and Waynesboro.

Homeless At Some Point in the Past 2 Years

Total Area



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: ● Asked of all respondents.

Key Informant Input: Housing

Note the following input from key informants related to housing:

Homelessness

> Homelessness. Housing is health care. No one can address chronic or major health issues if they are sleeping outside and can address it only minimally in a shelter. How can one focus on managing diabetes when someone else feeds them? How can they decide to pursue sobriety when they don't know where they're sleeping tonight? How can they prioritize attending PCP appointments if they are struggling to survive? How are they going to get to their PCP appointments? If they had the means to do that, they wouldn't be homeless. Homelessness is not something anyone chooses, just like trauma isn't something anyone chooses. It happens to people. We need to be asking what happened to them. We need to stop acting, as a community and a nation, like it's some kind of character flaw that causes people to be homeless. I live in a two-income family and STILL qualify for financial assistance with Augusta Health. Any of us could be one more traumatic event and be in the same position – homeless. – Social Services Provider
>
> Homelessness. I was surprised it wasn't a part of the survey, unless I just missed it somehow. There are homeless people everywhere and especially low-income, mentally ill, substance-using people. This is a major problem. – Social Services Provider

Lack of Affordable Housing

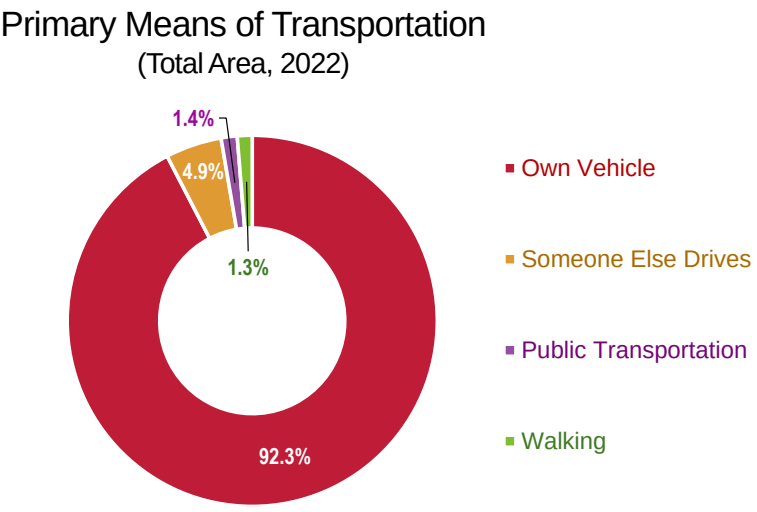
> Lack of affordable/permanent supportive housing. Housing is healthcare; those who are experiencing homelessness are often unable to address their healthcare needs. – Other Health Provider
>
> Lack of affordable housing. – Other Health Provider

Contributing Factors

> Food insecurity and homelessness. – Other Health Provider
>
> Homelessness and affordable housing. – Other Health Provider

Transportation

While most area residents own their own vehicle, 7.6% do not and must get rides from someone else, use public transport, or walk as their primary means of transportation.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.

Food Access

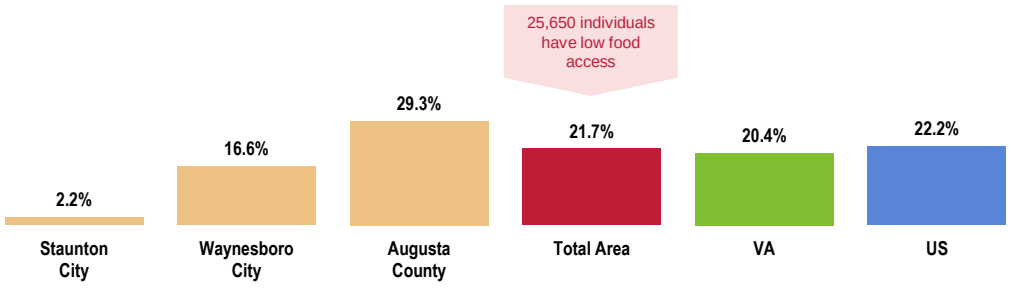
Low Food Access

US Department of Agriculture data show that 21.7% of the Total Area population (representing over 25,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

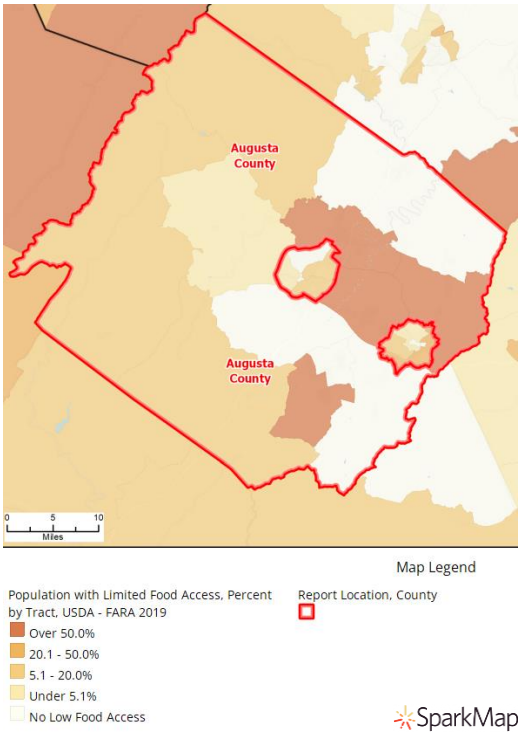
DISPARITY ► Considerably higher in Augusta County.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* in the **Modifiable Health Risks** section of this report.



Sources: ● US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
Notes: ● This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



Food Insecurity

Overall, 20.8% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

BENCHMARK ► Much lower than the US percentage.

TREND ► Significantly higher than the 2016 benchmark.

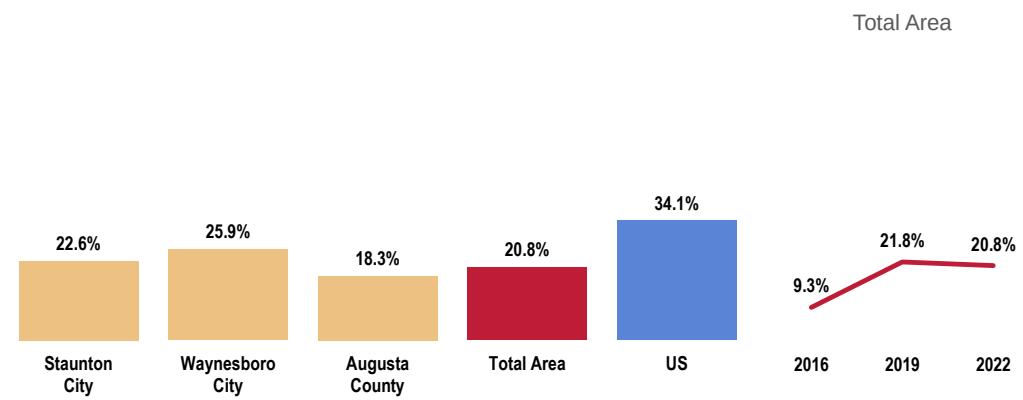
DISPARITY ► Women, younger adults, and especially lower-income residents are more likely to report being food insecure.

Surveyed adults were asked: "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "Often True," "Sometimes True," or "Never True" for you in the past 12 months:

- I worried about whether our food would run out before we got money to buy more.
- The food that we bought just did not last, and we did not have money to get more."

Those answering "Often" or "Sometimes True" for either statement are considered to be food insecure.

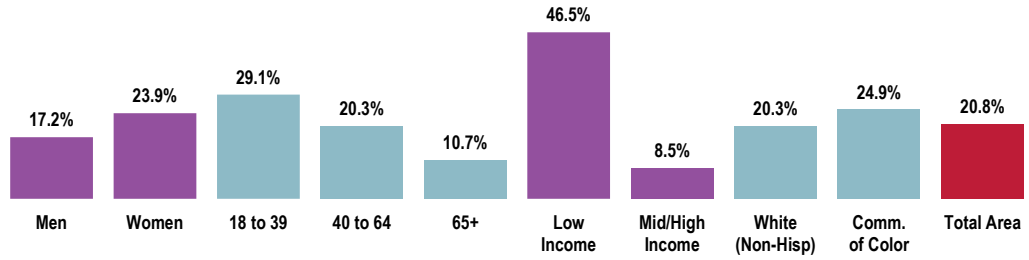
Food Insecurity



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(Total Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]

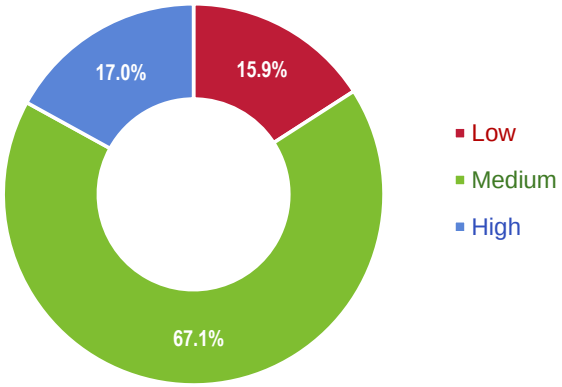
Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Health Literacy

Low health literacy is defined as those respondents who "Seldom/Never" find written or spoken health information easy to understand, and/or who "Always/Nearly Always" need help reading health information, and/or who are "Not At All Confident" in filling out health forms.

Most surveyed adults in the Total Area are found to have at least a moderate level of health literacy.

Level of Health Literacy
(Total Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 155]

Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

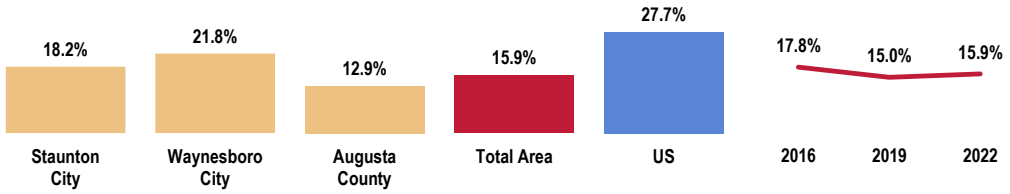
However, a total of 15.9% are determined to have low health literacy.

BENCHMARK ► Better than found across the US.

DISPARITY ► Highest in Waynesboro. Also more often reported among lower-income adults, communities of color, and adults age 18 to 39.

Low Health Literacy

Total Area



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 155]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Low Health Literacy
(Total Area, 2022)

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 155]

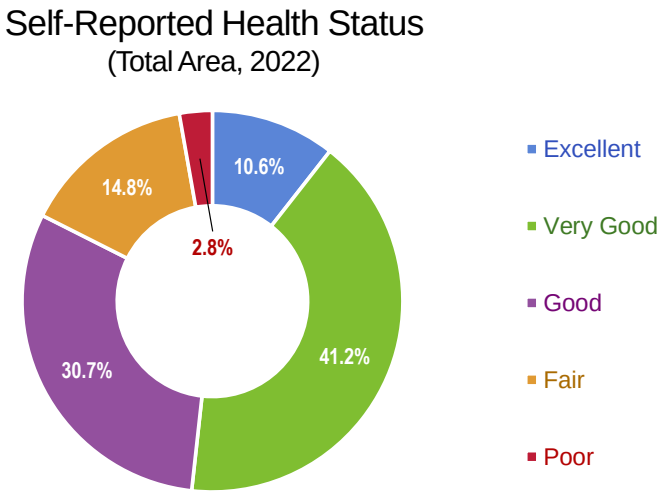
Notes:
- Asked of all respondents.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"

Most Total Area residents rate their overall health favorably (responding "excellent," "very good," or "good").

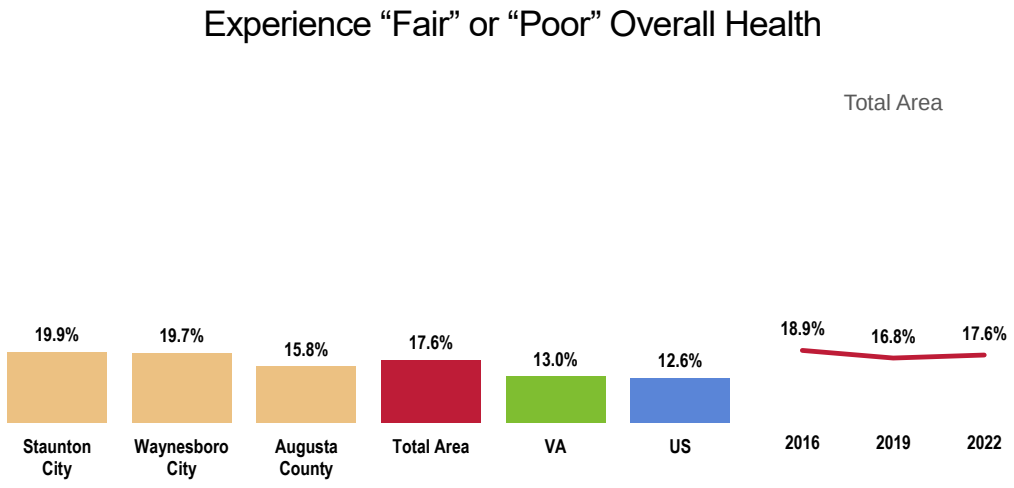


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

However, 17.6% of Total Area adults believe that their overall health is "fair" or "poor."

BENCHMARK ► Worse than state and national percentages.

DISPARITY ► More often reported among adults age 40+ and among lower-income respondents.



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Total Area, 2022)

Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

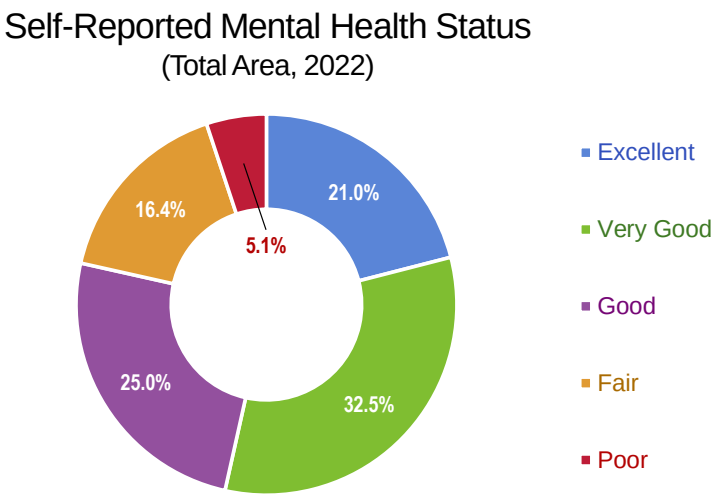
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

Adults

Most Total Area adults rate their overall mental health favorably ("excellent," "very good," or "good").

"Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: Excellent, Very Good, Good, Fair, or Poor?"



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: ● Asked of all respondents.

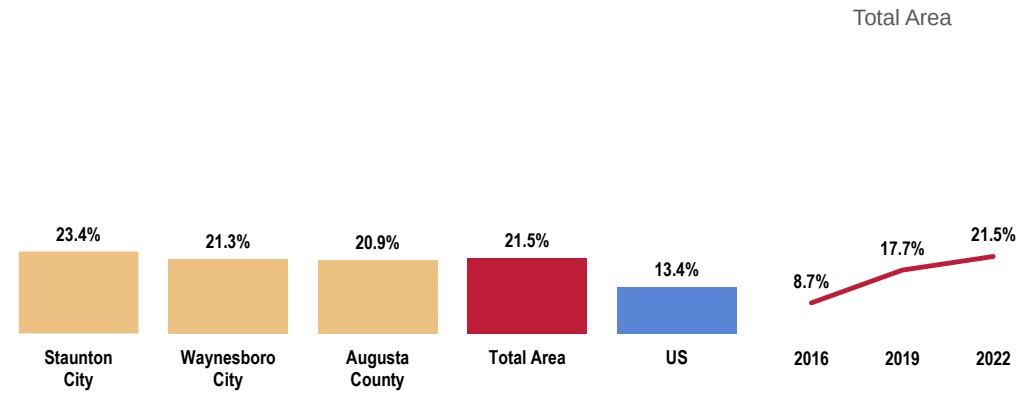
However, 21.5% believe that their overall mental health is "fair" or "poor."

BENCHMARK ► Worse than the US finding.

TREND ► Trending significantly higher over time.

See also the "Coronavirus Disease/ COVID-19" section of this report for data relating to the perceived mental health impact of the pandemic.

Experience "Fair" or "Poor" Mental Health



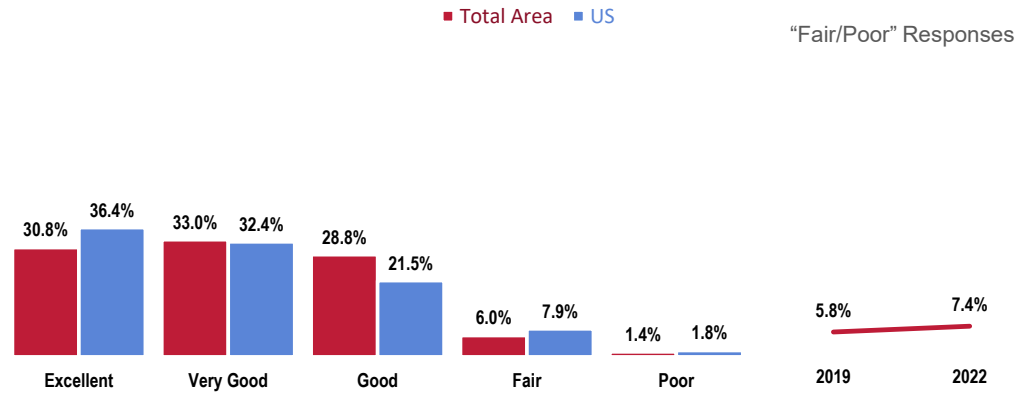
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Children

While most Total Area parents of children age 5 to 17 consider their child's mental health status to be "excellent," "very good," "or "good," a total of 7.4% rate it as "fair" or "poor."

Child's Mental Health Status

(Total Area Parents of Children Age 5-17)

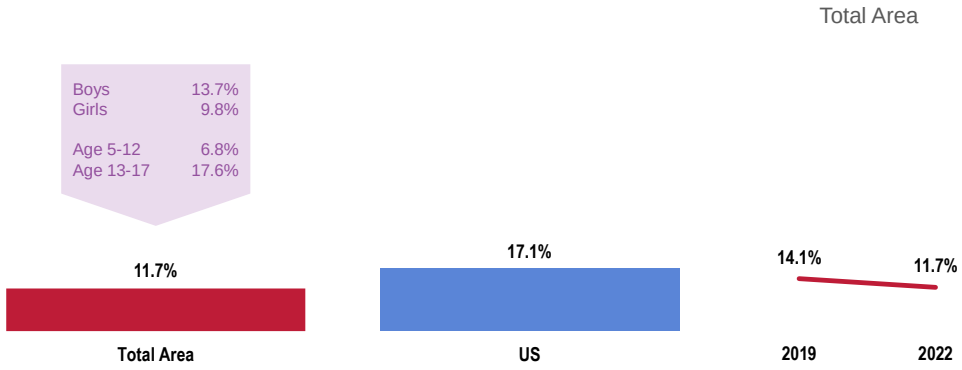


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 322]
● 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.
Notes: ● Asked of all respondents about a child age 5 to 17 at home.

In response to a related inquiry, 11.7% of area parents with children age 5 to 17 indicate that their child needed mental health services at some point in the past year.

DISPARITY ► Reported most often among parents of children age 13 to 17.

Child Needed Mental Health Services in the Past Year
(Total Area Parents of Children Age 5-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 323]
- 2020 PRC National Child & Adolescent Health Survey, PRC, Inc.

Notes:
- Asked of all respondents about a child age 5 to 17 at home.

Depression

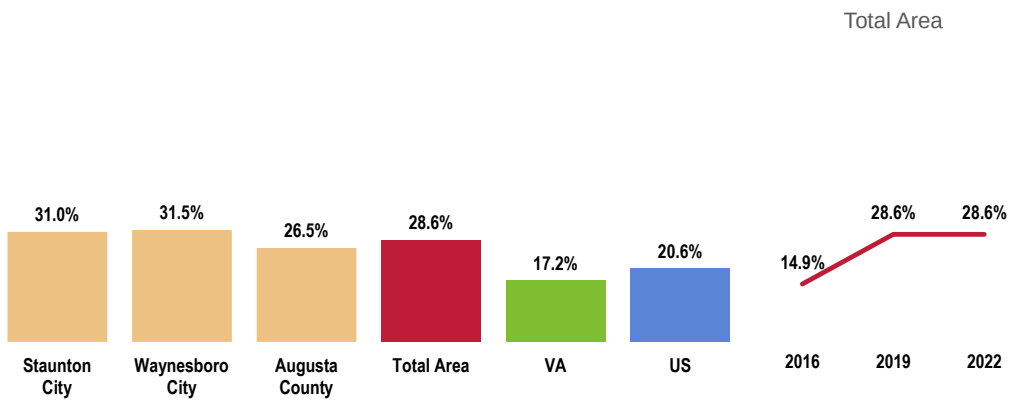
Diagnosed Depression

A total of 28.6% of Total Area adults have been diagnosed by a physician, nurse, or other health professional as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

BENCHMARK ► Higher than statewide and national findings.

TREND ► Significantly higher than the 2016 benchmark.

Have Been Diagnosed With a Depressive Disorder



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

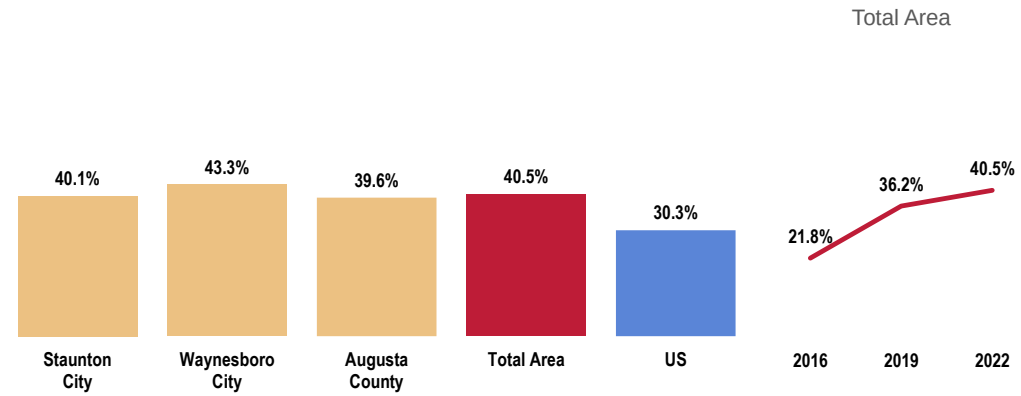
A total of 40.5% of Total Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

BENCHMARK ► Less favorable than the US percentage.

TREND ► Trending significantly higher over time.

DISPARITY ► More often reported among women, adults age 18 to 39, lower-income respondents, and communities of color.

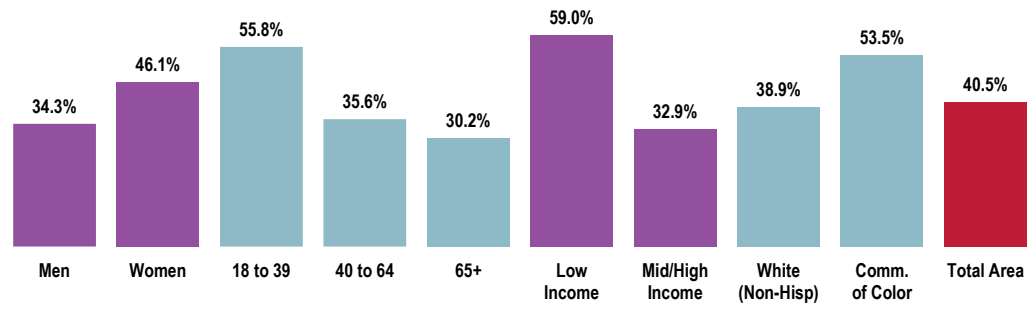
Have Experienced Symptoms of Chronic Depression



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression
(Total Area, 2022)

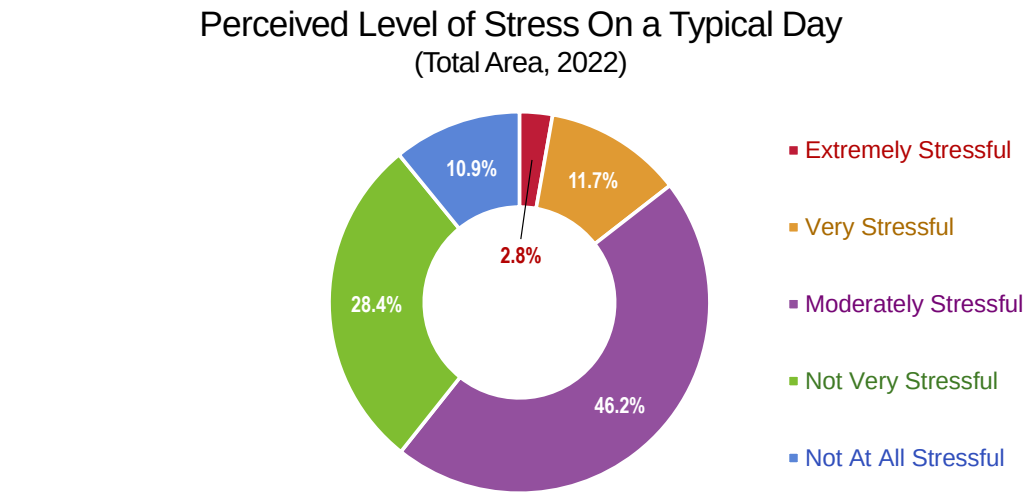


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Stress

Most surveyed adults characterize most days as no more than "moderately" stressful.

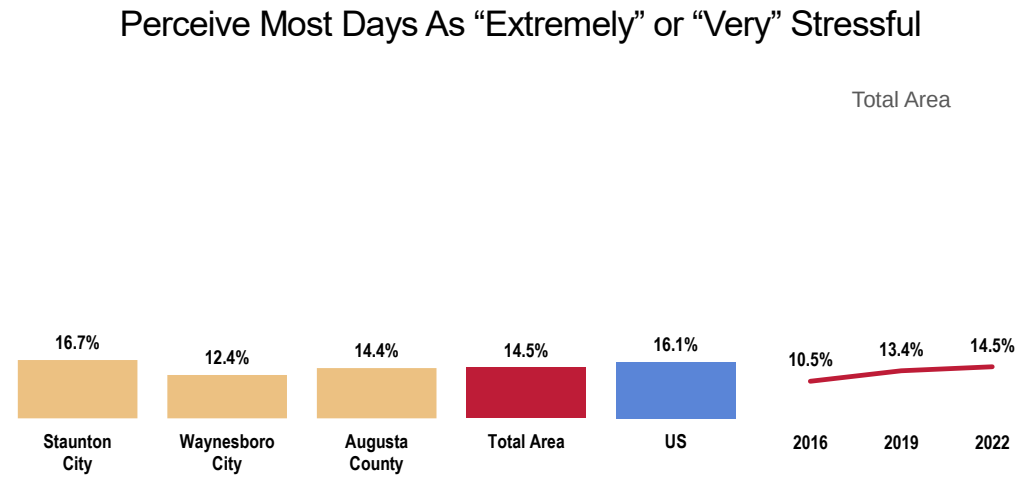


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: ● Asked of all respondents.

In contrast, 14.5% of Total Area adults feel that most days for them are "very" or "extremely" stressful.

TREND ► Significantly higher than the 2016 benchmark.

DISPARITY ► More often reported among women, adults younger than 65, and White residents.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 92]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful
(Total Area, 2022)

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: ● Asked of all respondents.

Suicide

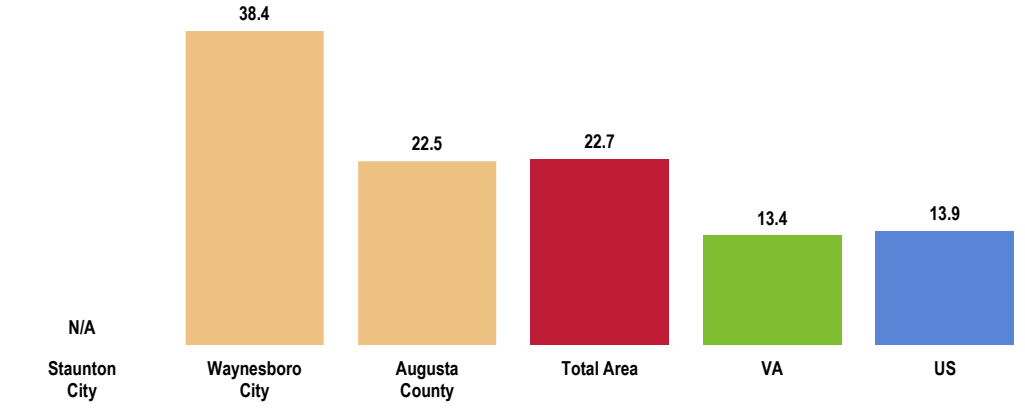
In the Total Area, there were 22.7 suicides per 100,000 population (2018-2020 annual average age-adjusted rate).

BENCHMARK ► Higher than the state and US rates. Fails to satisfy the Healthy People 2030 objective.

TREND ► Trending significantly higher in recent years.

DISPARITY ► Higher in Waynesboro.

Suicide: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower

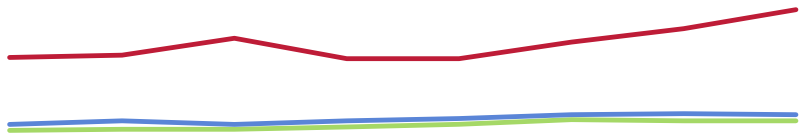


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	18.7	18.9	20.3	18.6	18.6	20.0	21.1	22.7
VA	12.6	12.7	12.7	12.9	13.1	13.5	13.4	13.4
US	13.1	13.4	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Mental Health Treatment

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the Total Area and residents in the Total Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

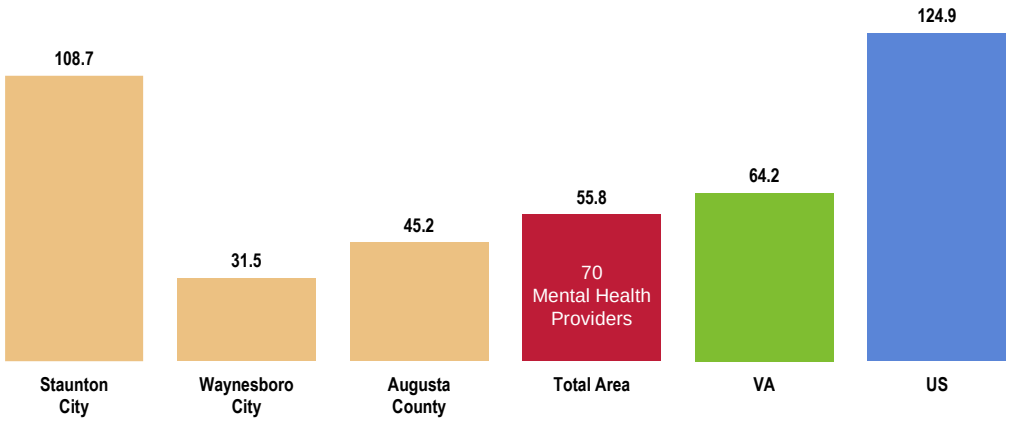
In the Total Area in 2021, there were 55.8 mental health providers for every 100,000 population.

BENCHMARK ► Much lower than the US proportion.

DISPARITY ► Lower in Waynesboro.

Access to Mental Health Providers

(Number of Mental Health Providers per 100,000 Population, 2021)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Currently Receiving Treatment

A total of 22.9% of area adults are currently taking medication or otherwise receiving treatment from a doctor, nurse, or other health professional for some type of mental health condition or emotional problem.

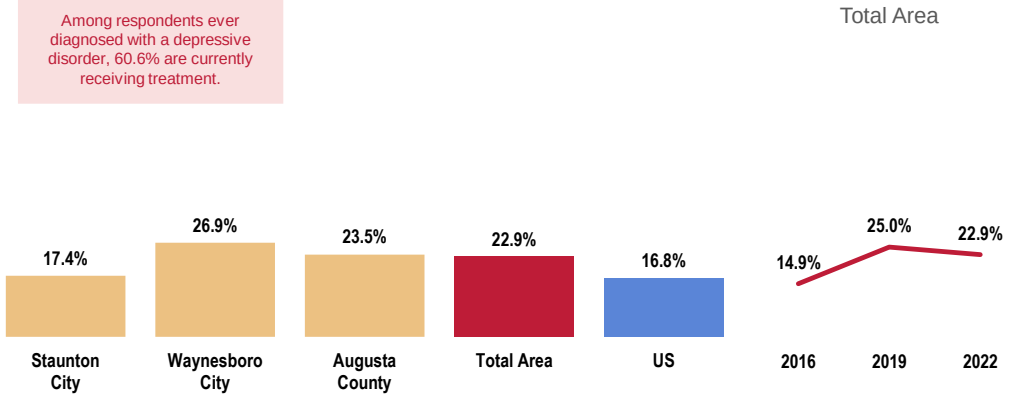
BENCHMARK ► Less favorable than the US finding.

TREND ► Significantly higher than the 2016 benchmark.

DISPARITY ► Lower in Staunton.

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 60.6% are currently receiving treatment.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

Difficulty Accessing Mental Health Services

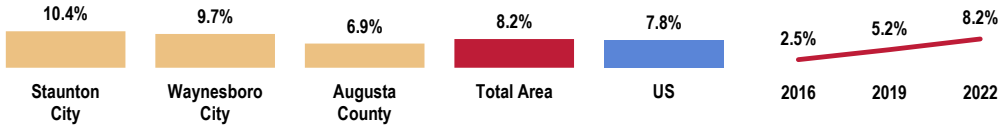
A total of 8.2% of Total Area adults report a time in the past year when they needed mental health services but were not able to get them.

TREND ► Rising significantly over time.

DISPARITY ► More often reported among women, adults younger than 65, and lower-income adults.

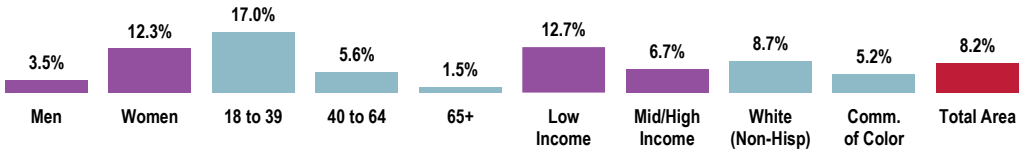
Unable to Get Mental Health Services When Needed in the Past Year

Total Area



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 95]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

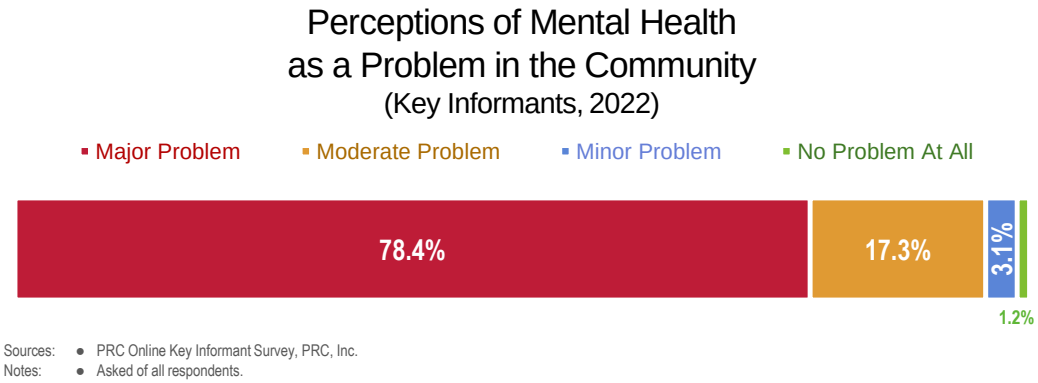
Unable to Get Mental Health Services When Needed in the Past Year
(Total Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

A high percentage of key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Having services when they need them. – Community Leader

Open beds for treatment. Strong outpatient support. – Other Health Provider

Lack of outpatient therapy options. Ability to pay for services. Lack of short-term inpatient facilities or care before transitioning to outpatient therapy. – Other Health Provider

Lack of mental health offerings for people with minimal concerns and since they are addressed early, they get worse. – Other Health Provider

Residential treatment and lack of psychiatrists willing to treat all patients. – Other Health Provider

Severe lack of services, especially residential services for those in crisis. – Other Health Provider

Access to timely and appropriate level care. Our area lacks robust options for crisis management (Crisis Stabilization Unit, mobile crisis teams, etc.). – Community Leader

Access to care. It takes over two months to get an initial appointment. – Other Health Provider

Lack of both outpatient and inpatient resources to help person suffering with mental health disorders. Need more, and more accessible, mental health providers. – Community Leader

Access to all levels of mental health care is needed, although, focusing on drug and alcohol abuse and chemical dependency is often behind mental health issues. So, providing more facilities for this need would go a long way. – Other Health Provider

Access to behavioral health beds; related substance abuse issues; burdens on health system and local law enforcement. Virginia needs to take a larger role in this issue and provide beds and resources to allow proper, swift placement of behavioral health patients. – Other Health Provider

Access to services, funding for services. Inadequate in and outpatient services, mostly because of funding. – Physician

Access to care. Licensed therapists have long waitlists and few take insurance, due to the challenges inherent in working with insurance companies, from clawbacks to initial denials, that are nearly impossible to overcome without a dedicated billing staff. – Other Health Provider

Access to mental health services. Most individuals wait weeks/months for an appointment while experiencing a mental health crisis. Also, individuals who have mental capacity concerns often cannot get an evaluation of their capacity, making it difficult when they are making poor choices. – Social Services Provider

Lack of mental health experts in the community. There are a number of folks who deal with mental health issues that are not receiving the help they need and tend to be isolated from the main community. There is limited understanding within the community about mental health issues and what they can do to help. – Social Services Provider

Access to care before issues become more severe. – Community Leader

Access to care. – Physician

There are limited resources both statewide and at a local level and the entire mental health system is collapsing in on itself. This is a critical need for our area and the recent expansion at Augusta Health is inadequate. – Community Leader

Access to appropriate long-term care. State facilities with staffing issues and not able to admit the patients as needed. – Community Leader

Lack of inpatient resources. Lack of alternatives to inpatient resources. Waits in the ED awaiting bed placement. Help with substance abuse, improved over last few years, but still lacking. – Physician

Access to care! Especially those with substance abuse problems. Community would benefit from a unique setting where people could receive both care for infections caused by opioid abuse (i.e. blood stream infection, wound infection, Hepatitis C, etc.) while receiving the mental health care to treat their primary problem (substance abuse and mental health) – Physician

Access/availability of MH counselors. There are resources once a person is in crisis, but there are long wait times for counseling (especially for children). – Other Health Provider

Access to services is so limited right now. Major demand for mental health services and waiting lists are long to get in and see a counselor/practitioner. Limited space in inpatient/residential treatment due to low staffing. – Other Health Provider

Establishing care in the community and maintaining that care relationship. – Physician

Not enough access to psychiatry and psychology and inability to get medication covered. – Physician

Limited access to longitudinal care. – Other Health Provider

I think there needs to just be more programs and providers. Those who need help seem to face quite a waiting list unless in acute crisis. – Other Health Provider

Lack of outpatient treatment options. – Other Health Provider

Lack of access to/education about availability of help. Area therapists have monthlong waiting lists. Valley Community Services Board has helpers, but finding and actually talking to them can prove quite difficult. – Community Leader

Access to quality care. – Community Leader

Services to support community participation, e.g., work, leisure. Non-crisis services. Crisis services. Physical health and wellness. – Other Health Provider

Access to care for their behavioral health issues. Management and follow up. There is nowhere for these patients to go. – Other Health Provider

Lack of access to care. Overwhelmed system that is not adequately funded and staffed. This is a nationwide issue that requires not only local attention but increased state and federal resources and attention. – Community Leader

Access to treatment. Waitlists are long, support groups to know how to recognize and how to deal with family members or for self. – Social Services Provider

Access to care, lack of mental/behavioral healthcare beds, lack of opportunities for supported housing and productive activity. – Public Health Representative

Lack of access for care. – Community Leader

Access to care. – Public Health Representative

Lack of consistent access to counseling services, particularly for adolescents and young adults. There were many adolescents during COVID who needed resources and were on waitlists for counselors or only able to meet once a month. – Community Leader

Access to care, limited facilities, mental health providers. – Other Health Provider

Access to care. Good mental health care (similar to good care in general) relies not only on excellence but also consistent and ongoing care from the same provider. Trust in the system is hard to overemphasize. – Physician

No services. – Social Services Provider

Lack of available services. Because of the pandemic, mental health services seem to be less available, while the need has increased. – Social Services Provider

Contributing Factors

Access to emergency services, including inpatient care. Excessive wait times. Reliance on law enforcement and ER to provide emergency assessment prior to escalation and care until inpatient care is available. Lack of providers, especially providers who accept insurance. – Community Leader

There is definitely a lack of resources in our community related to mental health services. Not enough clinicians and long waiting lists prohibit people from getting the care they need. There is also minimal diversity in the field, which also deters some individuals from receiving care. – Social Services Provider

Access to providers, medications, and emergency services. Mental health impacts how well you can manage other diseases such as your diabetes or heart disease. Long wait times for OPBH for counselling. Intake process at VCSB is quite difficult to navigate and even harder for the elderly and challenge patients. Poorly controlled mental health leads to emergency needs for hospitalizations. Many of the homeless have unmet mental issues that has led to them being homeless – Other Health Provider

Unable to get the care they need. One person may assess them and say they're fine and nothing gets done. No community support, going to VCSB is hard to get into — appts are months out, you have to wait a long time in waiting area, poor follow up. It's sad there is also no education available for anyone having to deal with people who have mental illness. We have contacted WSH and they said that was not a service they provided. Who do you turn to for help managing this, there are roadblocks everywhere you turn? Navigating a system for this should not be this hard, it's sad. – Other Health Provider

There has been a major increase in depression, anxiety, substance use, etc. Inpatient resources (i.e., residential facilities) are difficult to find, especially for adults. In addition, if admitted to a hospital for mental health stability, patients are often discharged either too soon and/or without the follow up support that is needed. Many people need consistent follow up and support in order to maintain compliance with medications and/or therapy. We need to get away from the stigma of mental health because many people will not seek help for that reason and/or because providers will not take the insurance (Medicaid, Medicare, etc.). – Other Health Provider

Access to care/providers. Cost for care/providers. Social stigma/lack of awareness. – Social Services Provider

Access to care, not enough providers, specifically not enough providers for kids, lack of awareness, stigma, etc. – Social Services Provider

Inadequate resources to address problems on both inpatient and outpatient basis. Housing issues compound the problem. With Western State in our community, many patients do not leave upon release creating larger issues for our community. Strains of pandemic have also exacerbated underlying problems. – Community Leader

Access to help, parents/guardians/family members that can't commit or get services for another adult family member in need, misunderstanding of how to help, bullying in school leading to mental health issues, social media influence on mental health issues. – Community Leader

There are not enough mental health resources available, including providers and facilities. People with mental health issues often access the ED, but then have nowhere to go to seek help after that. Due to lack of insurance, they may also not be able to afford the intervention treatment that they need. There is also a stigma associated with mental health issues, which can prevent people from getting the care and help that they need. – Other Health Provider

There are inadequate outpatient services, state beds have closed, COVID has resulted in a dramatic increase in behavioral health issues. – Other Health Provider

Lack of services, lack of drug rehabilitation centers. Accessibility in finding providers and services, long wait times for services, transportation. – Other Health Provider

Access to care for inpatient and outpatient services. Lack of ability to pay for mental health services. – Other Health Provider

Lack of timely access to psychiatry services. Often wait list for local community services board (CSB) psychiatry. Very arduous track to get in with psychiatrist at CSB. Not enough case management services to assist patients with community living, especially intensive case management. Lack of affordable housing. Limited community living education. – Other Health Provider

Access to care in a timely manner due to the limited number of mental health professionals in the community in comparison to the number of patients in need. Also, a lack of resources and burnout within the primary care community to help manage patients with mental health needs. – Social Services Provider

Immediate access to care, crisis services, and consistent follow up care, stigma related to mental health, access to services for children, flexible scheduling for appointments, lack of expertise/access to trauma informed care. – Community Leader

The mental health system is broken across the state. People are essentially warehoused for mandatory but inept legal periods because of laws written by elected officials based on kneejerk, emotional reactions to situations that fit a narrative. There is no forethought into placing adequate facilities, staffing, and funding before enaction. There is no sense of individual choice or responsibility. The fallout created has put this state so far in the hole no amount of money would fix it in the foreseeable future. Individuals who go through the ECO/TDO process receive no real long-term help and are stuck with an LEO and medical staff who are berated for hours or days. The patient is often released with no substantive change. Law enforcement is stuck in the middle on non-criminal issues. It puts law enforcement in situations the laws do not cover. The ER and mental health facilities are regularly at or over capacity. There is a local need for a separate mental health/detox medical center. – Community Leader

The biggest challenges are access to mental health providers, access to face-to-face provision of mental health services since COVID, increase in suicide, increase in depression/anxiety, transportation to mental health appointments so that face-to-face sessions can occur, stigma related to obtaining counseling, and long psychiatry waitlists for all clients. – Social Services Provider

Access due to workforce shortage. Inability to pay if no insurance or Medicaid/Medicare. – Social Services Provider

Where to begin, this is my number one, not enough resources. Lots of stressors caused by COVID. More patients than counselors. Cost of healthcare, counseling and medication, too expensive for folks on tight household incomes. – Social Services Provider

Stigma, cost, lack of providers, lack of knowledge around navigating the system, transportation, folks who need treatment ending up in the justice system instead, not enough emphasis on trauma-informed approaches to working with clients and as an agency in general. – Social Services Provider

Those with psychological or psychiatric help. Those with an attachment to the Community Services Board – oversight of their diagnosed disease with frequency of visitation as a major issue. Finding housing for these individuals if they are without housing. Western State – finding housing to enable release from the hospital. – Social Services Provider

Stigma. Not affordable at all! Low-income families can get these sessions for free from many nonprofit agencies or with Medicaid; however, there are more appointments needed than counselors. Medium income (or "middle class") are in a worse boat as they have insurance through an employer with high deductibles and end up saving money as a self-pay client. This is still $75-$150 on a sliding scale with nonprofit organizations for a paycheck-to-paycheck family. If they have a son or daughter needing counseling or themselves, that's more than the price of daycare … and when it comes to mental health, it's the first to get cut in the budget. More affordable counseling needs to be done for not just low-income, but those that do work and bring home an income that still can't afford it. The sliding scales are still way too high. – Other Health Provider

Stigma, lack of low-cost counseling services, difficulty of accessing, lack of knowledge of where to go for help. Lack of funding for school programs. Lack of funding for services such as CSB programs impacting all areas of mental health. Lack of understanding of treatment. – Social Services Provider

Aside from the general stigma involved or associated with mental health, it seems to be very hard for people to find the resources they need and/or to financially pay for them when needed. Medication costs often seem to be an issue from what I have seen and heard. – Other Health Provider

Mental health stigmas – not wanting to get the help that you need. Lack of education at a young age about mental health to reduce those stigmas. Access to healthcare/ getting to and from appointments/cost of mental health services. HUGE lack of postpartum support for new mothers in our area. – Other Health Provider

Stigma. Lack of transportation or technology to access telehealth options. Homelessness. Lack of entitlements. Substance use disorder. Waiting lists. Procedures surrounding access to services are tricky and full of barriers. – Social Services Provider

Lack of providers – there are more individuals in need of support than there are providers to offer the needed services. Lack of awareness of supports – many community members are unaware of the providers/programs/options for finding and participating in mental health services. Lack of prevention services – commonly mental health distress comes to light when a person is in/has experienced a crisis. However, there is a benefit to participating in prevention services that can decrease the likelihood/impact of mental health distress. – Community Leader

Individuals don't know the resources and availability of services. Lack of access is due to transportation issues, hours, or lack of providers. Individuals in the community do not always recognize the signs of mental health issues or concerns in themselves and others and if they do are unsure of steps to access help. – Social Services Provider

Realizing that resources are available and knowing how to access those resources. Cost. Stigma of admitting to mental health problems. – Community Leader

Mental health is either the main complaint or a complicating factor in many Augusta Health admissions. We do not have enough psychiatrists and other providers, especially for people living in poverty. – Other Health Provider

Lack of support, lack of education, lack of understanding from the general public. This mindset that it's always somebody else having a mental health issue needs to stop. We are all humans and we all have a brain therefore we all need to take care of our own mental health. – Social Services Provider

There are many challenges for those with mental health issues. We have yet to locate a mental health medical professional (psychologist, psychiatrist, licensed therapists, etc.) that provides service in Spanish. We recently had to find a child psychologist for a client and the closest one we could find that speaks Spanish was in Harrisonburg, which is located almost an hour away. A related problem is cultural competency – non-Hispanic mental health professionals need to understand the community they are helping. There is also a general and not insignificant problem in the community itself, and that is prevailing stigma that remains about seeking and/or receiving treatment for mental health issues. – Social Services Provider

Culturally competent and affirmative treatment in ASL (American Sign Language). There are less than five providers who can sign and communicate directly with a deaf patient. ASL interpreters are available to facilitate communication and are also bound by HIPAA, but not all are trained in mental health terminology. Mental health information is also hard to find in accessible language formats. Wait times and insurance types accepted (which providers take Medicare or Medicare vs. private insurance or self-pay only) are additional barriers. – Social Services Provider

It seems that many individuals with mental health issues go undiagnosed. There continues to be a stigma about mental health, which possibly results in individuals not seeking help. – Community Leader

Stress due to high levels of low-income family situations. Lack of early intervention. – Social Services Provider

Lack of Providers

> Insufficient mental health service providers, unable to meet the demands of the community, lack of short-term detox program, shortage of psychiatric hospital beds. – Other Health Provider
>
> Insufficient number of mental health providers in this region. – Physician
>
> Lack of providers and services in our area to meet the needs of everybody who needs support. – Social Services Provider
>
> Access to support! We have a shortage of clinicians. – Social Services Provider
>
> The biggest challenge is finding a provider who is able to see persons in a timely manner, and who accepts Medicaid or offers sliding scale (nonexistent). Many times, this results in crisis and clients need to have a TDO in place to be admitted to the hospital. This issue could also result in suicide, criminal activity, or harm to another person before the client is able to receive help. – Public Health Representative
>
> Very limited number of providers, especially pediatric supports. – Social Services Provider
>
> There are few community providers who are able to attract mental health providers to address the significant needs of children and youth in crisis in our community. – Community Leader
>
> Lack of psychiatry physicians/absence of mental health professionals. – Other Health Provider
>
> Lack of mental health providers. – Community Leader

Denial/Stigma

> Discrimination, and fear of discrimination, can make mental health problems for many in our community worse. Many LGBTQ people also struggle to find affordable mental health services that are also affirming of their identities. – Social Services Provider
>
> Mental health still has a stigma attached to it. Many people experiencing mental health issues are afraid to address them. – Community Leader
>
> The stigma is still very real in this area, and we lack facilities and programs to serve those dealing with these diagnoses. – Other Health Provider
>
> The stigma still around it in our community and knowing where to go to get appropriate help. It's just to the point where men in our community haven't even started to have conversations about counseling. Even with counseling, there tends to be a cultural barrier between us and the therapists, which often don't look like us. Adam Thomason writes beautifully about this is his book My Journey with Jesus and Jay-Z. – Community Leader
>
> Stigma. – Community Leader
>
> We all have some degree of mental health issue to deal with. Those who don't think so are just better at hiding it from themselves and/or others. – Community Leader
>
> Stigma of these issues seems to continue to exist. Lack of beds for hospitalizations. – Other Health Provider

Affordable Care/Services

> Access to affordable help and alternative medicine options (not just medication). – Other Health Provider
>
> Lack of access to affordable services, lack of insurance coverage or copays/deductibles too high. – Social Services Provider
>
> Obtaining appropriate assistance at an affordable cost along the continuum of mental health issues. It seems as though someone has to be homicidal or suicidal to receive assistance. – Other Health Provider
>
> Lack of appropriate and/or affordable resources. – Other Health Provider

Due to COVID-19

> The Covid pandemic has exacerbated challenges for those with mental health issues, spotlighting lack of mental health services providers, cost of mental health services, waiting lists for treatment. – Social Services Provider
>
> With everyone having experienced prolonged stress during the pandemic, it's difficult to identify when it's the right time to reach out for help. It's my feeling that there's many more people struggling now and many of them for the first time in their lives, thus they aren't aware of resources available to them. I think our community needs additional options for treating people experiencing a mental health crisis. – Social Services Provider
>
> Behavioral health is a growing issue and COVID enhanced it. – Community Leader
>
> Many people experienced or had an exacerbation of mental health problems (e.g., anxiety, depression) especially related to COVID. There are increased numbers in the ER a well as the mental health unit at Augusta Health, and many don't have a place to go for treatment due to lack of staff at long-term mental health facilities and are not compliant with taking medication long-term to treat their mental health conditions. – Other Health Provider

Disease Management

> Compliance with medications and ease of getting an appointment. – Other Health Provider
>
> Medicine management. Support systems. – Social Services Provider

Awareness/Education

> Education, resources and knowledge, help. – Other Health Provider
>
> How to identify individuals needing care and then finding resources to help them. The mental health field seems to be underpaid and overworked. – Community Leader

Prevalence/Incidence

> High incidence and limited services. – Physician
>
> Everyone knows someone who is suffering from or has suffered from mental illness. Mental illness often goes undiagnosed and untreated and there is much stigma around this very common issue. – Community Leader

Eating Disorders

> Eating Disorders – Just know too many families that are impacted. And it's one that remains well-hidden. Generally, the children (and adults) impacted are functioning normally and high achievers and even admired for their physiques. Until it's a problem. Ties into mental health issues, but a bit more specific and overlooked, I think, when folks think of 'mental health'. – Other Health Provider

Housing

> Housing and employment, which in turn can lead to criminal activity. – Social Services Provider

Impact on Quality of Life

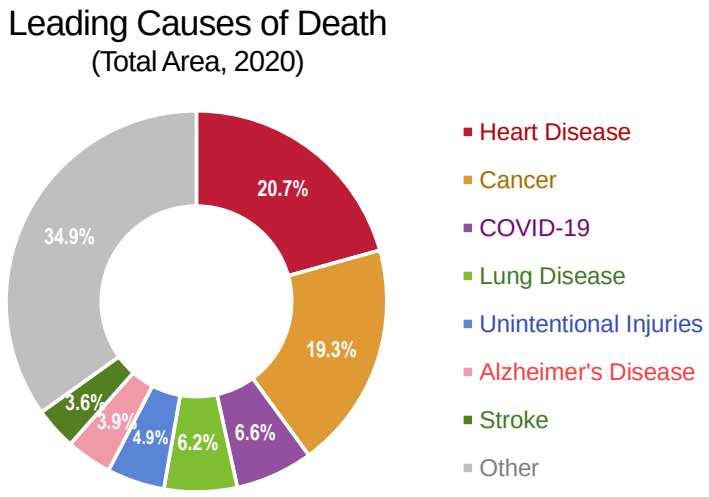
> Mental health affects everything we do. It affects our family relationships, our ability to be productive members of society, our ability to be good parents. – Other Health Provider

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for 4 in 10 of all deaths in the Total Area in 2020.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Virginia and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

The following chart outlines 2018-2020 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Total Area.

Each of these is discussed in greater detail in subsequent sections of this report.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Total Area	Virginia	US	HP2030
Diseases of the Heart	164.0	149.7	164.4	127.4*
Malignant Neoplasms (Cancers)	156.2	146.9	146.5	122.7
Falls [Age 65+]	78.8	68.4	67.1	63.4
Unintentional Injuries	50.3	46.7	51.6	43.2
Coronavirus Disease/COVID-19 [2020]	50.0	56.3	85.0	—
Chronic Lower Respiratory Disease (CLRD)	47.8	34.4	38.1	—
Alzheimer's Disease	36.6	27.6	30.9	—
Cerebrovascular Disease (Stroke)	35.8	39.0	37.6	33.4
Diabetes	23.6	23.5	22.6	—
Intentional Self-Harm (Suicide)	22.7	13.4	13.9	12.8
Unintentional Drug-Related Deaths	14.8	19.0	21.0	—
Firearm-Related	14.6	12.3	12.5	10.7
Cirrhosis/Liver Disease	14.5	10.4	11.9	10.9
Kidney Disease	14.0	16.1	12.8	—
Motor Vehicle Deaths	13.3	10.0	11.4	10.1
Pneumonia/Influenza	12.4	11.9	13.4	—
Septicemia	9.3	10.5	9.8	—
Homicide/Legal Intervention [2011-2020]	3.1	4.9	5.9	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

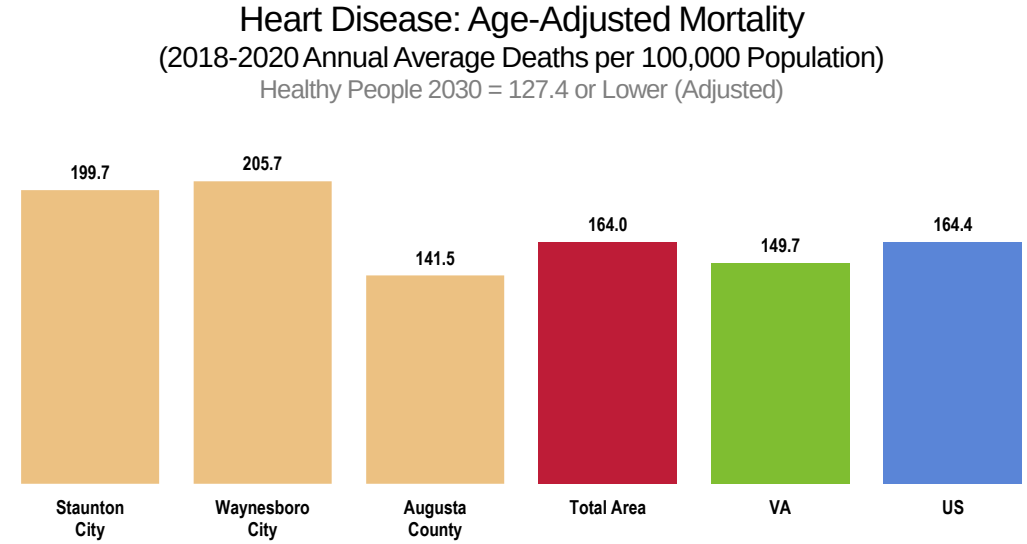
Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2018 and 2020, there was an annual average age-adjusted heart disease mortality rate of 164.0 deaths per 100,000 population in the Total Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lower in Augusta County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	166.5	168.4	168.4	173.4	169.1	164.2	163.9	164.0
VA	159.3	157.3	155.8	153.7	153.1	151.0	150.5	149.7
US	190.6	188.9	168.9	167.5	166.3	164.7	163.4	164.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

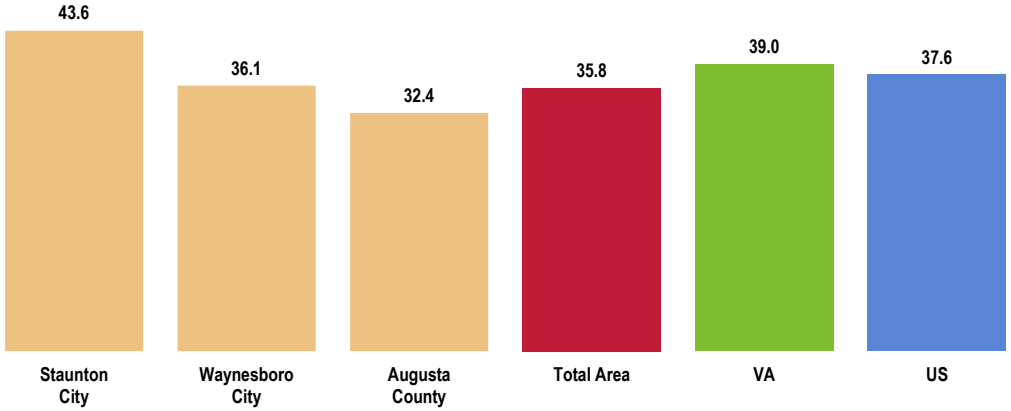
Between 2018 and 2020, there was an annual average age-adjusted stroke mortality rate of 35.8 deaths per 100,000 population in the Total Area.

DISPARITY ▶ Higher in Staunton.

Stroke: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	37.6	35.8	38.7	40.8	36.9	35.6	34.2	35.8
VA	40.3	38.8	37.9	37.7	37.9	38.2	38.2	39.0
US	40.7	40.6	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

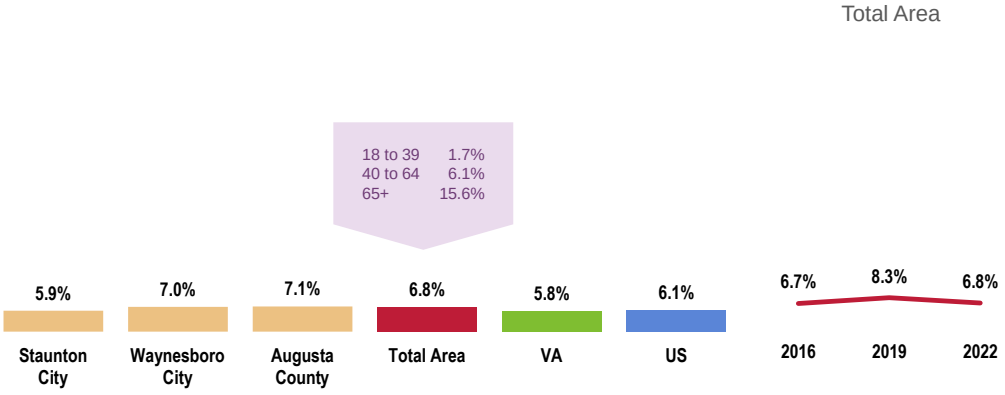
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 6.8% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

DISPARITY ► More often reported among adults age 40+ (especially those age 65+).

Prevalence of Heart Disease



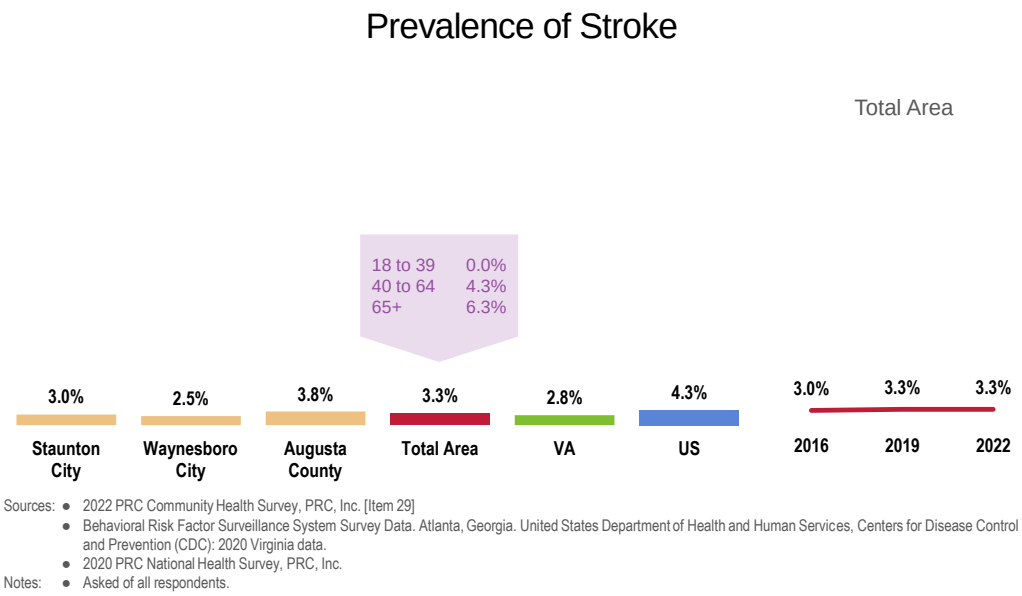
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke

A total of 3.3% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

DISPARITY ► More often reported among adults age 40+.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

A total of 40.1% of Total Area adults have been told by a health professional at some point that their blood pressure was high.

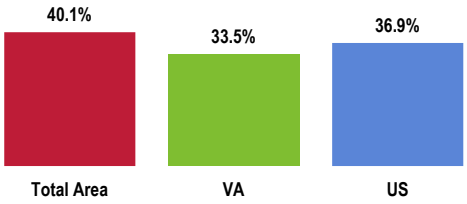
BENCHMARK ► Higher than found statewide. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Higher in Augusta County (not shown).

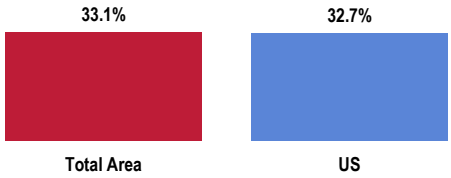
A total of 33.1% of adults have been told by a health professional that their cholesterol level was high.

Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower



Prevalence of High Blood Cholesterol

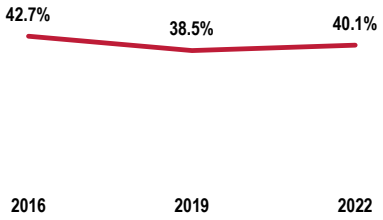


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35, 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

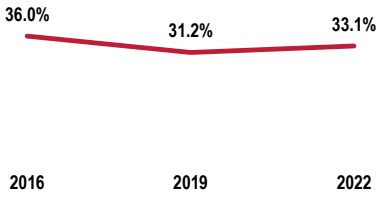
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure (Total Area)

Healthy People 2030 = 27.4% or Lower



Prevalence of High Blood Cholesterol (Total Area)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35, 36]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

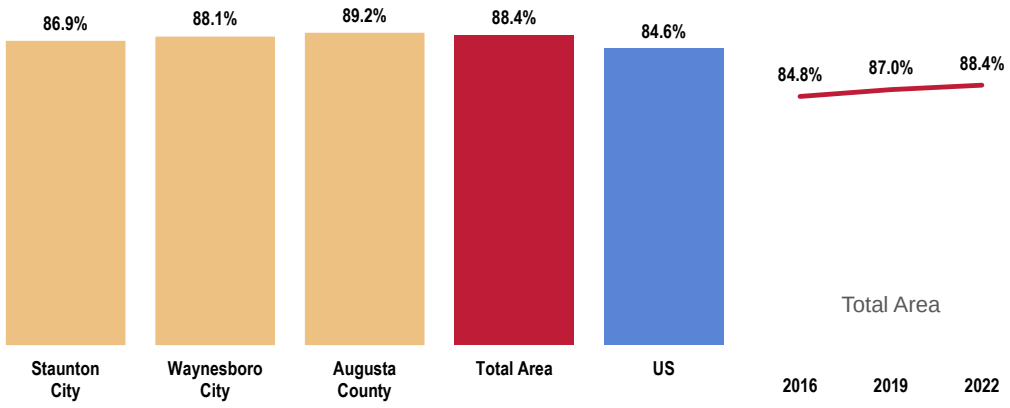
A total of 88.4% of Total Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

BENCHMARK ► Higher than the national percentage.

DISPARITY ► More often reported among adults age 65+ (when compared to young adults) and lower-income respondents.

RELATED ISSUE
See also *Nutrition*, *Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

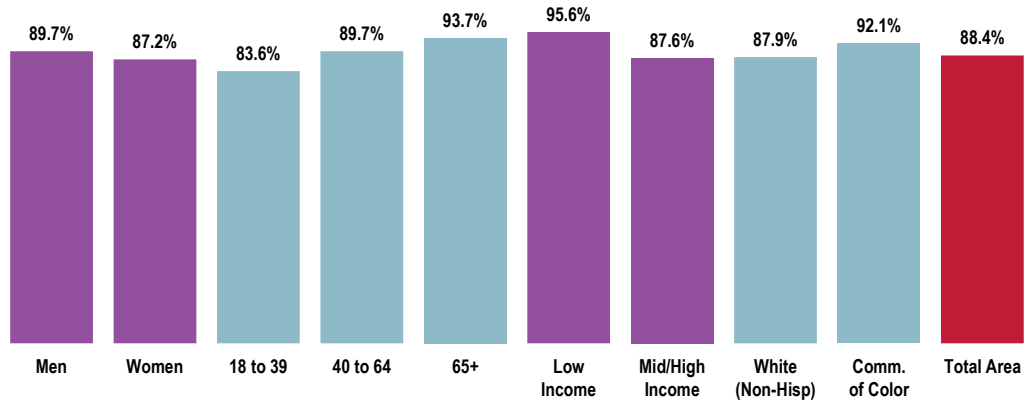
Present One or More Cardiovascular Risks or Behaviors



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Present One or More Cardiovascular Risks or Behaviors
(Total Area, 2022)

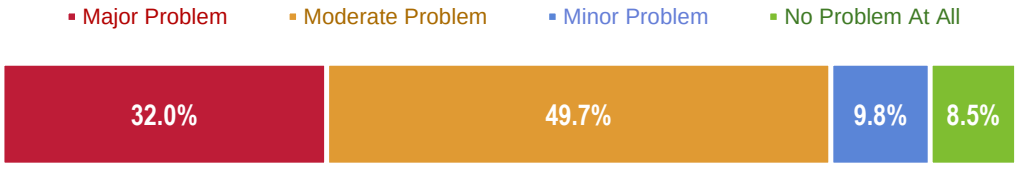


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
Notes: ● Reflects all respondents.
● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2022)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> It is a national issue. – Other Health Provider
>
> Widespread incidence. – Community Leader
>
> Prevalence and increased strain on overall health and well-being. – Other Health Provider
>
> Large number of hospital procedures and the need for a dedicated heart and vascular center. – Other Health Provider
>
> They are major causes of death and disability. – Community Leader
>
> Experientially, I had a stroke on September 7, 2019, in my early 40s. Thankfully, no permanent damage, but still super scary. – Community Leader
>
> High incidence of heart disease, lifestyle issues. – Physician
>
> Numbers are rising due to unhealthy eating and lack of exercise. – Community Leader

Heart disease is a leading cause of death in our area. The ACSO carries AEDs in all of patrol vehicles. In a county this size where minutes count, additional resources are needed. – Community Leader

It's the leading cause of death in the United States and is fairly high in our community, as well. Our community average is higher than the state average, which is alarming. – Social Services Provider

High prevalence of disease. High prevalence of metabolic dysfunction in the population, which is the gateway to heart disease and stroke. – Other Health Provider

I believe these are major problems in our community because I believe I saw that heart disease is the number one cause of death in America. – Social Services Provider

Volume of emergent cardiac cases that come through Augusta Health Emergency Room. Wait time for scheduling appointments with cardiologists. – Other Health Provider

Open-heart surgery. – Physician

Prevalence of heart disease in the community and impact on quality of life. – Public Health Representative

Volumes at the hospital; number of people I personally know with heart disease, high blood pressure or high cholesterol. Some of these are educated patients who are doing what's required, but family history is pervasive. – Other Health Provider

I see it and hear about it in the community. Hear about it from church community. – Community Leader

Contributing Factors

The disease in general is prevalent and is the number-one cause of death in most communities. Our community is not well educated on the benefits of fresh fruits and vegetables, cutting out processed foods and soda. Some of it is a matter of cost and convenience – unhealthy food is usually cheaper and quicker to get – Physician

An aging population, a remarkably stressful last two years, and an overall lack of healthy lifestyles. Trauma. – Social Services Provider

The over-65 population is expected to grow from 20% to 25% over the next five years. In addition, poor nutrition will increase the risk of CV disease. – Other Health Provider

High incidence of DM. Likely related to decreased physical activity. Likely related to overconsumption of high fat/calorie/sodium foods. – Other Health Provider

Based upon what I understand about rural regions in general, I observe lack of proper diets, lack of exercise and lack of awareness on proper nutrition that would help with these issues. Furthermore, without proof, I suspect that many individuals are unaware of the issue until a physical malady becomes acutely obvious. – Community Leader

A high percentage of the population is sedentary, overweight, or obese, and/or consume a high fat/high sugar/high salt "Western" diet that puts them at risk for heart disease and stroke. – Other Health Provider

Specifically related to the risk factors that lead to heart disease and stroke, I believe that this community does not have easy and affordable access to healthy foods and gyms necessary to help prevent these conditions. I also believe there is a lack of health literacy within the community to help individuals understand what are and are not high-risk health behaviors (such as smoking, diet, exercise, etc.). – Social Services Provider

Lack of education on when to seek care and/or inability to access needed care. High rates of diabetes, which are linked to heart disease and stroke. The local diet is very poor, as well. – Other Health Provider

Low socioeconomic levels. Limited access to healthcare. Older population. Lack of knowledge. Lack of low-cost wellness programs. – Social Services Provider

Obesity

This is a nationwide problem. Obesity is driving increase. – Community Leader

Obesity and aging contribute to heart disease. – Social Services Provider

Obesity. – Social Services Provider

The prevalence of obesity and diets high in fat and cholesterol, as well as poor fitness levels. – Social Services Provider

Obesity, immobility. – Other Health Provider

Co-Occurrences

It's a major problem everywhere and definitely in our area where there is a high level of obesity and hypertension and comorbidities such as heart disease. – Other Health Provider

There are typically severe problems in any community and with our community, rampant with undiagnosed diabetes and morbid obesity. – Physician

Overweight, lack of activity and diabetes. – Other Health Provider

Diabetes, obesity, health equity issues. – Community Leader

Heart disease and stroke are linked to obesity. We have a huge problem with obesity in our community. – Other Health Provider

Stress

> They are problems in most communities. Stress is prevalent everywhere. Heart-healthy foods are usually far more expensive. – Community Leader
>
> Average Americans, including in our community, are dealing with consequences of stress, unhealthy diets, and inactivity. – Social Services Provider

Lifestyle

> Heart disease and stroke are lifestyle diseases with a hereditary component. These can mostly be prevented with education to a willing population. Many people are unaware of the risks until they are diagnosed with cardiac problems or have a stroke. – Other Health Provider
>
> The lifestyle of residents in our community is not healthy from the perspective of diet and exercise, and cardiovascular disease is often a generational issue. – Public Health Representative

Prevention/Screenings

> Many people visit the ED with heart disease in late stages. Not enough free screenings for heart disease for the community. – Other Health Provider

Education

> Heart disease and strokes are not necessarily a major problem, in that I do not know if the Hispanic population shows higher rates that other local population – but the lack of preventative medicine, education, and care are issues that need to be resolved. For example, few people would know to recognize the telltale signs of a stroke or heart attack, whether pain in the left arm or drooping on one side of the face. – Social Services Provider

Follow-Up/Support

> AH provides great care once the stroke or heart disease occurs, but there are minimal services to support them after the fact, as well as minimal resources in prevention. – Other Health Provider

CANCER

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

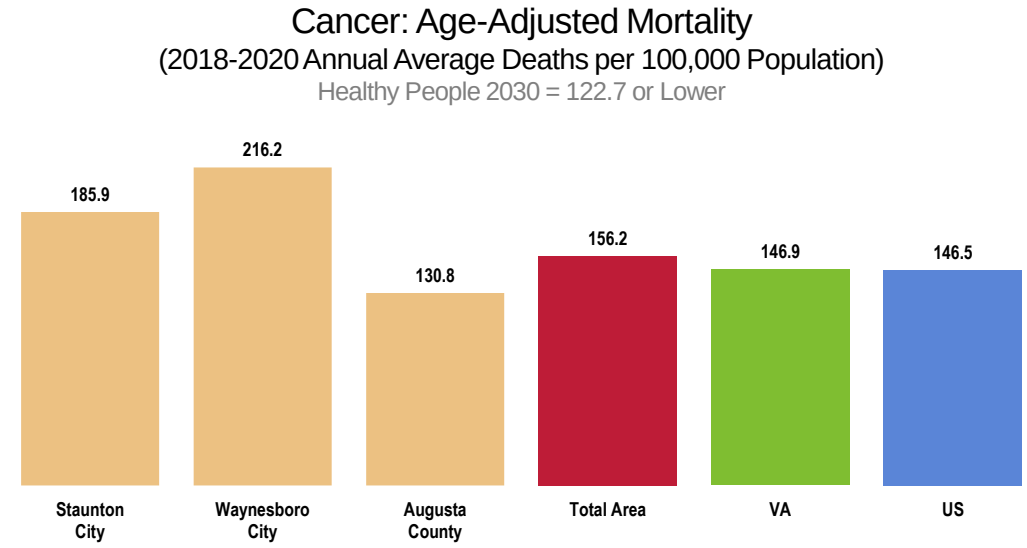
All Cancer Deaths

Between 2018 and 2020, there was an annual average age-adjusted cancer mortality rate of 156.2 deaths per 100,000 population in the Total Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Trending significantly lower within the service area over time.

DISPARITY ► Lower in Augusta County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	181.3	175.7	175.4	172.0	162.5	159.1	152.8	156.2
VA	165.9	162.8	161.0	159.0	156.1	152.7	148.9	146.9
US	171.5	168.0	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the Total Area.

Other leading sites include female breast cancer, colorectal cancer (both sexes), and prostate cancer.

BENCHMARK

Lung Cancer ► Fails to satisfy the Healthy People 2030 objective.

Female Breast Cancer ► Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Higher than both state and national rates. Fails to satisfy the Healthy People 2030 objective.

Prostate Cancer ► Lower than both state and national rates. Similar to the Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site

(2018-2020 Annual Average Deaths per 100,000 Population)

	Total Area	Virginia	US	HP2030
ALL CANCERS	**156.2**	**146.9**	**146.5**	**122.7**
Lung Cancer	**36.5**	**33.9**	**33.4**	**25.1**
Female Breast Cancer	**19.6**	**20.1**	**19.4**	**15.3**
Colorectal Cancer	**16.0**	**13.3**	**13.1**	**8.9**
Prostate Cancer	**14.8**	**19.7**	**18.5**	**16.9**

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

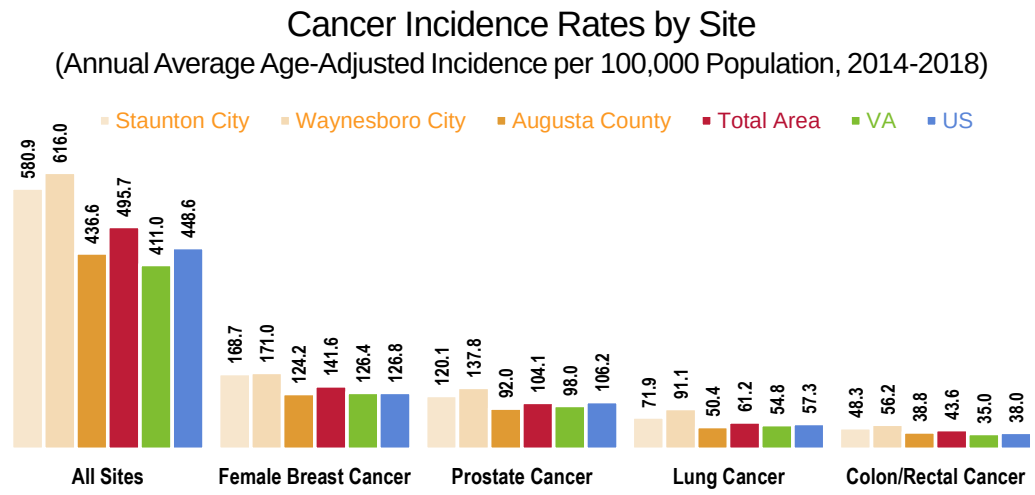
Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

The highest cancer incidence rates are for female breast cancer and prostate cancer.

BENCHMARK

Colorectal Cancer ► Higher than both state and national rates.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

A total of 12.7% of surveyed Total Area adults report having ever been diagnosed with cancer. The most common types include skin cancer, breast cancer, and prostate cancer.

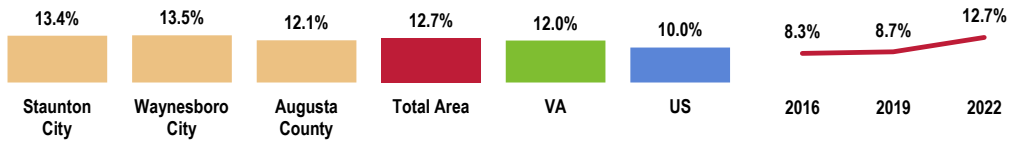
DISPARITY ► Especially high among seniors (age 65+).

Prevalence of Cancer

Total Area

The most common types of cancers cited locally include:

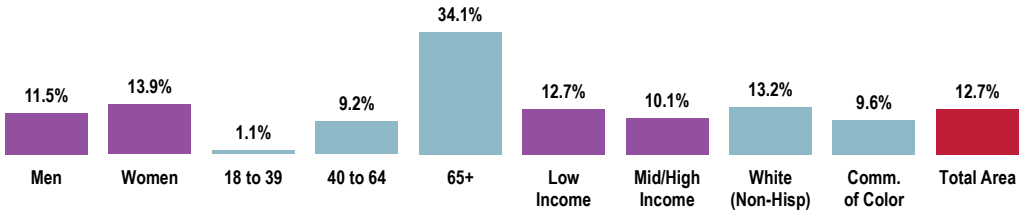
1) Skin Cancer 22.7%
2) Breast Cancer 21.6%
3) Prostate Cancer 14.7%



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Prevalence of Cancer
(Total Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 25]

Notes:
- Reflects all respondents.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.
Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear/HPV testing); and colorectal cancer (colonoscopy/sigmoidoscopy and fecal occult blood testing).

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Among women age 50-74, 76.7% have had a mammogram within the past 2 years.

Among Total Area women age 21 to 65, 76.0% have had appropriate cervical cancer screening.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

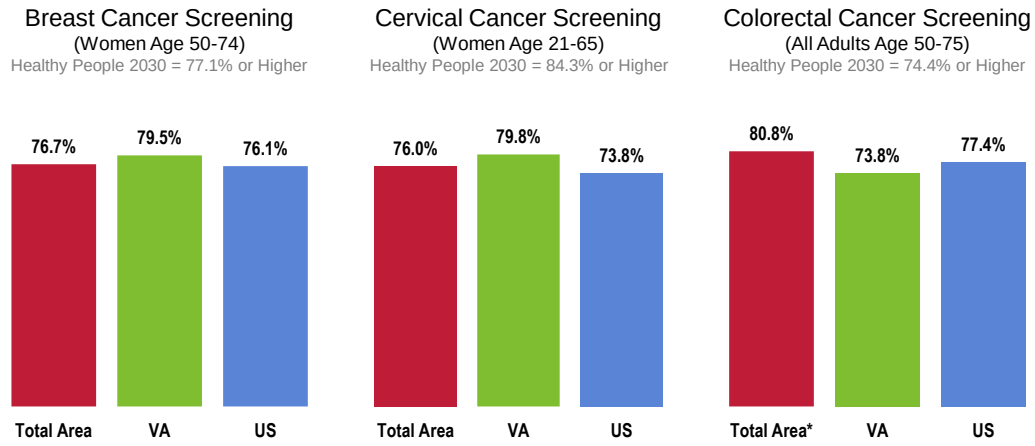
DISPARITY ► Lower in Staunton (not shown).

"Appropriate colorectal cancer screening" includes a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

Among all adults age 50-75, 80.8% have had appropriate colorectal cancer screening – in this case, sigmoidoscopy or colonoscopy.

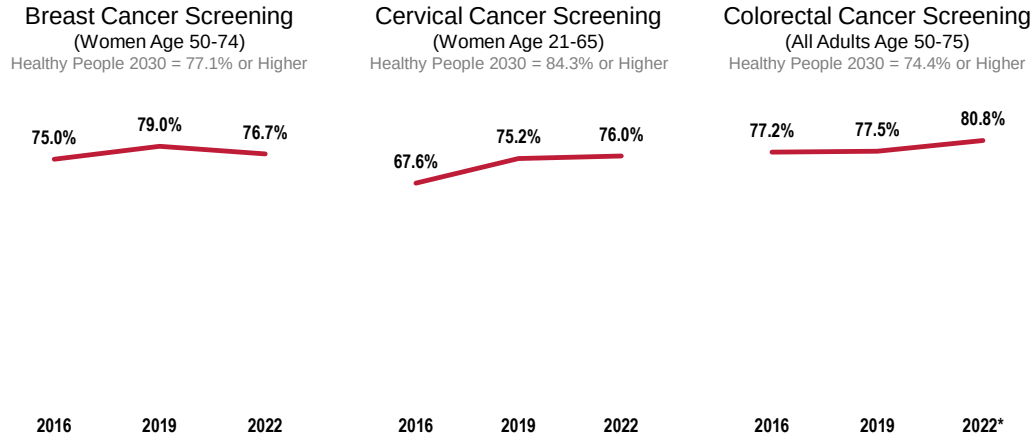
BENCHMARK ► More favorable than the statewide percentage. Satisfies the Healthy People 2030 objective.

DISPARITY ► Lower in Augusta County (not shown).



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 75, 116, 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.
- * 2022 Total Area data for colorectal cancer screening does not include blood stool testing.

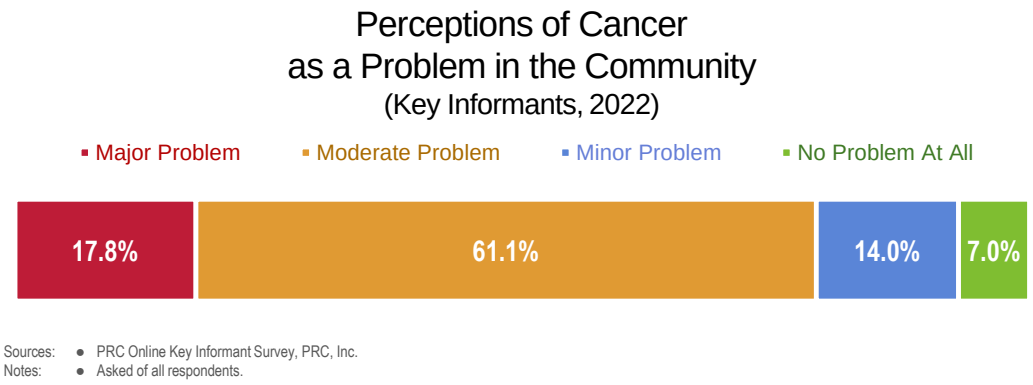


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 75, 116, 117]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.
- * 2022 Total Area data for colorectal cancer screening does not include blood stool testing.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

There are so many individuals in every community that have been affected by cancer. Cancer is nondiscriminatory and too many lives have been lost, including children. – Social Services Provider

Seems the number of deaths and individuals diagnosed with cancer in my organization has increased. – Community Leader

Cancer is a major problem due to the amount of people that are diagnosed and/or die from it annually. It affects everyone in our community; everyone knows someone or is related to someone who has/had cancer. – Community Leader

The numbers who access our services seem to be growing. New diagnosis in children in this area also seems to be on the rise. These patients utilize many resources in order to meet their needs medically as well as psychosocially. – Other Health Provider

Everywhere you look in this community, someone has cancer. Churchville area seems to be a high-cancer area with a large number of children and adults with cancer. – Other Health Provider

The incidence is not improving, although it is being detected at earlier stages with those patients that have preventive screening. Many patients continue to not participate in preventive screening (especially low-dose CT screening), and advanced lung cancer cases continues to be a problem. There also continue to be a large number of breast cancer patients. – Other Health Provider

There are so many affected. – Other Health Provider

It's a problem across the world, not just in our community. Catching cancer in its early stages is the difference between life and death. Screenings are important and screening education. – Other Health Provider

It seems that there are more people being diagnosed at a younger age and later stage. – Other Health Provider

I hear frequently of various forms of cancers in a wide population. I know of no one unaffected within their families or groups to cancer. – Community Leader

We have a high rate of cancer in our community. – Other Health Provider

Rates of cancer continue to rise each year. People are becoming more secluded to office space, home space, with the advancement of technology and the pandemic aftermath. – Social Services Provider

There seems to be a disproportionate number of children in the area who are diagnosed with cancer. – Social Services Provider

It is my understanding that this is a problem that affects all parts of our world presently. Therefore, because it consistently is a concern, I listed it as a major problem. – Social Services Provider

The amount of cases in our youth in the area. – Community Leader

I believe cancer is a major problem because so many people, at one point or another, are diagnosed with some form of cancer, many of which are fatal. – Social Services Provider

So many people have been diagnosed recently. – Community Leader

Pediatric cancer specifically has touched many lives in our community, and there is a lack of research and funding around this. – Community Leader

> The number of people in my immediate circle of family and friends with or having fought cancer is the predominant health issue. – Community Leader
>
> I hear about cancer as a diagnosis for many of my friends and acquaintances, especially those over 60. My husband has recently been diagnosed with cancer, and I have become familiar with the Cancer Center and how many individuals receive treatment there. – Community Leader
>
> In many of the communities that we serve, cancer is in the top three medical issues that we hear about. – Social Services Provider
>
> There is a huge amount of cancer in our community, specifically in children. – Community Leader

Diagnosis/Treatment

> Late-stage diagnosis. However, I do feel AH has done a great job of promoting the benefit of early diagnosis through cancer screening and cancer prevention. However, there always seems to be community members/communities that do not take advantage of cancer screening available to them either through insurance, or free/reduced screenings that may be available to them, based on income. This especially rings true (in nearly every community nationwide) due to the pandemic and public health concerns. Again, this is all based on my professional responsibilities as a partner with AH in the cancer space. – Social Services Provider
>
> One reason is people only visit the doctor when death feels eminent. In these cases, something that could have been curable is now a death sentence. I've seen on two occasions men in their 50s in my old neighborhood diagnosed and then dead weeks later. – Community Leader

Contributing Factors

> The Cancer Center is yet again in shambles, and provider turnover is a severe issue. Also, patients are not being appropriately screened for a multitude of reasons, including lack of follow up by the patient. – Physician
>
> It seems that more and more people are being diagnosed with some form of cancer every day. Our diets and habits are contributing factors. – Community Leader

Affordable Care/Services

> Costs of treatment are very high and an obstacle to early detection. – Social Services Provider

Co-Occurrences

> Poor metabolic health increasing risk of cancers related to metabolic dysfunction. – Other Health Provider

Lack of Providers

> We have had considerable turnover in our oncologists for Augusta. Good cancer care (similar to good care in general) relies not only on excellence but also consistent and ongoing care from the same provider. Trust in the system is hard to overemphasize. – Physician

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

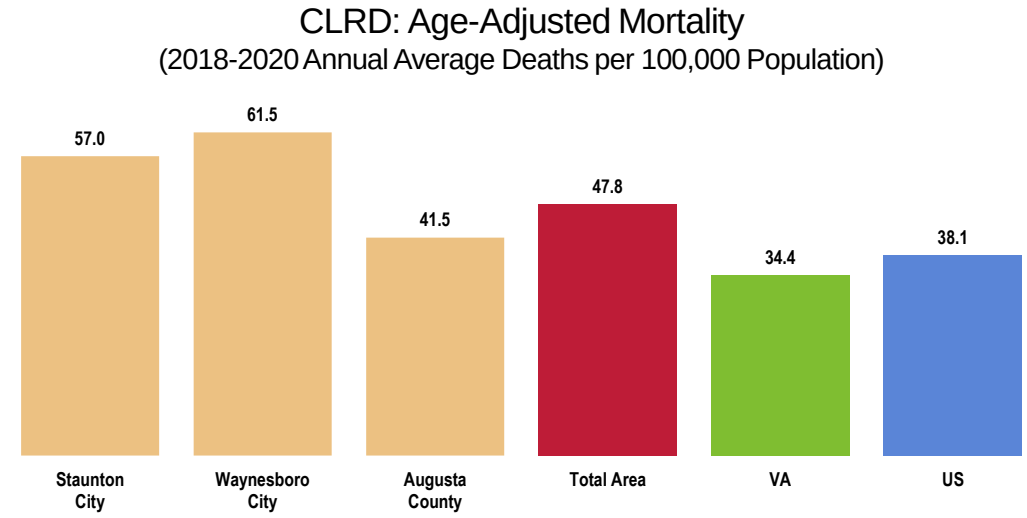
Chronic Lower Respiratory Disease Deaths (CLRD)

Note: Chronic lower respiratory disease (CLRD) includes lung diseases such as emphysema, chronic bronchitis, and asthma.

Between 2018 and 2020, there was an annual average age-adjusted CLRD mortality rate of 47.8 deaths per 100,000 population in the Total Area.

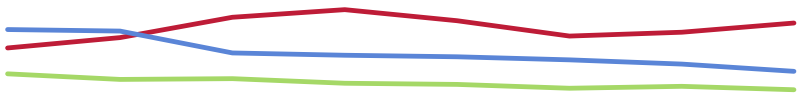
BENCHMARK ► Higher than found across the state and nation.

DISPARITY ► Lower in Augusta County.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
Notes: • CLRD is chronic lower respiratory disease.

CLRD: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	42.8	44.9	49.0	50.5	48.3	45.2	46.0	47.8
VA	37.6	36.5	36.6	35.7	35.5	34.7	35.1	34.4
US	46.5	46.2	41.8	41.3	41.0	40.4	39.6	38.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Notes:
- CLRD is chronic lower respiratory disease.

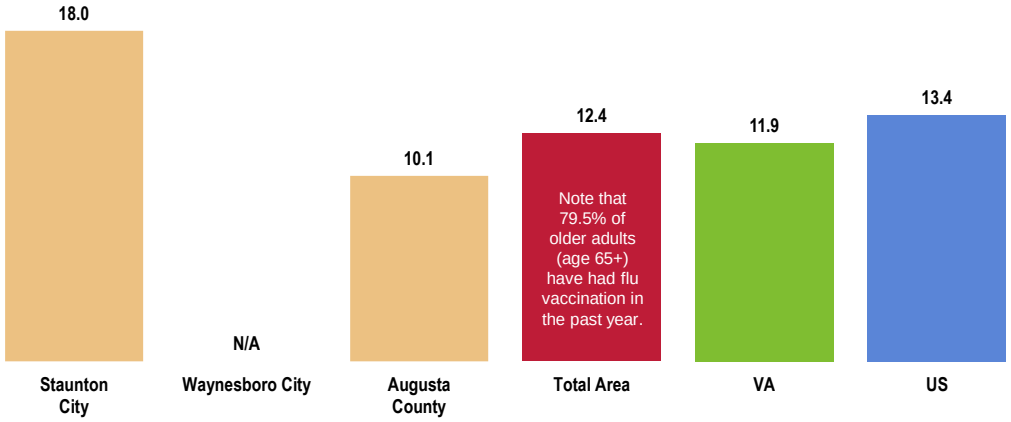
Pneumonia/Influenza Deaths

Between 2018 and 2020, the Total Area reported an annual average age-adjusted pneumonia influenza mortality rate of 12.4 deaths per 100,000 population.

TREND ► Trending significantly lower within the service area over time.

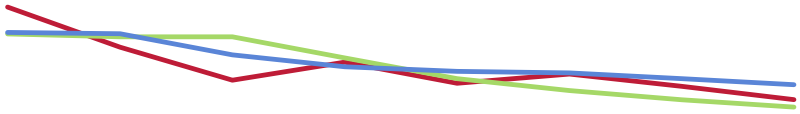
DISPARITY ► Higher in Staunton.

Pneumonia/Influenza: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 124]
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	18.6	15.9	13.7	14.9	13.5	14.1	13.3	12.4
VA	16.8	16.6	16.6	15.2	13.8	13.0	12.4	11.9
US	16.9	16.8	15.4	14.6	14.3	14.2	13.8	13.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

ABOUT INFLUENZA & PNEUMONIA

Influenza (flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness. Serious outcomes of flu infection can result in hospitalization or death. Some people, such as older people, young children, and people with certain health conditions, are at high risk of serious flu complications. There are two main types of influenza (flu) virus: Types A and B. The influenza A and B viruses that routinely spread in people (human influenza viruses) are responsible for seasonal flu epidemics each year. The best way to prevent flu is by getting vaccinated each year.

Pneumonia is an infection of the lungs that can cause mild to severe illness in people of all ages. Depending on the cause, doctors often treat pneumonia with medicine. In addition, vaccines can prevent some types of pneumonia. However, it is still the leading infectious cause of death in children younger than 5 years old worldwide. Common signs of pneumonia include cough, fever, and difficulty breathing. You can help prevent pneumonia and other respiratory infections by following good hygiene practices. These practices include washing your hands regularly and disinfecting frequently touched surfaces. Making healthy choices, like quitting smoking and managing ongoing medical conditions, can also help prevent pneumonia.

Vaccines help prevent pneumococcal disease, which is any type of illness caused by *Streptococcus pneumoniae* bacteria.

– Centers for Disease Control and Prevention (CDC – www.cdc.gov)

Prevalence of Respiratory Disease

Asthma

Adults

Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

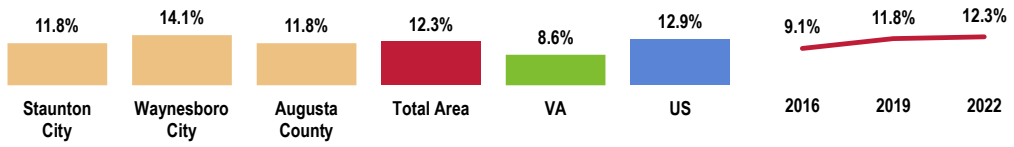
A total of 12.3% of Total Area adults currently suffer from asthma.

BENCHMARK ► Less favorable than the statewide percentage.

DISPARITY ► More often reported among women and adults age 40 to 64.

Prevalence of Asthma

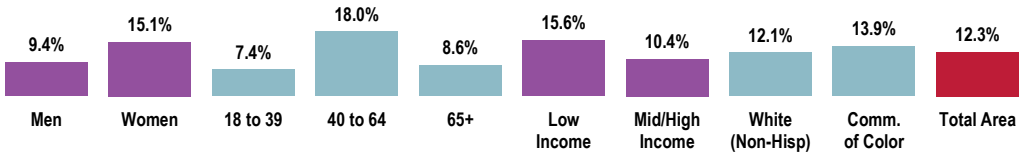
Total Area



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma
(Total Area, 2022)



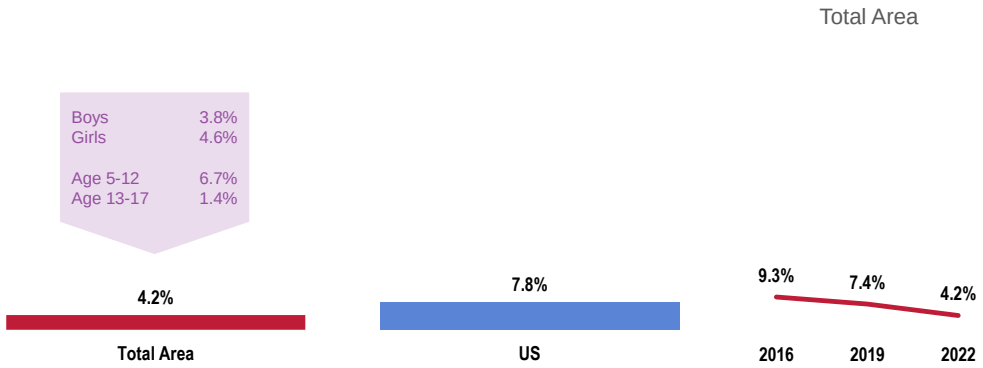
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Children

Among Total Area children under age 18, 4.2% currently have asthma.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

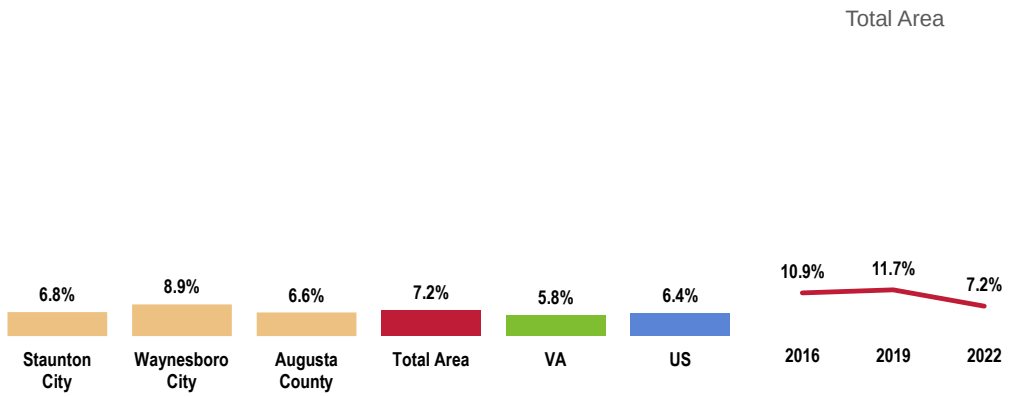
Chronic Obstructive Pulmonary Disease (COPD)

Note: COPD includes lung diseases such as emphysema and chronic bronchitis.

A total of 7.2% of Total Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

TREND ► Marks a significant decrease from previous surveys.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

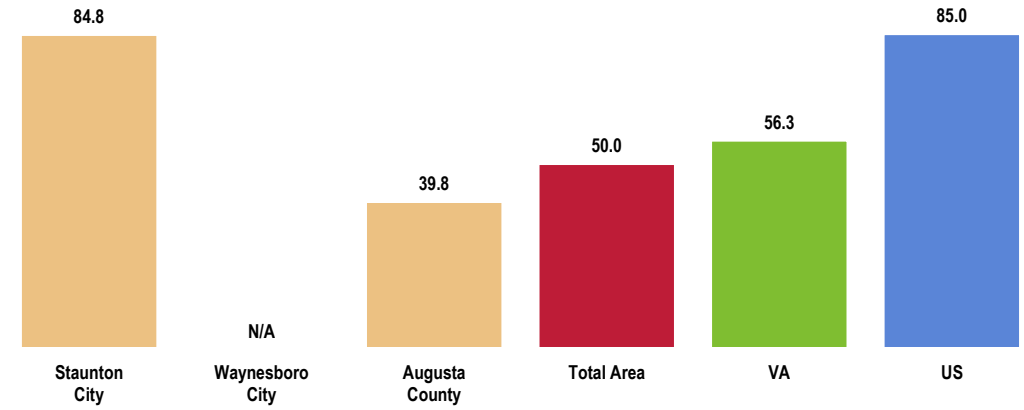
Coronavirus Disease/COVID-19

In 2020, the Total Area reported an annual average age-adjusted Coronavirus Disease/ COVID-19 mortality rate of 50.0 deaths per 100,000 population.

BENCHMARK ► Much lower than the national rate.

DISPARITY ► Higher in Staunton.

COVID-19: Age-Adjusted Mortality
(2020 Annual Average Deaths per 100,000 Population)

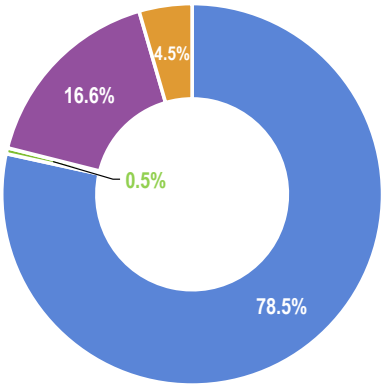


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

More than three-fourths of Total Area adults (78.5%) report being vaccinated against Coronavirus Disease/COVID-19.

Prevalence of COVID-19 Vaccination
(Total Area, 2022)

Among unvaccinated respondents, the main reasons given included:
- Safety/trust (40.9%)
- No need/don't want (27.7%)
- Personal beliefs (15.4%)
- Doesn't Work (5.3%)
- Already had COVID (4.7%)
- Other health reasons (2.8%)
- Uncertain (2.2%)
- Unavailable (0.5%)
- Lack of transportation (0.4%)



Among vaccinated respondents, 69.8% have received a booster.

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 318–320]
Notes: ● Asked of all respondents.
● Vaccinated respondents further were asked whether they had received a booster in addition to their original COVID-19 vaccine. This was defined as a third shot following a Pfizer or Moderna vaccine series, or a second shot following a Johnson & Johnson vaccine.

Surveyed adults reported a change in certain health-related behaviors and activities since the pandemic began in March 2020:

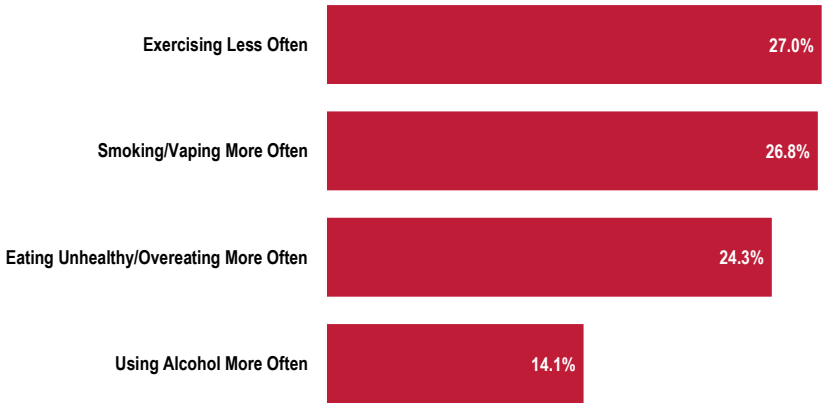
EXERCISE ► 27.0% are exercising *less often*.

TOBACCO USE ► 26.8% are smoking or vaping *more often*.

DIETARY HABITS ► 24.3% are eating unhealthy foods or overeating *more often*.

ALCOHOL USE ► 14.1% are drinking alcohol *more often*.

Adverse Changes in Health-Related Behaviors Since the Beginning of the Pandemic
(Total Area, 2022)

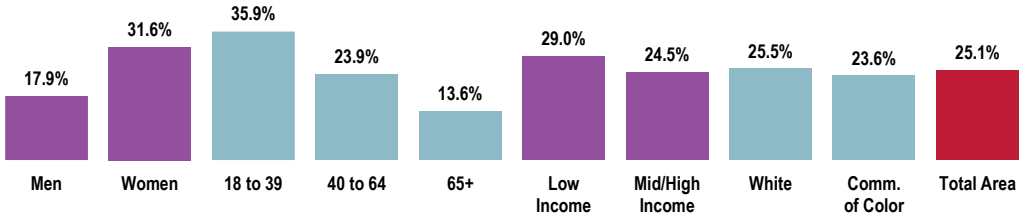


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 313-316]
Notes: • Asked of all respondents.
• Beginning of pandemic specified as March 2020.

While most Total Area adults report that their mental health has "improved" or "stayed about the same" since the pandemic began in March 2020, one-fourth (25.1%) believes their mental health has "become worse."

DISPARITY ► More often reported among women and adults younger than 65.

Mental Health Has Gotten Worse Since the Beginning of the Pandemic
(Total Area, 2022)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 311]
Notes: • Asked of all respondents.
• Beginning of pandemic specified as March 2020.

A total of 19.0% of surveyed adults report that the pandemic has caused a member of their household to lose a job, work fewer hours than wanted or needed, or led to a loss of health insurance coverage.

DISPARITY ► More often reported among women, adults younger than 65, and lower-income residents.

Financially Impacted by the Pandemic
(Total Area, 2022)

Sources: ● PRC Community Health Survey, Professional Research Consultants, Inc. [Item 312]
Notes: ● Asked of all respondents.
● Includes respondents reporting that they or another household member lost a job, worked fewer hours, or lost health insurance coverage as a result of COVID-19 since March 2020.

Nearly 1 in 5 Total Area adults (19.6%) have chosen to avoid receiving medical care at some point during the pandemic because of concerns about coronavirus.

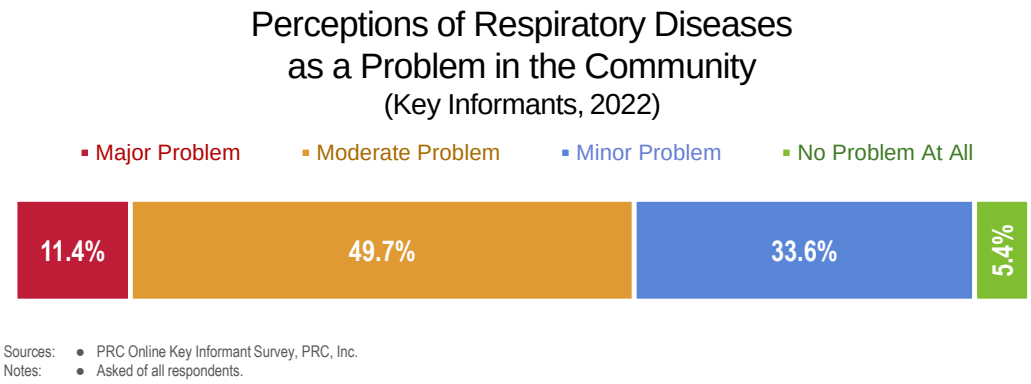
DISPARITY ► Women are more likely than men to report having avoided medical care during the pandemic.

Have Avoided Medical Care Because of Concerns Over COVID-19
(Total Area, 2022)

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 317]
Notes: ● Asked of all respondents.
● Beginning of pandemic specified as March 2020.

Key Informant Input: Respiratory Disease

Key informants taking part in an online survey generally characterized *Respiratory Disease* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Tobacco Use

> Primarily driven by tobacco use in adults and poorly addressed asthma in children. – Community Leader
>
> It's still an area with lots of smokers. – Other Health Provider
>
> Large number of population that smokes leads to respiratory disease as well as the issues caused by secondhand smoke. The vaping trend brings more issues that we don't know about yet. – Community Leader
>
> We have COPD patients often related to long-term use of tobacco products. This leads to frequent ED visits/hospitalizations. – Other Health Provider
>
> Significant smoking and pollutants in the area due to factory work. – Physician

Prevalence/Incidence

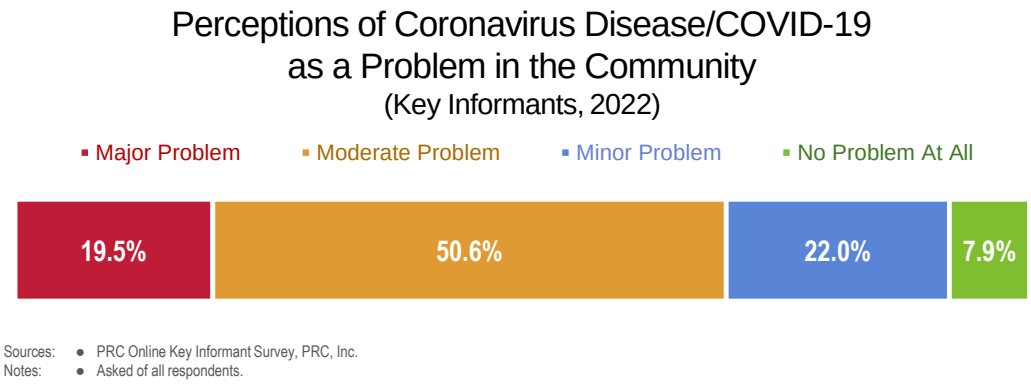
> A significant number of individuals are burdened by chronic lung conditions such as COPD, which are preventable. Activities like "vaping" are becoming more prevalent amongst young people and an increasing number of stores are opening that sell a variety of these products. – Social Services Provider
>
> As people age and due to chronic conditions and environmental factors such as smoking, respiratory disease is prevalent. – Community Leader
>
> Number of individuals with COPD, asthma, Coronavirus lingering respiratory issues, smoking, and vaping. – Community Leader

Contributing Factors

> Younger folks who are obese end up being older folks with respiratory problems. Smoking seems to be quite popular with our population, as well. – Community Leader
>
> High prevalence of COPD and asthma. High cost of medications, especially inhalers. – Other Health Provider
>
> Access and education. – Social Services Provider

Key Informant Input: Coronavirus Disease/COVID-19

Key informants taking part in an online survey were more likely to characterize *Coronavirus Disease/COVID-19* as a "moderate problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Vaccination Rate

Number of people still unvaccinated. – Other Health Provider

Low vaccination rates among sub-communities and older population overall. – Social Services Provider

The percentage of fully vaccinated in the SAW is about 8 percentage points less than the state, and in turn, the number of people who have had COVID-19 is 24% in the SAW compared to19% in the state. We now know that the more fully vaccinated people there are, the fewer patients contract the disease. The SAW is behind in accepting COVID-19 vaccination, and this continues to leave the community more vulnerable than other places in the state. Given Augusta Health is the primary provider for the majority of patients in the SAW, patients with COVID-19 impose a significant burden on Augusta Health's role as the primary provider of acute care services for patients who live within a 30-mile radius. – Other Health Provider

Vaccination status remains lower and transmission rates were trending higher in this area. – Social Services Provider

So many in our community are resistant to vaccination, which puts those most vulnerable in the community at risk for severe disease. – Other Health Provider

Low vaccination rates, hospitalization rates, and deaths. – Other Health Provider

Poor vaccination rate, subsequent healthcare staff burnout, and it has taken away resources for other illnesses. – Physician

Lack of vaccination. Vaccines are available, but many of the population do not want to be vaccinated. – Social Services Provider

There is a large unvaccinated population and a large group who did not believe in wearing masks. This led to high surges in the community. – Other Health Provider

Much of population is not vaccinated. – Community Leader

Contributing Factors

Multiple surges led to significant morbidity and mortality. Many people with post-COVID/long COVID symptoms that have not been addressed. There were ample opportunities for vaccination; however, there is a portion of the population that has comorbidities or older in age that have not accepted vaccination as a tool to prevent hospitalization and death. – Physician

The impacts are deep and wide, even with the decrease in severity currently. The underlying issues around communication and community trust are profound. – Social Services Provider

Lack of vaccine compliance. Surges create hospital bed capacity concerns and reduction of hospital services. – Other Health Provider

Poor vaccination rate and lack of education on the real impact of illness. – Other Health Provider

> The vaccination rates are still relatively low, and mask compliance is minimal. There seems to be a significant number of patients coming into clinics with "COVID like" symptoms that refuse testing because they "don't think it's COVID" or they don't want it to impact their ability to go to work. Patients in the area often seem concerned about how it will impact their job and are also frustrated with the "healthcare system making such a big deal about COVID." The misinformation that patients have and the limitations companies provide on their workers contributes to the lack of control of COVID in the community and negatively impacts the community. If workers fear not getting paid for being out for COVID testing, they are less likely to want to get tested for COVID. Some companies are also still requiring repetitive PCR testing for workers who have tested positive for COVID and are beyond the quarantine restrictions requiring extra time off and extra cost to patients and HC. – Social Services Provider
>
> The effects of COVID-19 are still very much prevalent, affecting the costs of many essential items and leading to financial strains. Individuals are still contracting this virus, and there is still a lack of confidence in the vaccine. – Social Services Provider
>
> Lower vaccination and booster rates, lower pediatric vaccination rates, significant impact on the health care system, increase in mental health issues, impacts to the schools and education, health equity issues. – Community Leader
>
> Testing capacity was insufficient to meet demands during surge periods; wait times at urgent care centers often exceeded three hours. There is poor acceptance of basic public health measures, like mask wearing, quarantine, and avoiding large social gatherings during periods of high community transmission. Employers could do more to promote vaccination among their staff, like providing incentives, time off, etc. – Public Health Representative

Prevalence/Incidence

> I know of a lot of people who have had COVID-19. I helped sponsor two community vaccine events with poor turnout. I know of many friends and family that will not get vaccinated. – Public Health Representative
>
> I feel this continues to be a major problem. Individuals are exhausted, and many have been left with mental health issues as a result of COVID-19. – Social Services Provider
>
> I am happy to see that there is a decline in the numbers in our area. However, because it still very obviously a continued health issue, I feel it's important to list as it will be something we are projected to be dealing with for the long term through different variants. – Social Services Provider
>
> Number of hospitalizations. AH had to designate COVID-19 units. Rate of infection was over 70% a couple of weeks ago. Is now moderate, but another variant is on the way. – Social Services Provider

Impact on Overall Health

> As a mental health professional, this is less about the disease itself and more about the ways that this pandemic as a whole has negatively impacted the mental health and wellness of our community members. There is already data, and reports that suggest that "recovery" from this pandemic will be a long process that will require an abundance of available supports for our community members. – Community Leader
>
> The effects of the pandemic have been waning, but this impacted all aspects of life – including access to routine health care, mental health, substance use, domestic violence, work/school, etc. Communities are going to be recovering from the pandemic for a long period of time, and likewise, need to take time to reflect on the successes and failures of response in order to be better prepared for the future. – Community Leader
>
> The COVID-19 pandemic not only endangered the physical health of our community but also created isolation, stress, anxiety, fear, conflict, financial strains, etc., all of which have negatively impacted the mental health of many. We know substance use is up, family units are at risk, businesses have been lost, a sense of trust in leaders and experts is lost with many. This is more than a major problem, it's a crisis. – Community Leader

Vulnerable Population

> The COVID-19 outbreak has impacted our local community and is particularly detrimental to members of those social groups in the most vulnerable situations: impoverished, disabled, elderly, families with young and school-age children. Sustainable and affordable housing is a real issue, as inventory and competition issues impact. Childcare affordability and access have challenged young working families. COVID continues to affect older persons and disabled physically, yes, but mentally and emotionally, too, since increased isolation, caregiver stress, and reduction in home health aide availability. – Social Services Provider
>
> LGBTQ people are at a higher risk for negative effects of COVID-19 – due to higher rates of smoking, lack of access to health care, and other reasons. The isolation felt by many during the pandemic has also exacerbated mental health struggles for many in our community. – Social Services Provider

Access to Care/Services

> Health screenings. Colon cancer screening, for instance, was decreased due to pandemic and shift of staffing resources in hospital, many people on waiting list. HIV PrEP screening underutilized in community. – Physician
>
> Limits availability of healthcare providers. Increase demands on inpatient healthcare team. Increase stress to community members. – Other Health Provider

Awareness/Education

> We seem to have been unable to convince enough of the population of the importance of vaccinations and other measures. The politics of this area worked against this. – Social Services Provider

Isolation

> Isolation, believe this leads to a number of other health-related issues. – Social Services Provider

Co-Occurrences

> Has led to an increase in behavioral health issues in our community. – Other Health Provider

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

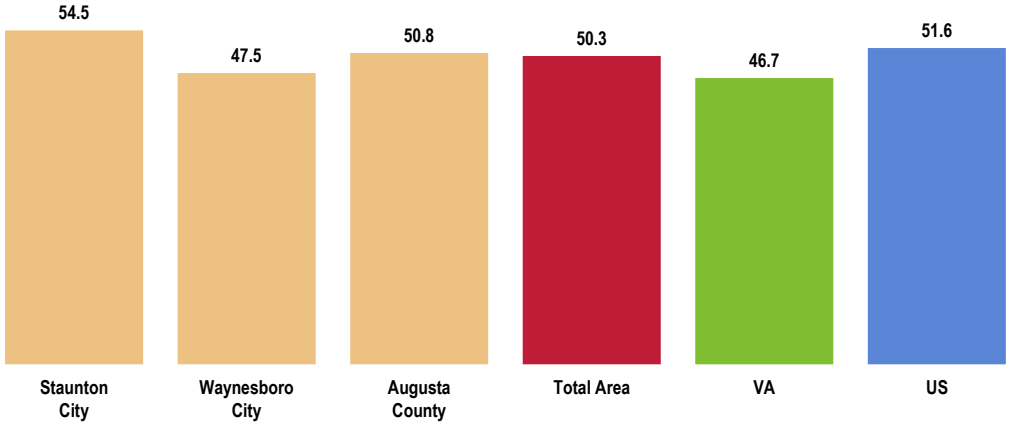
Age-Adjusted Unintentional Injury Deaths

Between 2018 and 2020, there was an annual average age-adjusted unintentional injury mortality rate of 50.3 deaths per 100,000 population in the Total Area.

Unintentional Injuries: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower

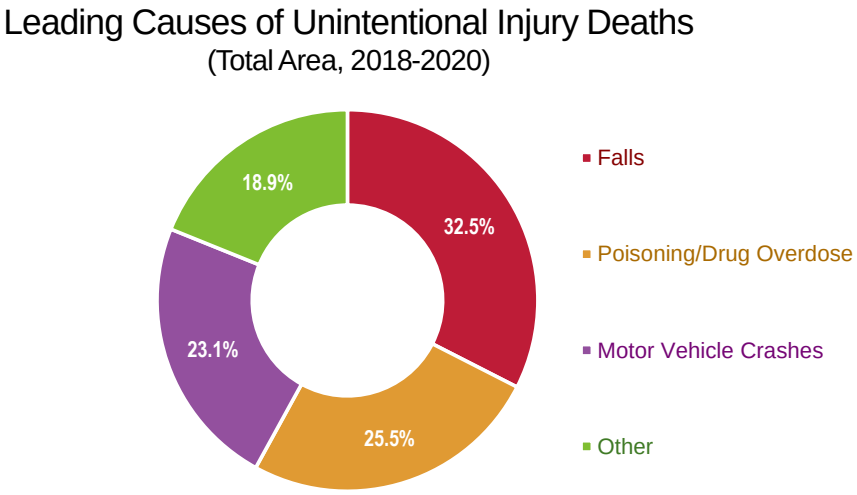
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	46.5	47.2	43.6	39.4	44.8	45.8	50.7	50.3
VA	34.6	35.4	37.1	39.6	42.0	43.4	43.8	46.7
US	41.9	43.3	41.9	44.6	46.7	48.3	48.9	51.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Falls, poisoning (including unintentional drug overdose), and motor vehicle crashes accounted for most unintentional injury deaths in the Total Area between 2018 and 2020.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

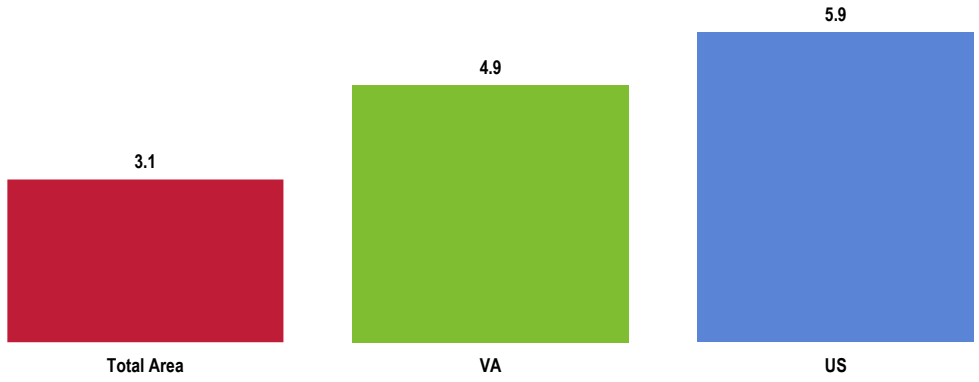
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

In the Total Area, there were 3.1 homicides per 100,000 population (2011-2020 annual average age-adjusted rate).

BENCHMARK ► Lower than state and national rates. Satisfies the Healthy People 2030 objective.

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Violent Crime

Violent Crime Rates

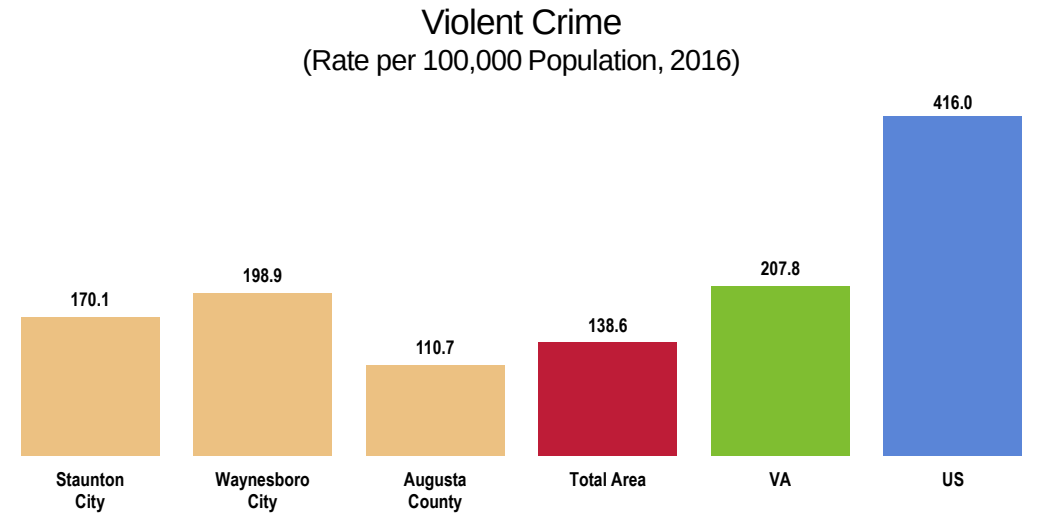
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

In 2016, there were a reported 138.6 violent crimes per 100,000 population in the Total Area.

BENCHMARK ► Considerably lower than state and national rates.

DISPARITY ► Lower in Augusta County.



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Family Violence

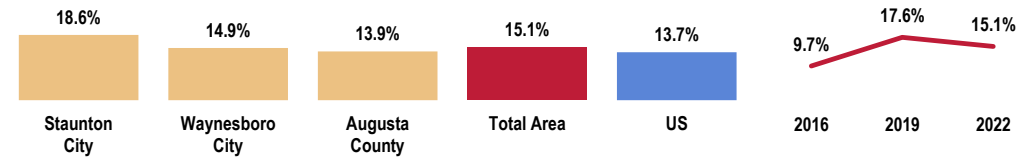
Respondents were read: "By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 15.1% of Total Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

TREND ► Significantly higher than the 2016 benchmark.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

Total Area

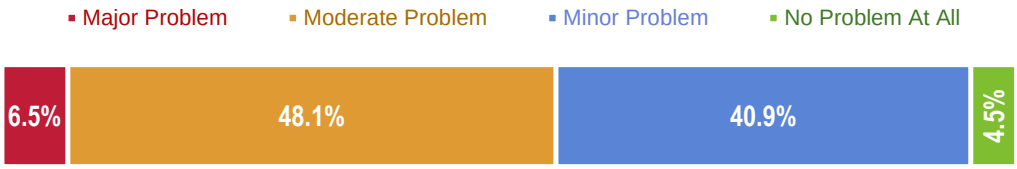


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 39]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

Key informants taking part in an online survey generally characterized *Injury & Violence* as a "moderate problem" in the community.

Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2022)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> Anecdotally, we hear of more gun violence, domestic and child abuse and crime in our area. – Community Leader
>
> The number of court cases in JDR courts is astounding. It's not just here, it's everywhere. Intimate partner violence is serious. – Social Services Provider
>
> Too many women and children are subjected to domestic violence, which impacts their ability to fully participate in our community. – Community Leader

Due to COVID-19

> Physical, psychological, and mental abuse have been on the rise since the COVID-19 pandemic started. This leads to childhood trauma, which has lasting physical and mental effects throughout a person's lifetime. – Social Services Provider

> We have seen an uptick in our services due to COVID-specific domestic violence and child abuse, where individuals have sustained a traumatic brain injury. – Social Services Provider

Prevention

> Injury and violence prevention. These have greater impact on younger people, can cause disability, can cause psychological trauma, and are associated with drug and alcohol abuse, as well as poverty. – Public Health Representative

Contributing Factors

> Combination of lots of guns with high level of mental health/substance abuse in the community. Not a good combination. – Other Health Provider

Gun Violence

> Even in a small town like Staunton, I've been to funerals for several young Black men killed by gun violence. – Community Leader

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

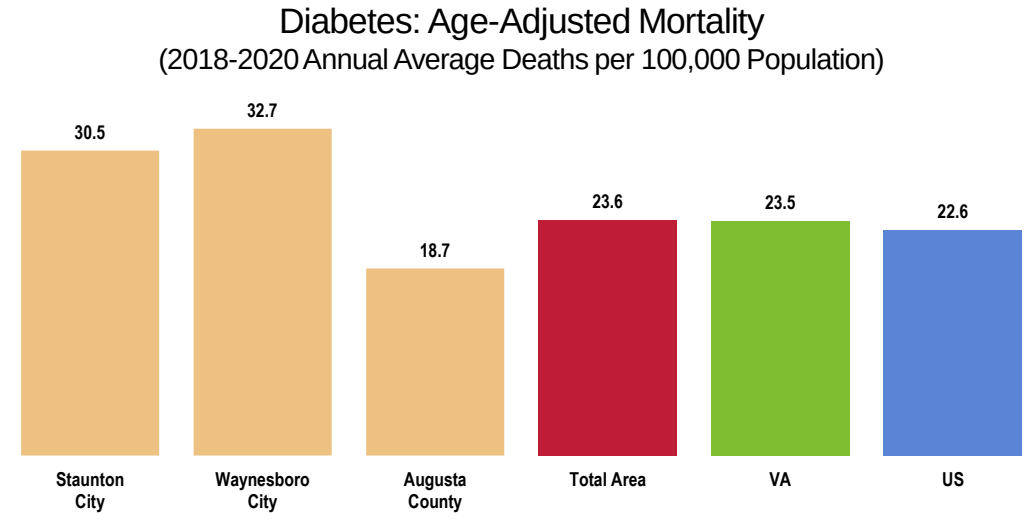
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Between 2018 and 2020, there was an annual average age-adjusted diabetes mortality rate of 23.6 deaths per 100,000 population in the Total Area.

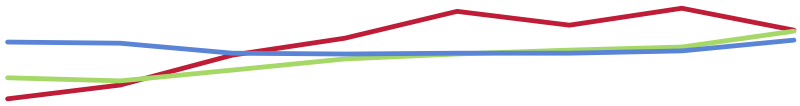
TREND ► Denotes a significant increase from the baseline.

DISPARITY ► Lower in Augusta County.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Diabetes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	16.7	18.1	21.1	22.8	25.5	24.1	25.8	23.6
VA	18.8	18.5	19.6	20.7	21.2	21.6	21.9	23.5
US	22.4	22.3	21.3	21.2	21.3	21.3	21.5	22.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of Diabetes

A total of 14.9% of Total Area adults report having been diagnosed with diabetes.

TREND ► Less favorable than the statewide percentage.

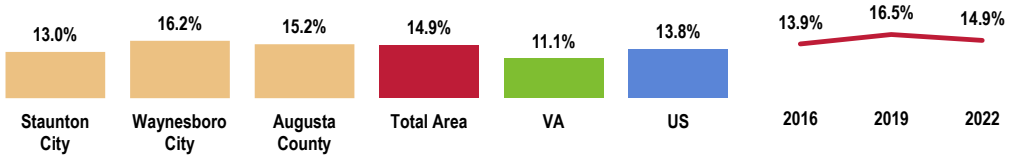
DISPARITY ► More often reported among adults age 40+.

Prevalence of Diabetes

Another 9.4% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Total Area

89.0% are taking action to control their diabetes

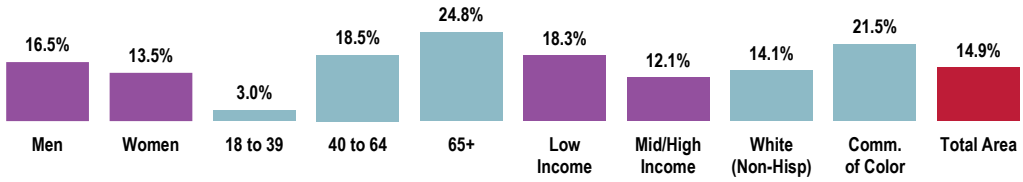


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 121, 302]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(Total Area, 2022)

Note that among adults who have not been diagnosed with diabetes, 45.3% report having had their blood sugar level tested within the past three years.

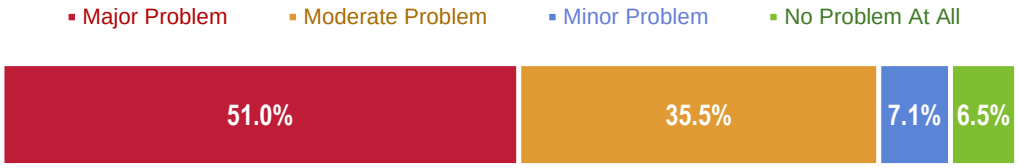


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The greatest share of key informants taking part in an online survey characterized *Diabetes* as a "major problem" in the community.

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> For the people we serve, the biggest challenges are lack of education about diabetes management, cost of insulin and other diabetes medications, and cost of healthy food. – Social Services Provider
>
> Our community as a whole is unhealthy and overweight due to lack of education and affordable nutritional options. Our hectic lives also make it much easier to stop for fast-food options. – Community Leader
>
> Education and medicine. – Other Health Provider
>
> Lack of knowledge, medication compliance/affordability. – Other Health Provider
>
> Diet, education, and access to fresh produce, especially those with food and/or housing insecurities. – Physician
>
> Obesity is often linked with diabetes. Often, diabetic medications (especially the ones that are easy to use, like the insulin pens) are expensive. Lots of people retire to Augusta County and have trouble administering their insulin. – Other Health Provider

Poor diet and lack of diet, as well as being underinsured, contributing to their diabetes being uncontrolled. – Other Health Provider

Diet, access/cost of healthy eating, medications, physician appointments limited, lack of telehealth knowledge with electronics. – Other Health Provider

Access to care, affordable nutritious foods, and affordable exercise and/or physical therapy, especially for residents in the outreaching rural areas of Augusta County. – Public Health Representative

Diet management and compliance, cost of medical resources. – Community Leader

Inability to afford medications and testing supplies, as well as access to healthy foods. – Other Health Provider

Diabetes is an expensive disease that requires a lot of time commitment, discipline, support. Not enough to just go see the doctor and take the medicine, which is often very expensive. Need to have access to healthy food, ability to exercise, psychosocial support from family and friends. Most people with uncontrolled diabetes lacking one or more of these things. – Physician

Limited choices and education for living a heathier lifestyle that is accessible and within their budget. – Social Services Provider

Prevalence and greater strain on overall health and well-being. Access to affordable medications, food, other resources. – Other Health Provider

Access to healthy foods, costs for insulin and other drugs to treat. – Community Leader

I think some of the biggest challenges for people with diabetes in our community is medication access, understanding what resources are available to them to assist with their diagnosis, and being able to afford healthy food alternatives. – Other Health Provider

Nutritional food is expensive. SNAP often isn't enough. Lack of knowledge on how to prepare nutritional meals. Medications that have ridiculous side effects. – Social Services Provider

Lack of access to healthy foods. Lack of education on how to eat healthy. Inactivity. Mental health challenges to "get off the couch." – Social Services Provider

Low health literacy – not fully understanding that diabetes is treatable, and complications may be prevented – this impacts how much education they seek and/or take advantage of – high cost of DM meds. Access to meds – actually getting the meds into the patients' hands. – Other Health Provider

Ability to afford copays for medications and strips. Ability to understand and navigate their prescription coverage. Picking up refills of medications. Getting in with a provider in a timely manner, although access has improved and the AH Endocrinology clinic has really worked to improve this need and be flexible for patient needs. – Other Health Provider

Access to healthy food/improvements in physical activity/education and support on healthy lifestyle changes. – Community Leader

Diabetes medications are high-cost, ease of access to unhealthy, low-cost food options (i.e., fast food) that do not support diabetes management. – Other Health Provider

The biggest challenges that people with diabetes in our community face include being unable to access their medications, being unable to afford their medications, and not knowing how to properly manage their diabetes. – Other Health Provider

Lack of knowledge on diet and staying healthy. Lack of interest in exercising and eating well. – Social Services Provider

Referencing type 2 diabetes in particular, folks struggle to shift their lifestyles for a number of reasons. Access to health food and making cooking/preparing this food a norm in their lifestyle is a challenge. Incorporating exercise into daily life can feel like a big ask for folks who are not used to this. The cost of insulin could be a barrier to controlling both type 1 and 2 diabetes. – Social Services Provider

Cost of care, medications and routine follow up treatment. Cost of healthy foods. Limited patient education, including how to prevent or slow disease progression. Widely accepted this is a progressive disease. Lack of resources, including mental health, to address the barriers to lifestyle changes that could improve management of the disease. – Other Health Provider

Not having enough providers to get frequent visits and follow-up. Misinformation. Price of supplies and medications to control well. Supplies not all available in one location. – Other Health Provider

Nutrition

Poor nutrition and lack of physical activity, especially kids. COVID has only made it worse. – Other Health Provider

Lack of good diet and exercise. – Other Health Provider

Nutrition services, exercise. – Physician

A heathy diet and physical activity are so important to people with diabetes. While these are personal choices, they could be supported better if the community offered more healthy food options and active recreational endeavors. – Social Services Provider

Knowing they need to change their diet accordingly, but not having the desire to do it, the know-how to do it, and the means to afford a healthier diet. – Community Leader

> Numbers are rising due to unhealthy eating and lack of exercise. – Community Leader
>
> Poor nutritional eating habits. The culture seems to prefer foods which lead to a higher BMI, obesity, and ultimately diabetes. Healthy food options do not seem to be the best sellers and are secondary choices at restaurants and grocery stores. The other challenge is some low-income families tend to avoid more expensive produce and foods. – Other Health Provider

Disease Management

> Following a treatment plan and compliance. – Other Health Provider
>
> Compliance and monitoring. – Physician
>
> I'm going to call it compliance. I think many know what to do, and their providers have helped direct them or guide the way. But unless you really see it as a major problem impacting your health – and are willing to make the necessary lifestyle changes – you will only fully or partly comply with what you really need to do. I'm not sure if it's denial of the disease, of the impact or the disease or what. But it's probably just as hard to change diet, start exercising, monitor blood sugar, etc., as it is to stop smoking. – Other Health Provider
>
> Maintaining healthy weight and blood glucose control. – Public Health Representative
>
> Their compliance with nutrition and medication prescriptions. – Other Health Provider
>
> Compliance with making life changes and access to affordable medication, healthy food, etc. Some people that I know eat fast food because they are unable to physically cook for themselves. – Other Health Provider

Lifestyle

> Unwillingness to adjust lifestyle to reduce prevalence of diabetes. Perhaps an educational issue. – Community Leader
>
> Making sustainable lifestyle choices and having the resources to do so. – Community Leader
>
> Making and sustaining the necessary lifestyle changes has been a consistent issue. – Social Services Provider
>
> Balancing lifestyle and diabetes treatment. – Community Leader
>
> Difficulty in easily leading a healthy lifestyle that would minimize the chances of developing type 2 diabetes. – Social Services Provider

Awareness/Education

> I would guess that a general lack of education exists around diabetes and along with that, a motivation or desire to improve this health condition. – Social Services Provider
>
> Education. – Social Services Provider
>
> Lack of understanding of disease process. Education regarding healthy food options. – Community Leader
>
> Understanding of the different types, education about prevention, treatment, long-term effects. – Community Leader
>
> Education about and support for changing lifestyle to treat and/or manage the disease. – Community Leader

Access to Affordable Healthy Food

> Access to easy, nutritious food. – Other Health Provider
>
> Access to healthy foods. Lack of nutritional education. Money and time. Healthy foods are far more expensive and time consuming to prepare each night as compared to hitting the McDonald’s drive-thru. – Other Health Provider
>
> Access to healthy food and knowing how to prepare it. – Other Health Provider
>
> I believe access to affordable fresh fruits and vegetables (or affordable and convenient healthy options) is the biggest challenge for those with diabetes. – Social Services Provider

Access to Care/Services

> Access to weight loss programs that have all avenues to help them, including medication providers. – Other Health Provider
>
> Access to primary care, free/low-cost opportunities for year-round physical activity, cost of insulin. – Public Health Representative
>
> Holistic support and care (medication, physical activity, diet, support groups/individual) that helps retain dignity

Obesity

> I am thinking about type 2 diabetes. Being overweight impacts every body system negatively. Knowledge and motivation to control weight through diet and exercise are challenged by disregard for signs and symptoms of the disease process and/or the mentality that diabetes can be controlled by medication. – Other Health Provider
>
> Morbid obesity and subscribe weight loss, poor eating habits. – Physician
>
> Obesity. Diets. – Community Leader

Affordable Medications/Supplies

> Cost of supplies, availability of resources for support. – Community Leader
>
> I feel the biggest challenges for people with diabetes in the community is proper and affordable care and treatment, along with education on managing and preventing the disease. – Community Leader
>
> Paying for medicine. – Community Leader

Income/Poverty

> Low economic levels leading to poor nutritional understanding and habits. High costs of healthy foods and lack of help in understanding needs. – Social Services Provider
>
> People living in poverty do not have the resources necessary to deal with their diabetes and take the necessary steps to prevent complications. – Other Health Provider

Prevention/Screenings

> Access to prevention-based programs and then the resources to effectively live the strategies out. – Social Services Provider
>
> Diabetes prevention and diabetes self-management. – Other Health Provider

Access to Care for Uninsured/Underinsured

> Lack of medical insurance, so they are not getting enough instructions on how to manage their diabetes. – Community Leader

Denial/Stigma

> Fear of diagnosis/stigma of diabetes with resistance to visiting health care providers, lack of knowledge and fear of what changes they may be asked to make if/when they seek treatment. Fear of having to take insulin or check blood sugars or give up foods they like to eat. – Other Health Provider

Impact on Quality of Life

> Recognizing that diabetes causes long-term, serious health problems. – Community Leader

Insufficient Physical Activity

> Activity and weight management. – Other Health Provider

Co-Occurrences

> High blood pressure is rampant. I see this with most of my employees and at least 3/4 of my clients. I think it is related to other untreated, underlying diseases, as well as stress and overconsumption of salt, especially cheaper convenience foods. – Social Services Provider

KIDNEY DISEASE

ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

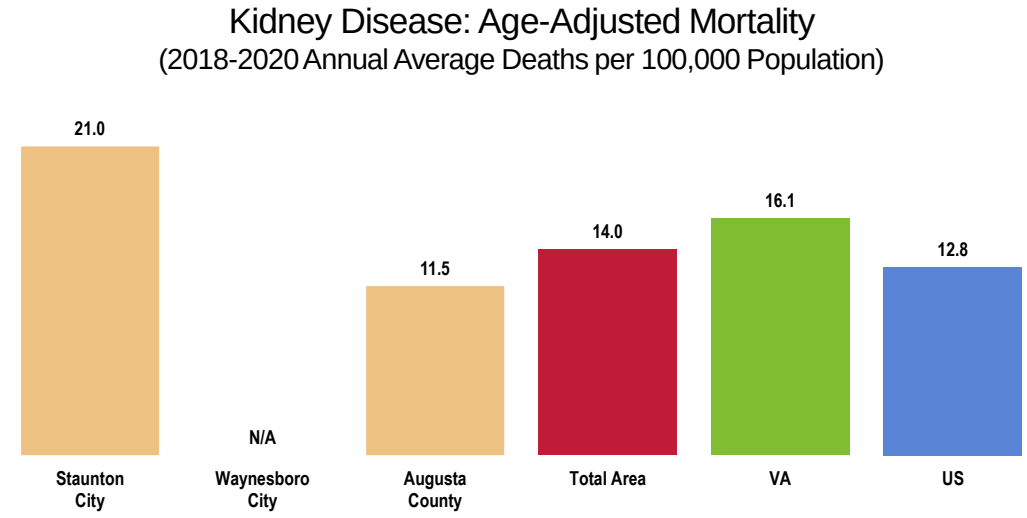
Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

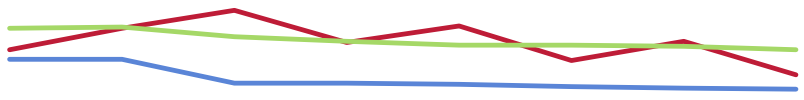
Between 2018 and 2020, there was an annual average age-adjusted kidney disease mortality rate of 14.0 deaths per 100,000 population in the Total Area.

DISPARITY ► Higher in Staunton.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Kidney Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	16.1	17.9	19.4	16.7	18.1	15.2	16.8	14.0
VA	17.9	18.0	17.2	16.8	16.5	16.5	16.4	16.1
US	15.3	15.3	13.3	13.3	13.2	13.0	12.9	12.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

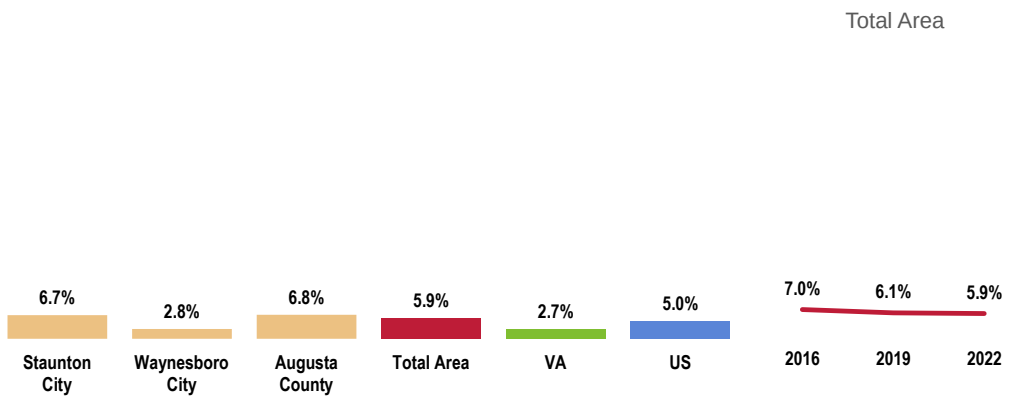
Prevalence of Kidney Disease

A total of 5.9% of Total Area adults report having been diagnosed with kidney disease.

BENCHMARK ► Higher than found across Virginia.

DISPARITY ► Lower in Waynesboro. More often reported among adults age 40+, especially seniors.

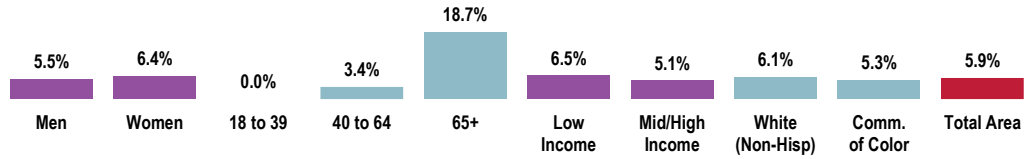
Prevalence of Kidney Disease



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Kidney Disease
(Total Area, 2022)

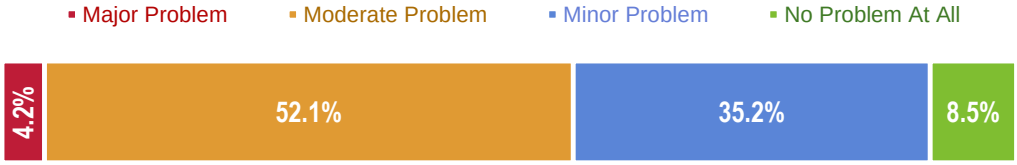


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: • Asked of all respondents.

Key Informant Input: Kidney Disease

Key informants taking part in an online survey generally characterized *Kidney Disease* as a "moderate problem" in the community.

Perceptions of Kidney Disease
as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> Reports from community members. – Community Leader
>
> Again, anecdotally, I've seen someone in my community with kidneys failing and dead three weeks after the diagnosis. These aren't just statistics to us. They are people. – Community Leader
>
> UVA and DaVita are both in the area and they are very busy. UVA opened up another location. – Other Health Provider
>
> High prevalence of dialysis patients. High prevalence of risk factors, such as metabolic dysfunction and diabetes that lead to kidney disease. – Other Health Provider

Co-Occurrences

> It goes along with poorly controlled hypertension and diabetes. – Physician

Contributing Factors

> Similar to diabetes, strategies to combat kidney disease require a lifestyle change, which can seem impossible. Perhaps primary care screenings could help prevent kidney disease, but attending wellness check-ups not normalized in our community. Many folks don't have a PCP at all. – Social Services Provider

SEPTICEMIA

ABOUT SEPSIS

Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have —in your skin, lungs, urinary tract, or somewhere else—triggers a chain reaction throughout your body. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death.

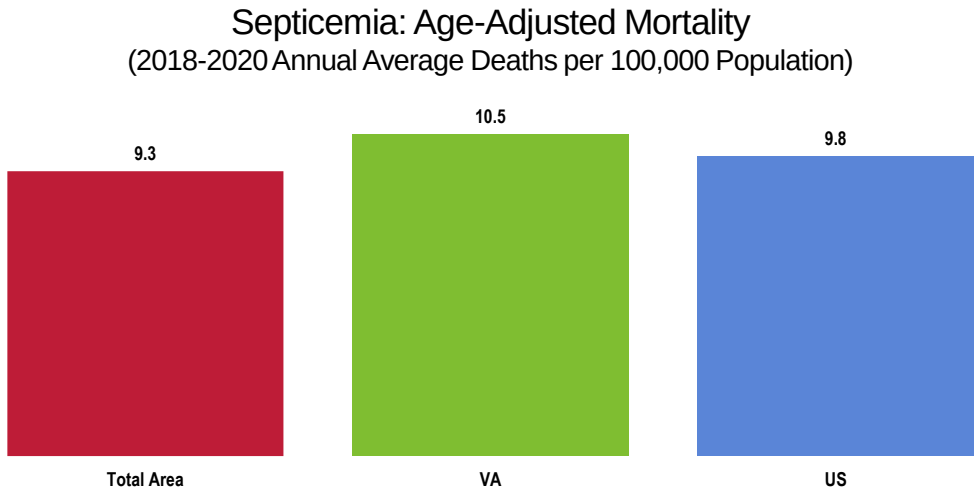
When germs get into a person's body, they can cause an infection. If that infection isn't stopped, it can cause sepsis. Anyone can get an infection and almost any infection can lead to sepsis. Certain people are at higher risk:

- Adults 65 or older
- People with chronic medical conditions, such as diabetes, lung disease, cancer, and kidney disease
- People with weakened immune systems
- Children younger than one

– Centers for Disease Control (https://www.cdc.gov/sepsis/what-is-sepsis.html)

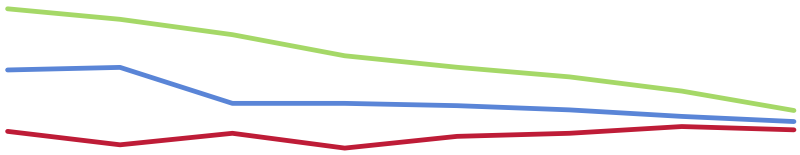
Age-Adjusted Septicemia Deaths

Between 2018 and 2020, the Total Area reported an annual average age-adjusted septicemia mortality rate of 9.3 deaths per 100,000 population.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Septicemia: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	9.2	8.4	9.1	8.2	8.9	9.1	9.5	9.3
VA	16.6	16.0	15.0	13.8	13.1	12.5	11.6	10.5
US	12.9	13.1	10.9	10.9	10.8	10.5	10.1	9.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

POTENTIALLY DISABLING CONDITIONS

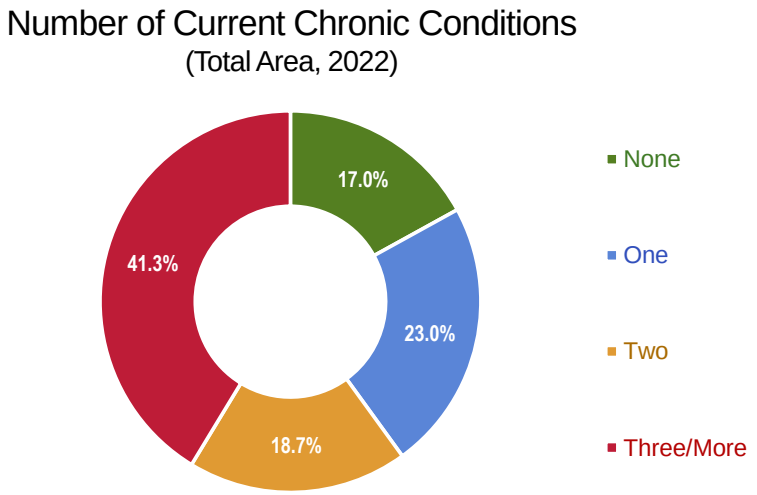
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

Among Total Area survey respondents, most report currently having at least one chronic health condition.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]

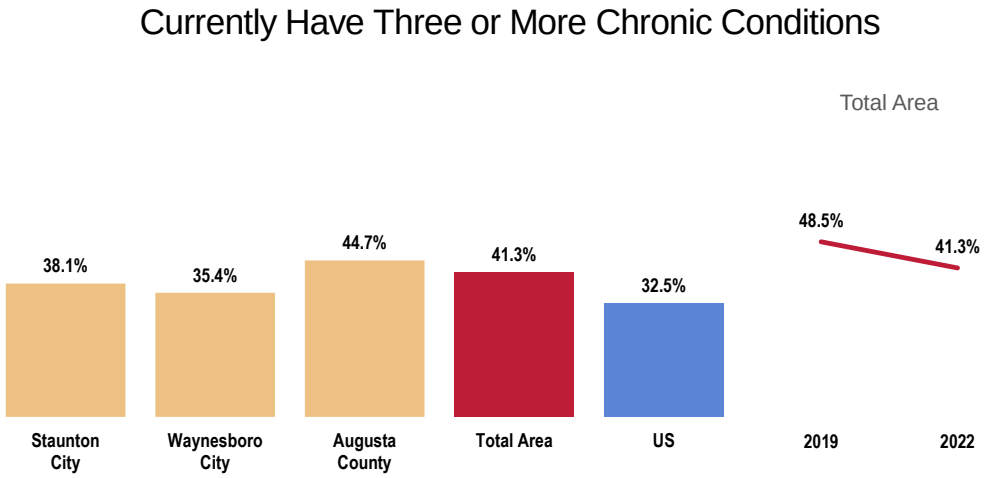
Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

In fact, 41.3% of Total Area adults report having three or more chronic conditions.

BENCHMARK ► Less favorable than the national finding.

TREND ► Denotes a significant decrease since the 2019 survey.

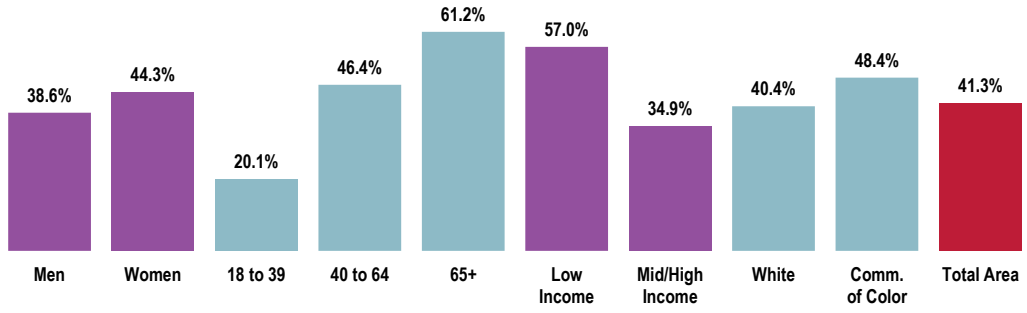
DISPARITY ► Higher in Augusta County. More often reported among adults age 40+ (especially seniors) and lower-income respondents.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(Total Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: • Asked of all respondents.
• In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

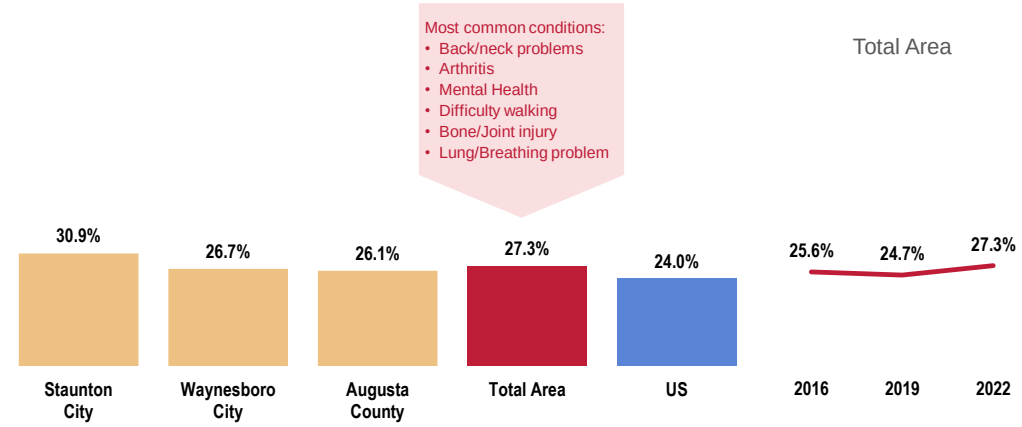
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

A total of 27.3% of Total Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

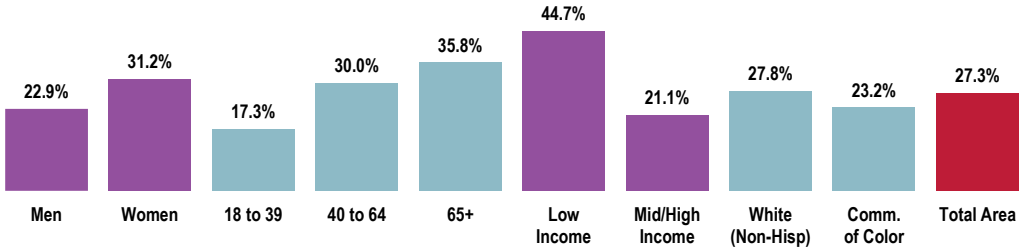
DISPARITY ► More often reported among women, adults age 40+, and lower-income residents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 96-97]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(Total Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: ● Asked of all respondents.

Chronic Pain

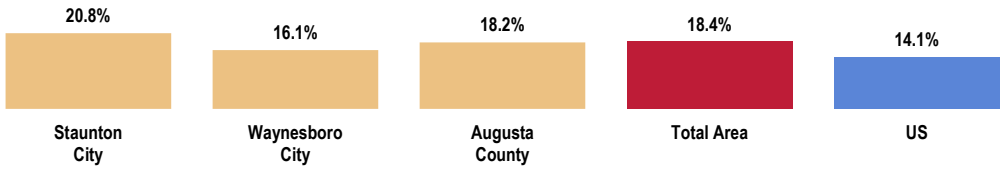
A total of 18.4% of Total Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months.

BENCHMARK ► Worse than the US percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► More often reported among adults age 40+ and lower-income respondents.

Experience High-Impact Chronic Pain

Healthy People 2030 = 7.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain

(Total Area, 2022)

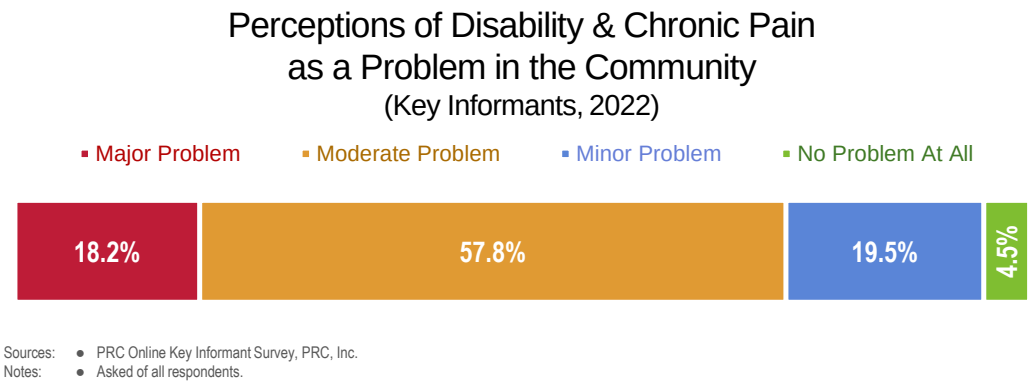
Healthy People 2030 = 7.0% or Lower

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

Key informants taking part in an online survey most often characterized *Disability & Chronic Pain* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> I've heard from friends and colleagues that one reason for our workforce shortage is people being on disability. – Social Services Provider
>
> How many patients I see with complaints of chronic pain and are on disability. – Physician
>
> High prevalence of disability cases and high demand for pain management. – Other Health Provider
>
> Augusta Health has a pain clinic, so there must be patients that need that service. The scooters at Walmart and the grocery stores are always in use. – Other Health Provider
>
> I am uncertain regarding the statistics, but disability and chronic pain are major problems in most communities. – Social Services Provider
>
> Disability from CVA and other neurological impairments are very common, and there is very little in terms of services to support them. – Other Health Provider
>
> I speak to many with these issues. – Social Services Provider
>
> I see and hear about disability conditions and chronic pain from church members. I see it at the AH Fitness Center. – Community Leader
>
> In our community, we can live with the pain, but we can't produce money for medical procedures we can't afford. What other option do we have? – Community Leader

Contributing Factors

> There are many individuals who are on disability or who suffer from chronic pain in the community and are not able to work or are limited in the work they can do (whether that is in their home or outside of the home), which can increase financial and emotional stress for patients and their loved ones. Some of the primary care offices in the area have policies against managing chronic pain and disability, and the specialist's offices equipped to help these patients are limited. – Social Services Provider
>
> Office does not manage chronic pain, but we certainly see people who are greatly affected by it. Because of physical jobs, physical injuries are often cumulative and disabling. Due to opioid epidemic, other ways must be found to manage chronic pain, often inadequate. It affects other chronic diseases, such as diabetes/obesity. – Physician
>
> Again, lack of access plays a major role in this. Residents too often overlook early stages of conditions which will inevitably devolve into chronic pain. Lack of education about pain is not limited to local residents: It's a national (and increasingly widespread) problem. – Community Leader
>
> Not enough public transportation for disabled to use, high costs of medical care and support, lack of insurance. – Social Services Provider
>
> There are limited resources in the community focused on helping those with disabilities to maintain their independence. Disabilities and chronic pain can occur at any age, but often they develop as people age. With a higher-than-average percentage of people over age 60 in our community, there are more people with these issues. There's also currently a significant shortage of home health aides and other such supports in our area. – Social Services Provider

> People with injuries or chronic conditions often do not seek appropriate care and treatment due to financial burden, transportation, or distrust in the healthcare system. Many who do seek care are labeled as drug seekers and then "give up" on finding help for their pain issues. – Public Health Representative

Follow-Up/Support

> Support for people and families with debilitating disease, such as ALS. When a family member has been diagnosed with ALS particularly, their lives and needs change drastically in such a small amount of time. – Other Health Provider
>
> We lack good social supports for those experiencing disability and chronic pain. – Other Health Provider
>
> There is a lack of support for older adults with chronic pain and diseases in our community. Pain medications are rarely prescribed due to the fear of narcotic additions, and other "natural alternatives" are not yet offered in Virginia. For people in our area with diseases and chronic pain, they have nowhere to turn for pain management. For example, someone I know has a chronic disease and a massive amount of pain and they are not even allowed to take ibuprofen due to their condition. This person is still working but thinking of getting on disability because their pain is so unmanageable. – Other Health Provider

Aging Population

> An aging population in these communities means more people leaving the workforce before Social Security retirement age and trying to manage chronic pain due to conditions like arthritis, mobility limitations, etc. – Public Health Representative

Alcohol/Drug Use

> Large population with chronic pain in setting of community with some people with opioid dependence. – Physician

Access to Care/Services

> Lack of health care or attention to health care when younger. Chronic pain seems to be prevalent in the area. – Social Services Provider

Homelessness

> Forty percent of persons experiencing homelessness report having one or more disabling conditions in our community. Folks who receive SSI cannot afford to pay rent on their own, much less any enjoyable life activities. – Social Services Provider

Impact on Quality of Life

> Disability and chronic pain are major problems because they diminish quality of life for sufferers who often can't work or lead active, healthy lives. This leads to even further deterioration of health and can cause depression, anxiety, and dependence on pain medication. – Community Leader

Labor Shortage

> A significant labor shortage in the home care industry has left many frail older adults without the support they need to live independently, leading to health and safety problems and unnecessary placement in long-term care. – Social Services Provider

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

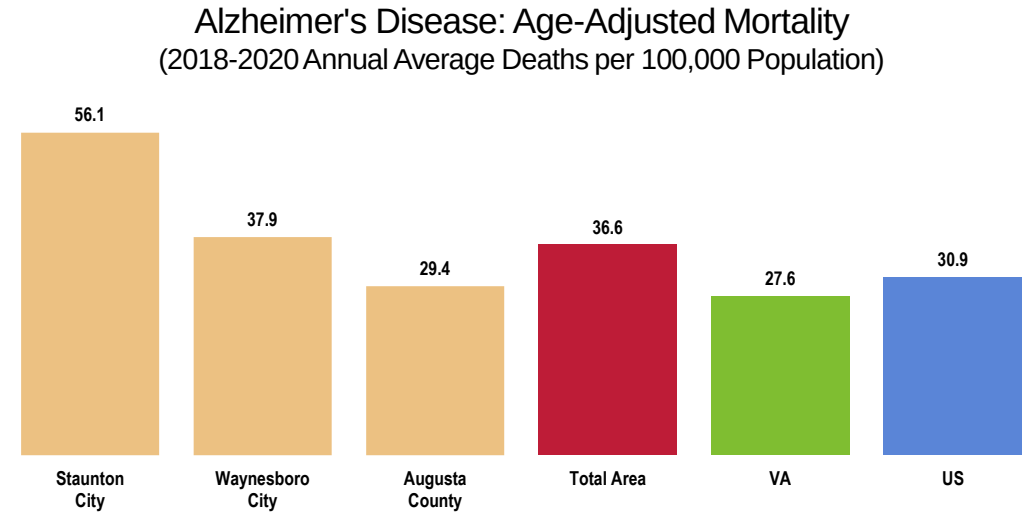
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

Between 2018 and 2020, there was an annual average age-adjusted Alzheimer's disease mortality rate of 36.6 deaths per 100,000 population in the Total Area.

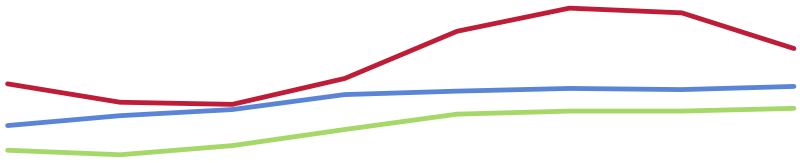
BENCHMARK ► Worse than state and US rates.

DISPARITY ► Considerably higher in Staunton.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Alzheimer's Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	31.3	28.5	28.2	32.1	39.2	42.7	42.0	36.6
VA	21.3	20.6	22.0	24.4	26.7	27.2	27.2	27.6
US	25.0	26.5	27.4	29.7	30.2	30.6	30.4	30.9

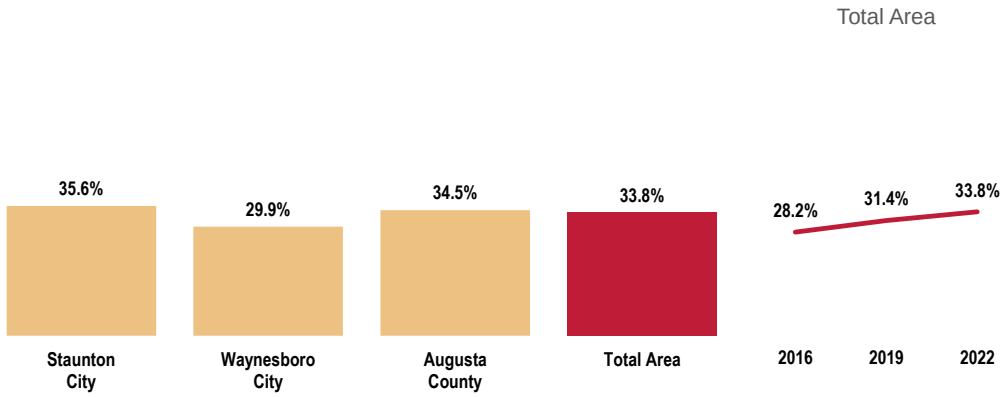
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of Alzheimer's Disease

One-third (33.8%) of area adults report that a member of their family ever has been diagnosed with Alzheimer's disease or dementia.

TREND ► Increasing significantly within the service area.

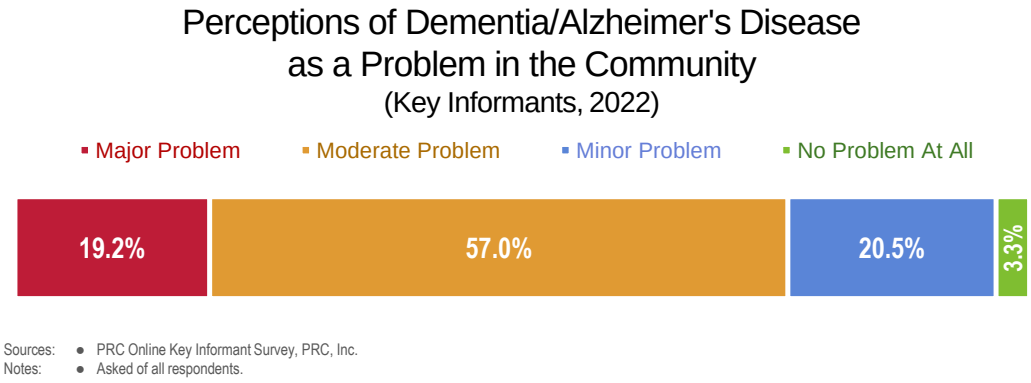
Family Member Has Been Diagnosed with Alzheimer's Disease



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 321]
Notes: ● Asked of all respondents.

Key Informant Input: Dementia/Alzheimer's Disease

Key informants taking part in an online survey were most likely to consider *Dementia/ Alzheimer's Disease* as a "moderate problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

> Ours is an older population. I don't know how we can possibly have enough caregivers to relieve the family members who end up being overwhelmed by care of their loved ones. – Community Leader
>
> Increasing incidence of the condition, particularly with growing size of the aging population, and the need for greater support or resources to help both persons suffering with the condition as well as the family involved in the care of the person. – Community Leader
>
> People are living longer, and that this disease is running rampant through the elderly community and there is no cure. Preventive medicines don't work because by the time the family realizes someone is suffering from this, it is too late. – Community Leader
>
> It is common among the elderly, and there are a larger percentage of elderly in this area. – Other Health Provider
>
> I don't know if it is statistically, I answered that way based on our aging population. – Social Services Provider
>
> We are an aging population and there is stigma tied to these diseases. – Social Services Provider
>
> Our area has a higher percentage of older individuals than the state or national average. This leads to more people with dementia diagnosis, and thus more family caregivers. Dementia has dramatic impacts on the family, as well as the person living with dementia. – Social Services Provider
>
> Aging population. – Social Services Provider

Prevalence/Incidence

> I have known many people with this disease living in this area. – Other Health Provider
>
> Prevalence seems to be rising. – Community Leader
>
> National numbers indicate such. – Community Leader
>
> Growing rates. – Physician
>
> I believe it's a major problem throughout the United States. I see many patients with undiagnosed dementia, need for increased neurology presence. – Physician
>
> It appears the incidence of this disease is increasing nationwide. – Other Health Provider
>
> Dementia/Alzheimer's is a growing elder problem. We don't have nearly adequate research or resources to help this population. – Other Health Provider

Access to Care/Services

> Lack of day care/respite care. – Community Leader
>
> Alzheimer's/dementia placement. – Other Health Provider
>
> Many people in the community have it but don't have the resources available to get the support they need. – Other Health Provider
>
> There are very few placement options for individuals who need memory care placement after they can no longer live alone. – Other Health Provider
>
> Lack of neurology. – Physician

Contributing Factors

> Our local population of Medicare-aged community members is growing, but the resources available for those experiencing dementia have not expanded. Care for those who are in poverty is particularly challenging, with very limited support options available locally that accept Medicaid. There is only one secure dementia unit locally. – Other Health Provider
>
> 35,151 SAW residents, or 28.24%, are 60 years of age or older, according to UVA's Weldon Cooper Center. This is far above the 22.56% state's population of older adults. The number of residents living with dementia is steadily increasing as the Baby Boomers age, bringing with it an increasing number of family caregivers bearing the physical, financial, and emotional stress that caregiving brings. The incidence of physical health problems extends not only to those living with dementia but to caregivers, extended family, and the community at large. Health care providers, as a rule, are not well-equipped to provide support to these residents. – Social Services Provider
>
> High incidence, lack of availability of support and facilities, including day facilities. – Community Leader
>
> High prevalence, decreased community services, and little to no attention to prevention. – Other Health Provider

Follow-Up/Support

> Our families who are managing individuals with dementia/Alzheimer's do not have the support they need to manage these individuals at home. They often end up in facilities with poor outcomes. – Social Services Provider
>
> Lack of resources for families trying to care for their own. Memory care unit living is well beyond the financial reach of many residents -- and finding affordable in-home care is nearly impossible. It's also difficult to find a central source of information/help for these patients and their families. – Community Leader
>
> Not enough support groups for families, good facilities are not affordable. In home help is not obtainable for the middle-class working family. – Other Health Provider

Affordable Care/Services

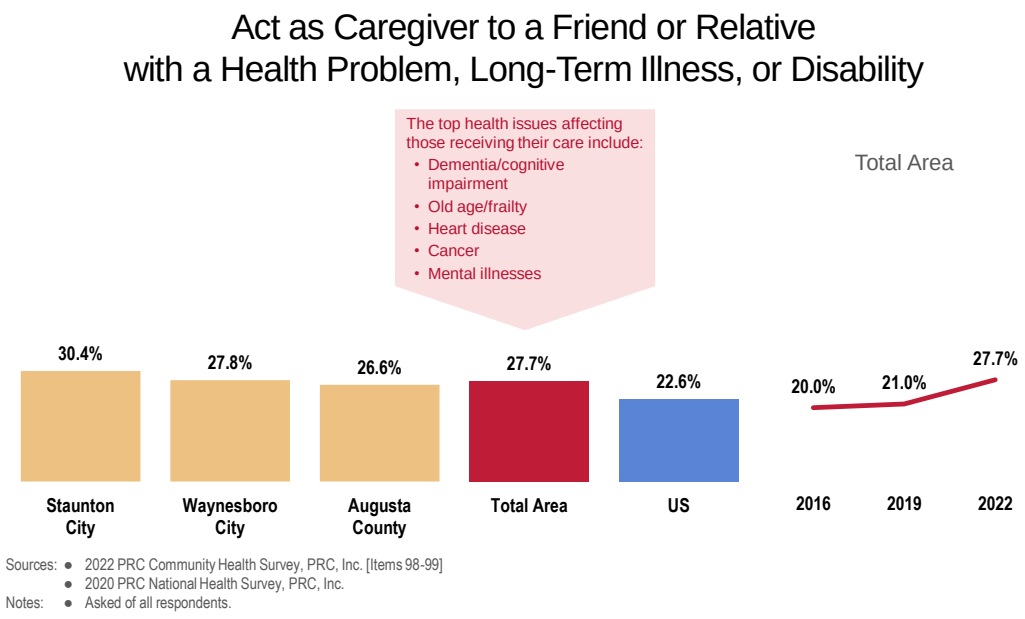
> The level of care folks require with dementia/Alzheimer's is a major cost both monetarily (for specific care facilities) and ecumenically among families who care for individuals 24/7. – Social Services Provider

Caregiving

A total of 27.7% of Total Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

BENCHMARK ► Higher than the US finding.

TREND ► Represents a significant increase from previous surveys.



BIRTHS

BIRTH OUTCOMES & RISKS

Low-Weight Births

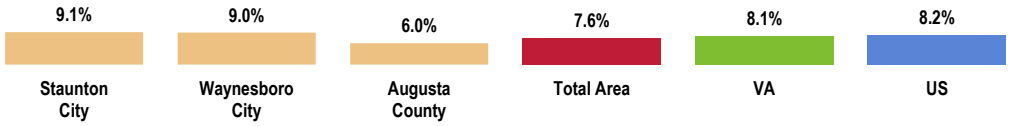
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 7.6% of 2013-2019 Total Area births were low-weight.

DISPARITY ► Lower in Augusta County.

Low-Weight Births
(Percent of Live Births, 2013-2019)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.
Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2018 and 2020, there was an annual average of 6.1 infant deaths per 1,000 live births.

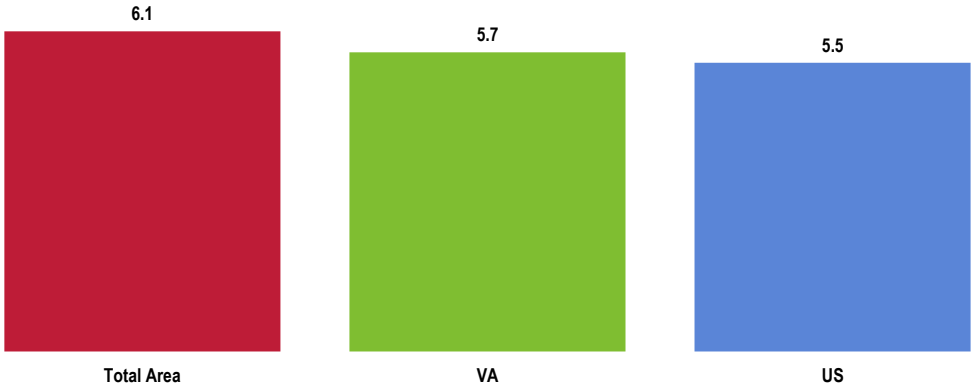
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Trending significantly higher in recent years.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2018-2020)

Healthy People 2030 = 5.0 or Lower



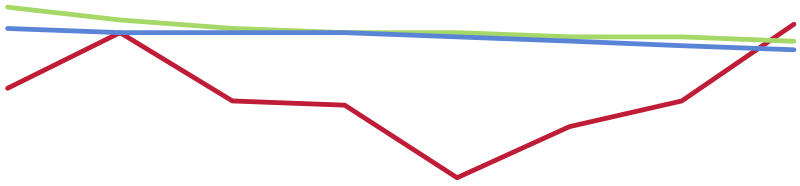
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Infant Mortality Trends

(Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2030 = 5.0 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	4.6	5.9	4.3	4.2	2.5	3.7	4.3	6.1
VA	6.5	6.2	6.0	5.9	5.9	5.8	5.8	5.7
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

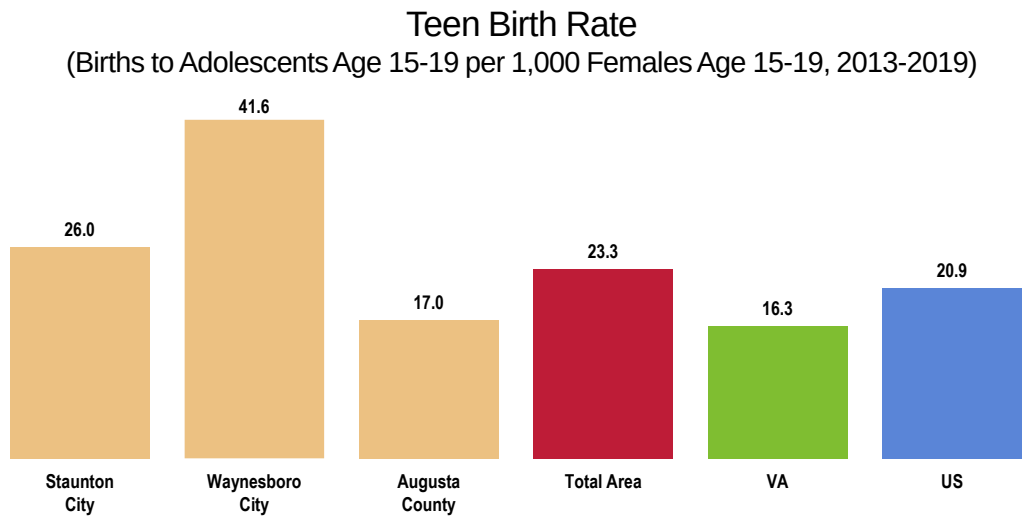
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2013 and 2019, there were 23.3 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Total Area.

BENCHMARK ► Less favorable than the statewide rate.

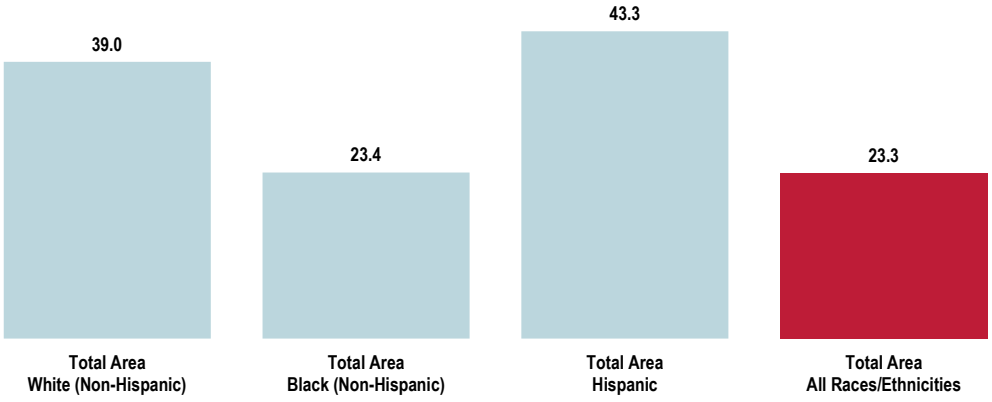
DISPARITY ► Considerably higher in Waynesboro. Higher among White and Hispanic female adolescents.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Teen Birth Rate
(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2013-2019)



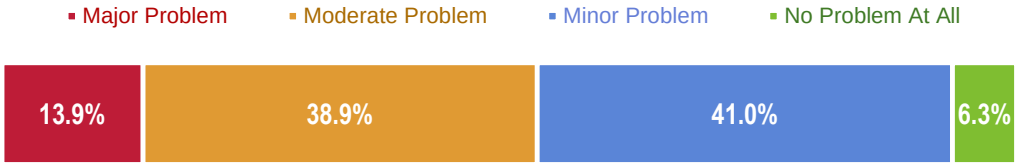
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

Key informants taking part in an online survey most often characterized *Infant Health & Family Planning* as a "minor problem" in the community.

Perceptions of Infant Health and Family Planning as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> While this may not affect large numbers, for those that are impacted it is a major problem. Lack of health literacy for some parents and lack of sufficient numbers of pediatricians and inpatient care for infants in the immediate community is problematic. Resources such as healthy foods, financial support, day cares, etc., are limited to some parents and their infants. – Social Services Provider
>
> Lack of knowledge of low-cost resources. Political pressure to avoid family planning help in public places. Stigma of infant health program use. Significant lack of appropriate parenting. – Social Services Provider
>
> I believe that the teen pregnancy rates are increasing but am not sure if that is true. I have also heard that doctors' appointments, etc., were pushed back by the pandemic and that nonemergency health care procedures were delayed. – Social Services Provider
>
> Trauma. Free will. Adults who haven't healed themselves trying to heal themselves with babies. Substance use disorder is rampant. – Social Services Provider

> Again, I am not certain of the extent of the problem, but just accessing basic healthcare for mothers and their infants can be very difficult. It is important that mothers know that they can qualify for Medicare (or is it Medicaid?) when they are pregnant, and that their children can be covered once born in the U.S. The U.S. healthcare system can generally be confusing, daunting even, for Hispanic immigrants – especially so for expectant mothers. Perhaps more education on the resources that are available to expectant mothers. Channel them somehow into pediatric care, guide them, using language they understand. – Social Services Provider

Teen Pregnancy

> Our teen pregnancy rate in Waynesboro exceeds the state average. Even though there have been a number of interventions to address this issue, the pregnancy rate remains high. The children born to young mothers and fathers are more at-risk for adverse outcomes. – Community Leader
>
> Our teen pregnancy rates always seem to be absurdly high. I worry about the resources that teens have when they are still kids themselves about to give birth. – Community Leader
>
> High school pregnancy leading to infant care without education. – Other Health Provider

Awareness/Education

> Individuals do not have access or are unaware of how to access resources around family planning. This would include general information for family planning to contraception access. Many are unaware of the types and safety of contraception and the benefits. The same for infant health, education, and resources for new parents are not readily available to all parents or they are unaware of how to access resources. – Social Services Provider
>
> Rural communities with lower levels of education result in less pregnancy prevention. – Other Health Provider

Unplanned Pregnancy

> Unplanned pregnancies, especially in low-income populations, limit the ability of those affected to improve their situations. No infant should be unwanted, unloved, and uncared for or under-cared for. – Other Health Provider
>
> High unplanned pregnancy rates. – Community Leader

Alcohol/Drug Use

> Drug addiction contributes to infant health issues. – Social Services Provider

Access to Care/Services

> The health department is the only resource in our immediate area that offers Title X and sliding scale for reproductive health/family planning services. Many patients will not seek care at the health department because of the stigma it carries. The HD no longer offers prenatal care, BabyCare, or case management, which leaves a large void for uninsured and high-risk mothers and their babies. – Public Health Representative

Due to COVID-19

> I currently work at the Waynesboro Health Department, and we serve this population. The services have decreased due to COVID. Most of our children are behind in immunizations. A CDC worker is currently working in the Waynesboro High School to connect students with method options. – Community Leader

Vulnerable Population

> The mortality rates of Black mothers in childbirth are skewed when compared to other races, and many times adding a child into a place where people are already living below the poverty line compounds things. – Community Leader

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Daily Recommendation of Fruits/Vegetables

Adults

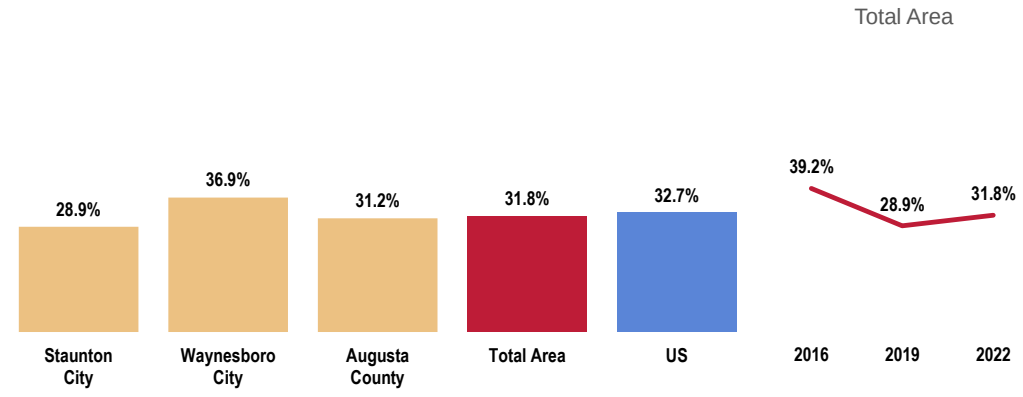
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 31.8% of Total Area adults report eating five or more servings of fruits and/or vegetables per day.

TREND ► Marks a significant decrease from the 2016 baseline.

DISPARITY ► Male respondents and lower-income adults are less likely to report eating fruits and vegetables.

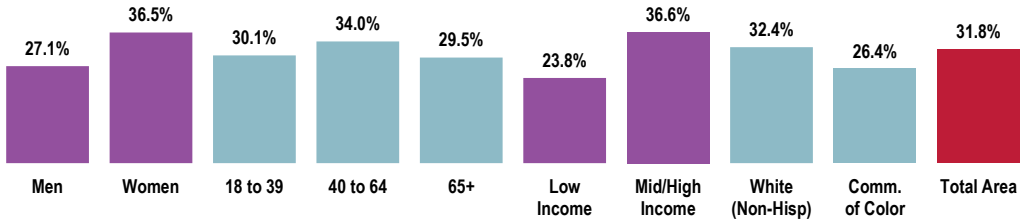
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Total Area, 2022)



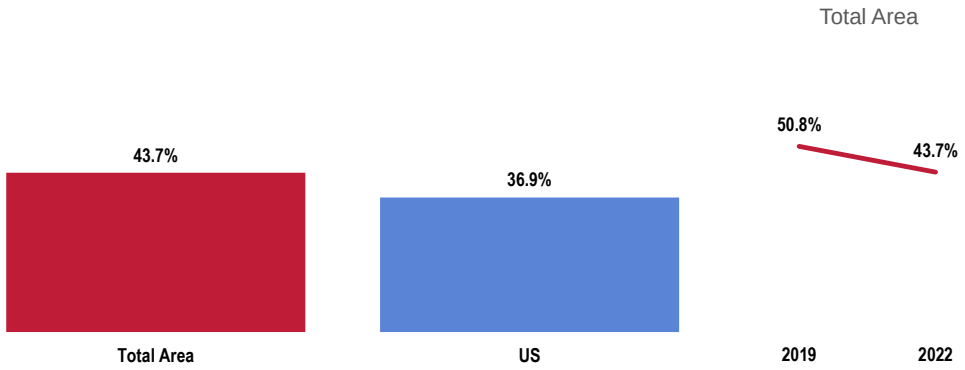
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 125]

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Children

Among area parents, 43.7% report that their child eats five or more servings of fruits and/or vegetables in a typical day.

Child Consumes Five or More Servings of Fruits/Vegetables Per Day



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 154]
- 2020 PRC National Health Survey, PRC, Inc.

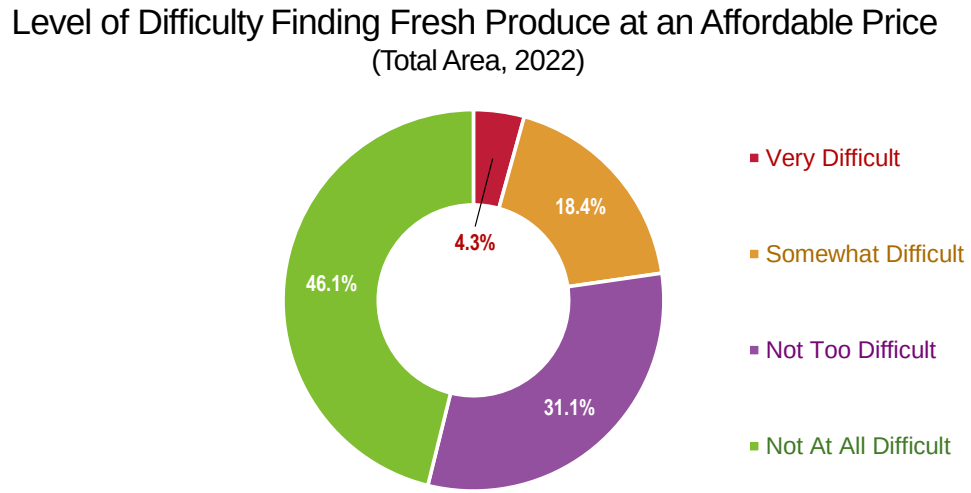
Notes:
- Asked of all respondents with children age 2 through 17.
- For this issue, respondents were asked to estimate their child's intake on a typical day.

Difficulty Accessing Fresh Produce

Respondents were asked: "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

RELATED ISSUE
See also *Food Access* in the **Social Determinants of Health** section of this report.

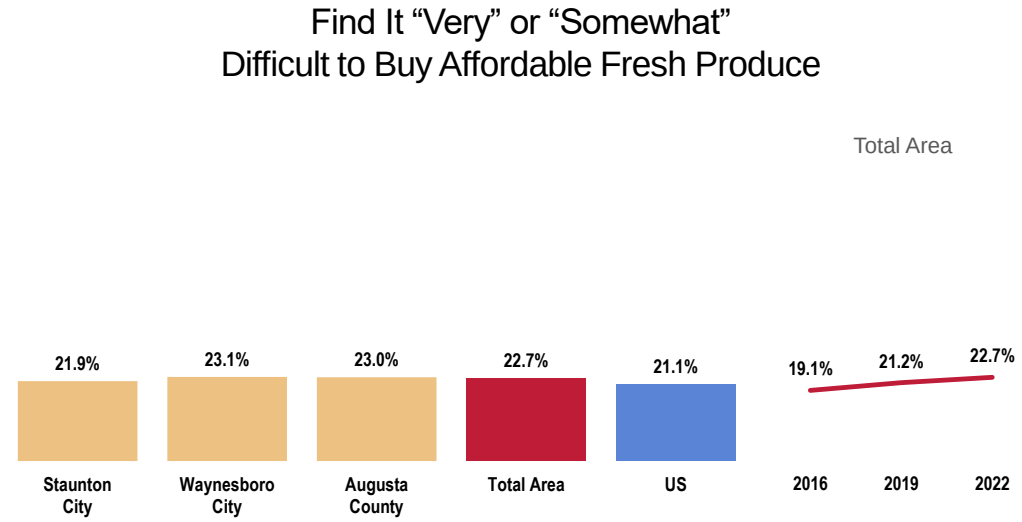
Most Total Area adults report little or no difficulty buying fresh produce at a price they can afford.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

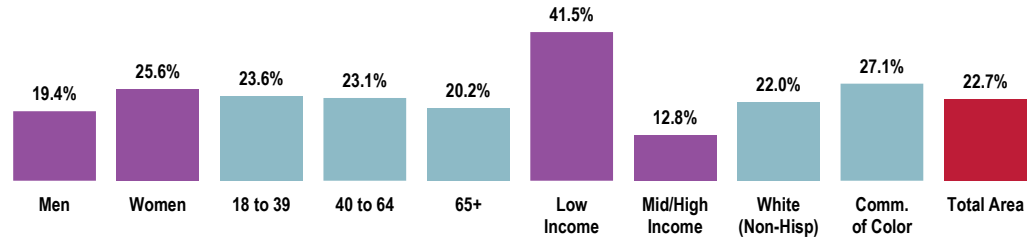
However, 22.7% of Total Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

DISPARITY ► More often reported among female respondents and especially lower-income adults.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce
(Total Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: • Asked of all respondents.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

A total of 37.3% of Total Area adults report no leisure-time physical activity in the past month.

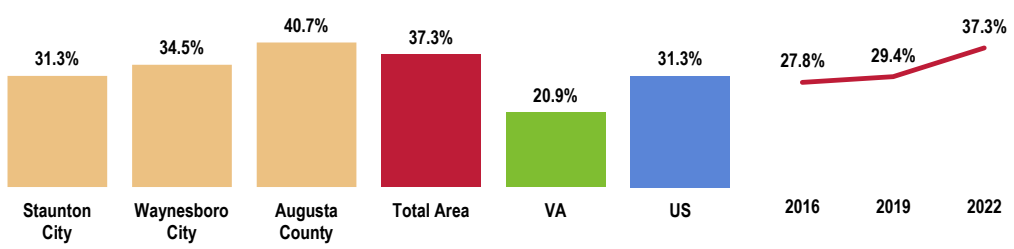
BENCHMARK ► Higher than the state and national percentages. Fails to satisfy the Healthy People 2030 objective.

TREND ► Trending significantly higher over time.

DISPARITY ► Higher in Augusta County.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

A total of 14.4% of Total Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

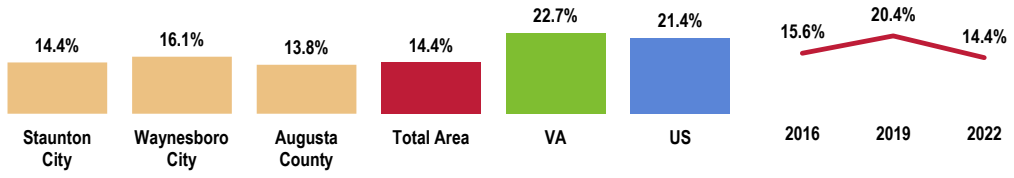
BENCHMARK ► Less favorable than found across the state and nation. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lower-income adults are less likely than higher-income adults to meet physical activity recommendations.

Meets Physical Activity Recommendations

Healthy People 2030 = 28.4% or Higher

Total Area



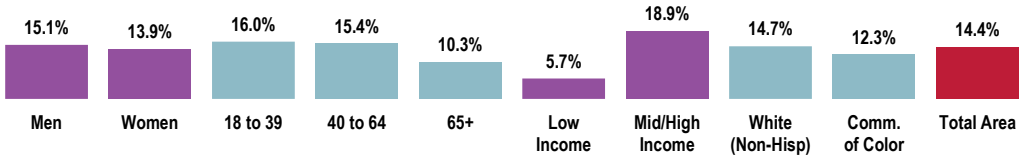
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Meets Physical Activity Recommendations

(Total Area, 2022)

Healthy People 2030 = 28.4% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

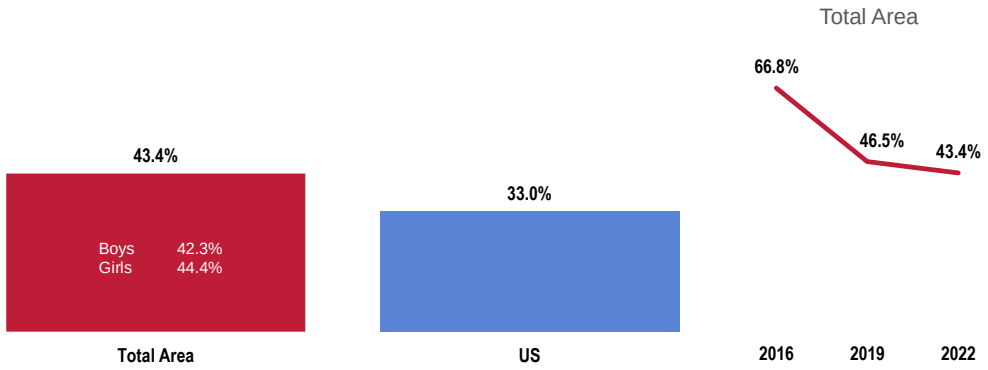
– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among Total Area children age 2 to 17, 43.4% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

BENCHMARK ► More favorable than the US finding.

TREND ► Trending significantly lower over time.

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

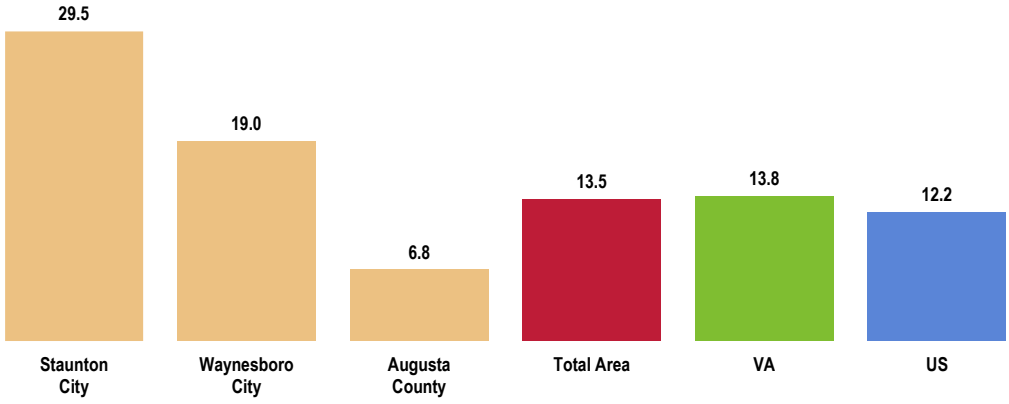
In 2019, there were 13.5 recreation/fitness facilities for every 100,000 population in the Total Area.

DISPARITY ► Considerably lower in Augusta County.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access
(Number of Recreation & Fitness Facilities per 100,000 Population, 2019)



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Overweight Status

Here, "overweight" includes those respondents with a BMI value ≥25.

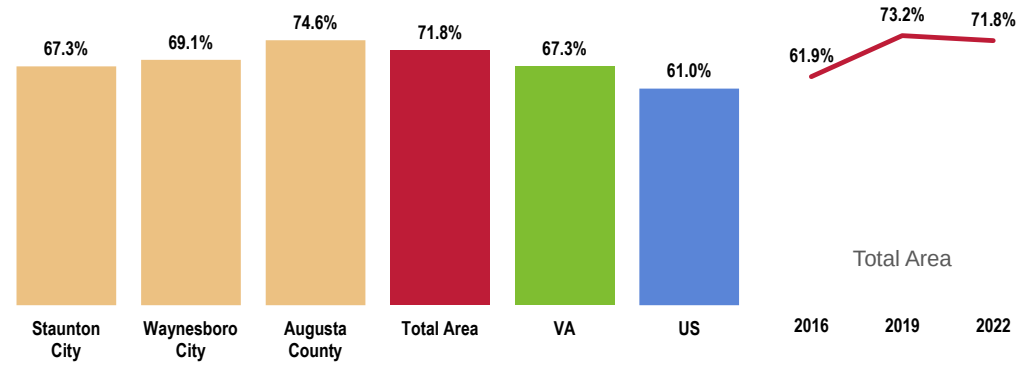
A total of 7 in 10 Total Area adults (71.8%) are overweight.

BENCHMARK ► Worse than the Virginia and US findings.

TREND ► Denotes a significant increase from the 2016 benchmark.

DISPARITY ► Higher in Augusta County.

Prevalence of Total Overweight (Overweight and Obese)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

The overweight prevalence above includes 40.9% of Total Area adults who are obese.

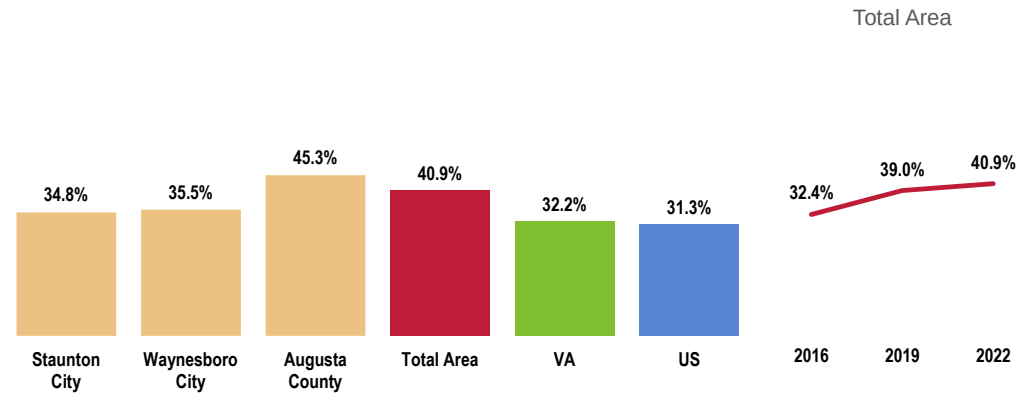
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Marks a significant increase over time.

DISPARITY ► More often reported among communities of color and adults age 40 to 64 (when compared to those age 65+).

Prevalence of Obesity

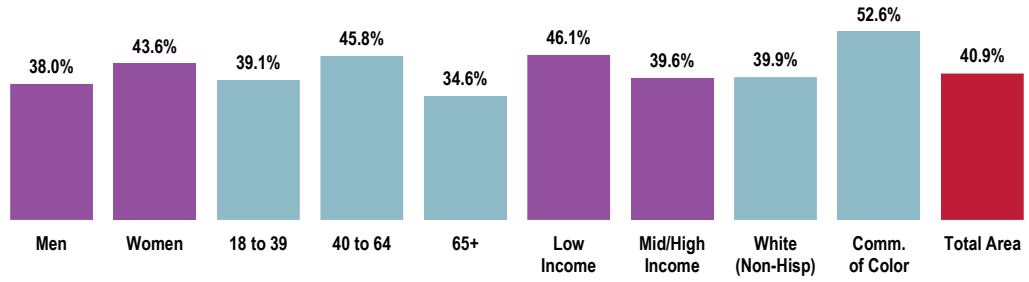
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 130]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(Total Area, 2022)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 130]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

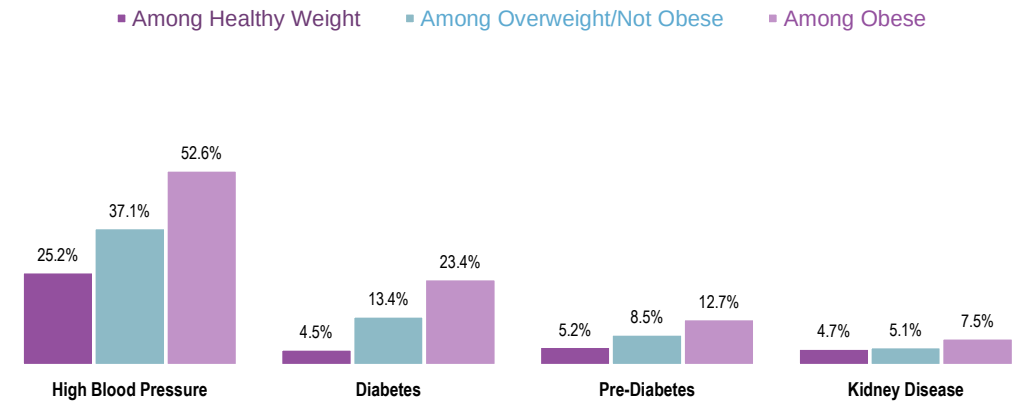
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.

The correlation between overweight and various health issues cannot be disputed.

Relationship of Overweight With Other Health Issues
(Total Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]

Notes:
- Based on reported heights and weights, asked of all respondents.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

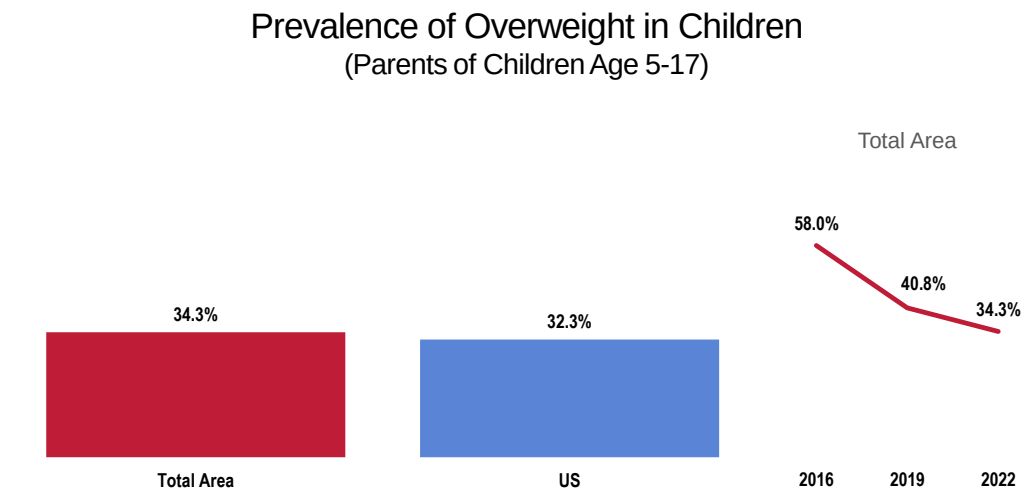
BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 34.3% of Total Area children age 5 to 17 are overweight or obese (≥85th percentile).

TREND ► Marks a significant decline over time.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

The childhood overweight prevalence above includes 21.9% of area children age 5 to 17 who are obese (≥95th percentile).

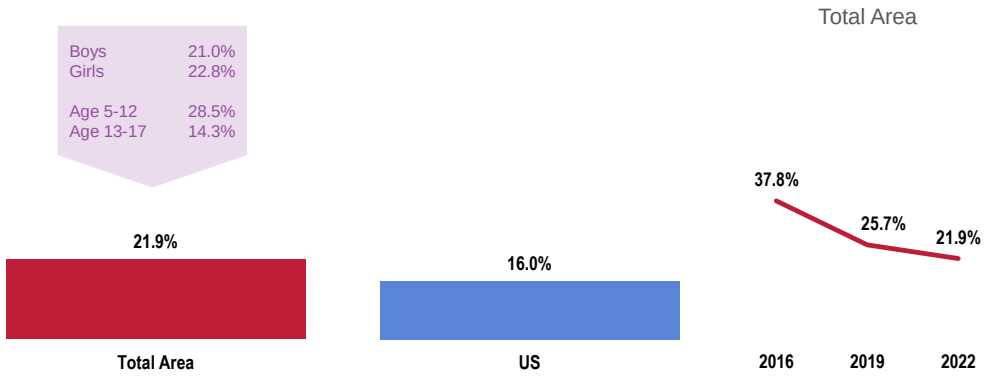
TREND ► Marks a significant decline over time.

DISPARITY ► More often reported among parents of children age 5 to 12.

Prevalence of Obesity in Children

(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2030 = 15.5% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 133]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

A high percentage of key informants taking part in an online survey characterized *Nutrition, Physical Activity & Weight* as a "major problem" in the community.

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2022)

Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Contributing Factors

> Lack of understanding that food choices impact not just weight but overall quality of life. No easy access to better food choices. I'm sure better food choices are also cost-prohibitive. Physical activity doesn't seem to be a priority. – Public Health Representative
>
> Lack of awareness among the people impacted on proper behavior and lack of easily accessible amenities that could promote healthy behavior, e.g., greenways, parks, bike paths, etc. – Community Leader
>
> Insufficient public education on healthy food choices. People lacking time for healthy food prep and exercise. Cost of healthy foods. Current stress of pandemic, political and world events. Lack of healthy food role-modeling in health care settings, including cafeteria food options and rewards, appreciation, and celebration events. – Other Health Provider
>
> Access to information, access to programs and services, fitness facilities denying the right to ASL interpretation in violation of federal non-discrimination laws, lack of culturally sensitive education. – Social Services Provider
>
> Lack of understanding of risk. Lack of low-cost programs. Stigma. – Social Services Provider
>
> Again, lack of education and affordable, nutritional options for food and gym memberships lead to weight gain and poor nutrition. Technology has also played a role in peoples' lack of physical activity. – Community Leader
>
> For those with limited incomes, money to buy nutritious food. Lack of desire to exercise or no place to do so. Overeating, poor nutritional foods that are less expensive than healthy foods. – Social Services Provider
>
> Advertisements for high-fat foods, price of healthier food, and time restraints in order to exercise. Too many activities that don't require movement, i.e., video games, numerous television channels, and the constant use of cell phones. – Community Leader
>
> Lack of education on the importance of physical activity. Food insecurity. – Other Health Provider
>
> Lack of knowledge, lack of transportation/accessibility to area walking paths, parks. Increased availability of high fat/calorie, low nutrient foods. – Other Health Provider
>
> Access to and education about healthy food. – Other Health Provider
>
> Healthy food is more expensive. Very few people sit down to prepare meals, they just eat on the go. There's no incentive for physical activity. Very few bike paths and sidewalks to get to and from areas. – Community Leader
>
> Cost of healthy eating. Education is needed on healthy eating and exercise. Access to gyms and YMCA (lack of transportation) and cost of those programs. Education on free exercise in parks through walking and bike paths, greenways and hiking trails. Lack of transportation to access those free options. A perception that greenways and other walking, bike, hike trailers are unsafe. – Social Services Provider
>
> Lack of access to healthy foods and too many fast-food options. Lack of sidewalks and only a few well-maintained parks in the area. Lack of funding for nutrition services and for fitness programs. The need for more nutrition/cooking education for all members of community. – Other Health Provider
>
> One of the greatest challenges around nutrition is access to fresh, healthy, affordable foods. Many people in our community are considered to be food insecure. One of the greatest challenges to physical activity is lack of sidewalks and bike paths in the community that would make it safe for people to walk and bike. – Other Health Provider
>
> Lack of access to affordable healthy food and gym options is one of the biggest challenges for many. Time to participate in physical activity for those that work long hours or have to manage family needs. Lack of health literacy. These all contribute then to obesity problems within a community. Workplaces also do not support breaks that would allow for physical activity and often do not provide healthy food options onsite. – Social Services Provider
>
> Our community tends to be less active and consume pre-packaged (less healthy) foods. – Other Health Provider
>
> My personal opinion is that access to affordable, nutritious choices are often quite limited. As well as the general adherence to education provided regarding nutrition, physical activity and weight. – Social Services Provider
>
> We have become a sedentary society, and nutrition, physical activity, and obesity all play a role in controlling other comorbidities. We have obesity issues in children and adults. Access to health food is being worked on, as well. – Other Health Provider
>
> People are working too much and staying too stressed to focus on their physical activity. Also, children are not getting enough play outside and away from the television/computer. Access to nutritional foods has become more reasonable in terms of cost (with SNAP), but it is still not a priority for people. Obesity is rampant, especially among the most impoverished in our community (which is counterintuitive but true). Cheap food is unhealthy food. – Social Services Provider
>
> Large obesity problem. Lack of effective, coordinated programs to educate people on food choices, portion control, exercise, and fitness that is affordable. – Physician
>
> The lack of commitment to establish a plan and follow through. Some people may want to go to a gym but may not be able to afford. There are also time constraints for some people. Also, the difficulty with affording to buy healthy foods. – Other Health Provider

Time management around physical fitness and meal planning, free services, access to affordable nutritious foods, too much processed food and fast foods, lack of knowledge around cooking and food label reading. Lack of motivation. – Community Leader

Our challenges seem to be those shared by communities nationwide. As a rural community, we are heavily car-dependent. Schools have cut back on their physical education opportunities, and meals provided tend to be less than nutritionally helpful (although I am grateful to see increasing numbers of free lunch/free breakfast programs). – Community Leader

Our community is getting "bigger." Healthy habits are hard to develop, particularly if you are worried about basic needs. Health food is expensive, and there are food deserts as well throughout the region. Physical activity may be limited for those with physical limitations or those without transportation to parks, etc., lack of safe walking routes, after-school and summer sports are often expensive or hard to coordinate in terms of transportation. – Social Services Provider

Most people in our community need to improve their nutrition and physical activity. We have a significant problem with obesity. – Other Health Provider

There is a significant preference for high-caloric food in the community, and the cost of healthier foods is challenging for low-income people. – Other Health Provider

Lack of education. Lack of resources, generational cycle of unhealthy behaviors passed down. – Social Services Provider

OBESITY is a huge issue in our community. This stems from a lack of education about the importance of a healthy diet and physical activity at a young age. Cost of healthy foods, especially now with the current inflation, prevents lower-income families from cooking with REAL foods. Lack of caring – the older generation is set in their ways. Their unhealthy cooking habits and lack of physical activity probably trace back to the way THEY were raised. Appalachian residents and regional food ways play a big part in this. The focus of most diets in our area (especially lower-income areas) are based on high-carb and fried foods. Church socials, family influences, cultural trends and the fact that schools put so much emphasize on "food parties" contribute to this. If we target children, we might be able to make a difference! Food addiction is another issue in our community, and there are NO resources (that I am aware of) for food addiction for our community. – Other Health Provider

Lifestyle, lack of affordable programs related to exercise, weight loss. – Other Health Provider

Lack of self-care. Lack of education/awareness. Lack of affordable resources. Discrepancies, for example, between nutrition goals and school meals/corporate marketing from food industry. Lack of integrated care approach. – Social Services Provider

Metabolic syndrome – this is the gateway to a myriad of health conditions, including heart disease, stroke, diabetes, certain cancers, hypertension, etc. Caught early, people can be educated in lifestyle changes that will mitigate their risk. Food addictions – research is expanding in this area of study. – Other Health Provider

Family history and habits of poor nutrition and fitness. High levels of obesity. High percentage of low-income families. – Social Services Provider

Access to easy, healthy food and knowing how to prepare it. Also, need more sidewalks for walking. – Other Health Provider

Too much emphasis on weight loss and not enough on healthy lifestyle habits such as good nutrition, physical activity. Nutrition education for the community must include teaching people how to shop and cook on a budget. Fitness program membership costs are not a priority for those with limited incomes, and weight bias keeps people from participating for many reasons. More focus on behaviors which improve health and less on the number on the scale which does not directly equate to how healthy a person is. – Other Health Provider

Lack of individuals who are interested in exercise and diet. Little interest in learning more about self-care. Expense for services is prohibitive. For some fall within the Alice data population. Which seems to be over 40% of our population currently in Waynesboro. – Social Services Provider

Local diet tends to be high-calorie/high-fat. Limited access to free or affordable exercise programs. Limited places to walk/run other than in the roads. – Other Health Provider

Fitness facilities cost money. Eating poorly is cheaper on the front end (not when your body starts to shut down), and organizations often prepare vegetables that aren't part of our cultural context. – Community Leader

How to get the attention of young children who live in poverty and their parents have to spend so much money on fast food to keep meal costs lower, plus so many overweight people do not seem to want to change lifestyle to accommodate a healthier life. – Community Leader

Lifestyle

Active lifestyles are not "trendy" in the area. – Social Services Provider

Maintaining healthy weight and active lifestyle. – Public Health Representative

All issues relate to personal choice, changing behavior will be difficult. Not really sure how you change behavior when it's up to the individual to make the necessary changes in lifestyle. – Community Leader

Compliance and follow through to improve these outcomes. – Other Health Provider

> Actually, I think there are many fitness facilities and many nutrition programs (a very large amount if you want to participate virtually/online). It's just really hard to change your lifestyle as much as you need to in order to have a lasting change. I know it's popular to talk about access/affordable food – but I think those are kind of 'convenient' reasons that shift the focus away from the need to make your own personal changes. For the first time in my life, post-COVID, I need to lose 10 pounds. And it's really hard to break decades of habits to get that done. And once I do it, I'm not sure what it will be like to have to maintain it. – Other Health Provider
>
> As previously mentioned, asking folks to make a lifestyle change without any intervention or education is a hard ask. We ask people to lose weight, eat better, or exercise more, and for folks who don't have a framework for what that looks like, they don't even know where to begin. Healthy food is not always cheap or accessible, and when people can access it, they often don't know how to prepare it. – Social Services Provider
>
> Lack of individual initiative. – Community Leader
>
> Getting patients involved in lifestyle changes. – Physician

Obesity

> Obesity. – Other Health Provider
>
> Our obesity prevalence is 33.1%, and much of this is due to the rural community, lack of transportation, and lack of access to fresh food because of the expense. – Social Services Provider
>
> We have an obese community, which leads to multiple chronic medical illnesses. – Physician
>
> Go shop at Walmart in either Staunton or Waynesboro. There are way too many people in poor, poor health in terms of their weight and physical activity, lack thereof. – Community Leader
>
> Obesity is a significant concern. – Community Leader
>
> An underlying issue that typically cuts across or involves many other health issues would be obesity/access to healthy nutritional sources. – Physician
>
> Obesity. – Other Health Provider
>
> Obesity (strongly correlated to the two previous categories I believe are major problems). – Community Leader

Awareness/Education

> Many people attending our free meal program are not aware of what services are available for the health issues they or loved ones have. Since most health care services have relocated to Fishersville, there is a need for some type of health clinic in the Waynesboro area east of the river. – Social Services Provider
>
> More education is needed in this area. – Social Services Provider
>
> Education. People, like myself, do not take time for themselves. – Other Health Provider
>
> A large and growing percentage of the population either doesn't understand the role of nutrition and physical activity for weight management or lacks the motivation or long-term support to maintain a healthy weight via healthy nutrition habits and physical activity. This has led to a continued high rate of cancer, cardiac disease, and diabetes in our community. – Other Health Provider
>
> Poor health literacy. – Physician
>
> Education, unwillingness to adapt a healthier lifestyle. – Community Leader

Access to Affordable Healthy Food

> Access to fresh food due to monetary constraints. There are resources, but many do not have fresh food and/or frozen food. The majority is canner or boxed. Some clients don't have vehicles, and some don't have money to put in vehicles. – Other Health Provider
>
> School nutrition programs seem to have declined with the "free meal" program in the county. Options are not as healthy. – Other Health Provider
>
> Price of food increasing, leaving families with limited resources and money for nutritious food. Also, diet culture, in terms of problems related to obesity and weight. – Other Health Provider
>
> The cost of fresh food versus prepackaged quick meals. Time for healthy meal prep. – Community Leader
>
> For nutrition, increasing food costs make it even more challenging for people with limited income to get healthy fresh foods consistently. Also, our community has an abundance of fast-food restaurants and very limited restaurants that showcase great tasting healthy meals. So, the culture of the area is that healthy food is not for everyday consumption. Our community has some physical fitness type recreational activities, but not much of a variety to help people find something they really enjoy. – Social Services Provider
>
> Cost of healthy food, normalized overweight. – Social Services Provider

Built Environment

> There are relatively few chances to walk to basic needs due to the area's land use pattern. – Community Leader

> Lack of opportunity for free/low-cost year-round physical activity. Parks are good options during warm months, but during the winter the only options are outside the budget of many local residents. For Staunton, some walkability concerns related to absent sidewalks on main connector roads. Many roads in the area are dangerous for cyclists. – Public Health Representative
>
> Lack of facilities in the region to make it easy to be active. – Social Services Provider
>
> Need sidewalks and a place for activity. There is nothing to do in this area in the winter that is healthy. Our community has access to food problems and food pantries are often stocked with unhealthy, expired, and weird (what do you do with a box of whey protein or canned milk anyways--nobody wants to eat that!). – Other Health Provider
>
> Disconnected walk/bike trails in SAW make biking to work/school difficult, limited access to fresh foods vs. prevalence of fast-food options, fitness centers can be cost prohibitive. – Other Health Provider

Access to Care/Services

> Lack of resources for those with food and housing insecurity. – Physician
>
> Accessibility of professionals to address prevention of chronic disease in those who are overweight/obese. Motivation to participate in available programs. COVID restrictions on available programs. – Other Health Provider
>
> Lack of access to dieticians and other resources to help redesign eating patterns for better nutrition, especially for people with other health issues related to being overweight. – Community Leader

Insufficient Physical Activity

> Lack of activity. – Other Health Provider
>
> People need to make time to get physical. Our bodies are not automobiles. Break down, change parts, and keep driving. – Other Health Provider

Follow-Up/Support

> Not enough support to eat healthy and be active. – Other Health Provider
>
> Lack of support (financial, emotional) for improved physical activity and healthy eating. – Community Leader

Prevention/Screenings

> The biggest issue is preventing people from becoming overweight. There should be a renewed emphasis on physical activity in our schools and workplaces, and affordable healthy food options. – Community Leader

Denial/Stigma

> Denial by community members that obesity is a problem, therefore not seeking help. Discomfort with seeking help. – Community Leader

SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

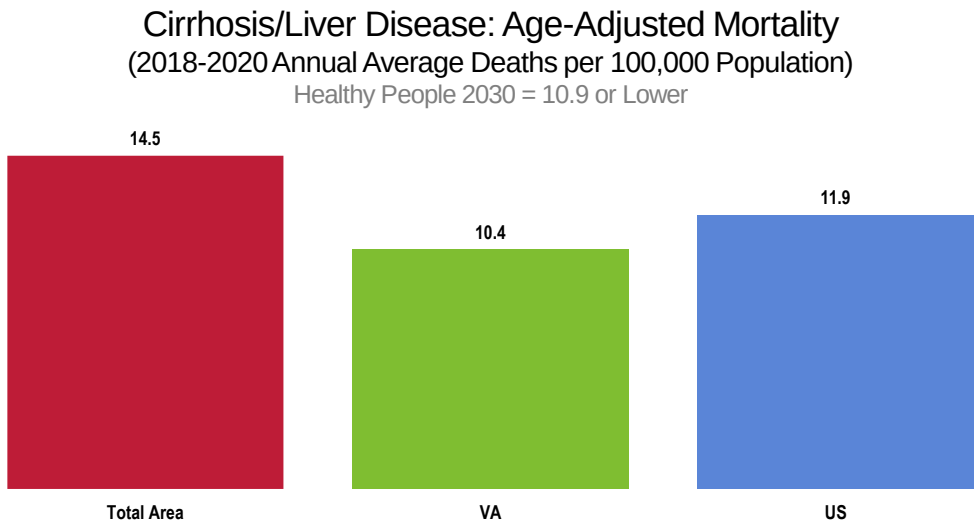
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2018 and 2020, the Total Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 14.5 deaths per 100,000 population.

BENCHMARK ► Worse than state and national rates. Fails to satisfy the Healthy People 2030 objective.

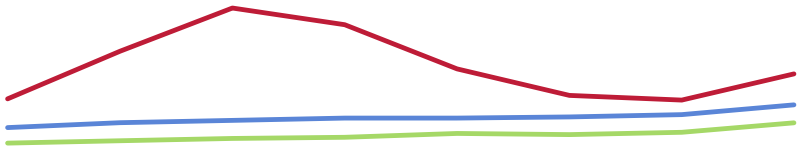


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	12.4	16.4	20.0	18.6	14.9	12.7	12.3	14.5
VA	8.7	8.9	9.1	9.2	9.5	9.4	9.6	10.4
US	10.0	10.4	10.6	10.8	10.8	10.9	11.1	11.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Alcohol Use

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

A total of 18.4% of area adults are excessive drinkers (heavy and/or binge drinkers).

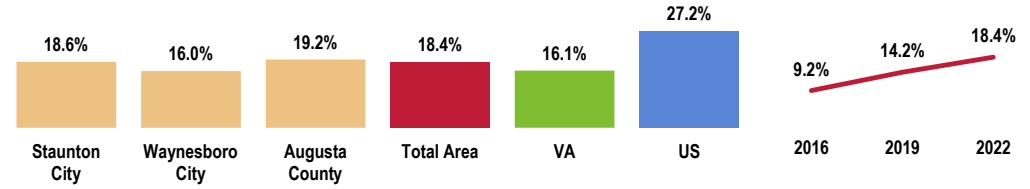
BENCHMARK ► More favorable than the US percentage.

TREND ► Denotes a significant increase over time.

DISPARITY ► More often reported among men and adults younger than 65 (especially those age 18 to 39).

Excessive Drinkers

Total Area



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers
(Total Area, 2022)

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

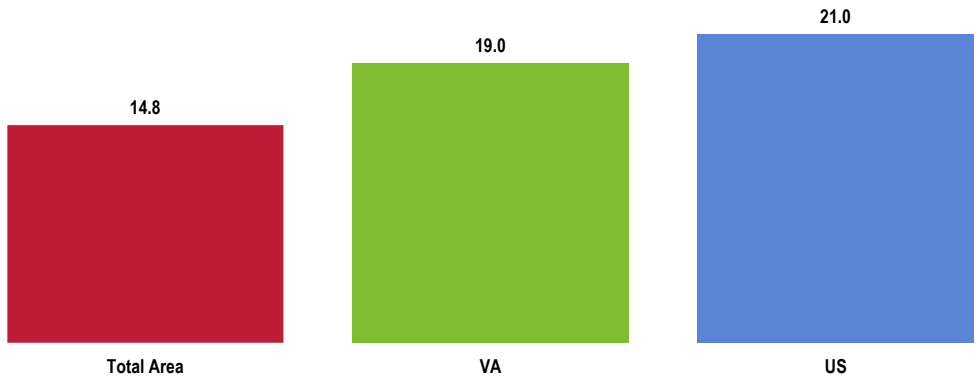
Age-Adjusted Unintentional Drug-Related Deaths

Between 2018 and 2020, there was an annual average age-adjusted unintentional drug-related mortality rate of 14.8 deaths per 100,000 population in the Total Area.

BENCHMARK ► More favorable than the Virginia and US rates.

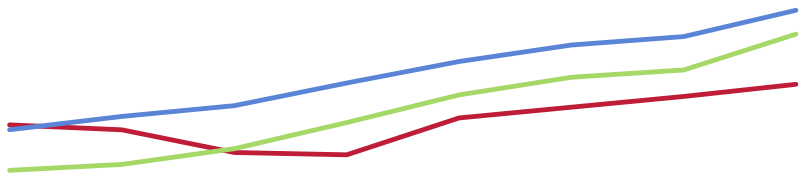
TREND ► Increasing within the service area to the highest level recorded since 2011-2013.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Total Area	11.4	11.0	9.1	8.9	12.0	12.9	13.8	14.8
VA	7.6	8.1	9.4	11.6	13.9	15.4	16.0	19.0
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 3.1% of Total Area adults acknowledge using an illicit drug in the past month.

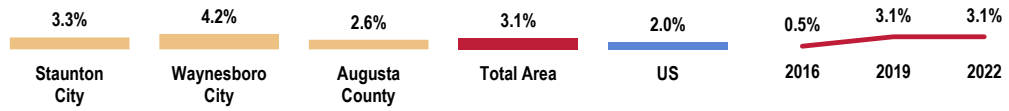
BENCHMARK ► Satisfies the Healthy People 2030 objective.

TREND ► Denotes a significant increase since the 2016 survey.

DISPARITY ► More often reported among men, young adults, lower-income respondents, and communities of color.

Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower



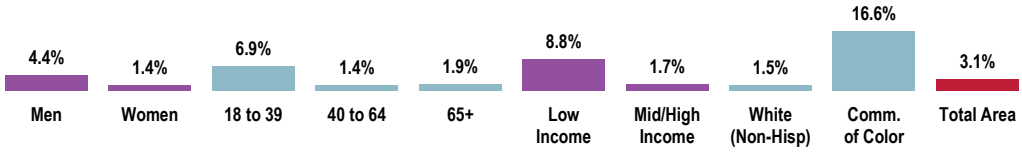
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Illicit Drug Use in the Past Month

(Total Area, 2022)

Healthy People 2030 = 12.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

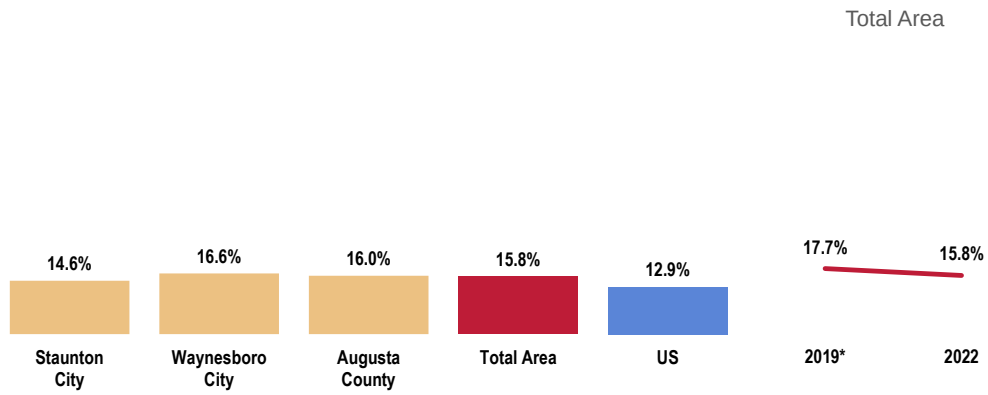
Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

A total of 15.8% of Total Area adults report using a prescription opioid drug in the past year.

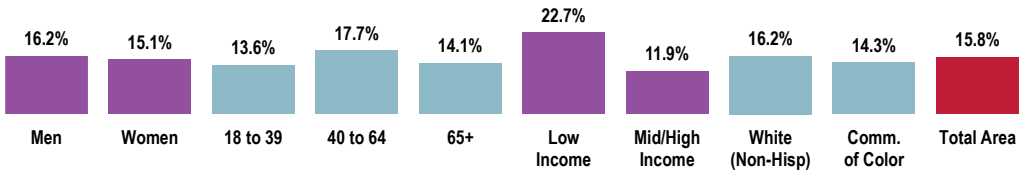
DISPARITY ► Lower-income adults are more likely than higher-income adults to report using prescription opioids.

Used a Prescription Opioid in the Past Year



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● *The 2019 survey asked about the use of prescription opioids, whether prescribed by a physician or not.

Used a Prescription Opioid in the Past Year
(Total Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
Notes: ● Asked of all respondents.

Alcohol & Drug Treatment

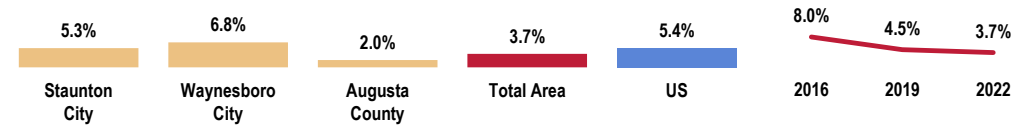
A total of 3.7% of Total Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

TREND ► Denotes a significant decrease from the 2016 benchmark.

DISPARITY ► Lower in Augusta County.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Total Area



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 51]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

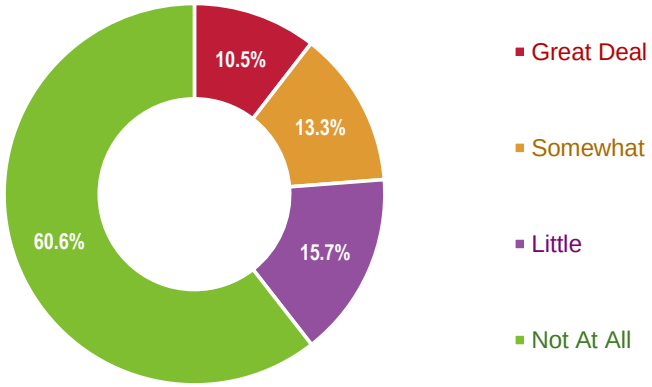
Personal Impact From Substance Abuse

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

A majority of Total Area residents' lives have <u>not</u> been negatively affected by substance abuse (either their own or someone else's).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)

(Total Area, 2022)

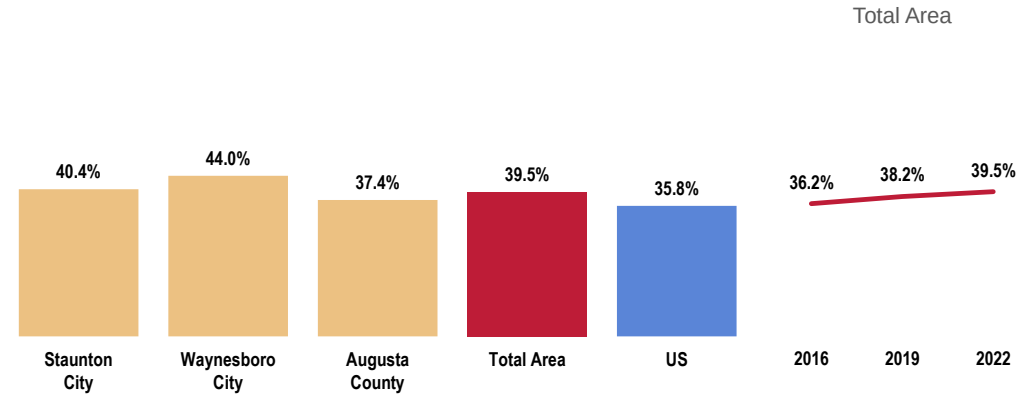


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.

However, 39.5% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

DISPARITY ► More often reported among women, adults younger than 65, and lower-income adults.

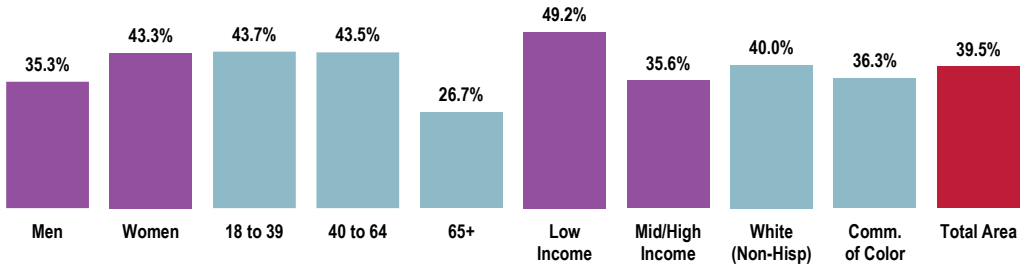
Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes response of "a great deal," "somewhat," and "a little."

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

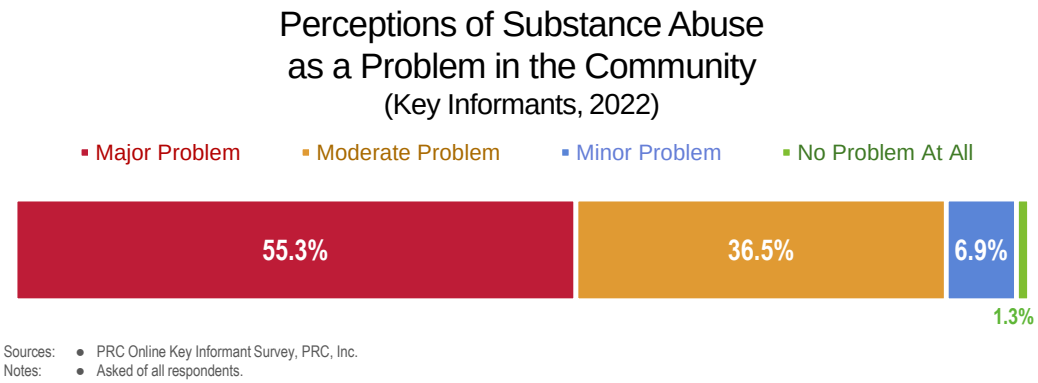
(Total Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.
● Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

The greatest share of key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Lack of spaces in existing facilities, lack of rehabilitation opportunities. Connection between mental health and substance abuse. – Social Services Provider

Insufficient number of inpatient and outpatient programs in area. – Physician

Insufficient options for evidence based secular treatment support groups. Insufficient options for harm reduction through needle exchanges, free contraception, MAT, free testing for HIV/hepatitis/etc. – Public Health Representative

Lack of crisis support centers and detox centers. – Social Services Provider

No treatment centers locally. Difficult to get a bed, no insurance. – Community Leader

Need active and coordinated outpatient/inpatient detox and rehab programs. – Physician

Lack of facilities for continuum of care, starting with the time law enforcement is involved to rehabilitation. Very bad meth problem. – Other Health Provider

Access to high quality care. Lack of detox center. – Community Leader

I feel our greatest barrier is not having a crisis stabilization/detox center. – Social Services Provider

Lack of access to both inpatient and outpatient programs. Lack of drug court and other options for addressing substance abuse outside of the legal system. – Community Leader

Lack of services in the SAW. – Other Health Provider

Problem exceeds available community resources. – Community Leader

Little to no intermediate treatment programs, partial hospitalizations, intensive outpatient programs. No long-term treatment facilities for substance use or alcohol use disorders. – Other Health Provider

Lack of treatment programs affordable to all. – Community Leader

Lack of local treatment resources. – Other Health Provider

Lack of treatment. – Other Health Provider

There is no detox center or crisis stabilization unit and there is no funding at the local, state, or federal level. – Community Leader

Lack of facilities to treat patients. – Community Leader

I don't even know where one would begin to access substance abuse treatment, and I'm a rather decently connected person. – Community Leader

Lack of access to care and overwhelmed, understaffed, and underfunded system. – Community Leader

Lack of a local detox medical center. The area is inundated with methamphetamine and prescription drug problems. There is a backlog of access to treatment and care. Long-term, constant treatment is needed for folks to have a chance to overcome addiction. – Community Leader

Limited options. Patients provided a "list" of resources, though I do not feel that much is invested to help get them enrolled and "navigate the system." Those that enroll find resources helpful; however, not everybody is motivated enough to seek out resources and support. – Physician

Little to no resources or funding. – Other Health Provider

There are no places for treatment in this area. My close friend drove to New Jersey this week to get into an alcohol rehab. – Other Health Provider

We don't have a detox facility in our area anymore. We don't have an inpatient SA Program in our immediate area. We do have an IOP at VCSB and a two-times-a-week program at ABH, and we do have people who are seen individually at ABH. But if an intake is over two months away here and a person has a desire to get clean and sober, he or she is unlikely to wait over two months. You have to engage the person when he or she wants help, or it could be months before he or she reaches out again. – Other Health Provider

Lack of long-term resources for recovery. With the Community/Services Board, lack of resources/personnel to oversee short-term treatment. – Social Services Provider

It's my impression there are not a lot of programs to deal with it. No residential/inpatient programs at all. – Other Health Provider

Ease of getting in for treatment. – Other Health Provider

Lack of resources for addiction services. – Public Health Representative

Contributing Factors

Limited resources in identifying the problem. Limited resources for temporary facilities. Inability of law enforcement to keep the drugs off the street. – Other Health Provider

Lack of a formal, large-scale detox center to intervene and create pathways to recovery. Cycles of poverty for many families leading to substance abuse as their chosen remedy for poor mental health. – Social Services Provider

Lack of mental health resources – people self-medicate with substances when their mental health issues are left unaddressed. The availability of substances in our community; our area was once described to me as a "candy shop for addicts" by a family member with substance abuse issues. Early substance abuse in children and adolescents. Finding root causes for early substance abuse in our areas and implementing education and prevention programs is important. Substances are FAR too accessible in schools. – Other Health Provider

Lack of substance abuse services. Lack of knowledge of existing services. Fear of participating due to other personal factors, such as involvement with law enforcement, or potential loss of employment. – Community Leader

Lack of facilities. Too expensive. – Other Health Provider

Lack of mental health services, especially residential programs. Cost of those services when available. – Other Health Provider

The greatest barriers to needed substance abuse treatment are lack of crisis stabilization facilities, inpatient and outpatient treatment facilities, and the affordability of care and stigma. – Community Leader

Not enough services available and lack of transportation to those with abuse problems. – Social Services Provider

Lack of detox facilities, transportation to treatment, cost, wait lists for treatment (which is particularly unfortunate for SA issues). Often times, folks who might need a higher level of treatment are forced to settle for a more community-based approach due to lack of treatment options. There's a different level of stigma associated with SA issues: people see if as a choice versus a brain disorder like other mental health issues. – Social Services Provider

I believe there are limited options in our community for SA treatment, which then lends to long waiting lists and overworked staff. Transportation issues are also a factor. – Social Services Provider

Stigma. Lack of free or low-cost treatment. Lack of knowledge of where to access helpful programs. – Social Services Provider

Lack of awareness of treatment options, how to access treatment, cost. – Community Leader

Identify those needing help and then finding counselors to assist. I know it’s a big problem but only from conversations with health care professionals. I know that there are many deaths from opioid overdose in this area, but it seems to be under the radar, and this is only one facet of a very big problem – Community Leader

Patients' accountability, patients tend to not follow up with their treatment. Affordability of care, it is impossible for uninsured people to find support. – Social Services Provider

Desire on the part of the person using the substance, too few outpatient facilities, inadequate pay for the providers, self-pay for people without insurance, waiting lists due to the workforce shortage, transportation. – Social Services Provider

Funding and social support. – Community Leader

Insurance, inpatient/halfway houses to get people started on the road. – Physician

Transportation, cost, limited availability. – Other Health Provider

Awareness of different treatment options, number of treatment opportunities specifically focused on substance abuse, unwillingness to recognize need for help until incidents with law. – Community Leader

Lack of financial resources, lack of inpatient options, lack of support groups outside of self-help. – Social Services Provider

> Financial insecurity, lack of LGBTQ-affirming programs, lack of sober spaces for LGBTQ adults, discrimination. – Social Services Provider
>
> Addiction is a disease that often does not lend itself to treatment. Mental health issues, social isolation, transportation, and addictive patterns themselves are the greatest barriers. Also, the most prevalent treatment (methadone) is good physically for addicts but mentally I feel it encourages them to simply replace one drug with another. – Social Services Provider
>
> Transportation, financial constraints, lack of treatment centers. – Other Health Provider
>
> The person who is using substances have to want the help. Many times, family or friends will enable the person to continue the use (perhaps not meaning to do so, but still do). In addition, if insurance is involved, you have to start with outpatient treatment before you can have inpatient treatment (when often, the person needs inpatient care from the start). Also, inpatient treatment is often limited to the number of days that a person can stay in treatment and substance abuse is not a quick fix. – Other Health Provider
>
> High prevalence and waning addiction services. Cost of services. Barriers to programs, especially inpatient treatment programs. – Other Health Provider
>
> Cost of treatment is difficult, as well as lack of programs in the OP setting to provide support for patients. This pairs along with the mental health needs of our community. Unfortunately, SA then impacts other body systems, which lead to increase healthcare demand. – Other Health Provider
>
> Lack of technology to access telehealth options. Lack of harm reduction focus. Lack of client choice. It does not work for judges to order treatment. Period. – Social Services Provider
>
> Not enough providers for adults or youth. No inpatient detox or crisis facility. Lack of transportation to providers. People are apathetic to the issue and feel there is nothing they can do to help someone else. – Social Services Provider

Denial/Stigma

> Recognizing the need in one's own self. – Other Health Provider
>
> Stigma. – Community Leader
>
> Mental health. Stigma. Fear. Lack of folks who can walk alongside someone who is struggling in this area. – Social Services Provider
>
> Stigma, shame, quality affordable care. – Community Leader

Awareness/Education

> Lack of education on how addictive some of these substances can be and the importance of never starting down that path. – Other Health Provider
>
> There are few known programs, need help that is more advertised and known. – Other Health Provider

Co-Occurrences

> I see the interconnectedness of some of these issues. The man I knew with the kidney problems had a serious issue with alcohol dependency, especially Wild Irish Rose or something like that. – Community Leader
>
> This is similar to mental health and typically management is one and the same as most of our community members with substance abuse issues will have coinciding mental health issues. – Physician

Substance Use Disorders

> Substance use disorders. – Social Services Provider

Follow-Up/Support

> Lack of support groups. – Community Leader

Diagnosis/Treatment

> Treatment. – Other Health Provider

Youth

> Our children are vaping illegal drugs. – Community Leader

Most Problematic Substances

Key informants (who rated this as a “major problem”) identified **methamphetamine/other amphetamines** as causing the most problems in the community, followed by **alcohol**, **prescription medications**, and **heroin/other opioids**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a “Major Problem”)	
METHAMPHETAMINE OR OTHER AMPHETAMINES	28.2%
ALCOHOL	27.3%
PRESCRIPTION MEDICATIONS	16.4%
HEROIN OR OTHER OPIOIDS	13.2%
COCAINE OR CRACK	4.5%
MARIJUANA	4.1%
CLUB DRUGS (e.g. MDMA, GHB, Ecstasy, Molly)	2.7%
OVER-THE-COUNTER MEDICATIONS	1.8%
INHALANTS	0.9%
SYNTHETIC DRUGS (e.g. Bath Salts, K2/Spice)	0.5%
HALLUCINOGENS OR DISSOCIATIVE DRUGS (e.g. Ketamine, PCP, LSD, DXM)	0.5%

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

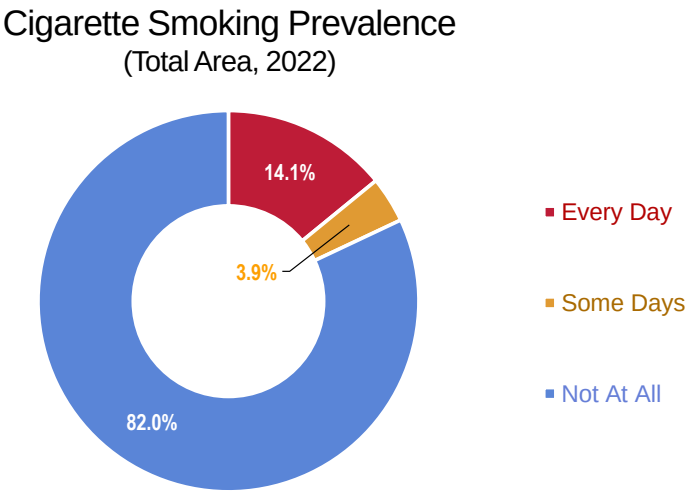
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 18.0% of Total Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in the Total Area.

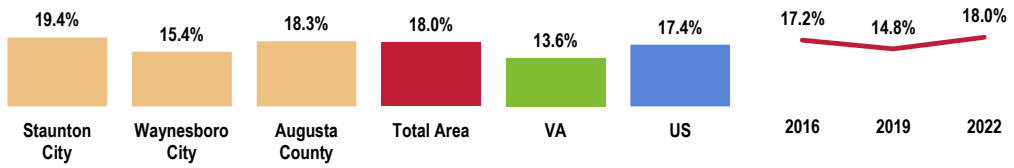
BENCHMARK ► Worse than the statewide percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Men, adults younger than 65, and lower-income adults are more likely to report smoking cigarettes.

Current Smokers

Healthy People 2030 = 5.0% or Lower

Total Area



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers

(Total Area, 2022)

Healthy People 2030 = 5.0% or Lower

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

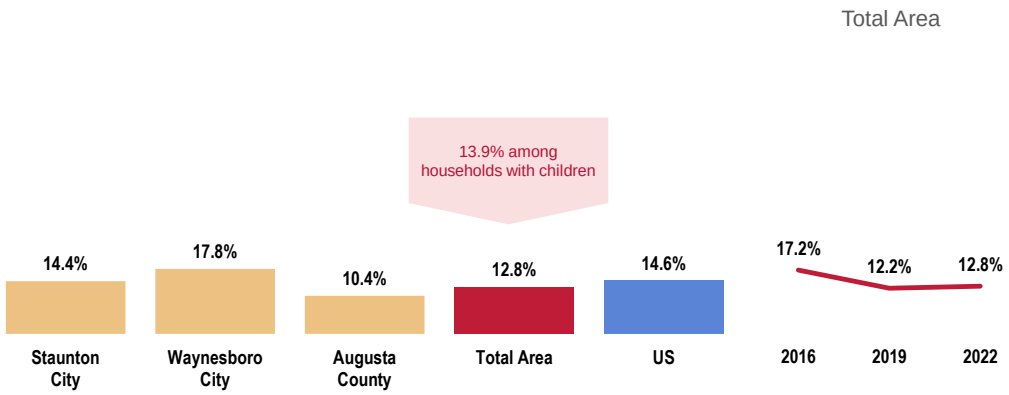
Notes:
- Asked of all respondents.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

Among all surveyed households in the Total Area, 12.8% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

DISPARITY ► Lower in Augusta County.

Member of Household Smokes at Home



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

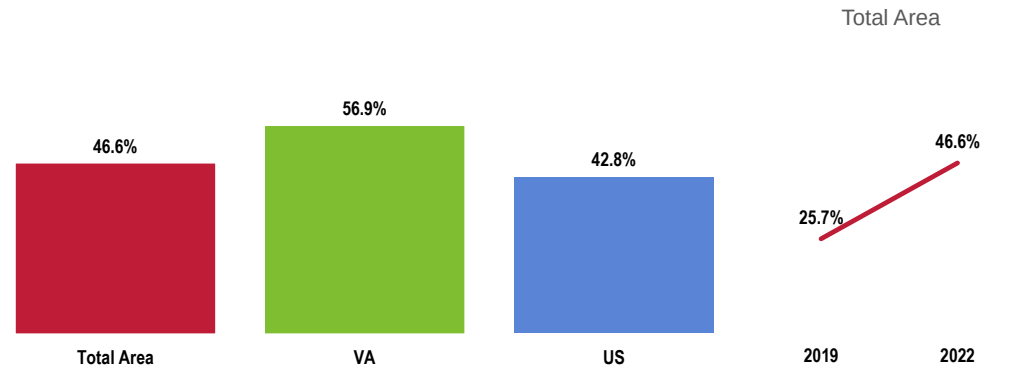
Smoking Cessation

Among regular smokers, 46.6% went without smoking for one day or longer in the past year because they were trying to quit smoking.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Represents a significant increase since the previous survey.

Have Stopped Smoking for One Day or Longer in the Past Year
(Everyday Smokers)
Healthy People 2030 = 65.7% or Higher



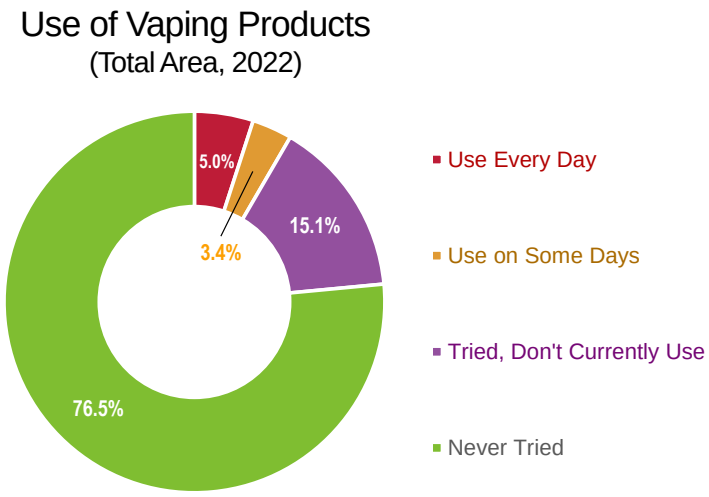
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 41]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of respondents who smoke cigarettes every day.

Other Tobacco Use

Use of Vaping Products

Most Total Area adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.



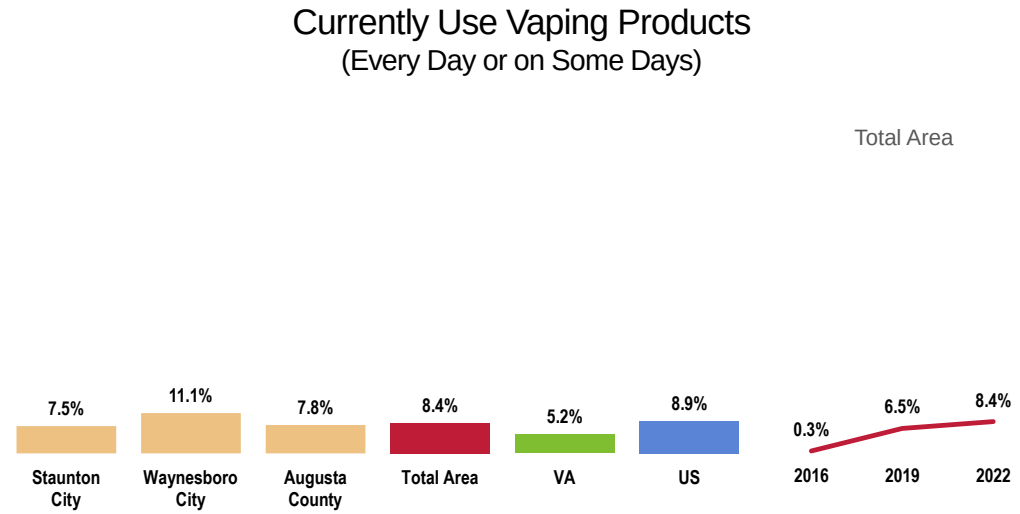
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
Notes: ● Asked of all respondents.

However, 8.4% currently use vaping products either regularly (every day) or occasionally (on some days).

BENCHMARK ► Higher than found statewide.

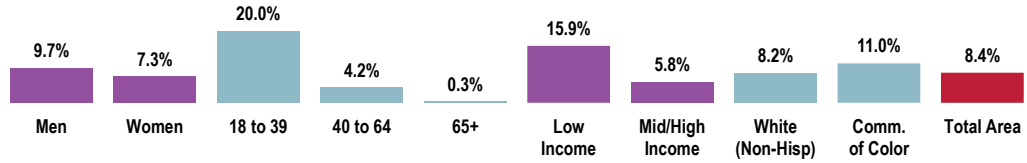
TREND ► Denotes a significant increase over time.

DISPARITY ► More often reported among adults younger than 65 (particularly young adults) and lower-income respondents.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Currently Use Vaping Products
(Total Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
Notes: • Asked of all respondents.
• Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

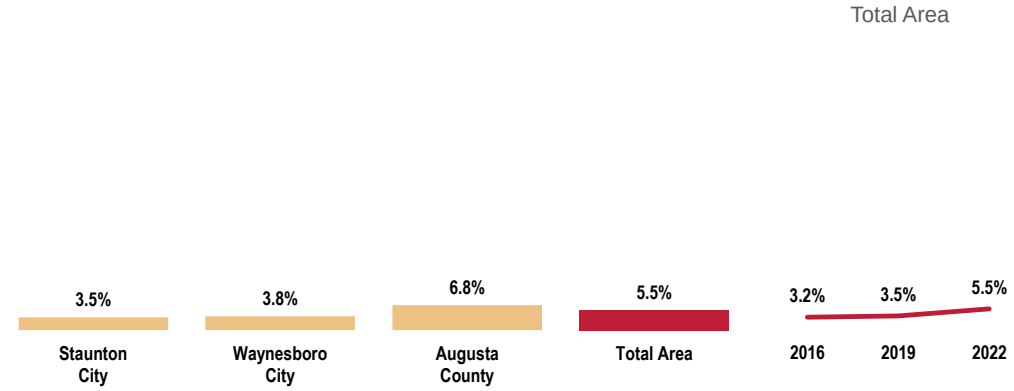
Smokeless Tobacco

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 5.5% of Total Area adults use some type of smokeless tobacco every day or on some days.

DISPARITY ► Higher in Augusta County.

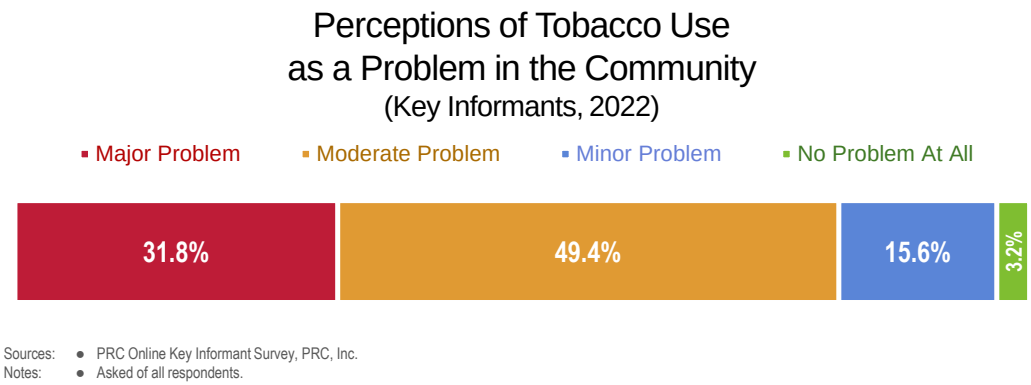
Currently Use Smokeless Tobacco
(Total Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: • Asked of all respondents.
• Includes use of chewing tobacco, snuff, or snus every day or on some days.

Key Informant Input: Tobacco Use

Key informants taking part in an online survey generally characterized *Tobacco Use* as a "moderate problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

High prevalence of use. – Other Health Provider

Widespread use. – Community Leader

It is very common in our community. – Other Health Provider

Too many people smoke, and too many young people vape. – Physician

The number of people in the community that smoke, vape, or use smokeless tobacco seems to remain high. A large number of youth under 20 also continue to smoke despite the public media campaigns that educate about the dangers of it. – Other Health Provider

Because chewing tobacco is as popular as cigarettes. – Other Health Provider

It is still a national problem in all socio-economic groups and ages. – Physician

Tobacco use has been a chronic issue in our area, and the increasing use of nicotine products (especially vaping) in adolescents that leads to tobacco use is very concerning. – Community Leader

High use rates. – Other Health Provider

There are countless smokers in the community, and we no longer offer a tobacco cessation program. – Physician

High incidence of smoking and smokeless tobacco use. – Physician

Still prominent tobacco abuse and many patients in community with sequelae of tobacco abuse. – Physician

Significant proportion of smokers/COPD. – Physician

Simple observation. – Community Leader

Again, a high number of smokers. – Other Health Provider

In a rural area with many jobs outdoors, chewing tobacco, smokeless tobacco. Vaping is a huge, huge increasing problem with teens, including THC. – Community Leader

Common use in the area of smoke and dip products. The rural community often adopts tobacco use through generations as part of the lifestyle and as a coping mechanism for stress or for social interaction. – Community Leader

Smoking and chewing tobacco are still very prevalent here, and you can witness teenagers using both substances. – Public Health Representative

Because a whole lot of people smoke, dip, or chew. Let's include vaping as well. – Social Services Provider

Frequent use, normalization of use. – Social Services Provider

Vape usage is a huge problem in my organization. Not only vape with nicotine but vaping (and other products) with THC. – Community Leader

Number of individuals who smoke, popularity of vaping and smoke shops. – Community Leader

No educated answer other than prevalent conservative views and continuation of tobacco habits as an exercise of personal freedom. – Social Services Provider

> When I am in other parts of our state, I do not see nearly as many people smoking as I do locally. Also, vaping is incredibly popular among teenagers, and this is really scary considering the fact that those substances are NOT regulated. I feel that the legalization of marijuana has also encouraged/increased smoking in general. – Social Services Provider
>
> Population is addicted to tobacco. – Social Services Provider

Impact on Quality of Life

> Many disease processes are affected by those that smoke. Providing support around those who are ready to quit is very important. – Other Health Provider
>
> Number of smokers is above the national average and often results in poor health. – Other Health Provider
>
> Tobacco creates major health problems and is widely used in our community. – Social Services Provider
>
> Tobacco use leads to such poor health and wellness outcomes that I believe it's important to continue to focus efforts on reducing the numbers of people engaging in this practice. – Social Services Provider

Contributing Factors

> So costly and so addictive and a health hazard, especially to younger folks. – Community Leader
>
> Addiction and harm caused by extended use. – Community Leader
>
> Prevalence. Expense. Cause of chronic disease. – Other Health Provider

Awareness/Education

> Lack of education on the long-term impacts of smoking, peer pressure. Also vaping. – Other Health Provider

Homelessness

> Homeless people or those with very low incomes have little to do with their day. My estimate is that 75% have a smoking habit. They consume very low-priced tobacco brands. – Social Services Provider

Social Norms/Community Attitude

> Use of tobacco products appears to be more socially acceptable in rural areas. Including chewing tobacco and vaping. – Community Leader

Stress

> I'm afraid I've run out of creative answers. People in my neighborhood tend to have more stress than money and look for things to ease life's pain. – Community Leader

Vulnerable Population

> LGBTQ people smoke at higher rates than the rest of the population. Much of this can be related to discrimination and other external stressors. – Social Services Provider

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

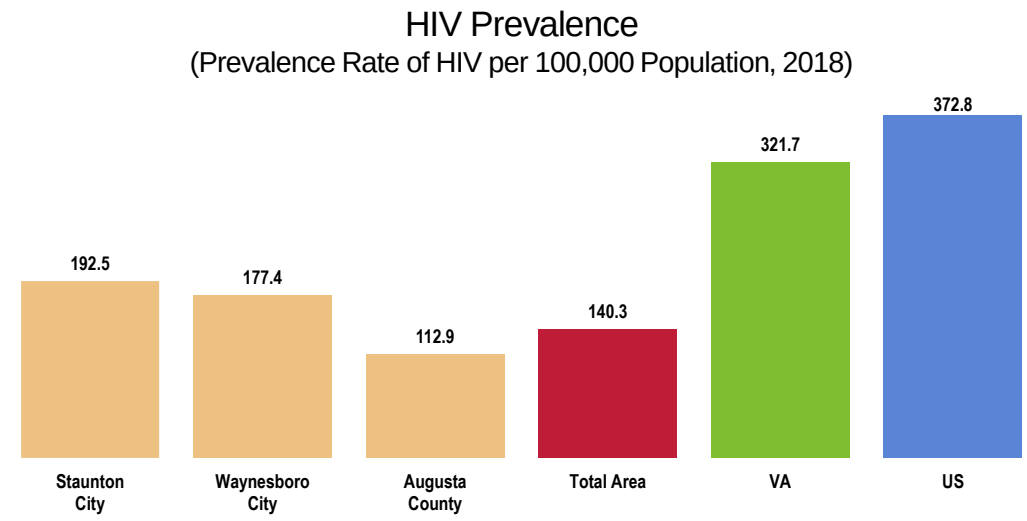
HIV

HIV Prevalence

In 2018, there was a prevalence of 140.3 HIV cases per 100,000 population in the Total Area.

BENCHMARK ► Considerably lower than state and national rates.

DISPARITY ► Lower in Augusta County.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

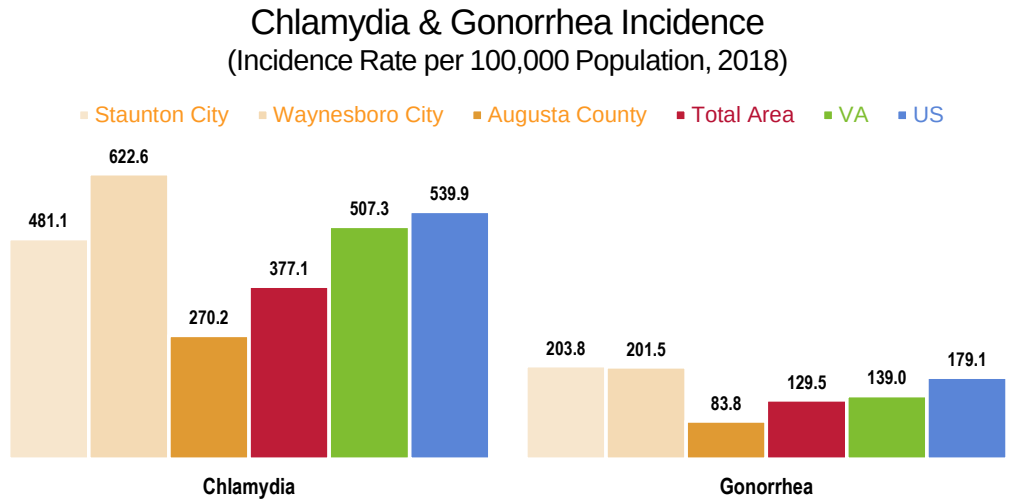
Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in the Total Area was 377.1 cases per 100,000 population.

The Total Area gonorrhea incidence rate in 2018 was 129.5 cases per 100,000 population.

BENCHMARK ► Each is lower than the corresponding US rate. Chlamydia incidence is lower than the statewide rate.

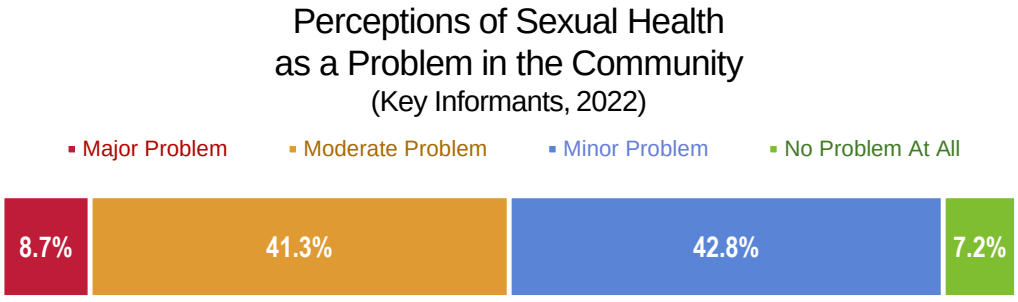
DISPARITY ► Rates for both chlamydia and gonorrhea are lower in Augusta County. Chlamydia incidence is higher in Waynesboro.



Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
Notes: ● This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

Key informants taking part in an online survey were more likely to characterize *Sexual Health* as a "minor problem" in the community.



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Diagnosis/Treatment

> There are very few providers who are comfortable discussing sexual health with patients, and this deters patients from even broaching the subject. Many patients seek STI testing at urgent cares and the emergency department once they become symptomatic instead of feeling comfortable asking for routine testing. At these locations, patients only receive screening for gonorrhea and chlamydia. Many are referred to their PCP or the Health Department for HIV and syphilis testing; few follow through on this crucial testing. The health department has very limited appointments available for STI but is the only provider with options for low- to no-cost testing. – Public Health Representative

> Most providers don't treat. STI testing is limited. – Community Leader

Contributing Factors

> Honestly, there is nothing in this area to do for teens except each other and drugs. I grew up in an area with skate parks – inside and outside, rec centers, awesome YMCA programs, the beach, and many more business that gave kids stuff to do. The kids around here are bored, and they are not being smart about their choices. I speak to you as a parent of two kids that just made it out of their teen years, telling me all the happenings in the area. Thankfully, they had the education from their mom and the strict upbringing. Some kids just don't have that, due to no fault of their own or sometimes even their parents. Education to teens about not just birth control, but STD and STI prevention. Did you know that young teenage boys have "counts" of the girls they slept with and competition to who can get the most? This has always been the case, but the numbers of these kids are or with the goal of being over 50!!! Education for both parents and children. And others. – Other Health Provider

> Lack of resources and lack of acknowledgement. – Community Leader

Prevalence/Incidence

> STD/STI rates continue to increase. The pregnancy rate among 18- to 19-year-olds continues to be one-and-a-half to two times higher than the state average. The pregnancy rate among 15- to 17-year-olds is rising again in both Waynesboro and Staunton. – Social Services Provider

Prevention/Screenings

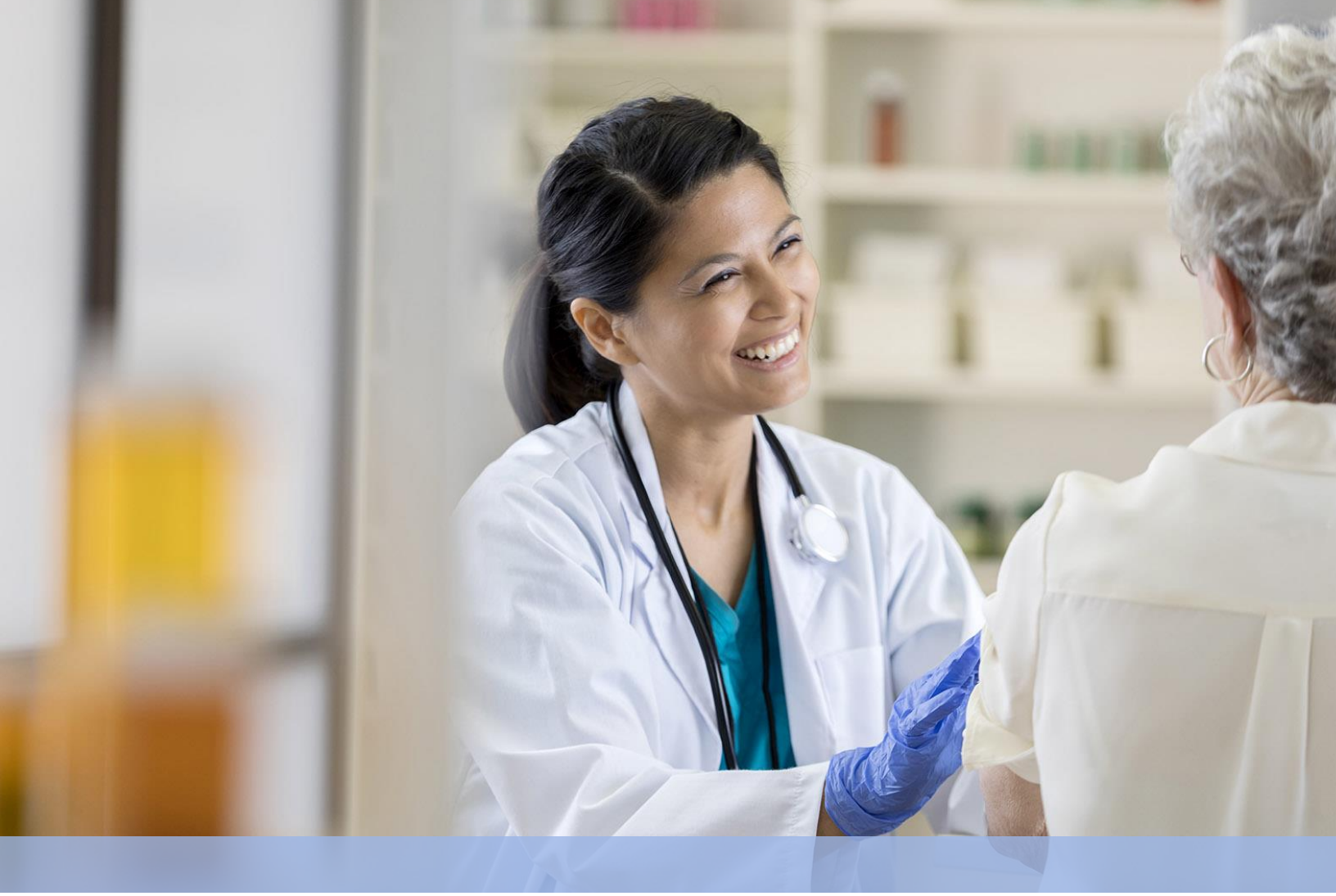
> I should have maybe found a different answer here, like perhaps, “I have no idea how bad it is, but all STDs seem preventable”? – Social Services Provider

Unsafe Sex

> I had a conversation in March about a young person in the community with HIV passing, having sexual relations with multiple partners. – Community Leader

Teen Pregnancy

> Teen pregnancy. – Other Health Provider



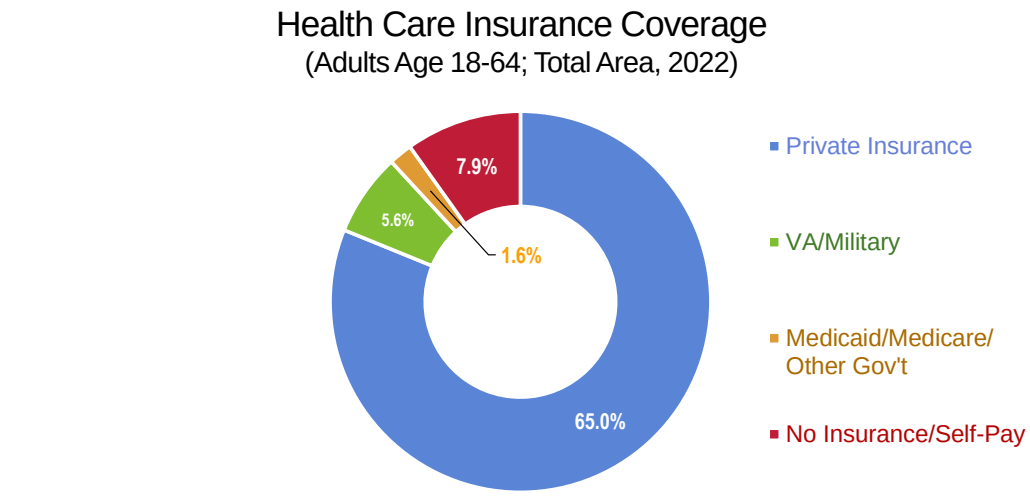
ACCESS TO HEALTH CARE

HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 65.0% of Total Area adults age 18 to 64 report having health care coverage through private insurance. Another 7.2% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 7.9% report having no insurance coverage for health care expenses.

BENCHMARK ► Better than the statewide percentage.

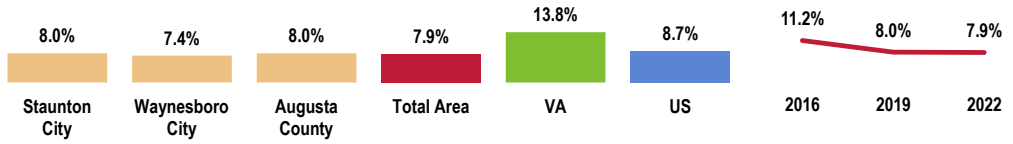
DISPARITY ► Those with lower incomes are more likely than those with higher incomes to lack health insurance.

Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower

Total Area



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; Total Area, 2022)

Healthy People 2030 = 7.9% or Lower

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

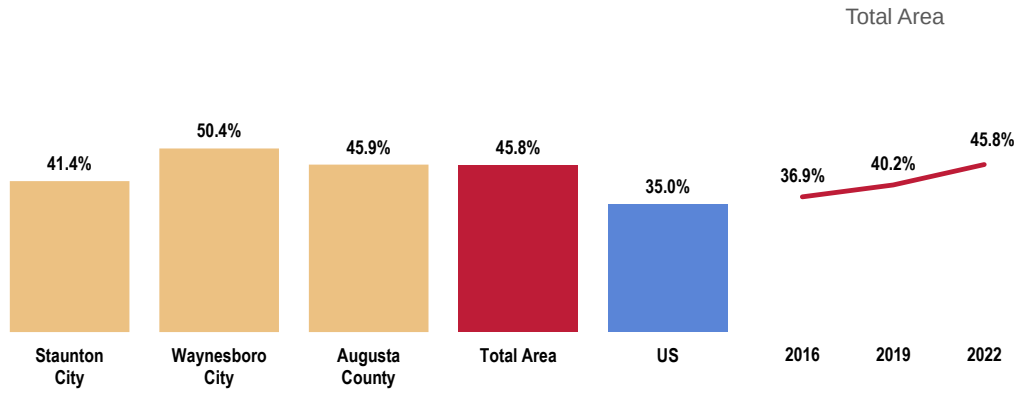
A total of 45.8% of Total Area adults report some type of difficulty or delay in obtaining health care services in the past year.

BENCHMARK ► Worse than the national percentage.

TREND ► Represents a significant increase over time.

DISPARITY ► More often reported among women and adults younger than 65.

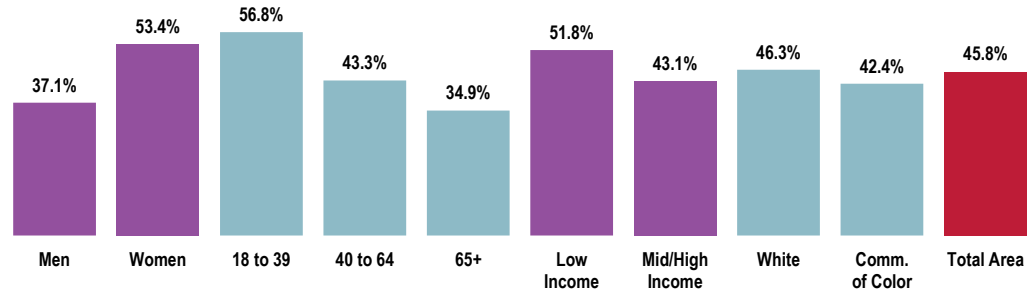
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind
in Receiving Needed Health Care in the Past Year
(Total Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Barriers to Health Care Access

Of the tested barriers, appointment availability impacted the greatest share of Total Area adults.

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

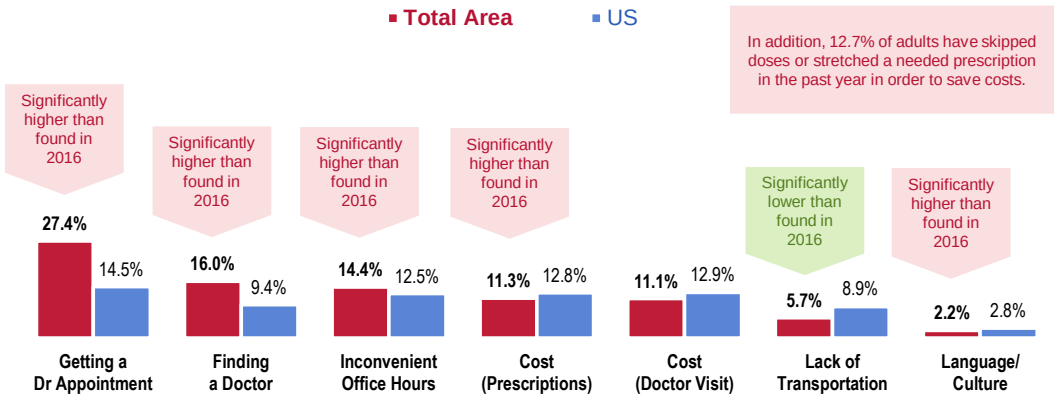
BENCHMARK ► As barriers, **appointment availability** and **finding a physician** affected area adults more than their US counterparts. However, area adults were less affected by a **lack of transportation**.

TREND ► Compared to 2016, five categories have received significantly higher mention as barriers to care: **appointment availability**; **finding a physician**; **inconvenient office hours**; **cost of prescriptions**; and **language/culture**. Meanwhile, **lack of transportation** has received significantly lower mention.

DISPARITY ► Although not shown, those in Waynesboro were more likely to cite **appointment availability**, **inconvenient office hours**, and **language/culture** as barriers to care. Those in Staunton were more likely to cite **transportation** as a barrier.

Note also the percentage of adults who have skipped or reduced medication doses in the past year in order to stretch a prescription and save costs.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 7-14]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

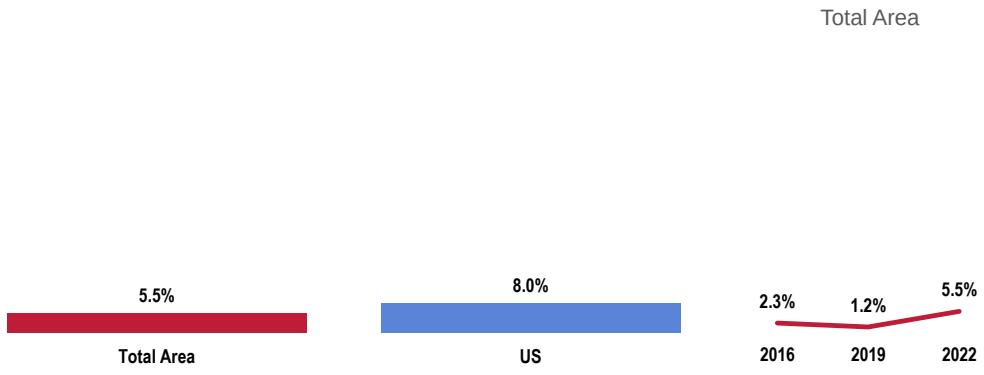
Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

A total of 5.5% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

TREND ► Denotes a significant increase since the 2019 survey.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

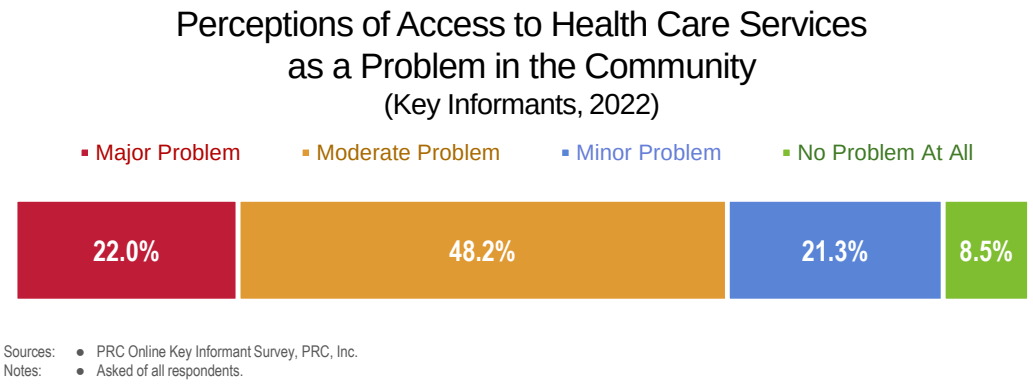


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 104]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

Transportation. As a physical therapist, our patients often can't make it to their therapy appointments to get the care that they need due to lack of consistent transportation. Lack of rehab services and adult day care services for patients and their families with significant impairments from long term chronic illness or disability. – Other Health Provider

Transportation and lack of behavioral health services along the continuum of care. – Other Health Provider

Lack of transportation. Lack of trust of hospitals in general. Lack of insurance or high deductible insurance and families living check to check. – Social Services Provider

Transportation, poverty rates, access to affirming providers and safe spaces. Lack of available services that speak directly to LGBTQ+ health needs, particularly access to PrEP, readily available STI testing, etc. – Social Services Provider

Literal access in terms of transportation for those without cars, also lack of insurance or high deductible plans, inability to find a general care provider resulting in overuse of emergency room services. – Social Services Provider

Transportation, geographic barriers for rural residents, mobility/disability, poverty and greater number of uninsured, financial constraints, great number of social determinants of health barriers, racial and health inequities, minimal providers for LGBTQ and Hispanic populations. – Other Health Provider

There are several: transportation, lack of funds, lack of education, cultural barriers. – Other Health Provider

Transportation remains a barrier for folks, although access to telehealth across the pandemic has provided some relief. Stigma associated with accessing mental health care specifically. Cost of healthcare services and medication, which could tie back to a larger issues like lack of affordable housing and well-paying jobs in the area. Lack of providers and wait lists for both physical and mental health care. No insurance, or insurance only covering certain costs associated with healthcare. A general lack of understanding around accessing mental health/substance use services. A strain on the workforce due to being understaffed and the effects of the pandemic in general creates retention issues which further exacerbate the aforementioned issues. – Social Services Provider

Transportation is a huge barrier to accessing health care services – people may have a doctor but no way of getting to their appointments or picking up their prescriptions. Not having health insurance is also a barrier – there are many people who would qualify for Medicaid but don't know how to apply for it. Lack of trust in the health system also contributes to lack of access to healthcare services for certain populations of the community. – Other Health Provider

Transportation. Low health literacy, not understanding the depth of the disease nor that small changes may be impactful when dealing with their health issues. – Other Health Provider

Cost and transportation. – Other Health Provider

This is multilayered. Expense, even if insured. Preventative health care is not a priority. Expense of medications decreases motivation to be proactive about health. Trust in healthcare system, suspicious of profit motive. – Other Health Provider

High copays and coinsurance, challenging financial assistance process, lack of transportation services, limited number of providers impacts appointment availability (especially behavioral health and specialty care), language and cultural barriers to care – lack of diversity of our healthcare workforce. – Other Health Provider

Cost, availability of providers. – Community Leader

Affordable care. Choice of competent providers. Transportation to services. Childcare for families where the adults need to access health care. – Other Health Provider

Community members in need of services are often "waitlisted" and unable to access the services that are needed. Additionally, barriers to access include not enough qualified professionals, cost of needed services, lack of understanding/connection to possible resources. – Community Leader

Not enough providers and services for the need that is in our community. Wait times to be seen are astronomical, and the frustration level of individuals is extremely high. Transportation is an issue that needs to be addressed. Affordable services for families not on government assistance are barriers as well. – Social Services Provider

Provider shortages (adult and pediatric), poverty (increased number of uninsured), and proximity to providers/services in more rural areas and affordability. – Social Services Provider

Language barrier (need bilingual staff, health interpreters), transportation, affordable health care prices, prevention education, underserved community needs to feel inclusion. – Social Services Provider

The most significant challenge for Latinx population: LANGUAGE ACCESS. Need more Spanish-speakers on administrative and medical staff. Use certified medical interpreters instead of tele-health. FINANCIAL SERVICES. As for Augusta's financial assistance, we have many reports of patients being discouraged from applying because their income places them above the 200% federal poverty guidelines. If patient nets 2k a month, they do not qualify. Raise the poverty guidelines to 300%, consistent with area providers (ARDC, Carilion, UVA). Patients are, moreover, overwhelmed by several bills – one from Augusta, another from the medical group, then another from the specialist, yet another from the anesthesiologist, and one more from the ambulance. Even if they can access financial assistance from Augusta, it is of little assistance when several different medical services are billing the patient. DIGNIFIED TREATMENT. Many reports of poor treatment from admin and staff alike. – Social Services Provider

Uninsured and underinsured patients have very limited local options. Staunton/Augusta/Waynesboro is not served by a federally qualified health center. Although many people in the area do have personal vehicles, they often lack money for gas to drive as far as Harrisonburg or Lexington to visit an FQHC. There is no Planned Parenthood clinic in the area, either, or the local health departments have reduced the extent/frequency of clinical services. As a result, people go to the emergency department for conditions that should be managed in a PCMH and/or postpone healthcare until the problem has exacerbated. In addition, I do not know where to refer people for facilitated enrollment in ACA health plans. – Public Health Representative

Not having access to internet, health insurance, transportation. – Other Health Provider

Transportation

Because we are a large rural community, many patients do not have access to services such as the BRITE Bus, which has multiple stops in the city, or patients are in too poor health to walk to a bus stop. These services do not serve the rural areas such as Deerfield, Churchville Greenville. Medicaid transportation system is overloaded and often unreliable. Some patients live in rural areas that Medicaid transport has difficulty finding and accessing. – Other Health Provider

Based on my professional responsibilities as a partner with AH in the cancer space, I would say transportation and financial challenges are expressed the most by patients traveling from such a large, rural catchment area for cancer treatment. Access to reliable transportation and/or the financial support to gain access to reliable transportation. – Social Services Provider

Transportation. – Social Services Provider

Transportation from the majority of the county. Lack of technology or phone service to access telehealth options. – Social Services Provider

For the area residents we serve, the biggest challenge is finding reliable, accessible, and affordable transportation to health care services. – Social Services Provider

Vulnerable Population

Immigrants from other countries. – Community Leader

Transgender health care. There are no providers in this area that offer affirming services to the trans community. Providers are not inclusive, and this can be very damaging to a trans person and inhibit progress in their health journey. – Public Health Representative

Minority or underinsured access to health care. We are no different than every other community in the country where this is an issue. – Physician

Lack of access to health services for immigrants. – Social Services Provider

For the vulnerable populations that exist in our community, I believe there are many barriers that exist that limit accessing health care services. That can include insurance coverage, documentation of citizenship/lack of trust with healthcare system, transportation barriers, and homelessness. – Other Health Provider

> The LGBTQ community struggles to find health care services that are affirming and inclusive. Many LGBTQ people put off accessing health care services for fear of discrimination. Insurance and financial insecurity are also major challenges to accessing services. – Social Services Provider

Affordable Care/Services

> Affordability. Even with insurance and relatively well-paying jobs, health costs are a major barrier to obtaining adequate health care. – Other Health Provider
>
> I just think there are so many financial barriers to health care historically that people in culture just try to figure it out the best they can on their own unless it's immediately life-threatening. Even with insurance, there isn't often left money for copays. In the Black community, we see an average of 11 times less the wealth in this country, and that means some things that are absolutely vital are seen as luxuries. – Community Leader
>
> Loss of the free clinic. Large Hispanic population without insurance. – Community Leader

Access to Care/Services

> Access to care is "OK" within the two cities included in this survey, but Augusta County is one of the state's largest – and is extremely rural. Health care resources are "bunched" in the eastern half of the county. Residents who live west and south of Staunton must drive anywhere from 10 to 40 miles to reach even the most basic health care facility. (Craigsville, west of Staunton, is an example of one office/clinic that has had repeated bad luck in remaining operational.) I cannot understand why "mobile clinics" are not available. – Community Leader
>
> Access to mental health and substance services are the biggest concerns I see. They overlap with diabetes due to the weight gain that happens with MH treatment. It can take over two months to get an intake for MH. – Other Health Provider

Lack of Providers

> There is simply just not enough of providers, particularly physician-providers. There is also too much instability in the provision of physician services, with the coming and going of so many doctors (is very hard to establish a good working relationship with a doctor when there are so many doctors who join and work a couple years here, and then go elsewhere). – Community Leader

Stigma

> An entire reworking of how the medical field interacts with individuals pertaining to mental health diagnosis needs to happen ASAP. THE STIGMA surrounding mental health diagnosis and substance use disorders is an epidemic in and of itself. We need a change in the way professions treat humans as a whole, mentally and physically! – Social Services Provider

Government Funding

> It's difficult to get government and consolidated community support to confront the issues. Community seems fragmented, and state funding sources are scarce. – Other Health Provider

Health Literacy

> Follow-up care and patient education support. There is a major gap in how well a patient can understand and follow care instructions, test results, next steps when it is shared solely in written English or through an interpreter (professional interpreter or untrained family member chosen by a deaf patient to communicate). More can be done in this area of concern. Perhaps clearer, plain language handout materials with visual images. Perhaps developing trained community health workers who are bilingual and bimodal (can translate written materials into ASL). [See: https://www.nih.gov/health-information/nih-clinical-research-trials-you/guidelines-communicating-informed-consent-individuals-who-are-deaf-or-hard-hearing-scientists and "Sign Here: How to Conduct Informed Consent" https://youtu.be/HtPGWljNVeg] – Social Services Provider

Lack of Continuity of Care

> There are services in the area, yet they do not communicate with one another. For example, the hospital has its own psychiatric services, and then there are outpatient therapy services that do not have one vision. Continuity of care is a problem. – Other Health Provider

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

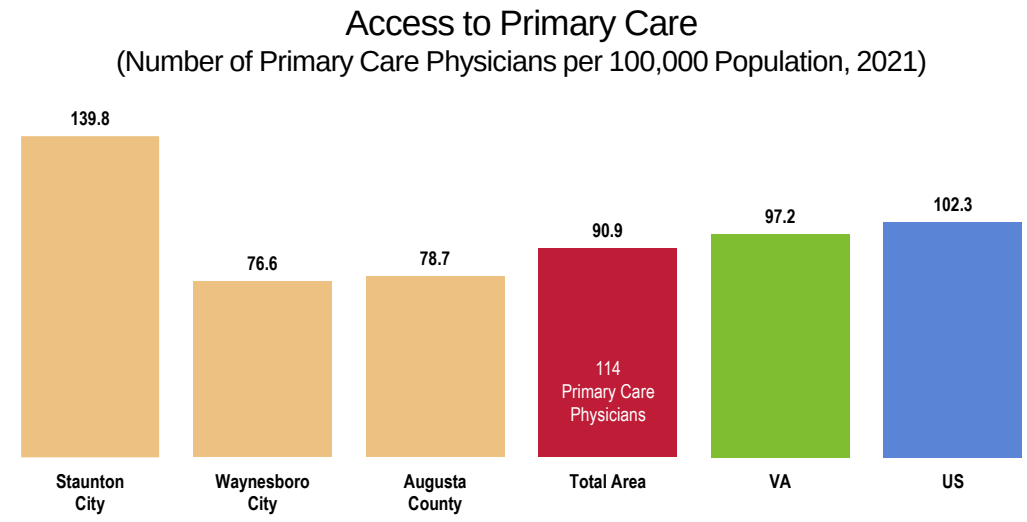
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

In 2021, there were 114 primary care physicians in the Total Area, translating to a rate of 90.9 primary care physicians per 100,000 population.

DISPARITY ► Higher in Staunton.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

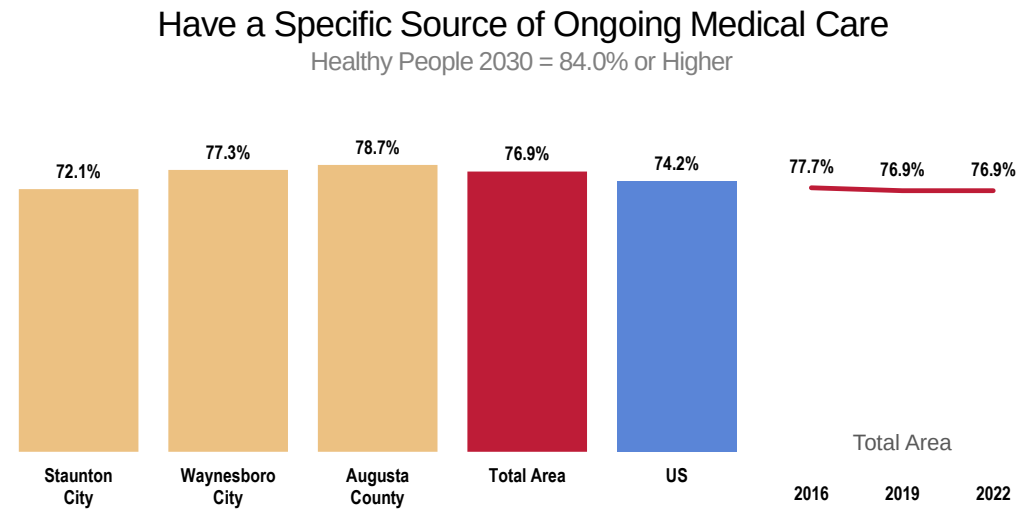
Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 76.9% of Total Area adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 139]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Utilization of Primary Care Services

Adults

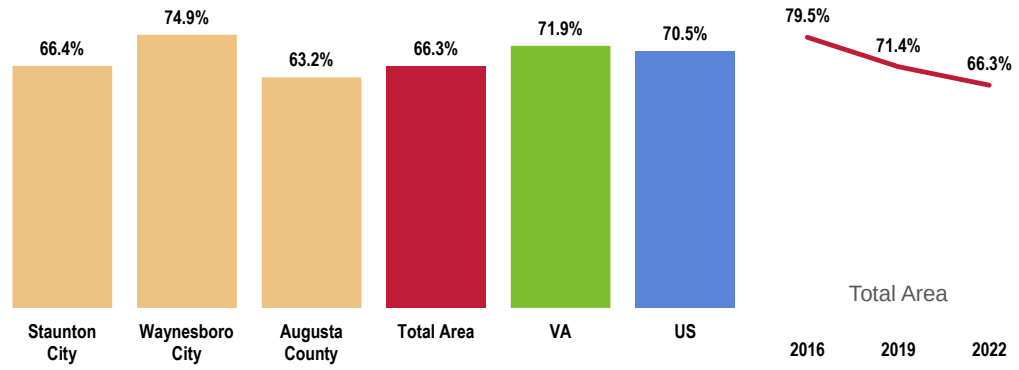
Two-thirds of adults (66.3%) visited a physician for a routine checkup in the past year.

BENCHMARK ► Less favorable than the statewide finding.

TREND ► Declining significantly over time.

DISPARITY ► Lower in Augusta County. Note the positive correlation with age.

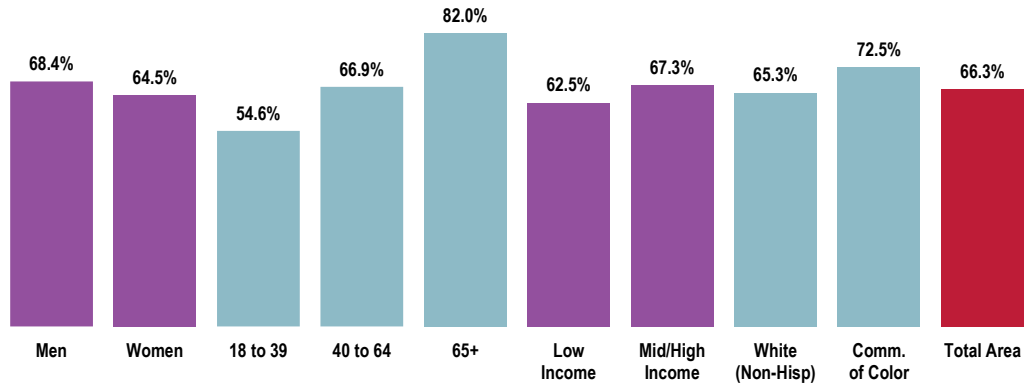
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(Total Area, 2022)



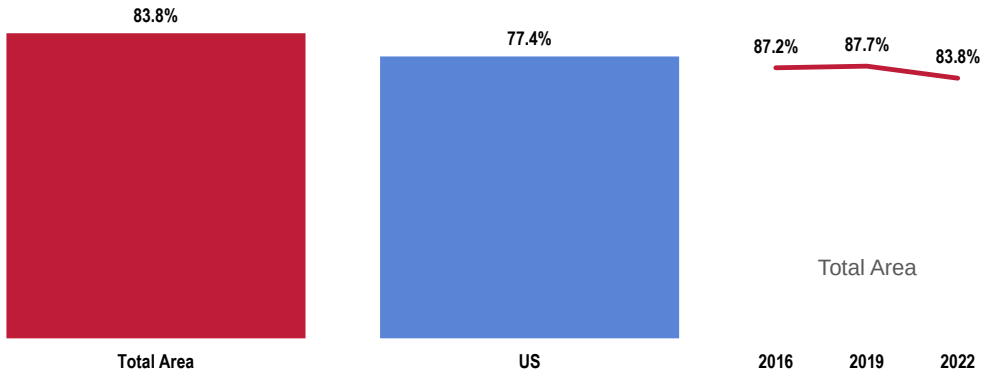
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 18]

Notes:
- Asked of all respondents.

Children

Among surveyed parents, 83.8% report that their child has had a routine checkup in the past year.

Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parents of Children 0-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

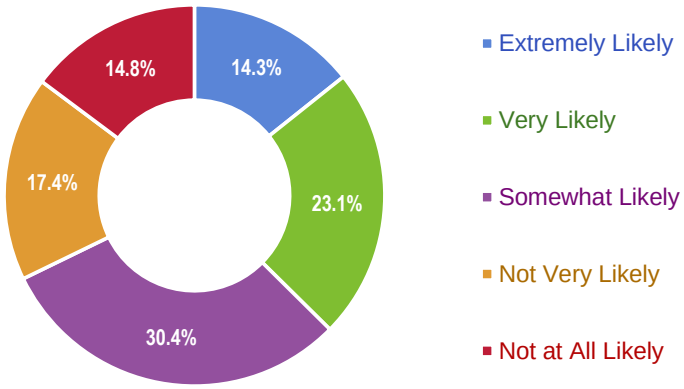
Notes:
- Asked of all respondents with children 0 to 17 in the household.

Willingness to Use Telemedicine

Among Total Area adults, 37.4% said they would be "extremely likely" or "very likely" to use telemedicine instead of office visits for routine medical care.

DISPARITY ► Adults younger than 65 are more likely than seniors (age 65+) to report a willingness to use telemedicine.

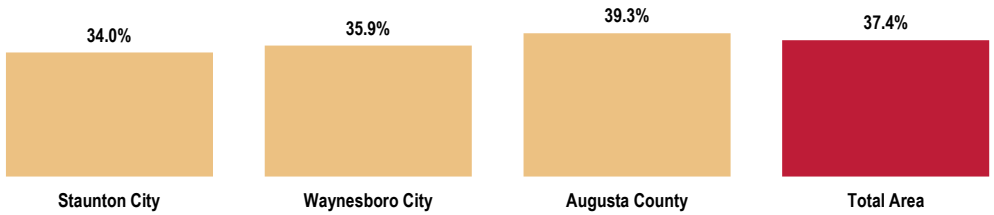
Likelihood of Using Telemedicine
(Total Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 301]

Notes:
- Asked of all respondents.
- During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a healthcare professional in real time without being face to face.

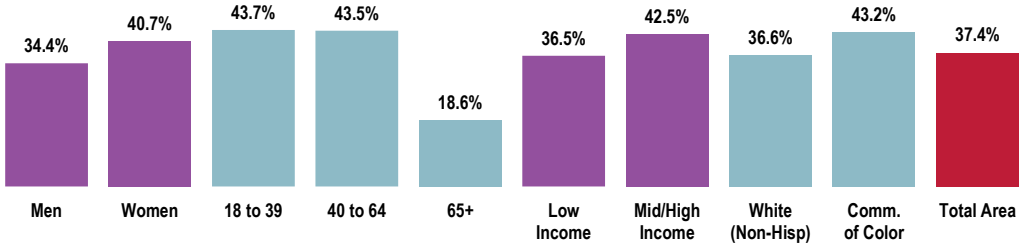
“Extremely Likely/Very Likely” to Use Telemedicine



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 301]

Notes:
- Asked of all respondents.
- During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a healthcare professional in real time without being face to face.

“Extremely Likely/Very Likely” to Use Telemedicine
(Total Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 301]

Notes:
- Asked of all respondents.
- During a telemedicine visit, a patient uses a computer, smartphone, or telephone to communicate with a healthcare professional in real time without being face to face.

EMERGENCY ROOM UTILIZATION

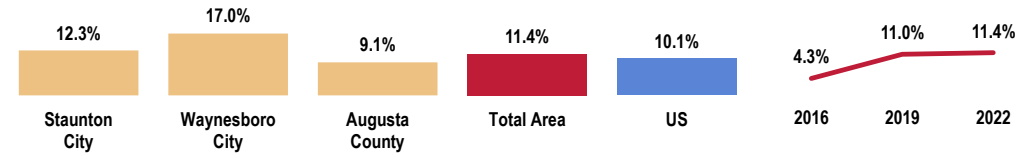
A total of 11.4% of Total Area adults have gone to a hospital emergency room more than once in the past year about their own health.

TREND ► Significantly higher than the 2016 benchmark.

DISPARITY ► Higher in Waynesboro. Lower-income adults are much more likely to report using the ER.

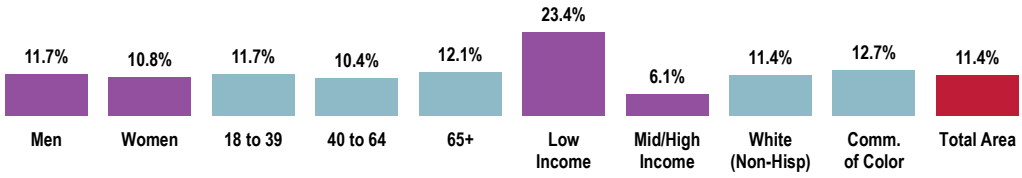
Have Used a Hospital Emergency Room More Than Once in the Past Year

Total Area



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 22]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(Total Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 22]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

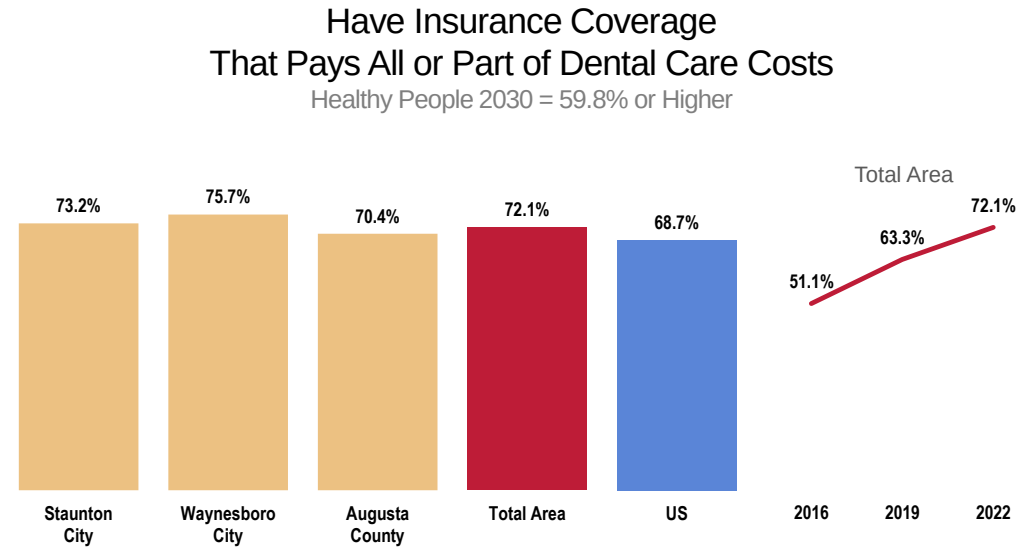
– Healthy People 2030 (https://health.gov/healthypeople)

Dental Insurance

In the Total Area, 7 in 10 adults (72.1%) have dental insurance that covers all or part of their dental care costs.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

TREND ► Denotes a significant increase over time.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 21]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Dental Care

Adults

A total of 61.9% of Total Area adults have visited a dentist or dental clinic (for any reason) in the past year.

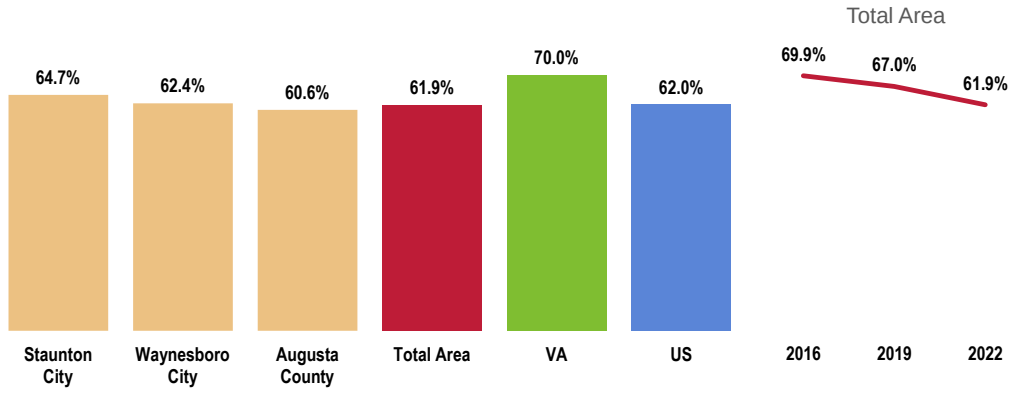
BENCHMARK ► Less favorable than found across Virginia. Satisfies the Healthy People 2030 objective.

TREND ► Represents a significant decrease over time.

DISPARITY ► Those less likely to report receiving dental care include young adults, lower-income respondents, and adults without dental insurance.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



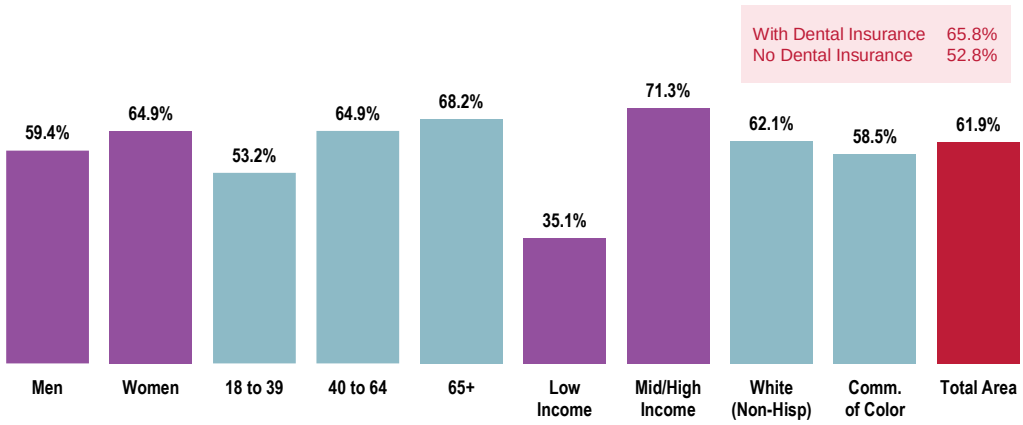
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 Virginia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Total Area, 2022)

Healthy People 2030 = 45.0% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

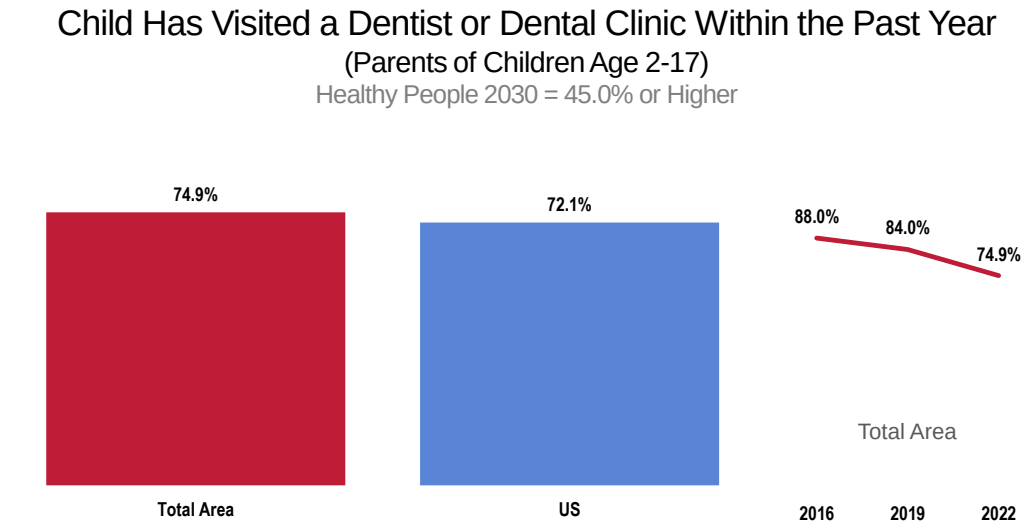
Notes:
- Asked of all respondents.

Children

A total of 74.9% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

TREND ► Denotes a significant decrease over time.

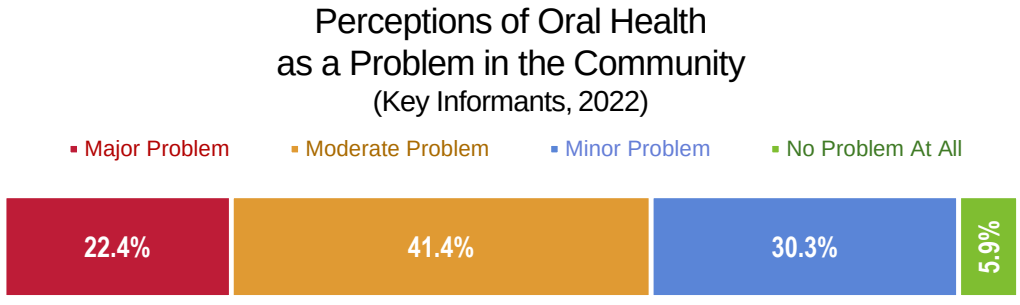


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 108]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Insurance Issues

> Lack of insurance and lack of dentists that provide care on a sliding scale or accept public insurance. – Social Services Provider
>
> Lack of dentists that accept Medicaid, free dental program has limited availability. – Community Leader
>
> Very few resources for patients without dental insurance. This affects their entire health, including diabetic control. – Physician
>
> Access to dental care for uninsured and underinsured individuals. Many Medicaid plans now have dental coverage, but no providers accept the plans. – Social Services Provider
>
> Poor dental coverage for Medicaid and Medicare patients. Cost of care even with insurance. Very poor options for dentures (edentulous people can't find good jobs). – Other Health Provider
>
> Dental insurance isn't an automatic for most people. – Community Leader
>
> Many people in the area do not have dental insurance. – Other Health Provider
>
> Limited access to dental insurance plans and cost of dental repairs. – Other Health Provider

Contributing Factors

> Lack of dental insurance for low-income families. Lack of early intervention (dentistry) for youth, which leads to more severe oral health problems as adults. – Social Services Provider
>
> A lack of dental insurance for many individuals and a lack of dentists that provide care to patients who are self-pay or have government-assisted insurance options. Also, while there are many dentists in the area, many are not open five days a week and almost none are available on weekends or after 4 or 5 p.m. This makes it very challenging for those who cannot take time away from work to access care, even if insurance is not the problem. – Social Services Provider
>
> Lack of dental insurance, substance abuse, and mental health issues all lead to poor oral health. – Community Leader
>
> Where do I begin? This is huge. When I first moved here, the lack of healthy teeth in every smile I met was disheartening. The culture of the generation before us, not needing to take care of teeth, still remains ... and now they are seeing the consequences of bad oral hygiene, except they passed that around to their kids, too, which are now adults. Drugs are a HUGE problem in this area, as well, which destroy teeth. I feel that our community is scared of the dentist. I was just in getting dental work done at my dentist and heard a man in the next bay which was being told that his toothache was due to a decayed tooth next to the root. He was offered a root canal (which are very expensive) or to just pull the tooth. The dentist also asked him to set up a cleaning and he strongly refused, as the last time he had a cleaning he was "crying for the next two days in pain," which was 10 years ago. He is a grown, elderly man afraid of the dentist. – Other Health Provider
>
> Aging population, cost of dental care, drug use. – Social Services Provider
>
> Methamphetamine is rampant and this drug wreaks havoc on oral health. Also, lack of insurance to pay. Many dentists do not take Medicaid/Medicare, so any work is "out of pocket." This is often not affordable. – Social Services Provider
>
> The answer for poor people is to pull teeth. Preventative care isn't a priority, and the dentist hurts. Pulling teeth means dentures eventually, and insurance doesn't cover them. Apparently, chewing food is a luxury. – Social Services Provider

Prevalence/Incidence

> Issue throughout the nation. – Physician
>
> Valley Supportive housing has 42 tenants in its 42 apartments. Virtually 100% have oral health problems. We have gotten grants from Delta Dental and then sponsored denture treatment. – Social Services Provider
>
> I see this need on a daily basis. – Social Services Provider
>
> From what I've observed in helping with a meal program, there seems to be need for this in the Waynesboro area. – Social Services Provider

Affordable Care/Services

> Patients who do not have sufficient financial resources have difficulty accessing dentistry. – Physician
>
> Our free dental clinic is at capacity, which results in long waits for persons needing care. – Public Health Representative
>
> So many people cannot afford to go to a dentist. I have met so many people who have not been to a dentist since they were children. Even if you have dental insurance, it is very limited what the insurance will cover. – Other Health Provider

> There is an alarming lack of dental/affordable dental care option in our area. The Augusta Regional Dental Clinic is routinely at capacity, and there is no other facility in the county. It is therefore almost impossible for Medicaid members to find a provider. Even for children. This leads to community members waiting until the last moment to seek treatment and go to the ER/urgent care. There is also a general lack of education and awareness on the importance of dental care, oral hygiene, and healthy eating habits. – Social Services Provider

Access to Care/Services

> Access to timely and affordable dental care (preventive and restorative) for adults. – Community Leader
>
> The biggest problem in terms of dental care is access and availability. – Social Services Provider
>
> Unable to get appointments for patients with acute needs. Limited participation with Medicare and Medicaid. – Other Health Provider

Co-Occurrences

> I know that it contributes to so many secondary issues, such as nutrition, and it is not universally available to impoverished families. – Community Leader

Impact on Quality of Life

> Dental care is one of the important elements of overall health and impacts every aspect of being healthy – weight, nutrition, heart health, digestive health, etc. Maintaining oral health in children is critical to their success in school and beyond. Prevention is key. – Community Leader

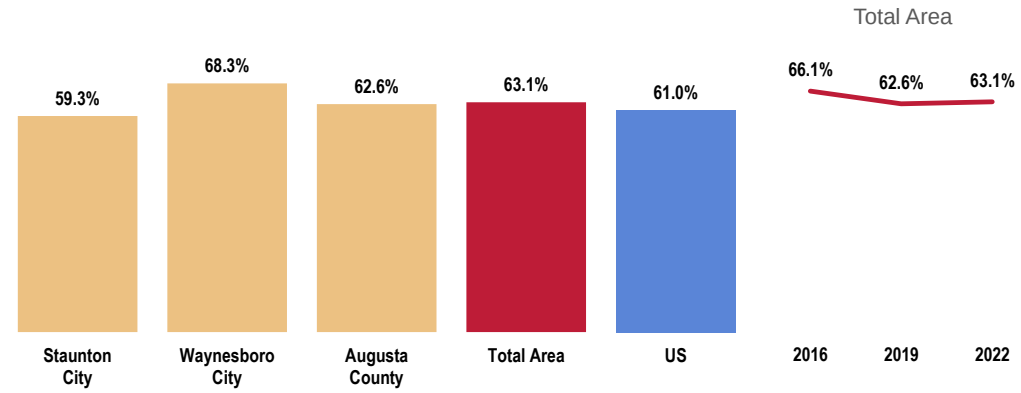
VISION CARE

A total of 63.1% of Total Area residents had an eye exam in the past two years during which their pupils were dilated.

DISPARITY ► Those less likely to report receiving vision care include men, young adults (note the correlation with age), and lower-income residents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

Healthy People 2030 = 61.1% or Higher



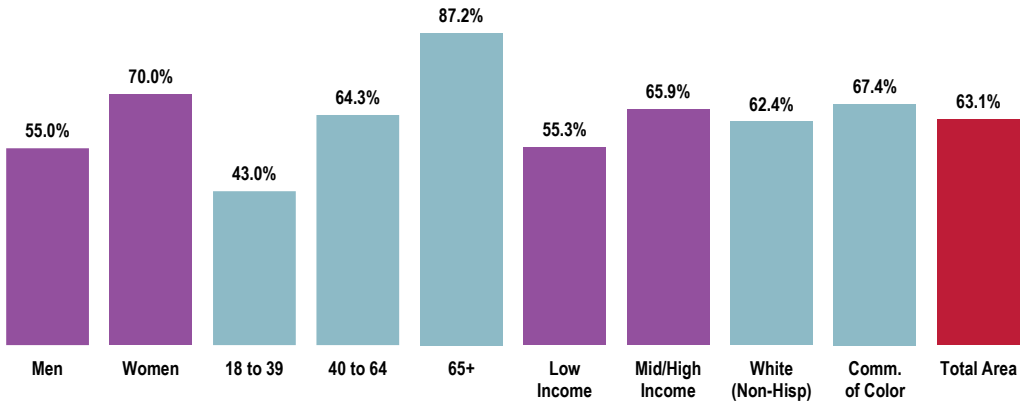
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 19]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Total Area, 2022)

Healthy People 2030 = 61.1% or Higher



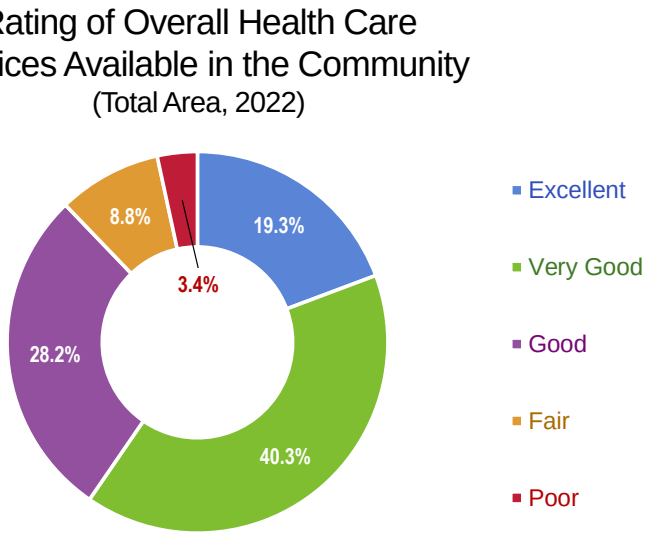
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 19]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

A majority of Total Area adults rate the overall health care services available in their community as "excellent" or "very good."



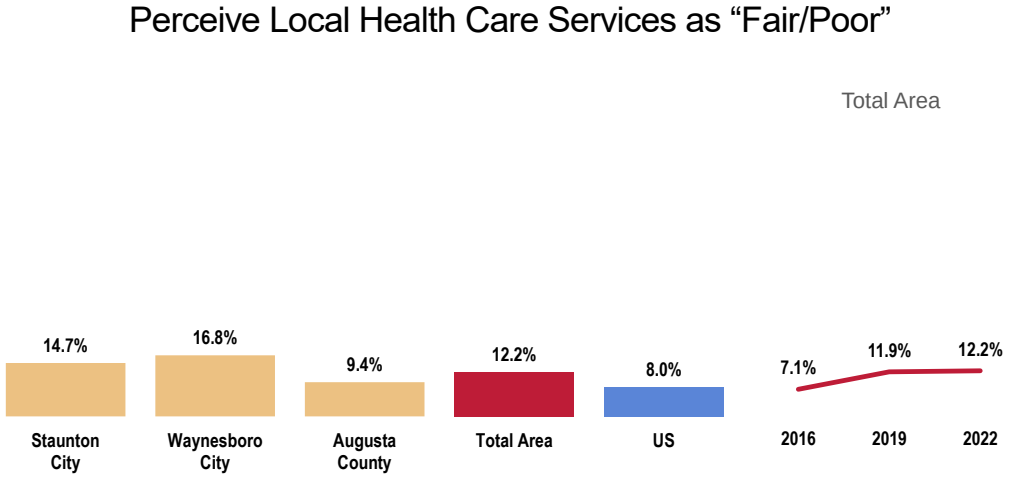
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: ● Asked of all respondents.

However, 12.2% of residents characterize local health care services as "fair" or "poor."

BENCHMARK ► Worse than the US percentage.

TREND ► Marks a significant increase from the 2016 baseline.

DISPARITY ► Lower in Augusta County. More often reported among young adults, lower-income residents, and those with difficulty accessing services.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Local Health Care Services as “Fair/Poor”
(Total Area, 2022)

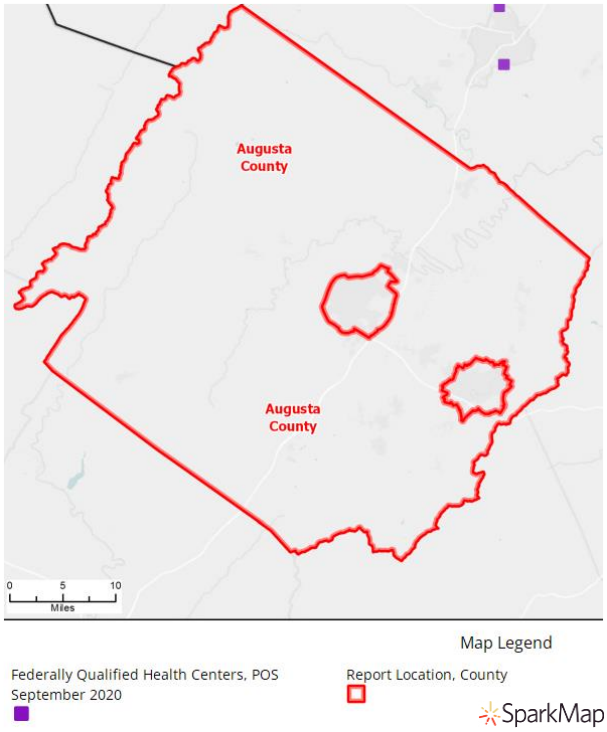
With Access Difficulty	20.5%
No Access Difficulty	5.3%

Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the Total Area as of September 2020.



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Adult Day Care Programs
- American Cancer Society
- Arrow Project
- Augusta Care Partners
- Augusta Health
- Augusta Regional Dental Clinic
- BRITE Bus
- Cab Services
- Case Managers
- Central Shenandoah Health District
- Certified Peer Recovery Specialists
- Churches
- Community Health Worker
- Comprehensive Behavioral Health
- Doctor's Offices
- Free Clinics
- Friendly City Safe Space
- Health Department
- Healthy Community Health Centers
- Hospitals
- Infant and Toddler Connection
- Lifeforce
- Medicaid
- Medicare Transport
- Medication Assistance Program
- Mental Health America of Augusta
- Molina Healthcare
- National Alliance on Mental Illness
- Outreach Workers
- Rescue Squads
- School System
- Sentara
- Shenandoah District Health Department
- Shenandoah LGBTQ Center
- Shenandoah Psychiatry
- Sin Barreras
- Support Groups
- Telehealth
- University of Virginia
- Urgent Care Centers
- Valley Community Services Board
- Valley Homeless Connection
- Valley Hope Counseling
- Valley Program for Aging Services
- Virginia Department of Health
- YMCA

Cancer

- Ad Campaigns
- American Cancer Society
- Augusta Health
- Community Health Worker
- Doctor's Offices
- Genetic Screening
- Health Department
- Hospice Services
- Madee Project
- Madee Project
- Mamm and Glam Events
- Martha Jefferson
- Nonprofits
- Preventative Screening Booths at Health Fairs
- Screenings
- Sentara RMH
- Shenandoah Valley Beat Cancer Boot Camp
- Smoking Cessation Program
- Support Resources

Coronavirus Disease/COVID-19

- Arrow Project
- Augusta Health
- Blue Ridge Health Department
- Central Shenandoah Health District
- Central Shenandoah Planning District
- cfcbr.org/covid-19-assistance
- Community Services Board
- Covid Testing at Assessment Center
- Doctor's Offices
- EMS
- Food Banks
- Government
- Habitat for Humanity
- Health Care and Public Health System

- Hospitals
- James Madison University
- Local Response Fund Coalition
- Mental Health America of Augusta
- Pharmacies
- Public and Private Partnerships
- Salvation Army
- SAW Mental Health Taskforce
- School System
- Staunton Redevelopment and Housing Authority
- United Way
- Vaccine Clinics
- Vulnerable Communities Group

Dementia/Alzheimer's Disease

- Adult Day Care Programs
- Alzheimer's Association
- Assisted Living Facilities
- Augusta County Department of Social Services
- Augusta Health
- Daily Living Center
- Doctor's Offices
- Elder Care Services
- Faith Community
- Home Health
- Long-Term Care Facilities
- Martha Jefferson
- Memory Care Facilities
- Mental Health Association
- Non-Profits
- Occupational Therapy
- Physical Therapy
- Residential Care Facilities
- Sentara RMH
- Skilled Nursing Facilities
- Speech Therapy
- United Way
- UVA Hospital
- Valley Community Services Board
- Valley Program for Aging Services
- Virginia Department of Health

Diabetes

- Allegheny Mountain Institute
- American Diabetes Association
- Augusta Health
- Augusta Health AMI Farm
- Augusta Medical Group
- Blue Ridge Area Food Bank
- CDC Diabetes Prevention Program
- Community and Civic Organizations
- Community Diabetes Day
- Community Health Worker
- Comprehensive Behavioral Health
- Daily Social Services Clubs
- Diabetes Center
- Diabetic Education
- Doctor's Offices
- Education
- Extension Agents
- Faith Community
- Farmer's Markets
- Farms
- Fitness Centers/Gyms
- Food Pantries
- Food Stamps
- Grant Funded Meters and Supplies
- Grocery Stores
- Health Care and Public Health System
- Health Department
- Health System Diabetes Program and Counselor
- Home Health
- Hospitals
- Insurance Providers
- Martha Jefferson
- Meals on Wheels
- Medicaid
- Medication Assistance Program
- Mental Health Services
- Metabolic Clinic
- Mobile Clinic
- Nutrition Services
- Parks and Recreation
- Pharmacies
- Project Grows
- Restaurants
- RxEx
- School System
- Sentara RMH
- UVA Hospital
- Valley Program for Aging Services
- Virginia Cooperative Extension
- Virginia Department of Health
- Weight Loss Programs
- WIC
- YMCA

Disability and Chronic Pain

- Adagio House
- Augusta Health
- Augusta Health Pain Management
- Community Services Board
- DARS
- Doctor's Offices
- DSS
- Hospitals
- Parks and Recreation
- Physical Therapy
- Social Services
- Spas
- The Arc of Augusta County
- Valley Associates for Independent Living
- Valley Community Services Board
- Valley Program for Aging Services
- VCSS
- WWRC
- YMCA

Heart Disease and Stroke

- American Heart Association
- Augusta Health
- Brain Injury Connections
- Cardiovascular Rehab
- Carilion
- Community and Civic Organizations
- Community Stroke Education
- Doctor's Offices
- Fitness Centers/Gyms
- Fresh Local Foods
- Health Care and Public Health System
- Health Department
- Heart Success Clinic
- Hospitals
- James Madison University
- Lifestyle Changes
- Martha Jefferson
- Parks and Recreation
- Quit Smoking Programs
- RxEx
- Sentara RMH
- University of Virginia
- University of Virginia Medical Center
- Valley Program for Aging Services
- Virginia Cooperative Extension
- Virginia Department of Health
- Weight Management Clinic
- YMCA

Infant Health and Family Planning

- Augusta Health
- Carilion
- Comfort Care
- Community Health Worker
- Doctor's Offices
- DSS
- Family Planning Programs
- Health Department
- Infant and Toddler Connection
- Office on Youth
- Planned Parenthood
- School System
- Sin Barreras
- University of Virginia
- Virginia Department of Health
- Waynesboro Health Department
- Waynesboro High School
- WIC

Injury and Violence

- Augusta Health
- Boys & Girls Club
- Brain Injury Connections
- CASA
- Child Protective Services
- Law Enforcement
- New Directions Center
- New Valley Church
- University of Virginia
- Valley Children's Advocacy Center
- Valley Community Services Board
- Valley Mission
- Valley Young Life
- WARM
- Western State Hospital
- YMCA

Kidney Disease

- Augusta Health
- DaVita Dialysis
- Dialysis Centers
- University of Virginia

Mental Health

- Adagio House
- Apartments
- Arrow Project
- Associated Mental Health Professionals
- Augusta Care Partners
- Augusta Health
- Augusta Psychology Associates
- Behavioral Health Services
- Blue Ridge Community College
- Blue Ridge Court Services
- Church of Jesus Christ of Latter-Day Saints
- Churches
- Clergy
- Collins Center
- Commonwealth Center for Children and Adolescents
- Community Nurses
- Compass
- Comprehensive Behavioral Health
- Counselors
- Court System
- Crozet ACES
- Doctor's Offices
- DSS
- EAP
- Faith Community
- Friendly City Safe Space
- Health Care and Public Health System
- Health Department
- Hope House
- Hospice of the Shenandoah Community Bereavement
- Hospitals
- Inpatient Beds
- Insurance Providers
- Intercept Health
- Kuley and Associates
- Law Enforcement
- LPC
- Martha Jefferson
- Mental Health America of Augusta
- Mental Health Association
- Mental Health Services
- National Alliance on Mental Illness
- New Directions Center
- Non-Profits
- Office on Youth
- SAW Mental Health Taskforce
- School System
- Sentara RMH
- Shenandoah LGBTQ Center
- Shenandoah Psychiatry
- Social Services
- UVA Hospital
- Valley Advocacy Center
- Valley Area Community Support, Inc.
- Valley Community Services Board
- Valley Homeless Connection
- Valley Hope Counseling
- Valley Mission
- Valley Pastoral Counseling
- Virginia Program Vouchers
- Virtual Resources
- WARM
- Western State Hospital

Nutrition, Physical Activity, and Weight

- Affinity Groups
- Aldi
- Allegheny Mountain Institute
- American Cancer Society
- AMG Metabolic Weight Loss Program
- Augusta Health
- Augusta Health AMI Farm
- Blue Ridge Area Food Bank
- Bowling Alleys
- Churches
- City and County Public Works Department
- Community Garden Projects
- Community Health Worker
- Comprehensive Behavioral Health
- CrossFit
- Department of Tourism
- Diabetes Team
- Doctor's Offices
- Faith Community
- Farmer's Markets
- Farms
- Fitness Centers/Gyms
- Food Banks
- Food Pantries
- Friends/Family
- GI - Weight Management Program
- Government
- Health Department
- Jones Garden
- Lifeforce
- Lifetime Fitness
- Lifeworks Project
- Martha Jefferson
- Meals on Wheels
- Media
- Munsey Medical Clinic
- Nursery Schools

- Nutrition Services
- Parks and Recreation
- Planet Fitness
- Private Developers
- Project Grows
- Restaurants
- RxEx
- School System
- Sentara RMH
- Social Services
- South River Rehabilitation and Performance
- The Mission
- Universities
- UVA Hospital
- Virginia Cooperative Extension
- Virginia Department of Health
- Weight Loss Programs
- Weight Watchers
- Wellness Center
- YMCA
- Youth Sports Programs

Oral Health

- All Smiles
- Augusta Health
- Dentist's Offices
- Federally Qualified Health Centers
- Health Department
- Hospitals
- RAM Clinics
- Rockbridge Area Health Center
- School System

Respiratory Disease

- American Lung Association
- Augusta Health
- Augusta Health Smoking Cessation
- Doctor's Offices
- Martha Jefferson
- Medication Assistance Program
- Quit Now
- School System
- Sentara RMH
- University of Virginia
- University of Virginia Medical Center
- UVA Hospital
- Virginia Department of Health

Sexual Health

- Central Shenandoah Valley Office on Youth
- Community Health Worker
- Doctor's Offices
- Hospitals
- Office on Youth
- School System
- Urgent Care Centers
- Virginia Department of Health
- Waynesboro High School

Substance Abuse

- AA/NA
- Arrow Project
- ASAP
- Augusta Circuit Court-Drug Court
- Augusta Health
- Behavioral Health Group
- Behavioral Health Services
- Blue Ridge Community College
- Blue Ridge Court Services
- Celebrate Recovery
- Church of Jesus Christ of Latter-Day Saints
- Community Support Organizations
- Counselors
- Doctor's Offices
- Drug and Alcohol Counseling Centers
- DSS
- Health Care and Public Health System
- Health Connect America
- Health Department
- Hospitals
- Law Enforcement
- Legal System
- Mental Health Services
- Methadone Clinic
- Mid-Atlantic Recovery Center
- Motivational Interviewing Network of Trainers
- National Alliance on Mental Illness
- Outpatient Opioid Abuse Treatment
- Peer-Led Support Groups
- Recovery Choice
- SaVida Health
- Sentara
- Social Services
- Spero Health
- Staunton Treatment Center
- Suboxone Clinics
- Valley Community Services Board
- Valley Hope Counseling
- Western State Hospital

Tobacco Use

Augusta Health
Doctor's Offices
Nicorette
Over the Counter Medication Businesses
Quit Now
Smoking Cessation Program
Smoking Lung Scans
Social Services
Valley Community Services Board
WIC

APPENDIX

EVALUATION OF PAST ACTIVITIES

2020-2022 Implementation Strategy: Internal Plan

Access to Health Care

Program/Activity	Action Steps	Accountability	Timeline	Budget	Impact will be Measured through these Indicators
Homeless Healthcare Connection provides people experiencing homelessness on-site as well as a mobile access to health care services and social services in order to reduce barriers to accessing health care. Through health screenings, health education, vaccinations, sexual health screenings and resource referrals, including assistance with transportation and case management, participants are able to learn new lifestyle practices which encourage wellness and chronic disease management.	1. Provide health education, screenings and basic first aid to those individuals experiencing homelessness at Valley Mission, WARM, Disciple's Kitchen and Waynesboro Library. 2. Collaborate with agencies to connect clients with health and social resources in the community 3. Explore and Implement Prescription courier service implemented for individuals experiencing homelessness at Valley Mission and WARM. 4. Replicate HHC program in the Hispanic/Latinx community	Gayle Shultz	1. 2020-2022 2. 2020-2022 3. 2020-2022 4. 2021-2022	1. $3,850	1. a) Number of unique encounters **2020: 92 (80 individual intakes completed)** **2021: 326 (Majority of these encounters were for COVID/FLU vaccines ONLY-which also includes 1,2, and 3 doses)** **** 44 intakes were completed through traditional HHC program** b) Number and percentage of participants screened: -blood pressure **2020: 56/92 =60.8%** **2021: 9/44 =20.45%** -heart rate **2020: 40/92=43.4%** **2021: 1/44 =0.2%** -oxygen saturation (O2 Sat) **2020:38/92=41.3%** **2021: 1/44 =0.2%** -prediabetes risk **2020: 9/92=9.7%** **2021: 3/44=6.8%** -mental health **2020:7/92 =7.6%** **2021: 0/44=0%** -foot screenings for those with diabetes **2020:2/12=16.6%** **2021: 0/44=0%** c) Number and percentage of participants screened who are high/positive: -blood pressure **2020:19/56=33.9%** **2021: 5/9=55.5%** -heart rate **2020:5/40=12.5%**

					2021: 1/1=100% -oxygen saturation (O2 Sat) **2020:0/38=0%** **2021:0/1=0%** -prediabetes risk **2020:3/9=33.3%** **2021: 2/3=66.7%** -mental health **2020: 5/7=71.4%** **2021: 0=0%** -foot screenings for those with diabetes **2020:0/2=0%** **2021: 0 performed** d) Number of participants that are diagnosed with diabetes and hypertension, not under management -diabetes **2020: 2/12=16.6%** **2021: 2/12=16.6%** -hypertension **2020:12/37=32.4%** **2021: 2/14=14.2%** e) Number and percentage of clients with a history of substance abuse **2020:33/92=35.8%** **2021: 13/44=29.5%** f) Social determinants of health data will be collected during intake of client for the following determinants: **2020: Total months of homelessness** **-44/80 Less than 1 year** **-15/80 1-2 years** **-16/80 2-5 years** **-5/80-Permanent Housing** **2021: Total months of homelessness** **-15/44 Less than 1 year** **-14/44 1-2 years** **-12/44 2-5 years** **-3/44-Permanent Housing** -Current work status **2020:** **-40/92 Unemployed** **-17/92 Disabled** **-8/92 Retired**

					-6/92 Full-time **-9/92 Part-time** **-3/92 Temporary** **2021: Data not collected in 2021** -Transportation barriers **2020: 41/79 (51.8)** **2021: 32/44 (41.7%)** -Education level **2020: 20/79 did not graduate from HS** **2021: 7/44 did not graduate from HS** -Food access **2020: 73/79 have low food access** **2021: 37/44 have low food access** g) Number and percentage of participants who receive an immunization: **2020:** -**Flu 36/80=45%** **-Hep-A 19/80=23.8%** **-Tdap 13/80=16.3%** **-Shingles 7/80=8.8%** **2021:** **-Flu vaccines-17** **-COVID vaccines-275** h) Total number of STI screenings completed: **20201/80=1.3%** **2021: 0 =0% unable to provide by VDH** i) Number and percentage who are referred to a PCP **2020:27/80=33.8%** **2021: 8/44=18.2%** j) Number of participants who are provided transportation resources through bus tokens/taxi vouchers **2020:12/80=15%** **2021: 0=0% Transportation/Taxi resources limited due to COVID** k) Number of participants who self-report transportation has prevented them from seeing a PCP or obtaining their medications **2020:39/80=48.8%** **2021: 21/44=48%** l) Number and percentage of participants who have a chronic condition **2020:69/80=86.3%** **2021: 30/44= 68%**

					m) Number and percentage of participants who have been prescribed medication for diabetes management **2020:12/13=92.3%** **2021: 11/12=91.6%** n) Number and percentage of participants who have been prescribed medication for behavioral health **2020:43/60=71.7%** **2021: 21/44=47.7%** 2. a) Total number of persons who received COVID vaccines **2021: 275 (This includes 1st, 2nd, and Boosters)** b) Total number of persons who receive Flu vaccines **2021: 17** 3. a) Explore Prescription Courier service through AH Outpatient Pharmacy **2020: YES** b) Implemented (Yes/No) **2021: YES** c) Number of residents served **2021:5** 4. a) Total number of encounters b) Total number of screenings c) Total number of COVID vaccines d) Total number of Flu vaccines

Faith Community Nursing (FCN) is a specialized practice of professional nursing that focuses on the intentional care of the spirit as well as the promotion of whole-person health and the prevention or minimization of illness through screenings, health education, and referrals to health care resources.	1. Conduct a Social Determinants of Health screening in Faith Communities 2. Conduct a community FCN sponsored health fair or health education event 3. Collaborate with Faith Communities to sponsor and conduct COVID vaccine and Flu vaccine clinics within Faith Communities 4. Engage additional Faith Communities to increase FCN membership in the network	Gayle Shultz	1. 2020-2022 2. 2021-2022 3. 2021-2022 4. 2020-2022	1. $3,000	1. **a)** Number of screenings completed **2020: 14** **2021: 17** b) Number of people who are connected with AH resources **2020:10/14=71.4% (this was the answer to the previous food insecurity question)** **2021: 17/17=100% (Food Box program, Grief Support, Transportation)** 2. a) Total number of virtual events **2020: N/A** **2021: 3** b) Total number of people attending these events **2020: N/A** **2021: 37** c) Average number of minutes attendees were connected to WebEx events **2020: N/A** **2021: 53 minutes** 3. a) Total number of vaccine clinics **2020: N/A** **2021: 21** b) Total number of COVID vaccines provided **2020: N/A** **2021: 725 (This includes 1,2,3 doses)** c) Total number of Flu vaccines provided **2020: N/A** **2021: 74** 4. a) Total number of new FCN's and Faith Communities receiving resources **2020: 3** **2021: 0 (Due to COVID)**

Teen pregnancy prevention initiative aims to coordinate efforts to reduce the overall teen pregnancy rate in Waynesboro to the Virginia benchmark rate by 2023 by establishing dedicated teen health services, implementing prevention standardized teen risk assessments, increasing the use of reversible forms of birth control, as well as utilizing school-based community health workers to provide education on reproductive health.	1. Establish a school-based community health worker position that works in the school and the health department, as well as the Office on Youth on teen pregnancy prevention 2. Establish a dedicated teen clinic run by the health department that provides birth control education and counseling 3. Develop a process for birth control drop off and delivery to the students in order to reduce barriers to care 4. Provide delivery of Depo (3-month hormonal injection) by health department nurse	Krystal Moyers	2020-2021	$15,000	1. a) Number of educational sessions offered in the school **2020: 0 (due to COVID-19; Utilized Google Classroom, Instagram and Google Website instead)** **2021: 3** b) Number of referrals for services outside the teen clinic **2020: 0** **2021: 1** 2. a) Number of teens started on/referred for long-acting reversible contraceptives (LARC's) **2020: 121** **2021: 0** b) Number of teens served in teen clinic **2020: 142** **2021: 32** 3. Number of students served by birth control program (Goal: 75) **2020: N/A** **2021: 0** 4. Number of students receiving Depo **2020: N/A** **2021: 7**

Explore telehealth service expansion across the system to determine if/how services can be implemented to improve access to care, enhance community health and advance healthcare knowledge.	1. Explore the feasibility of and need for implementing telehealth services 2. Pilot Telehealth Audio/Visual Sessions in Outpatient Behavioral Health using Doxy.Me, a secure, HIPAA-compliant platform. 3. Implement Teledoc "Augusta Anywhere" platform organization-wide	Andy West Michael Day Amy Ghaemmagham Clint Merritt	2020-2022	1. Operational 2. Operational	1. Service explored (Yes/No) **2020: Yes** **2021: N/A** 2. Service Implemented (Yes/No) **2020: Yes (4/1/20)** **2021: N/A** 3. Number of Patients Served **2020:3665** **2021: 1899** 4. Patient Satisfaction **2020: N/A** **2021: 75%** 5. Teledoc Implemented (Yes/No) **2020: N/A** **2021: No**
Explore a community paramedicine model to allow paramedics and emergency medical technicians to operate in expanded roles by assisting public health, primary healthcare and preventative services in the community in order to improve access to care yet avoid duplicating existing services.	1. Meet with community partners to determine if and what type of community paramedicine model is appropriate for Staunton, Augusta County and Waynesboro 2. Partner with EMS partners to support COVID-19 vaccination efforts for vulnerable communities	Jackie Sims Cindy Sheets Marvella Rea Amy Ghaemmaghami Dan O'Connor Mary Arrowood Krystal Moyers	1. 2020-2022 2. 2021	1. Operational	1. Service explored (Yes/N0) **2020: Yes** **2021: Yes** 2. Convene and facilitate appropriate referral of patients (Yes/No) **2020: N/A** **2021: Yes (COVID-19 patients)**

Implement Social Determinants of Health screening tool at both the community and health system level, enabling multiple team members to track and identify social needs, detect associations between social factors and health outcomes and implement population health programs.	1. Create standardized Augusta SDOH screening tool 2. Implement SDOH screening tool at community events 3. Implement SDOH screening tool at Augusta Care Partners 4. Implement SDOH screening in inpatient/outpatient settings in EMR 5. Connect patients with positive screening results to appropriate clinical action and/or community resource	Krystal Moyers Mary Arrowood	1. 2020 2. 2020 3. 2020 4. 2020-2022 5. 2021-2022	1. $0 2. $500 3. $500 4. Operational 5. $0	1. Completed (Yes/No) **2020: Yes** **2021: N/A** 2. Number of patients screened **2020: 292** **2021: N/A** 3. Number of patients screened **2020:7491** **2021: N/A** 4. Number of -patients screened **2020: 27,817 (implemented, not yet linked to ICD-10 codes)** **2021: 27,000 (implemented, not yet linked to ICD-10 codes)** 5. a) Explore UniteUs platform (Yes/No) **2020: N/A** **2021: Yes** b) Number of total patient referrals **2020: N/A** **2021: 92** c) Percent of patient referrals marked as “closed” **2020: N/A** **2021: 57%**
The Bridge Fund provides financial support to bridge the gap until a more permanent resource is in place. It is offered to patients receiving cancer care at the Augusta Health Center for Cancer and Blood Disorders who meet the criteria to receive financial support.	1. Complete assessment of need after receiving application. 2. Seek approval from at least one other Bridge Fund Committee member (if request is over $500.00). 3. If approved, facilitate payment request ($5,000.00 limit per request)	Leigh Anderson	2020-2022	Augusta Health Fund (Bridge Fund Annual Investment Earnings)	1. Number of patients served by fund **2020: 72 patients** **2021: 61 patients (transportation, medication, dental, rent)**

Continue expansion of the Medication Assistance Program to help eligible uninsured/under insured patients in our community obtain free medications through identified patient assistance programs.	1. Merge the medication assistance patients from Augusta Regional Clinic with the Augusta Health Program. 2. Participate in the Homeless Healthcare Connection programs with Valley Mission, Waynesboro Area Refugee Ministry, and other identified community partners. 3. Expand marketing campaign for community awareness of the program.	Jackie Sims	1. Dec 2020 2. November 2020 3. 2021-2022	1. Operational 2. $1,000 3. $1,500	1. Completion of transition of patients by May 2020 **2020: Completed** **2021: N/A** 2. Operationalize the involvement of the MAP in the Healthcare for the Homeless connection by 11/2020 to include monthly participation. **2020: Attended when held (some cancellations due to COVID-19)** **2021: N/A** 3. Yearly target for prescriptions filled will be 2,800. **2020: N/A** **2021: 3,280 Prescriptions filled**
Explore community models of care that offer opportunities for Augusta Health to partner with Augusta Regional Clinic to improve access to care for the uninsured in our community.	1. Member of Augusta Medical Group leadership team will commit to Augusta Regional Clinic board positions so that Augusta Health has active participation in developing coordinated community programs 2. Explore and implement a coordinated care model between Augusta Health and Augusta	Jackie Sims	1. April 2020 2. 2020-2022		**Augusta Regional Clinic closed Medical Clinic on July 1, 2020.**

	Regional Clinic that supports the uninsured patients in our community.				
Improve the patient outcomes in Primary Care through the standardization of workflow, alignment of community resources, and the integration of care coordination using the Patient Centered Medical Home model of care.	1. Obtain Primary Care Medical Home certification 2. Offer behavioral health services in the primary care setting 3. Develop standardized workflows in primary care to close care gaps for preventative services 4. Develop diabetes, hypertension and chronic obstructive pulmonary disease cohorts of high risk patients in each primary care practice for coordinated and/or case management services	Jackie Sims	1. Dec 2020 2. January 2021 3. December 2020 4. June 2021	Operational	1. Medical Home certification awarded by 12/2020. **2020: Certification awarded 10/20** **2021: N/A** 2. Behavioral Health visits for Primary Care will meet or exceed 100 visits in 2021. **2020: N/A** **2021: Not met due to staffing constraints** 3. Improvement of preventative care gaps for breast cancer and colorectal cancer by 20% from 2019 results. **2020: Not met due to COVID-19** **2021: Not met due to COVID-19** 4. Cohorts established by disease process for each primary Care practice by June 2021. **2020: N/A** **2021: Accomplished by June 2021**

Explore community resources and opportunities to partner with existing transportation options to increase patient follow up ability with primary care.	1. Contact existing providers to determine current services. Compile a list of transportation services in our area. 2. Identify gaps in our service area and then prioritize the gaps by service area. 3. Update transportation resources annually	Marvella Rea Kim Galloway	1. 2020 2. 2020 3. 2021-2022		1. List compiled (Yes/No) **2020: Yes** **2021: N/A** 2. Gaps identified (Yes/No) **2020: Yes** **2021: N/A** 3. Resources updated (Yes/No) **2020: N/A** **2021: Yes**
Grant funds will be awarded to nonprofit organizations whose mission and values align with Augusta Health. Funding will be offered for programs focused on access to health care services.	1. Call for funding applications to be completed on Smarter Select 2. Review funding applications and make funding recommendations through the Funding SubCommittee 3. Following Board approval, award funding to local, non-profit organizations whose mission aligns with the Community Health Needs Assessment priority area of Access to Healthcare	Krystal Moyers Trisha Fillion	1-3. 2020-2022	$150,000	1. a) Number of organizations that receive funding **2020: 12 (1 restricted for Access to Healthcare)** **2021: 17 (2 restricted for Access to Healthcare)** b) Total amount of funding provided **2020: $150,000** **2021: $215,000** c) Number of people in the community impacted by the funding **2020: Data not available until December 2020** **2021: TBD**

Behavioral Health

Program/Activity	Action Steps	Accountability	Timeline	Budget	Impact will be Measured through these Indicators
Increase the proportion of primary care physicians and advanced practitioners who screen patients for depression during office visits. The target population for 2020 – 2022 will include all adolescents and adults, with emphasis on the following high risk groups: post-partum women, seniors 65+, and veterans.	1. The program will utilize depression screenings built into Athena that are done during AMG primary care office visits. Screening rates and rates for documentation of a follow-up plan for those who screen positive will be tracked and reported, based on the CMS sample of patients provided to Augusta Care Partners for annual reporting. 2. Partner with Hospice of the Shenandoah to conduct depression screenings during home health and hospice patients visits. 3. Partner with local obstetrician practices to conduct depression screenings during post-partum follow-up visits. 4. Partner with the Veterans Affairs Medical Clinic in	Krystal Moyers Dr. Clint Merritt	1. 2020-2022 2. 2021 3. 2022 4. 2022	Operational	1. a) Percentage of AMG patients receiving screening (goal: 80%) **2020:85%** **2021: 91%** b) Number and percentage of patients who had a 'positive' depression screening result who received a follow-up treatment plan of care (Note: Only for ACO patients sampled for CMS in Athena **2020: N/A** 2. Percentage of Home Health and Hospice patients receiving screening **2020: N/A** **2021: 0 (Hospice); 94% (Home Health)** 4. Percentage of OB patients receiving screening **2020: N/A** **2021: N/A** 5. Percentage of VA patients receiving screening **2020: N/A** **2021: N/A**

	Staunton to conduct depression screenings during patient appointments.				
Increase access and reduce stigma to behavior health services by embedding a behavioral health provider in the family practice.	1. Collaborate with AMG leadership to locate appropriate practice to place the behavioral health provider 2. Hire an LCSW and embed in AMG practice 3. Establish clinical operations	Amy Ghaemmaghami	2021-2022	Operational ($65,000)	1. AMG practice selected (Yes/No) **2020: N/A** **2021: Yes** 2. LCSW hired (Yes/No) **2020: N/A** **2021: No** a) Total number of patients seen by the LCSW in the family practice setting **2020: N/A** **2021: N/A** b) Total number of referrals made for psychiatry **2020: N/A** **2021: N/A** c) Total number of referrals made to other behavioral health or substance abuse services **2020: N/A** **2021: N/A**

The Pain Management (Opioid) Stewardship Committee is a multidisciplinary team responsible for promoting the proper use of pharmacologic and non-pharmacologic treatments for pain in patients within the Augusta Health system and community.	1. The scope of the committee shall include engaging with key stakeholders to review and revise existing order sets, monitoring data related to pain management, and conducting a gap analysis to identify opportunities for improvement. 2. The committee will make formal recommendations related to opioid use and pain management, including the use of non-pharmacologic interventions and non-opioid medications. 3. The committee will coordinate educational activities for staff, prescribers, and patients. 4. Recommendations will be developed related to pain specialist referral and referral to substance abuse treatment programs as appropriate.	John Lubkowski	2020-2022	Operational/ Augusta Health Foundation Grant	1. Engage key stakeholders (Yes/No) **2020: Yes** **2021: Yes** 2. Gap analysis conducted (Yes/No) **2020: Yes (Completed on 7/29/20)** **2021: Yes** 3. Formal recommendation made (Yes/No) **2020: Yes (Sent to AMG Providers, Surgical Committee and posted on intranet)** **2021: Yes** 4. Number of educational activities conducted annually **2020: 7** **2021: 3** 5. Recommendations developed (Yes/No) **2020: Yes** **2021: yes** 6. Number of referrals made to substance abuse treatment programs based on developed recommendations **2020: 7** **2021: 4** 2022 1. Decrease the number of opioid discharge prescriptions, and the total Milligrams Morphine Equivalents of discharge prescriptions by 10% each 2. Decrease the percentage of patients by provider/specialty given discharge opioid prescriptions by 5%

Improve access to mental health services for targeted populations by holding Mindful U support groups. Mindful U will present a DBT-informed program of mindfulness and relaxation strategies, emotional regulation, distress tolerance and interpersonal relationship skills.	1. Continue established program for adolescents 2. Explore expanding adolescent program to additional locations outside of Augusta Health 3. Establish and promote program for seniors (partner with assisted living facilities, senior centers/VPAS, and Staunton, Augusta and Waynesboro area churches) 4. Augusta Health OPBH therapist will facilitate group for seniors	Lisa Tungate	2021-2022	Operational ($7,000)	1. a) Total number of youth participants **2020: N/A** **2021: 41 (27 summer camp and 14 after-school)** b) Percentage participants with increased emotional regulation **2020: N/A** **2021: 65%** c) Percentage participants with increased distress tolerance **2020: N/A** **2021: 25%** d) Percentage participants with increased interpersonal relationship skills **2020: N/A** **2021:2 5%** e) Percentage participants with increased goal-setting **2020: N/A** **2021: 33%** 2. Second youth location identified **2020: N/A** **2021: Yes (Staunton Augusta YMCA - Summer Camp & After-school)** 4. a) Total number of senior participants **2020: N/A** **2021: N/A** b) Percentage participants with increased emotional regulation **2020: N/A** **2021: N/A** c) Percentage participants with increased distress tolerance **2020: N/A** **2021: N/A** d) Percentage participants with increased interpersonal relationship skills **2020: N/A** **2021: N/A** e) Percentage participants with increased self-esteem **2020: N/A** **2021: N/A**

The Warm Line will be a volunteer based tele-counseling chat line offered Monday through Friday from 4-9 pm for callers who are experiencing mood or anxiety issues.	1. Research similar programs and establish best practices standard operating procedure including HIPAA compliance 2. Choose and acquire appropriate platform and technology 3. Recruit interns area allied health and social work programs 4. Train resource clinicians and interns 5. Identify relevant area organizations and promote the initiative 6. Implement Warm Line	Amy Ghaemmaghami	2021-2022	Operational ($60,000)	1. Deemed feasible (Yes/No) **2020: N/A** **2021: No** 2. Best practices and Standard Operating Procedures established (Yes/No) **2020: N/A** **2021: N/A** 3. Platform and necessary technology acquired (Yes/No) **2020: N/A** **2021: N/A** 4. Number of interns selected **2020: N/A** **2021: N/A** 5. a) Number of resource clinicians trainer **2020: N/A** **2021: N/A** b) Number of interns trained **2020: N/A** **2021: N/A** 6. a) Number of organizations reached **2020: N/A** **2021: N/A** b) Total number of interactions **2020: N/A** **2021: N/A** c) Percentage of callers who find service helpful **2020: N/A** **2021: N/A** d) Total number of referrals to Augusta Health OPBH made **2020: N/A** **2021: N/A**

Explore behavioral health partnership with local schools.	1. Identify community partners 2. Draft and submit proposal 3. Implement program, if deemed feasible by all program partners	Amy Ghaemmaghami	2021-2022	Operational and Community Benefit ($60,000)	1. Program deemed feasible (Yes/No) **2020: N/A** **2021: Yes** 2. Number of students impacted **2020: N/A** **2021: N/A** 3. Pre and post survey of participating students **2020: N/A** **2021: N/A**
Substance Abuse Partial Hospitalization Program will provide patients in Staunton, Waynesboro and Augusta County who have a Substance Abuse diagnosis with a step down day program to help equip them with the education, resources and support they need outside of an inpatient program. The program will be 5 hours/day for 5-10 days depending on the patients need. This program will be led by a Physician who will also see the patient 2x/week, Nursing support, 1:1 counseling weekly and daily groups from Recreation Therapy & Counselors.	1. Deem feasible? 2. Develop a business plan 3. Solidify referral partners 4. Work with project management team to develop standard operating procedures 5. Hire staff and clinician for program 6. Provide a minimum of 25 hours per week of skilled treatment services. Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreation therapy in the amounts, frequencies and intensities appropriate to the objectives of the	Michael Day Shelley Payne	2020-2022	Operational ($267,000)	1. Feasible (Yes/No) **2020: No** **2021: Yes** 2. Business Plan developed (Yes/No) **2020: N/A** **2021: No** 3. Number of Referral Partners Established **2020: N/A** **2021: N/A** 4. Standard Operating Procedures Developed (Yes/No) **2020: N/A** **2021: N/A** 5. Staff Hired (Yes/No) **2020: N/A** **2021: N/A** 6.. a) Number of patients in the program **2020: N/A** **2021: N/A** b) Number and percentage of patients with a history of substance abuse **2020: N/A** **2021: N/A** c) Number and percentage of patients whose clinical condition has improved as reflected in symptom relief and reduced interference with social and vocation goals to such a degree as to warrant reduction of treatment regimen to a lesser intensity **2020: N/A** **2021: N/A** d) Number and percentage of patients who met treatment goals established in individualized treatment plan

	treatment plan. Discharge planning and referral services consistent with treatment needs and condition.				**2020: N/A** **2021: N/A** e) Number and percentage of patients who are able to return to a level of independence and responsibilities in day to day activities and no longer require the structure and support of intensive outpatient programming **2020: N/A** **2021: N/A** f) Number and percentage of patients who remained sober after attending the program (six month's post) **2020: N/A** **2021: N/A**
Hold Trauma Informed Care Seminar for community partners in order to promote environments of healing and recovery. Presentations by consultants with the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center for Trauma Informed Care.	1. Engage Trauma Informed Care Consultant to teach Trauma Informed Care practices to employees, staff and community members 2. Hospital will use Trauma Informed Care principles to guide organizational decisions 3. Form a Trauma Informed Care Committee	Michael Day	Q4 2020-2022	Community Benefit Endowment ($15,000)	1. Engage consultant (Yes/No) **2020: No due to COVID-19** **2021: Yes** 2. Percent change in patient satisfaction scores after practices implemented **2020: No due to COVID-19** **2021: Not measured** 3. Committee formed (Yes/No) **2020: No due to COVID-19** **2021: Yes**

Create a veterans behavioral health program within Augusta Health and in the community at large to provide mental health and support services to those who have served in the military.	1. Resource clinicians will complete course in military culture and mindset 2. Collaborate with Augusta Health Fitness to develop marketing materials to help in making the community aware of offerings 3. Obtain referrals to the program from AH ED visits, the local National Guard unit, the Veteran's Administration clinic in Staunton, and area medical and psychiatry practices 4. Conduct in-person intake evaluations 5. Refer patients to ABH for individual counseling and for medication management as indicated 6. Develop a consecutive yoga class and counseling session to boost attendance and eliminate barriers 7. Initiate weekly group sessions after sufficient referrals (4-5)	Phil Harmon Stephanie Mims Olivia Hall Amy Ghaemmaghami Michael Day	2020	Operational ($4,800)	1. Total number of resource clinicians trained **2020: 1** **2021: N/A** 2. Total number of marketing methods **2020: N/A** **2021: N/A** 3. a) Total number of referrals from AH ED **2020: 0** **2021: N/A** b) Total number of referrals from National Guard **2020: 0** **2021: N/A** c) Total number of referrals from Staunton VA **2020: 0** **2021: N/A** d) Total number of referrals from area medical and psychiatry practices **2020: 4** **2021: N/A** 4. Total number of intake evaluations conducted **2020: 4** **2021: N/A** 5. a) Total number of referrals made for counseling **2020: 0 (already had counseling)** **2021: N/A** b) Total number of referrals made for medication management **2020: 0 (already had medications)** **2021: N/A** 6. a) Offer trauma-informed yoga class (Yes/No) **2020: N/A** **2021: N/A** b) Number of yoga class participants **2020: N/A** **2021: N/A** 7. a) Total number and percentage of group participants referred to complete the program **2020: Program suspended due to COVID-19** **2021: N/A**

	have been made. Group participants will be expected to attend a minimum of 12 sessions. 8. Adolescent family members will be referred into the adolescent program offered through ABH.				b) Percentage of participants who report lower perceived distress compared to at intake at the end of 12 weeks **2020: Program suspended due to COVID-19** **2021: N/A** 8. Total number of adolescent family members referred **2020: Program suspended due to COVID-19** **2021: N/A**
Increase prevention of post-partum depression and anxiety, as well as support services to families in Staunton, Augusta County and Waynesboro.	1. Staff will research information on best practices for treatment of postpartum depression – CBT and IPT approaches in particular. 2. Develop partnership with local OBGYN practices. 3. Create education related to signs of post-partum depression to be provided to women and their support partner at the prenatal appointments. 4. Provide therapeutic group to support new mothers dealing with depression and/or other mental health symptoms and help to build coping skills, interpersonal	Michael Day Amy Ghaemmaghami Stephanie Mims Alison Moats	2020-2021	1. $500-Community Benefit Endowment 2. Operational	1. Best practices are established (Yes/No) **2020: N/A** **2021: Yes** 2. Total number of intakes conducted **2020: N/A** **2021: 10** 3. Total Number of women who receive the education. **2020: N/A** **2021: 10** 4. Total number of group participants **2020: N/A** **2021: 48** 5. Percentage of those referred who participant in support group (Goal: 50%) **2020: N/A** **2021: 100%** 6. Percentage of those referred who participant in exercise group (Goal: 50%) **2020: N/A** **2021: 0** 7. Utilization of service to increase by 25% yearly **2020: N/A** **2021: Not measured** 8. Percentage of participants reporting decrease/alleviation of symptoms, improvement in coping and social supports, overall improved sense of well-being compared to intake **2020: N/A** **2021: Not measured** 9. Total number of referrals made **2020: N/A**

	supports, self-care skills, distress tolerance skills (intake evaluations will be conducted in person prior to initial group meeting) 5. Begin offering an exercise group for post-partum women to help manage their behavioral health risks. 6. Refer to other services as needed (for medication, individual therapy etc.). 7. Refer to other services as needed (for medication, individual therapy etc.).				**2021: Not measured**

Launch Tobacco Cessation Clinic within Augusta Medical Group to provide patients who would like to quit using tobacco products with physical, behavioral and medication support services.	1. Staff will complete the Duke-UNC Tobacco Treatment Specialist Training (TSS) program 2. Staff will obtain TSS certifications as required 3. Develop a rack card for advertising and marketing of the Tobacco Cessation Clinic 4. Screen all clients on previous methods used for tobacco cessation 5. Clinical operations are established and clients are seen on a regular basis 6. Establish the use of telemedicine in the initial phase of the tobacco cessation clinic 7. Establish a Mindfulness-based Support Group for smokers, led by the by Clinic's LCSW	Krystal Moyers John Girard Dr. Jason Lawrence	1. 2020-2021 2. 2020-2021 3. 2021-2022 4. 2021-2022 5. 2021-2022 6. 2020-2022 7. 2021-2022	Operational	1. Total number of staff trained **2020: 4** **2021:** 2. Total number of staff receiving TSS certifications **2020: 3** **2021: 1** 3. Total number of cards placed into AMG practices and throughout Augusta Health **2020: N/A** **2021: No due to COVID-19 Restrictions** 4. a) Total percentage who have enrolled in Quit Now VA **2020: N/A** **2021: Not measured** b) Total percentage who previously attended Tobacco Cessation classes **2020: N/A** **2021:Not measured** c) Total percentage who have used nicotine patch, gum, nasal spray, inhaler, lozenge or tablet **2020: N/A** **2021:Not measured** d) Total percentage who have been prescribed Zyban, Bupropion and Wellbutrin **2020: N/A** **2021: Not measured** e) Total percentage who have attempted to quit with a friend, relative or acquaintance **2020: N/A** **2021: Not measured** 5. a) Total number of clients receiving behavioral health support **2020: N/A** **2021: 225** b) Total number of clients seen in the clinic **2020: N/A** **2021: 226** c) Total number of clients who remain tobacco free for six or more months **2020: N/A** **2021: N/A**

					6. a) Total number of clients who enroll **2020:168** **2021: 225** b) Total number of counseling sessions conducted **2020:938** **2021: 756** 7. a) Total number of participants who enroll in the group **2020: N/A** **2021: Lack of community response** b) Total number and percentage of participants who enroll who complete all sessions **2020: N/A** **2021: Lack of community response**

Explore a Behavioral Health Navigator role to provide assessments, emotional support, referrals, and a variety of social services interventions, and to be available to both the community and patients, to ensure a flow of psychosocial and medical information.	1. Develop job description 2. Complete job position approval process 3. Candidate interviewed, selected, on-boarded. 4. Behavioral Health Navigator begin providing assessments, support, referrals and interventions by Q1 2021.	Michael Day	2021-2022	Operational ($65,000)	1. Job description developed (Yes/No) **2020: N/A** **2021: Yes** 2. Position Approved (Yes/No) **2020: N/A** **2021: Yes** 3. Candidate interviewed, hired and on-boarded (Yes/No) **2020: N/A** **2021: Yes** 4. a) Behavioral Health Navigator begin (Yes/No) **2020: N/A** **2021: No** b) Total number of patients receiving behavioral health support **2020: N/A** **2021: N/A** c) Number of referrals offered **2020: N/A** **2021: N/A** d) Number and percentage of successful referral placements **2020: N/A** **2021: N/A** e) Number and percentage of accurate logs of all encounters **2020: N/A** **2021: N/A**

Grant funds will be awarded to nonprofit organizations whose mission and values align with Augusta Health. Funding will be offered for programs focused on behavioral health care services.	1. Call for funding applications to be completed on Smarter Select 2. Review funding applications and make funding recommendations through the Funding SubCommittee 3. Following Board approval, award funding to local, non-profit organizations whose mission aligns with the Community Health Needs Assessment priority area of Behavioral Health	Krystal Moyers Trisha Fillion	1-3. 2020-2022	$150,000	3. a) Number of organizations that receive funding **2020: 12 (9 restricted for Behavioral Health)** **2021: 17 (11 restricted for Behavioral Health)** b) Total amount of funding provided **2020: $150,000** **2021: $215,000** c) Number of people in the community impacted by the funding **2020: Data not available until December 2020** **2021: TBD**

Diabetes

Program/Activity	Action Steps	Accountability	Timeline	Budget	Impact will be Measured through these Indicators
Explore and expand DSME and related programs with the goal of empowering those with diabetes to learn and utilize the tools available to help them properly manage their disease.	1. Investigate current American Diabetes Association Multi-Site License for Augusta Health (number of allowed sites, cost for additional sites, etc.) 2. Expand total number of Augusta Medical Group locations where Diabetes Education services are provided, with a focus on Primary Care offices 3. Expand class offerings to include continuous Glucose Monitor education class once per month 4. Increase total number of Diabetes Care and Education Specialists (DCES) by training newly hired staff	Caroline Hackley Kara Meeks Megan Cather	1-3. 2020-2022 4. 2022	1. $7,000 3. $750 4. $1,700	1-2. a) Number of patients receiving individual diabetes education **2020: 839** **2021: 843** b) Number of patients attending diabetes education classes **2020:42 classes offered- 1 to 2 participants in each class** **2021: 220 (total class attendance)** **c)** Total number of Augusta Medical Group Primary Care Offices participating in Diabetes Management Pilot **2021: 3** 3. a) Increase that number of patients who receive education on proper placement of CGM and interpretation of the CGM data to improve their blood glucose management **2020: 8 people (2 classes total d/t Covid** **2021: 30 people** b) Reduce A1C/blood glucose levels in persons who attend the class and start wearing CGM **2020: N/A** **2021: Unable to obtain A1C data** c) Total number of patients impacted (Goal: 25 patients/year) **2020: N/A** **2021: 30 people** 4. a) New staff will meet criteria to take and pass certification exam: Yes/No **2020: No** **2021: No (Staff not eligible until 2022 per exam requirements)**

Offer the BEATDiabetes text messaging service at no cost to eligible individuals with Type 2 Diabetes with the goal of reduction in A1c. Those enrolled in the program will be sent customizable text reminders as well as health tips to optimize diabetes self-management skills.	1. Identify and refer employees and AH health plan members 2. Identify and refer eligible Medicare beneficiaries 3. Identify and refer eligible participants in select Community Outreach programs (ex. Food Farmacy or DPP) 4. Explore grant funding for patients not in identified populations 5. Track program adherence and outcomes	Mary Arrowood	2020-2021	Operational, Community Benefit Endowment ($10,000), Grant funding	1-3 a) Number and percentage referred **2020: 131 (13.8%)-compared to average total of LIFE participants for 2020** **26 enrolled; 5 dropouts** **2021: Program suspended** 4. Grant funding explored **2020: Yes** **2021: Program suspended** 5. a) Number and percentage of participants who see a decrease in A1C (pre/post) **2020: 2 (9.5%)- 76% did not have data available for comparison** **2021: Program suspended** b) Number and percentage of participants who see a decrease in fasting blood glucose levels (pre/post) **2020: N/A** **2021: Program suspended**
Utilizing a system wide approach of patient-facing technology to expand access and knowledge of diabetes health education. This type of education will allow patients to learn more about diabetes self-management.	1. Workgroup to choose a vendor and begin to implement technology 2. Workgroup will assess the total number of resources available for diabetes education	Gayle Shultz Crystal Farmer Matthew Fidler	1. 2021-2022 2. 2022	Operational	1. Vendor for patient-facing technology determined (Yes/No) **2021: NO (Due to COVID)** 2. Total number of Diabetes Education resources using patient-facing technology. **2021: N/A**

Increase access to and participation in outpatient Diabetes education.	1. Improve the patient outcomes for diabetes patients in Augusta Health Primary Care offices (3 locations) by creating a coordinated plan of care to connect poorly controlled diabetics (A1C >9) to health and social resources. 2. Increase involvement of primary care physicians with the Diabetes Pilot Program.	John Mack Caroline Hackley Marvella Rea Clint Merritt Abby Calvert	1-2021-2022 2-2021-2022	Operational	1. a.) Number of patients referred to Outpatient Diabetes/Nutrition Education Program as a result of participation in the Diabetes Pilot Program. **2021: 77** b.) Total number of patients showing a reduction in A1C <9. **2021: 14** 2. Number of primary care physicians involved with the Diabetes Pilot Program. **2021: 14**

Augusta Health's diabetes prevention programs will provide education and lifestyle change programming to the community with the long-term goal of reducing the incidence of type 2 diabetes.	1. Increase attendance at Blue Ridge Healthy U Diabetes Prevention Program through referrals, advertisement and screening for employees and patients at our Augusta Medical Group offices and at community events 2. Maintain the number of active and certified Diabetes Prevention coaches between 5-7 coaches. 3. Investigate and implement online Diabetes Prevention Program cohorts by using applications like Zoom for virtual classes. 4. Increase outreach and attendance at 90 minute Diabetes Prevention Class through referrals from Physicians	Kathryn Berger Caroline Hackley Megan Cather	1-5 2020-2022	1-4.$2,000 5. $900	1. a.) Total number of new classes started per year (Goal: 6) **2020: 0 (Due to COVID)** **2021: 9** b.) Total number of participants Goal: 40) **2020: 0 (Due to COVID)** **2021: 43** 2. Total Number of Active DPP coaches (Goal:5) **2020: 5** **2021: 1** 3. Explored and implemented online applications: Yes/No **2020: Yes** **2021: Yes** 4. Total number of participants attending 90 minute DPP class **2020: 47** **2021: 10**

This program consists of community-directed programs (such as *Get Fresh*) and curriculum aimed at preventing or delaying the onset of prediabetes and type II diabetes in youth. It may consist of classroom nutrition education, fresh food tastings, field trips to local farms, cooking lessons, summer camps and/or afterschool nutrition programming for the entire family, thus promoting the development of healthy habits and lifestyle changes to improve nutrition, overall health and in turn help prevent diabetes.	1. Continue Get Fresh program in current academic year in two Waynesboro City Elementary Schools 2. Expand current Get Fresh program in Waynesboro City Elementary Schools from two to three elementary schools 3. Expand Get Fresh program in all eligible Waynesboro City Elementary schools and Elk Hill School	Krystal Moyers Gayle Shultz Abby Calvert	1. 2020-2022 2. 2020-2021 3. 2021-2022	$5050	1-3 a) Number of participating students. **2020: 1,290** **2021: 1,294** b) Total number of participants who receive weekly classroom instruction **2020: 747** **2021: 600 (online curriculum) 15 (In-person at Elk Hill)** c) Total number of participants and families who attend Families, Food, and Fun **2020: 27** **2021: 19** d) Total number of estimated individual servings consumed per school per tasting **2020: 131** **(WP- 106; Wenonah- 32)** **2021: 1420 (Berkeley Glenn (180), Westwood (250), Wenonah (180), William Perry (220), Wayne Hills (110), Kate Collins Middle** **School (375), Waynesboro High School (90), Elk Hill (15)** e) Number of students who participate in field trips to Project Grows farm (Fall/Spring) **2020: 0 (Due to COVID-19)** **2021: 0 (Due to COVID-19)** f) Total number of estimated individual servings consumed for the Get Fresh Program **2020: 2,005** **Family shares (55 units); 1,950 HOM in Fall of 2020** **2021: 11,041= 932.35 pounds** g) Number of students and total percentage of students who participate in classroom food tastings each week **2020: 138 (79%)** **WP- 106** **Wenonah- 32** **2021: Unable to obtain because tastings were distributed through the school meal program**

Diabetes Day is a free education event offered to community members every November in honor of National Diabetes Month. The goal is to provide our community with information about diabetes and both the prevention and treatment of the disease.	1. Offer Educational Event in honor of National Diabetes month. This will include 2 or 3 presentations on relevant diabetes related topics (e.g. affording medications, nutrition updates) 2. Event to be held either in-person or virtually depending upon allowances for COVID 19	Kara Meeks	2020-2022	$2,500	1-2. a) Total number of participants (Goal:20 if virtual or 30 if in-person) **2020:24 (virtually)** **2021: 11 (In-person)** b) Event held in-person Yes/No **2020: No** **2021: Yes (Held at Booker T. Washington Community Center)** c) Event held virtually Yes/No **2020: Yes** **2021: No**
SYNC is an innovative, team-based, collaborative experience that emphasizes hands-on problem solving. Utilizing this model, diabetes workgroup members will work to identify a specific challenge surrounding diabetes or prediabetes in their community, apply the SYNC concepts, and implement a solution.	1. Workgroup will identify a specific community or organizational need surrounding diabetes or prediabetes 2. Workgroup will attend webinars and hands-on SYNC workshops 3. Develop action steps and strategies for increasing the number of referrals to Community Health Worker 4. Develop action steps and strategies to increase the total number of diabetic patients working with Community Health Worker	Gayle Shultz Stephanie Mims Caroline Hackley Michael Campbell Marvella Rea Clint Merritt Abby Calvert	1. 2020-2021 2. 2020-2021 3. 2020-2021 4. 2020-2021	Grant-funded	1-2 a) Total number in workgroup attending SYNC webinars and workshops **2020: 6** **2021**: **N/A** 3-4 a) Total number of diabetic patients working with a Community Health Worker (CHW) **2020:3** **2021: 17** b) Total number of diabetic referrals received by Community Health Worker **2020: 3** **2021: 40**

Participate in a learning collaborative to design and implement an Upstream Quality Improvement Campaign to address health-related social needs for patients in the community using a stepwise approach to move upstream. The learning collaborative will focus on the high rate of hospital encounters at Augusta Health among adult diabetics in a four zip code area that includes Craigsville, Buena Vista, Staunton and Waynesboro	1. Engage the Blue Ridge Area Food Bank and related pantries as a distribution resource for produce from the AMI Farm at Augusta Health and partner with them to leverage their "Nourish" stoplight food guide program to the four targeted zip codes. 2. Engage as many key stakeholders as possible for assistance with potential Social Determinants of Health screenings. 3. Hold Food Farmacy cohorts for targeted populations	Dan O'Connor Amy Hougan Mary Arrowood Penny Cooper Krystal Moyers Clint Merritt	1. 2020 2. 2021-2022 3. 2021-2022	2020- $5,250 2021-$5,250	1. Number of tons of food delivered to targeted zip codes (Goal: Two tons) **2020: .75 ton** 2. a) Baseline of total diabetics in our EMR in the targeted zip code areas, measuring percent of screenings completed at Augusta Health (Goal: 10%) **2020: N/A** **2021:** • **Craigsville—20 patients screened food insecure, 6 were diabetic.** • **Buena Vista—29 patients screened food insecure, 6 were diabetic.** • **Staunton—319 patients screened food insecure, 73 were diabetic** • **Waynesboro—239 patients screened food insecure, 55 were diabetic** b) Total number of community SDH screenings completed as a percent of census reported population in the set time period (Goal: 10%) **2020: N/A** **2021:1%** 3. Presence of Food Farmacy cohort in each zip code area (Goal: 1 in each of 4 zip codes) **2020: N/A** **2021: Staunton and Waynesboro** 1-3. a) Reduce hospital encounters among diabetics by 10% in our targeted zip code area in 2022 **2020: N/A** **2021: N/A**

Increase awareness and utilization of the health coaching program within the community.	1. Develop a prediabetes group health coaching cohort 2. Work with community partners to offer community health coaching	1. Stephanie Mims, Sarah Martin, Michael Campbell 2. Stephanie Mims, Sarah Martin	1. 2021-2022 2. 2020-2022	1. $1,650 2. $2,000	1. a) Total number of participants **2021:** 4 enrolled; 4 completed (100%) b) Increased self-reported minutes of weekly activity **2020: N/A** **2021: N/A- Unable to complete Due to COVID** c) Improved emotional well-being as evidenced by an improved score on the Quality of Life questionnaire **2020: N/A** **2021: 2021: N/A- Unable to complete Due to COVID** d) Improvement in physical capabilities as evidenced an improvement in their pre- and post- testing **2020: N/A** **2021: N/A- Unable to complete Due to COVID** 2. a) Wellness behavioral changes as evidenced by a reduction in their A1C **2020: Program on hold due to COVID-19** **2021: N/A- Unable to complete Due to COVID** b) Increase in the number of program participants **2020: Program on hold due to COVID-19** **2021: N/A- Unable to complete Due to COVID** c) Percentage improvement in their Lifestyle Behavior change questionnaire **2020: Program on hold due to COVID-19** **2021: N/A- Unable to complete Due to COVID**

Grant funds will be awarded to nonprofit organizations whose mission and values align with Augusta Health. Funding will be offered for programs focused on diabetes services.	1. Call for funding applications to be completed on Smarter Select 2. Review funding applications and make funding recommendations through the Funding SubCommittee 3. Following Board approval, award funding to local, non-profit organizations whose mission aligns with the Community Health Needs Assessment priority area of Diabetes	Krystal Moyers Trisha Fillion	1-2.2020-2022	$150,000	3. a) Number of organizations that receive funding **2020: 12 (0 restricted for Diabetes)** **2021: 17 (0 restricted for Diabetes)** b) Total amount of funding provided **2020: $150,000** **2021: $215,000** c) Number of people in the community impacted by the funding **2020: Data not available until December 2020** **2021: TBD**

Nutrition and Physical Activity

Program/Activity	Action Steps	Accountability	Timeline	Budget	Impact will be Measured through these Indicators
Augusta Health, in collaboration with community partner(s), will host a sustainable production farm and demonstration garden located on Augusta Health's campus. The purpose of the farm is to: • Provide fresh, locally grown produce for use in our food system, to be served to our patients, employees and visitors and to be integrated in clinically settings • Teach nutrition, sustainable agriculture, cooking and other educational workshops and classes to enhance knowledge in the community • Offer nutrient dense food solutions to community members who have low food access • Hold a Food Farmacy prescription produce program for persons with specific chronic disease diagnoses; through the program participants will receive nutrition education, take part in cooking demonstrations and receive free produce • Explore the possibility of connecting food insecure patients with an onsite food pantry	1. Partner with Alleghany Mountain Institute (AMI) to continue the AMI Farm at Augusta Health, a 1.5 acre high intensity production farm which uses sustainable agriculture practices and is located on Augusta Health's campus. Produce from the farm will be used in our food system, to be served to our patients, employees and visitors, be integrated in clinical settings and be donated to local nonprofit organizations. 2. Nutrition, sustainable agriculture, cooking and other educational workshops and classes will be taught to enhance knowledge in the community. Classes will be offered in conjunction with AMI and other	Krystal Moyers Dan O'Connor Catherine Hill	1. 2020-2022 2. 2020-2022 3. 2020-2022 4. 2020-2021 5. 2021-2022	2020- $115,250	1. a) Number of pounds of produce produced from the farm in total **2020: 23,549** **2021: 30,053.80** b) Number of pounds of produce produced by the farm and used by Augusta Health **2020: 15,677.5** **2021: 22,381.80** c) Number of pounds of produce used in Augusta Health's food system **2020: 1,671.7** **2021: 1,489.30** 2. a) Number of education classes held through farm partnership **2020: 18** **2021: 12** b) Number of participants attending education classes held through farm partnership **2020: 700** **2021: 895 unique individuals attended the 12 workshops. 1,138 unique individuals were reached through workshops in addition to educational materials that accompanied produce and farm tours.** c) Number of recipes and other educational materials give out in Blue Ridge Café **2020: 0 due to COVID-19** **2021: recipes and veggie info cards reached approximately 2,300 people (some of these are households so the actual number is higher).** 3. a) Number of pounds of produce sold at the AMI Farm at Augusta Health farm stand /Harvest Boxes **2020: 1,916.92** **2021: 2,567.70**

	community partners. 3. Offer nutrient dense food solutions to patients and community members who have low food access with program partners such as Valley Program for Aging Services' Meals on Wheels, subsidized Community Supported Agriculture (CSA) shares and COVID Response Fresh Food Boxes. 4. Hold a Food Farmacy prescription produce program for persons with specific chronic disease diagnosis, and in targeted zip code areas. The program participants will receive nutrition education, take part in cooking demonstrations and receive free produce 5. Explore the possibility of connecting food insecure patients				b) Number of FCN CSA shares subsidized by Augusta Health **2020: 4** **2021: 13** c) Number of pounds of local food distributed to individuals through CSA farm shares **2020:** **FCN: 800** **C2C: 1,916.2** **2021:** **C2C: 4,913.6** d) Number and percentage of individuals with low food access receiving CSA farm shares **2020:** **FCN:8/11 (73%)** **C2C: 4,400** **2021:** **C2C: 3,250** e) Number and percentage of individuals receiving farm shares who eat five or more servings of fruit and/or vegetables per day (pre/post) **2020:** **FCN: 4/11 (36%)** **C2C: Not measured in 2020** **2021:** **C2C: Pre- 2/31 (6%); post-2/26 (7.7%)** f) Number of community partners engaged in COVID-19 response programs **2020: 12** -AH Foundation -AMI Farm at AH -CAPSAW -Community Foundation of Central Blue Ridge -Cool Breeze Farms -Malcolm's Market -MARFAC -Newtown Baking and Kitchen -Poplar Ridge -Project Grows -VPAS -White Spring Farm **2021: 6** -AH Foundation -AMI Farm at AH

	with an onsite food pantry				-Augusta Kitchen -Cool Breeze Farms -Newtown Baking and Kitchen -The Cheese Shop g) Number of boxes provided to community members and patients with low food access **2020: 1,850** **2021: 1,250** h) Market value of produce provided to those with low food access **2020: $106,574.50** **2021: $94,782.25** i) Number of pounds of produce provided to COVID Fresh Food Boxes from AMI Farm at Augusta Health **2020: 5,554.6** **2021: 4,913.6** j) Number of pounds of produce provided by AMI Farm at Augusta Health for Home Health and Hospice patients during COVID-19 **2020: 6,430.3** **2021: 4,531.6** k) Number of pounds of produce provided by AMI Farm at Augusta Health to Blue Ridge Area Food Bank **2020: 1,477.7** **2021: 2,946.9** 4. a) Number of Food Farmacy participants **2020: 6** **2021: 40** b) Number and percentage of participants who start the class and finish the program **2020: 6/9 (66%)** **2021: 40/56 (71.4%)** c) Number of pounds of produce given to program participants **2020: 2,020.9** **2021: 5,831.1** ***Note: d-h for 2021 represents the Allen Chapel cohort only (cohort 2)** d) Number and percentage of participants who saw a decrease in A1C/fasting blood glucose **2020: 2/6 (33%)** **2021: 4/15 (27%)**

					e) Number and percentage of participants who saw a decrease in blood pressure **2020: 3/6 (50%)** **2021: 5/15 (33%)** f) Number and percentage of participants who saw a decrease in total cholesterol **2020: 2/6 (33%)** **2021: 2/15 (13%)** g) Number and percentage of participants who saw a decrease in Body Mass Index **2020: 3/6 (50%)** **2021: 9/15 (60%)** h) Number and percentage of participants who saw a decrease in waist circumference **2020: 3/6 (50%)** **2021: 4/15 (27%)** i) Number and percentage of participants who decrease medication usage **2020: 2/4 (50%)** ***Note: 4/6 participants completed post-survey** **2021: 12/29 (41.4%)** ***Note: 29/40 participants completed post-survey** j) Number and percentage of participants who self-report an increase in energy **2020:2/4 (50%)** **2021: 5/29 (17.2%)** k) Number and percentage of participants who feel more confident in cooking meals at home using fresh produce **2020:1/4 (25%)** **2021: 8/29 (27.6%)** l) Number and percentage of participants who self-report an increase in consumption of fruits and vegetables **2020: 2/4 (50%) fruits; ¾ (75%) veggies** **2021: 23/29 (79.3%)** m) Number and percentage of participants who self-report an increase in knowledge about healthy eating **2020:2/4 (50%)** **2021: 8/29 (27.6%)** n) Number and percentage of participants who self-report food insecurity

					2020: ¾ (75%) **2021: 10/29 (34.4%)** o) Number and percentage of participants who self-report feeling more confident in diabetes prevention/self-management strategies **2020: 4/4 (100%)** **2021: 28/29 (96.6%)** ***Note: p-w represents the Cancer Patient Cohort only (cohort 1 of 2021)** p) Number and percentage of participants who self-report an increase in 100% juice **2021: 2/14 (14%)** q) Number and percentage of participants who self-report an increase in consumption of fruit over the last month **2021: 8/14 (57%)** r) Number and percentage of participants who self-report an increase in consumption of lettuce salad **2021: 7/14 (50%)** s) Number and percentage of participants who self-report a decrease in consumption of French fries or fried potatoes **2021: 4/14 (29%)** t) Number and percentage of participants who self-report an increase in consumption of other white potatoes (not fried) **2021: 1/14 (7%)** u) Number and percentage of participants who self-report an increase in consumption of cooked dried beans **2021: 3/14 (21%)** v) Number and percentage of participants who self-report an increase in consumption of other vegetables over the last month **2021: 9/14 (64%)** w) Number and percentage of participants who self-report an increase in consumption of meals that include vegetables **2021: 8/14 (57%)** 5. Explore Concept: Yes/ No **2020: Yes** **2021: Yes- Food Pantry established** **-Total bags distributed= 2,286** **-Total patients served= 907**

					-Total weight of produce distributed= 2,552.8 lbs. **-Total weight of shelf stable items distributed= 13,466.1 lbs.**
Augusta Health Fitness will offer community members medically based fitness programming including Fit4Life and RxEX for free or at a reduced cost.	1. Offer medical fitness sessions twice per week with certified staff and send results to referring provider. 2. Offer free or reduced cost independent fitness memberships to Fit4 Life participants that qualify based on need and provider referral.	Olivia Hall Michael Campbell	Operational	2020-2022	1-2. a) Number and percentage of participants completing the program. **2020:167 participants; 79 completed (47%)** **2021**: **154 participants; 122 completed (79%)** b) Improvement in SF-36 QOL Measure (average pre/post delta). **2020 Percent Improved:** **-Physical Functioning: 12%** **-Emotional Well-being: 1%** **-Social Functioning: 6%** **-Pain: 13%** **General Health: 8%** **-Functional Activity Rating Scale: 13%** **2021 Percent Improved:** **-Physical Functioning: 9%** **-Emotional Well-being: 5%** **-Social Functioning: 6%** **-Pain: 8%** **General Health: 7%** **-Functional Activity Rating Scale: 19%** c) Number and percentage of participants who complete the program and meet visit requirements. **2020:87 enrolled; 31 met visit requirement (36%)** **2021: 35 enrolled; 10 met visit requirement (29%)**

Augusta Health Fitness will promote active lifestyles for children and families through expanded family membership options at the fitness center, family fun days for the community, and collaborative fitness initiatives with local program partners.	1. Expand family memberships at fitness center to include ages 9-12 (previously 13+). 2. Offer Family Fun days twice per year to promote fitness for all ages. 3. Reach out to local program partners to explore collaborative initiatives and youth scholarship opportunities.	Olivia Hall Stephanie Mims	Operational	2021-2022	1. a) Report new family memberships and measure increase year over year. **2020: N/A** **2021: N/A** b) Number of yearly fitness visits for 9-12 year olds. **2020: N/A** **2021: N/A** c) Number of children 9-12 who participate in our child specific group classes. **2020: N/A** **2021: N/A** d) Number of children who participate in our youth personal training program and clinics. **2020: N/A** **2021: N/A** e) Percentage change in participation for youth tennis lessons and clinics. **2020: N/A** **2021: N/A** 2. Number of children and families participating in our family fun day event. **2020: N/A** **2021: 90** 3. Number of collaborations or scholarships formed. **2020: N/A** **2021: N/A**

The Nutrition Awareness Program utilizes the Augusta Health cafeteria, cafes and vending as venues for nutrition information dissemination with regard to healthier food choices and food preparation methods, as well as provides access to healthier foods through the continuation of Sodexo's Mindful Program.	1. Focus on the Jazzman's venue in the Wellness building with a goal of 50% food and beverage items compliant with Sodexo's Mindful criteria. 2. Provide Mindful Meal "punch cards" to use when eating at venues. Free meal after punch card is full. 3. Work with Canteen (vending machine vendor) to make 30% of options healthier choices	Laura Johnson	Operational	2021-2022	1. a) Percent of food and beverage items compliant with Sodexo's Mindful criteria (Goal: 50%) **2020: N/A** **2021: 60% in cafeteria (April-Dec)** b) Number of recipes and other educational materials given out in the cafes and cafeteria. **2020: N/A** **2021: 50 recipes handed out during March for National Nutrition Month** 2. a) Number and percentage of Mindful Meal punch cards redeemed. **2020: N/A** **2021: 0** b) Number and percentage of Mindful meals and food items sold in cafes and cafeteria. **2020: N/A** **2021: N/A** c) Dollar amount of Mindful options purchased. **2020: N/A** **2021: N/A** 3. a) Number and percentage of healthier vending machine food options sold. **2020: N/A** **2021: 2,960 (19%)** b) Number and percentage of healthier vending machine drink options sold. **2020: N/A** **2021: 12,814 (39%)**

Walkability Initiatives such as Walk to School Week, the Walk-Bike Summit, and walking clubs help to promote and increase physical activity in the community by: • Providing a safe space for students to walk to school and learn pedestrian safety • Bringing awareness of how to make Staunton, Augusta County, and Waynesboro more walk and bike-friendly • Promoting physical activity for students during recess time at school	1. Continue Walk to School Week for Waynesboro elementary and middle schoolers. 2. Expand Walk to School Week to Staunton City Schools. 3. Continue to hold the SAW Walk-Bike Summit to determine ways to make our community more walk and bike-friendly. 4. Work with Waynesboro Schools to implement walking clubs for students during their recess time.	Catherine Hill	1. 2020-2022 2. 2020-2022 3. 2020-2022 4. 2020-2022	1. $2,000 (2020) 3. $3,100 4. $1,300	1-2. a) Number and percent of students participating **2020: 0 due to Covid-19** **2021: 1,150 (57%)** b) Percent increase of students participating **2020: 0 due to Covid-19** **2021: 22% decrease from 2019 (less numbers due to Covid-19)** c) Number of steps **2020: 0 due to Covid-19** **2021: 2,012,500** d) Number of schools participating **2020: 0 due to Covid-19** **2021: 5** **-Berkeley Glenn** **-Kate Collins** **-Wenonah** **-Westwood** **-William Perry** 3. a) Number of attendees **2020: 0 due to Covid-19** **2021: 0 due to Covid-19** b) Number of goals/needs that come out of the Summit **2020: 0 due to Covid-19** **2021: 0 due to Covid-19** c) Number of actionable plans that are a result of the summit **2020: 0 due to Covid-19** **2021: 0 due to Covid-19** 4. a) Number and percentage of students participating **2020: 0 due to Covid-19** **2021: N/A** b) Number of laps/miles walked (baseline and percentage increase) **2020: 0 due to Covid-19** **2021: N/A** c) Number of laps walked by students who won end of year award (baseline and percent increase) **2020: 0 due to Covid-19** **2021: N/A**

Grant funds will be awarded to nonprofit organizations whose mission and values align with Augusta Health. Funding will be offered for programs focused on improved nutrition and physical activity.	1. Call for funding applications to be completed on Smarter Select 2. Review funding applications and make funding recommendations through the Funding SubCommittee 3. Following Board approval, award funding to local, non-profit organizations whose mission aligns with the Community Health Needs Assessment priority area of Nutrition and Physical Activity	Krystal Moyers Trisha Fillion	1-3. 2020-2022	$150,000	3. a. Number of organizations that receive funding **2020: 12 (2 restricted for Nutrition and Physical Activity)** **2021: 17 (4 restricted for Nutrition and Physical Activity)** b. Total amount of funding provided **2020: $150,000** **2021: $215,000** c. Number of people in the community impacted by the funding **2020: Data not available until December 2020** **2021: TBD**