2018 - 2021 Farmville Area Community Health Needs Assessment

Town of Farmville and Amelia,
Buckingham, Charlotte,
Cumberland, Lunenburg, Nottoway,
& Prince Edward Counties

CENTRA

Southside Community

www.centrahealth.com/wellness/community-health-needs-assessment

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Acknowledgements

The 2018 Farmville Area Community Health Needs Assessment was the result of numerous hours of leadership and service by the following individuals, institutions, and partnerships.

Partnership for HEALTHY COMMUNITIES

CENTRA Foundation

CENTRA

Community Access Network

Central Virginia VDH Health District

Bedford Community Health Foundation

United Way of Central Virginia

Greater Lynchburg Community Foundation

Working Today For A Healthier Tomorrow
Piedmont Health District

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Executive Summary

Centra Health is pleased to provide the 2018-2021 Community Health Needs Assessment (CHNA) for Centra Southside Community Hospital located in Farmville, Virginia. For the purposes of this report, the service area is referred to as the Farmville Area and includes the town of Farmville and the counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward. The CHNA provides an overview of the health status of the communities served by the hospital system. It is the intent of this report to provide readers with a deeper understanding of the needs of the Farmville Area as well as to guide Centra Health, and its community partners and stakeholders, in developing an Implementation Plan to address the prioritized needs identified as a result of the assessment process. The Community Health Needs Assessment and Prioritization of Needs was approved by the Centra Southside Community Hospital Board of Directors on December 12, 2018, the Centra Foundation Board of Directors on December 12, 2018, and the Centra Board of Directors on December 17, 2018.

The Counties Centra Serves

In 2017, the Partnership for Healthy Communities was formed and is a planning initiative led by Centra, Centra Foundation, the Community Access Network and the Central Virginia, Piedmont, and Pittsylvania/ Danville Health Districts in collaboration with the Bedford Community Health Foundation, Greater Lynchburg Community Foundation, and United Way of Central Virginia. The partners are committed to regional alignment of a collaborative and rigorous needs assessment process that will result in action-oriented solutions to improve the health of the communities they serve. A Community Health Assessment Team composed of 30 individuals with a broad representation of community leaders and cross-sector stakeholders acted to oversee, advise and support the CHNA activities.

The 2018 Farmville Area Community Health Needs Assessment focused on lifting the voice of the community through the collection of 920 Community Health Surveys as well as conducting stakeholder surveys, a stakeholder focus group, and target population focus groups. In addition, over 65 sources of publically available secondary data were collected.

Key Findings

The data for the Community Health Needs Assessment is reported using the framework for the County Health Rankings from the University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation County Health Rankings and Roadmaps. These rankings, released annually, measure the health of a community and rank them against all other counties within a state. The Farmville (Piedmont Health District) service area has striking deficits in health outcomes (which is a measure of the morbidity and mortality of a county) and health factors (which represents what influences the health of a county) as published by County Health Rankings & Roadmaps. Five out of seven localities have health outcome and health factor measures that rank in the bottom 25% of all Virginia localities (N = 133).

TABLE 1: 2018 County Health Rankings

Locality	Health Outcomes Rank	Health Factors Rank
Amelia	48	68
Buckingham	75	114
Charlotte	110	108
Cumberland	101	106
Lunenburg	111	95
Nottoway	105	111
Prince Edward	106	97

1 = Best Ranking; 133 = Worst Ranking

Demographics, Social and Economic Status

The total population for the service area is 102,922 individuals where 51.2% of the population is male and 48.8% is female. The median age is 40.9 years. Approximately 17.8% of the population is 65 years of age or older which is higher than those 65 years of age or older living in Virginia as whole (13.9%). Approximately 62.6% of those living in the service area are White, 32.0% are Black, and 2.5% are Hispanic or Latino.

The median household income in the service area is $42,540 as compared to $66,149 in Virginia. Approximately 43.2% of the population lives at or below 200% of the Federal Poverty Level as compared to 26.6% in Virginia. In Farmville, 62.1% of the population lives at or below 200% of the Federal Poverty Level. Additionally, approximately 38% of the 36,548 households in the service area are classified as Asset Limited, Income Constrained, Employed.

Of the public school-aged children in the service area, 65.9% (8.424) are eligible for free and reduced lunches as compared to 44.31% of children in the Commonwealth. This is even more pronounced for children attending Buckingham, Cumberland and Prince Edward County Schools where 74 to 76% are eligible for free and reduced lunches. More than half of children (54.9%) living in the Farmville service area live at or below 200% of the Federal Poverty as compared to 34.0% in Virginia which is an estimated 11,026 children. The greatest concentration of these children are living in Charlotte, Cumberland, Lunenburg, Nottoway and Prince

Edward counties.

Although unemployment rates continue to decrease in the service area, they are higher across all localities compared to the rate of 3.8 in Virginia with the highest unemployment rate in Buckingham County (5.4) followed closely by Prince Edward County (5.1). In the service area, of the population age 25 and over, educational attainment is 29.7% for less than high school graduate; 16.6% for high school graduate or equivalency; 10.0% for some college or Associate's Degree; and 4.2% for Bachelor's Degree or higher.

The majority of Community Health Survey respondents (92%) lived in the Farmville Area with a median age of 46 years. A disproportionate number of females (84.2%) completed the survey as compared to males (15.3%). Fewer survey respondents were White and more were Black/African American as compared to the service area population as a whole and fewer were Hispanic or Latino. More than 57.1% of survey respondents reported an annual income of $30,000 or less per year and 19.7% reported an annual income greater than $70,000. An estimated 61.9% of respondents lived no greater than 200% of the Federal Poverty Level. Survey respondents had higher education attainment rates than the population as a whole and over 40% were employed full-time with an additional 19.1% reporting they were retired. Approximately 30% of respondents reported not having enough money in the past 12 months to buy food or pay their rent or mortgage and 30% could not afford to pay for their medications.

Health Behaviors

The obesity rate for the service area is 32.6% with the highest rates in Nottoway (34.5%) and Buckingham (34.0%) counties. Approximately 20% of Community Health Survey respondents reported being overweight while 52% reported being obese. A greater proportion of the population report no leisure time physical activity especially in the rural communities of Buckingham (34%), Charlotte (29%), Lunenburg (28%), Amelia (27%) and Nottoway Counties (27%) as compared to 22% of adults in the Commonwealth.

Approximately half of Community Health Survey respondents reported that their neighborhoods don't support healthy eating or physical activity while over 40% reported it is not easy to get affordable fresh fruits and vegetables in their neighborhoods. Although the large majority of respondents reported that they get their food from grocery stores, it is important to note that 36% use a Dollar Store, 34.8% use take-out/fast foods, 26.2% use home gardens, 21.9% use farmers markets, and 18% use food pantries for the food they eat. Additionally, the majority of respondents did not meet the minimum requirements for daily fruit and vegetable consumption. Secondary data reveals that 30% of the population in Nottoway, 24% in Cumberland, 15% in Charlotte, and 12% in Prince Edward counties have limited access to healthy foods as compared to 4.3% in Virginia. This represents the percentage of the population that is low income and does not live close to a grocery store.

Data for the service area reveals that 14-17% report binge or heavy drinking while 16-20% are current tobacco smokers. More than 60% of Community Health Survey respondents reported using tobacco products, 39% reported binge drinking during one occasion, while approximately 4% reported using illegal drugs in the past 30 days.

On June 1, 2017, based on a range of drug overdose indicators, the Virginia State Health

Commissioner declared a Public Health Emergency for Virginia as a result of the opioid addiction epidemic. In the same year Charlotte County had the highest mortality rate due to prescription opioids among service area localities while Buckingham County had the highest mortality rate from Fentanyl and/or Heroin use.

Clinical Care

All of the localities in the service area are federally designated as Medically Underserved Areas and as Health Professional Shortage Areas for Primary Care, Dental and Mental Health. There are six Federally Qualified Health Centers (FQHCs) and one Free Clinic that serve the area.

Over 80% of Community Health Survey respondents reported having a usual source of medical care. Of those who use medical services, the large majority get their care at a doctor's office or Centra Medical Group (48.8% and 34.5% respectively) however 26.8% also reported using the Emergency Room. Over 37.5% of respondents do not use dental services and of those who do, 47.5% reported not having a dental exam within the past 12 months. Even more striking is that approximately 90% of respondents reported not using mental health or substance use services.

A similar number of survey respondents (16.7%) were uninsured as compared to the service area as a whole (16.5%) while more respondents were publically insured (24.9% Medicaid, 24.9% Medicare) as compared to the service area (14.4%, 6.1% respectively). In June of 2018, the Virginia General Assembly expanded Medicaid coverage for individuals with incomes up to 138% of federal poverty level and now includes able-bodied adults without children who had previously been ineligible for coverage. In Virginia, it is estimated that an additional 400,000 residents will qualify. In the Farmville Area, it is estimated the number of uninsured residents who will be newly eligible for Medicaid is 5,380 with the largest majority living in Prince Edward County.

When asked which services are hard to get in the community, survey respondents reported (1) safe and affordable housing; (2) adult dental care; (3) affordable food; (4) transportation; and (5) specialty care. When asked what prevents them from getting the services they need, survey respondents reported (1) cost; (2) high co-pays; (3) long waits for appointments; (4) lack of evening and weekend services; and (5) don't know what types of services are available.

Ten percent (10.2%) of survey respondents reported more than two weeks of physically unhealthy days while 11.1% reported more than two weeks of mentally unhealthy days in the past month. Additionally, survey respondents diagnosed with a chronic condition had high blood pressure, depression or anxiety, obesity/overweight, diabetes, or high cholesterol most frequently. In the service area, death rates are higher for overall deaths; premature deaths; deaths due to injury; hypertension; stroke; and heart disease while cancer incidence rates are higher for lung, colon and rectal cancers as compared to Virginia as a whole. Three of the service area's seven localities (Buckingham, Nottoway, and Prince Edward) have suicide rates higher than the overall state rate. Infant mortality rates and teen birth rates were higher for the service area as compared to Virginia as a whole.

Physical Environment

The physical environment can impact a wide range of health and quality-of-life outcomes and include such factors as the natural environment, transportation, the built environment, housing, exposure to toxic substances, and physical barriers especially for those living with disabilities. In the service area, 6,145 (16.4%) of households have severe housing problems with the largest number in Nottoway County where 1,100 households (20.0%) have severe housing problems. Housing problems include overcrowding, high housing costs, or lack of kitchen or plumbing facilities. Additionally residential segregation (the degree to which two or more groups live separately from one another in a geographic area) is highest in Nottoway. Regarding access to transportation, approximately 11% of Community Health Survey respondents do not own a car and 18.6% rely on friends and family for transport.

Prioritization of Needs

Upon completion of primary and secondary data collection, the Farmville Area Community Health Assessment Team (CHAT) was charged with prioritizing the needs of the community on September 27, 2018. A "Prioritization of Needs Worksheet" was developed based on the importance placed on areas of need identified through two methods:

1. Responses from the Community Health Survey (Top 25 responses)
   a. Q5. Thinking about the community, what are the five most important issues that affect the health of the community?
2. Responses from the Stakeholders' Survey and Focus Group Meeting (Top 31 responses)
   a. Q1. What are the top 5 greatest needs in the community(s) you serve?

CHAT members were asked to rank the needs from 1 to 10, with 1 being the greatest need and 10 being the 10th greatest need.

The 2018 Prioritization of Needs Top 10 Rankings for the Farmville Area includes:

1. Access to affordable health care
2. Access to healthy foods
3. Access to affordable housing
4. Diabetes
5. Access to mental services; mental health problems
6. Substance use; alcohol and illegal drug use
7. Overweight and obesity
8. Transportation
9. Poverty
10. Poor eating habits

Project Background

A. Organizational Overview

Centra Health (Centra) is the dominant regional nonprofit healthcare system based in Lynchburg, Virginia. The mission of the organization is "*excellent care for life*" with a vision "t*o be the most trusted provider of innovative healthcare.*" It was created with the merger of Lynchburg General Hospital (LGH) and Virginia Baptist Hospital (VBH) in 1987. In 2006, Southside Community Hospital in Farmville joined Centra as an affiliate. In 2014, Bedford Memorial Hospital in Bedford joined Centra's network and became the 4th hospital in the system. Altogether there are 685 licensed acute care beds throughout the system. In 2017, there were 29,744 medical/surgical, 2,591 psychiatry, 61 substance use, and 327 acute rehab discharges throughout the Centra network.

With more than 7,500 employees and a medical staff of nearly 700 providing care in 64 locations, Centra serves over 380,000 people throughout central and southside Virginia and provides a comprehensive array of medical services in a variety of convenient settings. Centra serves patients across 9000 square miles, a geographic area larger than the state of New Jersey. Centra's service to the community and commitment to excellent care are demonstrated by its many physician practices, outreach programs, screenings and diagnostic tests, educational media and publications, and community health programs. In addition to its hospitals, Centra owns Piedmont Community Health Plan, with a total fully-insured membership of 17,629; the Centra College of Nursing with campuses in Lynchburg and Bedford; and the Centra PACE program.

Centra Southside Community Hospital (CSCH) located in Farmville, Virginia is a 116-bed full-service acute care facility with a state-of-the art birth center, serving a medical hub for an eight-county region. Each year, Southside has approximately 4,000 admissions and sees more than 36,000 patients in its emergency department. The hospital has a long rich history in the community that started in 1925 when a group of citizens set out to obtain a hospital that would serve all residents

as well as measure up to "big city" standards of medicine in a rural setting. CSCH has been the healthcare center of Southside Virginia since opening its doors on November 9, 1927. Since then it has operated on a non-profit basis whose mission is "i*mproving the quality of life in the communities we serve by providing high-quality healthcare with a personal touch*". The hospital now serves the residents of Amelia, Appomattox, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward Counties.

Since 2008, the Alan B. Pearson Regional Cancer Center, located one hour away in Lynchburg, has been providing medical oncology and radiation oncology services for central and southside Virginia. It has earned Accreditation with Commendation as a Comprehensive Community Cancer Program from the American College of Surgeons Commission on Cancer. In addition to radiation and medical oncologists, the multidisciplinary team includes a broad range of expertise from nurse practitioners and nurses to clinical trials, patient navigators, social workers, and chaplaincy staff members.

Centra Medical Group (CMG), with 450 employed advanced practice providers and physicians, is a network of local family practices, primary care physicians, and specialty practices in cardiology, gerontology, neurosurgery, orthopedics, physiatry, psychiatry, rehabilitation and urology covering the greater Lynchburg area and spanning to Amherst, Bedford, Big Island, Danville, Farmville, Gretna and Moneta. In addition, CMG- Lynchburg Family Medicine Residency is a training ground for future Family Physicians. Many of the physicians at the site hold academic appointments with the University of Virginia, Virginia Commonwealth University, Edward Via College of Osteopathic Medicine, and Liberty University.

Since 2014, Centra Medical Group has opened five primary care and multispecialty Medical Centers in areas of need including Gretna Medical Center in Pittsylvania County, Danville Medical Center, Amherst Medical Center, Farmville Medical Center, and Lynchburg Medical Center. The facilities offer primary care, diagnostic services and other specialty care under one roof. The Gretna Medical Center also includes a 10 room emergency department with two trauma bays, a CT scanner, on-site ambulance and helipad. Previously, residents in this rural region had to drive 30 minutes or more to the nearest hospital for emergency and diagnostic services.

Patient care encompasses wellness and prevention, recognition of disease and health, patient teaching and advocacy, spirituality and research. Under the auspices of Centra, physicians, registered nurses and allied health care professionals function collaboratively as part of an interdisciplinary team to achieve positive patient outcomes. Patient care at Centra occurs through organized and systematic processes designed to ensure safe and effective care and timely treatment. Patient care providers recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each patient served.

The mission of the Centra Foundation is to develop resources to enhance and enrich the services, programs and facilities of Centra Lynchburg General, Centra Virginia Baptist, Centra Bedford Memorial and Centra Southside Community hospitals and other subsidiaries in order to assist the Centra system in meeting and solving community health problems. To support community efforts in meeting the area's health needs, Centra established the Centra Community Health Initiative Fund. Administered by the Centra Foundation, this fund provides support to community organizations whose services align with the priorities established through the Community Health Needs Assessment.

B. Scope and Purpose of Community Health Needs Assessment

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

Centra defines its triennial Community Health Needs Assessment (CHNA) as a continuous process for evaluating the health needs of the communities served. The reasons for doing this are varied, but most importantly it is to support the system's overall mission and vision to improve the health status of the community. The CHNA is a key driver of Centra's strategic planning process and is used to design and implement new services, programs, and partnerships in response to identified unmet community health needs. In addition, the CHNA and Implementation Plan are used to guide the actions of Centra Foundation's Community Health Initiative, which provides grant funding for the area non-profit organizations delivering needed healthcare services to the community. The fund supports community health projects and programs, consistent with the prioritized needs identified during the CHNA process. Lastly, the completion of both the triennial Community Health Needs Assessment and successful execution of the associated Implementation Plan ensures compliance with the Patient Protection and Affordable Care Act of 2010 which is promulgated in regulation by the Internal Revenue as documented annually in Centra's Form 990- Schedule H.

C. Project Overview

"Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be." (Healthy People 2020, Social Determinants of Health at https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health)

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

and Health Systems, Issue Brief- Robert Wood Johnson Foundation at https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf435716, pages 3-4)

In order to ensure we all have the opportunity to live in vibrant healthy communities, it is important to assess the strengths, weaknesses and unique resources across all sectors of each community and to listen to those who live, work and play there. A community-driven assessment provides the data and information that allows us to take action and develop goals and strategies that can contribute to long-lasting social changes and positive health outcomes. Recognizing the importance of these collaborative efforts, in 2017, Centra and the Centra Foundation contracted with the Community Access Network (CAN) in Lynchburg, Virginia to lead efforts for Centra's triennial Community Health Needs Assessment (CHNA) and Implementation Planning. CAN has proven experience in actively listening to community members and involving them in decision-making resulting in programs and services that respond to the needs of the most vulnerable in the community.

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

In Virginia, a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) are a Virginia Department of Health (VDH) requirement for all health districts every 5 years. This process is required to achieve health department accreditation as administered by the Public Health Accreditation Board (PHAB). In April of 2018, "the VDH and Virginia Hospital and Healthcare Association (VHHA) formed a new partnership to improve the population health in the Commonwealth. The Partnering for a Healthy Virginia Initiative will coordinate efforts between VHHA and its member hospitals and health systems, and VDH, local health departments, local jurisdictions, the medical community, and other stakeholders to address population health. This work will be informed by the findings of current and future community health needs assessments (CHNA)." A Memorandum of Agreement establishing this effort was signed by both the VDH and VHHA. (Virginia Hospital & Healthcare Association, Communications- Virginia Hospitals, Virginia Department of Health Partner on New Population Health Effort. http://www.vhha.com/communications/virginia-hospitals-virginia-department-of-health-partner-on-new-population-health-effort/)

The Piedmont Health District (PHD) of the Virginia Department of Health serves the counties of Amelia, Buckingham, Cumberland, Charlotte, Nottoway, Lunenburg, and Prince Edward. The district covers over 3100 square miles and is a rural district with the principle population focal center in Farmville, located in Prince Edward County. PHD's mission is *to achieve and maintain optimum personal and community health.* PHD has been aligning their CHA/CHIP

with the previous Centra CHNA's and Implementation Plans. Piedmont Health District is proud to serve the population to promote the mission of the Virginia Department of Health to be the healthiest state in the United States.

In addition to meeting with the Piedmont Health District in 2017, CAN met with other organizations that conduct regular needs assessments including local foundations, community services boards, departments of social services, community action agencies, and safety net providers (free clinics and federally qualified health centers). It was found that the CHNA/Implementation Plan fulfilled their requirements and these organizations agreed the data from the CHNA would be used to develop organizational implementation plans that will feed into and support Centra's Implementation Plans for its three hospital service areas.

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

For more than 30 years the Bedford Community Health Foundation (BCHF) has been supporting area organizations that provide health related services to the citizens of Bedford County. The foundation works to identify and address community health issues by leading initiatives and providing funding. In that time, BCHF has provided more than $5.5 million in grants and scholarships to Bedford residents. The Greater Lynchburg Community Foundation is committed to enhancing the lives of central Virginians through the provision of grants and scholarships to nonprofits and students in the city and the four surrounding counties. These totaled over $1.7 million last year alone and benefitted 169 different nonprofits and thousands of people. The United Way of Central Virginia's (UWCV) mission is to mobilize the compassionate power of our community to improve the quality of lives in Central Virginia. In the past year, UWCV funded 38 programs through its partner agencies, investing $1.5 million in the community impacting over 60,000 people living in the counties of Amherst, Appomattox, Bedford, and Campbell and the city Lynchburg.

A Core Team was developed with the Partnership for Healthy Communities partners and includes representatives from each of the entities involved. In addition, CAN contracted with CommunityWorks in Roanoke, Virginia for Project Management of the 2018 Community Health Needs Assessments and with Christopher Nye Consulting in Stuarts Draft, Virginia for data collection and analysis. Students from Centra College of Nursing, Liberty University and Virginia Commonwealth University contracted with CAN to perform data entry of the primary data.

In addition to the Core Team, a Community Health Assessment Team (CHAT) made up of over 30 individuals with a broad representation of community leaders and cross-sector stakeholders in the service area was developed. The role of the CHAT is to oversee, advise and assist in CHNA data collection activities, prioritize needs, and participate in the development of the Implementation Plan as appropriate. A list of these individuals is presented in the "Acknowledgements" section of this report.

CHNA activities began in March 2018 and concluded in September with the Prioritization of Needs. A timeline and work plan was created for the 2018-19 CHNA and Implementation Planning process for all Centra catchment areas. The work plan included an expansion of Centra's previous primary data collection to include a Community Health Survey, target population focus groups and stakeholders' focus group as well as secondary data collection.

Activity	Date
CHAT: Launch of CHNA activities Presentation of Draft Secondary Data	March 29, 2018
Data Collection: Primary & Secondary Data	April- July 2018
CHAT: Presentation of Community Health Survey Findings	August 30, 2018
CHAT: Presentation of Focus Group Summaries Prioritization of Needs	September 27, 2018
Centra Board Approval of CHNA: • Centra Southside Community Hospital Board of Directors • Centra Foundation Board of Directors • Centra Board of Directors	 December 12, 2018 December 12, 2018 December 17, 2018
Implementation Planning	January – April 2019
Centra Board Approval of Implementation Plan	By June 15, 2019

The Centra Executive Leadership Team received briefings during the assessment period prior to the launch of the CHNA activities on February 15, 2018 and again prior to the formal CHNA approval process on November 1, 2018. Several members of the Executive Leadership Team were also members of the Community Health Assessment Team.

The 2018 Farmville Area Community Health Needs Assessment and Prioritization of Needs was presented for approval to the Centra Southside Community Hospital Board of Directors on December 12, 2018, the Centra Foundation Board of Directors on December 12, 2018, and the Centra Board of Directors on December 17, 2018. Upon approval, the Community Health Needs Assessment was made publically available on the Centra website which was widely shared with Community Health Assessment Team and other key community stakeholders and leaders.

D. Service Area

The service area for the 2018 Farmville Area Community Health Needs Assessment (CHNA)

includes the counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward and the town of Farmville. These localities are served by the Piedmont Health District. The service area was determined by assessing 80% of the hospital discharges for Centra Southside Community Hospital by zip code and locality for the 2nd Quarter 2016 to 1st Quarter 2017 (Source: Virginia Health Information, Truven Health Analytics, January 2018).

The findings revealed:

Southside Community Hospital Discharge Summary		
Locality		
Prince Edward	1,575	37.3%
Nottoway	680	16.1%
Charlotte	447	10.6%
Buckingham	234	5.5%
Lunenburg	168	4.0%
Cumberland	158	3.7%
Appomattox*	148	3.5%
	3,410	80.8%

*Appomattox will be included in the 2018 Lynchburg Area (Centra Lynchburg General, Virginia Baptist, and Specialty Hospitals) Community Health Needs Assessment and is served by the Central Virginia Health District.

Although Amelia County was not included in the top 80% of hospital discharges for Centra Southside Community Hospital, it is included in the Farmville Area CHNA to align with the area served by the Piedmont Health District.

The Farmville Area is one of the largest and most sparsely populated areas in Virginia. Largely rural in nature and encompassing 3,118 square miles, the region consists of the town of Farmville and the counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward. Part of the Piedmont region of Virginia, the area boasts rolling hills, agricultural fields, state parks, forests, lakes and rivers including the James and Appomattox rivers. It is a destination point for wildlife and outdoor recreation enthusiasts and is steeped in US history and architectural heritage. Amelia and Charlotte counties are close to the state capitol of Richmond and Fort Pickett, a Virginia Army National Guard installation, is located in Nottoway County.

Prince Edward County is located in “the Heart of Virginia”, at the crossroads of US 460 and US 15, two of Virginia’s primary east-west and north-south transportation corridors, which provides direct access to four interstate highway systems: I-95, I-85, I-81 and I-64 and serves as the commercial hub for the region. (www.co.prince-edward.va.us) The town of Farmville, is the county seat and is approximately 64 miles west of the city of Richmond, 47 miles east of the city of Lynchburg and 76 miles south of the city of Charlottesville. Farmville is home to both Hampden-Sydney College and Longwood University which play a significant role in the vitality of its downtown area. The town is a destination for tourism, recreation, retirement and

trade not only because of its attention to infrastructure, but also because of its attention to its beauty. (www.farmvilleva.com)

E. Target Population

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

F. Methodology

The 2018 Farmville Area Community Health Needs Assessment (CHNA) incorporated an expanded community "voice" (primary data) as well as the collection of over 65 sources of publically available secondary data. In addition, information regarding available community resources was gathered. Primary data included findings from a Community Health Survey; Stakeholders' Focus Group and Survey; and Target Population Focus Groups. Details on the specific methodology and findings of the primary and secondary data components are included in the following sections.

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

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

- Length of Life (Mortality)
  - Premature death
- Quality of Life (Morbidity)
  - Health-related quality of life (overall health, physical and mental health)
  - Birth outcomes

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

- Social and Economic Factors (accounts for 40% of what influences health)
  - Community safety
  - Education
  - Employment
  - Family and social support
  - Income
- Health Behaviors (accounts for 30% of what influences health)
  - Alcohol and drug use
  - Diet and exercise
  - Sexual activity
  - Tobacco use
  - Other behaviors

- Clinical Care (accounts for 20% of what influences health)
  - Access to care
  - Quality of care
- Physical Environment (accounts for 10% of what influences health)
  - Air and water quality
  - Housing and transit

(http://www.countyhealthrankings.org/)

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

Primary Data

Community Health Survey

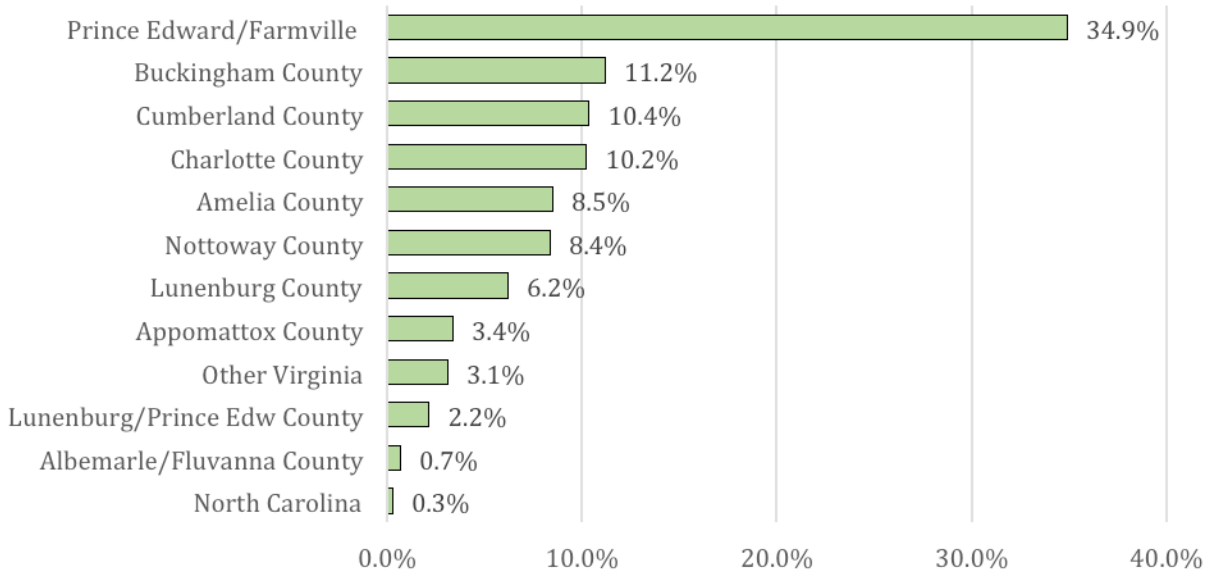
A Community Health Survey was administered to Farmville Area community residents, 18 years of age and older, from April 15, 2018 to June 15, 2018. The survey tool was developed by Carilion Clinic and Healthy Roanoke Valley headquartered in Roanoke, Virginia and adopted by the Partnership for Healthy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

The Community Health Survey was administered both electronically through a publically available link via Survey Monkey and through paper surveys (which were in turn entered into Survey Monkey). Paper surveys were available in both English and Spanish. All survey respondents were offered the opportunity to enter a raffle to win a $25 gift card if they completed the survey. In addition to marketing the survey to the general population, attempts were made to oversample the target population in the service area. Members of the Community Health Assessment Team (CHAT) who serve and represent the target population, were asked to assist in advertising and distributing the survey (both electronically and paper) to their client base. In addition, the survey link was advertised in local newspapers, on social media, and through a mass email to all Centra staff.

A total of 920 surveys were collected with an 88% completion rate (respondents could skip questions). All responses for the Farmville Area Community Health Survey can be found in the Appendix. Findings of the Community Health Survey were presented to the Farmville Area CHAT on August 30, 2018:

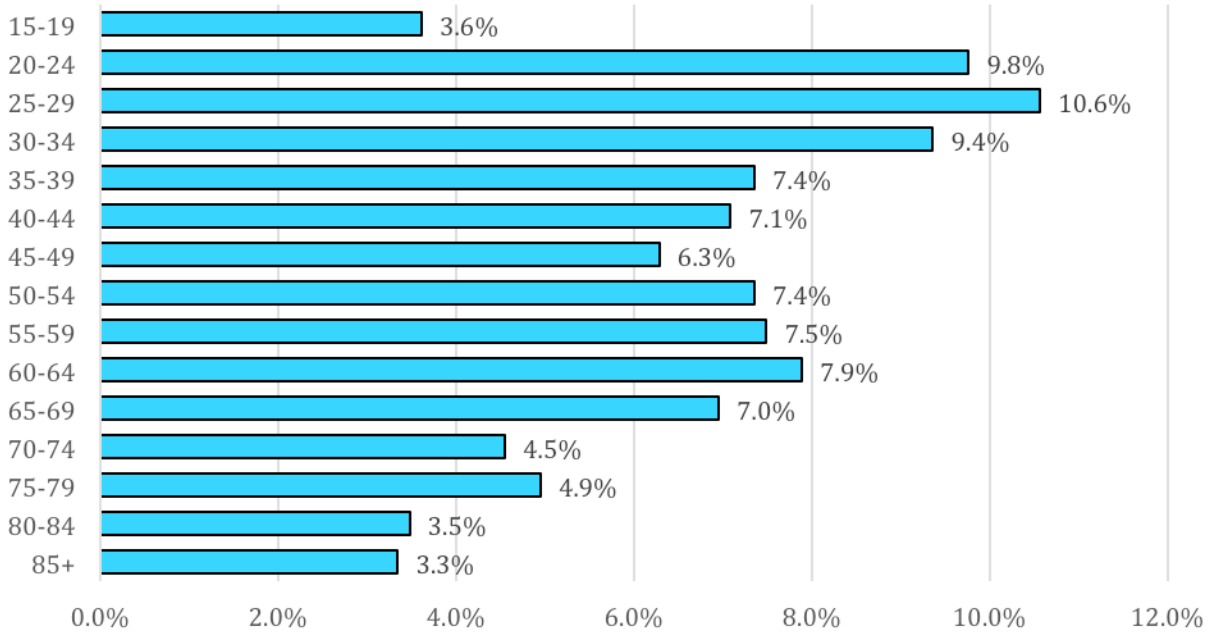
Social and Economic Status

Q25. What is your zip code?



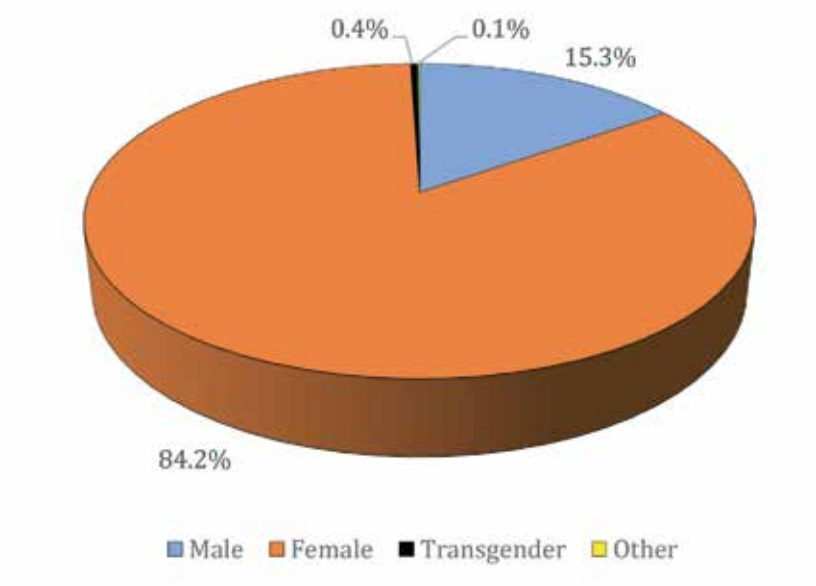
The majority of respondents (92%) lived in the service area.

Q26. What is your age?



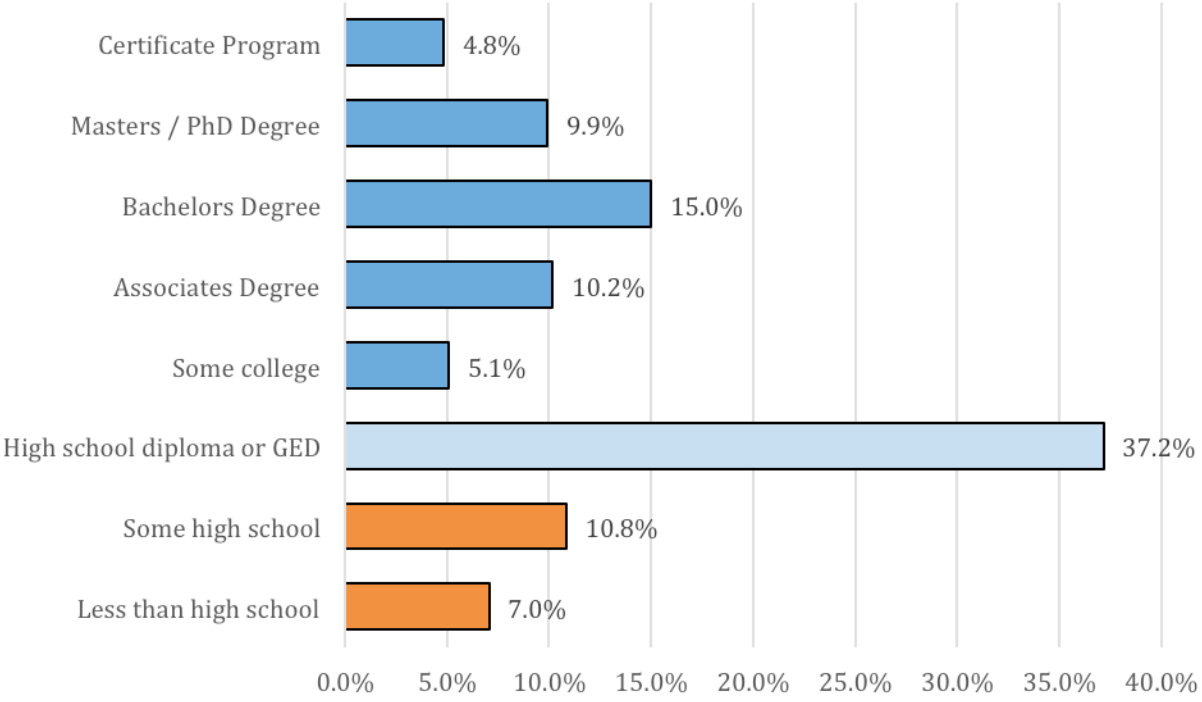
The median age of respondents was 46 years which is higher than the median age of 40.9 years in the service area. (US Census. American Fact Finder. ACS Demographic and Housing Estimates. 2012-2016 American Community Survey Estimates)

Q27. What is your gender?



A disproportionate amount of females completed the survey as compared to males. In the service area, 51.2% of the population is male and while 48.8% of the population is female (US Census. American Fact Finder. American Community Survey Demographic and Housing Estimates 2012-2016).

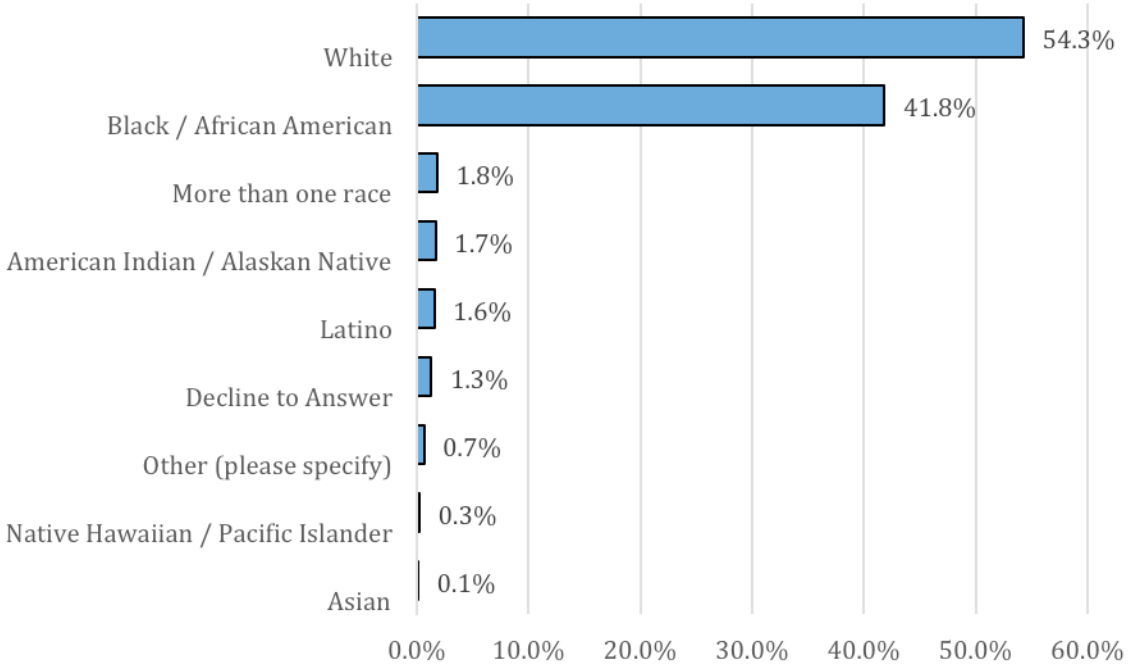
Q32. What is your highest education level completed?



Survey respondents had higher education attainment rates than the population as a whole. In the service area, of the population age 25 and over, educational attainment is 20.7% for less than high school graduate; 37.5% for high school graduate or equivalency; 25.9% for some college or Associate's Degree; and 15.9% for Bachelor's Degree or Higher. (US Census.

American Fact Finder, Educational Attainment 2012-2016 American Community Survey 5-Year Estimates)

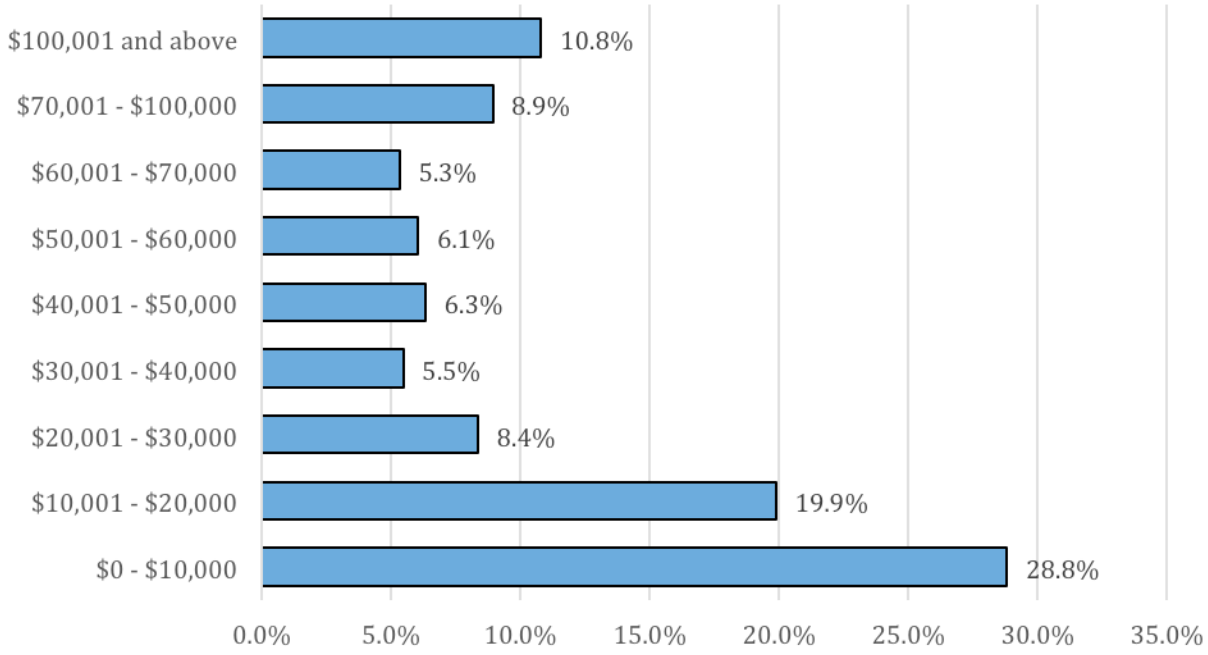
Q34. What ethnicity do you identify with? (Check all that apply)



Of those completing the survey, more than 95% reported that English is their primary language (Q33). In the service area as a whole, 3.4% of residents speak a language other than English at home (US Census, American Fact Finder. American Community Survey 5-Year Estimates 2012-2016).

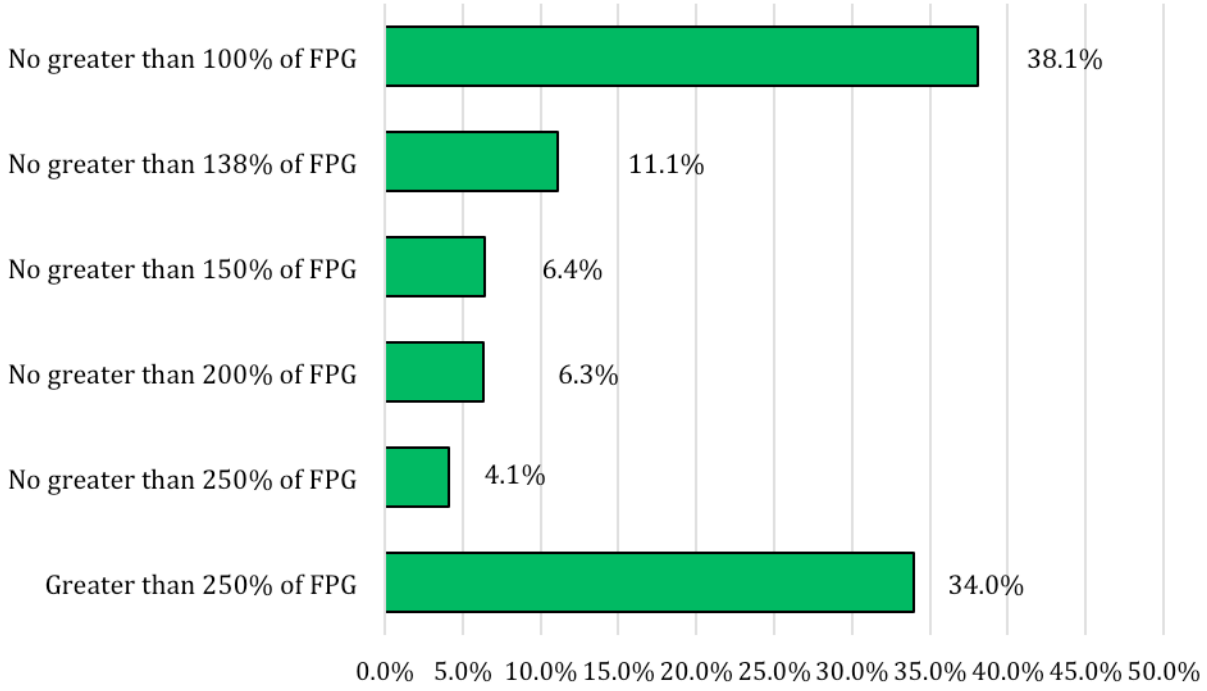
Compared to the population by race for the service area, fewer survey respondents were White (54.3% compared to 62.6% for the entire service area); more respondents were Black (41.8% compared to 32.0% for the entire service area); and fewer respondents were Latino (1.6% compared to 2.5% for the service area). (US Census. American Fact Finder. Demographic and Housing Estimates. 2012-2016 American Community Survey 5-year Estimates)

Q36. What is your yearly household income?



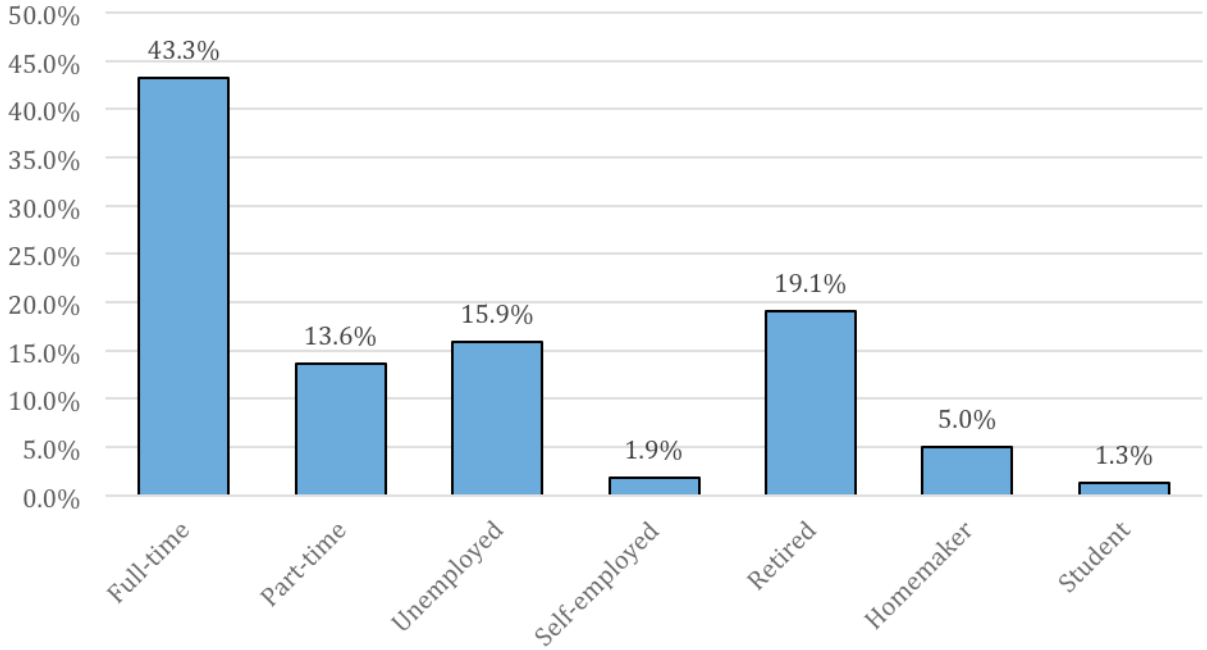
In the service area, the average median income is $42,540 (US Census. American Fact Finder. Median Income in the Past 12 Months, 2012-2016 American Community Survey 5-Year Estimates). Of the survey respondents, 57.1% reported an annual income of $30,000 or less per year, 23.2% reported an annual income between $30,000 and $70,000 and an additional 19.7% reported an annual income greater than $70,000.

Of respondents who reported the number living in their household (Q31), "Income as a Percent of Federal Poverty Guidelines" was estimated comparing the reported annual income with household size to the 2018 published Federal Poverty Guidelines (FPG).



Based on these estimates, more of the survey respondents (61.9%) lived no greater than 200% of the FPG's with 38.1% of respondents living no greater than 100% of FPG's as compared to the total service area population where 43.2% live at or below 200% of FPG's and 20.2% live at or below 100% of FPG's. (US Census. American Fact Finder, 2012-2016 American Community Survey 5-Year Estimates)

Q37. What is your current employment status?



Almost 20% of respondents reported being retired and 16% were unemployed. Additionally,

12.7% of survey respondents reported receiving disability benefits (Q38) while 5.7% of survey respondents were Veterans (Q30).

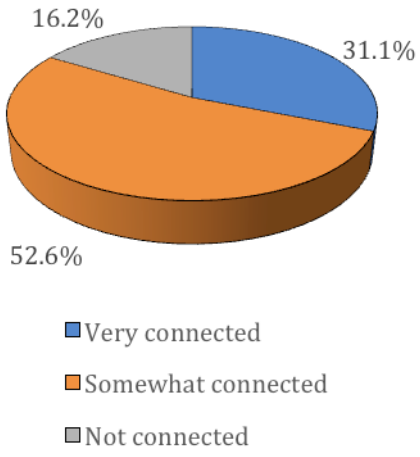
In addition to reporting their demographic and socioeconomic status, survey respondents were asked questions regarding the affordability of basic needs, their personal safety, and family and social support.

Question	Yes (%)	No (%)	N/A (%)
8(i) I can afford medicine needed for my health conditions.	52.23	29.97	17.80
8(p) Have there been times in the past 12 months when you did not have enough money to buy the food that you or family needed?	31.79	68.21	
8(q) Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?	28.26	66.62	5.12

Of those who responded, roughly 30% cannot afford their medications and did not have enough money to buy food and/or pay their rent or mortgage in the past year.

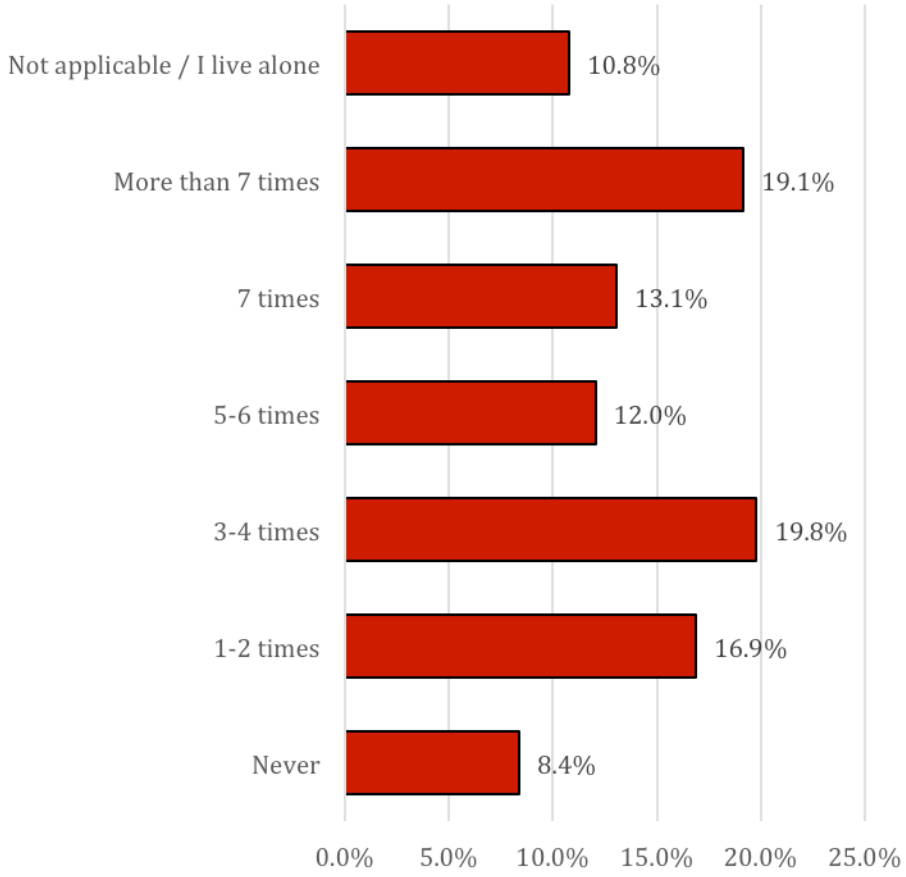
Question	Yes (%)	No (%)
8(f) I have been a victim of domestic violence or abuse in the past 12 months.	2.16	97.84
8(r) Do you feel safe in your neighborhood?	92.67	7.33

Q14. How connected do you feel with the community and those around you?



Over 68% of respondents feel somewhat or not connected to their community.

Q16. During the past 7 days, how many times did all, or most, of your family living in your house eat a meal together?



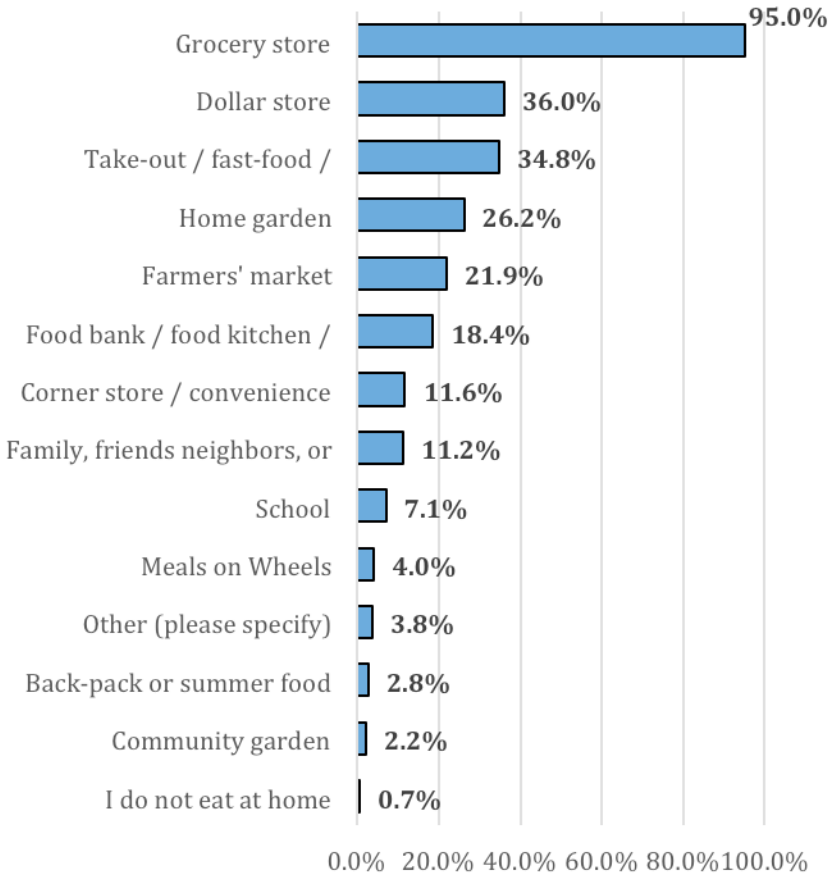
Eating meals together daily is associated with decreased risky behaviors especially in youth. Of those who responded to this question, 45% ate meals together 3 to 4 times per week or less. (The Benefits of the Family Table, American College of Pediatricians, May 2014, https://www.acpeds.org/the-college-speaks/position-statements/parenting-issues/the-benefits-of-the-family-table.)

Health Behaviors

Question	Yes (%)	No (%)
8(m) Does your neighborhood support physical activity such as parks, sidewalks, bike lanes, etc.?	43.75	56.25
8(n) Does your neighborhood support healthy eating such as community gardens, farmers' markets, etc.?	51.37	48.63
8(o) In the area that you live, is it easy to get affordable fresh fruits & vegetables?	58.56	41.44

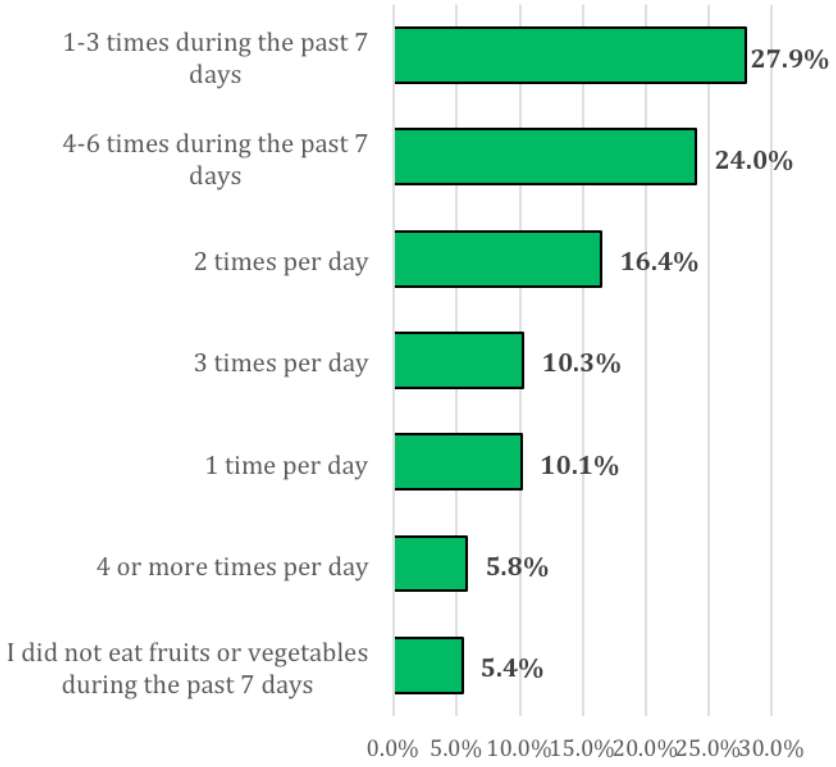
Roughly half of respondents reported that their neighborhoods don't support healthy eating or physical activity while over 40% reported it is not easy to get affordable fresh fruits and vegetables in their neighborhoods.

Q9. Where do you or your family get the food that you eat? (Check all that apply)



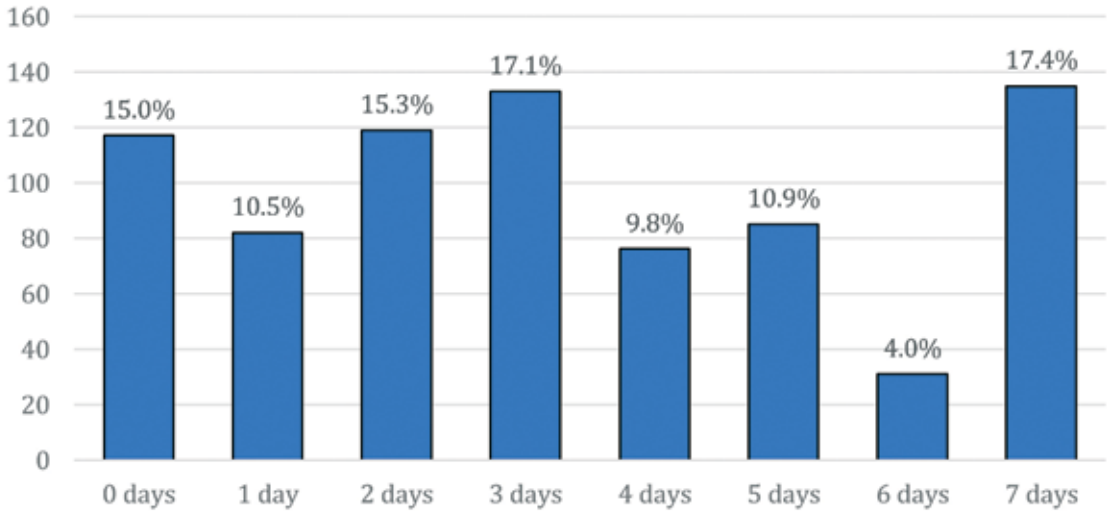
Although the large majority of respondents reported that they get their food from grocery stores, it is important to note that approximately 35% get their food from a Dollar Store and/ or take-out, fast food restaurant while almost one-fourth of respondents get their food from home gardens and farmers' markets.

Q10. During the past 7 days, how many times did you eat fruits or vegetables (fresh or frozen)?



According to the USDA's MyPlate recommendations, adults should get 5 to 9 servings of fruits and vegetables daily. (https://www.choosemyplate.gov/) Survey responses revealed that the majority of respondents did not meet the minimum requirements for fruit and vegetable consumption with only 5.8% eating fruits and vegetables 4 or more times per day.

Q15. In the past 7 days, on how many days were you physically active for a total of at least 30 minutes? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard for some of the time).

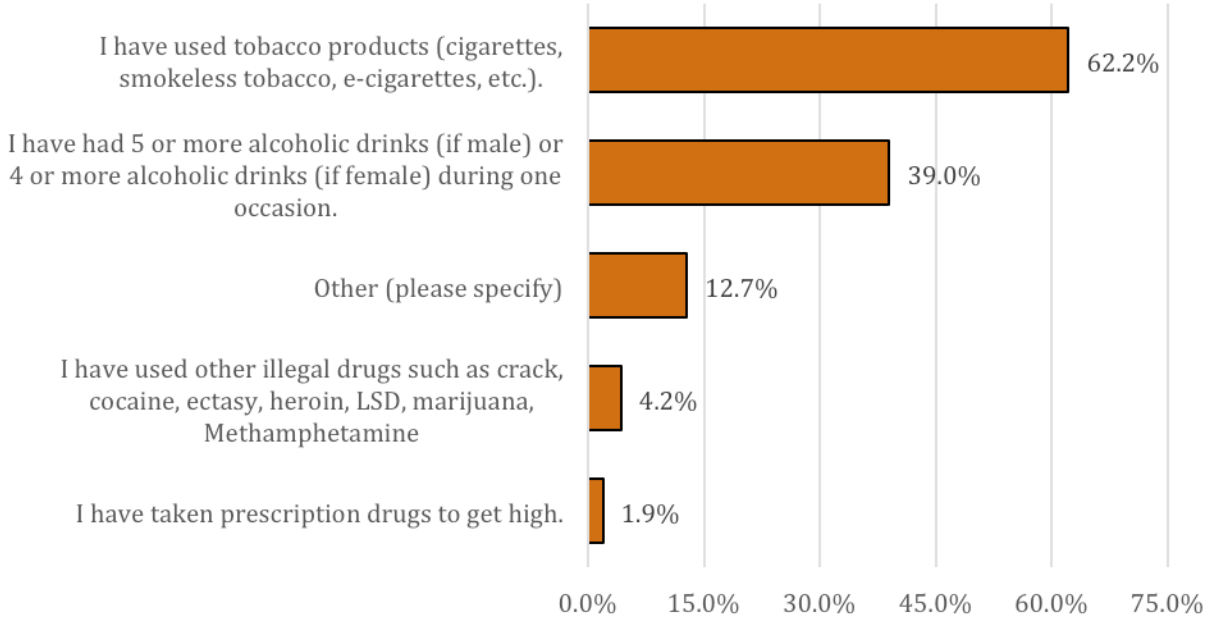


For most healthy adults, the Department of Health and Human Service recommends at least 150 minutes a week of moderate-intensity or 75 minutes a week of vigorous-intensity physical activity or an equivalent combination. (https://health.gov/dietaryguidelines/2015/guidelines/appendix-1/). Of the survey respondents, only 32% met the guidelines.

Survey respondents were asked to report their height and weight (Q28, Q29). From these responses, Body Mass Index was calculated and revealed that 25% of respondents were overweight and 52% were obese.

BMI Range	Percent of Population	Frequency
Underweight <19	4%	25
Normal Weight 19-25	25%	176
Overweight 26-30	20%	141
Obese >30	52%	372

Q20. During the past 30 days: (Check all that apply)

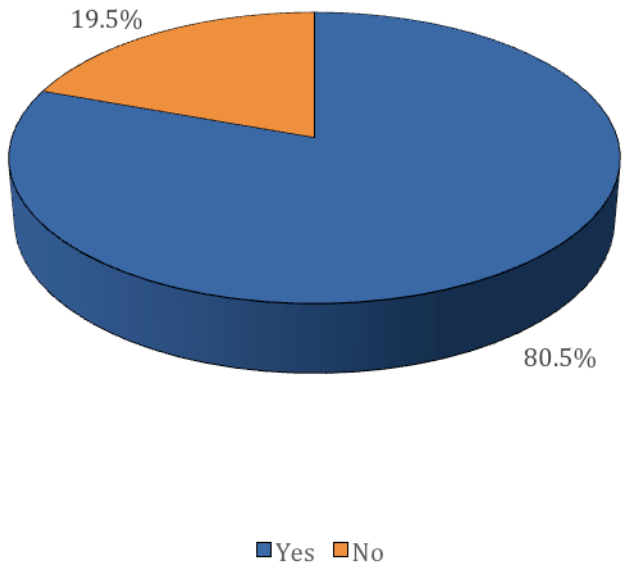


More than 60% of survey respondents reported using tobacco products, 39% reported binge drinking during one occasion, while 6.1% reported using illegal or prescription drugs to get high in the past 30 days. Of those that replied “other” (n=31), 96% reported “none” or “not applicable”.

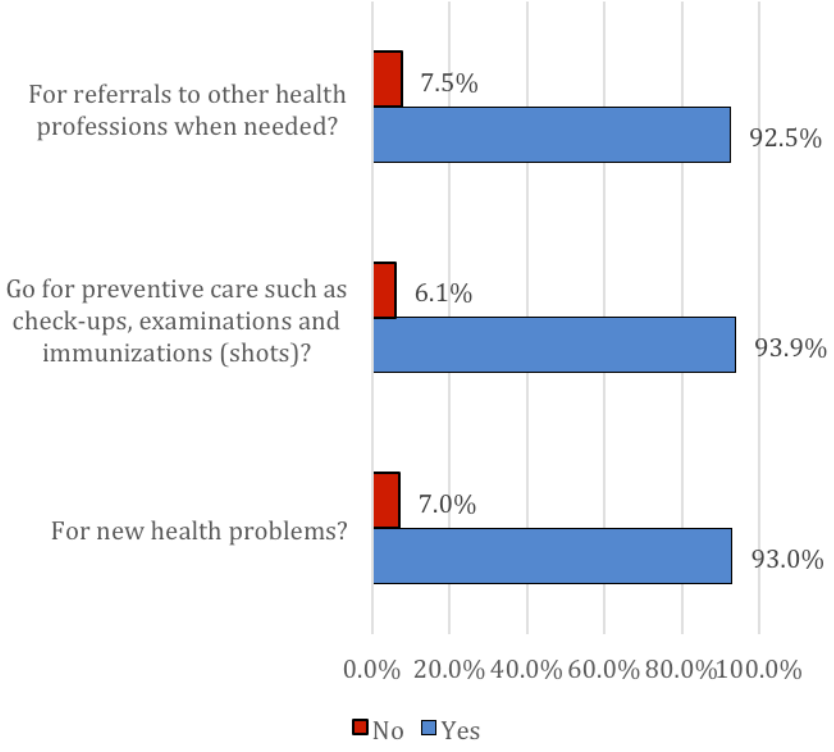
Clinical Care and Clinical Data

Access to Care

Q1. Is there a specific doctor's office, health center, or other place that you usually go if you are sick or need advice about your health?

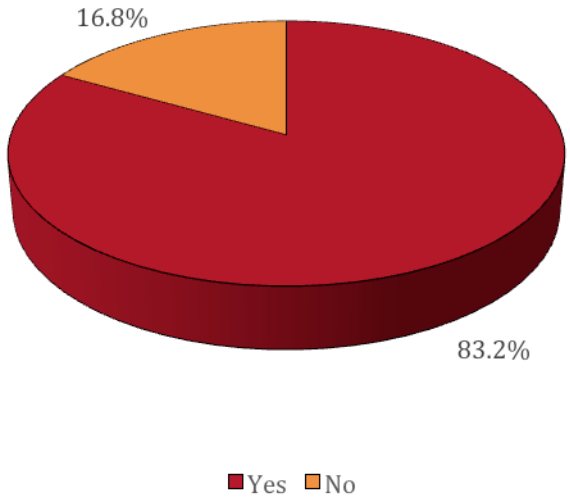


If you answered "Yes" is this where you go…

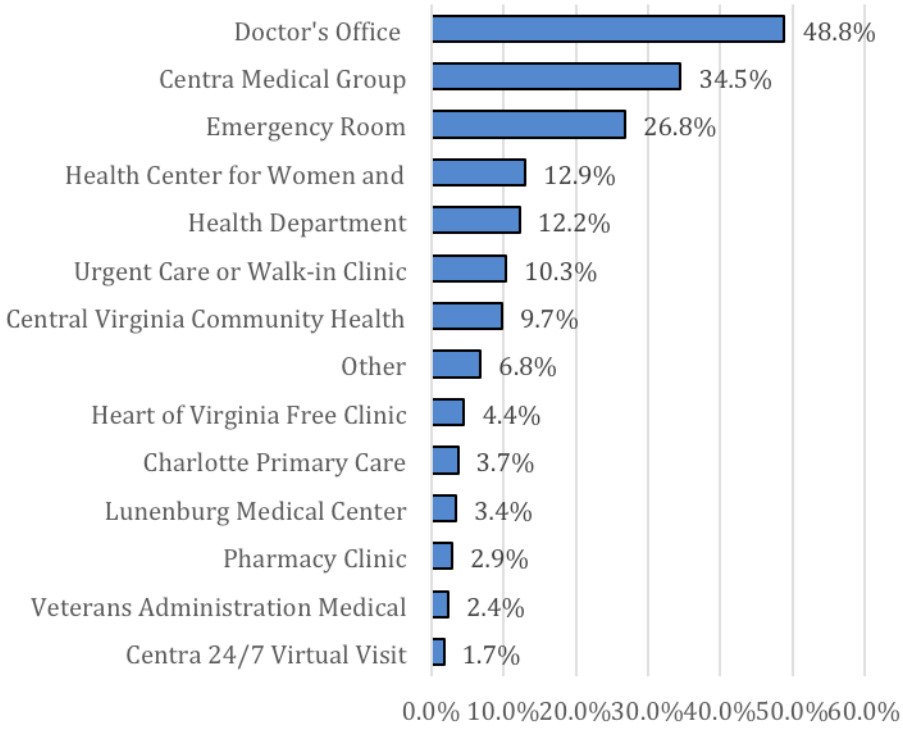


This question aligns with the Healthy People 2020 objective for "Access to Health Services-Increase the proportion of persons who have a specific source of ongoing care". (https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives#3970). Approximately 20% of survey respondents do not have a usual source of care.

Q2. Do you use medical services?

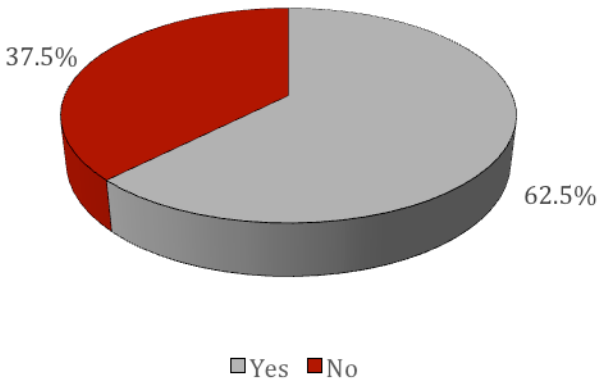


If you answered "Yes" to Question 2, check all that apply.



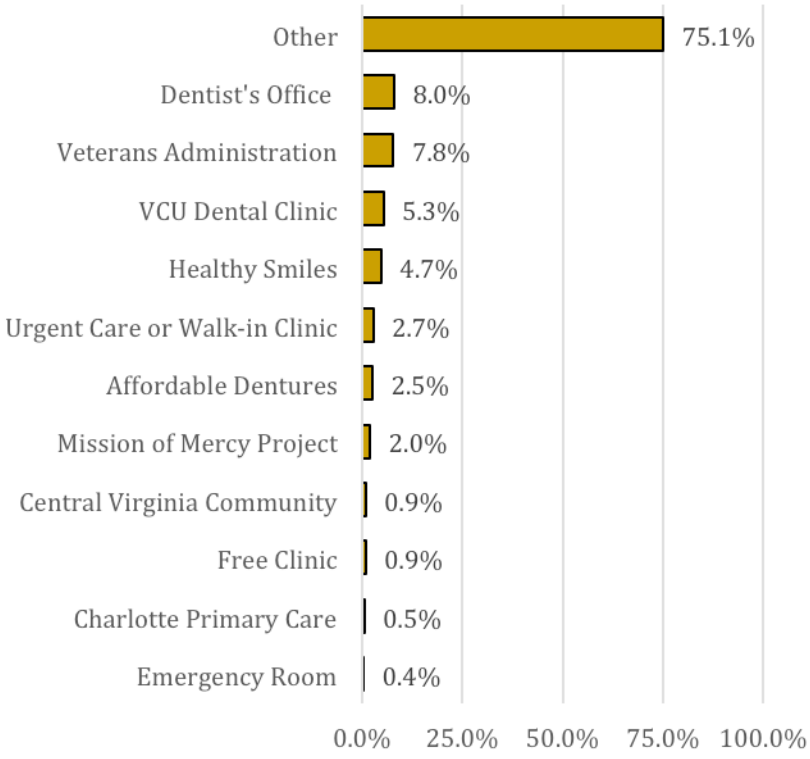
The large majority of respondents use a doctor's office for care. Additionally, over 26.8% report using the Emergency Room for medical services.

Q3. Do you use dental services?

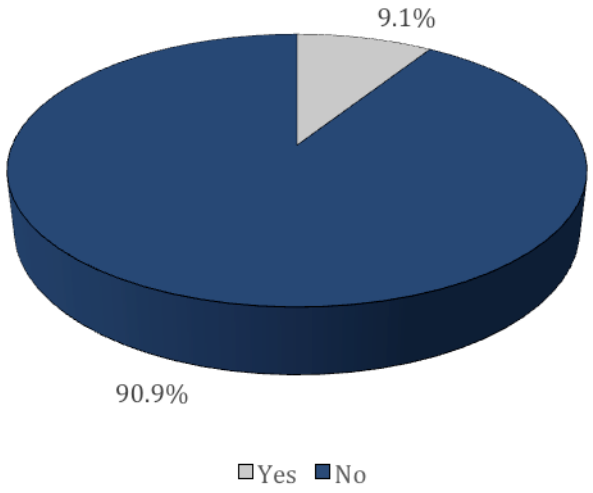


Almost 38% of respondents do not use dental services.

If you answered "Yes" to Question 3, check all that apply.

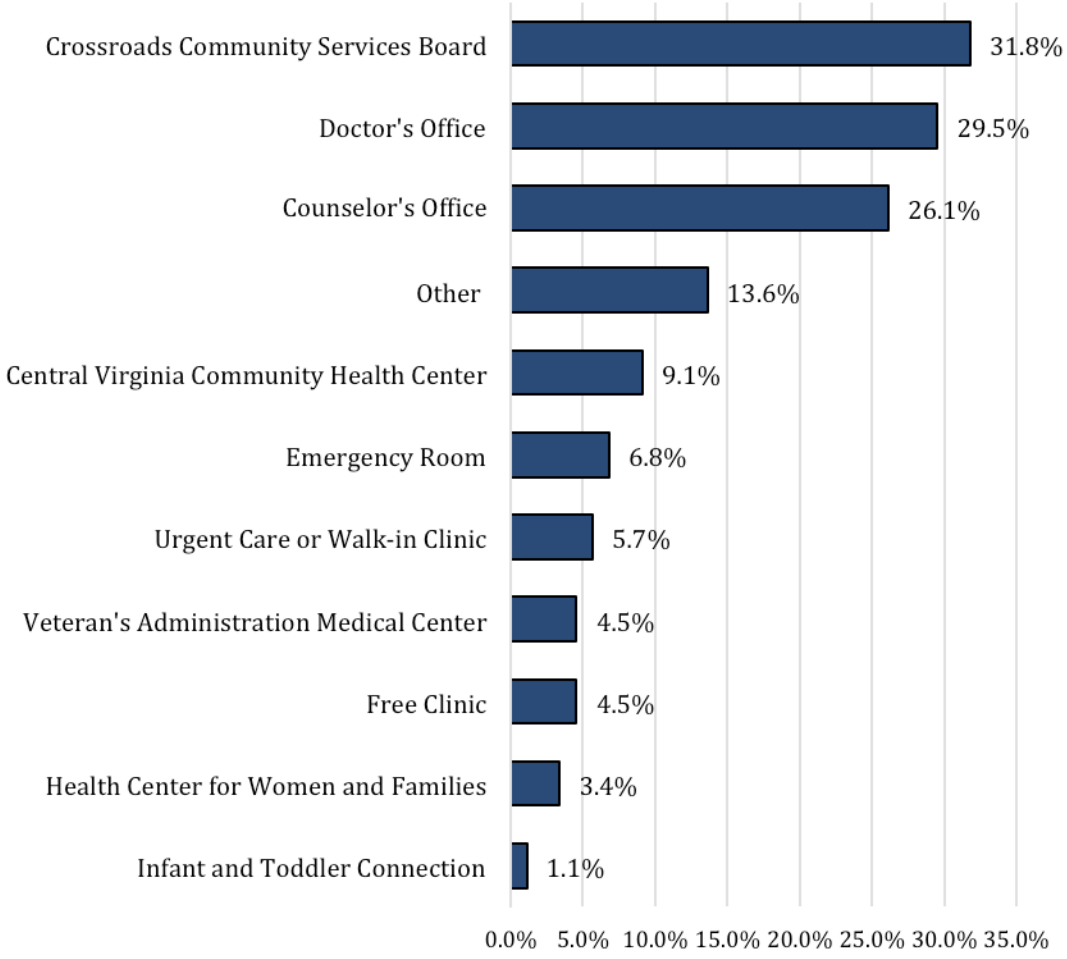


Q4. Do you use mental health, alcohol abuse, or drug abuse services?



Over 90% of respondents do not use mental health and substance use services.

If you answered "Yes" to Question 4, check all that apply.



Q6. Which services are hard to get in our community? (Check all that apply)

Housing - safe, affordable	36.60%
Dental care - Adults	29.36%
Food - affordable	29.22%
Transportation	28.82%
Specialty care such as for Asthma, Cancer care, Cardiology (heart) care, Dermatology (skin) care	23.59%
Mental health / counseling	22.25%
Alternative therapy (herbals, acupuncture, massage)	21.58%
Nutrition and weight loss	21.18%
Family doctor	18.90%
Eldercare	18.10%
Urgent Care or Walk-in Clinic	17.69%
Substance abuse services - drug & alcohol	16.76%
Workforce readiness	16.49%
Vision care	14.75%
Programs to quit using tobacco	14.21%
Emergency Room care	13.40%
Ambulance services	11.93%
Legal services	11.93%
Medication / medical supplies	11.53%
Domestic violence services	10.86%

These responses represent the top 20 responses for this category. Of the top 10 responses, social determinants are addressed (safe and affordable housing; affordable food; and transportation) as well as access to care (dental care for adults; specialty care; mental health/counseling; alternative therapy; nutrition and weight loss; and family doctor).

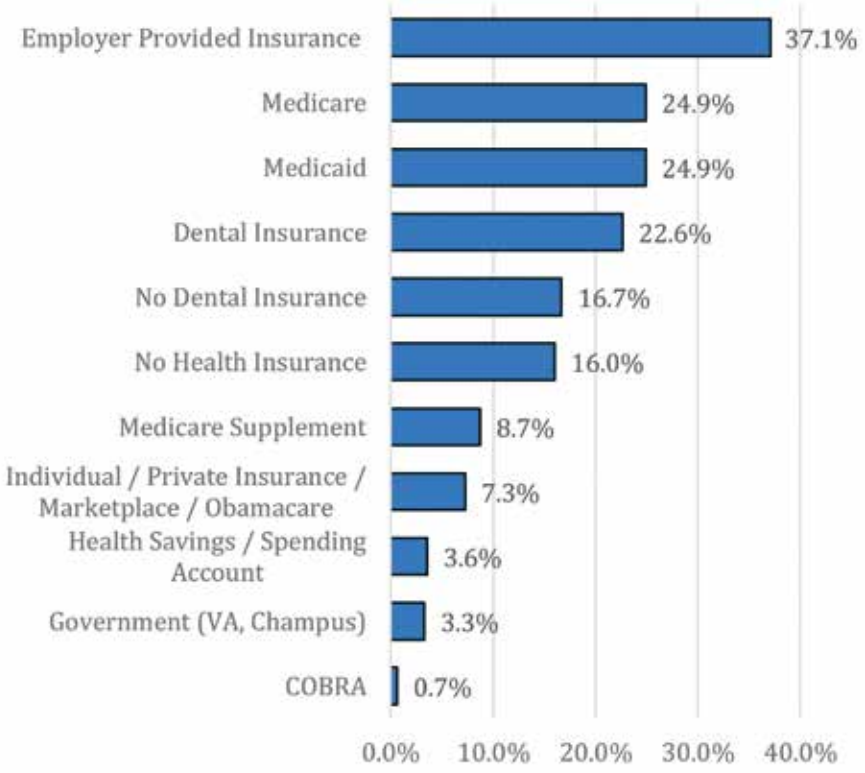
Q7. What do you feel prevents you from getting the services you need? (Check all that apply)

	Percent
Cost	48.90%
High co-pays	32.68%
Long waits for appointments	23.99%
Lack of evening and weekend services	23.35%
Don't know what types of services are available	17.51%
No health insurance	17.38%
I can get the healthcare I need	16.47%
Can't find providers that accept my insurance	15.82%

No transportation	13.88%
Don't have the time	13.10%
Location of offices	11.15%
Don't have internet access	10.77%
Don't like going to the doctor	10.12%
Have no regular doctor	9.99%
Childcare	8.43%
Afraid to have check-ups	6.23%
Other (please specify)	3.89%
Don't like accepting government assistance	3.50%
Don't trust doctors / clinics	3.24%
Language services	1.30%

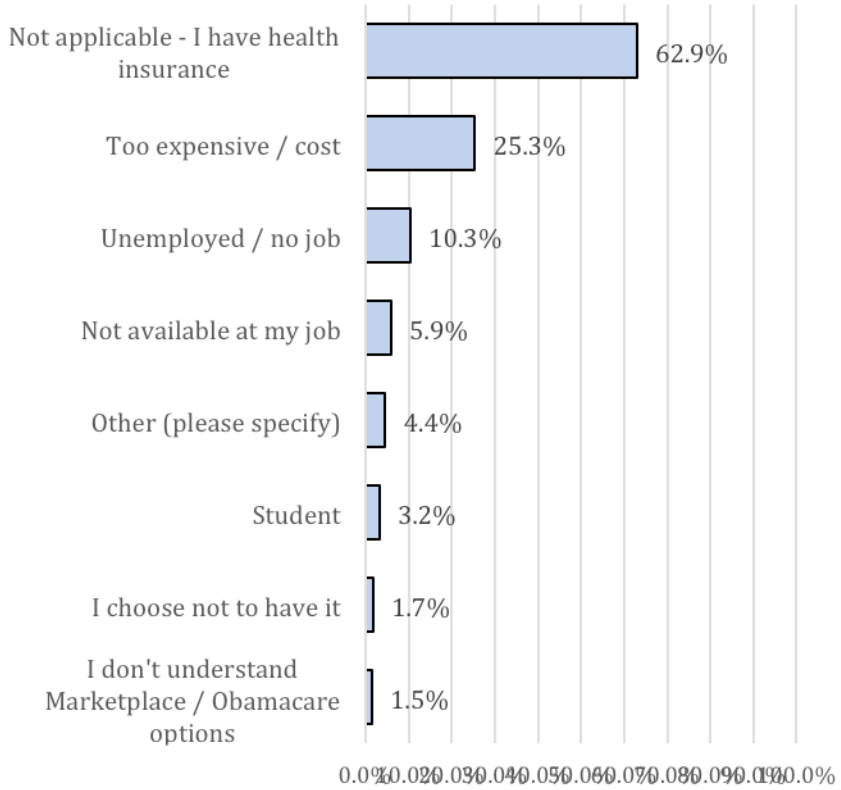
Health Insurance Status

Q23. Which of the following describes your current type of health insurance? (Check all that apply)



Survey respondents who reported being uninsured reflect the rates for the service as a whole (16.5%) (County Health Rankings for Virginia Localities 2015-2018. Small Area Health Insurance Estimates) while more respondents were publically insured (24.9% Medicaid, 13.9% Medicare) as compared to the service area where 14.4% of the population are Medicaid beneficiaries and 6.1% are Medicare beneficiaries (US Census. American Fact Finder. Public Health Insurance Coverage by Type. 2012-2016 American Community Survey 5-Year Estimates).

Q24. If you have no health insurance, why don't you have insurance? (Check all that apply)



Utilization of Services

Question	Yes (%)	No (%)
8(a). I have had an eye exam in the past 12 months.	49.45	50.55
8(b). I have had a mental health/substance abuse visit within the past 12 months.	11.74	88.26
8(c). I have had a dental exam within the past 12 months.	52.55	47.45
8(d). I have been to the Emergency Room in the past 12 months.	37.61	62.39
8(e). I have been to the Emergency Room for an injury in the past 12 months (such as motor vehicle crash, fall, poisoning, burn, cut, etc.).	12.13	87.88

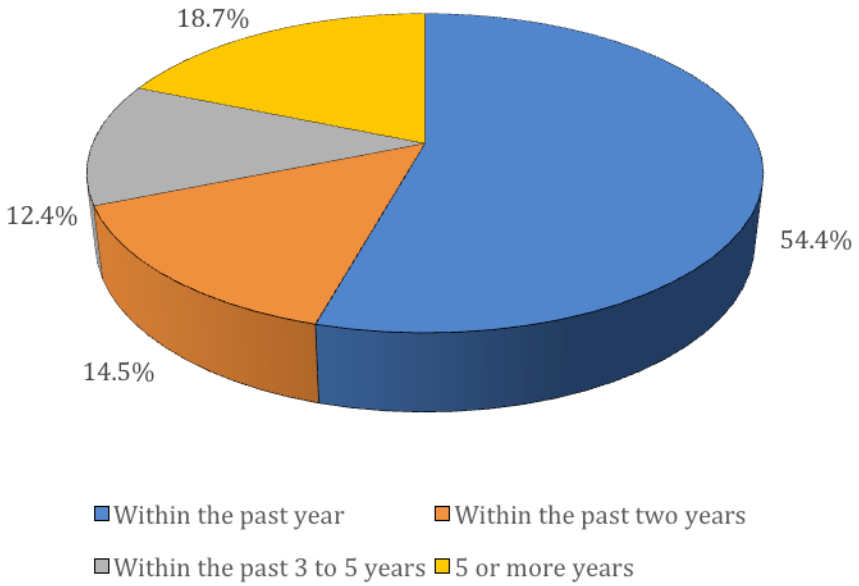
Utilization of Preventive Services

Question	Yes (%)	No (%)	N/A (%)
8(j). I am over 21 years of age and have had a pap smear in the past three years.	53.22	27.71	19.07
8(k). I am over 40 years of age and have had a mammogram in the past 12 months.	31.07	31.71	37.23
8(l). I am over 50 years of age and have had a colonoscopy in the past 10 years.	31.24	27.78	40.97

According to the US Preventive Services Task Force, cervical cancer screenings (Pap Smear) for women 21 to 65 years should occur every 3 years; biennial screening mammography for women aged 50 to 74 years; and colonoscopies for adults age 50 to 75 years every 10 years. (https://www.uspreventiveservicestaskforce.org/). For survey respondents where these screenings are applicable, on average one in three respondents are not meeting the recommendations.

Approximately 77% of respondents reported visiting a doctor for a routine check-up in the past year; 11% reported having a check-up within the past 2 years, 6.5% within the past 3 to 5 years, and 5.9% in 5 or more years (Q12).

Q13. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.



Of survey respondents, over 45% had not visited a dentist or dental clinic within the past year.

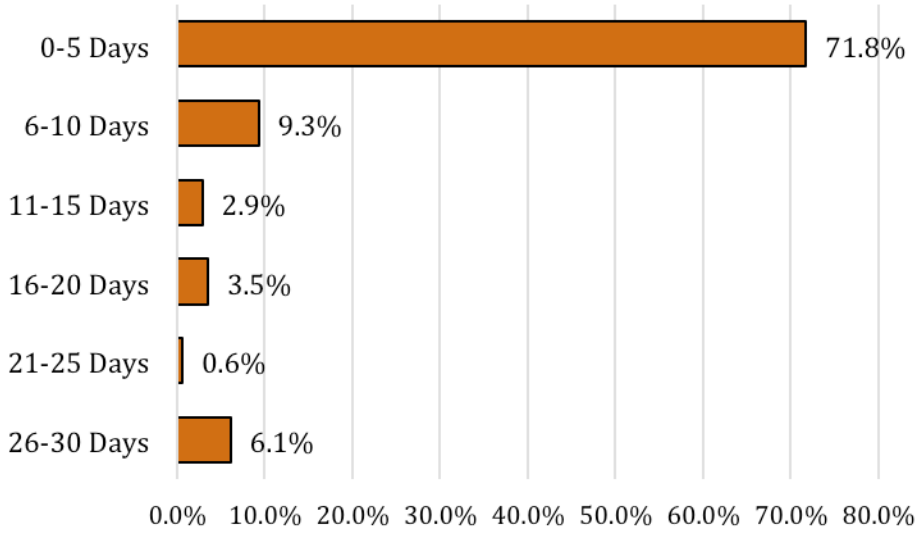
Chronic Disease

Question	Yes (%)	No (%)	N/A (%)
8(g). My doctor has told me that I have a long-term or chronic illness.	22.97	77.03	
8(h). I take the medicine my doctor tells me to take to control my chronic illness.	33.03	36.02	30.95

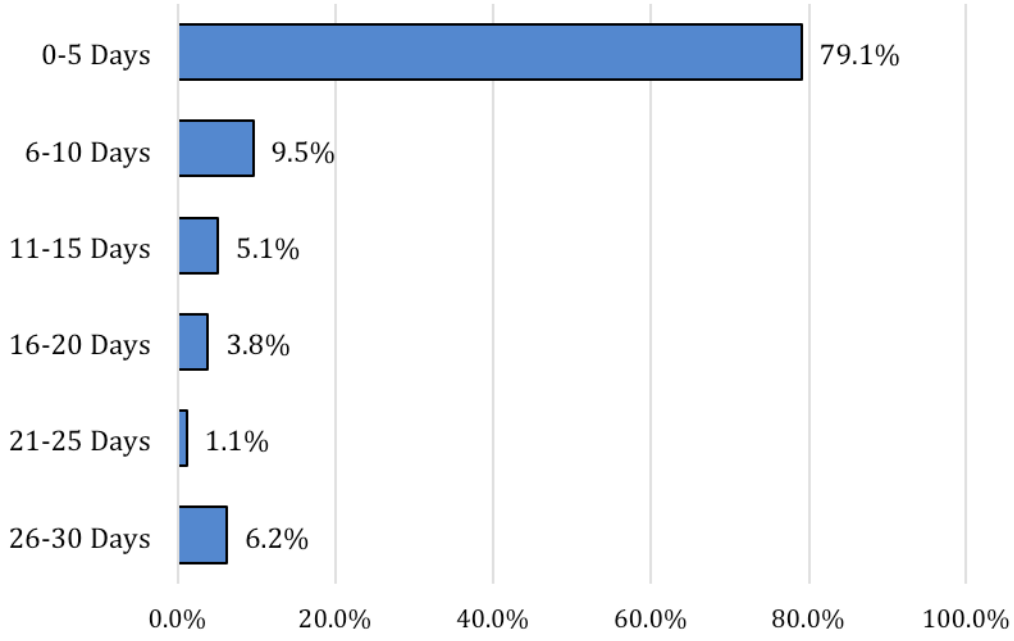
Q11. Have you been told by a doctor that you have...(Check all that apply)

	Percent
High blood pressure	40.85%
Obesity / Overweight	29.10%
Depression or anxiety	24.18%
Diabetes or high blood sugar	21.04%
I have no health problems	19.95%
High Cholesterol	17.08%
Asthma	15.44%
Other (please specify)	10.79%
Heart disease	7.24%
Mental health problems	6.69%
Cancer	5.33%
COPD/chronic bronchitis/emphysema	5.19%
Stroke / cerebrovascular disease	3.01%
Drug or alcohol problems	0.82%
HIV / AIDS	0.41%
Cerebral palsy	0.14%

Q18. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?



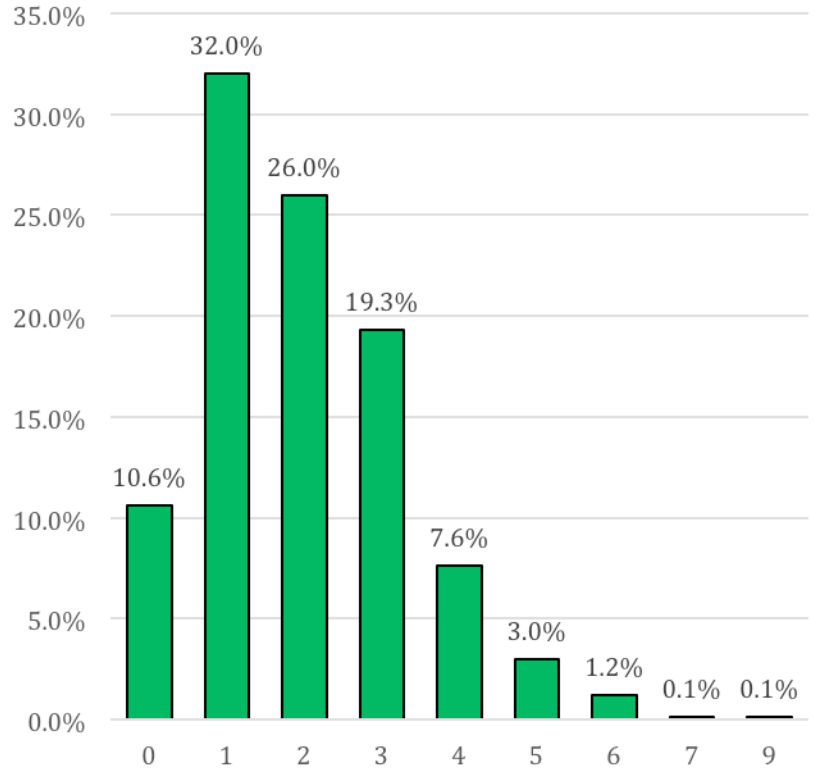
Q19. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?



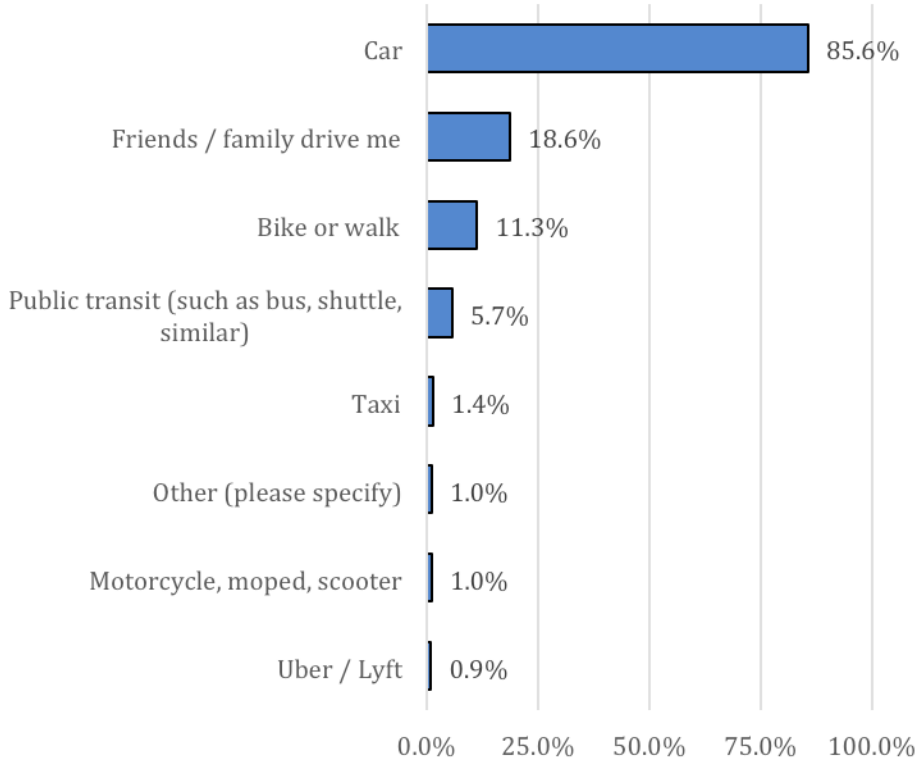
Ten percent (10.2%) of survey respondents reported more than two weeks of physically unhealthy days while 11.1% reported more than two weeks of mentally unhealthy days in the past month. These two indicators are used by the County Health Rankings to determine quality of life (morbidity) and are used to measure health-related quality of life.

Physical Environment

Q21. How many vehicles are owned, leased, or available for regular use by you and those who currently live in your household? Please be sure to include motorcycles, mopeds and RVs.



Q22. What mode of transportation do you typically use? *Respondents were able to select more than one answer.



Almost 20% of respondents rely on friends and family for transportation.

Top Needs

Q5. Thinking about the community, what are the five most important issues that affect the health of our community?

	Percent
Access to affordable health care	54.87%
Alcohol and illegal drug use	29.12%
Overweight/Obesity	28.65%
Affordable housing	25.41%
Access to healthy foods	25.17%
Diabetes	24.83%
Poor eating habits	19.95%
Cancers	19.72%
High Blood Pressure	19.49%
Joblessness	18.21%

Of the top 10 responses for the most important issues, survey respondents addressed social determinants of health (affordable housing; access to healthy foods; and joblessness); healthy behaviors (poor eating habits; alcohol and illegal drug use;); and clinical care and access to

services (access to affordable health care; overweight/obesity; diabetes; cancers; and high blood pressure).

In Their Own Words

Q39. Is there anything else we should know about your (or someone living in your home) needs in the Farmville Area?

Comments from respondents included the following:

Access to Care- Cost of Services

- While I can barely afford my insurance, the copay and direct costs associated with it are beyond my reach... I am currently having to do a payment plan for $7,500 in emergency room bills for a car accident.

Access to Care- Healthcare Services

- I think the biggest thing we are lacking is an urgent care facility which is open EVERY day, including holidays. Not everyone can drive to Richmond or Lynchburg for those services. The (Centra) Medical Group here has a half day Saturday, but after hours or on Sunday the only choice is to drive to a big city or hit the ER...it is a big miss to have no option for this.
- If possible extend urgent care walk in clinic for Centra Medical Group and bring in as many more specialty practices as possible—i.e. Dermatology

Access to Care- Mental Health Services

- We've found it difficult to secure mental health care for our son's depression. The long wait times at Centra Southside Clinic make doctor appointments difficult with both adults in our family working full time.

Access to Healthy Food

- A supermarket is badly needed in Cumberland.
- Decent grocery stores that allow healthy low fat low carbohydrate choices.
- I am 84 and receive home delivered meals. It would be nice to receive vegetables and seasonal fruits, can goods and boxes of food. Variety-not frozen.
- I live in the Nottoway Area (Crewe, VA). There is no grocery store in our area. My vehicle is not always dependable so we have a hard time getting vegetables that I can afford.
- We need better access to good and affordable food.
- We need better grocery stores that offer better produce and natural foods.

There were over 18 different comments related to access to healthy foods and grocery stores.

Care Giver Support

- · Care giver support. Training and therapy for those who care for others who are failing. Needs to be pro-active, positive.

Place of Residence

- I live in Keysville area
- I live in Lunenburg County

- I live in the far west of Buckingham County and many of the resources are not convenient for people in that area. It takes me an hour to get to Farmville, Charlottesville, Lynchburg and 2 hours to Richmond. My husband is on occupational disability at this time.
- More out towards the Blackstone

Given the rural nature of the service area, geography itself, where the respondent lived, was often the answer to Question 39.

After reviewing the Community Health Survey data, Community Health Assessment Team (CHAT) members were asked to address:

1. What trends, data jump out from the Community Health Survey?
2. What are actionable priorities based on current community resources?
3. Who else in the community is not in the room who can take action?

Trends/data:

Discussion focused on the following questions and topics:

Question 27 "What is your gender?" The large number of female respondents is not reflective of the actual community demographic. This may be because women may take the initiative to complete surveys and make the health care decisions for families and males are less likely to do so.

Preventative dental care may be underutilized, with 47.45% of survey respondents not having a dental exam in the past year (Question 8c) because people either don't believe they need it or don't see the benefits in preventative care (6-month cleanings). The Heart of Virginia Free Clinic has a grant for a voucher program for dental services provided by the Free Clinic of Central Virginia where patients can travel to Lynchburg to receive Dental Care.

According to national statistics, CHAT members felt that the questions "I have been a victim of domestic violence or abuse in the past 12 months" (Question 8f) and "Do you feel safe in your neighborhood" (Question 8r) are being under reported or not recognized due to the level of education and/or perception about what domestic violence is. It would be helpful to do an analysis of how this question was answered by income level of survey respondents. Domestic violence also includes child abuse/ neglect. A question should be added to include child abuse and neglect.

Substance abuse services were ranked 13 in Question 6 "Which services are hard to get in our community" with a total of 16.76%. Participants questioned whether these services are hard to get because of a lack of providers that offer substance abuse services or is it due to lack of health insurance coverage for these services.

Question 7 "What do you feel prevents you from getting the services you need", 23.35% of respondents replied "lack of evening and weekend hours". Is this related to an actual lack of health care services or is it more of a function of lack of transportation to these services?

Overall, CHAT members present agreed that the Community Health Survey responses reflect the needs of the populations they serve in the Farmville Area.

Actionable priorities:

- Many residents are not aware of resources available in the community. Improved communication from service providers to their clients/patients is needed to ensure available resources are used often and appropriately.
- Collaboration and partnerships to improve transportation options are needed throughout the region.

Who else from the community is needed to take action?

No additional recommendations were made by CHAT members.

Stakeholder Focus Group and Survey

In order to further understand the needs of the target populations in the Farmville Area and the factors that impact the health of these residents, a Stakeholder Focus Group meeting was held on May 14, 2018 at Hampden Sydney College in Farmville. A total of 38 individuals attended the meeting including members of the Community Health Assessment Team and other identified cross-sector stakeholders, non-profit organizations, service providers, business leaders, and local government officials. A directory of participants can be found in the Appendix.

The focus group meeting was a two hour session. Participants were randomly assigned to a table at registration. During the session, there were small group break-outs at each table. Participants were asked to individually complete a Stakeholder's Survey and then have small group discussion about their responses. After the break-out session, each small group reported out to the larger group. Survey responses were collected after the meeting and entered into Survey Monkey. In addition, the Stakeholder's Survey was available on-line for individuals and/or organizations who were unable to attend the focus group meeting. All total, 31 surveys were completed. An example of the survey can be found in the Appendix.

Survey questions included:

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

Responses for each survey question were sorted using an Excel workbook generated by Survey Monkey. Similar responses for each question were grouped together and coded by topic area so that the frequency of responses could be quantified by total number and percentage of responses for each question. In addition when applicable, pertinent comments depicting community need were noted.

Stakeholder Focus Group and Survey responses reflected many of the needs identified in the Community Health Survey and are delineated by question as follows.

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

Area of Need	Number of Responses	% of Responses	Comments
Transportation	23	13%	To the hospital, to medical appointments; Medicaid taxi; using ambulances & EMS for transportation; public system needed; public transportation needed for out of town transportation; for uninsured; progress needed on this issue
Access to healthcare	16	9%	Affordable services; durable medical equipment for children; health screenings for students for conditions generally affecting older populations (i.e. hypertension, diabetes, hypercholesterolemia); lack of timely access to MD's; lack of Emergency Department close by; long waiting times; not enough pediatricians, specialists; telemedicine services; affordable prescriptions
Access to housing	14	8%	Affordable and safe housing lacking; poor, substandard housing conditions; housing for homeless
Substance Use	13	7%	Opioid crisis; drug abuse; mental health resources
Health Literacy	12	7%	Awareness of available resources including 211; centralized source for resource information; education about disease management and other health education (i.e. STD', wellness); low literacy levels;
Access to Mental Health Services	12	7%	Mental health challenges & limited resources; access to services
Food Access	10	6%	Access to healthy foods; eating healthy foods; nutrition education; food deserts in rural areas; feeding programs
Workforce Development	9	5%	Employment opportunities; good entry level employment for 18-30 year olds; job readiness; work ethic
Access to Substance Use Services	8	4%	Substance use services needed including access to treatment programs
Education	7	4%	Improved K=12 education
Childcare	6	3%	Access to affordable services; lack of childcare providers; need year round care for infants and older children

Area of Need	Number of Responses	% of Responses	Comments
Mental Illness	6	3%	
Community Advocate	5	3%	Medical advocate
EMS	5	3%	Active & functional
Collaboration	4	2%	Use civic organizations (Lions, Rotary) as "information sharers"; engaging and coordinating resources with churches (can offer facilities, access to congregations); coordinate resources for strong referral network
Health Insurance	4	2%	Uninsured populations; affordability of healthcare services
Active Living	3	2%	Fitness; safe options
Financial Security	3	2%	Livable wages; paying for healthcare
Policy	3	2%	Disconnect between the state and rural areas; support federal rural policies; lack of "rural" agenda
Access to dental services	2	1%	High need, low rate of insurance
Broad Band	2	1%	
End of Life Care	2	1%	Hospice at home & inpatient
Lifestyle Management	2	1%	Healthy lifestyles
Access to resources	1	1%	Rural areas outside of Farmville
Attention Deficit Disorders	1	1%	
Communications	1	1%	Advertisement of resources
Domestic Violence	1	1%	Child abuse
Economic Development	1	1%	
Elder care	1	1%	Senior supports at home
Funding	1	1%	Lack of
Programs "in Place"	1	1%	Opportunities
Total	179	100%	

1a. Are there particular localities in the service area that have greater needs than others?

Localities	Number of Responses	Percentage of Responses	Comments
Buckingham	11	22%	Far corners of the county; literacy; rural areas outside of the downtown area
Cumberland	9	18%	Health care; rural areas outside downtown area
Charlotte	5	10%	Rural areas outside of the downtown area
Farmville	5	10%	Areas 30 minutes outside Farmville; lacking resources beyond the colleges & hospital; "Most of the resources are concentrated in the town of Farmville. People in outlying areas drive long distances to access these resources including grocery stores and gyms."
Lunenburg	5	10%	Entire county especially rural areas outside of the downtown area
All	4	8%	Universal across all areas; all have their unique set of issues
Rural	4	8%	The more rural a community, the greater the need, the greater the lack of resources & access to services. Outlying areas have greater transportation issues as well.
Special Populations	3	6%	Colleges (substance use), school-age children, low-income families
Nottoway	2	4%	
Amelia	1	2%	
Prince Edward	1	2%	
Total	**50**	**100%**	

2. What do you see as the root cause of these needs?

Root Cause	Number of Responses	% of Responses	Comments
Education	15	16%	High drop-out rates; lack of education; educate about resources for low-income residents; health literacy
Employment	9	10%	Lack of opportunities & jobs; living wages needed; unemployment
Poverty	8	9%	
Community Awareness	6	7%	Lack of awareness of resources, promote information
Civic Pride	5	5%	Lack a sense of community, where everyone is a contributing member
Funding	5	5%	Lack of funding
Infrastructure	5	5%	Lack of infrastructure; lack of internet access
Diet and Exercise	3	3%	Lack of exercise; obesity, poor diet
Cost of Living	3	3%	Expensive
Generational Inequality	3	3%	Generations have lived isolated in these communities; "generational slide"; multi-generational poverty
Lack of Resources	3	3%	
Socioeconomic	3	3%	
Communication	2	2%	Need a communication hub; communicate a sense of community
Breakdown of Family Unit	2	2%	
Motivation	2	2%	Lack of; Seniors with inability to read; taking initiative is needed to succeed
Positive Role Models	2	2%	Lack of
Transportation	2	2%	Limited access
Accessibility	1	1%	
Culture of Defeat	1	1%	
"Marginalism"	1	1%	Economic margins
Financial Literacy	1	1%	
Rural Geography	1	1%	

Root Cause	Number of Responses	% of Responses	Comments
Cost of Insurance	1	1%	
School Closings	1	1%	
Inaction	1	1%	
Economy	1	1%	Lack of
Opportunities	1	1%	Lack of
Life Skills	1	1%	
Multifaceted Causes	1	1%	
Stigma	1	1%	
Technology	1	1%	
Total	**92**	**100%**	

3. What resources are available in the community to meet these needs?

Resources	Number of Responses	% of Responses	Comments
Churches	7	6%	
Colleges & Universities	7	6%	Hampden Sydney College; Liberty University; Longwood University
Crossroads Community Services Board	6	5%	
Centra	5	4%	Financial Assistance; PACE; Centra Medical Group- Hope Clinic
Department of Social Services	5	4%	
Workforce Investment Boards	5	4%	
Fort Pickett	4	3%	
Free Clinic	4	3%	
Growth and Development	4	3%	Industry
Poorly Advertised	4	3%	Community resources
STEPS	4	3%	Community Action Agency

Resources	Number of Responses	% of Responses	Comments
FAPT - Family Assessment Planning Team	3	3%	
Head Start	3	3%	
Meals on Wheels	3	3%	FACES
Multiple Resources	3	3%	Churches, DSS, civic organizations (Lions, Rotary), Boy Scouts, 4H; Many resources but need to know about them and how to use them
Schools	3	3%	
Virginia Cooperative Extension	3	3%	
Coalitions/Advocacy/School Boards	2	2%	
Farmville Area Bus	2	2%	FAB; Medical transport services
Farmville Parks & Recreation	2	2%	5 parks in Prince Edward County
Habitat for Humanity	2	2%	
History	2	2%	History that has shaped our nation
Hospitals and Satellite Clinics	2	2%	
Libraries	2	2%	Public and school
Mental Health	2	2%	Psychiatry
Piedmont Senior Resources	2	2%	
Public and Private Service Providers	2	2%	
Transportation	2	2%	University of Richmond-transportation from Richmond
YMCA	2	2%	
211	1	1%	
Activities	1	1%	
Blackstone Bus	1	1%	
Board of Supervisors	1	1%	

Resources	Number of Responses	% of Responses	Comments
Collaboration (Lack of)	1	1%	Many resources siloed and not connected
Community Health Workers	1	1%	Community HUB
Community Organizations	1	1%	
FAMA - Farmville Area Ministers Association	1	1%	
Health Centers	1	1%	
Health Fairs	1	1%	
Motor Museum	1	1%	
Non-Profits	1	1%	
Privacy Concerns	1	1%	
Outreach Programs	1	1%	
SNAP	1	1%	SNAP-Ed
Southside Electrical Cooperative	1	1%	Annual Meeting
SVCC	1	1%	
Taxi Services	1	1%	
Technology	1	1%	Can shop, make virtual doctor's visit, educate oneself using the internet
Total	**116**	**100%**	

4. What are the barriers to accessing these resources?

Barriers	Number of Responses	% of Responses	Comments
Community Awareness	17	18%	Knowledge of services & how to access them; better marketing needed; lack of awareness
Transportation	14	15%	Lack of
Funding	10	11%	Funding in general; needed for equipment; transportation; restrictions on how state & federal dollars can be spent
Education	7	7%	Literacy; educate about resources; lack of student accountability for a formal education
Collaboration	5	5%	Lack of; Connect resources; organizations operate in silos; lack of partnerships, coalitions
Motivation	5	5%	Lack of; No interest; no initiative to access resources; how do you change attitudes?
Employer Benefits	4	4%	Local jobs do not have benefits; service jobs
Communication	3	3%	Communication about services
Shared Data	3	3%	
Accessibility	2	2%	Access to programs; difficult to access good programs
Distance	2	2%	
Financial Health	2	2%	Lack of financial resources
Diversity Among Stakeholders	2	2%	Lack of
Visibility	2	2%	
Pride	1	1%	
Diversity	1	1%	More diverse population
Emergency Medical Technicians	1	1%	
Employment	1	1%	
Infrastructure	1	1%	For services
Police	1	1%	
Policy	1	1%	

Barriers	Number of Responses	% of Responses	Comments
Poor Internet Connection	1	1%	In certain areas
Poverty	1	1%	
Racism/Segregation	1	1%	Need African American representation
Resources	1	1%	Lack of
Stigma	1	1%	
Teacher Recruitment & Pay	1	1%	
Technology Literacy	1	1%	
Unsure	1	1%	
Total	**93**	**100%**	

5. What is one issue/need we can work on together, to create a healthier community? How?

One Issue	Number of Responses	% of Responses	Comments
Collaboration	8	15%	Coalitions can work toward addressing problems; come to the table to address multiple needs; continue to work as a team to reach out to those affected, help them traverse the system
Community Health Fairs	6	11%	Community resource fairs; workshops; student health fairs & education; help to bring awareness to resources
Develop Network of Resources	4	7%	Develop public service announcements
Increase Community Awareness	4	7%	Awareness on how behaviors impact health in the long-term; help people with health navigation
Transportation	4	7%	Build app to obtain transportation vouchers; transportation issue is solvable- there are talks underway about solutions but to implement the programs we need, it will take multiple partners
Increase Hospital Navigators	3	6%	Help with resources and information
Education	2	4%	

One Issue	Number of Responses	% of Responses	Comments
Expand Free Clinic	2	4%	Heart of Virginia Free Clinic
No Wrong Door	2	4%	
411	1	2%	
Better Low-Income Housing	1	2%	Advocate for affordable, healthy homes- this is the vaccine for community health.
Culture	1	2%	Complicated; no one answer
Create Commercials	1	2%	Show in waiting rooms, churches to share resources
DARS	1	2%	
Diet & Exercise	1	2%	
Ensure Fundamental Needs are met	1	2%	
Identify Problems & Resolve	1	2%	
Increase Home Health Nurses	1	2%	
Opioid Task Force	1	2%	With the increase of substance abuse in our community we could work together to build community partnerships & substance abuse community coalition that would work on raising awareness, increasing knowledge, increase community readiness to address the opioid crisis, and reduce the number of accidental deaths for prescription & other opioid abuse.
Social Services	1	2%	
Southside Electrical Corporation Annual Meeting	1	2%	Fall fundraising event
Stable Food Sources	1	2%	
Strategic Planning	1	2%	Short-term vs. long-term planning
Underutilized Services	1	2%	

One Issue	Number of Responses	% of Responses	Comments
Access to services- Specialty services in rural areas	1	2%	Figure out how to lessen the "ruralness" of the outlying areas. Can specialists see patients one day a week in some of the outlying clinics? Telemedicine for specialists in outlying clinics?
Utilize University Student Agency	1	2%	
Volunteerism	1	2%	Finding more medical volunteers to help at the Free Clinic
Total	**53**	**100%**	

Target Population Focus Groups

To further understand the needs and factors that impact the health of target populations in the Farmville Area, Target Population Focus Group meetings were conducted May- June 2018. All attempts were made to host four focus groups in the service area stratified by the life cycles (i.e. children, women of child-bearing years, adults and seniors) and/or other targeted populations. Participants were 18 years of age or older with no more than 10-15 participants/group.

Focus groups were conducted at the following sites:

Site of Meeting	Date	Number of Participants	Cohort
Crossroads Senior Center, Prospect, VA	5/16/2018	17	Seniors
Silver Sneakers, Southside YMCA, Farmville	5/29/2018	14	Seniors
Southside YMCA, Farmville VA	5/29/2018	13	Adults
First Baptist Church, Farmville, VA	6/14/2018	9	Adults, Seniors
Total		**53**	

Each focus group meeting was a one hour face-to-face session in sites that were accessible and/or where participants already congregate. A facilitator conducted the meetings and a scribe captured the notes. Prior to beginning the meeting, the facilitator explained the format and asked participants to sign a Confidentiality Statement. At the end of the meeting, participants were asked to complete a Community Health Survey if they had not done so already. Food and beverages were provided at each meeting. (The Target Population Focus Group Notes page and Confidentiality Statement can be found in the Appendix)

Focus group questions included:

1. In one to two words, what does health mean to you?
2. What resources/programs/services in your community help you and/or your family stay healthy?
3. How do you and/or your family know where to go for these resources/programs/services in your community?
4. What keeps you and/or your family from being healthy?
5. Is there anything else you would like to share?

Responses for each survey question were sorted using an Excel workbook. Similar responses for each question were grouped together and coded by topic area so that the frequency of responses could be quantified by total number and percentage of responses for each question. In addition when applicable, pertinent comments depicting community need were noted.

Target Population Focus Group responses reflected many of the needs identified in the Community Health Survey and Stakeholders Survey and Focus Group and are delineated by question as follows.

1. In one to two words, what does health mean to you?

What is health?	Number of Responses	% of Responses	Comments
Exercise	4	11%	
Quality of Life	4	11%	Lifestyle
Freedom/Independence	3	8%	
Nutrition	3	8%	Eat right, healthy eating
Good Health	2	5%	Everything is good health
Increased Life Expectancy	2	5%	Longevity

What is health?	Number of Responses	% of Responses	Comments
Physical and Mental Healing	2	5%	Spirituality
State of Being	2	5%	Well-being; Are you well?
Wellness	2	5%	
Accessibility	1	3%	Available healthcare
Awareness	1	3%	
Check-Ups	1	3%	
Concern/Worry	1	3%	
Everything	1	3%	
Help When Sick	1	3%	
Holistic Healing	1	3%	Mind, body, spirit
Mental Health	1	3%	
Mobility	1	3%	Able to move
Prevention	1	3%	
Safe Housing	1	3%	
Sleeping Enough	1	3%	Good night's sleep
Socially Accepted	1	3%	Socialize
Total	**37**	**100%**	

2. What resources/programs/services in your community help you and/or your family stay healthy?

Resources	Number of Responses	% of Responses	Comments
YMCA	6	13%	Silver sneakers; cardio rehab
Centra	4	9%	Centra Southside Medical Center
Meals on Wheels	3	7%	
Piedmont Senior Resources	3	7%	
Crossroads Community Service Board	2	4%	
FACES/Food Bank	2	4%	
PACE	2	4%	

Resources	Number of Responses	% of Responses	Comments
Trails/Outdoors	2	4%	
Churches	1	2%	
Communication	1	2%	
Diabetes Prevention	1	2%	Classes
Doctor	1	2%	
Exercise Physiology	1	2%	
Farmer's Market	1	2%	Coupons for the market
Farmville Area Ministerial Alliances	1	2%	
Home Health	1	2%	
Hospice	1	2%	Grief care
Library	1	2%	
Madeline's House	1	2%	
Motor Museum	1	2%	
New Life Ministries	1	2%	
Parenting Classes	1	2%	
Prayer Breakfast	1	2%	
Pregnancy Support Center	1	2%	
Rehabilitation Facilities	1	2%	
Salvation Army	1	2%	
School Outreach	1	2%	Including higher ed in Farmville
The Woodland	1	2%	
University of Virginia	1	2%	
Total	**45**	**100%**	

3. How do you and/or your family know where to go for these resources/programs/services in your community?

How do you know about resources?	Number of Responses	% of Responses	Comments
Neighbor/Friend/Word of Mouth/Family	7	19%	
Newspaper	4	11%	
Radio	3	8%	Local morning announcements; WFLO
Television	3	8%	Local station; Community announcements (Shentel)
Advertisements/Bulletin Boards	2	5%	
Churches	2	5%	
Facebook/Social Media	2	5%	
Road Signs	2	5%	
911	1	3%	
Chamber of Commerce	1	3%	
City Government	1	3%	
Community Meetings	1	3%	
Doctor	1	3%	
Don't Know About Resources	1	3%	
Hospital	1	3%	
Internet	1	3%	
Piedmont Senior Resources	1	3%	
Sheriff's Office	1	3%	
Social Worker	1	3%	
Triad Meetings	1	3%	
Total	**37**	**100%**	

4. What keeps you and/or your family from being healthy?

Barriers to health	Number of Responses	% of Responses	Comments
Lack of Motivation	7	12%	Lack of discipline, willpower; "I stand in my own way"; laziness
Diet & Exercise	5	8%	Lack of exercise; eating out too much; not eating right; lack of information about good nutrition
Lack of Money	5	8%	Not being able to pay for meds or co-pay

Barriers to health	Number of Responses	% of Responses	Comments
Awareness	3	5%	Not knowing about resources & knowing where to go
Isolation/Loneliness	3	5%	No one to talk to; not seeking help
Non-Compliance	3	5%	Not following protocols for chronic disease; not going to the doctor; not taking prescriptions
Fear	2	3%	Intimidation
Geography	2	3%	Unique geography- people have to travel to different places for different issues (Richmond, Lynchburg, Farmville, UVA, Appomattox)
Insurance	2	3%	No health insurance; too expensive
Mental Health	2	3%	Not thinking clearly
Stigma	2	3%	Cultural stigmas
Transportation	2	3%	Lack of
Access to Computers	1	2%	
Alcohol/Tobacco	1	2%	
Bad Habits	1	2%	
Continuity of Care	1	2%	
Denial	1	2%	
Education	1	2%	Lack of
Feeling Embarrassed	1	2%	
Homelessness	1	2%	
Lack of Resources	1	2%	
Lack of Self Care	1	2%	
Lack of Sleep	1	2%	
Lack of Specialty Care	1	2%	
Moderation	1	2%	
No Flu Shot	1	2%	
No Fresh Air	1	2%	
No Relationships with Providers	1	2%	Too many faces
Not Drinking Enough Water	1	2%	
Patient-Doctor Ratio	1	2%	

Barriers to health	Number of Responses	% of Responses	Comments
Price of Food	1	2%	Money, expense of healthy food
Pride	1	2%	
Too Many Medications	1	2%	
Unprofessionalism of Providers	1	2%	
Total	**60**	**100%**	

5. Is there anything else you would like to share?

Other	Number of Responses	% of Responses	Comments
Add mobile medical care	3	14%	Mobile screenings through faith communities; from University of Virginia, Richmond
Expand eligibility for medical transportation	3	14%	Middle income who are not poor enough or rich enough; help with travel for long-distance appointments; transport of follow-up, on-going care
Expand Meals on Wheels/Senior Services	2	9%	Piedmont Senior Resources
Specialists should host education sessions in community.	2	9%	Twice/month- specialists come to the area for education (i.e. churches or other gatherings); "being educated about something/issue helped fix the problem I had been suffering with for a long time"
Cost of Prescriptions	1	5%	
Expand gerontology services	1	5%	
Expand geriatric psychiatry services.	1	5%	
Expand hearing services.	1	5%	Need to know what to do about hearing issues and clinics
Expand Medicare dental coverage	1	5%	Medicare does not cover dental
Expand respite care	1	5%	We need resources for caregivers
Family is best motivator.	1	5%	My family helps me stay healthy

Other	Number of Responses	% of Responses	Comments
Farmville has great Police-Church-Resident relations.	1	5%	There is a strong network
God is best motivator	1	5%	We need to stay busy and do God's work. He will provide.
Improve re-Recruitment of Physicians	1	5%	It is difficult to keep doctors in town, whether it is about not liking the area, money…it keeps us from having continuity of care.
Increase awareness for affordable dental care	1	5%	
People do not take care of themselves.	1	5%	
Total	**22**	**100%**	

Secondary Data

Introduction

Secondary data in this assessment includes population data for the Centra Farmville Service Area. The service area includes Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway and Prince Edward counties.

TABLE: Population by Age Category by Locality

AGE GROUP	Amelia		Buckingham		Charlotte	
	Number	Percent	Number	Percent	Number	Percent
Under 5 years	702	5.5%	849	5.0%	701	5.7%
5 to 9 years	854	6.7%	884	5.2%	749	6.1%
10 to 14 years	684	5.3%	981	5.8%	683	5.6%
15 to 19 years	800	6.3%	867	5.1%	875	7.2%
20 to 24 years	829	6.5%	1,107	6.5%	736	6.0%
25 to 34 years	1,182	9.2%	2,243	13.2%	1,034	8.5%
35 to 44 years	1,415	11.1%	2,209	13.0%	1,372	11.2%
45 to 54 years	2,006	15.7%	2,637	15.5%	1,771	14.5%
55 to 59 years	1,107	8.7%	1,340	7.9%	669	5.5%
60 to 64 years	890	7.0%	1,076	6.3%	1,150	9.4%
65 to 74 years	1,453	11.4%	1,725	10.1%	1,426	11.7%
75 to 84 years	595	4.7%	920	5.4%	688	5.6%
85 years and over	276	2.2%	192	1.1%	378	3.1%
Median Age	**44.3**	**100.0%**	**42.4**	**100.0%**	**44.7**	**100.0%**
TOTAL	**12,793**		**17,030**		**12,232**	

Table Source: US Census. American Fact Finder. Table DP05. ACS Demographic and Housing Estimates. 2012-2016 American Community Survey 5-Year Estimates. Retrieved from https://factfinder.census.gov

TABLE: Population by Age Category by Locality

AGE GROUP	Cumberland		Lunenburg		Nottoway	
	Number	Percent	Number	Percent	Number	Percent
Under 5 years	526	5.4%	630	5.1%	839	5.4%
5 to 9 years	550	5.6%	746	6.0%	856	5.5%
10 to 14 years	590	6.0%	648	5.2%	913	5.8%
15 to 19 years	595	6.1%	600	4.8%	980	6.3%
20 to 24 years	665	6.8%	724	5.8%	1,043	6.7%
25 to 34 years	944	9.7%	1,359	10.9%	1,917	12.3%
35 to 44 years	1,082	11.1%	1,480	11.9%	1,973	12.6%
45 to 54 years	1,518	15.5%	1,805	14.5%	2,201	14.1%
55 to 59 years	766	7.8%	960	7.7%	1,041	6.7%
60 to 64 years	641	6.6%	1,035	8.3%	1,017	6.5%
65 to 74 years	1,263	12.9%	1,424	11.4%	1,567	10.0%
75 to 84 years	430	4.4%	758	6.1%	938	6.0%
85 years and over	199	2.0%	281	2.3%	356	2.3%
Median Age	**44.4**	**100.0%**	**45.2**	**100.0%**	**41.9**	**100.0%**
TOTAL	**9,769**		**12,450**		**15,641**	

TABLE: Population by Age Category by Locality

AGE GROUP	Prince Edward		Farmville Town		Service Area		
	Number	Percent	Number	Percent	Number	Percent	VA
Under 5 years	972	4.2%	436	5.1%	5,219	5.1%	6.1%
5 to 9 years	978	4.2%	291	3.4%	5,617	5.5%	6.3%
10 to 14 years	1,013	4.4%	355	4.1%	5,512	5.4%	6.2%
15 to 19 years	3,069	13.3%	1,625	19.0%	7,786	7.6%	6.6%
20 to 24 years	4,077	17.7%	2,386	27.9%	9,181	8.9%	7.1%
25 to 34 years	2,040	8.8%	738	8.6%	10,719	10.4%	13.9%
35 to 44 years	2,335	10.1%	733	8.6%	11,866	11.5%	13.2%
45 to 54 years	2,484	10.8%	649	7.6%	14,422	14.0%	14.2%
55 to 59 years	1,177	5.1%	190	2.2%	7,060	6.9%	6.7%
60 to 64 years	1,436	6.2%	262	3.1%	7,245	7.0%	5.9%
65 to 74 years	1,853	8.0%	342	4.0%	10,711	10.4%	8.2%
75 to 84 years	1,038	4.5%	327	3.8%	5,367	5.2%	4.0%
85 years and over	605	2.6%	228	2.7%	2,287	2.2%	1.7%
Median Age	**31.5**	**100.0%**	**22.1**	**100.0%**	**40.9**	**100.0%**	**37.8**
TOTAL	**23,077**		**8,562**		**102,992**		

Tables Source: US Census. American Fact Finder. American Community Survey 2012-2016 Demographic and Housing Estimates. Table DP05.

TABLE: Population by Sex

LOCALITY	Male	Percent	Female	Percent
AMELIA	6,642	51.9%	6,151	48.1%
BUCKINGHAM	9,453	55.5%	7,577	44.5%
CHARLOTTE	6,121	50.0%	6,111	50.0%
CUMBERLAND	4,779	48.9%	4,990	51.1%
LUNENBURG	6,498	52.2%	5,952	47.8%
NOTTOWAY	8,483	54.2%	7,158	45.8%
PRINCE EDWARD	11,532	50.0%	11,545	50.0%
FARMVILLE TOWN	3,586	41.9%	4,976	58.1%
SERVICE AREA	**57,094**	**51.2%**	**54,460**	**48.8%**
VIRGINIA		**49.2%**		**50.8%**

Source: US Census. American Fact Finder. American Community Survey 2012-2016 Demographic and Housing Estimates. Table DP05

TABLE: Population by Race

LOCALITY	White	Black	American Indian/ Alaskan Native	Asian	Native Hawaiian/ Pacific Isl.	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino
AMELIA	9,237	3,010	65	16	-	33	280	152	12,641
BUCKINGHAM	10,380	5,818	23	75	11	-	320	403	16,627
CHARLOTTE	8,230	3,750	21	16	-	-	99	116	12,116
CUMBERLAND	6,144	3,272	67	-	-	-	271	15	9,754
LUNENBURG	7,454	3,907	18	327	-	14	205	525	11,925
NOTTOWAY	8,605	6,075	22	92	23	-	226	598	15,043
PRINCE EDW	14,360	7,514	127	297	-	-	215	564	22,513
FARMVILLE	5,447	2,405	17	96	-	-	184	413	8,149
SERVICE AREA	**69,857**	**35,751**	**360**	**919**	**34**	**47**	**1,800**	**2,786**	**108,768**

TABLE: Population by Race by Percent of Total Population

LOCALITY	White	Black	American Indian / Alaskan Native	Asian	Native Hawaiian/ Pacific Isl.	Some Other Race	Two or More Races	Hispanic or Latino	Not Hispanic or Latino
AMELIA	72.2%	23.5%	0.5%	0.1%	0.0%	0.3%	2.2%	1.2%	98.8%
BUCKING-HAM	61.0%	34.2%	0.1%	0.4%	0.1%	0.0%	1.9%	2.4%	97.6%
CHARLOTTE	67.3%	30.7%	0.2%	0.1%	0.0%	0.0%	0.8%	0.9%	99.1%
CUMBER-LAND	62.9%	33.5%	0.7%	0.0%	0.0%	0.0%	2.8%	0.2%	99.8%
LUNENBURG	59.9%	31.4%	0.1%	2.6%	0.0%	0.1%	1.6%	4.2%	95.8%
NOTTOWAY	55.0%	38.8%	0.1%	0.6%	0.1%	0.0%	1.4%	3.8%	96.2%
PRINCE EDW	62.2%	32.6%	0.6%	1.3%	0.0%	0.0%	0.9%	2.4%	97.6%
FARMVILLE	63.6%	28.1%	0.2%	1.1%	0.0%	0.0%	2.1%	4.8%	95.2%
SERVICE AREA	62.6%	32.0%	0.3%	0.8%	0.0%	0.0%	1.6%	2.5%	97.5%
VIRGINIA	63.1%	18.9%	0.2%	6.0%	0.1%	0.2%	2.8%	8.7%	91.3%

Tables Source: US Census. American Fact Finder. Table DP05. ACS Demographic and Housing Estimates. 2012-2016 American Community Survey 5-Year Estimates. Retrieved from https://factfinder.census.gov

TABLE: Language Spoken at Home

LOCALITY	Percent	Total Population	Non-English Speakers	% Non-English Speakers	Spanish	Asian or Pacific Isl.
AMELIA	1.1%	12,091	139	1.10%	60	16
BUCKINGHAM	3.4%	16,181	552	3.40%	289	61
CHARLOTTE	1.8%	11,531	206	1.80%	62	0
CUMBERLAND	1.3%	9,243	123	1.30%	48	0
LUNENBURG	6.0%	11,820	706	6.00%	420	194
NOTTOWAY	4.1%	14,802	608	4.10%	387	68
PRINCE EDWARD	4.5%	22,105	1001	4.50%	514	181
SERVICE AREA	**3.4%**	**97,773**	**3335**	**3.41%**		
VIRGINIA	**15.5%**		**1,211,386**	**15.5%**		**287,396**

Table Source: US Census, American Fact Finder. American Community Survey 5-Year Estimates 2016-2012. Table S1601.

SOCIOECONOMIC FACTORS

Social Vulnerability Index

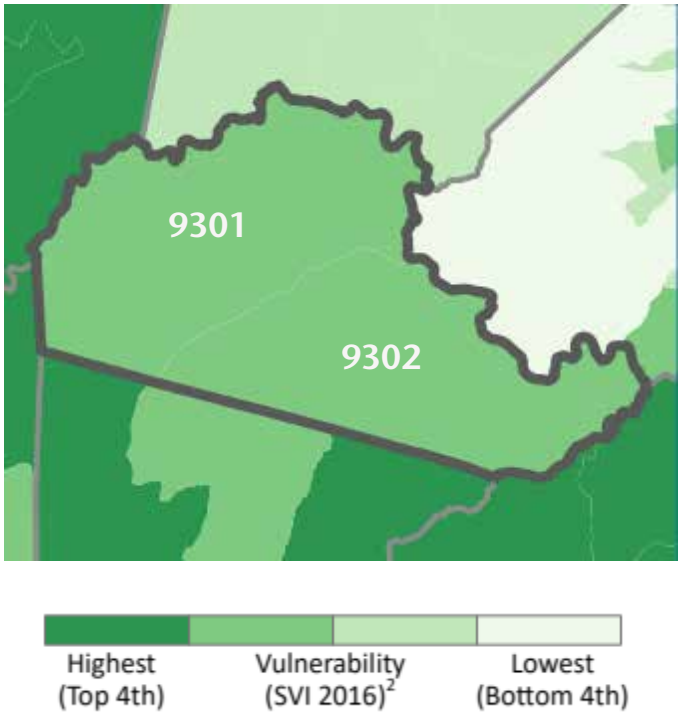
"What is Social Vulnerability? Every community must prepare for and respond to hazardous events, whether a natural disaster like a tornado or a disease outbreak, or an anthropogenic (caused by human action or inaction) event such as a harmful chemical spill. The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The Agency for Toxic Substances and Disease Registry's Geospatial Research, Analysis & Services Program (GRASP) created a tool to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event. The Social Vulnerability Index (SVI) indicates the relative vulnerability of every U.S. Census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. The SVI ranks the tracts on 15 social factors, including unemployment, minority status, and disability, and further groups them into four related themes. Thus, each tract receives a ranking for each Census variable and for each of the four themes, as well as an overall ranking. The Socioeconomic theme includes the American Community Survey's 5-year date for 2010-2014 for the following variables; below poverty, unemployed, income and no high school diploma."

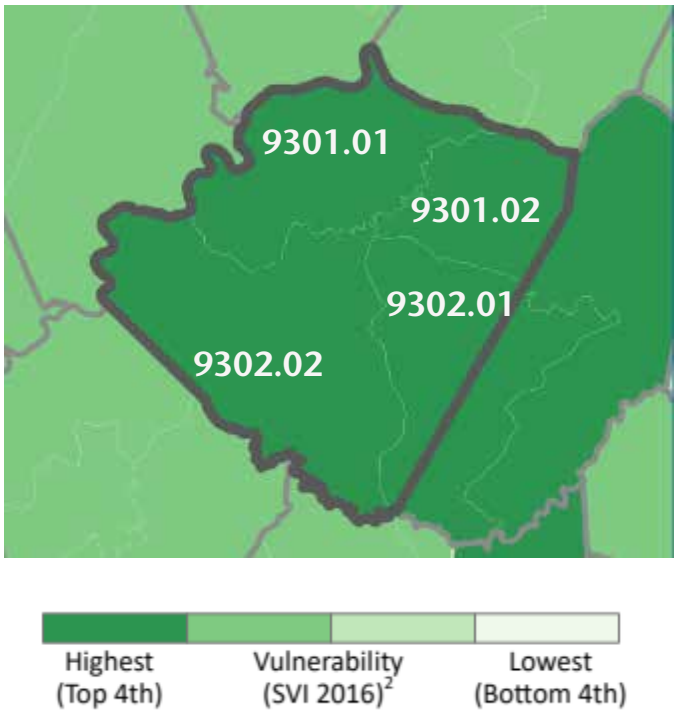
[Citation: Agency for Toxic Substances & Disease Registry. Social Vulnerability Index (SVI) Mapping Dashboard. Retrieved from https://svi.cdc.gov/map.aspx]

For purposes of this assessment, the maps provide visual representation of highest vulnerability combining the four Socioeconomic factors. The last four digits of the Census Tract are used for identification.

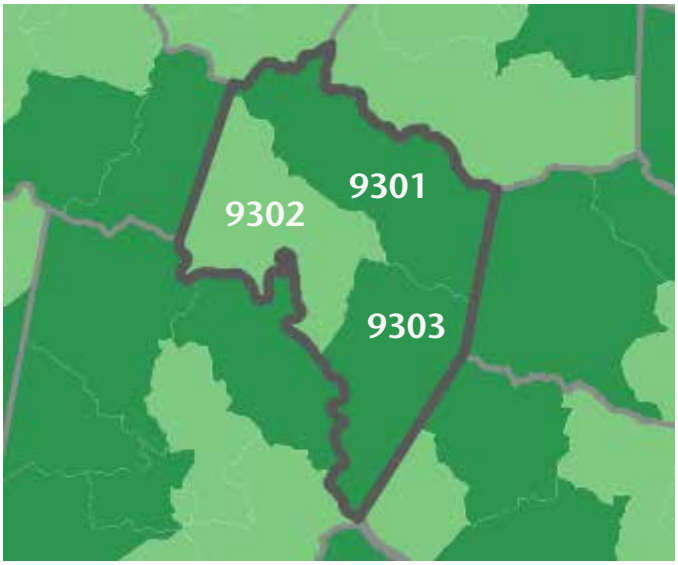
Amelia County - Population residing in highest quartile: 0% (0)



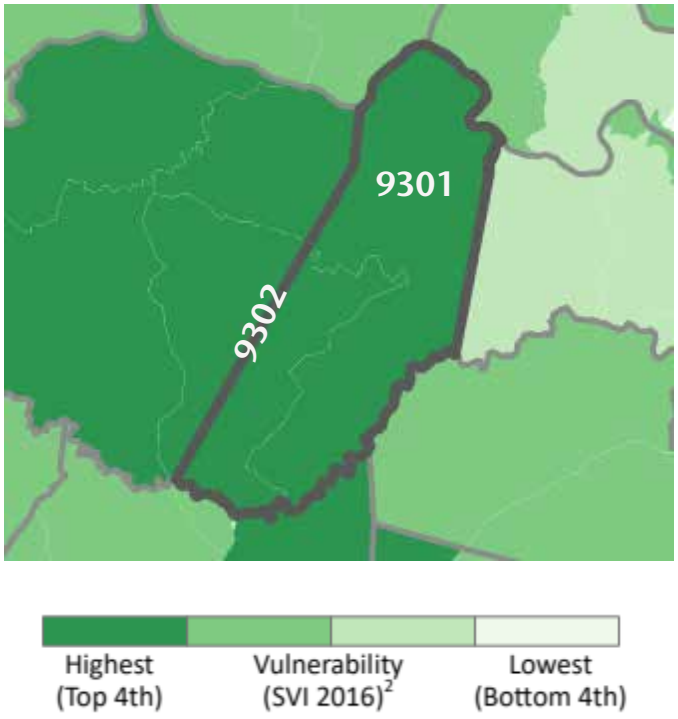
Buckingham County – Population residing in highest quartile: 100% (17,030)



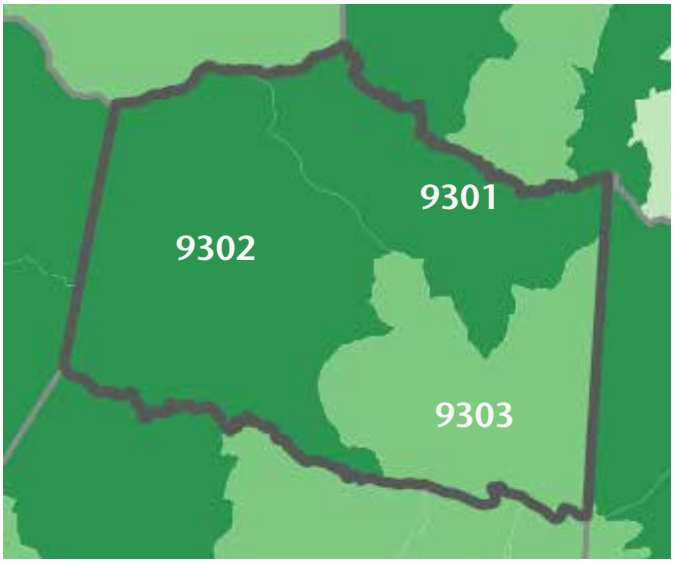
Charlotte County – Population residing in highest quartile: 77.0% (9,425)



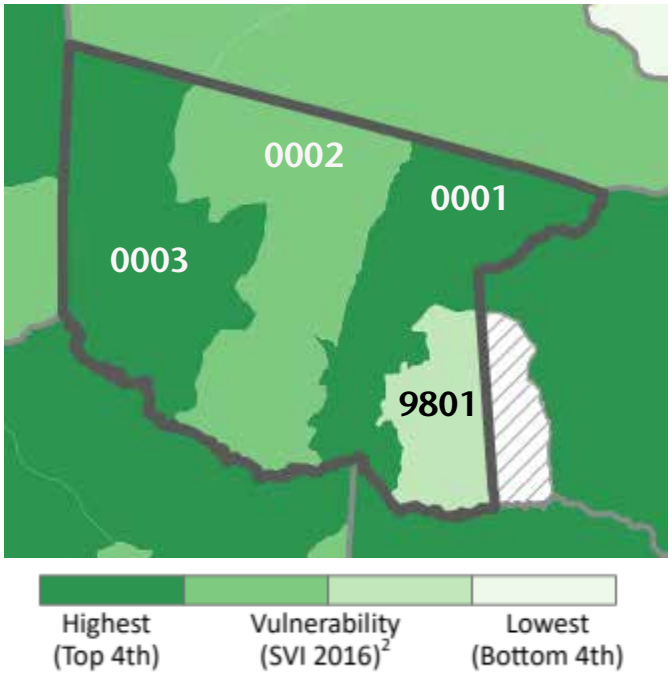
Cumberland County – Population residing in highest quartile: 100% (9,766)



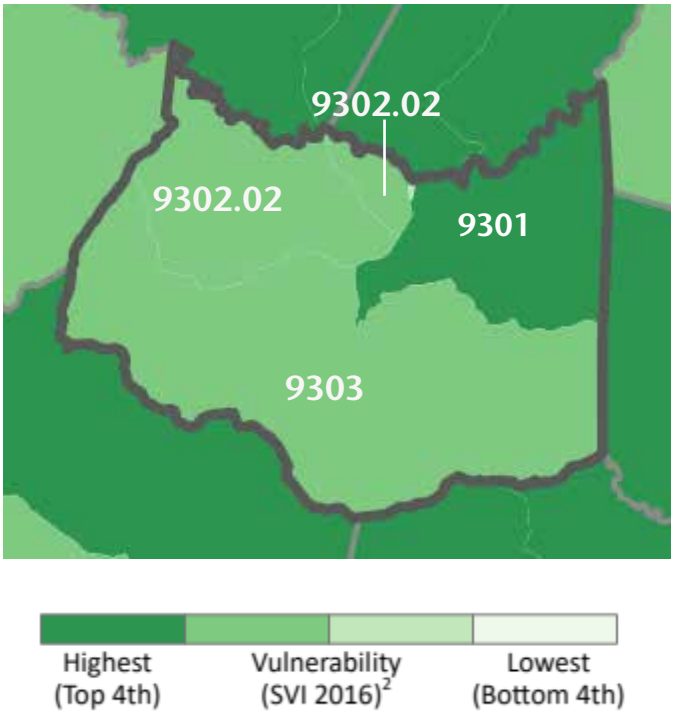
Lunenburg County – Population residing in highest quartile: 81.0% (10,084)



Nottoway County – Population residing in highest quartile: 55.5% (35,249)



Prince Edward County – Population residing in highest quartile: 28.6% (6,600)



Map Source: Agency for Toxic Substances & Disease Registry. Social Vulnerability Index (SVI). Retrieved from https://svi.cdc.gov/PreparedCountyMaps.html

SOCIOECONOMIC FACTORS

1. Education

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

- At age 25, U.S. adults without a high school diploma can expect to die 9 years sooner than college graduates.
- According to one study, college graduates with only a Bachelor's degree were 26 percent more likely to die during a 5-year study follow-up period than those with a professional

degree. Americans with less than a high school education were almost twice as likely to die in the next 5 years compared to those with a professional degree.

- Among whites with less than 12 years of education, life expectancy at age 25 fell by more than 3 years for men and by more than 5 years for women between 1990 and 2008.
- By 2011, the prevalence of diabetes had reached 15 percent for adults without a high school education, compared with 7 percent for college graduates."

Citation: Zimmerman, E. B., Woolf, S.H., Haley, A. Agency for Healthcare Research and Quality. Population Health: Behavioral and Social Science Insights. Understanding the Relationship Between Education and Health. Accessed March 22, 2018. Retrieved from https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html. Footnotes in article - Missing Page. Content last reviewed July 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/ref12/index.html

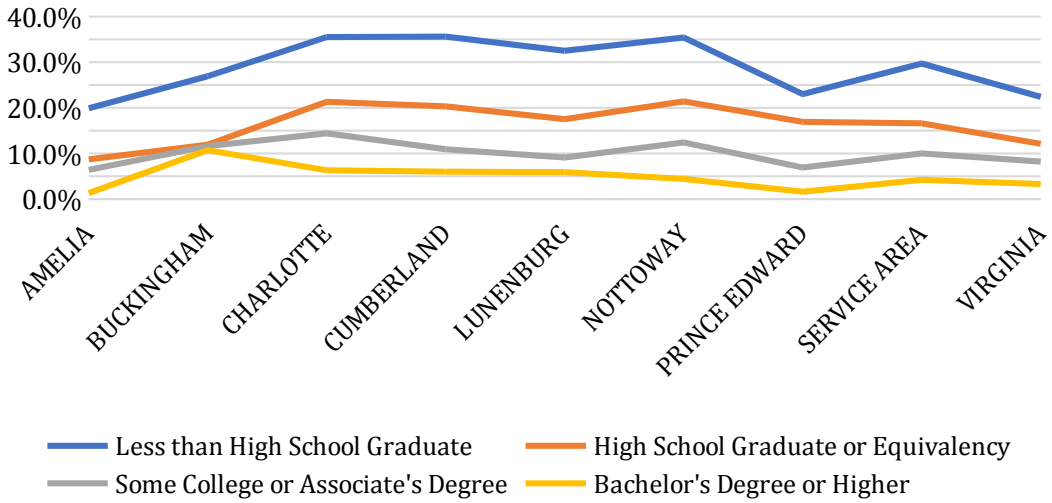
Poverty Status and Educational Attainment

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

LOCALITY	Less than High School Graduate	High School Graduate or Equivalency	Some College or Associate's Degree	Bachelor's Degree or Higher
AMELIA	19.9%	8.7%	6.4%	1.3%
BUCKINGHAM	26.9%	11.9%	11.6%	10.7%
CHARLOTTE	35.5%	21.3%	14.4%	6.3%
CUMBERLAND	35.6%	20.3%	10.9%	6.0%
LUNENBURG	32.5%	17.5%	9.1%	5.9%
NOTTOWAY	35.4%	21.4%	12.4%	4.4%
PRINCE EDWARD	23.0%	16.9%	6.9%	1.6%
SERVICE AREA	**29.7%**	**16.6%**	**10.0%**	**4.2%**
VIRGINIA	**22.4%**	**12.1%**	**8.2%**	**3.3%**

Table and Chart 1 Source: US Census. American Fact Finder. Poverty Status in the last 12 months. 2012-2016. American Community Survey 5-Year Estimates. Table S1701.

Chart: Poverty Status and Educational Attainment



Among service area localities, 1 in 3 Charlotte, Cumberland, and Nottoway County residents living in poverty have less than a high school education. Not far behind these counties are persons living in poverty in Lunenburg County where a little over 3 in ten persons in poverty have less than a high school education. Across localities, the service area, and overall state rate, the largest difference is between those who have less than a high school education and those who have a high school education or equivalent – a stark representation of the value of achieving, at a minimum, a high school or equivalent education. Chart 1 provides a visual representation of the difference in poverty status based on educational attainment with a clear indication of the gulf between less than a high school education and those with a high school education.

Educational Attainment

TABLE: Educational Attainment by Locality for the Population Age 25 and Over

LOCALITY	Population 25 Years and Over	Less than High School Graduate	High School Graduate or Equivalency	Some College or Associate's Degree	Bachelor's Degree or Higher
AMELIA	8,924	18.7%	36.8%	30.4%	14.1%
BUCKINGHAM	12,342	22.5%	42.0%	23.6%	11.9%
CHARLOTTE	8,488	20.0%	41.1%	25.8%	13.0%
CUMBERLAND	6,843	20.6%	35.7%	28.6%	15.1%
LUNENBURG	9,102	24.2%	35.5%	28.5%	11.8%
NOTTOWAY	11,010	25.1%	36.5%	23.1%	15.2%
PRINCE EDWARD	12,968	16.9%	34.6%	25.3%	23.2%
FARMVILLE TOWN	3,469	13.1%	36.9%	21.2%	28.8%
SERVICE AREA	**73,146**	**20.7%**	**37.5%**	**25.9%**	**15.9%**
VIRGINIA		**11.4%**	**24.5%**	**27.2%**	**36.9%**

Source: US Census. American Fact Finder. Educational Attainment 2012-2016 American Community Survey 5-Year Estimates. Table S1501.

There is striking difference between the overall state rate across all attainment categories and the overall service area and localities that comprise the service area rates. Most glaring is the 1 in 4 Nottoway County residents age 25 and older with less than a high school education. One of five Buckingham, Charlotte, and Cumberland County residents have less than a high school education. With the exception of the persons with some college or an Associate's Degree, the service area has education attainment rates that are significantly lower than the overall state education attainment rates.

Graduation and Drop-Out Rates

TABLE: On Time Graduation and Drop-Out Rates by School, by Locality by Race by Selected Subgroup by Percent Selected by Subgroup

AMELIA							
Amelia High School	Total	Male	Female	White	Black	Economically Disadvantaged	Disabilities
On-Time Graduation Rate	93.5	91.6	95.8	91.0	100.0	87.5	78.9
Drop-out Rate	6.5	8.4	4.2	9.0	0.0	12.5	21.1

BUCKINGHAM							
Buckingham High School	Total	Male	Female	White	Black	Economically Disadvantaged	Disabilities
On-Time Graduation Rate	94.4	93.0	95.8	94.5	96.5	92.8	86.7
Drop-out Rate	4.2	5.6	2.8	4.1	3.5	6.0	13.3

CHARLOTTE							
Randolph Henry High School	Total	Male	Female	White	Black	Economically Disadvantaged	Disabilities
On-Time Graduation Rate	87.0	84.3	90.1	80.9	95.1	85.5	84.2
Drop-out Rate	9.1	12.0	5.6	12.4	4.9	10.5	15.8

CUMBERLAND							
Cumberland High School	Total	Male	Female	White	Black	Economically Disadvantaged	Disabilities
On-Time Graduation Rate	94.0	95.5	92.9	95.7	95.6	91.5	NR
Drop-out Rate	4.0	4.5	3.6	4.3	2.2	5.1	NR

LUNENBURG							
Central High School	Total	Male	Female	White	Black	Economically Disadvantaged	Disabilities
On-Time Graduation Rate	88.0	8.5	92.0	91.0	84.4	87.1	90.9
Drop-out Rate	9.4	11.9	6.0	9.0	11.1	9.4	9.1

NOTTOWAY							
Nottoway High School	Total	Male	Female	White	Black	Economically Disadvantaged	Disabilitiess
On-Time Graduation Rate	87.1	79.1	95.3	85.9	90.9	80.2	79.2
Drop-out Rate	9.4	16.3	2.4	9.8	6.1	14.8	20.8

PRINCE EDWARD							
Prince Edward High School	Total	Male	Female	White	Black	Economically Disadvantaged	Disabilities
On-Time Graduation Rate	93.2	89.0	98.6	95.7	91.8	95.9	100.0
Drop-out Rate	3.7	6.6	0.0	2.2	4.5	0.0	0.0

Table Source: Virginia Department of Education. Statistics and Reports. Graduation, Completion, Dropout & Postsecondary Date. 2013-2017 Cohort. Accessed March 22, 2018. Retrieved from http://www.doe.virginia.gov/statistics_reports/graduation_completion/cohort_reports/index.shtml

Chronic Absenteeism

"Chronic absenteeism—or missing at least 10 percent of school days in a school year for any reason, excused or unexcused—is a primary cause of low academic achievement and a powerful predictor of those students who may eventually drop out of school. An estimated five to seven and a half million students miss 18 or more days of school each year, or nearly an entire month or more of school, which puts them at significant risk of falling behind academically and failing to graduate from high school. Because they miss so much school, millions of young people miss out on opportunities in post-secondary education and good careers.

Chronic absenteeism is also an equity issue, and it is particularly prevalent among students who are low-income, students of color, students with disabilities, students who are highly mobile, and/or juvenile justice-involved youth—in other words, those who already tend to face significant challenges and for whom school is particularly beneficial. Moreover, chronic absenteeism is often confused with truancy, which can lead to disproportionate suspensions and expulsions from school and inappropriate referrals of students and families to law enforcement."

[Citation: US Department of Education. Every Student, Every Day National Conference: Eliminating Chronic Absenteeism by Implementing and Strengthening Cross-Sector Systems of Support for All Students. June 2016. Retrieved from https://www2.ed.gov/about/inits/ed/chronicabsenteeism/index.html]

TABLE: Chronic Absenteeism by Percent

LOCALITY	2017-2016	2016-2015	2015-2014
AMELIA	19.5	15.3	16.4
BUCKINGHAM	15.1	24.9	15.1
CHARLOTTE	14.2	13.6	16.2
CUMBERLAND	14.9	16.6	13.7
LUNENBURG	18.4	16.2	13.2
NOTTOWAY	17.1	17.0	16.9
PRINCE EDWARD	18.5	17.5	17.5
SERVICE AREA	**16.9**	**17.4**	**15.8**
VIRGINIA	**10.6**	**10.4**	**10.1**

Source: KIDS COUNT data center at https://datacenter.kidscount.org/data/tables/9607-chronic-absenteeism#detailed/5/6812-6821,6823-6945/false/1636,1635,1634/any/18819,18820

The chronic absenteeism rate in the service area is higher than the overall state rate. Absenteeism rates rather for the state, service area, or the localities that comprise the service area have generally remained steady over the four-year period (2014-2017). Four of the seven localities in the service area have rates that have increased from 2015-2014 to 2017-2016. The service area chronic absenteeism rate is much higher than the state chronic absenteeism rate. The rates parallel the gaps between the service area's educational attainment rate and the overall state rate for persons with less than a high school education.

Free and Reduced Lunch Data

"The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or no-cost lunches to children each school day. Participating school districts and independent schools receive cash subsidies and USDA Foods for each reimbursable meal they serve. In exchange, NSLP institutions must serve lunches that meet Federal meal pattern requirements and offer the lunches at a free or reduced price to eligible children. School food authorities can also be reimbursed for snacks served to children who participate in an approved afterschool program including an educational or enrichment activity. All NSLP lunches must meet Federal requirements, though decisions about the specific foods to serve and the methods of preparation are made by local school food authorities."

Eligibility

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

[Citation: United States Department of Agriculture. The National School Lunch Program. Retrieved from https://fns-prod.azureedge.net/sites/default/files/cn/NSLPFactSheet.pdf]

TABLE: Free and Reduced Lunch Program Statistics by Locality by School

AMELIA COUNTY	School Type	SNAP Member	FREE Eligibility	FREE Percent	Reduced Eligibility	Reduced Percent	TOTAL Eligibility	TOTAL Percent
AMELIA COUNTY HIGH	High	551	198	35.9%	29	5.3%	227	41.2%
AMELIA COUNTY MIDDLE	Combined	515	210	40.8%	33	6.4%	243	47.2%
AMELIA COUNTY ELEM	Elementary	726	342	47.1%	56	7.7%	398	54.8%
		1,792	750	41.9%	118	6.6%	868	48.4%
BUCKINGHAM COUNTY								
BUCKINGHAM PRE SCHOOL	Elementary	108	88	81.5%	0	0.0%	88	81.5%
BUCKINGHAM CO HIGH	High	550	292	53.1%	64	11.6%	356	64.7%
BUCKINGHAM MIDDLE	Middle	426	247	58.0%	45	10.6%	292	68.5%
BUCKINGHAM PRIMARY	Elementary	464	380	81.9%	0	0.0%	380	81.9%
BUCKINGHAM CO ELEM	Elementary	518	424	81.9%	0	0.0%	424	81.9%
		2,066	1,431	69.3%	109	5.3%	1,540	74.5%
CHARLOTTE COUNTY								
EUREKA ELEM	Elementary	452	252	55.8%	19	4.2%	271	60.0%
CENTRAL MIDDLE	Middle	449	224	49.9%	39	8.7%	263	58.6%
PHENIX ELEM	Elementary	272	137	50.4%	18	6.6%	155	57.0%
RANDOLPH-HENRY HIGH	High	525	204	38.9%	43	8.2%	247	47.1%
BACON DISTRICT ELEM	Elementary	174	106	60.9%	14	8.1%	120	69.0%
		1,872	923	49.3%	133	7.1%	1,056	56.4%

CUMBERLAND COUNTY	School Type	SNAP Member	FREE Eligibility	FREE Percent	Reduced Eligibility	Reduced Percent	TOTAL Eligibility	TOTAL Percent
CUMBERLAND ELEM	Elementary	534	458	85.8%	0	0.0%	458	85.8%
CUMBERLAND HIGH	High	420	260	61.9%	13	3.1%	273	65.0%
CUMBERLAND MIDDLE	Combined	399	240	60.2%	25	6.3%	265	66.4%
		1,353	958	70.8%	38	2.8%	996	73.6%
LUNENBURG COUNTY								
VICTORIA ELEM	Elementary	366	228	62.3%	33	9.0%	261	71.3%
LUNENBURG MIDDLE	Middle	384	214	55.7%	48	12.5%	262	68.2%
KENBRIDGE ELEM	Elementary	375	241	64.3%	23	6.1%	264	70.4%
CENTRAL HIGH	High	410	196	47.8%	34	8.3%	230	56.1%
		1,535	879	57.3%	138	9.0%	1,017	66.3%
NOTTOWAY COUNTY								
NOTTOWAY INTERMED	Elementary	322	181	56.2%	27	8.4%	208	64.6%
NOTTOWAY HIGH	High	588	322	54.8%	35	6.0%	357	60.7%
NOTTOWAY MIDDLE	Middle	305	178	58.4%	14	4.6%	192	63.0%
CREWE PRIMARY	Elementary	396	270	68.2%	16	4.0%	286	72.2%
BLACKSTONE PRIMARY	Elementary	474	299	63.1%	35	7.4%	334	70.5%
		2,091	1,255	60.0%	127	6.1%	1,382	66.1%
PRINCE EDWARD CO.								
PRINCE EDWARD ELEM	Elementary	843	749	88.9%	0	0.0%	749	88.9%
PRINCE EDWARD MIDDLE	Combined	596	414	69.5%	20	3.4%	434	72.8%
PRINCE EDWARD HIGH	High	633	358	56.6%	24	3.8%	382	60.4%
		2,072	1,521	73.4%	44	2.1%	1,565	75.5%
SERVICE AREA		**12,781**	**7,717**	**60.4%**	**707**	**5.5%**	**8,424**	**65.9%**
VIRGINIA				**39.0%**		**5.3%**		**44.3%**

Table Source: Virginia Department of Education retrieved from http://www.doe.virginia.gov/support/nutrition/statistics/index.shtml

The tables above compare Free and Reduced Program rates among localities and individual schools. This data is valuable in identifying school districts and their geographic boundaries that have higher rates of low income families and children. Overall, 65.9% of service area schools have students eligible for free and reduced lunch.

SOCIOECONOMIC FACTORS

2. Employment

"For millions of Americans, a steady job in safe working conditions means more than simply a paycheck—employment can also provide the benefits and stability critical to maintaining proper health. On the flip side, job loss and unemployment are associated with a variety of negative health effects.

A good-paying job makes it easier for workers to live in healthier neighborhoods, provide quality education for their children, secure child care services, and buy more nutritious food—all of which affect health. Good jobs also tend to provide good benefits. Higher earning also translates to a longer lifespan—since 1977, the life expectancy of male workers retiring at age 65 has risen 5.8 years in the top half of the income distribution, but only 1.3 years in the bottom half. By contrast, unemployed Americans face numerous health challenges beyond loss of income. Laid-off workers are far more likely than those continuously employed to have fair or poor health, and to develop a stress-related condition, such as stroke, heart attack, heart disease, or arthritis. With respect to mental health, a 2010 Gallup Poll found that unemployed Americans were far more likely than employed Americans to be diagnosed with depression and report feelings of sadness and worry."

[Citation: https://www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health-.html]

"Research points to a link between an unhealthy workforce and unhealthy communities. [2] Even when an employer implements health-promoting strategies at the worksite, if employees then go home to unhealthy neighborhoods, the workplace progress is compromised. Improved community conditions for health, such as clean air laws, access to an abundance of healthy food options, clean and safe neighborhoods, and opportunities for exercise and physical activity, can help positively influence health behaviors and lead to a more productive workforce. Conversely, habits like cigarette smoking, nutritionally poor food intake, and insufficient exercise contribute to chronic health conditions that impact worker productivity and employer spending. [3]"

[Citation: Robert Wood Johnson Issue Brief: Why Healthy Communities Matter to Business. Retrieved from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf428899]

References

[2] Oziransky V, Yach D, Tsu-Yu T, Luterek A, ad Stevens D. Beyond the Four Walls: Why Community is Critical to Workforce Health. Vitality Institute; 2015.

[3] Centers for Disease Control and Prevention. Smoking & Tobacco Use. Last reviewed February 14, 2014. Accessed March 3, 2014.

Unemployment Rates

TABLE: Unemployment Rates 2014 to 2017

LOCALITY	Percent Change 2014 to 2017	2017	2016	2015	2014
AMELIA	-1.4	4.0	4.2	4.5	5.3
BUCKINGHAM	-1.4	5.4	5.3	5.9	6.8
CHARLOTTE	-2.0	4.8	5.0	5.7	6.8
CUMBERLAND	-1.9	4.2	4.6	5.1	6.1
LUNENBURG	-1.5	4.4	4.6	5.1	5.9
NOTTOWAY	-1.5	3.9	3.9	4.5	5.4
PRINCE EDWARD	-2.6	5.1	5.3	6.3	7.7
VIRGINIA	**-1.4**	**3.8**	**4.1**	**4.5**	**5.2**

Table Source: Virginia Employment Commission, Economic Information & Analytics, Local Area Unemployment Statistics.

TABLE: Employees and Wages

LOCALITY	Number of Employees	Average Hourly Wage*	Average Weekly Wage*	Average Annual Wage*
AMELIA	3,464	$17.38	$695	$36,140
BUCKINGHAM	3,119	$17.50	$700	$36,400
CHARLOTTE	2,927	$15.98	$639	$33,228
CUMBERLAND	1,411	$16.25	$650	$33,800
LUNENBURG	2,569	$15.95	$638	$33,176
NOTTOWAY	5,484	$17.28	$691	$35,932
PRINCE EDWARD	9,212	$16.93	$677	$35,204
SERVICE AREA	**28,186**	**$16.89**	**$676**	**$35,133**
VIRGINIA	**3,836,789**	**$26.30**	**$1,052**	**$54,704**
*** Assumes a 40-hour week worked year-round.**				

Table Source: Virginia Employment Commission, Economic Information & Analytics, Local Area Unemployment Statistics.

While unemployment rates have declined from 2014 to 2017 a more important indicator is the wage information as this directly corresponds to income and a household's ability to purchase and acquire goods and services that impact health. State wages are impacted by areas within the commonwealth that have higher costs of living and therefore have higher wages such as Northern Virginia. Despite this fact, there are localities within the service area where wages are low relative to the costs of insurance, food and other commodities that impact health. The hourly wage in the service area is approximately $9.41 an hour less than the overall state hourly wage and $376 a week lower than the state weekly wage.

Largest Employers

TABLE: Largest Employers at the End of the Third Quarter 2017

AMELIA	
Amelia County School Board	250-499 Employees
Amelia Life Care LLC	100-249 Employees
County of Amelia	50-99 Employees
Star Children's Dress Company	50-99 Employees
Food Lion	20-49 Employees
Average Employment	2,464

BUCKINGHAM	
Buckingham Correctional Center	250-499 Employees
Buckingham County School Board	250-499 Employees
Dillwyn Correctional Center	250-499 Employees
Kyanite Mining Corporation	100-249 Employees
County of Buckingham	100-249 Employees
Central Virginia Health Service Inc	100-249 Employees
Average Employment	3,119

CHARLOTTE	
Charlotte County School Board	250-499 Employees
Southside Virginia Community College	100-249 Employees
County of Charlotte	100-249 Employees
W & L Mail Service, Inc.	100-249 Employees
Average Employment	2,997

CUMBERLAND	
Cumberland County School Board	250-499 Employees
Primoris Energy Services	100-249 Employees
County of Cumberland	100-249 Employees
Gemini	100-249 Employees
Average Employment	1,411

LUNENBURG	
Virginia Marble Manufacturing	250-499 Employees
Lunenburg Correctional Center	250-499 Employees
Lunenburg County Public School	250-499 Employees
S & M Brands	50-99 Employees
Lunenburg County	20-49 Employees
Benchmark Community Bank	50-99 Employees
Average Employment	2,569

NOTTOWAY	
Virginia Center for Behavioral Rehab.	250-499 Employees
Nottoway Correctional Center	250-499 Employees
Nottoway County Public School Board	250-499 Employees
Piedmont Geriatric Hospital	250-499 Employees
U.S. Department of Defense	250-499 Employees
Virginia Department of Military Affairs	250-499 Employees
Heritage Hall	100-249 Employees
Wal Mart	100-249 Employees
County of Nottoway	100-249 Employees
Average Employment	5,485

PRINCE EDWARD	
Longwood University	1000 and over employees
Centra Health	500 to 999 employees
Prince Edward County Public Schools	250-499 Employees
Hampden-Sydney College	250-499 Employees
Wal Mart	250-499 Employees
Holly Manor Nursing Home	100-249 Employees
Immigration Centers of America	100-249 Employees
Crossroads Services Board	100-249 Employees
Aramark Campus LLC	100-249 Employees
Piedmont Regional Jail	100-249 Employees
County of Prince Edward	100-249 Employees
Town of Farmville Department of Public Works	100-249 Employees
Lowes' Home Centers, Inc.	100-249 Employees
Helton House Inc	100-249 Employees
P A B Inc	100-249 Employees
Average Employment	9,212

SOCIOECONOMIC FACTORS

3. Income

"The greater one's income, the lower one's likelihood of disease and premature death.[1] Studies show that Americans at all income levels are less healthy than those with incomes higher than their own.[2] Not only is income (the earnings and other money acquired each year) associated with better health, but wealth (net worth and assets) affects health as well. [3] Though it is easy to imagine how health is tied to income for the very poor or the very rich, the relationship between income and health is a gradient: they are connected step-wise at every level of the economic ladder. Middle-class Americans are healthier than those living in or near poverty, but they are less healthy than the upper class. Even wealthy Americans are less healthy than those Americans with higher incomes. Income is a driving force behind the striking health disparities that many minorities experience. In fact, although blacks and Hispanics have higher rates of disease than non-Hispanic whites, these differences are 'dwarfed by the disparities identified between high-and low-income populations within each racial/ethnic group.'[4] That is, higher-income blacks, Hispanics, and Native Americans have better health than members of their groups with less income, and this income gradient appears to be more strongly tied to health than their race or ethnicity."

[Citation: Virginia Commonwealth University Center for Society and Health and the Urban Institute. How are Income and Wealth Linked to Health and Longevity. April 2015. Retrieved from https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf]

References:

[2] Braveman, Paula A., Catherine Cubbin, Susan Egerter, David R. Williams, and Elsie Pamuk. 2010. "Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us." American Journal of Public Health 100 (S1): S186–S196. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837459/.

[3] Pollack, C. E., C. Cubbin, A. Sania, M. Hayward, D. Vallone, B. Flaherty, and P. A. Braveman. 2013. "Do Wealth Disparities Contribute to Health Disparities within Racial/Ethnic Groups?" Journal of Epidemiology and Community Health 67 (5): 439–45. http://www.ncbi.nlm.nih.gov/pubmed/23427209.

[4] Dubay, Lisa C., and Lydie A. Lebrun. 2012. "Health, Behavior, and Health Care Disparities: Disentangling the Effects of Income and Race in the United States." International Journal of Health Services 42 (4): 607–25. http://www.pubfacts.com/detail/23367796/Health-behavior-and-health-care-disparities:-disentangling-theeffects-of-income-and-race-in-the-Uni.

"Americans living in poverty have significantly constrained budgets that severely limit their ability to pay out-of-pocket health care costs; those in deep poverty have literally no available income after they pay for their most basic necessities each month, necessities which do not include health care, child care, or transportation. People in poverty tend to be less healthy than those with higher incomes and therefore need more medical care. But people in poverty are often unable to afford even nominal premiums and copayments, and research shows that they may forgo necessary medical treatment as a result of required cost-sharing."

[Citation: US Department of Health & Human Services. Office of the Assistant Secretary for Planning and Evaluation. Financial Condition and Health Care Burdens of People in Deep Poverty. July 16, 2015. Retrieved from https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty]

2018 Federal Poverty Guidelines

2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family/Household	Poverty Guideline
1	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$38,060
8	$42,380
For families/households with more than 8 persons, add $4,320 for each additional person.	

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

TABLE: Number and Percent of Population at or Below 100% Poverty and at or Below 200% of Poverty

LOCALITY	Number at or Below 100% of Poverty	Percent at r Below 100% of Poverty	Number at or Below 200% of Poverty	Percent at or Below 200% of Poverty
AMELIA	1,471	11.6%	4,261	33.6%
BUCKINGHAM	2,634	17.6%	5,632	37.6%
CHARLOTTE	2,979	24.7%	6,439	53.4%
CUMBERLAND	2,208	22.8%	4,097	42.3%
LUNENBURG	2,364	20.6%	5,585	48.7%
NOTTOWAY	3,034	21.3%	6,130	43.0%
PRINCE EDWARD	3,347	18.0%	8,766	47.1%
FARMVILLE TOWN	2,004	35.0%	3,554	62.1%
SERVICE AREA	**20,041**	**20.2%**	**44,464**	**43.2%**
VIRGINIA		**11.4%**		**26.6%**

Source: US Census, American Fact Finder. 2012-2016 American Community Survey 5-Year Estimates. Table 1701.

Persons in the service area living below 100% of the poverty level are approximately 1.8 times higher than that found in the overall state at or below poverty percentage. In Charlotte County, close to 1 in 4 residents live at or below poverty and over 1 in 3 Farmville residents reside below the poverty level. Every locality in the service area exceeds the state rate for both poverty groupings (100% and 200%).

TABLE: Median Household Income by Locality, by Race 2016-2012

LOCALITY	Median Household Income Total	Median Household Income White	Median Household Income Black	Median Household Income Hispanic
AMELIA	$58,269	$66,940	$43,616	
BUCKINGHAM	$43,514	$47,018	$33,250	$101,538
CHARLOTTE	$33,837	$36,384	$25,921	
CUMBERLAND	$37,489	$43,053	$26,290	
LUNENBURG	$39,911	$44,386	$30,264	$28,519
NOTTOWAY	$36,849	$43,347	$29,293	
PRINCE EDWARD	$42,283	$49,647	$29,513	
SERVICE AREA	**$42,540**	**$47,638**	**$30,599**	**$47,885**
VIRGINIA	**$66,149**	**$71,220**	**$45,374**	**$61,545**

Source: Source: US Census. American Fact Finder. Median Income in the Past 12 Months (in 2016 Inflation-Adjusted Dollars). 2012-2016 American Community Survey 5-Year Estimates. Table S1903.

Most striking is the difference between Household Income between Black and White households for each locality. The gap ranges from a low of $10,463 (Charlotte County) to a high of $23,324 (Amelia) with an average difference of $20,134 by household. This difference is a significant factor when considering health outcomes and behaviors by race listed in the assessment.

Impact of Poverty on Physical Health of Children

With the cost of living higher than what most people earn, **ALICE** families – an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed – have incomes above the Federal Poverty Level, but not high enough to afford a basic household budget that includes housing, child care, food, transportation, and health care. ALICE households live in every county and independent city in Virginia – urban, suburban, and rural – and they include women and men, young and old, and all races and ethnicities. While the Federal Poverty Level reports that 11 percent of Virginia households faced financial hardship in 2015, an additional 28 percent (859,079 households) qualified as ALICE. There are so many ALICE households in Virginia due to the fact that low wage jobs dominate the local economy; the basic cost of living outpaces wages; economic conditions worsened for these households during the Great Recession especially related to housing affordability, job opportunities and community resources; and public and private assistance do not provide financial stability for these households.

TABLE: ALICE Households by Locality by Percent, 2016

LOCALITY	Number of Households	ALICE Households #	ALICE Households %
Amelia	4,540	1,554	34%
Buckingham	5,689	2,143	38%
Charlotte	4,594	1,739	38%
Cumberland	4,085	1,427	35%
Lunenburg	4,670	1,690	36%
Nottoway	5,676	2,058	36%
Prince Edward	7,294	3,285	45%
Service Area	**36,548**	**13,896**	**38%**

Table Source: ALICE: Asset Limited, Income Constrained, Employed- Study of Financial Hardship, Virginia. United Ways of Virginia. Spring 2017. http://UnitedWayALICE.org/Virginia*)*

"Numerous studies have demonstrated that poverty is associated with higher rates of poor health and chronic health conditions in children. National surveys find that compared with parents who are not poor, parents who are poor more often rate their children's health as 'fair' or 'poor' and are less likely to rate their children's health as 'excellent.'[14] Children who are poor have higher rates of hospital admissions, disability days, and death rates. They have inadequate access to preventive, curative, and emergency care and are affected more frequently by poor nutrition, single-parent families, dysfunctional families, and poor housing. Exposure to lead hazards is an example of how poverty directly impacts child health. Four to 5 million children, the vast majority of whom are poor, reside in older homes with lead levels exceeding the accepted threshold for safety. More than 1.5 million of these children (younger than 6 years) have elevated blood lead levels. [15]

[Citation: Wood, David. American Academy of Pediatrics. Pediatrics. Effect of Child and Family Poverty on Child Health in the United States. September 2003, Volume 112/Issue Supplement 3. Retrieved from http://pediatrics.aappublications.org/content/112/Supplement_3/707]

References:
[14] Dawson DA. Family structure and children's health: United State, 1988. Vital Health Stat 10.1991;(178) :1– 47

[15] Brody DJ, Pirkle JL, Kramer RA, et al. Blood lead levels in the US population. Phase 1 of the Third National Health and Nutrition Examination Survey (NHANES III, 1988 to 1991). JAMA.1994;272 :277– 283

TABLE: Children that are Economically Disadvantaged

LOCALITY	Number at or Below 100% of Poverty	Percent at or Below 100% of Poverty	Number at or Below 200% of Poverty	Percent at or Below 200% of Poverty
AMELIA	473	17.0%	1,312	48.0%
BUCKINGHAM	1,023	31.0%	1,561	48.0%
CHARLOTTE	820	31.0%	1,720	65.0%
CUMBERLAND	763	38.0%	1,277	64.0%
LUNENBURG	635	27.0%	1,418	61.0%
NOTTOWAY	783	27.0%	1,686	59.0%
PRINCE EDWARD	827	23.0%	2,052	57.0%
SERVICE AREA	**5,324**	**26.5%**	**11,026**	**54.9%**
VIRGINIA	**280,144**	**16.0%**	**621,843**	**34.0%**

Source: Kids Count Data Center; US Census Bureau, American Community Survey 2014 & 2015. Retrieved from https://vakids.org/wp-content/uploads/2015/09/Southside-Region-1.pdf.

Approximately 1 in 4 children in the Service Area live at or below the Federal Poverty Level and over one-half live at or below 200% of poverty. Higher rates are found among children residing in Buckingham, Charlotte, and Cumberland counties. Children and adults between 200% and 300% of poverty are often economically vulnerable and may live "pay check-to-pay check". This reality suggests that more than 50% of the children residing in the Service Area are subject to the impact of living in or near poverty as described in the American Association of Pediatrics brief cited above and are at risk for poor health and issues associated with poverty.

Poverty and Seniors

"Payments from Social Security and Supplemental Security Income have played a critical role in enhancing economic security and reducing poverty rates among people ages 65 and older. Yet many older adults live on limited incomes and have modest savings. In 2016, half of all people on Medicare had incomes less than $26,200. This analysis provides current data on poverty rates among the 49.3 million seniors in the U.S. in 2016, as context for understanding the implications of potential changes to federal and state programs that help to bolster financial security among older adults.

The U.S. Census Bureau currently reports two different measures of poverty: the official poverty measure and the Supplemental Poverty Measure (SPM). Unlike the official poverty

measure, the SPM reflects available financial resources and liabilities, including taxes, the value of in-kind benefits (e.g., food stamps), and out-of-pocket medical spending (generally higher among older adults), and geographic variations in housing costs. This analysis presents national and state estimates of poverty under both measures for adults ages 65 and older. Current estimates of poverty based on the SPM indicate that the share (and number) of older adults who are struggling financially is larger than is conveyed by the official poverty measure.

Key Findings

- Under the SPM, 7.1 million adults ages 65 and older lived in poverty in 2016 (14.5%), compared to 4.6 million (9.3%) under the official poverty measure.
- Nearly 21 million people ages 65 and older had incomes below 200% of poverty under the SPM in 2016 (42.4%), compared to 15 million (30.4%) under the official measure.
- Under both the official measure and the SPM, the poverty rate among people ages 65 and older increased with age and was higher for women, blacks and Hispanics, and people in relatively poor health.
- Under the SPM, 4.4 million older women lived in poverty in 2016, 1.5 million more than under the official measure; 2.8 million older men lived in poverty under the SPM, 1.1 million more than under the official measure.
- Under the SPM, at least 15% of people ages 65 and older lived in poverty in 10 states (CA, FL, GA, HI, IN, LA, NJ, NM, TX, and VA) plus Washington, D.C. in 2016; under the official poverty measure, only D.C. had a poverty rate above 15% for older adults in 2016."

[Citation: Juliette Cubanski, Kendal Orgera, Anthony Damico, and Tricia Neuman, Kaiser Family Foundation. How Many Seniors Are Living in Poverty? National and State Estimates Under the Official and Supplemental Poverty Measures in 2016. March 2, 2018. Retrieved from https://www.kff.org/medicare/issue-brief/how-many-seniors-are-living-in-poverty-national-and-state-estimates-under-the-official-and-supplemental-poverty-measures-in-2016/]

TABLE: Person 65 Years and Over Below Poverty

LOCALITY	Persons Age 65 and Older Below Poverty	Percent Age 65 and Older Below Poverty
AMELIA	134	6.0%
BUCKINGHAM	486	17.9%
CHARLOTTE	362	14.8%
CUMBERLAND	354	18.7%
LUNENBURG	352	14.5%
NOTTOWAY	351	13.2%
PRINCE EDWARD	402	12.0%
SERVICE AREA	**2,441**	**13.8%**
VIRGINIA	**84,788**	**7.6%**

Source: US Census, American Fact Finder. American Community Survey 5-Year Estimates 2016-2012. Table S1701.

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

LOCALITY	All Families	Married Couple Families	Female Householder no Husband Present
AMELIA	9.5%	3.7%	35.7%
BUCKINGHAM	13.5%	4.9%	35.9%
CHARLOTTE	14.8%	6.7%	36.3%
CUMBERLAND	16.9%	7.1%	33.3%
LUNENBURG	14.9%	5.4%	40.8%
NOTTOWAY	17.4%	8.0%	40.2%
PRINCE EDWARD	11.3%	3.5%	28.8%
SERVICE AREA	**13.8%**	**5.5%**	**35.6%**
VIRGINIA	**8.1%**	**3.6%**	**25.2%**

Source: US Census, American Fact Finder. Selected Economic Characteristics 2012-2016 American Community Survey 5-Year Estimates. Table DP03.

Family Support

Local Departments of Social Services work to promote self-sufficiency while supporting residents throughout the service area. Services include financial assistance programs including aid to families with dependent children-foster care; emergency assistance and energy assistance; Medicaid and FAMIS (Family Access to Medical Insurance Security); Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families (TANF). Other support programs include adult and child protective services; prevention services for families; foster care and adoption services; and child care development.

Food Insecurity

TABLE: SNAP Participation Report

	% +/-2018 - 2015	Mar 2018	Mar 2017	Mar 2016	Mar 2015
AMHERST	-6%	3,325	3,316	3,515	3,550
APPOMATTOX	-10%	2,182	2,381	2,441	2,428
CAMPBELL	-17%	6,217	6,623	7,074	7,462
LYNCHBURG	-16%	11,004	11,497	12,387	13,040
PITTSYLVANIA	-16%	8,237	8,580	9,196	9,822
SERVICE AREA	**-15%**	**30,965**	**32,397**	**34,613**	**36,302**
VIRGINIA	**-14%**	**36,973**	**771,192**	**827,483**	**855,200**

TABLE: SNAP Participation Report

	% +/- 2018 - 2015	Mar 2018	Mar 2017	Mar 2016	Mar 2015
AMELIA	-13%	1,448	1,527	1,624	1,670
BUCKINGHAM	-15%	2,527	2,601	2,862	2,983
CHARLOTTE	-14%	1,896	2,003	2,086	2,201
CUMBERLAND	-13%	1,719	1,760	1,862	1,978
LUNENBURG	-22%	1,859	2,010	2,074	2,394
NOTTOWAY	-16%	2,824	2,926	3,130	3,349
PRINCE EDW	-14%	3,016	3,182	3,325	3,514
SERVICE AREA	**-15%**	**15,289**	**16,009**	**6,963**	**18,089**
VIRGINIA	**-14%**	**736,973**	**771,192**	**827,483**	**855,200**

Table 1 Source: Virginia Department of Social Services retrieved from http://www.dss.virginia.gov/files/about/reports/financial_assistance/food_stamps/participation/2016/03-2016.pdf.

As the economy has improved, SNAP participation rates fall. "The data needed to rigorously assess the causes of recent caseload trends won't be available for several years, but the economic recovery is likely playing a major role (in decline). SNAP caseloads have historically tracked economic conditions, rising when the economy weakens and then falling — with a several-year lag — when it recovers. The lag reflects the fact that people with lower education and skills aren't the first to benefit from an improving economy (emphasis added).One study, which tested different measurements of the economy and SNAP caseloads at the state and local level, found that the economy explained 70 to 90 percent of the increase in caseloads; it also found substantial lags — of up to two years — between changes in the economy and changes in SNAP participation."

[Citation: Center on Budget and Policy Priorities. SNAP Costs and Caseloads Declining – Trends Expected to Continue. March 8, 2016. Retrieved from https://www.cbpp.org/research/food-assistance/snap-costs-and-caseloads-declining]

TABLE: Food Insecurity Among Child Population Under Age 18 by Percent

LOCALITY	2015	2014	2013	2012
AMELIA	15.1	14.8	13.8	12.5
BUCKINGHAM	19.5	23.5	23.2	22.9
CHARLOTTE	20.1	21.4	20.9	18.6
CUMBERLAND	22.1	22.0	20.1	16.0
LUNENBURG	17.9	19.3	22.3	20.3
NOTTOWAY	17.8	18.3	16.5	15.7
PRINCE EDWARD	17.2	19.9	20.1	18.1
VIRGINIA	**14.0**	**16.0**	**16.8**	**16.2**

Source:Map the Meal Gap: Food Insecurity and Child Food Insecurity Estimates at the County Level. Feeding America, 2016.

Despite the rate of decline in SNAP participation, the rate of food insecurity among children under age 18 has remained steady when 2015, ostensibly, would have begun to reflect an improving economy. The steady rate of food insecurity may also reflect the CBO's position that people with lower education and skills are not the first to benefit from an improving economy. Their dependents would also not experience any improvement. In fact, small economic improvement may result in the loss of eligibility for social benefit programs like SNAP.

TABLE: TANF Participation Report

	% +/- 2016 - 2013	Nov 2016	Nov 2015	Nov 2014	Nov 2013
AMELIA	-57%	49	49	83	114
BUCKINGHAM	-27%	83	103	119	113
CHARLOTTE	-45%	93	106	127	169
CUMBERLAND	-24%	88	94	122	116
LUNENBURG	-36%	69	61	103	107
NOTTOWAY	-60%	112	188	213	283
PRINCE EDWARD	-31%	183	181	241	265
SERVICE AREA	**-42%**	**677**	**782**	**1,008**	**1,167**
VIRGINIA	**-34%**	**39,934**	**49,056**	**54,241**	**60,250**

"The Temporary Assistance for Needy Families (TANF) block grant, created by the 1996 welfare law, is designed to provide a temporary safety net to poor families — primarily those with no other means to meet basic needs. But since the TANF block grant was created, its reach has declined dramatically. In 2016, for every 100 families in poverty, only 23 received cash assistance from TANF — down from 68 families when TANF was first enacted. This 'TANF-to-poverty ratio' (TPR) reached its lowest point in 2014 and remained there in 2015 and 2016.

[Citation: Ife Floyd, LaDonna Pavetti, PhD., Liz Schott. Center on Budget and Policy Priorities. TANF Reaching Few Poor Families. December 13, 2017. Retrieved from https://www.cbpp.org/research/family-income-support/tanf-reaching-few-poor-families]

Foster Care Rates

Rate of Chilren Entering Foster Care per 1,000
2017 - 2015

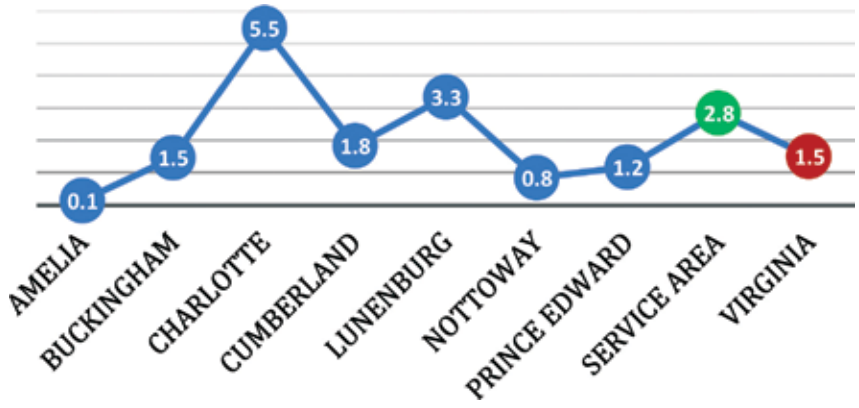


TABLE: Rate of child abuse and neglect (founded number per 1,000 children)

LOCALITY	2016	2015	2014	2013
AMELIA	1.5	0.4	1.5	1.4
BUCKINGHAM	0.9	3.1	3.1	4.6
CHARLOTTE	1.1	3.0	3.8	3.1
CUMBERLAND	1.0	2.9	1.9	1.3
LUNENBURG	1.7	3.9	3.4	2.0
NOTTOWAY	1.0	1.6	0.6	1.5
PRINCE EDWARD	1.6	1.8	1.8	3.6
SERVICE AREA	**1.3**	**2.4**	**2.3**	**2.5**
VIRGINIA	**2.5**	**2.2**	**2.3**	**3.0**

"Child abuse and neglect is one cause of children entering the foster care system. Nationally, the rising abuse of opioids has led to more children entering foster care. Although the rate of child abuse and neglect in the Farmville area is lower than the state as a whole, the number of children entering the foster care system is higher. "While most people in financial need do not maltreat their children, poverty can increase the likelihood of maltreatment, particularly when poverty is combined with other risk factors, such as depression, substance use, and social isolation."

[Citation: US Department of Health & Human Services. Administration for Children & Families. Children's Bureau. Child Welfare Information Gateway. Poverty and Economic Conditions. Retrieved from https://www.childwelfare.gov/topics/can/factors/contribute/environmental/poverty/]

HEALTH CARE FACTORS

1. Access

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. This topic area focuses on 3 components of access to care: insurance coverage, health services, and timeliness of care. When considering access to health care, it is important to also include oral health care and obtaining necessary prescription drugs.

According to the Institute of Medicine's Committee on Monitoring Access to Personal Health Services, access to health services means "the timely use of personal health services to achieve the best health outcomes" [1] It requires 3 distinct steps:

- Gaining entry into the health care system (usually through insurance coverage)
- Accessing a location where needed health care services are provided (geographic availability)
- Finding a health care provider whom the patient trusts and can communicate with (personal relationship) [2]

Access to health care impacts one's overall physical, social, and mental health status and quality of life.

Barriers to health services include:
- High cost of care
- Inadequate or no insurance coverage
- Lack of availability of services
- Lack of culturally competent care

These barriers to accessing health services lead to:
- Unmet health needs
- Delays in receiving appropriate care
- Inability to get preventive services
- Financial burdens
- Preventable hospitalizations

Access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. [3]

[Citation: Office of Disease Prevention and Health Promotion. HealthyPeople.gov. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services#2.]

References:
[1] Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to Health Care in America. Millman M, editor. Washington, DC: National Academies Press; 1993.

[2] National Healthcare Quality Report, 2013 [Internet]. Chapter 10: Access to Healthcare. Rockville (MD): Agency for Healthcare Research and Quality; May 2014. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/access.html

[3] Access and Disparities in Access to Health Care [Internet]. Rockville (MD): Agency for Healthcare Research and Quality; May 2016. Available from: http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/access.html

Insurance Coverage

"Health insurance coverage helps patients gain entry into the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Uninsured people are:

- More likely to have poor health status
- Less likely to receive medical care
- More likely to be diagnosed later
- More likely to die prematurely [4] [5] [6]

Health insurance coverage only "helps" but does not guarantee entry into the health care system. Many health care providers are not required to accept all insurances. Persons with Medicaid coverage are the best example of persons who may have insurance coverage but have difficulty accessing community-based services as a result of lower Medicaid reimbursement rates."

References:

[4] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. JAMA. 2007;297(10):1073-84.

[5] Institute of Medicine. Insuring America's health: Principles and recommendations. Acad. Emerg. Med. 2004;11(4):418-22.

[6] Durham J, Owen P, Bender B, et al. Self-assessed health status and selected behavioral risk factors among persons with and without healthcare coverage—United States, 1994-1995. MMWR. 1998 Mar 13;47(9):176-80.

TABLE: Uninsured Adults and Children by Year by Number by Percent

LOCALITY	2015				2014			
	Adults %	Adults #	Child %	Child #	Adults %	Adults #	Child %	Child #
AMELIA	15%	1,196	8%	224	18%	1,436	9%	264
BUCKINGHAM	17%	1,512	7%	217	20%	1,786	8%	260
CHARLOTTE	18%	1,288	7%	197	22%	1,560	9%	250
CUMBERLAND	16%	907	6%	126	21%	1,234	7%	160
LUNENBURG	18%	1,168	8%	189	22%	1,465	8%	202
NOTTOWAY	16%	1,286	6%	203	19%	1,509	7%	227
PRINCE EDWARD	16%	1,889	5%	208	19%	2,299	7%	262
SERVICE AREA	**16.5%**	**9,246**	**6.6%**	**1,364**	**20.0%**	**11,289**	**7.8%**	**1,625**
VIRGINIA	**12.0%**	**635,654**	**5.0%**	**96,291**	**12.0%**	**758,908**	**5.0%**	**116,454**

LOCALITY	2013				2012			
	Adults %	Adults #	Child %	Child #	Adults %	Adults #	Child %	Child #
AMELIA	21%	1,643	8%	224	23%	1,803	10%	277
BUCKINGHAM	23%	2,104	7%	245	24%	2,195	8%	277
CHARLOTTE	23%	1,663	8%	232	24%	1,780	9%	256
CUMBERLAND	22%	1,299	7%	157	24%	1,412	8%	187
LUNENBURG	23%	1,565	8%	189	24%	1,671	8%	205
NOTTOWAY	21%	1,743	6%	190	23%	1,875	7%	239
PRINCE EDWARD	20%	2,386	6%	233	21%	2,564	6%	266
SERVICE AREA	**21.7%**	**12,403**	**7.0%**	**1,470**	**23.1%**	**13,300**	**7.8%**	**1,707**
VIRGINIA	**17.0%**	**870,511**	**6.0%**	**11,220**	**12.0%**	**878,267**	**5.0%**	**115,189**

Source: County Health Rankings for Virginia Localities 2018, 2017, 2016, 2015. Small Area Health Insurance Estimates.

For the Service Area, there has been a significant increase in the number of persons with insurance coverage. There has been a combined adult and child decline of 27.4% in the number of uninsured from 2012 to 2015. During this time, the Affordable Care Act (ACA) was passed. It is not known how many residents of the service area may have gained insurance through the insurance exchanges established under the ACA. Despite these gains, the service area still lags slightly behind the overall insured rate for Virginia for both adults and children. As Virginia works to implement Medicaid expansion passed by the Virginia General Assembly in the spring of 2018, the number of uninsured in the service area and the state should continue to decline.

TABLE: Private health Insurance Coverage by Type 2012-2016

LOCALITY	Percent with Private Health Insurance	Private Ins that is Employer Based	Private Ins that is Direct Purchase	Private Ins that is Tri-Care / Military
AMELIA	47.9%	86.4%	10.3%	3.3%
BUCKINGHAM	49.5%	84.2%	14.4%	1.4%
CHARLOTTE	39.5%	84.2%	13.7%	2.1%
CUMBERLAND	41.2%	81.2%	17.3%	1.6%
LUNENBURG	56.8%	84.5%	12.6%	3.0%
NOTTOWAY	55.0%	89.4%	7.7%	2.1%
PRINCE EDWARD	71.6%	81.5%	15.4%	3.1%
SERVICE AREA	**55.2%**	**84.3%**	**13.3%**	**2.4%**
VIRGINIA	**59.7%**	**82.7%**	**10.7%**	**6.6%**

Source: US Census, American Fact Finder. American Community Survey 5-Year Estimates 2016-2012. Table S2703.

The overwhelming number of privately insured persons in the service area are utilizing insurance provided by employers (84.3%). This is slightly higher than the overall employer-provided insurance for all persons residing in Virginia. Offsetting this difference is the notable gap between service area residents provided Tri-Care insurance through the military. Persons purchasing insurance directly from a third-party insurer is higher in the service area than the overall Virginia rate. Private health insurance categories combined finds the service area with a difference of -4.5% for those with private health insurance compared with overall state rate. This difference is explained in the higher uninsured rates illustrated in Table 1 and those persons covered through Medicaid and Medicare indicated in Tables 3 and 4 respectively.

TABLE: Medicaid Coverage Alone

LOCALITY	Percent with Medicaid Coverage	Persons with Medicaid Coverage
AMELIA	10.2%	1,292
BUCKINGHAM	12.8%	1,934
CHARLOTTE	16.8%	2,035
CUMBERLAND	16.1%	1,575
LUNENBURG	16.3%	1,872
NOTTOWAY	22.3%	3,189
PRINCE EDWARD	9.6%	2,144
SERVICE AREA	**14.4%**	**14,041**
VIRGINIA	**8.2%**	**663,983**

Source: US Census. American Fact Finder. Public Health Insurance Coverage by Type. 2012-2016 American Community Survey 5-Year Estimates. Table 2704.

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

[Citation: Medicare.gov. Retrieved from https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html].

Virginia Medicaid recipients must renew annually. Should a person's assets increase, the person may no longer be eligible for Medicaid. The Department of Medical Assistance Services (DMAS), the Virginia Medicaid agency now has an automatic renewal "for up to five years without having to complete a renewal form if nothing has changed and you check a box at the end of the form that allows us to look at your electronic income data each year, including information from tax returns".

[Citation: Cover Virginia. Renew my Coverage. Retrieved from https://www.coverva.org/apply_renew.cfm]

Based on the poverty rates among the localities that comprise the Farmville Area (see Socioeconomic Factors), the higher percentage of Medicaid recipients in each locality and in the service area than the overall rate of Medicaid recipients in Virginia is expected.

In June of 2018, the Virginia General Assembly expanded Medicaid coverage for individuals with incomes up to 138% of federal poverty level and now includes able-bodied adults without children who had previously been ineligible for coverage. In Virginia, it is estimated that an additional 400,000 residents will qualify.

TABLE: Estimated Percent of Uninsured who would be eligible for Medicaid upon Medicaid eligibility expansion.

LOCALITY	NUMBER OF NEWLY MEDICAID ELIGIBLE	ESTIMATED PERCENT OF UNINSURED COVERED
AMELIA	610	37%
BUCKINGHAM	930	44%
CHARLOTTE	700	42%
CUMBERLAND	560	43%
LUNENBURG	700	45%
NOTTOWAY	780	45%
PRINCE EDWARD	1,100	46%
TOTAL SERVICE AREA	**5,380**	**43%**

Table Source: TCI analysis of United States Census Bureau data. August 4, 2015 (updated). Retrieved from http://www.thecommonwealthinstitute.org/2014/02/04/interactive-map-virginians-eligible-for-medicaid-expansion-in-every-locality/

With Medicaid expansion, the range of uninsured residents that would be eligible for Medicaid is a low of 37% in Amelia County to a high of over almost of one-half (56%) of Prince Edward County uninsured residents. The range of uninsured by locality who would be eligible for Medicaid is a low of 25% to a high of 63%.

TABLE: Medicare Coverage Alone

LOCALITY	Percent with Medicare Coverage	Persons with Medicare Coverage
AMELIA	4.0%	506
BUCKINGHAM	6.1%	914
CHARLOTTE	8.2%	990
CUMBERLAND	5.0%	490
LUNENBURG	7.5%	857
NOTTOWAY	7.6%	1,081
PRINCE EDWARD	5.1%	1,129
SERVICE AREA	**6.1%**	**5,967**
VIRGINIA	**4.0%**	**322,475**

Source: US Census. American Fact Finder. Public Health Insurance Coverage by Type. 2012-2016 American Community Survey 5-Year Estimates. Table 2704.

HEALTH CARE FACTORS

2. Availability

Medically Underserved Areas/Populations

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) identify geographic areas and populations with a lack of access to primary care services. MUAs have a shortage of primary care health services for residents within a geographic area such as: a whole county; a group of neighboring counties; a group of urban census tracts; or a group of county or civil divisions.

TABLE: Medically Underserved Area/Population Designation Status

Locality	Designation Status	Service Area Name Designation
Amelia	YES	Amelia Service Area
Buckingham	YES	Buckingham Service Area
Charlotte	YES	Charlotte Service Area
Cumberland	YES	Cumberlan Service Aread
Lunenburg	YES	Lunenburg Service Area
Nottoway	YES	Nottoway Service Area
Prince Edward	YES	Prince Edward Service Area

Source: Health Resources and Services Administration. Bureau of Health Workforce. Medically Underserved Areas and Populations (MUA/Ps). Accessed March 16, 2018. Retrieved from https://bhw.hrsa.gov/shortage-designation/muap

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

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

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

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

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

Facilities
Public or non-profit private medical facilities serving a population or geographic area designated as a HPSA with a shortage of health providers. Medium to maximum security federal and state correctional institutions and youth detention facilities with a shortage of health providers. State or county hospitals with a shortage of psychiatric professionals (mental health designations only). A facility that is automatically designated as a HPSA by statute or through

regulation without having to apply for a designation:

1. **Federally Qualified Health Centers (FQHCs)**—health centers that provide primary care to an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. All organizations receiving grants under Health Center Program Section 330 of the Public Health Service Act are FQHCs.
2. **FQHC Look-A-Likes (LALs)**—LALS are community-based health care providers that meet the requirements of the HRSA Health Center Program, but do not receive Health Center Program funding.An example of a FQHC Look-A-Like is the Community Access Network located in Lynchburg.

	PRIMARY CARE	
LOCALITY	DESIGNATION TYPE	SCORE
AMELIA	YES - Geographic Population	9
BUCKINGHAM	YES - Low Income Population	16
CHARLOTTE	YES - Geographic Population	14
CUMBERLAND	YES - Low Income Population	16
LUNENBURG	YES - Geographic Population	13
NOTTOWAY	YES - Geographic Population	11
PRINCE EDW	YES - Low Income Population	17

	DENTAL HEALTH	
LOCALITY	HPSA DESIGNATION TYPE	SCORE
AMELIA	YES - Geographic High Needs	4
BUCKINGHAM	YES - Low Income Population	20
CHARLOTTE	YES - Geographic	17
CUMBERLAND	YES - Low Income Population	16
LUNENBURG	YES - Low Income Population	18
NOTTOWAY	YES - Low Income Population	19
PRINCE EDW	YES - Low Income Population	18

	MENTAL HEALTH	
LOCALITY	DESIGNATION TYPE	SCORE
AMELIA	YES - Geographic Population	15
BUCKINGHAM	YES - Geographic High Needs	15
CHARLOTTE	YES - Geographic Population	15
CUMBERLAND	YES - Geographic High Needs	15
LUNENBURG	YES - Geographic High Needs	15
NOTTOWAY	YES - Geographic Population	15
PRINCE EDW	YES - Geographic Population	15

Source: Health Resources Services and Administration retrieved from https:// datawarehouse.hrsa.gov/ tools/analyzers/ HpsaFindResults.aspx

Safety Net Facilities Serving the Area

There are six Federally Qualified Health Centers (FQHCs) that serve the area.

Amelia Healthcare Center (SDHS) 8920 Otterburn Road Amelia, VA 23002	FQHC
Central Virginia Health Services (CVHS) 25892 N James Madison Highway PO Box 220 New Canton, VA 23123	FQHC
Charlotte Primary Care 165 LeGrande Avenue PO Drawer 470 Charlotte Court House, VA 23923	FQHC
Lunenburg Medical Center (SDHS) 1508 K-V Road Victoria, VA 23974	FQHC
Southern Dominion Health Services (SDHS) Counseling & Behavioral Services 1685 K-V Road Victoria, VA 23974	FQHC
Health Center for Women and Families (CVHS) 833 Buffalo Street Farmville, VA 23901	FQHC

Dental Care Utilization

Persons who self-report that they have not visited a dentist, dental hygienist or dental clinic in the past year. This indicator could be as a result of a lack of availability of oral health providers, financial barriers to oral health care, or other barriers to seeking oral health care.

TABLE: Dental Care Utilization

	Adults without Recent Dental Exam	Percent Adults without Recent Dental Exam
AMELIA	1,898	19.7%
BUCKINGHAM	5,348	36.9%
CHARLOTTE	NR	NR
CUMBERLAND	NR	NR
LUNENBURG	4,503	43.2%
NOTTOWAY	3,793	30.4%
PRINCE EDWARD	8,091	43.3%
SERVICE AREA	**23,633**	**28.5%**
VIRGINIA	**1,481,707**	**24.4%**

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional

data analysis by CARES. 2006-10. Retrieved from https://assessment.communitycommons.org/CHNA/report?page=4&id=519&reporttype=libraryCHNA

HEALTH BEHAVIOR and HEALTH INDICATOR FACTORS

1. Overall Health Rankings

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

[Citations: Robert Wood Johnson Foundation, County Health Rankings & Roadmaps. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-outcomes and http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors]

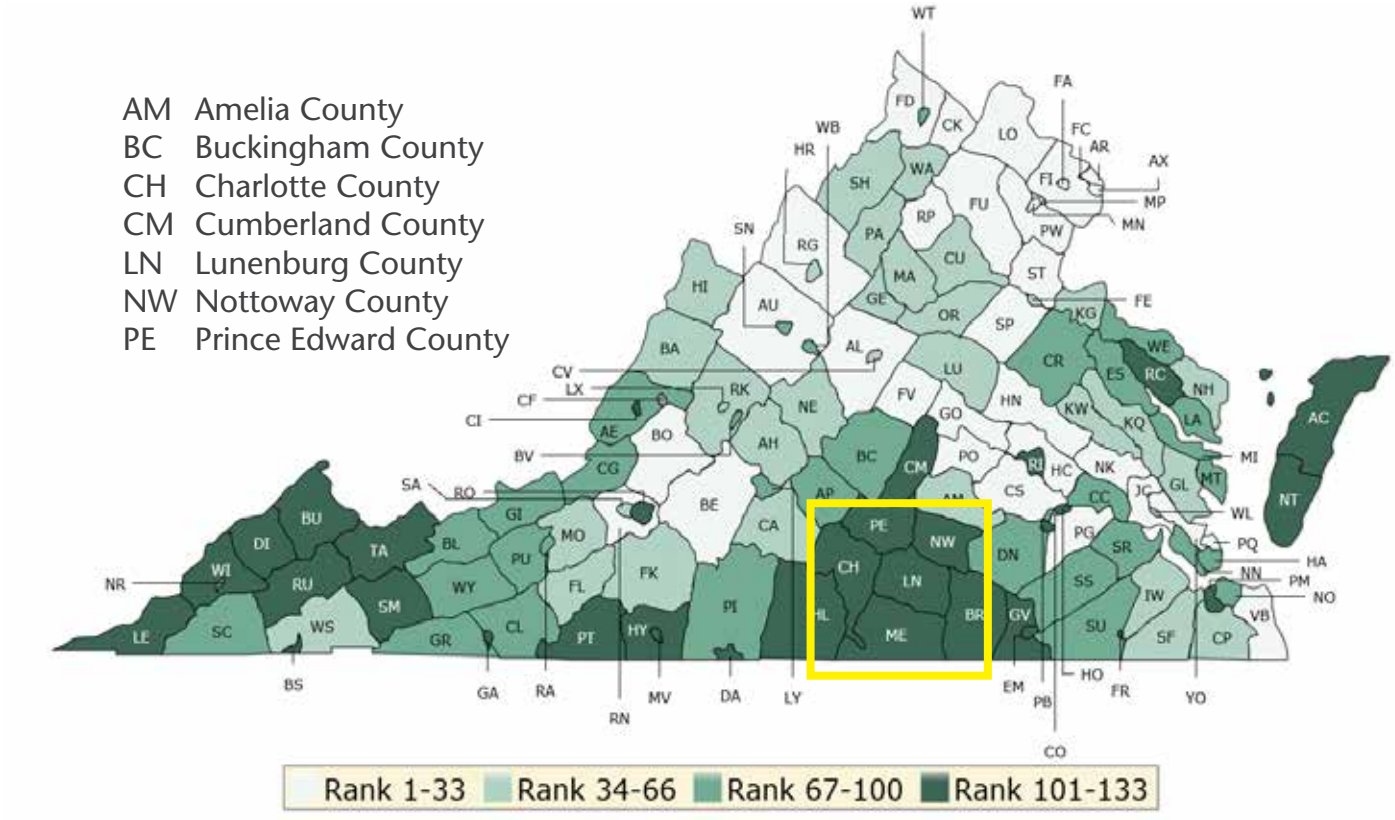
TABLE: 2018 County Health Rankings
(1 is best; 133 worst)

LOCALITY	Health Outcomes Rank	Health Factors Rank
AMELIA	48	68
BUCKINGHAM	75	114
CHARLOTTE	110	108
CUMBERLAND	101	106
LUNENBURG	111	95
NOTTOWAY	105	111
PRINCE EDWARD	106	97

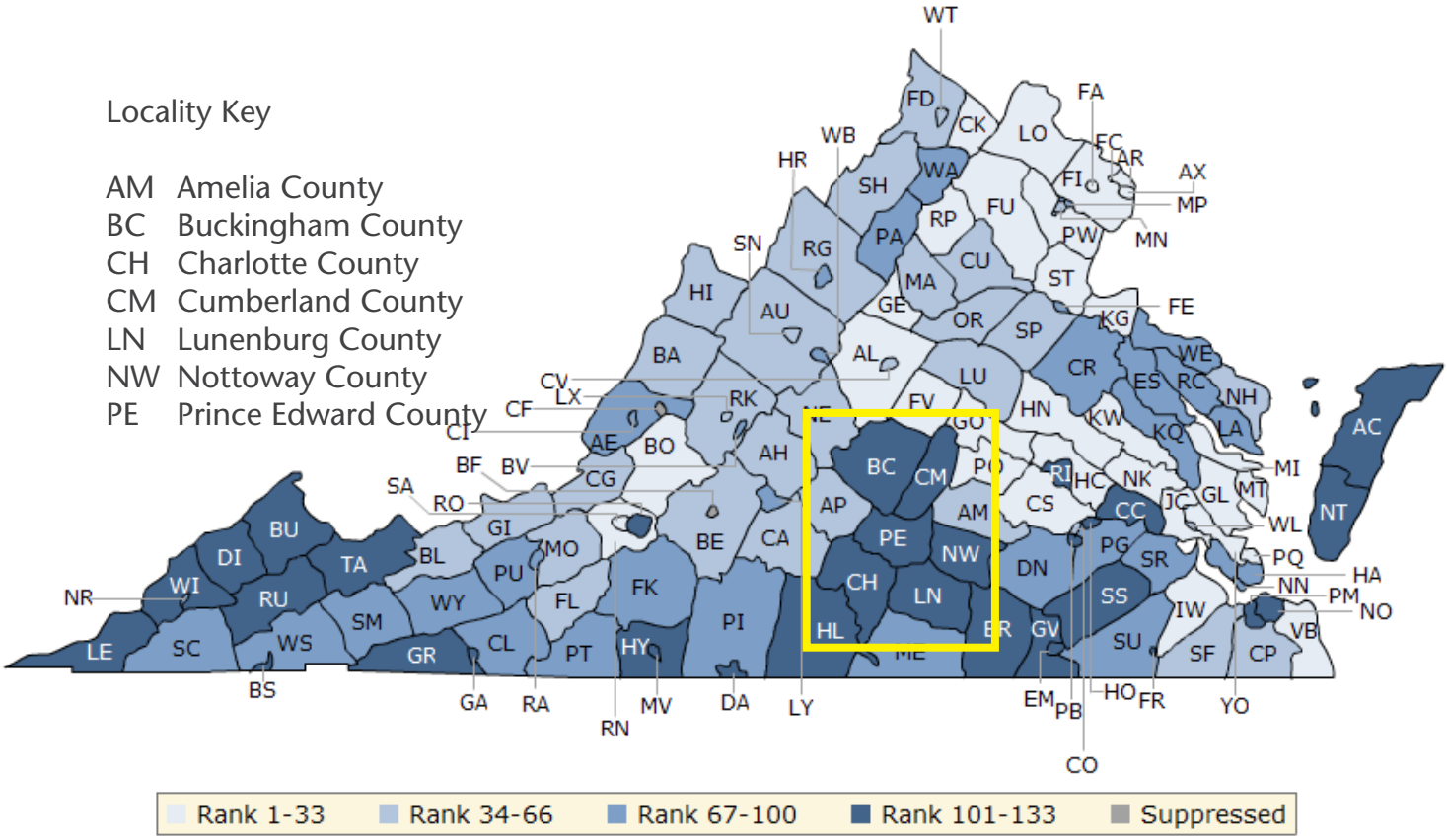
Tables/Charts/Maps Source: Robert Wood Johnson Foundation. County Health Rankings & Roadmaps. 2018, 2015. Retrieved March 12, 2018. Accessed at http://www.countyhealthrankings.org/app/virginia/ 2018/overview*;* …/2015/overview*.*

MAP: County Health Outcomes by Rank
Ranking key – 1 = best; 133 = worst

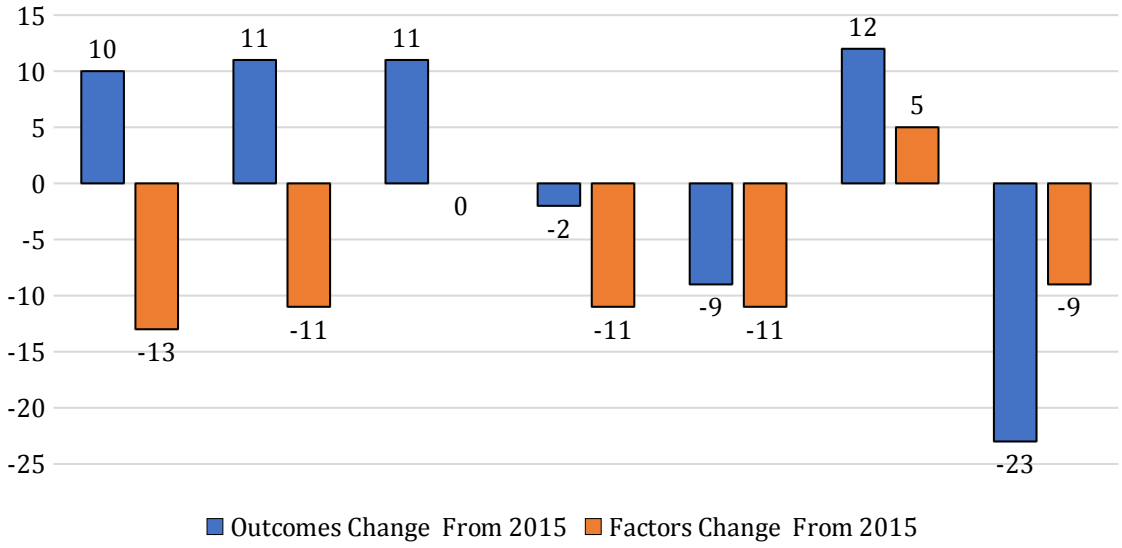
AM Amelia County
BC Buckingham County
CH Charlotte County
CM Cumberland County
LN Lunenburg County
NW Nottoway County
PE Prince Edward County



MAP: County Health Factors by Rank
Ranking key – 1 = best; 133 = worst



Changes in Health Rankings



The Farmville (Piedmont Health District) service area has striking deficits in health outcomes and health factors as published by County Health Rankings & Roadmaps. Five out of seven localities have health outcome and health factor measures that rank in the bottom 25% of all Virginia localities (N = 133). As indicated in Table 4, Cumberland, Lunenburg, and Prince Edward counties have dropped (where (-) is improvement) positions in health outcome rankings from 2015 to 2018.

Amelia and Buckingham counties having improved 10 and 11 places in health outcomes (respectively), had their health factor rankings drop by 13 and 11 places respectively between the 2015 and 2018 rankings. Lunenburg and Prince Edward counties improved their health factor rankings by 16 and nine places respectively. The health outcome and health factor data should be viewed in context of specific health and disease mortality and incidence data found in this assessment to better understand their rankings.

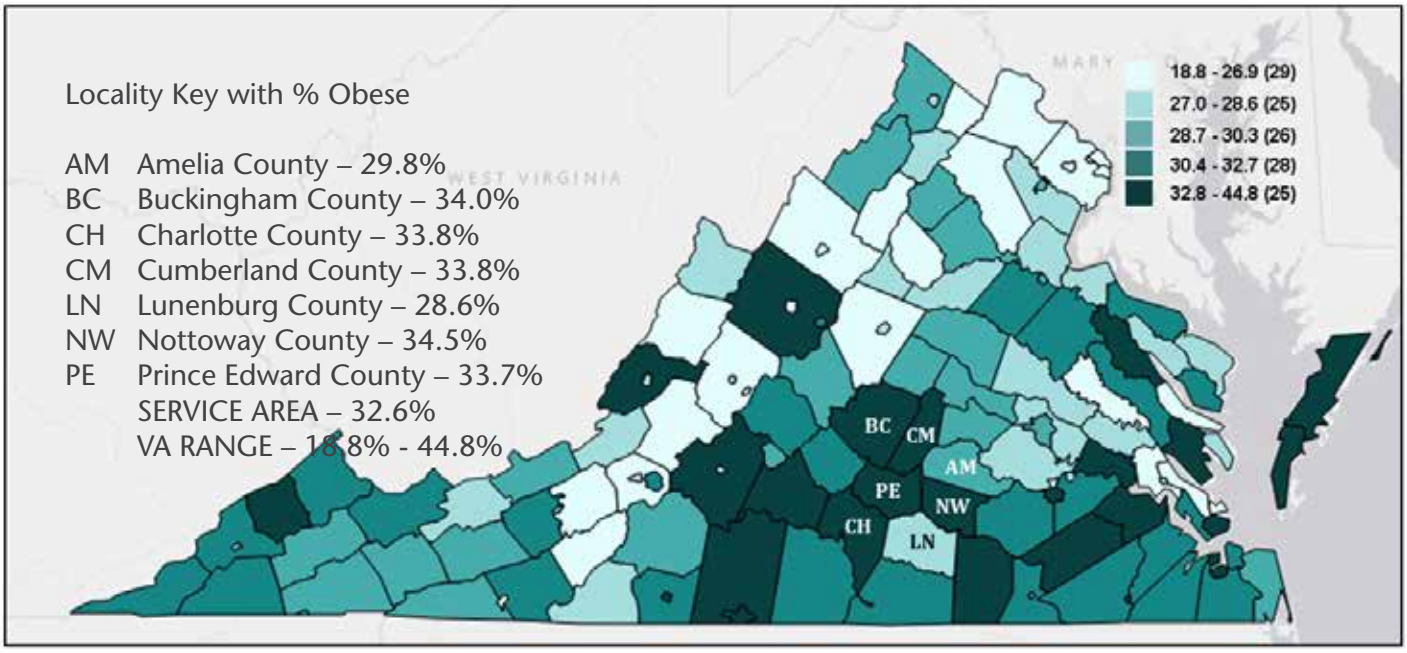
Obesity

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

[Citation: Harvard School of Public Health. Obesity Prevention Source. Retrieved from https://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/]

MAP: Obesity by Percentage by Locality

Five of the seven localities in the Farmville Service Area are in the top 20% of most obese localities in Virginia and one in the top 40% of localities of obese population percentages.



Map Source: Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Default.aspx?state=VA

Physical Activity

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

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/diet-exercise/access-to-exercise-opportunities]

TABLE: Percentage of Adults age 20 and over Reporting No Leisure-Time Physical Activity

LOCALITY	2014	2013	2012	2011
AMELIA	27	27	27	29
BUCKINGHAM	34	34	33	28
CHARLOTTE	29	29	28	25
CUMBERLAND	24	23	24	25
LUNENBURG	28	26	28	31
NOTTOWAY	27	28	31	30
PRINCE EDWARD	24	23	25	28
VIRGINIA	**22**	**21**	**22**	**22**

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

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/diet-exercise/access-to-exercise-opportunities]

TABLE: Percentage of population with adequate access to locations for physical activity

LOCALITY	2010 & 2016
AMELIA	33
BUCKINGHAM	35
CHARLOTTE	21
CUMBERLAND	35
LUNENBURG	46
NOTTOWAY	62
PRINCE EDWARD	82
SERVICE AREA	**52**
VIRGINIA	**83**

Source: County Health Rankings 2018 from Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files

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

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/diet-exercise/limited-access-to-healthy-foods]

TABLE: Percent with Limited Access to Healthy Food

LOCALITY	2015	2010
AMELIA	6	3
BUCKINGHAM	4	4
CHARLOTTE	15	14
CUMBERLAND	24	22
LUNENBURG	0	0
NOTTOWAY	30	21
PRINCE EDWARD	12	6
VIRGINIA	**4**	**4**

Table Source: Robert Wood Johnson Foundation. County Health Rankings 2018, 2017.

Alcohol Consumption

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

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/alcohol-and-drug-use]

TABLE: Percentage of Adults Reporting Binge or Heavy Drinking

LOCALITY	2016	2015	2014	2014
AMELIA	17	16	15	NR
BUCKINGHAM	16	16	15	NR
CHARLOTTE	14	15	14	NR
CUMBERLAND	15	14	14	NR
LUNENBURG	14	14	14	NR
NOTTOWAY	15	15	14	23
PRINCE EDWARD	17	17	16	NR
VIRGINIA	**17**	**17**	**17**	**16**

Source: County Health Rankings 2018, 2017, 2016, 2015 from the Behavioral Risk Factor Surveillance System.

Tobacco Use

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

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

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

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/tobacco-use]

TABLE: Percentage of Adults who are Current Smokers

LOCALITY	2016	2015	2014	2014
AMELIA	16	16	19	20
BUCKINGHAM	20	19	21	22
CHARLOTTE	20	19	20	26
CUMBERLAND	19	19	20	23
LUNENBURG	19	20	20	21
NOTTOWAY	20	21	22	20
PRINCE EDWARD	19	19	21	26
VIRGINIA	**15**	**17**	**20**	**18**

Source: County Health Rankings for Virginia Localities 2018, 2017, 2016, 2015.

Drug Use

"In 2016, there were 1,130 opioid-related overdose deaths in Virginia—a rate of 13.5 deaths per 100,000 persons—compared to the national rate of 13.3 deaths per 100,000 persons. Since 2010, the number of heroin-related overdose deaths has increased from 45 to 450 deaths—a tenfold increase. Overdose deaths related to synthetic opioids have increased even more dramatically from 87 to 648 deaths." (Source: National Institute for Drug Abuse. Virginia Opioid Summary (revised 2018). Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/virginia-opioid-summary).

Note: the data below breaks out opioid deaths from Fentanyl/Heroin and prescription opioids. This would lead to differences among rates as noted in the National Institute for Drug Abuse rate noted above.

TABLE: Mortality Rates (per 100,000) for overdose from Fentanyl/Heroin use and prescription opioid use 2017.

LOCALITY	Overdose Mortality Rate Fentanyl and/or Heroin 2017	Overdose Mortality Rate Prescription Opioids 2017
AMELIA	7.7	7.7
BUCKINGHAM	11.7	5.9
CHARLOTTE	8.2	8.2
CUMBERLAND	10.4	0
LUNENBURG	0	0
NOTTOWAY	0	6.4
PRINCE EDWARD	4.3	0
TOTAL SERVICE AREA	**6.0**	**4.0**
VIRGINIA	**11.0**	**5.9**

Table Source: Virginia Department of Health. Retrieved from http://www.vdh.virginia.gov/data/opioid-overdose/

Buckingham County has a higher mortality rate due to overdose of Fentanyl and/or Heroin than the overall state mortality rate. Cumberland County also has a high rate at 10.4. Three localities in the service area have a higher mortality rate due to prescription opioid use than the state rate (Amelia, Charlotte, and Nottoway) and one locality approximates the state rate (Buckingham County). The range of mortality by Virginia locality mortality rates from Fentanyl and/or Heroin use is 1.3 to 40.8 and 1.6 to 54.4 for mortality from prescription opioid use. On June 1, 2017, based on a range of drug overdose indicators, the Virginia State Health Commissioner declared a Public Health Emergency for Virginia as a result of the opioid addiction epidemic.

Sexually Transmitted Infections

TABLE: Gonorrhea Incidence Rate Per 100,000 Population

LOCALITY	4-Yr. Avg.	2016	2015	2014	2013
AMELIA	54.6	85.3	38.8	46.9	47.3
BUCKINGHAM	71.9	35.2	135.0	53.2	64.1
CHARLOTTE	73.6	73.8	73.8	49.2	97.7
CUMBERLAND	102.3	154.3	72.0	122.0	60.9
LUNENBURG	102.5	56.9	48.8	112.3	191.8
NOTTOWAY	60.8	57.4	19.1	83.5	83.0
PRINCE EDWARD	104.7	135.1	113.3	91.2	79.1
SERVICE AREA	**81.5**	**85.4**	**71.5**	**79.8**	**89.1**
VIRGINIA	**103.0**	**132.2**	**96.6**	**99.1**	**84.1**

TABLE: Chlamydia Incidence Rate Per 100,000 Population

LOCALITY	4-Yr. Avg.	2016	2015	2014	2013
AMELIA	273.1	255.8	279.0	258.1	299.3
BUCKINGHAM	311.0	293.6	334.7	265.8	349.9
CHARLOTTE	319.3	303.3	385.2	311.8	276.8
CUMBERLAND	442.2	473.3	432.1	416.7	446.8
LUNENBURG	399.2	317.1	447.2	369.1	463.5
NOTTOWAY	727.3	810.3	733.7	790.5	574.7
PRINCE EDWARD	546.3	610.0	557.7	538.5	478.9
SERVICE AREA	**431.2**	**437.6**	**452.8**	**421.5**	**412.8**
VIRGINIA	**432.7**	**473.2**	**421.7**	**432.8**	**403.0**

Source: US Department of Health & Human Services. Centers for Disease Control and Prevention,Atlas Plus retrieved from https://gis.cdc.gov/grasp/nchhstpatlas/maps.html.

Health Status

"Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. This measure is based on survey responses to the question: 'In general, would you say that your health is excellent, very good, good, fair, or poor?' The value reported in the County Health Rankings is the percentage of adult respondents who rate their health 'fair' or 'poor.' The measure is modeled and age-adjusted to the 2000 US population.Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in a population. Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures that consider how healthy people are while alive."

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-outcomes/morbidity/health-related-quality-of-life/poor-or-fair-health]

TABLE: Persons Reporting Being in Poor or Fair Health by Percent

LOCALITY	Avg. Rate	2016	2015	2014	2006-2012
AMELIA	14.3	15	14	15	13
BUCKINGHAM	19.5	18	17	19	24
CHARLOTTE	22.0	21	20	19	28
CUMBERLAND	21.3	20	19	20	26
LUNENBURG	19.5	20	19	19	20
NOTTOWAY	20.8	21	20	21	21
PRINCE EDWARD	17.3	21	18	20	10
SERVICE AREA	19.3	20	18	19	20
VIRGINIA	15.5	16	15	17	14

Source: County Health Rankings for Virginia Localities 2018, 2017, 2016, 2015 from Behavioral Risk Factor Surveillance System 2016, 2015, 2014, 2006-2012.

TABLE: Persons Reporting Physically Unhealthy Days In the Past Month

LOCALITY	Avg. Rate 2015-2016	2016	2015	2014	2006-2012
AMELIA	3.3	3.3	3.3	3.5	3.0
BUCKINGHAM	3.9	3.8	3.6	3.8	4.4
CHARLOTTE	4.2	4.1	3.9	3.9	4.7
CUMBERLAND	4.4	4.1	4.0	4.0	5.5
LUNENBURG	4.0	4.0	3.8	3.9	4.2
NOTTOWAY	4.2	4.0	4.0	4.1	4.6
PRINCE EDWARD	3.8	4.2	3.8	4.1	2.9
SERVICE AREA	**3.9**	**3.9**	**3.8**	**3.9**	**4.2**
VIRGINIA	**3.4**	**3.5**	**3.2**	**3.5**	**3.2**

Source: County Health Rankings for Virginia Localities 2018, 2017, 2016, 2015 from Behavioral Risk Factor Surveillance System 2016, 2015, 2014, 2006-2012.

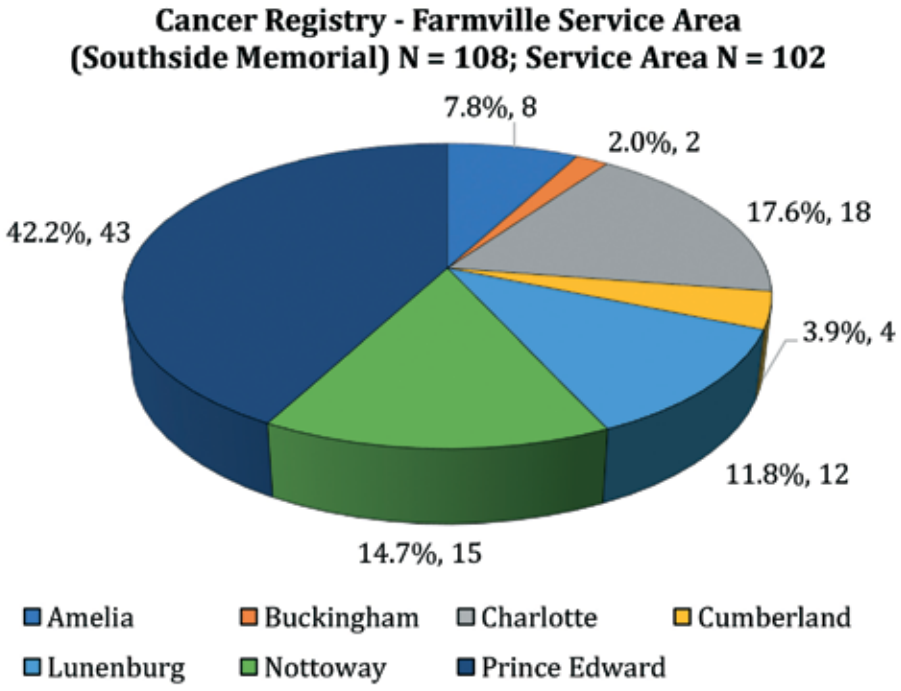
TABLE: Poor Mental Health Days in the Past 12 Months

LOCALITY	Average 2013-2016	2016	2015	2014	2013
AMELIA	3.6	3.5	3.3	3.3	4.3
BUCKINGHAM	3.8	3.7	3.5	3.6	4.5
CHARLOTTE	3.8	4.1	3.7	3.6	NR
CUMBERLAND	4.8	4.0	3.8	3.7	3.0
LUNENBURG	3.5	3.8	3.6	3.5	3.1
NOTTOWAY	3.7	3.7	3.7	3.6	3.6
PRINCE EDWARD	3.8	3.9	3.7	3.7	3.8
SERVICE AREA	**3.9**	**3.8**	**3.6**	**3.6**	**3.7**
VIRGINIA	**3.3**	**3.5**	**3.3**	**3.3**	**3.1**

Source: County Health Rankings for Virginia Localities 2018, 2017, 2016, 2015 from Behavioral Risk Factor Surveillance System 2016, 2015, 2014, 2006-2012

Incidence Rates

Cancer Registry (Southside Regional Hospital)



Source: Centra Hospital, Lynchburg

All Cancers

TABLE: Incidence Rate Report for Virginia by County
All Cancers, 2011-2015

	Total	White	Black	Hispanic
AMELIA	478.7	495.6	451.1	S
BUCKINGHAM	408.4	413.6	410.1	S
CHARLOTTE	449.1	456.3	426.1	S
CUMBERLAND	433.0	397.6	500.4	S
LUNENBURG	452.7	451.1	458.2	S
NOTTOWAY	505.0	516.1	498.1	S
PRINCE EDWARD	475.8	445.3	537.4	S
SERVICE AREA	**457.5**	**453.7**	**480.8**	-
VIRGINIA	**414.3**	**418.1**	**441.9**	**268.7**

Breast Cancer

TABLE: Incidence Rate Report for Virginia by County
Breast Cancer, 2011-2015

	Total	White	Black	Hispanic
AMELIA	122.3	130.4	S	S
BUCKINGHAM	102.0	88.9	137.2	S
CHARLOTTE	95.7	110.7	S	S
CUMBERLAND	104.0	72.5	151.9	S
LUNENBURG	130.3	134.8	110.2	S
NOTTOWAY	147.4	130.2	182.0	S
PRINCE EDWARD	151.6	135.6	128.0	S
SERVICE AREA	**121.9**	**114.7**	**141.9**	-
VIRGINIA	**127.9**	**131.0**	**133.5**	**79.1**

Lung and Bronchus Cancer

TABLE: Incidence Rate Report for Virginia by County
Lung and Bronchus Cancer, 2011-2015

	Total	White	Black	Hispanic
AMELIA	71.3	78.6	S	S
BUCKINGHAM	73.2	80.7	62.3	S
CHARLOTTE	82.7	89.9	67.9	S
CUMBERLAND	72.4	70.1	80.8	S
LUNENBURG	76.6	68.6	92.8	S
NOTTOWAY	61.4	57.1	68.9	S
PRINCE EDWARD	59.6	61.3	59.6	S
SERVICE AREA	**62.3**	**64.2**	**60.6**	-
VIRGINIA	**58.9**	**60.8**	**62.2**	**24.7**

Colon and Rectum Cancer

TABLE: Incidence Rate Report for Virginia by County
Colon and Rectum Cancer, 2011-2015

	Total	White	Black	Hispanic
AMELIA	33.4	30.0	S	S
BUCKINGHAM	39.7	42.5	S	S
CHARLOTTE	70.0	58.0	93.5	S
CUMBERLAND	55.1	47.0	68.2	S
LUNENBURG	41.9	46.6	S	S
NOTTOWAY	53.7	55.8	48.7	S
PRINCE EDWARD	49.3	45.7	59.2	S
SERVICE AREA	**49.0**	**46.5**	**67.4**	-
VIRGINIA	**36.0**	**35.2**	**42.8**	**25.3**

Cancer incidence Tables Source: National Cancer Institute. State Cancer Profiles. Interactive maps retrieved from https://statecancerprofiles.cancer.gov

Death Rates

Standardizing death rates

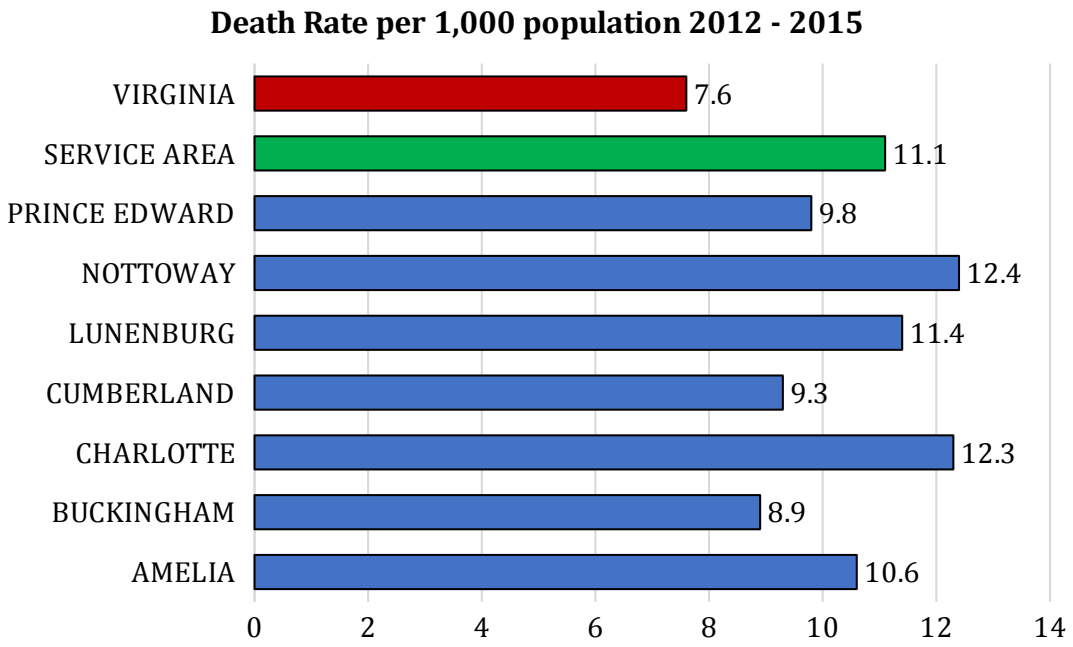
"The numbers of deaths found in a population are influenced by the age distribution of the population. Two populations with the same age-specific mortality rates for a cause of death will have different overall death rates if the age distributions of their populations are different. Age-standardized mortality rates adjust for differences in the population age distribution - for instance the population in the service region age 65 and older is a greater percentage than that found in the overall state population – by applying the overserved age-specific mortality rates for each population to a standard population."

[Citation: Age-standardized death rates per 100,000 by cause. Retrieved from www.who.int/whois/whostat-2006AgeStandardizedDeathRates.pdf]

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

TABLE: Deaths per 1,000 population (rate) 2012 - 2015

LOCALITY	4-Year Avg. Rate	2015	2014	2013	2012
AMELIA	10.6	11.1	9.4	10.2	11.6
BUCKINGHAM	8.9	8.6	8.8	9.6	8.4
CHARLOTTE	12.3	12.6	11.4	12.8	12.5
CUMBERLAND	9.3	9.3	8.4	10.6	9
LUNENBURG	11.4	11.5	11.3	10.9	11.9
NOTTOWAY	12.4	12.3	12.6	12.2	12.5
PRINCE EDWARD	9.8	10.6	10.8	9.2	8.6
SERVICE AREA	**11.1**	**11.3**	**10.9**	**11.1**	**10.9**
VIRGINIA	**7.6**	**7.7**	**7.6**	**7.5**	**7.5**



Source: Virginia Department of Health. Division of Health Statistics.

As a general health indicator each locality in the service area has a higher death rate among 1,000 residents than the overall state rate. Nottoway County has the highest death rate at 12.4 deaths – 4.8 deaths greater than the state rate and almost 1 death greater than that of the service area. Charlotte County has an equally high death rate at 12.3 deaths per 1,000 population.

Death Rates by Race

The Table compares death rates among white, blacks, and other races as published by the Virginia Department of Health's Division of Health Statistics. The death rate among Blacks in each of the three service areas approximates the death rate among Whites. The death rate among Blacks and Whites by individual locality are similar. "Other" races, where "Other" is the label used by the Virginia Department of Health, are lower than the death rate compared to Blacks and Whites. It should be noted that there were 52 data points for both Blacks and Whites for the four-year period and only 26 data points for "Other".

"African Americans have made significant gains in life expectancy, and the mortality gap between white and black Americans has been cut in half since 1999, the Centers for Disease Control and Prevention reported. Blacks experienced a 25 percent drop in their overall death rate, compared to a 14 percent decrease for whites, between 1999 and 2015. Deaths from heart disease, cancer and stroke declined sharply among blacks 65 and older, and in that age group, blacks now have a lower death rate than whites, the CDC has stated."

[Citation: Achenbach, Joel. Life expectancy improves for blacks, and the racial gap is closing, CDC reports. The Washington Post. May 2, 2017]

TABLE: Avg. Death Rate Over 4 Years by Race

LOCALITY	2015 - 2012 Avg. Death Rate			
	Total	White	Black	Other
AMELIA	10.6	10.1	12.5	NR
BUCKINGHAM	8.9	9.8	7.4	NR
CHARLOTTE	12.3	12.2	12.7	NR
CUMBERLAND	9.3	9.2	9.8	NR
LUNENBURG	11.4	11.9	10.8	NR
NOTTOWAY	12.4	13.4	11.2	NR
PRINCE EDWARD	9.8	9.1	11.6	NR
SERVICE AREA	10.3	11	11.1	NR
VIRGINIA	7.6	8.2	7.2	2.4

Tables and Chart Source: Virginia Department of Health. Division of Health Statistics. Retrieved February 7, 2018. Accessed at https://www.vdh.virginia.gov/HealthStats/documents/pdf/bk1dth01.pdf.

Premature Death Rates

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

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

LOCALITY	Average	2014-2016	2013-2015	2011-2013	2010-2012
AMELIA	412.3	422	391	437	399
BUCKINGHAM	370.8	370	368	379	366
CHARLOTTE	422.8	385	404	460	442
CUMBERLAND	359.5	326	372	384	356
LUNENBURG	396.8	406	383	397	401
NOTTOWAY	461.3	440	443	497	465
PRINCE EDWARD	421	460	429	396	399
SERVICE AREA	404.1	395	366	428	427
VIRGINIA	316	317	314	315	318

Table 3 Source: Robert Wood Johnson Foundation. County Health Rankings & Roadmaps. 2018, 2017, 2016, 2015. Retrieved March 15, 2018. Retrieved from http://www.countyhealthrankings.org/app/virginia/2018/overview; …/2017/overview; …/2016/overview; …/2015/overview.

Injury Death Rate

TABLE: Number of deaths due to injury per 100,000 population

LOCALITY	2016 -2012	2015 - 2011	2013 - 2009	2012 - 2008
AMELIA	114	98	88	98
BUCKINGHAM	70	66	59	61
CHARLOTTE	91	86	85	89
CUMBERLAND	90	89	84	68
LUNENBURG	85	81	82	79
NOTTOWAY	78	70	77	67
PRINCE EDWARD	68	61	56	55
SERVICE AREA	85	79	76	74
VIRGINIA	58	55	52	52

Source: County Health Rankings for Virginia Localities 2018, 2017, 2016, 2015. CDC WONDER mortality data by four-year groupings

Hypertension

MAP and TABLE: Hypertension Death Rate per 100,000 (any mention), 35+, All Races/Ethnicities, Both Genders, 2014-2016

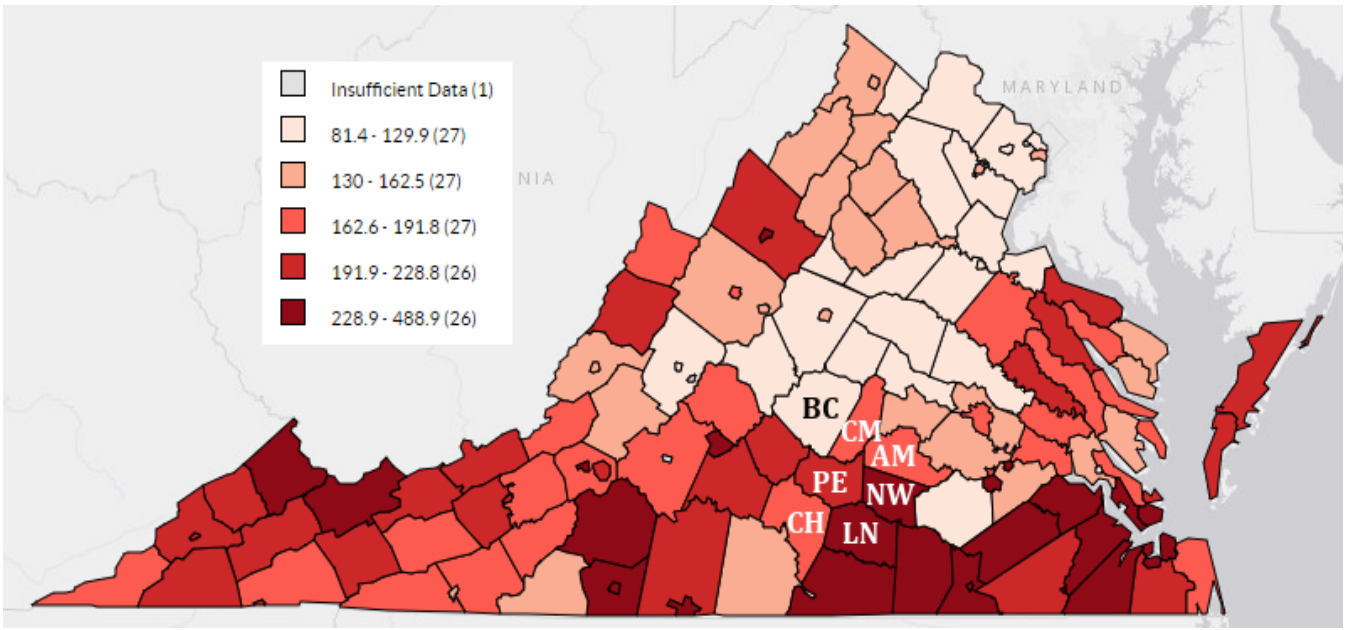


TABLE: Hypertension Death Rate per 100,000 (any mention), 35+, All Races/Ethnicities, Both Genders, 2014-2016

AMELIA	172.2
BUCKINGHAM	115.2
CHARLOTTE	187.2
CUMBERLAND	163.1
LUNENBURG	230.1
NOTTOWAY	259.3
PRINCE EDWARD	206.6
SERVICE AREA	**190.5**
VIRGINIA RANGE	**167.4**

Source: Map Source: Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. https://nccd.cdc.gov/DHDSPAtlas/Default.aspx?state=VA

Stroke Death Rate

TABLE: Stroke Death Rate per 100,000, Age 35+ by Race 2014-2016

LOCALITY	All Races Both Genders	White	Black	Hispanic
AMELIA	79.6	77.7	95.4	NR
BUCKINGHAM	65.3	65.1	78.1	NR
CHARLOTTE	88.0	88.6	94.9	NR
CUMBERLAND	71.9	68.3	91	NR
LUNENBURG	98.2	90.2	125.1	NR
NOTTOWAY	96.9	78.7	125	NR
PRINCE EDWARD	83.2	78.1	99	NR
SERVICE AREA	**74.0**	**68.8**	**90.1**	**NR**
VIRGINIA	**73.3**	**70.5**	**94.7**	**45.4**

Table Source: Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx. *Accessed April 25, 2018.*

TABLE: Heart Disease Death Rate per 100,000 Age 35+ by Race 2014-2016

LOCALITY	All Races Both Genders	White	Black	Hispanic
AMELIA	298.5	289.5	363.9	NR
BUCKINGHAM	349.1	330.1	407.2	NR
CHARLOTTE	380.3	385.0	383.9	NR
CUMBERLAND	318.3	300.2	371.6	NR
LUNENBURG	399.9	398.5	407.2	NR
NOTTOWAY	408.0	376.5	416.1	NR
PRINCE EDWARD	379.8	373.4	409.0	NR
SERVICE AREA	362.0	350.5	394.1	NR
VIRGINIA	297.4	299.4	370.4	130.1

Table Source: Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx. Accessed April 25, 2018.

Suicide Death Rate

According to the Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports, in 2016:

- Suicide was the tenth leading cause of death overall in the United States, claiming the lives of nearly 45,000 people.
- Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54.
- There were more than twice as many suicides (44,965) in the United States as there were homicides (19,362).

TABLE: Virginia Age-Adjusted Death Rates per 100,000 Population: Suicide 2008-2014

LOCALITY	Suicide Rate 2008-2014
AMELIA	suppressed
BUCKINGHAM	16.65
CHARLOTTE	suppressed
CUMBERLAND	suppressed
LUNENBURG	suppressed
NOTTOWAY	18.93
PRINCE EDWARD	12.31
TOTAL SERVICE AREA	**6.0**
VIRGINIA	**12.24**

Table Source: Centers for Disease Control and Prevention. Retrieved from https://wisqars.cdc.gov:8443/cdcMapFramework/mapModuleInterface.jsp

Rates based on 20 or fewer deaths over the period are considered unstable. These rates are therefore suppressed.

Three of the service area's seven localities have suicide rates higher than the overall state rate. The state locality suicide mortality rate ranges from 5.74 to 17.92.

MAP: Diabetes Percentage, Age Adjusted for the Population Age 20+: 2014

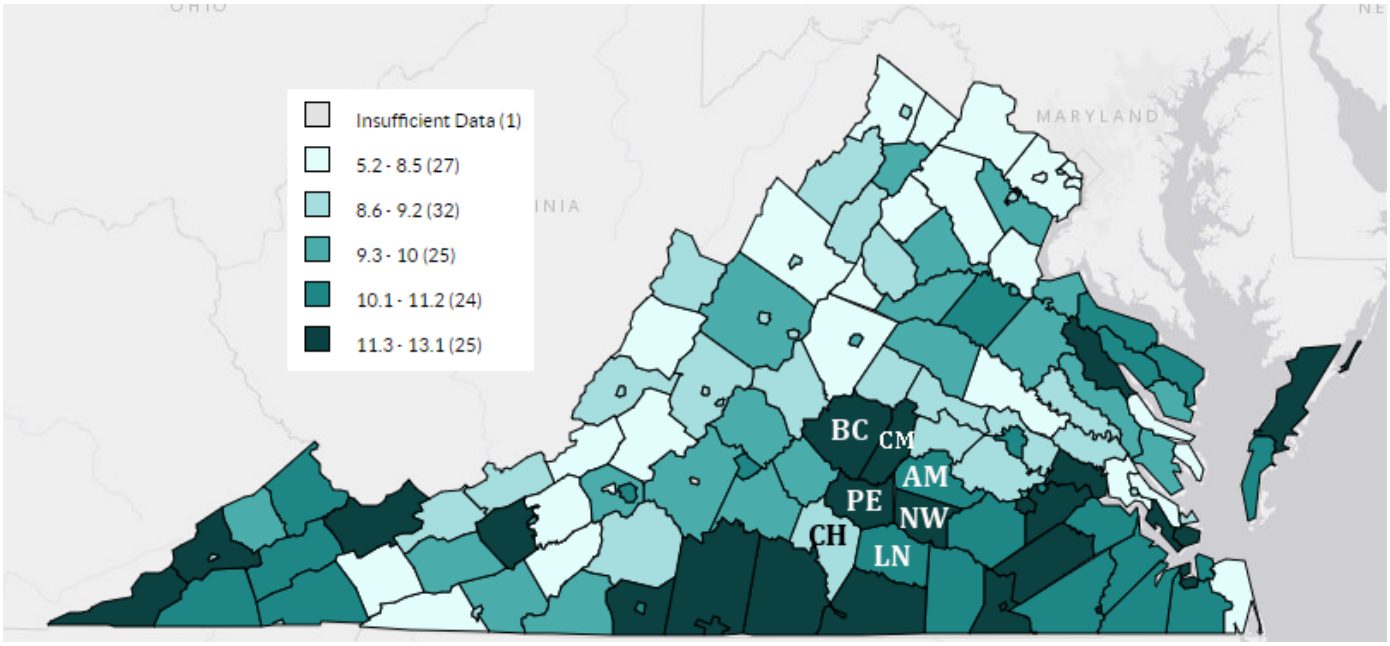


TABLE: Diabetes Percentage, Age Adjusted for the Population Age 20+: 2014

AMELIA (AM)	10.3%
BUCKINGHAM (BC)	12.1%
CHARLOTTE (CH)	9.2%
CUMBERLAND (CM)	12.0%
LUNENBURG (LN)	10.6%
NOTTOWAY (NW)	12.4%
PRINCE EDW (PE)	11.6%
VIRGINIA RANGE	**5.2% - 13.1%**

Map Source: Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/Reports.aspx

Maternal and Child Health Indicators

"The well-being of mothers, infants, and children determines the health of the next generation and can help predict future public health challenges for families, communities, and the medical care system. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.

Despite major advances in medical care, critical threats to maternal, infant, and child health exist in the United States. Among the Nation's most pressing challenges are reducing the rate of preterm births, which has risen by more than 20% from 1990 to 2006,[1] and reducing the infant death rate, which in 2011 remained higher than the infant death rate in 46 other countries.[2]

Each year, 12% of infants are born preterm and 8.2% of infants are born with low birth weight.[3] In addition to increasing the infant's risk of death in its first few days of life, preterm birth and low birth weight can lead to devastating and lifelong disabilities for the child. Primary among these are visual and hearing impairments, developmental delays, and behavioral and emotional problems that range from mild to severe.

Preconception (before pregnancy) and interconception (between pregnancies) care provide an opportunity to identify existing health risks and to prevent future health problems for women and their children. These problems include heart disease, diabetes, genetic conditions, sexually transmitted diseases, and unhealthy weight."

[Citation: Office of Disease Prevention and Health Promotion. HealthyPeople.gov. Retrieved from https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health]

TABLE: Prenatal Care Beginning in the First Trimester

LOCALITY	2015	2014	2013	2012
AMELIA	94.2	95.5	95.1	93.8
BUCKINGHAM	82.7	84.7	76.5	78.0
CHARLOTTE	68.3	65.1	75.9	69.9
CUMBERLAND	91.9	93.3	89.3	85.1
LUNENBURG	72.7	70.1	72.7	61.9
NOTTOWAY	87.7	84.6	84.2	78.6
PRINCE EDWARD	83.4	81.7	76.6	77.5
VIRGINIA	**85.2**	**82.8**	**82.9**	**83.0**

Low Birth Weight Births - 2012-2016

LOCALITY	TOTAL	WHITE	BLACK	OTHER
AMELIA	8.0%	5.7%	20.8%	0.0%
BUCKINGHAM	11.9%	8.7%	19.1%	9.1%
CHARLOTTE	10.5%	8.9%	15.2%	14.3%
CUMBERLAND	10.6%	6.8%	19.7%	10.0%
LUNENBURG	17.5%	14.6%	21.8%	25.0%
NOTTOWAY	12.6%	9.3%	17.5%	20.8%
PRINCE EDWARD	11.5%	8.3%	16.6%	8.0%
SERVICE AREA	11.8%	8.7%	18.1%	13.8%
VIRGINIA	**8.0%**	**6.5%**	**12.7%**	**7.6%**

Infant Mortality Rate

TABLE: Four-Year Infant Mortality Rate by Total, by Race, Per 1,000 Live Births

LOCALITY	Infant Mortality Rate Total 2012-2015	Infant Mortality Rate White 2012-2015	Infant Mortality Rate Black 2012-2015	Infant Mortality Rate Other 2012-2015
AMELIA	1.8	0.0	11.8	0.0
BUCKINGHAM	8.1	4.7	10.6	125.0
CHARLOTTE	12.0	13.8	7.0	0.0
CUMBERLAND	10.8	3.9	27.8	0.0
LUNENBURG	6.6	3.6	12.8	0.0
NOTTOWAY	12.7	0.0	35.2	0.0
PRINCE EDWARD	9.5	3.9	19.7	0.0
SERVICE AREA	**9.0**	**4.3**	**19.3**	**11.6**
VIRGINIA	**6.0**	**4.9**	**11.9**	**2.6**

Source: Virginia Department of Health. Division of Health Statistics. Retrieved from https://www.vdh.virginia.gov/HealthStats/stats.htm

Teen Birth Rate

TABLE: Teen Birth Rate

LOCALITY	Total 2010-2016	White	Black
AMELIA	25.0	23.0	32.0
BUCKINGHAM	26.0	26.0	25.0
CHARLOTTE	34.0	38.0	27.0
CUMBERLAND	25.0	27.0	25.0
LUNENBURG	42.0	28.0	65.0
NOTTOWAY	40.0	38.0	44.0
PRINCE EDWARD	11.0	6.0	31.0
SERVICE AREA	**29.0**	**26.6**	**35.6**
VIRGINIA	**21.0**	**NR**	**NR**

NR – Not Reported

Source: Robert Wood Johnson Foundation. County Health Rankings, 2018

PHYSICAL ENVIRONMENT

"Poor health outcomes are often made worse by the interaction between individuals and their social and physical environment. For example, millions of people in the United States live in places that have unhealthy levels of ozone or other air pollutants. In counties where ozone pollution is high, there is often a higher prevalence of asthma in both adults and children compared with state and national averages. Poor air quality can worsen asthma symptoms, especially in children. Social determinants of health reflect the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age. Also known associal and physical determinantsof health, they impact a wide range of health, functioning, and quality-of-life outcomes. Examples of physical determinants include:

- Natural environment, such as plants, weather, or climate change
- Built environment, such as buildings or transportation
- Worksites, schools, and recreational settings
- Housing, homes, and neighborhoods
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements, such as good lighting, trees, or benches"

[Citation: Office of Disease Prevention and Health Promotion. HealthyPeople.gov. Retrieved from https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health]

Housing Problems

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

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. Residential segregation – non-white/white. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/physical-environment/housing-transit/severe-housing-problems]

TABLE: Housing with at least 1 of 4 Housing Problems

	2010 - 2014		2009 - 2013	
LOCALITY	No. Households with Severe Problems	% Households w Severe Problems	No. Households with Severe Problems	% Households w Severe Problems
AMELIA	780	16.0%	775	16.0%
BUCKINGHAM	780	13.0%	915	16.0%
CHARLOTTE	755	16.0%	765	16.0%
CUMBERLAND	765	19.0%	850	21.0%
LUNENBURG	620	13.0%	740	16.0%
NOTTOWAY	1,100	20.0%	1,050	19.0%
PRINCE EDWARD	1,345	18.0%	1,300	17.0%
SERVICE AREA	**6,145**	**16.4%**	**6,395**	**17.2%**
VIRGINIA		**15.0%**		**15.0%**

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

Table Source: County Health Rankings from US Department of Housing and Urban Development. Retrieved from http://www.countyhealthrankings.org/app/virginia/2018/measure/factors/136/data

Residential Segregation

"Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with which two groups (non-white and white residents) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case). The index score can be interpreted as the percentage of white or non-white that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area. Residential segregation remains prevalent in many areas of the country and may influence both personal and community well-being. Residential segregation is considered to be a fundamental cause of health disparities in the US and has been linked to poor health outcomes, including mortality, a wide variety of reproductive, infectious, and chronic diseases, and other adverse conditions. [1,2] Structural racism is also linked to poor-quality housing and disproportionate exposure to environmental toxins. [3] Individuals living in segregated neighborhoods often experience increased violence, reduced educational and employment opportunities, limited access to quality healthcare and restrictions to upward mobility. [2,3]"

[Citation: Robert Wood Johnson Foundation. Community Health Rankings. Residential segregation – non-white/white. Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/social-and-economic-factors/family-social-support/residential-segregation-non-whitewhite]

References: [1] Gee G, Ford C. Structural racism and health inequities: Old issues, new directions. Du Bois Review. 2011;8:115-132. [2] Kramer MR, Hogue CR. Is segregation bad for your health? Epidemiol. Rev. 2009;31:178-194. [3] Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. Lancet. 2017;389:1453-1463.

TABLE: Residential Segregation - Non-white/White

LOCALITY	2016-2012	2015-2011	2014-2010
AMELIA	9.0	9.0	1.0
BUCKINGHAM	8.0	16.0	12.0
CHARLOTTE	11.0	5.0	5.0
CUMBERLAND	4.0	7.0	7.0
LUNENBURG	11.0	12.0	9.0
NOTTOWAY	16.0	12.0	15.0
PRINCE EDWARD	10.0	14.0	14.0
SERVICE AREA	**9.9**	**10.7**	**9.0**
VIRGINIA	**41.0**	**41.0**	**42.0**

Note: A score of "1" would represent maximum segregation

Source: Community Health Rankings 2018, 2017, 2016 from American Community Survey, 5-year estimates.

Air Quality

TABLE: Percentage of (Pop. Adjusted) Days Exceeding NAAQ Standards: Particulate Matter (PM2.5), 2009 through 2012

LOCALITY	2012	2011	2010	2009
AMELIA	0	0	0	0
BUCKINGHAM	0	0	0	0
CHARLOTTE	0	0	0	0
CUMBERLAND	0	0	0	0
LUNENBURG	0	0	0	0
NOTTOWAY	0	0	0	0
PRINCE EDWARD	0	0	0	0
VIRGINIA	**0.08**	**0.00**	**0.08**	**0.02**

Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012. Retrieved from https://assessment.communitycommons.org/CHNA/report?page=3&id=409&reporttype=ENVIRO

Water Quality

TABLE: Household Water Quality: Common Contaminants Percent of Samples Exceeding Standard 2009-2015

LOCALITY	Low pH (<6.5)	Copper	Total coliform bacteria	Lead	Manganese	E. coli bacteria
AMELIA	57%	NR	75%	21%	NR	11%
BUCKINGHAM	NR	NR	NR	NR	NR	NR
CHARLOTTE	30%	11%	57%	16%	13%	NR
CUMBERLAND	NR	NR	NR	NR	NR	NR
LUNENBURG	44%	22%	58%	20%	NR	9%
NOTTOWAY	72%	20%	64%	24%	10%	10%
PRINCE EDWARD	NR	NR	NR	NR	NR	NR
VIRGINIA	20%	9%	40%	10%	10%	8%

Table Source: Virginia Cooperative Extension. Virginia Household Water Quality Program. Retrieved from https://www.wellwater.bse.vt.edu/resources.php

Violent Crime

TABLE: Violent Crime Reported Offenses Rate per 100,000

LOCALITY	2014-2012	2012-2010
AMELIA	114	166
BUCKINGHAM	162	154
CHARLOTTE	166	148
CUMBERLAND	162	145
LUNENBURG	163	172
NOTTOWAY	231	154
PRINCE EDWARD	185	140
SERVICE AREA	**169**	**154**
VIRGINIA	**194**	**200**

Source: County Health Rankings for Virginia Localities 2018 (2014-2012), and 2016 (2012-2010) from Uniform Crime Reporting - FBI

Prioritization of Needs

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

1. Responses from the Community Health Survey (Top 25 responses)
   a. Q5. Thinking about the community, what are the five most important issues that affect the health of the community?
2. Responses from the Stakeholders' Survey and Focus Group Meeting (Top 31 responses)
   a. Q1. What are the top 5 greatest needs in the community(s) you serve?

The Farmville Area Prioritization of Needs Worksheet is available in the Appendix. For each "Area of Need" identified, the percentage of responses for each question from the Community Health Survey and/or Stakeholders' Survey and Focus Group Meeting was noted on the worksheet so that participants could see how they were prioritized by the appropriate community members.

At the September 27, 2018 CHAT meeting, members were asked to rank the needs from 1 to 10, with 1 being the greatest need and 10 being the 10th greatest need. Upon completing the ranking exercise, CHAT members discussed their rankings as a group. Many members expressed that many of the "Areas of Need" were interrelated (i.e. Access to Healthy Food, Lack of Exercise, and Overweight/Obesity) to other needs. Some members grouped similar items into one ranking when relevant.

Rankings by respondent for the "Areas of Need" were entered into Survey Monkey and analyzed using an Excel workbook. A total of 19 CHAT members completed the "Prioritization of Needs Worksheet". An average rank score per priority was calculated. Where an Area of Need was not ranked in the top 10, the number 11 was assigned to adjust rankings across all priority areas. The rankings were then summed and divided by 22 for an average rank score. When appropriate, Areas of Need ranked in the top 10 that had similarities were combined (i.e. Substance use and Alcohol and Illegal drug use).

The 2018 Prioritization of Needs Top 10 Rankings follow. Priority areas are reflective of the County Health Rankings' four categories for Health Factors including Social and Economic Factors, Health Behaviors, Clinical Care, and Physical Environment. These rankings will be used by Centra, the Piedmont Health District, the Partnership for Healthy Communities partners, and community leaders/stakeholders to develop Implementation Plans that will respond to these needs.

Farmville Area Prioritization of Needs 2018
Top 10 Rankings

Ranking n=19	Average Ranking n=19	Areas of Need	Community Health Survey Responses (%) n=862	Stakeholder Survey Responses (%) n=179	Comments
1	2.37	Access to affordable health care	54.87%		
2	5.37	Access to healthy foods	25.17%	6%	
3	6.11	Access to affordable housing	25.41%	8%	
4	6.95	Diabetes	24.83%		
5	7.25	Access to mental health services & mental health problems			Combined Access to mental health services (#5, Ranking 6.95) and Mental health problems (#7, Ranking 7.05)
	7.05	Mental Health problems	17.98%	3%	
	6.95	Access to mental health services		7%	
6	7.45	Substance use: Alcohol and illegal drug use			Combined Substance use (#12, Ranking 7.84) and Alcohol & illegal drug use (#4, Ranking 6.32)
	6.32	Alcohol and illegal drug use	29.12%		
	7.84	Substance Use		7%	
7	7.42	Overweight/Obesity	28.65%		
8	7.47	Transportation	9.40%	13%	
9	7.68	Poverty	17.63%		
10	7.74	Poor eating habits	19.95%		

Community Resources

A list of resources was developed from the area 2-1-1 database, as well as from input from the Stakeholder Focus Group meeting and Surveys and the Target Population Focus Group meetings. This list will assist Centra, the Piedmont Health District, the Partnership for Healthy Communities and other community stakeholders in identifying existing programs and community resources that are available to address the prioritized needs in the Implementation Plans. The list of Community Resources can be found in the Appendix.

Evaluation of Impact

The Farmville Area Community Health Needs Assessment and Implementation Plan was previously conducted in 2016 and identified three overarching action plan priorities aimed at improving the health of the various communities served. These priorities included mental health education, awareness, and access; transportation; and awareness of community resources.

With regard to "mental health education, awareness, and access", Centra has identified numerous opportunities and initiatives to support mental health awareness issues in the community including: de-stigmatize & normalize mental health through a public awareness campaign with a focus on prevention, increased awareness and education about the day to day mental health challenges such as stress, anxiety, depression, etc., and integration of mental health into medical offices and community services to promote the collaborative care model; explore the existing mental health landscape and coordinate mental health resources, navigation programs and coalitions to increase access in the community. In September of 2017 and March of 2018, Centra partnered with Crossroads Community Service Board, Longwood University, and other local organizations for an "Out of the Darkness" walk. This event is held to bring awareness to mental health issues and to raise money for the local American Foundation for Suicide Prevention (AFSP) chapter.

The "transportation" priority includes a number of opportunities aimed at fixing this fundamental access issue in the community. The opportunities include partnering with STEPS (Community Action Agency); a possible collaboration with FACES; exploring working with the Komen Foundation to gain access to gas cards for those receiving breast cancer treatment; exploring funding to expand the existing FAB (Farmville Area Bus) public transportation service; implement telemedicine; collaborating with Piedmont Senior Resources to expand van pick up program; exploring a partnership with Uber; establishing a mobile medicine program; investigating psychiatry residents coming to underserved communities where they can receive credit or gain loan forgiveness to complete their training. In April of 2018, Piedmont Senior Resources purchased a wheelchair accessible van with monies obtained from a Department of Rail & Public Transportation grant for medical transport. Utilization of this van will improve access to care for community members. In June of 2018, Centra started a community paramedic program in Farmville. In this program paramedics visit patients in their homes after hospital admissions to provide care and coordinate transportation to various medical appointments.

The "improving awareness of community resources" priority has resulted in the identification of a number of new programs and services including: partnering with No Wrong

Door to increase the number of not-for-profits using Communication, Referral, Information and Assistance (CRIA) electronic tool; partnering with STEPS, churches, schools, Chamber of Commerce, healthcare facilities and local governments to develop a healthcare Community Resource Guide that can be distributed via community gathering spots, not-for-profits, 2-1-1 Information and Referral and community partners, and can be published electronically; partnering with 2-1-1 to include mental health services, transportation and nutrition education into their system. In February of 2018, Centra Southside Community Hospital (CSCH) became an active partner with Virgnia's "No Wrong Door". This program is a virtual system that connects patients with a statewide network of shared resources supporting those in the community who are older adults (along with their family members/caregivers) as well as individuals of all ages who have disabilities. This system utilizes a database to provide applicable members access to resources such as local Departments of Social Services, Community Service Boards, centers for independent living, home health, home repair, transportation and meals programs. Members of CSCH's case management department as well as the patient navigator have been trained on how to use the secure database to enter in and locate resources for our patients. In Virginia, this program is led through a partnership with the Department of Aging and Rehabilitative Services, the Department of Medical Assistance Services, the Department of Behavioral Health and Development Services, Virginia Senior Navigator and the Virginia Hospital and Healthcare Association.

Appendix

1. Area Community Health Survey (English and Spanish)

SÓLO PARA USO INTERNO: Date:

La organización *The Partnership for Healthy Communities* está trabajando junto con los líderes en el área a fin de aprender más acerca de sus necesidades de atención médica. Favor de contestar las siguientes preguntas con la(s) mejor(es) respuesta(s). Todos los cuestionarios se mantendrán confidenciales. Gracias por tomar el tiempo de llenar este cuestionario. Se puede mandar el cuestionario al: Lynchburg Health Department, Attention Lindsey Cawood, 307 Alleghany Ave., Lynchburg, VA 24501. Usted tiene que ser mayor de 18 años para poder llenar este cuestionario. Favor de completar este cuestionario una sola vez.

CUESTIONARIO DE SALUD PARA LA COMUNIDAD DEL AREA DE FARMVILLE

ACCESO Y BARRERAS A LA ATENCIÓN MÉDICA

1. ¿Hay una clínica médica, centro de salud u otro lugar específico donde usted usualmente va si está enfermo o necesita consejo acerca de su salud? ☐ **Sí** ☐ **No**

Pase a la pregunta 2 si marcó No. Si marcó Sí:

- **¿Es este el lugar adonde iría para tratar un nuevo problema de salud?** ☐ Sí ☐ No
- **¿Es este el lugar adonde iría para asistencia médica preventiva, tal como un chequeo, examen o inmunizaciones generales?** ☐ Sí ☐ No
- **¿Es este el lugar adonde iría para conseguir un referido a otra profesional de salud, si fuera necesario?** ☐ Sí ☐ No

2. ¿Usted utiliza servicios de atención médica? ☐ **Sí** ☐ **No**

Si sí, ¿adónde va para atención médica? ***(Marque todos los que apliquen)***

- ☐ Clínica médica_____
- ☐ Centra Medical Group
- ☐ Central Virginia Community Health Center
- ☐ Charlotte Primary Care
- ☐ Sala de emergencias
- ☐ Departamento de salud
- ☐ Health Center for Women and Families
- ☐ Heart of Virginia Free Clinic
- ☐ Lunenburg Medical Center
- ☐ Pharmacy Clinic
- ☐ Veterans Administration Medical Center
- ☐ Urgent Care o Clínica sin cita previa
- ☐ Centra 24/7 Virtual Visit
- ☐ Otro_____

3. ¿Usted utiliza servicios de atención dental? ☐ **Sí** ☐ **No**

Si sí, ¿adónde va para atención dental? ***(Marque todos los que apliquen)***

- ☐ Clínica del dentista_____
- ☐ Affordable Dentures
- ☐ Central Virginia Community Health Center
- ☐ Charlotte Primary Care
- ☐ Sala de emergencias
- ☐ Clínica gratuita
- ☐ Clínica gratuita
- ☐ Healthy Smiles
- ☐ Mission of Mercy Project
- ☐ Urgent Care/Clínica sin cita previa
- ☐ VCU Dental Clinic
- ☐ Veterans Administration Medical Center
- ☐ Otro_____

4. ¿Usted utiliza servicios de salud mental, abuso de alcohol, o abuso de drogas? ☐ **Sí** ☐ **No**

Si sí, ¿adónde va para tales servicios? ***(Check all that apply)***

- ☐ Clínica del consejero_____
- ☐ Clínica médica_____
- ☐ Central Virginia Community Health Center
- ☐ Crossroads Community Services Board
- ☐ Health Center for Women and Families
- ☐ Sala de emergencias
- ☐ Clínica gratuita
- ☐ Infant and Toddler Connection
- ☐ Urgent Care/Clínica sin cita previa
- ☐ Veterans Administration Medical Center
- ☐ Otro_____

5. ¿Qué piensa usted que son los asuntos más importantes que afectan la salud de nuestra comunidad? ***(Escoja solo <u>cinco</u>)***

- ☐ El acceso económico a atención médica
- ☐ El acceso a alimentos saludables
- ☐ Los accidentes en el hogar
- ☐ La vivienda económica
- ☐ Los problemas de envejecimiento
- ☐ El uso de alcohol y drogas ilícitas
- ☐ El asma
- ☐ El bullying
- ☐ El cáncer
- ☐ El uso de teléfonos celulares/el mandar mensajes mientras maneja
- ☐ El abuso/la negligencia de niños
- ☐ Los problemas dentales
- ☐ La diabetes
- ☐ La discriminación/segregación
- ☐ La violencia doméstica
- ☐ El índice de deserción escolar
- ☐ La salud ambiental (agua, aire
- ☐ La actividad de pandillas
- ☐ La enfermedad cardíaca y el derrame cerebral
- ☐ La hipertensión
- ☐ El VIH / el SIDA
- ☐ El homicidio
- ☐ La muerte infantil
- ☐ El desempleo
- ☐ La falta de ejercicio
- ☐ La enfermedad pulmonar
- ☐ Los problemas de salud mental
- ☐ La seguridad en el vecindario
- ☐ El no vacunarse para prevenir enfermedad
- ☐ El uso de opioides
- ☐ La salud ambiental (la calidad del agua y el aire, el uso de pesticidas)
- ☐ El no usar cinturones de seguridad, las sillas infantiles, los cascos)
- ☐ El uso de tabaco, incluso el fumar y el fumar cigarrillos electrónicos
- ☐ Otro_____
- ☐ El sobrepeso/la obesidad
- ☐ Los malos hábitos de alimentación
- ☐ La pobreza
- ☐ El abuso de drogas recetadas
- ☐ El apoyo social
- ☐ El apoyo sexual
- ☐ El abuso sexual
- ☐ El estrés
- ☐ El suicidio
- ☐ El embarazo adolescente
- ☐ La transportación
- ☐ El sexo seguro
- ☐ La transportación
- ☐ El sexo seguro

6. ¿Cuáles servicios son difíciles de conseguir en nuestra comunidad? ***(Marque <u>todos</u> los que apliquen)***

- ☐ Los servicios de ambulancia
- ☐ La atención quiropráctica
- ☐ La atención dental de adultos
- ☐ La atención dental de niños
- ☐ Los servicios para la violencia doméstica
- ☐ El cuidado de ancianos
- ☐ La atención en la sala de emergencias
- ☐ El cuidado del final de la vida, hospicio, paliativo
- ☐ Los servicios para los ex delincuentes
- ☐ Un médico de familia
- ☐ La planificación familiar/los anticonceptivos
- ☐ La comida a buen precio
- ☐ La vivienda (segura y económica)
- ☐ Las inmunizaciones
- ☐ La atención hospitalaria
- ☐ El análisis de laboratorio
- ☐ Los servicios legales
- ☐ Las mamografías
- ☐ La medicación/los suministros médicos
- ☐ La salud mental/la consejería
- ☐ La nutrición y la pérdida de peso
- ☐ La terapia física
- ☐ El cuidado prenatal
- ☐ El cuidado preventivo (p. ej. los chequeos)
- ☐ La terapia alternativa (herbaria, la acupuntura, el masaje)
- ☐ Los servicios de abuso de sustancias – drogas y alcohol
- ☐ Los programas para dejar el tabaco
- ☐ El cuidado especializado
  - El asma
  - El cuidado de cáncer
  - La cardiología
  - La dermatología
- ☐ La transportación
- ☐ El cuidado urgente/clínica sin cita previa
- ☐ El cuidado de la visión
- ☐ Los servicios de salud de mujeres
- ☐ La preparación para el empleo

7. ¿Qué cree usted que le impide conseguir los servicios que necesita? ***(Marque <u>todos</u> los que apliquen)***

- ☐ Miedo de ir a un chequeo
- ☐ No encuentro proveedores que acepten mi seguro
- ☐ El cuidado infantil
- ☐ No tengo acceso al internet
- ☐ No me gusta ir al médico
- ☐ No confío en los médicos/las clínicas
- ☐ La ubicación de las oficinas
- ☐ Esperas muy largas para las citas
- ☐ No tengo seguro de salud

- ☐ El costo
- ☐ No sé cuáles servicios están disponibles
- ☐ No me gusta aceptar ayuda del gobierno
- ☐ No tengo el tiempo
- ☐ No tengo un médico regular
- ☐ Pagos compartidos (*co-pays)* costosos
- ☐ Servicios de idioma
- ☐ Falta de servicios ofrecidos en la tarde/fin de semana
- ☐ No tengo transporte
- ☐ Puedo conseguir la atención médica que necesito
- ☐ Otro_____

PREGUNTAS GENERALES DE LA SALUD

8. Marque uno de los siguientes para cada declaración, por favor.	**Sí**	**No**	**No aplica**
He tenido un examen de mis ojos durante los últimos 12 meses.			
He ido a una cita de salud mental/abuso de sustancias durante los últimos 12 meses.			
He tenido un examen dental durante los últimos 12 meses.			
He ido a la sala de emergencias durante los últimos 12 meses.			
He ido a la sala de emergencias debido a una herida durante los últimos 12 meses (p. ej. un accidente de automóvil, una caída, una intoxicación, una quemadura, una incisión, etc.)			
He sido víctima de la violencia o abuso doméstico durante los últimos 12 meses.			
Mi médico me ha dicho que tengo una enfermedad crónica o a largo plazo.			
Me tomo el medicamento que mi doctor me ha recetado para controlar mi enfermedad crónica.			
Puedo pagar el medicamento que necesito para tratar mis condiciones médicas.			
Tengo más de 21 años y he tenido un examen de papanicolaou durante los últimos tres años (si usted tiene menos de 21 años o es varón, marque “No aplica”).			
Tengo más de 40 años y he tenido una mamografía durante los últimos 12 meses (si usted tiene menos de 40 años o es varón, marque “No aplica”).			
Tengo más de 50 años y he tenido una colonoscopia durante los últimos 10 años (si usted tiene menos de 50 años, marque “No aplica”).			
¿Apoya su vecindario la actividad física? (p. ej. tiene parques, aceras, carril de bici, etc.)			
¿Apoya su vecindario la alimentación sana? (p. ej. tiene jardines de comunidad, un mercado de agricultores, etc.)			
En el área en donde usted vive, ¿es fácil conseguir frutas y verduras frescas a buen precio?			
¿Ha habido ocasiones durante los últimos 12 meses cuando no le alcanzaba para poder comprar la comida que usted o su familia necesitaba?			
¿Ha habido ocasiones durante los últimos 12 meses cuando no le alcanzaba para poder pagar su renta o hipoteca?			
¿Se siente usted seguro/a en su vecindario?			

9. ¿De dónde consigue usted o su familia los alimentos que comen? (*Marque <u>todos</u> los que apliquen*)

- ☐ Los programas de comida de verano o de mochilas
- ☐ Un jardín de comunidad
- ☐ La tienda de la esquina/la gasolinera
- ☐ La tienda del dólar
- ☐ El mercado de agricultores
- ☐ El banco de alimentos/comedor comunitario
- ☐ El supermercado
- ☐ Su propia cosecha de jardín
- ☐ No como en casa
- ☐ Mi familia, mis amigos, mis vecinos, o mi iglesia
- ☐ Meals on Wheels
- ☐ La escuela
- ☐ Un restaurante/comida para llevar/comida rápida
- ☐ Otro_____

10. Durante los últimos 7 días, ¿cuántas veces ha comido usted fruta o verduras (frescas o congeladas)? El jugo de fruta o vegetales no cuenta. *(Marque <u>uno</u> por favor)*

- ☐ No comí ni frutas ni verduras durante los últimos 7 días
- ☐ 1 – 3 veces durante los últimos 7 días
- ☐ 4 – 6 veces durante los últimos 7 días
- ☐ 1 vez por día
- ☐ 2 veces por día

☐ 3 o más veces por día
☐ 4 o más veces por día

11. ¿Un médico le ha dicho que usted tiene…? (*Marque <u>todos</u> los que apliquen*)

☐ El asma
☐ El cáncer
☐ El parálisis cerebral
☐ La EOPC/la bronquitis crónica/el enfisema
☐ La depresión o la ansiedad
☐ La diabetes o el azúcar en sangre elevado
☐ Los problemas de drogas o alcohol
☐ Una enfermedad cardíaca
☐ La hipertensión
☐ El colesterol elevado
☐ El VIH / el SIDA
☐ Un problema de salud mental
☐ La obesidad/el sobrepeso
☐ El derrame/una enfermedad cerebrovascular
☐ No tengo ningún problema de salud
☐ Otro_____

12. ¿Cuándo fue la última vez que usted vio a un médico por motivo de un chequeo rutinario? *(Marque <u>uno, por favor</u>)*

☐ Durante el último año
☐ Durante los últimos dos años
☐ Durante los últimos 3 a 5 años
☐ Hace 5 años o más

13. ¿Cuándo fue la última vez que usted fue con un dentista o a una clínica dental por cualquier motivo? Incluya visitas a especialistas dentales, como un ortodoncista. *(Marque <u>uno</u>, por favor)*

☐ Durante el último año
☐ Durante los últimos dos años
☐ Durante los últimos 3 a 5 años
☐ Hace 5 años o más

14. ¿Qué tan conectado/a se siente usted con la comunidad y con los a su alrededor?

☐ Muy conectado/a ☐ Un poco conectado/a ☐ No conectado/a

15. Durante los últimos 7 días, ¿por cuántos días estuvo usted activo/a por un total de por lo menos 30 minutos? (Suma todo el tiempo que usted pasó en cualquier tipo de actividad física que elevó su ritmo cardíaco e hizo que usted respirara fuertemente por parte del tiempo).

☐ 0 día ☐ 1 día ☐ 2 días ☐ 3 días ☐ 4 días ☐ 5 días ☐ 6 días ☐ 7 días

16. Durante los últimos 7 días, ¿cuántas veces se ha juntado toda, o la mayoría, de la familia que vive en su hogar para comer juntos?

☐ Ninguna vez
☐ 1-2 veces
☐ 3-4 veces
☐ 5-6 veces
☐ 7 veces
☐ Más de 7 veces
☐ No se aplica/vivo solo/a

17. ¿Cómo está su salud en general?: *(Marque <u>uno</u>, por favor)*

☐ Excelente ☐ Muy buena ☐ Buena ☐ Más o menos ☐ Mala

18. Pensando en su salud física, la cual incluye las enfermedades y las heridas físicas, ¿por cuántos días durante los últimos 30 días considera usted que su salud física no estaba bien? _____ Días

19. Pensando en su salud mental, la cual incluye el estrés, la depresión y problemas emocionales, ¿por cuántos días durante los últimos 30 días considera usted que su salud mental no estaba bien? _____ Días

20. Durante los últimos 30 días: ***(Marque <u>todos</u> los que apliquen)***

- ☐ Me he tomado 5 o más bebidas alcohólicas (si es varón) o 4 o más bebidas alcohólicas (si es mujer) durante una sola ocasión.
- ☐ He usado productos de tabaco (cigarrillos, tabaco sin humo, cigarrillos electrónicos, etc.)
- ☐ He usado las drogas recetadas para drogarme.
- ☐ He usado las drogas ilícitas como el crack, la cocaína, el éxtasis, la heroína, el LSD, la marihuana, la metanfetamina
- ☐ Otro_____

21. ¿Cuántos vehículos tiene usted o los que viven actualmente en su hogar a su alcance (sean propios, alquilados o disponibles para uso regular)? Asegúrese de incluir las motocicletas, las pasolas y las casas rodantes. _____Vehículos

22. ¿Qué tipos de transportación utiliza usted? ***(Marque <u>todos</u> los que apliquen)***

- ☐ Bicicleta
- ☐ Caminar/a pie
- ☐ Carro
- ☐ Motocicleta, pasola, scooter
- ☐ Amigos o familiares que me llevan
- ☐ Transporte público (p. ej. autobús, shuttle, etc)
- ☐ Taxi
- ☐ Uber/Lyft
- ☐ Otro_____

23. ¿Cuál de los siguientes describe su tipo de seguro de salud actual? ***(Marque <u>todos</u> los que apliquen)***

- ☐ COBRA
- ☐ Seguro dental
- ☐ Seguro proveído por el empleador
- ☐ Del gobierno (VA, Champus)
- ☐ Cuenta de ahorros para gastos médicos
- ☐ Seguro individuo/privado
- ☐ Marketplace/Obamacare
- ☐ Medicaid
- ☐ Medicare
- ☐ Suplemento de Medicare
- ☐ Ningún seguro dental
- ☐ Ningún seguro de salud

24. Si usted no tiene seguro de salud, ¿por qué motivo no lo tiene? ***(Marque <u>todos</u> los que apliquen)***

- ☐ No aplica – tengo seguro
- ☐ No entiendo mis opciones del Marketplace/Obamacare
- ☐ No está disponible a través de mi trabajo
- ☐ Soy estudiante
- ☐ El costo/muy caro
- ☐ No tengo trabajo
- ☐ Decido no tenerlo
- ☐ Otro_____

25. ¿Cuál es su código postal? _____

26. ¿Cuál es su edad? _____

27. ¿Cuál es su género? ☐ Varón ☐ Mujer ☐ Transgénero ☐ Otro _____

28. ¿Cuál es su altura? _____

29. ¿Cuál es su peso? _____

30. ¿Es usted un veterano de los EEUU? ☐ Sí ☐ No

31. ¿Cuántas personas viven en su hogar (incluya a sí mismo/a)?

Núm. de entre 0-17 años:_____ Núm. de entre 18-64 años:_____ Núm. de 65 años o mayor:_____

32. ¿Cuál es su nivel más alto de educación completada?

- ☐ No llegué a la escuela secundaria
- ☐ Un título de 2 años (Associate's)
- ☐ Programa de certificado_____

☐ Fui a la escuela secundaria pero no me gradué
☐ Recibí un diploma de secundaria o un GED
☐ Un título de 4 años (Bachelor's)
☐ Un título de maestría o doctorado

33. ¿Cuál es su idioma principal? ☐ inglés ☐ español ☐ Otro_____

34. ¿Con qué grupo étnico se identifica usted? *(Marque <u>todos</u> los que apliquen)*

☐ Nativo de Hawái/las islas del Pacífico
☐ Indio americano/nativo de Alaska
☐ Asiático
☐ Latino
☐ Negro/afroamericano
☐ Más que una raza
☐ Blanco
☐ Se niega a responder
☐ Otro_____

35. ¿Cuál es su estado civil?

☐ Casado/a ☐ Soltero/a ☐ Divorciado/a ☐ Viudo/a ☐ Unión libre

36. ¿Cuánto es su ingreso familiar anual?

☐ $0 - $10,000 ☐ $10,001 - $20,000 ☐ $20,001 - $30,000 ☐ $30,001 – 40,000 ☐ $40,001 - $50,000
☐ $50,001 - $60,000 ☐ $60,001 - $70,000 ☐ $70,001 - $100,000 ☐ $100,001 o más

37. ¿Cuál es su estado laboral?

☐ Jornada completa ☐ De media jornada ☐ Desempleado/a ☐ Trabajador independiente ☐ Jubilado/a ☐ Amo/a de casa ☐ Estudiante

38. ¿Usted actualmente recibe beneficios de discapacidad? ☐ Sí ☐ No

39. ¿Hay algo más que deberíamos saber acerca de las necesidades de usted (o de alguien que vive en su hogar) en el área de Farmville?

¡Gracias por ayudar a hacer de su comunidad un lugar más sano para vivir, trabajar y jugar!

FOR OFFICE USE ONLY: Site of Collection: Date:

The Partnership for Healthy Communities is working with leaders in the area to learn more about your health care needs. Please answer the following questions with the best answer or answers. All surveys will be kept confidential. Thank you for taking the time to complete this survey. Surveys can be mailed to: Lynchburg Health Department, Attention Lindsey Cawood, 307 Alleghany Ave., Lynchburg, VA 24501. You must be over 18 years of age to complete this survey. Please complete this survey only once.

FARMVILLE AREA COMMUNITY HEALTH SURVEY

ACCESS AND BARRIERS TO HEALTHCARE

1. Is there a specific doctor's office, health center, or other place that you usually go if you are sick or need advice about your health? ☐ **Yes** ☐ **No**

Skip to question 2 if you answered No If you answered Yes:

- **Is this where you would go for new health problems?** ☐ Yes ☐ No
- **Is this where you would go for preventive health care such as general check-ups, examinations, and immunizations (shots)?** ☐ Yes ☐ No
- **Is this where you would go for referrals to other health professions when needed?** ☐ Yes ☐ No

2. Do you use medical care services? ☐ **Yes** ☐ **No**

If yes, where do you go for medical care? ***(Check all that apply)***

- ☐ Doctor's Office_____
- ☐ Centra Medical Group
- ☐ Central Virginia Community Health Center
- ☐ Charlotte Primary Care
- ☐ Emergency Room
- ☐ Health Department
- ☐ Health Center for Women and Families
- ☐ Heart of Virginia Free Clinic
- ☐ Lunenburg Medical Center
- ☐ Pharmacy Clinic
- ☐ Veterans Administration Medical Center
- ☐ Urgent Care or Walk-in Clinic
- ☐ Centra 24/7 Virtual Visit
- ☐ Other_____

3. Do you use dental care services? ☐ **Yes** ☐ **No**

If yes, where do you go for dental care? ***(Check all that apply)***

- ☐ Dentist's Office_____
- ☐ Affordable Dentures
- ☐ Central Virginia Community Health Center
- ☐ Charlotte Primary Care
- ☐ Emergency Room
- ☐ Free Clinic
- ☐ Free Clinic
- ☐ Healthy Smiles
- ☐ Mission of Mercy Project
- ☐ Urgent Care/Walk-in Clinic
- ☐ VCU Dental Clinic
- ☐ Veterans Administration Medical Center
- ☐ Other_____

4. Do you use mental health, alcohol abuse, or drug abuse services? ☐ **Yes** ☐ **No**

If yes, where do you go for mental health and substance use care? ***(Check all that apply)***

- ☐ Counselor's Office_____
- ☐ Doctor's Office_____
- ☐ Central Virginia Community Health Center
- ☐ Crossroads Community Services Board
- ☐ Health Center for Women and Families
- ☐ Emergency Room
- ☐ Free Clinic
- ☐ Infant and Toddler Connection
- ☐ Urgent Care/Walk-in Clinic
- ☐ Veterans Administration Medical Center
- ☐ Other_____

5. What do you think are the most important issues that affect the health of our community?
(Check <u>five</u> only)

- ☐ Access to affordable healthcare
- ☐ Access to healthy foods
- ☐ Accidents in the home
- ☐ Affordable Housing
- ☐ Aging problems
- ☐ Alcohol and illegal drug use
- ☐ Asthma
- ☐ Bullying
- ☐ Cancers
- ☐ Cell phone use/texting while driving
- ☐ Child abuse/neglect
- ☐ Dental problems
- ☐ Diabetes
- ☐ Discrimination/Segregation
- ☐ Domestic violence
- ☐ Education-drop-out rates
- ☐ Environmental health (water, air
- ☐ Gang activity
- ☐ Heart disease and stroke
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Homicide
- ☐ Infant death
- ☐ Joblessness
- ☐ Lack of exercise
- ☐ Lung disease
- ☐ Mental health problems
- ☐ Neighborhood safety
- ☐ Not getting "shots" to prevent disease
- ☐ Opioid Use
- ☐ Environmental Health (water and air quality, use of pesticides)
- ☐ Not using seat belts, child safety seats, helmets
- ☐ Tobacco use including smoking and vaping
- ☐ Other_____
- ☐ Overweight/Obesity
- ☐ Poor eating habits
- ☐ Poverty
- ☐ Prescription drug abuse
- ☐ Social support
- ☐ Sexual support
- ☐ Sexual assault
- ☐ Stress
- ☐ Suicide
- ☐ Teenage Pregnancy
- ☐ Transportation
- ☐ Unsafe sex
- ☐ Transportation
- ☐ Unsafe sex

6. Which services are hard to get in out community? *(Check <u>all</u> that apply)*

- ☐ Ambulance services
- ☐ Chiropractic care
- ☐ Dental care – adults
- ☐ Dental care – children
- ☐ Domestic violence services
- ☐ Eldercare
- ☐ Emergency room care
- ☐ End of life, hospice, palliative care
- ☐ Ex-offender services
- ☐ Family doctor
- ☐ Family planning/birth control
- ☐ Food that is affordable
- ☐ Housing (safe and affordable)
- ☐ Immunizations
- ☐ Inpatient hospital
- ☐ Lab work
- ☐ Legal services
- ☐ Mammograms
- ☐ Medication/medical supplies
- ☐ Mental health/counseling
- ☐ Nutrition and weight loss
- ☐ Physical therapy
- ☐ Pregnancy care
- ☐ Preventive care (e.g. check-ups)
- ☐ Alternative therapy (herbal, acupuncture, massage)
- ☐ Substance abuse services – drug and alcohol
- ☐ Programs to quit tobacco
- ☐ Specialty care
  - Asthma
  - Cancer care
  - Cardiology
  - Dermatology
- ☐ Transportation
- ☐ Urgent care/walk-in clinic
- ☐ Vision care
- ☐ Women's health services
- ☐ Workforce readiness

7. What do you feel prevents you from getting the services you need? *(Check <u>all</u> that apply)*

- ☐ Afraid to have check-ups
- ☐ Can't find providers to accept my insurance
- ☐ Childcare
- ☐ Cost
- ☐ Don't know types of services available
- ☐ Don't like accepting government assistance
- ☐ Don't have the time
- ☐ Don't have internet access
- ☐ Don't like going to the doctor
- ☐ Don't trust doctors/clinics
- ☐ Have no regular doctor
- ☐ High co-pays
- ☐ Language services
- ☐ Lack of evening and weekend services
- ☐ Location of offices
- ☐ Long waits for appointments
- ☐ No health insurance
- ☐ No transportation
- ☐ I can get the healthcare I need
- ☐ Other_____

GENERAL HEALTH QUESTIONS

8. Please check one of the following for each statement.	Yes	No	Not Applicable
I have had an eye exam within the past 12 months.			
I have had a mental health / substance abuse visit within the past 12 months.			
I have had a dental exam within the past 12 months.			
I have been to the emergency room in the past 12 months.			
I have been to the emergency room for an injury in the past 12 months (e.g. motor vehicle crash, fall, poisoning, burn, cut, etc.).			
I have been a victim of domestic violence or abuse in the past 12 months.			
My doctor has told me that I have a long-term or chronic illness.			
I take the medicine my doctor tells me to take to control my chronic illness.			
I can afford medicine needed for my health conditions.			
I am over 21 years of age and have had a pap smear in the past three years (if male or under 21, please check "Not applicable").			
I am over 40 years of age and have had a mammogram in the past 12 months (if male or under 40, please check "Not applicable").			
I am over 50 years of age and have had a colonoscopy in the past 10 years (if under 50, please check "Not applicable").			
Does your neighborhood support physical activity? (e.g. parks, sidewalks, bike lanes, etc.)			
Does your neighborhood support healthy eating? (e.g. community gardens, farmers' markets, etc.)			
In the area that you live, is it easy to get affordable fresh fruits and vegetables?			
Have there been times in the past 12 months when you did not have enough money to buy the food that you or your family needed?			
Have there been times in the past 12 months when you did not have enough money to pay your rent or mortgage?			
Do you feel safe in your neighborhood?			

9. Where do you or your family get the food that you eat? ***(Check <u>all</u> that apply)***

- ☐ Back-pack or summer food programs
- ☐ Community garden
- ☐ Corner store / convenience store / gas station
- ☐ Dollar store
- ☐ Farmers' market
- ☐ Food bank /food kitchen /food pantry
- ☐ Grocery store
- ☐ Home garden
- ☐ I do not eat at home
- ☐ Family, friends, neighbors, or my church
- ☐ Meals on Wheels
- ☐ School
- ☐ Take-out / fast food / restaurant
- ☐ Other_____

10. During the past 7 days, how many times did you eat fruit or vegetables (fresh or frozen)? Do not count fruit or vegetable juice. ***(Please check <u>one</u>)***

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

11. Have you been told by a doctor that you have… *(Check all that apply)*

- ☐ Asthma
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ COPD/chronic bronchitis/emphysema
- ☐ Depression or anxiety
- ☐ Diabetes or high blood sugar
- ☐ Drug or alcohol problems
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV / AIDS
- ☐ Mental health problems
- ☐ Obesity/overweight
- ☐ Stroke/cerebrovascular disease
- ☐ I have no health problems
- ☐ Other_____

12. How long has it been since you last visited a doctor for a routine checkup? *(Please check one)*

- ☐ Within the past year
- ☐ Within the past 2 years
- ☐ Within the past 3 to 5 years
- ☐ 5 or more years ago

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

- ☐ Within the past year
- ☐ Within the past 2 years
- ☐ Within the past 3 to 5 years
- ☐ 5 or more years ago

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

☐ Very connected ☐ Somewhat connected ☐ Not connected

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

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

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

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

17. Would you say that in general your health is: *(Please check one)*

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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

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

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

- ☐ I have had 5 or more alcoholic drinks (if Male) or 4 or more alcoholic drinks (if female) during one occasion.
- ☐ I have used tobacco products (cigarettes, smokeless tobacco, e-cigarettes, etc.)
- ☐ I have used prescription drugs to get high.
- ☐ I have used illegal drugs such as Crack, Cocaine, Ecstasy, Heroin, LSD, Marijuana, Methamphetamine.
- ☐ Other_____

21. How many vehicles are owned, leased, or available for regular use by you and those who currently live in your household? Please be sure to include motorcycles, mopeds and RVs. _____**Vehicles**

22. What modes of transportation do you use? ***(Check <u>all</u> that apply)***

- ☐ Bike
- ☐ Walk
- ☐ Car
- ☐ Motorcycle, moped, scooter
- ☐ Friends / family drive me
- ☐ Public transit (i.e. bus, shuttle, similar)
- ☐ Taxi
- ☐ Uber/Lyft
- ☐ Other_____

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

- ☐ COBRA
- ☐ Dental Insurance
- ☐ Employer Provided Insurance
- ☐ Government (VA, Champus)
- ☐ Health Savings / Spending Account
- ☐ Individual/Private Insurance/ Marketplace/Obamacare
- ☐ Medicaid
- ☐ Medicare
- ☐ Medicare Supplement
- ☐ No Dental Insurance
- ☐ No Health Insurance

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

- ☐ Not applicable – I have insurance
- ☐ I don't understand Marketplace/Obamacare options
- ☐ Not available at my job
- ☐ Student
- ☐ Too expensive / cost
- ☐ Unemployed / no job
- ☐ I choose not to have it
- ☐ Other_____

25. What is your ZIP code? _____

26. What is your age? _____

27. What is your gender? ☐ Male ☐ Female ☐ Transgender ☐ Other _____

28. What is your height? _____

29. What is your weight? _____

30. Are you a Veteran? ☐ Yes ☐ No

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

Number 0-17 years of age_____Number 18-64 years of age_____Number 65 years or older_____

32. What is your highest education level completed?

- ☐ Less than High School
- ☐ Some High School
- ☐ High School Diploma / GED
- ☐ Associates
- ☐ Bachelors
- ☐ Masters / PhD
- ☐ Certificate Program_____

33. What is your primary language? ☐ English ☐ Spanish ☐ Other_____

34. What ethnicity do you identify with? ***(Check all that apply)***

- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Latino
- ☐ Black/African American
- ☐ More than one race
- ☐ White
- ☐ Decline to answer
- ☐ Other_____

35. What is your marital status?

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

36. What is your yearly household income?

☐ $0 - $10,000 ☐ $10,001 - $20,000 ☐ $20,001 - $30,000 ☐ $30,001 – 40,000 ☐ $40,001 - $50,000
☐ $50,001 - $60,000 ☐ $60,001 - $70,000 ☐ $70,001 - $100,000 ☐ $100,001 and above

37. What is your employment status?

☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Homemaker ☐ Student

38. Do you currently received disability benefits? ☐ Yes ☐ No

39. Is there anything else we should know about your (or someone living in your home) needs in the Farmville Area?

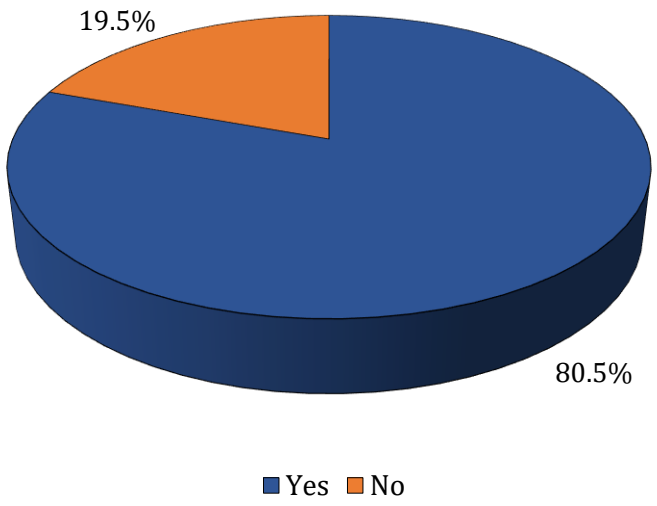
Thank you for helping make the Farmville Area a healthier place to live, work, and play!

2. Area Community Health Survey - Full Report

FARMVILLE AREA COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

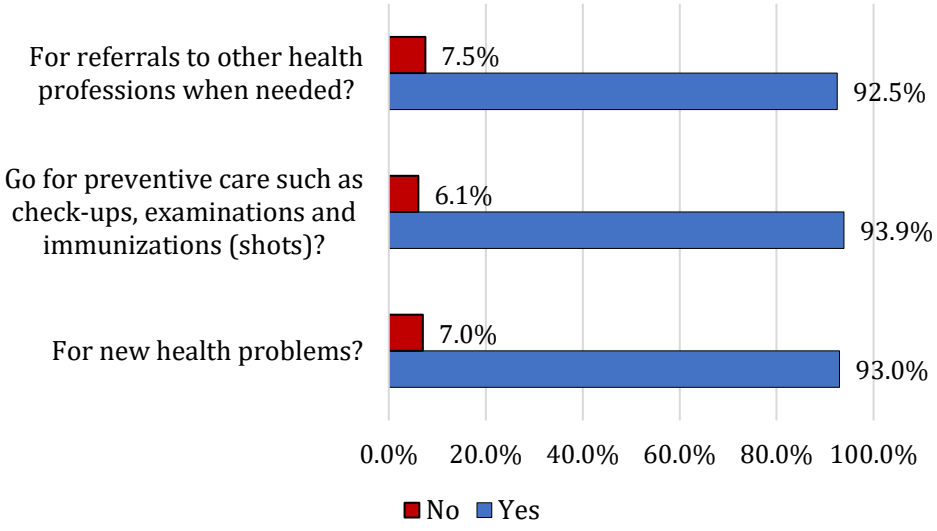
Q1. Is there a specific doctor's office, health center, or other place that you usually go if you are sick or need advice about your health?

Answered: 907 **Skipped: 16**



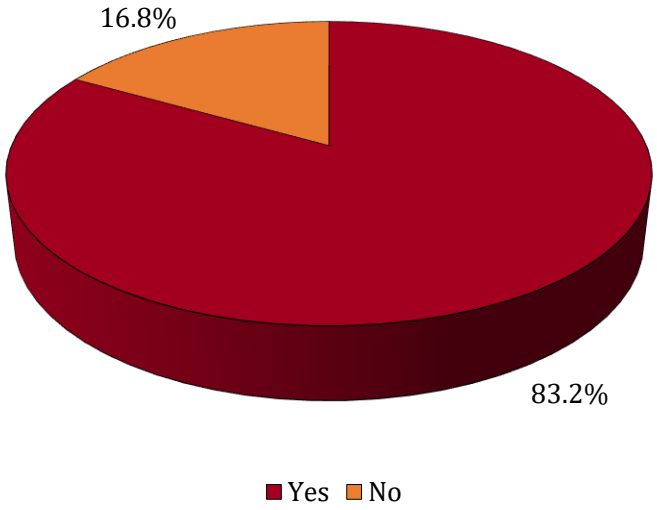
Q1. If you answered "Yes" is this where you go…

Answered: 705 **Skipped: 218**



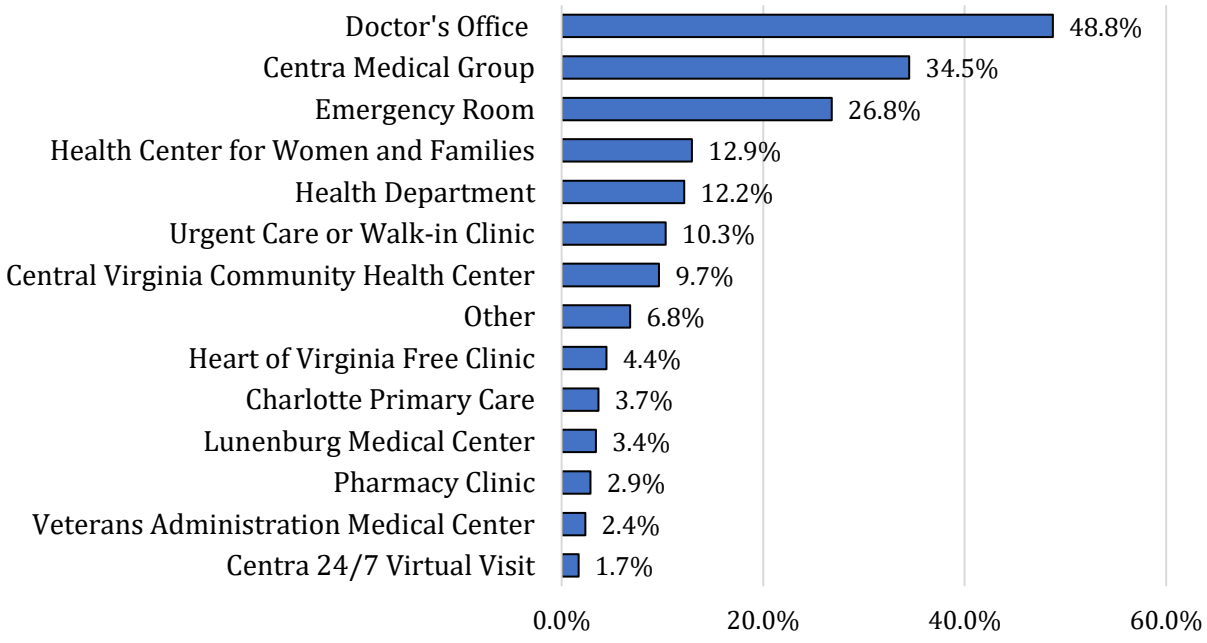
Q2. Do you use medical services?

Answered: 864 **Skipped: 59**



If you answered 'Yes' to Question 2 check all that apply.

Answered: 768 **Skipped: 155**



Q2. Doctor's Office		
Code	**Frequency**	**Valid Percent**
CMG Farmville	51	14.57%
CMG Burkeville	22	6.29%
Crewe Medical Center	21	6.00%
Bon Secours	20	5.71%
Sentara Health	15	4.29%
CMG	12	3.43%
Unknown Provider	12	3.43%
Centra Southside Medical Center	11	3.14%
Amelia Health Care Center	10	2.86%
Health Center For Women And Families	9	2.57%
Centra	8	2.29%
Timothy Corbett Sr, MD	8	2.29%
Rhonda Algeier, MD	7	2.00%
Virginia Physicians, Inc.	7	2.00%
Charlotte Primary Care	6	1.71%
CMG Cumberland	6	1.71%
Kenbridge Family Medicine	6	1.71%
Central VA Family Physicians	5	1.43%
Prince Edward Pediatrics. Dr. Ibtehal Al-Ani, MD	5	1.43%
Vara Bonagiri, MD	5	1.43%
Centra's Women's Center	4	1.14%
Central Virginia Community Health Center	4	1.14%
CMG Brookneal	4	1.14%
Family Practice Specialist of Richmond	4	1.14%
Medical Associates Of Central Virginia	4	1.14%
Rockwell Physicians of Salisbury PLLC	4	1.14%
UVA	4	1.14%
Women's Health Services of Central Virginia	4	1.14%
Bon Secours, Virginia Physicians for Women	3	0.86%
Centra, Michele M. Donoghue, NP-C	3	0.86%
Charlottesville Family Medicine	3	0.86%
Southern Dominion Health System, Inc.	3	0.86%
Vara P. Bonagiri, MD	3	0.86%
Appomattox Medical Center	2	0.57%
Centra Piedmont	2	0.57%

Centra, Mary Cabrera, MD	2	0.57%
CMG Keysville	2	0.57%
Commonwealth Pediatrics	2	0.57%
Commonwealth Primary Care	2	0.57%
HCA Primary Health Group - Appomattox	2	0.57%
Sutherland Family Practice Inc	2	0.57%
Teresita Dionisio, MD	2	0.57%
Virginia Diabetes and Endocrinology	2	0.57%
F. Read Hopkins Pediatric Associates	1	0.29%
Access Health Care	1	0.29%
Appomattox Family Practice Center	1	0.29%
Centra Keysville	1	0.29%
Centra Southside Community Hospital	1	0.29%
Centra, Shi Y. Lim, MD	1	0.29%
Centra, Sue Robinson NP	1	0.29%
Christianne McLean, MD	1	0.29%
Clarence Hall II, MD	1	0.29%
CMG Nationwide	1	0.29%
CMG Victoria	1	0.29%
CMG Village	1	0.29%
CMG, Michele Donahue, NP-C	1	0.29%
HCA Primary Health Group - Ironbridge	1	0.29%
HCA Primary Health Group - Retreat	1	0.29%
Heart of Virginia Free Clinic	1	0.29%
Henrico Pediatrics: Cristi Wilson MD	1	0.29%
Hope Clinic of Farmville	1	0.29%
John Holland, MD	1	0.29%
Kidz Docs Pediatric and Adolescent Medicine	1	0.29%
Lawrenceville Primary Care	1	0.29%
Multiple Medical Providers	1	0.29%
No Medical Provider	1	0.29%
OrthoVirginia: Lynchburg	1	0.29%
Physicians Treatment Center	1	0.29%
Randolph Lanford, MD	1	0.29%
Rebecca A. Biersbach DNP, FNP-C	1	0.29%
Riverview Physicians For Women	1	0.29%
RVA Pediatrics	1	0.29%
Southern Albemarle Family Practice	1	0.29%
Swift Creek Pediatrics	1	0.29%
Timothy W. Corbett Sr, MD	1	0.29%
VCU Community Memorial Hospital	1	0.29%

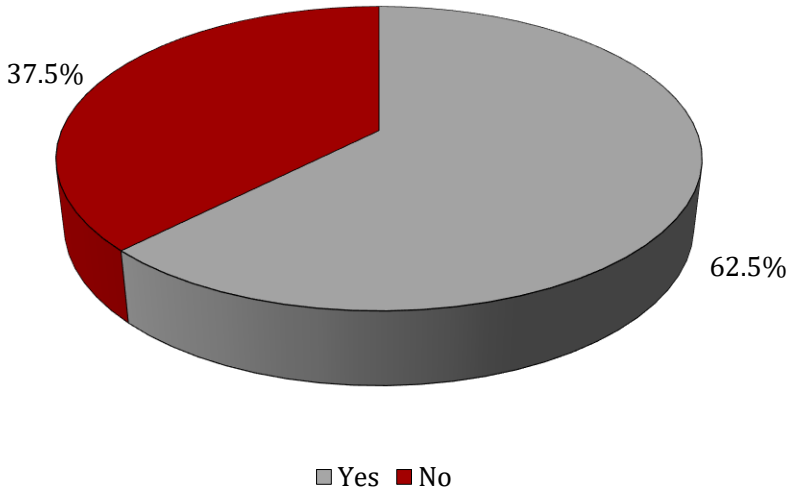
Veteran's Affairs	1	0.29%
Village Green Family Medicine	1	0.29%
Virginia Endocrinology & Osteoporosis Center	1	0.29%
Virginia Family Physicians, Midlothian, VA	1	0.29%
Total	**350**	**100.00%**

Q2. Urgent Care of Walk-in Clinic		
Code	**Frequency**	**Valid Percent**
CMG Farmville	30	26%
Centra Southside Medical Center	23	20%
CMG	11	10%
Patient First	10	9%
Bettermed Urgent Care	5	4%
Centra Southside Community Hospital	5	4%
Unknown Medical Provider	5	4%
CVS	3	3%
No Medical Provider	3	3%
Same as Primary	3	3%
Central VA Family Physicians	2	2%
MedExpress	2	2%
Multiple Medical Providers	2	2%
Sentara Health	2	2%
Bon Secours	1	1%
Central Virginia Community Health Center	1	1%
CMG Burkeville	1	1%
John Holland, MD	1	1%
KidMed Pediatric Urgent Care	1	1%
Physicians Treatment Center	1	1%
Sommerville Family Practice	1	1%
South Hill Family Urgent Care	1	1%
Swift Creek Pediatrics	1	1%
Total	**115**	**100%**

Q2. Other		
Code	**Frequency**	**Valid Percent**
Unknown Medical Provider	6	9%
UVA	6	9%
Amelia Health Center	4	6%
Centra Southside Community Hospital	4	6%
No Medical Provider	4	6%
Bon Secours	3	4%
Centra Southside Medical Center	3	4%
Veteran's Affairs	3	4%
Virginia Physicians for Women	3	4%
Women's Health Services of Central Virginia	3	4%
CMG	2	3%
CMG Cumberland	2	3%
CMG Physical Medicine & Pain Management	2	3%
CMG Stroobants Cardiovascular Center	2	3%
Health Center For Women And Families	2	3%
Johnston-Willis Hospital Richmond	2	3%
Bettermed Urgent Care	1	1%
Centra Women's Center	1	1%
Centra, Sue Robinson NP-C	1	1%
Central Virginia Community Health Center	1	1%
Cetra Southside Community Hospital	1	1%
Cetra Southside Medical Center	1	1%
CMG Burkeville	1	1%
CMG Farmville	1	1%
Heart of Virginia Free Clinic	1	1%
Longwood University Health Clinic	1	1%
MedExpress	1	1%
Multiple Medical Providers	1	1%
Nancy Giglio, CNM	1	1%
Patient First	1	1%
Physicians Treatment Center	1	1%
Prince Edward Pediatrics: Dr. Ibtehal Al-Ani, MD	1	1%
Rite Aid	1	1%
Teresita Dionisio, MD	1	1%
Total	**69**	**100%**

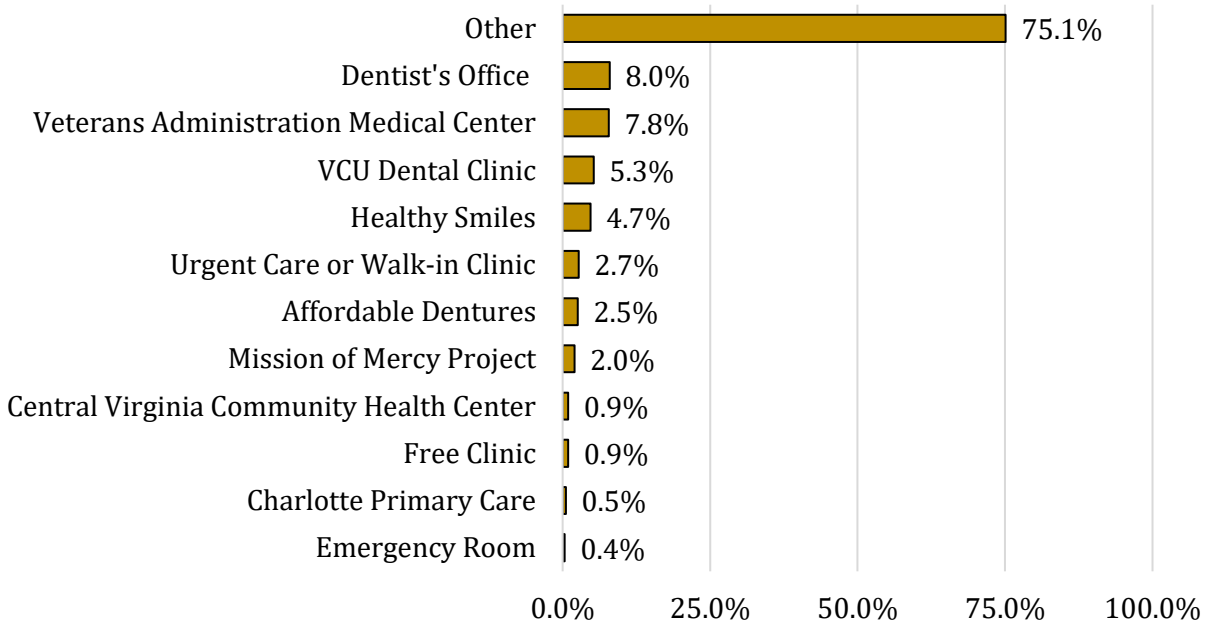
Q3. Do you use dental services?

Answered: 858 **Skipped: 65**



If you answered 'Yes' to Question 3 check all that apply.

Answered: 552 **Skipped: 371**



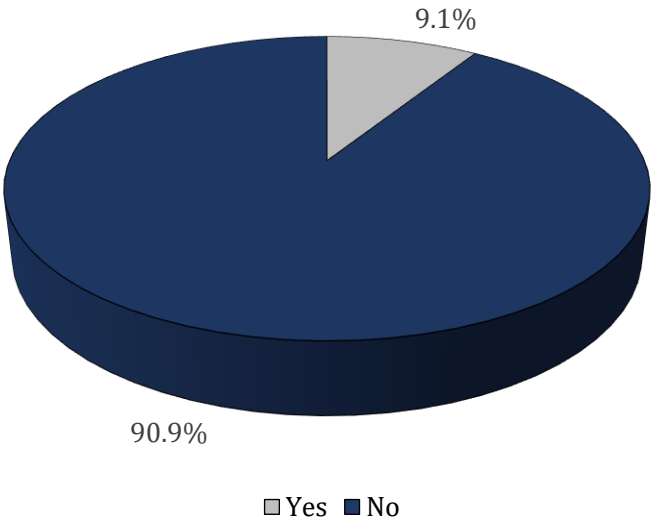
Q3. Dentist's Office		
Code Used	**Frequency**	**Valid Percent**
Andrew P. Johnson, DDS	37	11.18%
Campbell & Rutherford Keysville	36	10.88%
Timothy Marshall, DDS	33	9.97%
Brandon Newcomb DDS & Walter Saxon Jr DDS	24	7.25%
Ray Stephens, DDS	21	6.34%
Michael E. Krone, DDS	14	4.23%
VA Family Dentistry	14	4.23%
Commonwealth Dentistry	13	3.93%
Buckingham Family Dentistry	11	3.32%
Midlothian Family Dentistry	10	3.02%
Unknown Dental Provider	10	3.02%
Blackstone Family Dentistry: Irby Williams, DDS, Phillip Prater, DDS	9	2.72%
Charles Adkins, DDS	7	2.11%
Amelia Family Dentistry	6	1.81%
Central VA Family Dentistry	5	1.51%
Central Virginia Community Health Center	5	1.51%
Paul Harvey, DDS	5	1.51%
Pfabulous Gentle Dentistry: Michael Pfab, DDS	4	1.21%
Charlotte Primary Care	3	0.91%
Kool Smiles	3	0.91%
Multiple Dental Providers	3	0.91%
Travis L. Mueller, DDS, P.C.	3	0.91%
Dr Scott Thews, Chesterfield	2	0.60%
Murry and Kuhn Dentistry - Powhatan	2	0.60%
No Dental Care	2	0.60%
Quynhmai Truong, DDS	2	0.60%
Richard S. Vacca, DDS	2	0.60%
Southside Dental Center Charlottesville	2	0.60%
Toone Family Dental	2	0.60%
Aesthetic Dentistry of Charlottesville	1	0.30%
Allgood Family Dentistry	1	0.30%
Apple Tree Pediatric Dentistry: Jeni Kong, DMD, Steve Moore DDS	1	0.30%
Augustus Petticolas Jr., DDS	1	0.30%
Brady & Crist	1	0.30%
Brown, Reynolds, Snow, LeNoir Dentistry Richmond	1	0.30%
Charles Jewett, DDS Richmond	1	0.30%
Children's Dentistry of Virginia	1	0.30%
Christian Tabor, DMD	1	0.30%
Dabney Orthodontics	1	0.30%

Dale C. Evans, DDS	1	0.30%
Darren Flowers, DMD	1	0.30%
Dr. H. Charles Jelinek, JR., DDS Northern Virginia	1	0.30%
Farmville Pediatric Dentistry	1	0.30%
Forest Dental Center	1	0.30%
Forest Family Dentistry	1	0.30%
Hamer & Hamer Orthodontics	1	0.30%
Happy Smiles Dentistry	1	0.30%
Hendri	1	0.30%
J.A. Mera, DDS & Associates	1	0.30%
James Burton, DMD	1	0.30%
James L. Bradshaw, DDS	1	0.30%
John Knight, DDS & Associates	1	0.30%
Just 4 Kids Pediatric Dentistry and Sedation VA	1	0.30%
Karen Kenny, DDS	1	0.30%
Lynchburg Dental Center	1	0.30%
Patrick M. Todd & Associates	1	0.30%
Rice & Rice	1	0.30%
Richard Poe, DDS	1	0.30%
Richmond Dental Practice	1	0.30%
Robert N. Sorenson, DDS	1	0.30%
Robert Neighbors, DDS	1	0.30%
Ronald E. Cade D.M.D., M.S.	1	0.30%
Sang H Yu DDS Family Dentistry	1	0.30%
Scott Gore, DDS	1	0.30%
Scottsville Family Dentistry	1	0.30%
Smile32 Family Dentistry	1	0.30%
Stephanie K. Payne, DDS	1	0.30%
Tracy Spaur D.D.S.	1	0.30%
VCU School of Dentistry	1	0.30%
William Thomas, DDS	1	0.30%
Total	**331**	**100.00%**

Q3. Other		
Code	**Frequency**	**Valid Percent**
No Dental Care	5	20%
Unknown Dental Provider	4	16%
Central Virginia Community Health Center	3	12%
Brandon Newcomb DDS & Walter Saxon Jr DDS	2	8%
Amelia Family Dentistry	1	4%
Andrew P. Johnson, DDS	1	4%
Commonwealth Dentistry	1	4%
Timothy Marshall, DDS	1	4%
Midlothian Children's Dentistry	1	4%
Kool Smiles	1	4%
VCU School of Dentistry	1	4%
Midlothian Family Dentistry	1	4%
Orthodontic Arts	1	4%
Smileville Family Dentistry	1	4%
UVA	1	4%
Total	**25**	**100%**

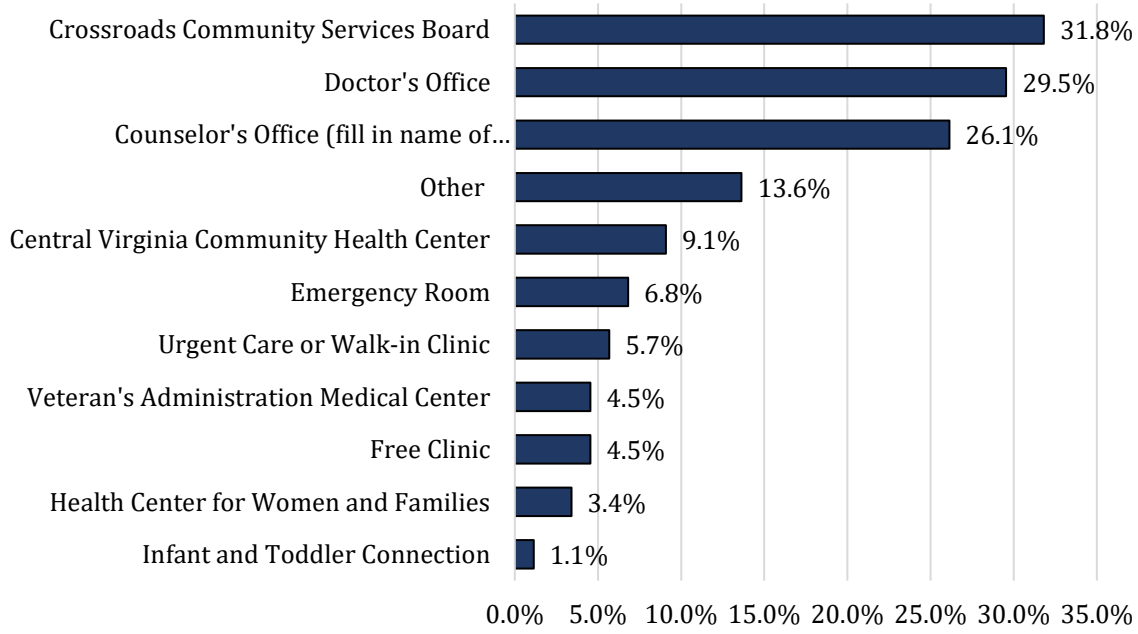
Q4. Do you use mental health, alcohol abuse, or drug abuse services?

Answered: 863 **Skipped: 60**



If you answered 'Yes' to Question 4 check all that apply.

Answered: 89 **Skipped: 834**



Q4. Counselor's Office		
Code	**Frequency**	**Valid Percent**
Unknown Counselor	5	19%
Centra Piedmont	3	12%
Peaks View Counseling	3	12%
Commonwealth Counseling Associates	2	8%
Advanced Psychotherapeutics, PLLC.	1	4%
Bon Secours Medical Group	1	4%
Crossroads Community Services Board	1	4%
Elizabeth Cook, LPC	1	4%
Fig Tree Therapy	1	4%
GraceMoves Richmond	1	4%
Horizon Behavioral Health	1	4%
Longwood University Counseling and Psychological Services	1	4%
Lynn Blackwood, PhD	1	4%
Margaret A. Luedke, PhD	1	4%
Mitzi Hendrick, LCSW	1	4%
Partners in Parenting Richmond	1	4%
Tucker Psychiatric Clinic	1	4%
Total	**26**	**100%**

Q4. Doctor's Office		
Code	**Frequency**	**Valid Percent**
Commonwealth Primary Care Richmond - Doctor's Office	1	50%
CMG Farmville - Michele Donahue, NP-C	1	50%
Total	**2**	**100%**

Q4. Other		
Code Used	**Frequency**	**Valid Percent**
Centra Piedmont	4	31%
Crossroads Community Services Board	2	15%
Charlotte Primary Care	1	8%
Amelia Health Center	1	8%
Tucker Psychiatric Clinic	1	8%
Central Virginia Psychiatry	1	8%
Region Ten CSB	1	8%
UVA Child and Family Psychiatry	1	8%
UVA Memory and Aging Care	1	8%
Total	**13**	**100%**

Q5. Thinking about the community, what are the five most important issues that affect the health of our community?

Answered: 862 **Skipped: 61**

	Percent	Number
Access to affordable health care	54.87%	473
Alcohol and illegal drug use	29.12%	251
Overweight/Obesity	28.65%	247
Affordable housing	25.41%	219
Access to healthy foods	25.17%	217
Diabetes	24.83%	214
Poor eating habits	19.95%	172
Cancers	19.72%	170
High Blood Pressure	19.49%	168
Joblessness	18.21%	157
Mental Health problems	17.98%	155
Poverty	17.63%	152
Cell phone use/texting and driving/distracted driving	16.59%	143
Heart Disease and Stroke	15.31%	132
Bullying	14.73%	127
Aging problems	14.62%	126
Lack of exercise	13.81%	119
Stress	12.99%	112
Dental problems	11.83%	102
Child abuse/Child neglect	10.44%	90
Domestic violence	10.09%	87
Tobacco Use/Smoking/Vaping	9.40%	81
Transportation	9.40%	81
Education - drop out rates	8.00%	69
Opioid Use	6.50%	56
Discrimination/Segregation	6.38%	55
Environmental Health (water quality, air quality, use of pesticides)	6.26%	54
Unsafe Sex	6.26%	54
Prescription Drug Abuse	5.80%	50
Other	5.68%	49
Suicide	5.34%	46
Accidents in the home	5.10%	44
Social support (lack of)	5.10%	44
Asthma	4.52%	39
HIV/AIDS	4.06%	35
Sexual assault	4.06%	35

Not using seat belts, child safety seats, helmets	3.94%	34
Teenage Pregnancy	3.71%	32
Net getting "shots" to prevent illness and disease	3.36%	29
Neighborhood Safety	3.02%	26
Gang activity	2.44%	21
Lung Disease	2.20%	19
Infant death	1.39%	12
Homicide	1.16%	10

Q5. Other		
Code	**Frequency**	**Valid Percent**
Sexual Education/Support for Victim's of Sexual Assault	2	13%
Poor Quality Health Care Options in Farmville	2	13%
Punctuality of First Responders	1	7%
Lack of Trust	1	7%
Loss of Moral Values	1	7%
Access to Food	1	7%
Affordable Housing	1	7%
Resources for Recreation and Physical Activity	1	7%
Access to Behavioral Health Care	1	7%
Access to Medical Care	1	7%
Abuse of Available Social Services	1	7%
Time	1	7%
Lack of Forgiveness	1	7%
Total	**15**	**100%**

34 Reponses were N/A; Did not answer; or respondent checked more than 15 responses

Q6. Which services are hard to get in our community? *(Check <u>all</u> that apply)*

Answered: 749 **Skipped: 174**

	Percent	Number
Housing - safe, affordable	36.60%	273
Dental care - Adults	29.36%	219
Food - affordable	29.22%	218
Transportation	28.82%	215
Specialty care such as for Asthma, Cancer care, Cardiology (heart) care, Dermatology (skin) care	23.59%	176
Mental health / counseling	22.25%	166
Alternative therapy (herbals, acupuncture, massage)	21.58%	161
Nutrition and weight loss	21.18%	158
Family doctor	18.90%	141
Eldercare	18.10%	135
Urgent Care or Walk-in Clinic	17.69%	132
Substance abuse services - drug & alcohol	16.76%	125
Workforce readiness	16.49%	123
Vision care	14.75%	110
Programs to quit using tobacco	14.21%	106
Emergency Room care	13.40%	100
Ambulance services	11.93%	89
Legal services	11.93%	89
Medication / medical supplies	11.53%	86
Domestic violence services	10.86%	81
Dental care - Children	10.19%	76
Ex-offender services	9.38%	70
Women's health services	9.38%	70
Physical therapy	7.77%	58
Lab work	6.43%	48
Mammograms	6.43%	48
Pregnancy care	6.03%	45
Preventive care (such as yearly check-ups)	5.76%	43
End of life, hospice, palliative (providing relief from the symptoms and stress of a serious illness) care	5.09%	38
Family planning / birth control	5.09%	38
Chiropractic care	4.83%	36
Inpatient hospital	3.49%	26
Other (please specify)	3.49%	26
Immunizations (shots)	2.82%	21

Q6. Other		
Code	**Frequency**	**Valid Percent**
Reliable Daycare	2	9%
Affordable, High-Quality Medical Care	2	9%
Dental Care/Orthodontics	2	9%
Affordable Legal Services	1	4%
Broadband/Internet	1	4%
Dermatology	1	4%
Prompt Emergency Care	1	4%
Safe Infrastructure	1	4%
Affordable Insulin	1	4%
Programs for Children	1	4%
Programs for Elderly	1	4%
Psychiatry	1	4%
Primary Care	1	4%
Community Awareness	1	4%
Higher Wages	1	4%
Specialists	1	4%
Competitive Market for Medical Care	1	4%
Hearing Assistance	1	4%
Life Essentials	1	4%
Sleep Disorders Care	1	4%
Total	**23**	**100%**

Q7. What do you feel prevents you from getting the services you need? Check all that apply.

Answered: 774 **Skipped: 149**

	Percent	Number
Cost	48.90%	377
High co-pays	32.68%	252
Long waits for appointments	23.99%	185
Lack of evening and weekend services	23.35%	180
Don't know what types of services are available	17.51%	135
No health insurance	17.38%	134
I can get the healthcare I need	16.47%	127
Can't find providers that accept my insurance	15.82%	122
No transportation	13.88%	107
Don't have the time	13.10%	101
Location of offices	11.15%	86
Don't have internet access	10.77%	83
Don't like going to the doctor	10.12%	78
Have no regular doctor	9.99%	77
Childcare	8.43%	65
Afraid to have check-ups	6.23%	48
Other (please specify)	3.89%	30
Don't like accepting government assistance	3.50%	27
Don't trust doctors / clinics	3.24%	25
Language services	1.30%	10

Q7. Other		
Code	**Frequency**	**Valid Percent**
Distance from Medical Care	9	38%
Cost of Medical Care/Insurance	4	17%
Provider Shortage	3	13%
Wait Times at CMG Farmville	1	4%
Limited Options for Underinsured/Uninsured	1	4%
Negligent Providers	1	4%
Referral Turnaround Time	1	4%
Piedmont Community Health Plan	1	4%
Being Responsible for Others	1	4%
Being a New Resident	1	4%
Everything in Farmville	1	4%
Total	**24**	**100%**

Question 8 – General Health Questions

I have had an eye exam in the past 12 months.

	Number	Percent
Yes	405	49.45%
No	414	50.55%
Total	819	

I have had a mental health/substance abuse visit within the past 12 months.

	Number	Percent
Yes	91	11.74%
No	684	88.26%
Total	775	

I have had a dental exam within the past 12 months.

	Number	Percent
Yes	422	52.55%
No	381	47.45%
Total	803	

I have been to the Emergency Room in the past 12 months.

	Number	Percent
Yes	299	37.61%
No	496	62.39%
Total	795	

I have been to the Emergency Room for an injury in the past 12 months (such as motor vehicle crash, fall, poisoning, burn, cut, etc.).

	Number	Percent
Yes	97	12.13%
No	703	87.88%
Total	800	

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

	Number	Percent
Yes	17	2.16%
No	771	97.84%
Total	788	

My doctor has told me that I have a long-term or chronic illness.

	Number	Percent
Yes	178	22.97%
No	597	77.03%
Total	775	

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

	Number	Percent
Yes	254	33.03%
No	277	36.02%
Not Applicable	238	30.95%
	769	

I can afford medicine needed for my health conditions.

	Number	Percent
Yes	399	52.23%
No	229	29.97%
Not Applicable	136	17.80%
	764	

I am over 21 years of age and have had a pap smear in the past three years.

	Number	Percent
Yes	413	53.22%
No	215	27.71%
Not Applicable	148	19.07%
	776	

I am over 40 years of age and have had a mammogram in the past 12 months.

	Number	Percent
Yes	242	31.07%
No	247	31.71%
Not Applicable	290	37.23%
	779	

I am over 50 years of age and have had a colonoscopy in the past 10 years.

	Number	Percent
Yes	244	31.24%
No	217	27.78%
Not Applicable	320	40.97%
Total	781	

Does your neighborhood support physical activity such as parks, sidewalks, bike lanes, etc.?

	Number	Percent
Yes	336	43.75%
No	432	56.25%
Total	768	

Does your neighborhood support healthy eating such as community gardens, farmers' markets, etc.?

	Number	Percent
Yes	393	51.37%
No	372	48.63%
	765	

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

	Number	Percent
Yes	455	58.56%
No	322	41.44%
	777	

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

	Number	Percent
Yes	248	31.79%
No	532	68.21%
Total	780	

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

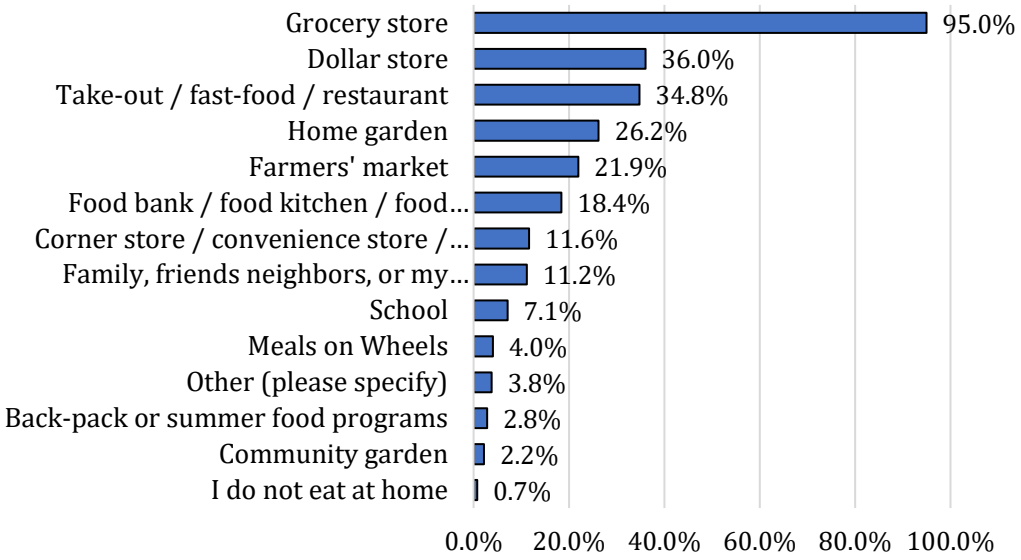
	Number	Percent
Yes	221	28.26%
No	521	66.62%
Not Applicable	40	5.12%
Total	782	

Do you feel safe in your neighborhood?

	Number	Percent
Yes	733	92.67%
No	58	7.33%
Total	791	

Q9. Where do you or your family get the food that you eat?

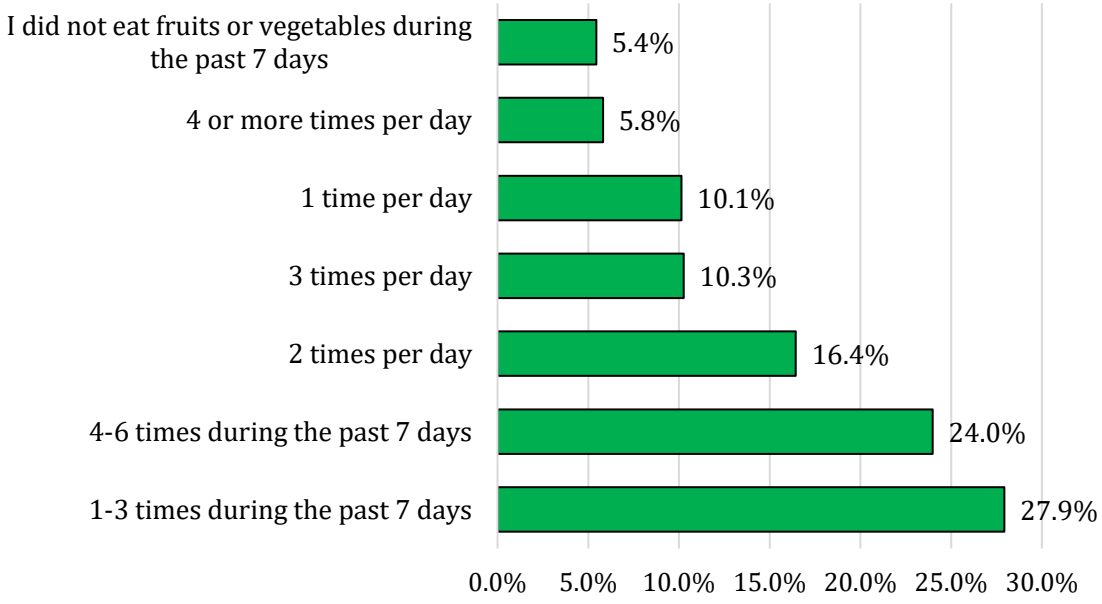
Answered: 819 **Skipped: 104**



Q9. Other		
Code	**Frequency**	**Valid Percent**
Local Farming/Hunting	9	31%
Piedmont Senior Resources	9	31%
Wal-Mart	4	14%
Richmond	2	7%
Unknown Food Source	2	7%
SNAP	1	3%
Work	1	3%
Multiple Grocery Stores	1	3%
Total	**29**	**100%**

Q10. During the past 7 days, how many times did you eat fruit or vegetables (fresh or frozen)?

Answered: 812 **Skipped: 111**



Q11. Have you been told by a doctor that you have… *(Check <u>all</u> that apply)*

Answered: 735 Skipped: 188

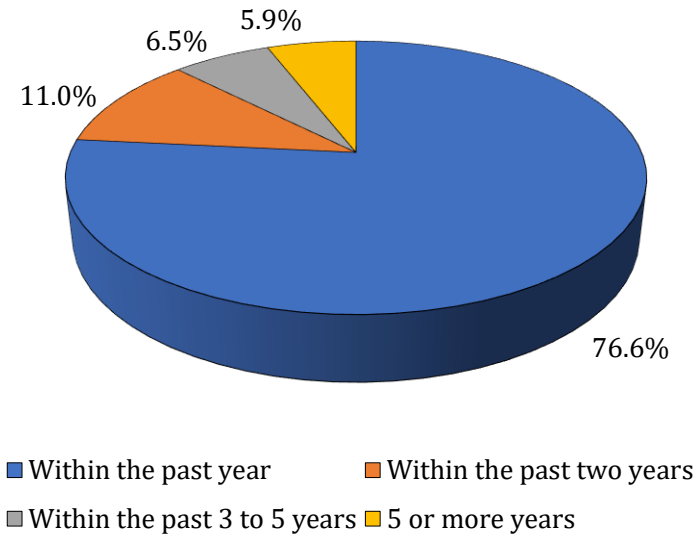
	Percent	Number
Asthma	15.44%	113
Cancer	5.33%	39
Cerebral palsy	0.14%	1
COPD/chronic bronchitis/emphysema	5.19%	38
Depression or anxiety	24.18%	177
Diabetes or high blood sugar	21.04%	154
Drug or alcohol problems	0.82%	6
Heart disease	7.24%	53
HIgh blood pressure	40.85%	299
High Cholesterol	17.08%	125
HIV / AIDS	0.41%	3
Mental health problems	6.69%	49
Obesity / Overweight	29.10%	213
Stroke / cerebrovascular disease	3.01%	22
I have no health problems	19.95%	146
Other (please specify)	10.79%	79
		732

Q11. Other		
Code	**Frequency**	**Valid Percent**
GERD	5	6.3%
Unknown Thyroid Disease	4	5.1%
Crohn's Disease	3	3.8%
Hyperlipidemia	3	3.8%
Unknown Kidney Disease	3	3.8%
AFIB	2	2.5%
Fibromyalgia	2	2.5%
Hypothyroidism	2	2.5%
IBS	2	2.5%
Migraines	2	2.5%
Unknown	2	2.5%
4+ Diagnoses	1	1.3%
7+ Diagnoses	1	1.3%
ADHD	1	1.3%
Allergies	1	1.3%
Alllergies	1	1.3%
Alzheimer's	1	1.3%
Arrhythmia	1	1.3%

Arthritis	1	1.3%
Arthritis/Fibromyalgia	1	1.3%
Arthritis/Migraines	1	1.3%
Back Pain	1	1.3%
Cancer, Remission	1	1.3%
Celiac's Disease	1	1.3%
Chronic UTI	1	1.3%
Colitis	1	1.3%
CRPS/Fibromyalgia/Migraine/Arthritis	1	1.3%
Degenerative Disc Disease	1	1.3%
Dementia	1	1.3%
Eczema	1	1.3%
Endometriosis	1	1.3%
Endometriosis/Tachycardia	1	1.3%
Epilepsy	1	1.3%
GERD/Connective Tissue Disease	1	1.3%
GERD/Migraine	1	1.3%
Graves' Disease	1	1.3%
HPV	1	1.3%
IBS/Gastroparisis/Divatriculitis	1	1.3%
Iron Deficiency	1	1.3%
Kidney Stones	1	1.3%
Kidney Stones/Psoriatic Arthritis	1	1.3%
Lung Disease	1	1.3%
Neuropathy	1	1.3%
Osteopeni	1	1.3%
osteoporosis	1	1.3%
Polycystic Ovarian Syndrome	1	1.3%
Poor Vision	1	1.3%
Pre-Cervical Cancer/Lupus	1	1.3%
Restless Leg Syndrome	1	1.3%
Rheumatoid Arthritis	1	1.3%
Sarcoidosis	1	1.3%
Scoliosis	1	1.3%
Seizure Disorder	1	1.3%
Sleep Disorder	1	1.3%
Spinal Cord Injury	1	1.3%
Tachycardia	1	1.3%
Thyrotoxicosis	1	1.3%
Unknown	1	1.3%
Unknown Autoimmune Disease	1	1.3%
Unknown Dental Disease	1	1.3%
Total	**79**	**100.0%**

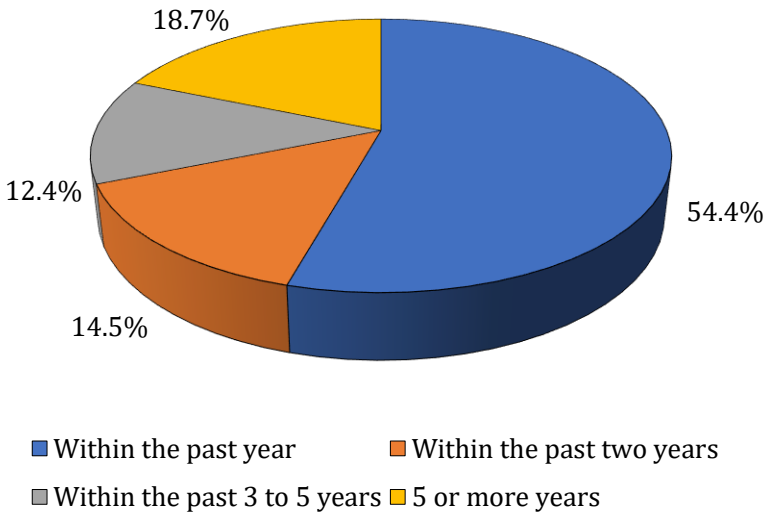
Q12. How long has it been since you last visited a doctor for a routine checkup?

Answered: 797 **Skipped: 126**



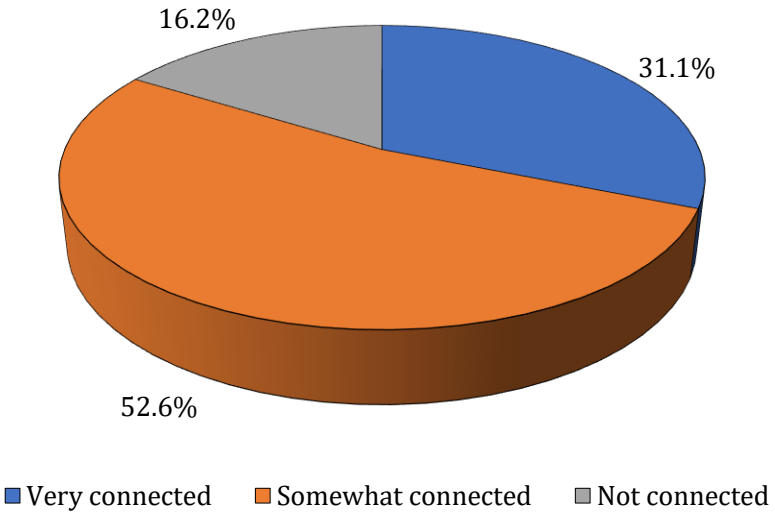
Q13. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.

Answered: 783 **Skipped: 140**



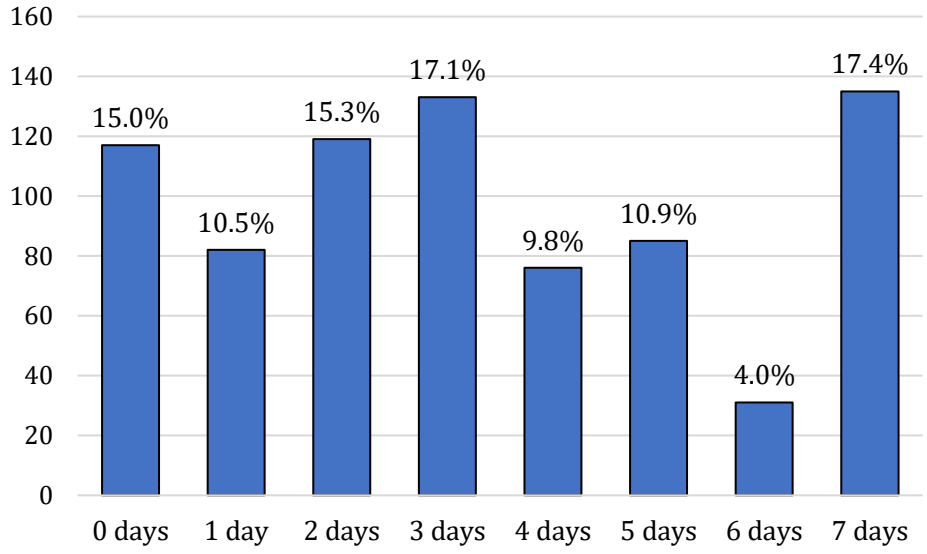
Q14. How connected do you feel with the community those around you?

Answered: 797 **Skipped: 126**



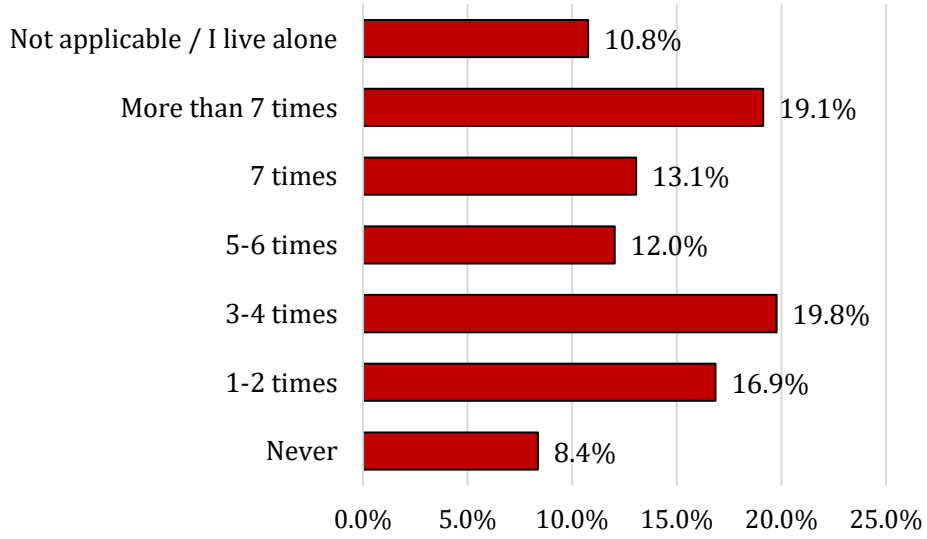
Q15. In the past 7 days, on how many days were you physically active for a total of at least 30 minutes? (Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard for some of the time).

Answered: 781 **Skipped: 142**



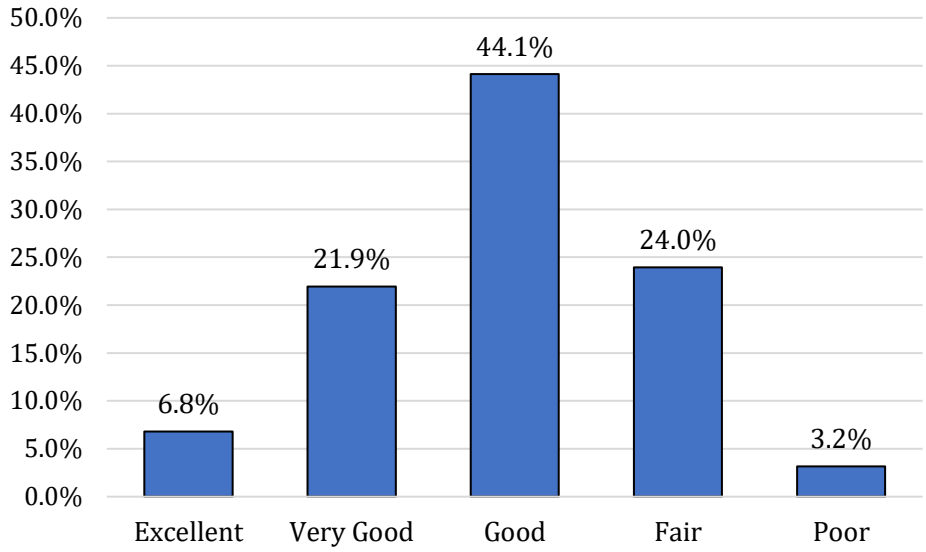
Q16. During the past 7 days, how many times did all, or most, of your family living in your house eat a meal together?

Answered: 792 **Skipped: 131**



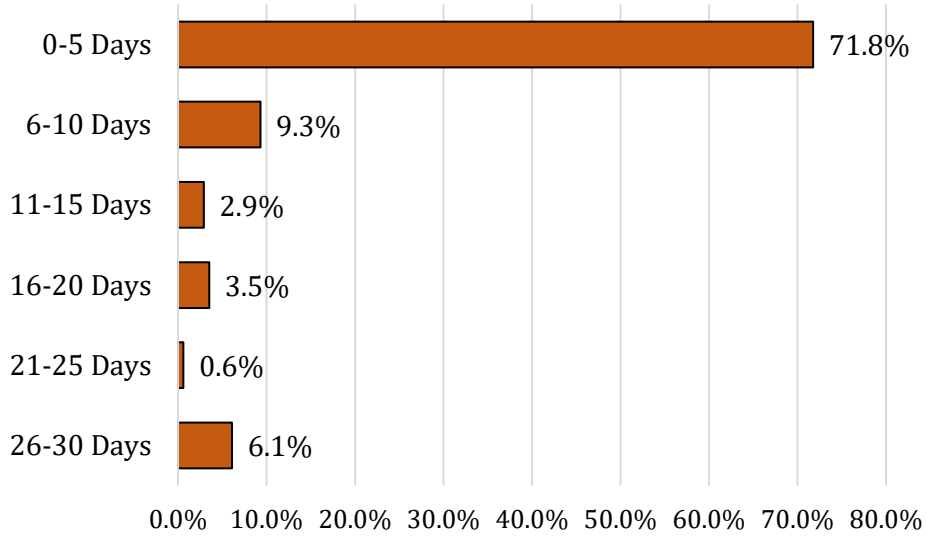
Q17. Would you say that in general your health is:

Answered: 796 **Skipped: 127**



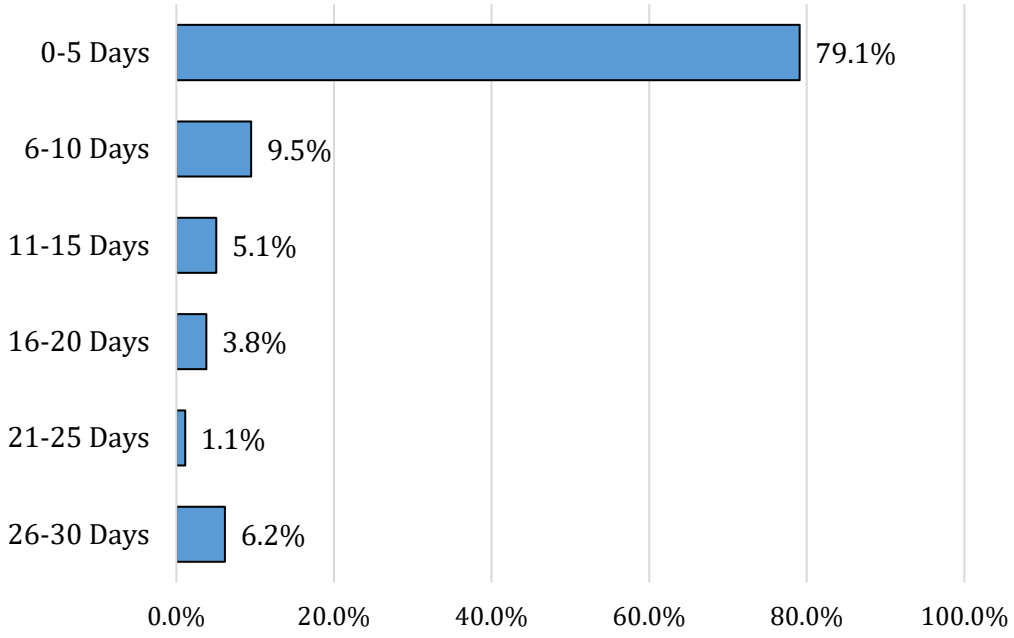
Q18. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Answered: 662 **Skipped: 261**



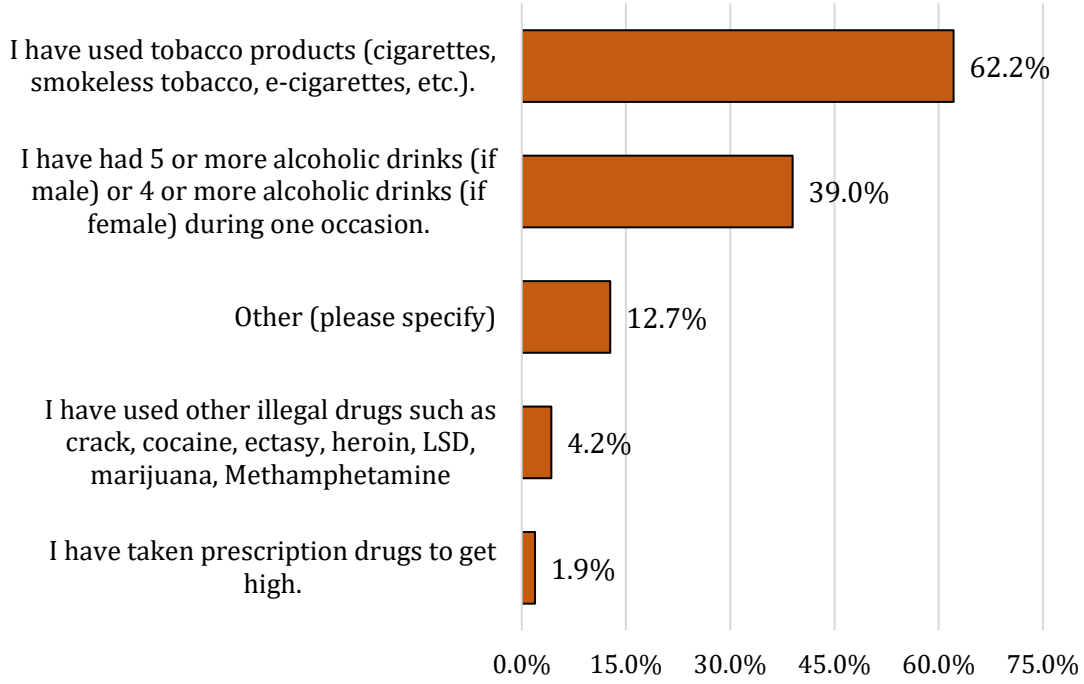
Q19. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Answered: 666 **Skipped: 257**



Q20. During the past 30 days: (Check <u>all</u> that apply)

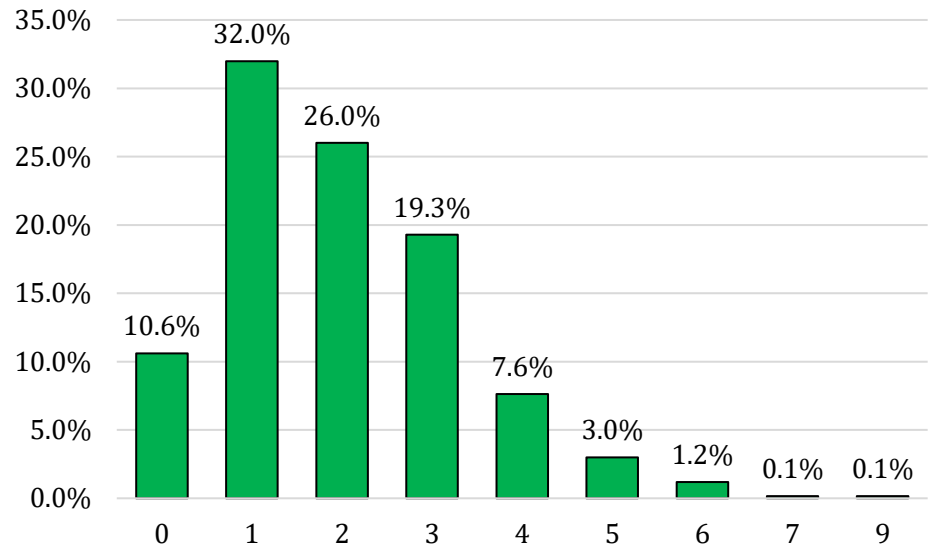
Answered: 260 **Skipped: 663**



Q20. Other		
Code	**Frequency**	**Valid Percent**
None	19	61%
N/A	11	35%
Alcohol	1	3%
Total	**31**	**100%**

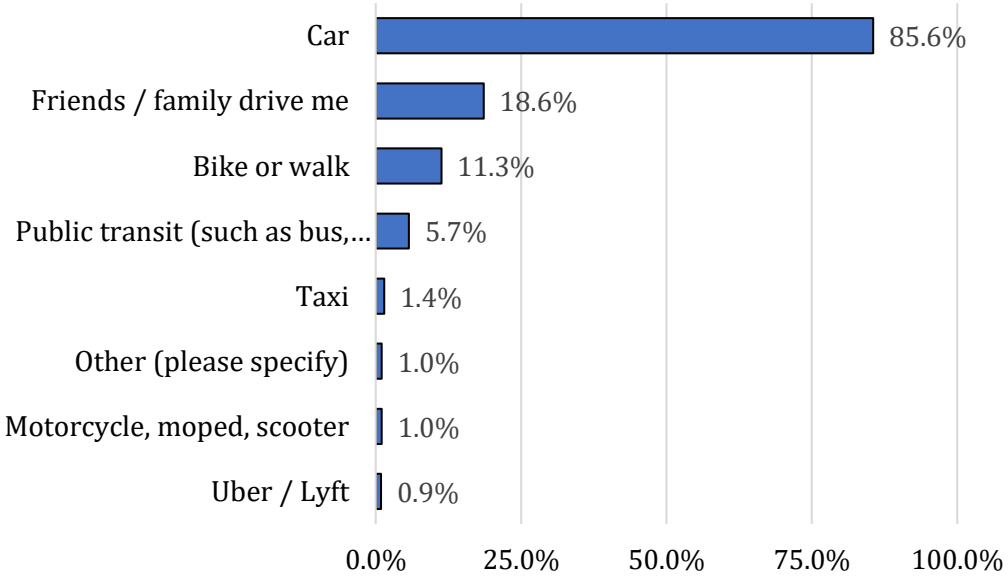
Q21. How many vehicles are owned, leased, or available for regular use by you and those who currently live in your household? Please be sure to include motorcycles, mopeds and RVs.

Answered: 673 **Skipped: 250**



Q22. What mode of transportation do you typically use?

Answered: 772 **Skipped: 151**

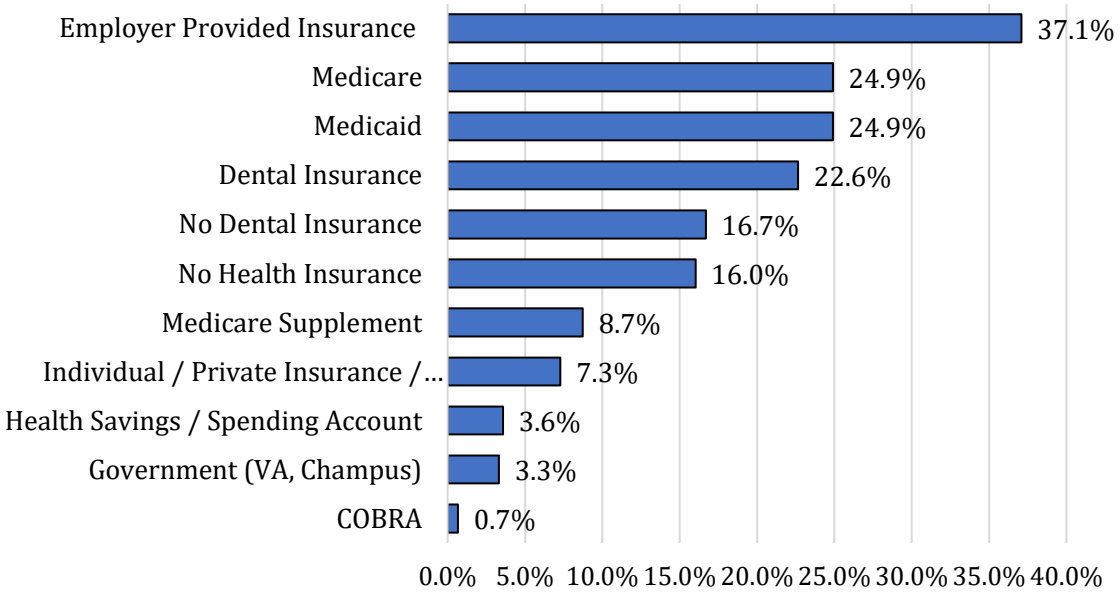


Note: Respondents were able to select more than one answer so the total will be more than 100%.

Q22. Other		
Code	**Frequency**	**Valid Percent**
Medicaid Transport	3	38%
Personal Vehicle	3	38%
N/A	1	13%
Walking	1	13%
Total	**8**	**100%**

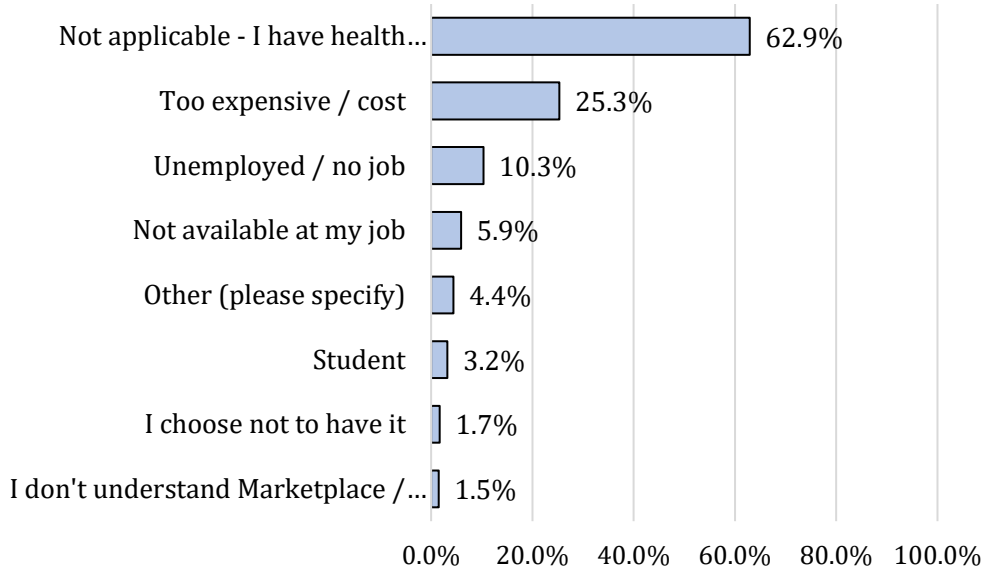
Q23. Which of the following describes your current type of health insurance? *(Check all that apply)*

Answered: 758 **Skipped: 165**



Q24. If you have no health insurance, why don't you have insurance? (Check all that apply)

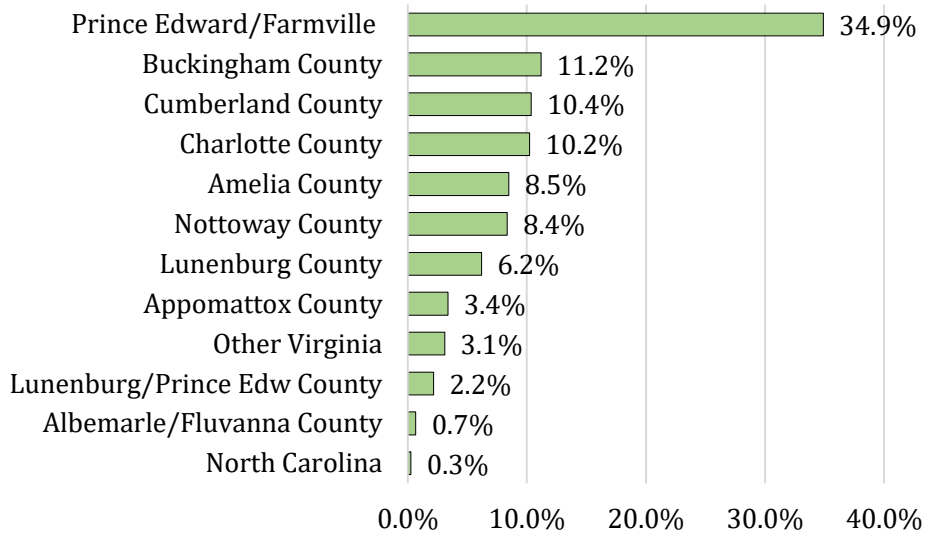
Answered: 410 **Skipped: 513**



Q24. Other		
Code	**Frequency**	**Valid Percent**
Insured	7	39%
N/A	4	22%
Failure to Apply	2	11%
Life Insurance Only	1	6%
Divorce	1	6%
Disability	1	6%
High Cost	1	6%
Retired	1	6%
Total	**18**	**100%**

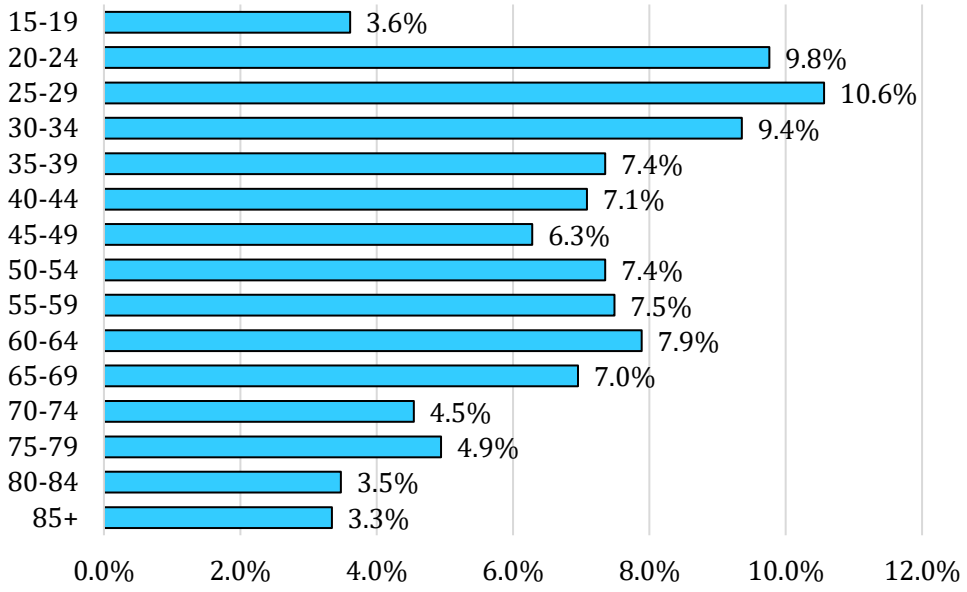
Q25. What is your Zip Code?

Answered: 746 **Skipped: 177**



Q26. What is your age?

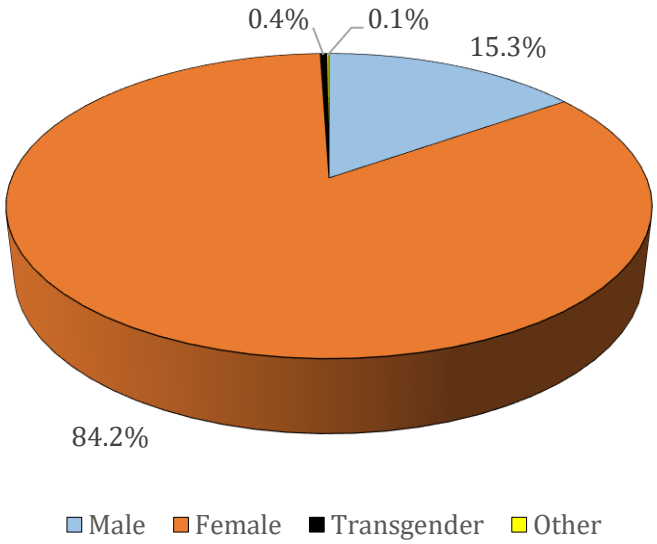
Answered: 749 Skipped: 174



Avg, age	47.1
Median Age	46
Mode	27
Range	15 - 101

Q27. What is your gender?

Answered: 767 **Skipped: 156**



Q28. What is your Height?

Answered: 733 **Skipped: 190**

Q29. What is your Weight?

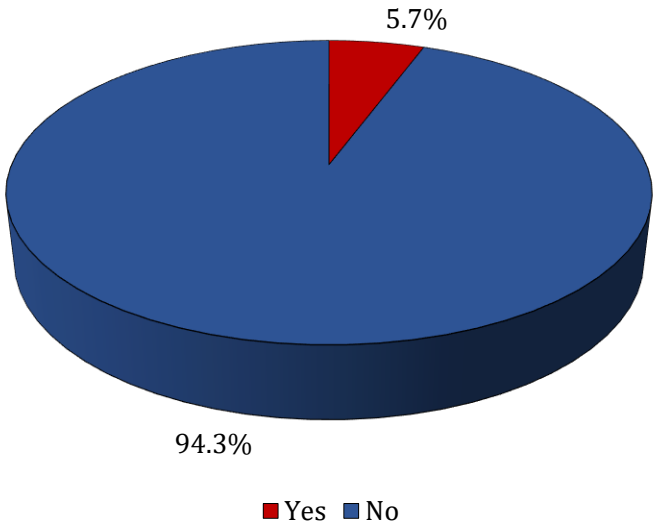
Answered: 726 **Skipped: 197**

Respondents self-reported their height and weight. From these responses, Body Mass Index was calculated and are represented as follows:

BMI Range	Percent of Population	Frequency
Underweight <19	4%	25
Normal Weight 19-25	25%	176
Overweight 26-30	20%	141
Obese 30<	52%	372

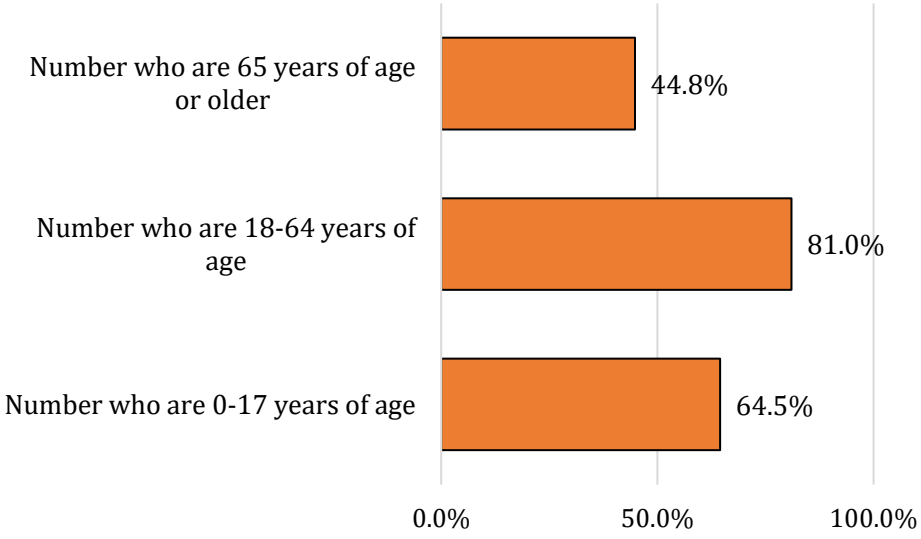
Q30. Are you a Veteran?

Answered: 760 Skipped: 163



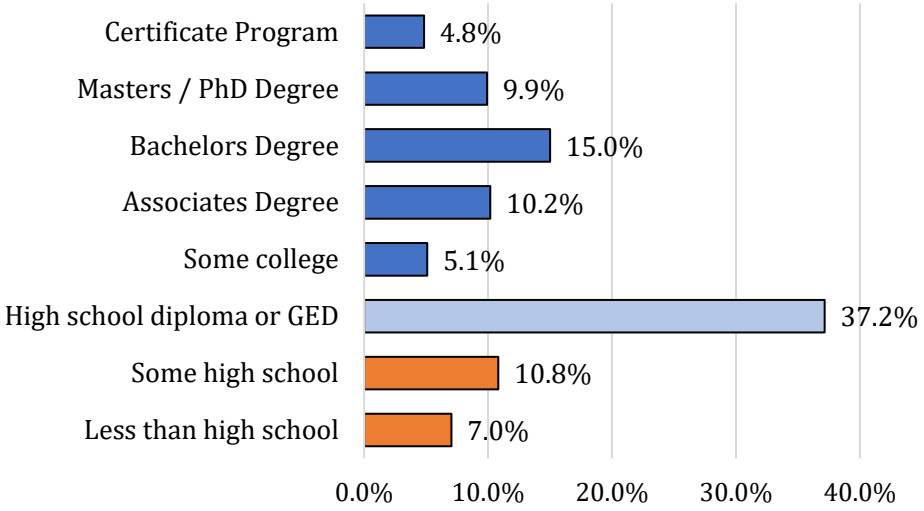
Q31. How many people live in your home including yourself?

Answered: 700 Skipped: 223



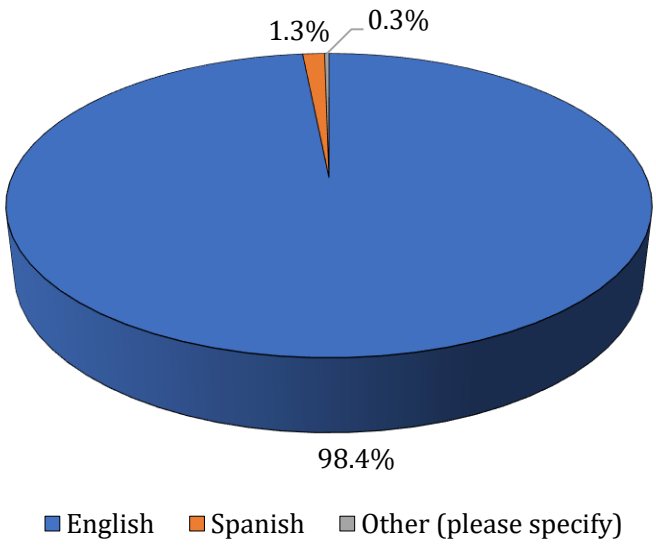
Q32. What is your highest education level completed?

Answered: 770 **Skipped: 153**



Q33. What is your primary language?

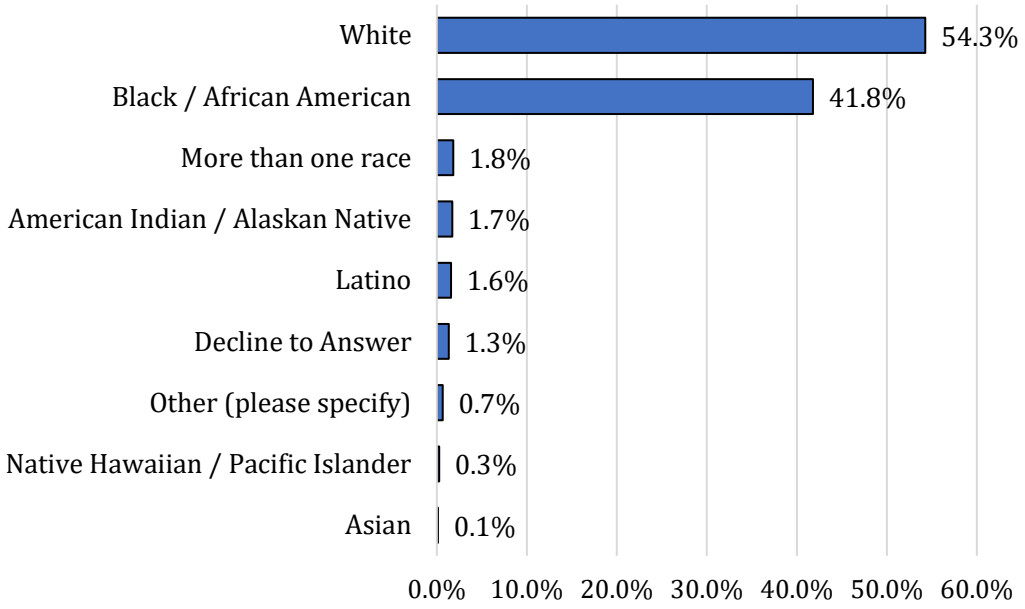
Answered: 767 **Skipped: 156**



Q33. Other		
Code	**Frequency**	**Valid Percent**
Tri-Lingual (French, English, Spanish)	1	50%
N/A	1	50%
Total	**2**	**100%**

Q34. What ethnicity do you identify with? (Check all that apply)

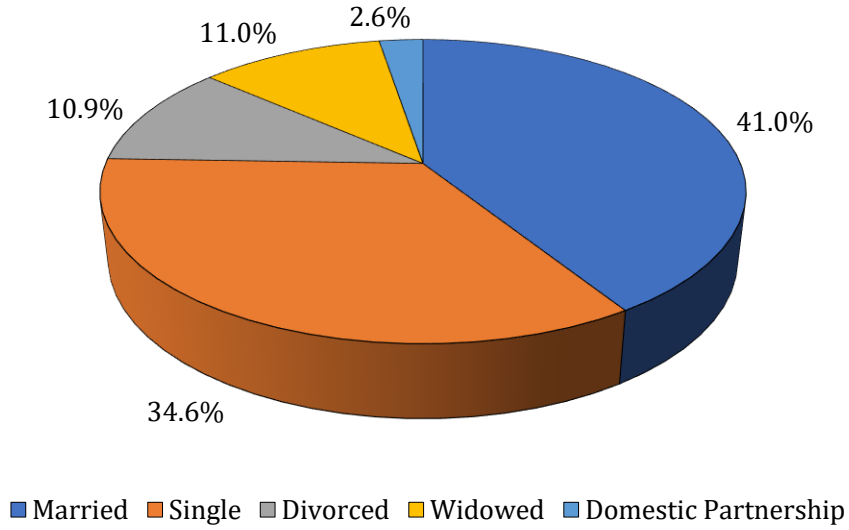
Answered: 764 **Skipped: 159**



Q34. Other		
Code	**Frequency**	**Valid Percent**
American	1	20%
Appalachian	1	20%
Caucasian	1	20%
Did Not Specify	1	20%
Human Race	1	20%
Total	**5**	**100%**

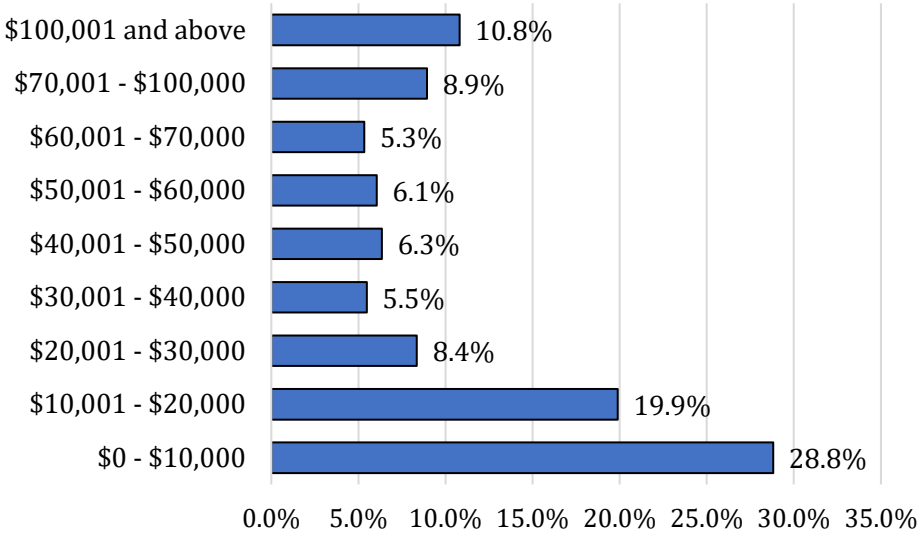
Q35. What is your marital status?

Answered: 767 **Skipped: 156**

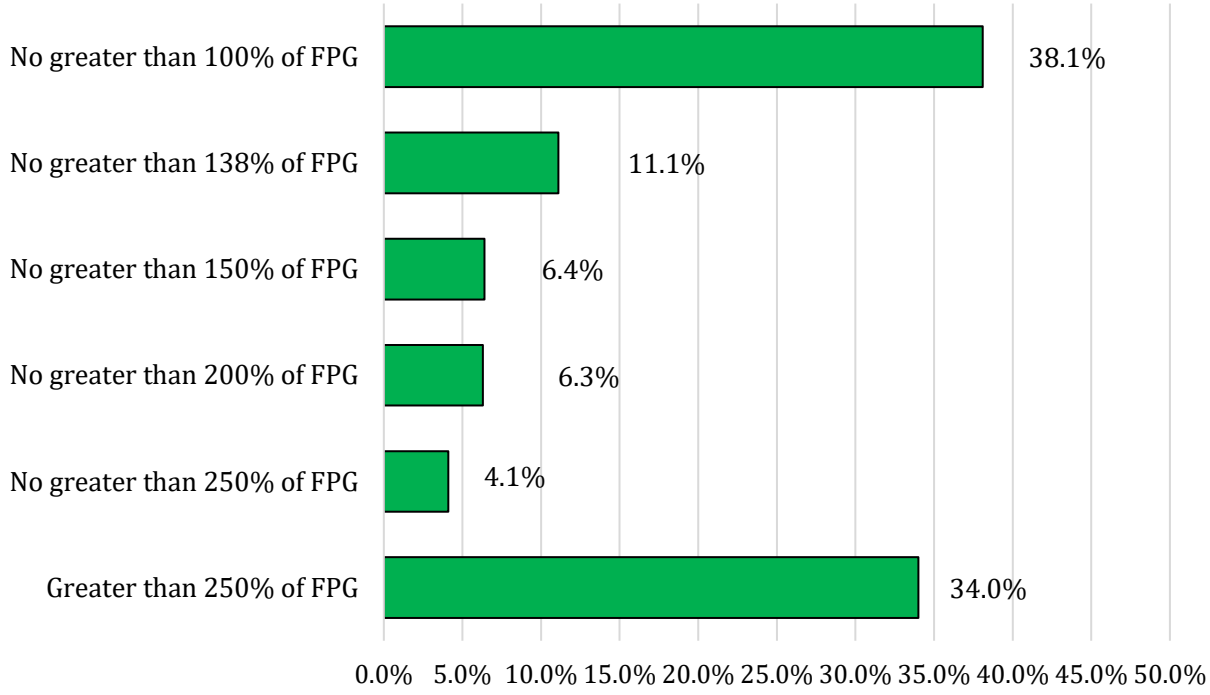


Q36. What is your yearly household income?

Answered: 697 **Skipped: 226**

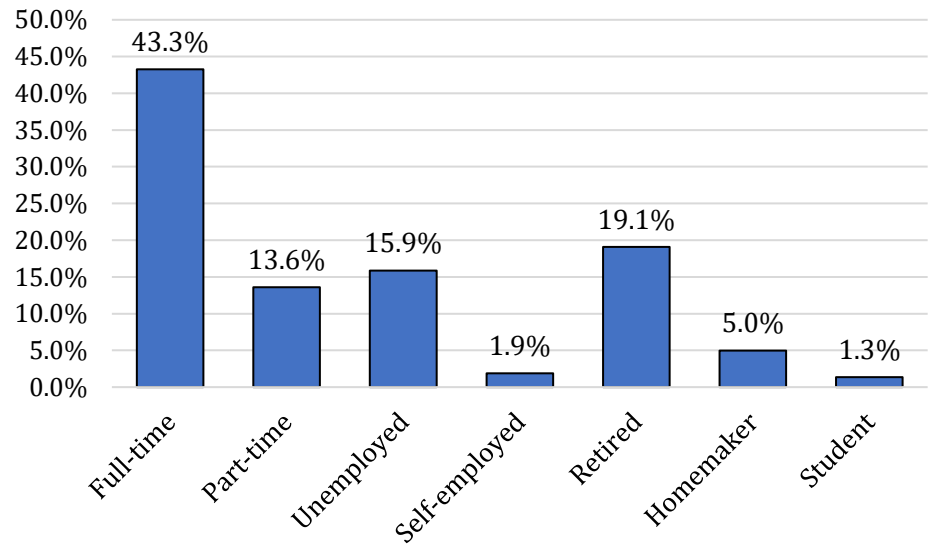


Income as a Percent of Federal Poverty Grouping (FPG) According to Household Size (N = 637)



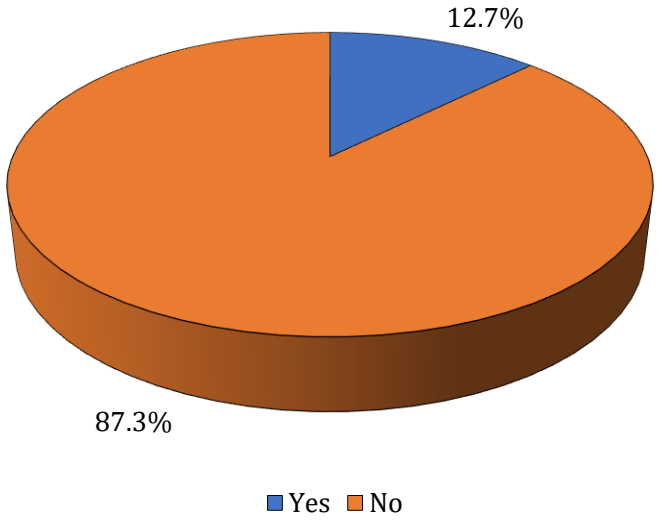
Q37. What is your current employment status?

Answered: 747 **Skipped: 176**



Q38. Do you currently receive disability benefits?

Answered: 745 **Skipped: 178**



Q39. Is there anything else we should know about your (or someone living in your home) needs in the Farmville Area?

Please refer to the data responses in the "Other" questions responses that are attached.

Code Used	Frequency	Valid Percent
Grocery Stores	14	13.86%
Healthy Food	7	6.93%
Affordable Dental Care	5	4.95%
Affordable Health Care	5	4.95%
Affordable Housing	5	4.95%
Transportation	5	4.95%
Affordable Insurance	4	3.96%
Affordable Mental Health Services	4	3.96%
Services in Rural Area	4	3.96%
Veteran's Affairs	4	3.96%
Child Care	3	2.97%
Home Repairs	3	2.97%
Endocrinology	2	1.98%
Health Care Competition	2	1.98%
Job Training	2	1.98%
Support for Children with Special Needs	2	1.98%
Trails/Walking Path	2	1.98%
Urgent Care	2	1.98%
Access to Budget Planning	1	0.99%
Affordable Prescriprions	1	0.99%
Affordable Vision Care	1	0.99%
After-Hours Dental Care	1	0.99%
Assisted Living/Skilled Nursing Facility	1	0.99%
Basic Home Necessities (Toiletries/Laundry Detergent)	1	0.99%
Boys and Girls Club	1	0.99%
Compassion	1	0.99%
Family Physicians	1	0.99%
Female Family Physicians	1	0.99%
Financial Assistance	1	0.99%
Help with Medicaid Application	1	0.99%
Home Health	1	0.99%
Home Kitchen	1	0.99%
Homeless Shelter	1	0.99%
List of Providers Who Accept Workman's Compensation	1	0.99%

Medical Supplies	1	0.99%
Psychiatry	1	0.99%
Recreation Center Besides YMCA	1	0.99%
Recreation Directory	1	0.99%
Respite Care	1	0.99%
Shorter Wait Times/Customer Service Training	1	0.99%
Social Outlets/Activities	1	0.99%
Support for Families with Pets	1	0.99%
Support for Physical Disabilities	1	0.99%
Tobacco Cessation Group	1	0.99%
Total	**101**	**100.00%**

3. Area Stakeholders Directory

Partnership for Healthy Communities
Farmville Area Stakeholder Directory

Please √	Date: 5/14/18		
	Last Name	**First Name**	**Organization**
x	Allen	Kimberly	
x	Angelo	Tom	Centra
x	Beatson	Amy	STEPS, Inc.
x	Bodine	Bill	Greater Lynchburg Community Foundation
x	Brown	Dennis	CSCH
x	Calhoun	Lonnie	United Way
x	Cole	Christine	Piedmont Health Coalition/HEAL
x	Coleman	Stephanie	Buckingham County DSS
x	Crowder	Deborah	South Central Workforce Development
x	Daniels	Sheila	Va Coop Extension (?)
x	Delzingaro	Christina	Community Access Network
x	Ellington	Andy	Farmville PD
x	Flores	Julie	CSCH
x	Fowler	Rob	Prince Edward County
x	Freeman	Kandy	Madeline's House
x	Harvie	Taylor	Amelia County
x	Jenkins	Jennie	Hampden Sydney College
x	Johnson	Jayne	Habitat for Humanity
x	Jones	Chip	Cumberland County Public Schools
x	Jordan	Daniel	Va Dept of Conservation & Recreation
x	Kendall	Michael	Farmville United Methodist Church
x	McGuire	Sheri	Longwood U
x	Melton	John	Fuqua School
x	Miles	Jordan	Piedmont Senior Resources

x	Morris	Roma	Prince Edward County DSS
x	Nash	Bob	Piedmont Health District
x	Payne	Pat	Heart of Virginia Free Clinic
x	Poulter	Jane	community volunteer
x	Pruitt	Rhonda	
x	Robinson	Thomas	Farmville Presbyterian Church
x	Snead	Rucker	UW/HSC
x	Speedie	Sam	
x	Stokes	Pauline	Va Coop Extension
x	Taylor	Lisa	CAN
x	Tomko	Paula	Central Va Health Services
x	Weeks	Heather	Centra Home Health
x	Young	Justine	Piedmont Senior Resources
x	Young	Pat	CommunityWorks
	Total Attendance	38	

4. Stakeholder Survey

Partnership for HEALTHY COMMUNITIES

Stakeholders Focus Group Survey

Please complete the following questions:

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

5. Target Population Focus Group Notes Page & Confidentiality Statement

TARGET POPULATION FOCUS GROUPS

MEETING NOTES

Name of Facilitator: _____

Name of Scribe: _____

Date of Meeting: _____

Site of Meeting: _____

Number of Participants: _____

1. In one to two words, what does health mean to you? *(Record on flip chart so that participants can see all responses)*
2. What resources/programs/services in your community help you and/or your family stay healthy?
3. How do you and/or your family know where to go for these resources/programs/services in your community?
4. What keeps you and/or your family from being healthy?
5. Is there anything else you would like to share?

CONFIDENTIALITY STATEMENT FOR FOCUS GROUP MEETING

Health starts in our homes, schools, workplaces, neighborhoods, and communities. The Partnership for Healthy Communities is committed to improving the health of the communities we serve. Please tell us what you need to be the healthiest you and your family can be!

Thank you for agreeing to be a part of this focus group meeting. During the meeting, you will be asked questions about yourself and/or your family. You will also hear answers by other people in the room. Please read the statements below and sign if you agree.

I have been told and understand that:

- I have been given the opportunity to ask questions about the purpose of the meeting.
- I am agreeing to have the meeting audio-taped.
- I will not talk about the information shared by me or others outside this meeting.
- My name (or the names of my family) will not be linked to the comments I make during this meeting.
- Information from this meeting will be included in a written report.

Signed _____ Date_____

Witness_____ Date_____

6. Area Prioritization of Needs Worksheet

Farmville Area Prioritization of Needs Worksheet
Rank the Top 10 Greatest Needs
2018
Instructions: Rank the following "Areas of Need" from 1 to 10
(1 is the greatest need)

Rank	Areas of Need	Community Health Survey Responses (%) n=862	Stakeholder Survey Responses (%) n=179
	Access to affordable health care	54.87%	
	Access to dental services		1%
	Access to healthcare		9%
	Access to healthy foods	25.17%	6%
	Access to affordable housing	25.41%	8%
	Access to mental health services		7%
	Access to resources		1%
	Access to substance use services		4%
	Active living		2%
	Aging problems	14.62%	
	Alcohol and illegal drug use	29.12%	
	Attention deficit		1%
	Broad band		1%
	Bullying	14.73%	
	Cancers	19.72%	
	Cell phone use/texting and driving/distract	16.59%	
	Child abuse/Child neglect	10.44%	
	Childcare		3%
	Collaboration		2%
	Communications		1%
	Community Advocate		3%
	Dental problems	11.83%	
	Diabetes	24.83%	
	Domestic violence	10.09%	1%
	Economic Development		1%
	Education		4%
	Education - drop out rates	8.00%	
	Elder care		1%
	EMS		3%
	End of life care		1%
	Financial security		2%
	Funding- Lack of		1%
	Health Insurance		2%
	Health Literacy		7%
	Heart Disease and Stroke	15.31%	
	High Blood Pressure	19.49%	
	Joblessness	18.21%	
	Lack of exercise	13.81%	
	Lifestyle management		1%
	Mental Health problems	17.98%	3%
	Opioid Use	6.50%	
	Overweight/Obesity	28.65%	
	Policy		2%
	Poor eating habits	19.95%	
	Poverty	17.63%	
	Programs "in Place"		1%
	Stress	12.99%	
	Substance Use		7%
	Tobacco Use/Smoking/Vaping	9.40%	
	Transportation	9.40%	13%
	Workforce Development		5%
	Other:		
	Other:		

7. Area Community Resources

Farmville Area Community Resources 2018	
Arts/Culture/Recreation VA Cooperative Extension Farmville Visitors Center Farmville Parks & Recreation Dept. Virginia Dept. of Conservation & Recreation	**Housing** Buckingham Housing Development Christian Outreach Program Farmville Area Habitat for Humanity Helping Every Life Prosper HOME of Virginia Madeline's House Southside Community Dev. & Housing Corp. STEPS, Inc. Telamon Corporation Tri-County CAA USDA Rural Development Virginia Fair Housing Office Virginia Housing Development Authority
Clothing/Personal/Household Christian Outreach Program Prom Bring It Southside Community Services Board Vehicles for Change	**Income Support/Assistance** Clearpoint Credit Counseling Solutions FAMIS Social Security Administration (South Boston) Departments of Social Services STEPS, Inc. Tri-County Community Action Agency Virginia Employment Commission
Disaster Services American Red Cross Emergency Management Services	**Individual, Family, & Community Support** Departments of Social Services: Amelia Buckingham Charlotte Cumberland Lunenburg Nottoway Prince Edward United Way Tri-County Community Action Agency STEPS, Inc. Virginia Cooperative Extension Piedmont Senior Resources
Education Public Schools: Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, Prince Edward Hampden-Sydney College Longwood University Southside Community College Virginia Adult Learning Resource Center John Tyler Community College Fuqua School Boy Scouts of America 4H	**Information Services** Access Now Autism Society of Central Virginia Piedmont Senior Resources Public Library System: Central Virginia Regional Charlotte James L. Hamner Lunenburg Nottoway Virginia Legal Aid Society Virginia 2-1-1
Employment Career Support Systems Community College Workforce Alliance South Central Workforce Development Board	**Mental Health/Addictions** Gamblers Anonymous Madeline's House

Virginia Employment Commission Virginia Job Corps	Richmond Intergroup Richmond Veteran Center Hope for Tomorrow Counseling Crossroads Community Services Board Southside Dominion Health Systems Williamsburg Place
Food/Meals Central Virginia Food Bank, FeedMore Farmville Area Community Emergency Services Helping Every Life Prosper Piedmont Senior Resources SNAP	**Public Safety** County Sheriff's Office: Nottoway, Prince Edward Emergency Management Services Town of Farmville – Police Department Victoria Police Department
Government/Economic Services Farmville Chamber of Commerce Charlottesville Regional Chamber of Commerce US Small Business Admin. Regional Office (Richmond) USDA Rural Development US Dept of Veterans Affairs Virginia Dept. of Transportation VA Hispanic Chamber of Commerce Foundation	**Children & Family Recreation** Farmville Parks & Recreation Southside YMCA
Healthcare Alzheimer's Association, Southeastern Chapter Centra Southside Community Hospital Enroll Virginia Heart of Virginia Free Clinic Hope Clinic Piedmont Health District: Virginia Dept. of Health Amelia County Buckingham County Charlotte County Cumberland County Lunenburg County Nottoway County Prince Edward County Hunter Holmes McGuire VA Medical Center Partnership for Prescription Assistance Virginia Dept. for Aging & Rehab Services	**Transportation** Farmville Area Bus (FAB) Logisticare Piedmont Senior Resources URZ - Richmond