# 2025 Community Health Assessment

Mary Washington Healthcare

RAPPAHANNOCK AREA HEALTH DISTRICT
RAHD
VIRGINIA DEPARTMENT OF HEALTH

Completed in partnership between the Rappahannock Area Health District (RAHD) and Mary Washington Healthcare (MWHC)

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# Letter from Leadership

This report marks the second time Mary Washington Healthcare and the Rappahannock Area Health District have partnered together on the Community Health Assessment (CHA), and we have again been reminded of what strength such partnerships bring to our region.

Although this systematic examination of community health is a requirement for both organizations, we are somewhat unique in our full commitment to work side by side to carry out the project and engage partners and community members along the way.

When we last completed the CHA in 2021-2022, both our organizations were still in the throes of COVID-19 response. We were unable to hold in person meetings, and we lamented that much of our data would only reflect pre-pandemic trends, not fully capturing the many changes the pandemic brought on, not only as a respiratory illness but as a pandemic with cultural, social, political, and economic impacts as well.

This updated version of the CHA allows us to more systematically examine the changes brought by the pandemic in our community. However, it is worth noting that this CHA is once again being published during a period of political shift and uncertainty with rapid change in the community and across the nation, with many changes to federal priorities and funding streams. As a result of these sociopolitical changes, there has been a change in the perception of social determinants of health during the period of data collection.

Despite these changes, our approach to health stays the same. We understand that there are many factors contributing to a person's health, and most of these factors take place outside the four walls of a doctor's office, health department, or hospital. Our health is also determined by the foods we have access to, our access to education and good job prospects, the quality of the water we drink, the laws which keep our community safe, and so much more. Through this assessment, we seek to use multiple types of data to understand the health of our community, not just as individuals, but also as a collective that must work together to optimize our collective health.

We are excited to share the findings of the CHA, which includes opportunities for improvement, as well as community strengths, and we look forward to the ongoing collaboration and partnership as we use these findings to develop the Community Health Improvement Plan (CHIP) for our region.

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# List of Abbreviations

Below is a list of abbreviations that can be found throughout the document.

**ALICE - Asset Limited Income constrained and employed**

**CDC - Centers for Disease Control and Development**

**CHA - Community Health Assessment**

**CHIP - Community Health Improvement Plan**

**COPD - Chronic Obstructive Pulmonary Disease**

**DNR - Do Not Resuscitate**

**ED - Emergency Department**

**FPL - Federal Poverty Line**

**GED - General Educational Development**

**LPHS - Local Public Health System**

**MAPP - Mobilizing for Action through Planning and Partnership**

**MMR - Measles, mumps and rubella**

**MOA - Memorandum of Agreement**

**MOU - Memorandum of Understanding**

**MWHC - Mary Washington Healthcare**

**NACCHO - National Association of County and City Health Officials**

**PD16 - Planning District 16**

**PSA - Prostate-Specific Antigen**

**RAHD - Rappahannock Area Health District**

**SDOH - Social Determinants of Health**

**SRMC - Spotsylvania Regional Medical Center**

**TDAP - Tetanus, diphtheria and pertussis**

**US - United States**

**VDH - Virginia Department of Health**

**VRE - Virginia Railway Express**

**YMCA - Young Men's Christian Association**

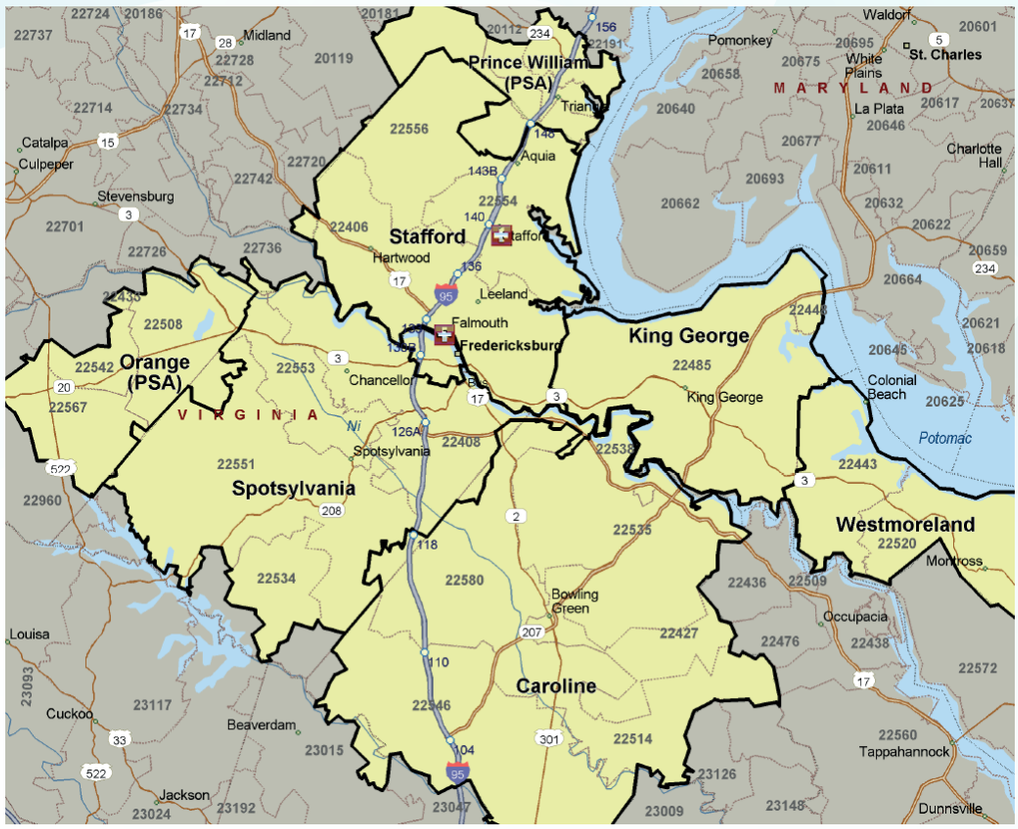
# Introduction

## Purpose

The Community Health Assessment (CHA) systematically examines community health using a variety of data sources. The purpose of this report is to determine the health status of residents of Caroline, King George, Spotsylvania, and Stafford Counties, and the City of Fredericksburg, as well as parts of neighboring counties that make up the Mary Washington Healthcare (MWHC) primary service area.

Ultimately, the CHA will inform the Community Health Improvement Plan (CHIP) to mobilize the community to act to improve key health issues. The CHIP will be released in July 2025.

## Service area




The CHA focuses on the 1,388-square mile area that makes up the Rappahannock Area Health District (RAHD), including the counties of Caroline, King George, Spotsylvania, and Stafford and the City of Fredericksburg. As of 2023, an estimated 405,152 individuals live in RAHD. Locality populations range from 28,568 in King George County to 165,428 in Stafford County[1].

This area is often referred to as Planning District 16, or PD16, in accordance with the Planning District Commissions outlined in the Virginia Regional Cooperation Act. PD16 is nestled halfway between Richmond, VA and Washington, D.C., and includes urban, suburban, and rural areas. Of the 21 planning districts in Virginia, PD16 is the 5th largest region in Virginia and fastest growing, at 6.5% since 2020[2].

In addition to PD16, Mary Washington Healthcare's service area includes Westmoreland, eastern Orange, and southern Prince William counties, and data on these counties is included in some sections of the report.

1 United States Census Bureau, 2024.
2 George Washington Regional Commission, "About GWRC", 2024.

## Summary of 2022 CHA/CHIP

MWHC and RAHD collaborated on a joint CHA and CHIP for the first time in 2022. Both organizations found this partnership beneficial to better understanding and responding to health needs in the community, as well as minimizing community "survey fatigue." A joint survey allowed for additional resources, creating a more in-depth assessment, and increased participation from community members and other community organizations. The two organizations established a memorandum of agreement (MOA) and met weekly for the duration of the CHA/CHIP process, serving jointly as the "Core Team."

The CHA and CHIP are conducted using the Mobilizing for Action through Planning and Partnerships (MAPP) tool, which provides a six-step process to engage stakeholders, collect and analyze relevant data, and develop and evaluate a health improvement plan.

Due to the threats posed by COVID-19 at the start of the assessment, some elements of the MAPP process were modified to ensure safety of participants. All CHA related meetings were held virtually, although three CHIP meetings were held in person once the COVID threat began to subside in the spring of 2022.

### Priorities from the 2022 CHA/CHIP

Analysis of the 2022 CHA data revealed eight key issues (listed alphabetically):

- Access to healthcare
- Affordable housing/homelessness
- Chronic disease
- Education
- Infant and maternal care in the African American community
- Mental health
- Obesity
- Substance abuse

At a community meeting in April 2022, the Core Team presented data on all eight topics and solicited community input to narrow down to three priorities to be addressed in the CHIP. The three selected priorities were:

- Mental health
- Affordable housing
- Access to healthcare

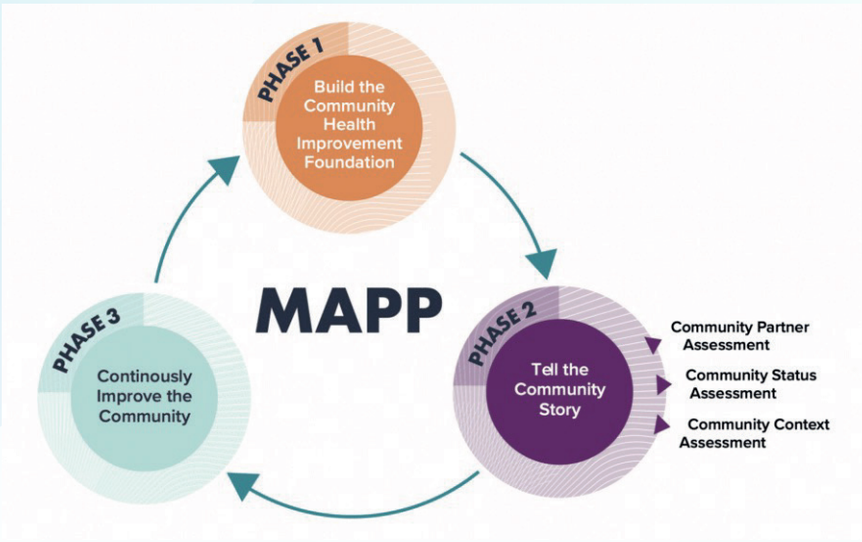
The 2022 CHIP included 12 organizations contributing strategies to improve health in these priority areas. This has included but is not limited to increased education about mental health in local schools, an increase in mental health providers, the establishment of a regional housing assembly, the approval of a site for a supportive housing development to serve the unhoused population, expanded referral activity across agencies, and new programs to increase the pipeline of healthcare workers in our area. As of March 2025, all 2022 CHIP strategies have been initiated.

Feedback from community partners showed enthusiasm for a similar collaborative approach in this updated CHA.

# 2025 Community Health Assessment (CHA) Methods

## MAPP 2.0 Process

This CHA utilized MAPP 2.0, the updated framework for Community Health Improvement from the National Association of State and Territorial Health Officials. This was an updated version of the framework used in the 2022 CHA.




MAPP 2.0 guides communities to assess their most pressing population health issues and align resources across sectors to improve community health.

One of the key differences between MAPP 2.0 and the original MAPP is the explicit connection between the CHA/CHIP process and health equity. The introduction to MAPP 2.0 states

**"The goal of MAPP is to achieve health equity by identifying urgent health issues in a community and aligning community resources."**

***Figure 1:*** *MAPP 2.0 Process*

**The MAPP process consists of three steps (shown in Figure 1):**

1. **Build the Community Health Improvement Foundation:** This phase brings together many partner organizations and people to plan for the CHA/CHIP. This includes identifying who will be involved, defining roles, engaging the community, and planning for data collection and analysis.
2. **Tell the Community Story:** This step is conducted by gathering data from a variety of sources through three assessments and then analyzing that data. The CHA report is completed in this phase.
3. **Continuously Improve the Community:** The CHIP is developed during this phase. Key issues are prioritized, and strategies to address these issues are identified, carried out, and evaluated.

**This document provides the data collected during the three MAPP assessments (see Figure 1):**

- **Community Context Assessment:** Data directly from the community, including information about community strengths and assets, the built environment, forces of change, and perceptions of community health needs. For this CHA, data for this assessment was collected through focus groups, community conversations, and a community survey.
- **Community Status Assessment:** A quantitative assessment of community health. Data includes information on demographics, health status, health outcomes, and health inequities. This includes data from secondary sources as well as primary data from MWHC's Social Determinant of Health (SDOH) screening, conducted with inpatients in the 2024 calendar year.
- **Community Partner Assessment:** Survey responses from community partners assessing local systems and collective capacities to address health inequities in PD16.

## Structure

To meet local needs and expectations, some elements of the MAPP 2.0 process were modified. The following structures carried out this process:

- The **Core Team** consisted of two representatives from RAHD and two representatives from MWHC. The group met weekly to plan and manage the overall CHA project. They identified community partners and community members, facilitated meetings, oversaw data collection and analysis, and wrote the report.
- The **Steering Committee** consisted of the Be Well Rappahannock group, a collaborative group of leaders and executive directors from various organizations across the local public health system and the community. The stated purpose of the council is to "identify priority community needs; provide advice, oversight, and stewardship to planned community improvements; and monitor progress on priority health and social concerns impacting the Rappahannock Region." The Steering Committee assisted with key decisions and participated in kick-off meetings and the community partner survey. A full list of Steering Committee members is available in Appendix A.
- **Additional community engagement** began with a series of six kick-off meetings, held in the fall of 2024, one in each locality within PD16, and one virtually. A total of 90 community members and representatives from partner organizations attended. Community feedback served as the basis for the Community Context Assessment, and presentations in March 2025 provided an avenue for ongoing community participation and feedback prior to the final CHA publication.

# Community Context Assessment

The Community Context Assessment focuses on primary data collected directly from the community to understand its strengths, weaknesses, and key factors influencing health and well-being. This includes an examination of the built environment, which consists of human-made structures and systems, such as buildings, transportation infrastructure, and public spaces. Additionally, the assessment considers forces of change, which are external and internal factors—such as economic shifts, policy changes, environmental conditions, and social dynamics—that can influence the community's health and well-being. Finally, this section examines community feedback about health needs gathered through a community-wide survey to ensure the assessment reflects the lived experiences and priorities of residents.

## Community Conversations

### Introduction

During the series of in-person kick-off meetings, small group discussions were held with 90 participants. These small group discussions focused on questions about:

- Community strengths and assets
- Physical assets and the built environment
- What is occurring or might occur that could affect the health of the community or the local public health system
- Which communities are disproportionately impacted by forces of change

### Community Strengths and Assets

#### Interconnectedness and Collaboration

Participants discussed a strong sense of community with active partnerships between local governments, schools, nonprofits, healthcare providers, and community organizations. Notable collaborations acknowledged included hospitals, faith-based organizations, food banks and local businesses.

#### Access to Services

The community noted access to resources, such as healthcare facilities (MWHC, Spotsylvania Regional Medical Center), free clinics, YMCA, and social services. Participants also noted there are mental health programs in schools, wellness services and various nonprofits supporting vulnerable populations. However, in many cases, there are not enough providers to meet the needs of the population.

#### Diverse and Engaged Populations

Conversations noted the region is characterized by high diversity, including urban and rural populations. There is also a strong volunteer base and commitment to improving community well-being through events and involvement.

#### Challenges

Although the questions posed during the small group discussions focused on strengths in the community, many participants acknowledged areas in need of improvement and gaps that exist. Navigating service availability, eligibility for assistance programs, transportation for marginalized groups, and a lack of affordable housing and healthcare access for certain specialties were mentioned. Participants also noted the need for better communication across organizations to streamline resources.

## Built Environment and Physical Assets

### Healthcare and Medical Resources

Participants believe the number of pharmacies, hospitals, and healthcare services have grown over the past several years, including safety net clinics, senior cafes, and mental health resources. There was, however, discussion about the lack of access to these services for those who live in the more rural areas.

### Transportation

While urban areas, like Fredericksburg, are walkable and have access to public transportation (i.e. Fredericksburg Regional Transit, VRE), rural areas, such as Caroline and parts of Stafford, lack reliable transportation options. This hinders access to healthcare and other essential services. Issues like overcrowding, long commutes, and limited walkability in some areas contribute to physical and mental health challenges. The need for more commuter lots, expanded bus systems, and transportation options for low-income individuals was highlighted.

### Recreational and Community Spaces

The community has a strong network of parks, YMCA facilities, walking trails, libraries, and community centers that provide valuable resources. These spaces support physical activity, socialization, and community engagement. Access to the resources can be limited in rural areas and some neighborhoods lack sidewalks or bike lanes, reducing walkability, and accessibility.

### Economic and Social Disparities

Resources vary significantly by neighborhood. Participants noted that urban areas, especially the City of Fredericksburg, tend to have better access to services, healthcare, and public amenities. In contrast, rural communities face significant barriers such as transportation gaps, limited healthcare access, and lack of infrastructure.

Participants also discussed how forces of change have a more significant impact on some populations, such as those who are low income, those who speak languages other than English, people of color, and senior citizens among other groups.

## External Factors That Could Impact Health

### Economic Struggles and Inequality

Poverty, lack of affordable housing, rising living costs, and low wages are all significant challenges for many community members. Discussions noted that many people are living paycheck to paycheck, struggling with high medical bills, food insecurity, and limited access to financial assistance.

### Healthcare Access and Workforce Shortages

There is a shortage of primary care providers, obstetricians, specialists, and mental health services, especially in rural areas. Long wait times, lack of insurance, and rising healthcare costs create barriers to accessing care, with mental health needs particularly underserved.

### Mental Health Crisis and Substance Abuse

The community is experiencing increasing rates of mental health issues (anxiety, depression, substance abuse), particularly among youth. The shortage of mental health providers, especially those able to work with youth and underserved populations, and the post-pandemic mental health burden is substantial. Participants, especially first responders, also noted that substance abuse issues, including overdoses, continue to be a concern.

**Population Growth and Strained Resources**
Rapid population growth, changing demographics, and an influx of new residents are putting significant strain on local resources, including housing, healthcare, and infrastructure. This contributes to overcrowding, long wait times for services, and increased demand for support across the community.

## Communities Disproportionately Affected by Forces of Change

**Low-income Populations**
Families who are low-income or asset-limited, income-constrained, and employed (ALICE) face financial instability, often falling through the cracks in accessing resources and services, particularly as costs rise.

**Non-English Speakers and Immigrants**
The growing immigrant and English learner populations face challenges in navigating systems that do not provide adequate translation and culturally sensitive support.

**Seniors and Elderly**
Older adults, particularly those 55+ or on fixed incomes, face challenges in maintaining their housing, accessing healthcare, and managing rising living costs.

**Rural communities**
People in rural areas, particularly in counties like Caroline and King George, suffer from limited access to healthcare, transportation, and other resources, resulting in disparities compared to more urban areas.

**People of Color and Refugees**
Racial and cultural disparities affect access to services, especially in mental health. Respondents mentioned that culturally many still stigmatize seeking mental health services and assistance. Health norms and beliefs about wellness vary across cultures which may affect when and what types of care individuals seek out. Additionally, many foreign-born individuals struggle with navigating pathways to care. Intersectional challenges are particularly severe for individuals who belong to multiple disadvantaged groups, amplifying the negative effects of change.

# Focus Groups

In addition to the kick-off meeting small group discussions, a series of focus groups and interviews were held in late 2024 and early 2025. In all, 45 individuals participated in ten sessions. Questions were asked relating to what their vision of a healthy community looks like, what strengths and resources exist within the community, what factors affect community health, who is most impacted by these factors, what actions could improve health in our community, and what advice they have for health providers getting community input on educational materials and programs or services.

Through these conversations, three top themes regularly came up across all five localities.

**Community Resources and Community Engagement**
Residents commented that they would like to have more opportunities to attend health fairs, participate in health education opportunities, and receive more communication about resources and events that will be happening in their areas. Stafford residents requested more community health education opportunities, while King George residents suggested repurposing vacant buildings to provide non-athletic activities for children and to bring people together in person.

### Access to Healthcare

Several participants noted there are not enough providers, especially specialty providers, in the area and that those living in more rural locations face even greater challenges. This challenge with access to healthcare also includes access to mental health services. Lack of transportation and distance to appointments were noted as additional barriers. A resident in Spotsylvania noted a need for more healthcare resources in rural areas of the localities. In King George, additional providers and specialists were requested. One resident noted the senior population spends a considerable amount of time driving to and from Fredericksburg for appointments.

### Built Environment

Participants regularly mentioned they would like to see places like additional parks, recreational centers, and basketball courts and noted the connection between physical activity and improving physical and mental health. In Fredericksburg, participants requested a place where people can socialize, learn new skills, and exercise. In Caroline, participants noted that additional grocery stores would be beneficial.

### Additional Themes

Other topics that came up frequently through these conversations included access to affordable, healthy foods, aging-related concerns and supports, transportation, and communication.

Residents in Stafford noted the rising cost of foods to be an issue for many, and some in King George and Spotsylvania recommended that information about planting and cultivating food in a home garden may be beneficial, especially to those in rural areas who may have space for a garden.

Seniors noted support systems for being able to age in place would be helpful. In Fredericksburg, ramps for homes and businesses, partnerships with organizations and non-profits to support them, and assistance in planning for death – such as writing wills or Do Not Resuscitate (DNR) documents, and transferring of deeds were mentioned. Grief support groups or services that would check in on seniors regularly were also suggested as supports that would be helpful in Spotsylvania.

Transportation, especially for seniors and those in rural areas repeatedly came up as a need. Many do not have access to public transportation, and those that do sometimes find it difficult to navigate or are frustrated with the amount of time it takes to get from their home to appointments and other resources. One Caroline resident stated that "Uber and Lyft do not exist in Caroline," and residents in Stafford stated public transportation does not run in their area past 4:00 p.m. It was also noted that the bus system can be challenging for seniors to navigate, and it can take a long time to get where you need to go.

Finally, communication needs improvement according to community members with whom we spoke. Many acknowledge that websites and social media work for large numbers of people, however there is still a large portion of the population who do not access electronic information regularly. It was mentioned by one Stafford resident that senior citizens have an especially hard time accessing information in modern ways. Utilization of more traditional ways of getting information out to the public was brought up throughout many of the conversations. It was also suggested that when electronic platforms are used to share information, that it be done in a more uniform or streamlined way. Requests for more information from localities were mentioned, especially rural communities. In Caroline, one participant noted the county should hire someone to control social media and get the word out about available resources and activities.

# Community Member Survey

## Overview

The Community Member Survey played a pivotal role in providing a comprehensive overview of the health needs within the community by gathering input from a large number of residents. The survey was designed to capture respondents' perceptions of the community's most pressing health concerns, health-related behaviors, and potential areas for improvement. By measuring community perceptions on these critical topics, the survey establishes a baseline of health needs, offering valuable insights for stakeholders and serving as one of the most direct forms of community feedback within the Community Health Assessment (CHA).

In September 2024, MWHC and RAHD launched the Community Health Assessment survey for community members. Surveys were distributed throughout PD16, as well as MWHC's greater service area. Surveys were shared extensively by RAHD, MWHC, and community partners. A total of 1,308 survey responses were received.

Although the populations of respondents were collected by convenience and did not represent a statistical sample of the communities, great effort was made to ensure the proportion of responses from each demographic group reflected the demographics of the service area. While racial and ethnic respondents proportion aligned closely with the actual population, we observed a higher response rate from older adults (55+) and women. Lower response rates were also observed from Spotsylvania and Stafford County residents.

## Demographic Summary of Respondents

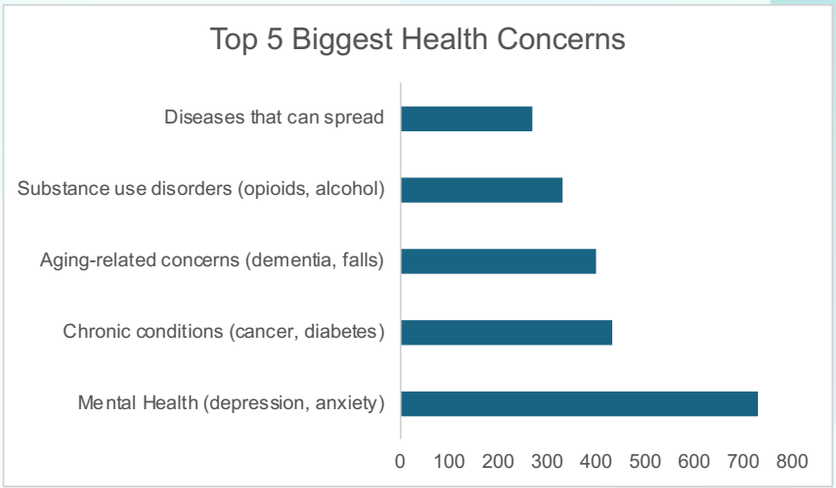
Participants were asked to provide basic demographic information including zip code, gender, age, race/ethnicity, highest education level, and annual household income. A summary of the responses to those questions can be found on page 13.

| | Attribute | Respondents (n) | Percentage (%) |
|---|---|---|---|
| **Areas/Locality** | Caroline County | 124 | 10.55% |
| | City of Fredericksburg | 221 | 18.81% |
| | King George County | 188 | 16.00% |
| | Orange County | 11 | 0.94% |
| | Prince William County | 5 | 0.43% |
| | Spotsylvania County | 343 | 29.19% |
| | Stafford County | 267 | 22.72% |
| | Westmoreland County | 13 | 1.11% |
| | Homeless/Unhoused (shelter, car, hotel) | 3 | 0.26% |
| **Gender Identity** | Woman | 858 | 75.00% |
| | Man | 268 | 23.43% |
| | Transgender | 8 | 0.70% |
| | Nonbinary | 6 | 0.52% |
| | Other/I don't know | 4 | 0.35% |
| **Sexual Orientation** | Straight or Heterosexual | 979 | 74.85% |
| | LGBTQIA+ | 80 | 6.12% |
| | Other | 8 | 0.61% |
| | Prefer not to say | 241 | 18.43% |
| **Age** | 15-17 | 23 | 1.97% |
| | 18-24 | 74 | 6.33% |
| | 25-34 | 173 | 14.80% |
| | 35-44 | 207 | 17.71% |
| | 45-54 | 186 | 15.91% |
| | 55-64 | 223 | 19.08% |
| | 65-74 | 174 | 14.88% |
| | 75+ | 109 | 9.32% |
| **Race/Ethnicity** | White | 662 | 60.68% |
| | Black or African American | 214 | 19.62% |
| | Hispanic or Latino | 96 | 8.80% |
| | Multiple Races | 63 | 5.77% |
| | African | 23 | 2.11% |
| | Asian or Pacific Islander | 20 | 1.83% |
| | Middle Eastern or North African | 6 | 0.55% |
| | American Indian or Alaska Native | 5 | 0.46% |
| | Another race/ethnicity not listed | 2 | 0.18% |
| **Education** | Elementary / Middle school | 39 | 3.41% |
| | High school diploma / GED | 187 | 16.33% |
| | Some college | 192 | 16.77% |
| | Associate's / Technical degree | 111 | 9.69% |
| | Bachelor's degree or higher | 610 | 53.28% |
| | Other (please describe) | 6 | 0.52% |
| **Annual household income** | Less than $25,000 | 126 | 12.64% |
| | $25,000 - $49,999 | 132 | 13.24% |
| | $50,000 - $99,999 | 223 | 22.37% |
| | $100,000 - $149,999 | 190 | 19.06% |
| | $150,000 - $199,999 | 133 | 13.34% |
| | $200,000+ | 136 | 13.64% |
| | Do not know/unsure | 57 | 5.72% |

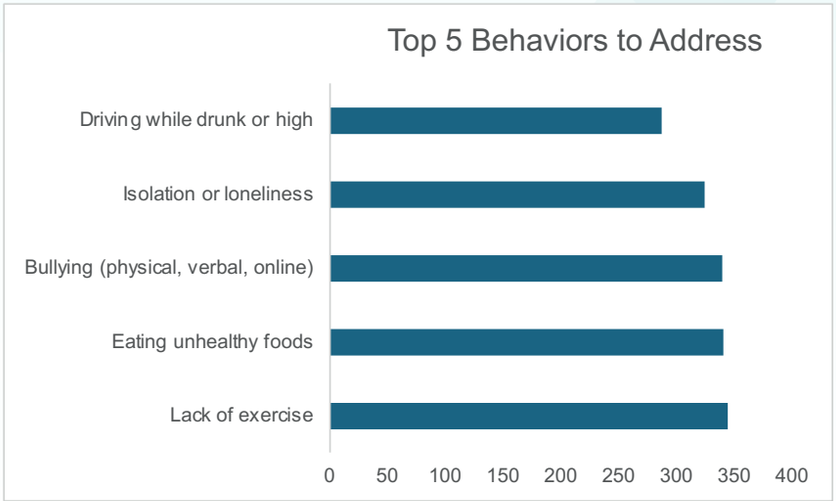
## Results

The assessment focused on three primary questions: what are the biggest health concerns, which health behaviors need to be addressed, and what would most improve health in our community. Respondents could select up to three choices for each question from the provided list, or they could enter their own responses via free-form textbox. The top five sections for each question are depicted in the charts below. A full summary of all the responses for each question can be found in Appendix B.

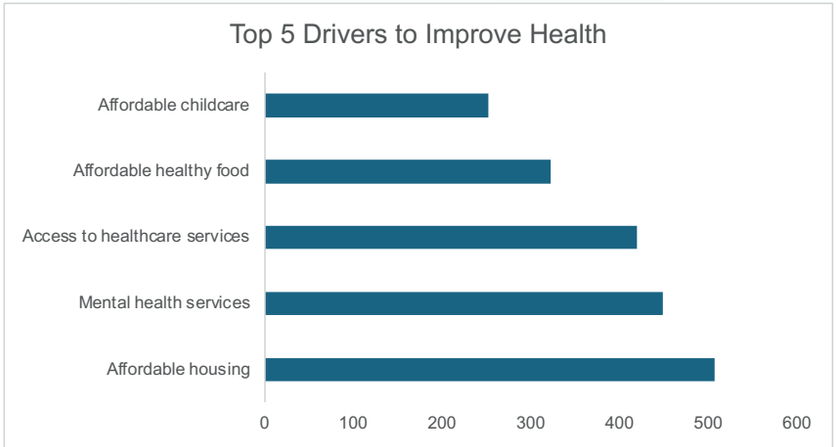
### What are the BIGGEST HEALTH CONCERNS in the community where you live?




### Which BEHAVIORS need to be addressed in the community where you live?




### What would MOST IMPROVE HEALTH in the community where you live?



While analyzing the overall top responses for each of the three questions is important, data was examined at both the demographic and locality levels to get a true understanding of the health needs in the service area. Notably, regarding the community's most pressing health concerns, there was a consistent trend across all counties, with mental health emerging as the top health concern in each locality. However, there were some variations across racial and income groups. For instance, dental issues ranked as a primary concern for both low-income and Hispanic/Latino respondents. Additionally, non-white respondents were more likely to express concerns about health disparities related to race/ethnicity or income, as well as issues of discrimination.

In terms of health behaviors that need attention within the community, similar patterns emerged, with lack of exercise, poor diet, bullying, and isolation/loneliness identified as key concerns across most localities. However, Hispanic/Latino respondents placed greater emphasis on addressing drug and alcohol related behaviors and domestic violence, while higher-income and more highly educated participants prioritized unhealthy eating and lack of exercise as the most significant behaviors to address.

When considering factors that could most improve health, affordability emerged as a recurring theme. Affordable housing, healthy food, and childcare ranked within the top five factors in overall responses. Access to dental care was particularly prioritized by Hispanic respondents, lower-income individuals, and those with a high school diploma or GEDs. Transportation options were more frequently prioritized by older adults and rural residents. Access to healthcare services was highlighted by King George residents as the greatest way to improve health and increases in healthcare accessibility and quality were consistently mentioned as key mechanisms for change throughout the survey.

Finally, participants were asked about their perceptions of safety at home, at work/school, in their neighborhoods, and within the broader community. Across all groups, most respondents indicated that they felt safe or very safe in each domain. This aligns with the relatively low response rates regarding health concerns and behaviors related to safety and security services.

| | Very Unsafe | Unsafe | Safe | Very Safe |
|---|---|---|---|---|
| **At Home** | **1.9%** | **2.2%** | **26.0%** | **69.9%** |
| **At School/Work** | **1.6%** | **7.5%** | **49.8%** | **41.1%** |
| **In your Neighborhood** | **2.0%** | **4.7%** | **50.2%** | **43.1%** |
| **In your community** | **1.8%** | **12.5%** | **65.0%** | **20.7%** |

# Community Status Assessment

This assessment seeks to understand patterns and trends in community health utilizing secondary, quantitative data. Much of this data is collected by federal or state agencies, such as the US Census Bureau, the Centers for Disease Control (CDC), and the Virginia Department of Health (VDH). Data from these sources tends to lag by several years, so much of the data reflects 2022 or 2023 as the most recent year.

In this iteration of the CHA, social determinant of health (SDOH) data from MWHC is also provided. This data was collected by surveying all adult inpatients during the calendar year 2024. Not only does this give us a more recent snapshot, but it also helps round out other data sources by identifying needs related to housing, transportation, food access, utilities, and interpersonal violence that may be affecting health outcomes.

Note that some tables in this assessment include grayed boxes. This graying indicates a data point that is worse than the Virginia average, and is meant to help the reader interpret the large amounts of data contained within the table.

## Secondary Data

### 1 – Demographics

**Resident Population**

The population throughout the area has continued to increase. Within PD16, Stafford has the largest population (165,428 people), followed by Spotsylvania (141,097 people). The remaining localities are much smaller in size, with around 30,000 residents.

Please note that 2022 population estimates are used to align with the majority of secondary health data indicators provided in this section. In the 2023 population estimates, the overall population in PD16 increased to 405,152.

| Area | Resident Population[3] |
|---|---|
| Virginia | 8,624,511 |
| **RAHD (PD16)** | |
| Caroline County | 31,181 |
| Fredericksburg City | 28,258 |
| King George County | 26,985 |
| Spotsylvania County | 141,097 |
| Stafford County | 157,606 |
| **Total** | **385,127** |
| **MWHC Additional Service Area** | |
| Orange County | 36,593 |
| Prince William County | 481,114 |
| Westmoreland County | 18,480 |
| **Total** | **536,187** |

[3] US Census Bureau, American Community Survey, 5-year Estimates, 2018-2022

## Age Distribution

The age distribution across all five localities is relatively consistent. Notably, nearly 20% of Fredericksburg's population is between 18-24 years of age, while all other localities within RAHD are below 10% for that group. This is attributed in part to the student body of the University of Mary Washington located within the city. Stafford has the highest number and percentage of children of PD16 localities. Spotsylvania has the highest number of older adults, but Caroline has the highest percentage of older adults relative to its population.

| Area[4] | Age 0-4 | Age 5-17 | Age 18-24 | Age 25-34 | Age 35-44 | Age 45-54 | Age 55-64 | Age 65+ |
|---|---|---|---|---|---|---|---|---|
| United States | 19,004,925 | 54,208,780 | 31,282,896 | 45,388,153 | 42,810,359 | 41,087,357 | 42,577,475 | 54,737,648 |
| Virginia | 494,148 | 1,382,678 | 828,543 | 1,170,113 | 1,145,151 | 1,102,944 | 1,119,928 | 1,381,006 |
| **RAHD (PD16)** | | | | | | | | |
| Caroline County | 1,835 | 5,234 | 2,601 | 4,083 | 3,916 | 4,000 | 4,398 | 5,114 |
| Fredericksburg City | 1,566 | 5,093 | 2,347 | 3,275 | 3,712 | 3,681 | 3,629 | 3,682 |
| King George County | 1,723 | 4,181 | 5,457 | 4,276 | 3,250 | 3,286 | 2,928 | 3,157 |
| Spotsylvania County | 8,367 | 26,168 | 12,060 | 17,847 | 18,459 | 19,000 | 18,630 | 20,566 |
| Stafford County | 9,758 | 31,324 | 14,992 | 20,087 | 22,864 | 22,266 | 19,040 | 17,275 |
| **Total** | **23,249** | **72,000** | **37,457** | **49,568** | **52,201** | **52,233** | **48,625** | **49,794** |
| **MWHC Additional Service Area** | | | | | | | | |
| Orange County | 2,033 | 5,698 | 2,651 | 4,442 | 4,196 | 4,710 | 5,579 | 7,284 |
| Prince William County | 33,047 | 95,085 | 44,083 | 62,380 | 72,562 | 68,094 | 55,429 | 50,434 |
| Westmoreland County | 886 | 2,482 | 1,202 | 2,210 | 1,709 | 2,231 | 3,003 | 4,757 |
| **Total** | **35,966** | **103,265** | **47,936** | **69,032** | **78,467** | **75,035** | **64,011** | **62,475** |

[4] US Census Bureau, American Community Survey, 5-year Estimates, 2018-2022

| Area[5] | Age 0-4 | Age 5-17 | Age 18-24 | Age 25-34 | Age 35-44 | Age 45-54 | Age 55-64 | Age 65+ |
|---|---|---|---|---|---|---|---|---|
| United States | 5.74% | 16.37% | 9.45% | 13.71% | 12.93% | 12.41% | 12.86% | 16.53% |
| Virginia | 5.73% | 16.03% | 9.61% | 13.57% | 13.28% | 12.79% | 12.99% | 16.01% |
| **RAHD (PD16)** | | | | | | | | |
| Caroline County | 5.88% | 16.79% | 8.34% | 13.09% | 12.56% | 12.83% | 14.10% | 16.40% |
| Fredericksburg City | 6.10% | 14.80% | 19.31% | 15.13% | 11.50% | 11.63% | 10.36% | 11.17% |
| King George County | 5.80% | 18.87% | 8.70% | 12.14% | 13.76% | 13.64% | 13.45% | 13.64% |
| Spotsylvania County | 5.93% | 18.55% | 8.55% | 12.65% | 13.08% | 13.47% | 13.20% | 14.58% |
| Stafford County | 6.19% | 19.87% | 9.51% | 12.75% | 14.51% | 14.13% | 12.08% | 10.96% |
| **Total** | **6.04%** | **18.70%** | **9.73%** | **12.87%** | **13.55%** | **13.56%** | **12.63%** | **12.93%** |
| **MWHC Additional Service Area** | | | | | | | | |
| Orange County | 5.56% | 15.57% | 7.24% | 12.14% | 11.47% | 12.87% | 15.25% | 19.91% |
| Prince William County | 6.87% | 19.76% | 9.16% | 12.97% | 15.08% | 14.15% | 11.52% | 10.48% |
| Westmoreland County | 4.79% | 13.43% | 6.50% | 11.96% | 9.25% | 12.07% | 16.25% | 25.74% |
| **Total** | **6.71%** | **19.26%** | **8.94%** | **12.87%** | **14.63%** | **13.99%** | **11.94%** | **11.65%** |

[5] US Census Bureau, American Community Survey, 5-year Estimates, 2018-2022

## Race

The population's racial composition is similar to that of Virginia for most racial groups. However, Virginia and the localities within RAHD and MWHC's additional service area have far fewer American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Some Other Race populations compared to the national figures.

| Area[6] | White | Black | Asian | American Indian/ Alaska Native | Native Hawaiian/ Pacific Islander | Some Other Race | Multiple Races |
|---|---|---|---|---|---|---|---|
| United States | 65.88% | 12.47% | 5.77% | 0.84% | 0.19% | 6.05% | 8.80% |
| Virginia | 63.47% | 18.90% | 6.85% | 0.28% | 0.07% | 3.52% | 6.91% |
| **RAHD (PD16)** | | | | | | | |
| Caroline County | 63.88% | 24.45% | 1.02% | 0.41% | 0.00% | 4.08% | 6.17% |
| Fredericksburg City | 59.89% | 21.53% | 3.84% | 0.18% | 0.00% | 5.47% | 9.10% |
| King George County | 72.55% | 15.80% | 1.36% | 0.09% | 0.00% | 3.60% | 6.60% |
| Spotsylvania County | 68.20% | 16.78% | 2.74% | 0.22% | 0.06% | 5.15% | 6.85% |
| Stafford County | 59.70% | 18.99% | 3.76% | 0.26% | 0.01% | 7.57% | 9.71% |
| **Total** | **64.07%** | **18.58%** | **3.00%** | **0.24%** | **0.03%** | **5.97%** | **8.11%** |
| **MWHC Additional Service Area** | | | | | | | |
| Orange County | 78.08% | 12.26% | 1.49% | 0.05% | 0.00% | 1.37% | 6.75% |
| Prince William County | 50.23% | 20.69% | 9.69% | 0.55% | 0.10% | 7.83% | 10.92% |
| Westmoreland County | 63.34% | 24.39% | 1.10% | 0.15% | 0.00% | 4.84% | 6.18% |
| **Total** | **52.58%** | **20.24%** | **8.83%** | **0.51%** | **0.09%** | **7.28%** | **10.47%** |

[6]U.S. Census Bureau, American Community Survey, 5-year Estimates, 2018-22.

## Ethnicity

Virginia and RAHD have a lower percentage of Hispanic or Latino populations compared to the U.S. figures. Stafford has the highest rate and largest number of Hispanic/Latino residents.

| Area[7] | Hispanic or Latino | Not Hispanic or Latino |
|---|---|---|
| United States | 18.65% | 81.35% |
| Virginia | 10.03% | 89.97% |
| **RAHD (PD16)** | | |
| Caroline County | 5.90% | 94.10% |
| Fredericksburg City | 11.71% | 88.29% |
| King George County | 6.35% | 93.65% |
| Spotsylvania County | 11.32% | 88.68% |
| Stafford County | 14.92% | 85.08% |
| **Total** | **12.04%** | **87.96%** |
| **MWHC Additional Service Area** | | |
| Orange County | 6.03% | 93.97% |
| Prince William County | 24.97% | 75.03% |
| Westmoreland County | 6.81% | 93.19% |
| **Total** | **23.05%** | **76.95%** |

[7] US Census Bureau, American Community Survey, 5-year Estimates, 2018-22.

## Gender

The gender distribution is roughly a 50/50 split within the United States, Viriginia, and the represented localities.

| Area[8] | Male | Female |
|---|---|---|
| United States | 49.59% | 50.41% |
| Virginia | 49.50% | 50.50% |
| **RAHD (PD16)** | | |
| Caroline County | 49.57% | 50.43% |
| Fredericksburg City | 46.72% | 53.28% |
| King George County | 50.84% | 49.16% |
| Spotsylvania County | 49.62% | 50.38% |
| Stafford County | 50.66% | 49.34% |
| **Total** | **49.92%** | **50.08%** |
| **MWHC Additional Service Area** | | |
| Orange County | 49.68% | 50.32% |
| Prince William County | 50.39% | 49.61% |
| Westmoreland County | 48.25% | 51.75% |
| **Total** | **50.32%** | **49.68%** |

[8] US Census Bureau, American Community Survey, 5-year Estimates, 2018-22.

## Language Spoken at Home

English is the dominant language spoken at home in all localities, with all localities having 80% or greater of their population speaking English only at home. Spanish is the second most widely spoken language at home, while other languages represent smaller percentages within each locality. Importantly, the growing population and changing demographics throughout the region suggest that languages other than English are likely to continue to increase, thus, the need for numerous language resources will likely increase as well.

| Area[9] | English Only | Spanish | Other Indo-European Languages | Asian and Pacific Island Languages | Other Languages |
|---|---|---|---|---|---|
| United States | 244,601,776 | 42,064,953 | 11,892,212 | 11,082,543 | 3,806,157 |
| Virginia | 6,760,591 | 642,108 | 306,277 | 308,444 | 144,798 |
| **RAHD (PD16)** | | | | | |
| Caroline County | 27,633 | 1,550 | 225 | 193 | 48 |
| Fredericksburg City | 21,781 | 2,462 | 1,719 | 297 | 357 |
| King George County | 24,326 | 857 | 398 | 173 | 129 |
| Spotsylvania County | 116,875 | 12,256 | 3,193 | 1,721 | 1,369 |
| Stafford County | 123,571 | 16,976 | 4,804 | 2,708 | 2,612 |
| **MWHC Additional Service Area** | | | | | |
| Orange County | 32,816 | 1,199 | 831 | 126 | 59 |
| Prince William County | 287,274 | 90,771 | 30,081 | 20,071 | 23,479 |
| Westmoreland County | 16,718 | 779 | 187 | 55 | 1 |

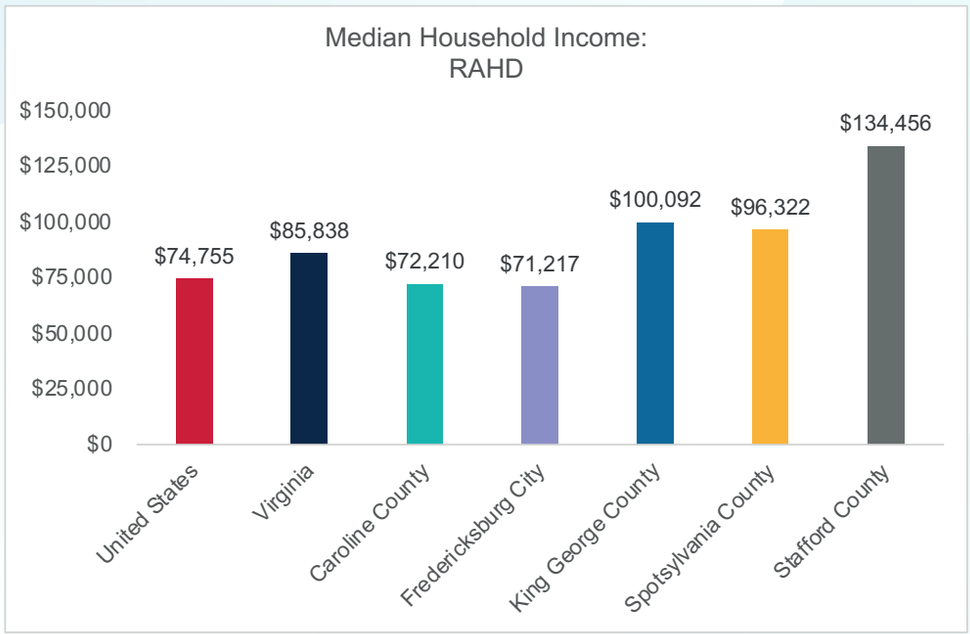
| Area | English Only | Spanish | Other Indo-European Languages | Asian and Pacific Island Languages | Other Languages |
|---|---|---|---|---|---|
| United States | 78.0% | 13.4% | 3.8% | 3.5% | 1.2% |
| Virginia | 82.8% | 7.9% | 3.8% | 3.8% | 1.8% |
| **RAHD (PD16)** | | | | | |
| Caroline County | 93.2% | 5.2% | 0.8% | 0.7% | 0.2% |
| Fredericksburg City | 81.8% | 9.3% | 6.5% | 1.1% | 1.3% |
| King George County | 94.0% | 3.3% | 1.5% | 0.7% | 0.5% |
| Spotsylvania County | 86.3% | 9.1% | 2.4% | 1.3% | 1.0% |
| Stafford County | 82.0% | 11.3% | 3.2% | 1.8% | 1.7% |
| **MWHC Additional Service Area** | | | | | |
| Orange County | 93.7% | 3.4% | 2.4% | 0.4% | 0.2% |
| Prince William County | 63.6% | 20.1% | 6.7% | 4.4% | 5.2% |
| Westmoreland County | 94.2% | 4.4% | 1.1% | 0.3% | 0.0% |

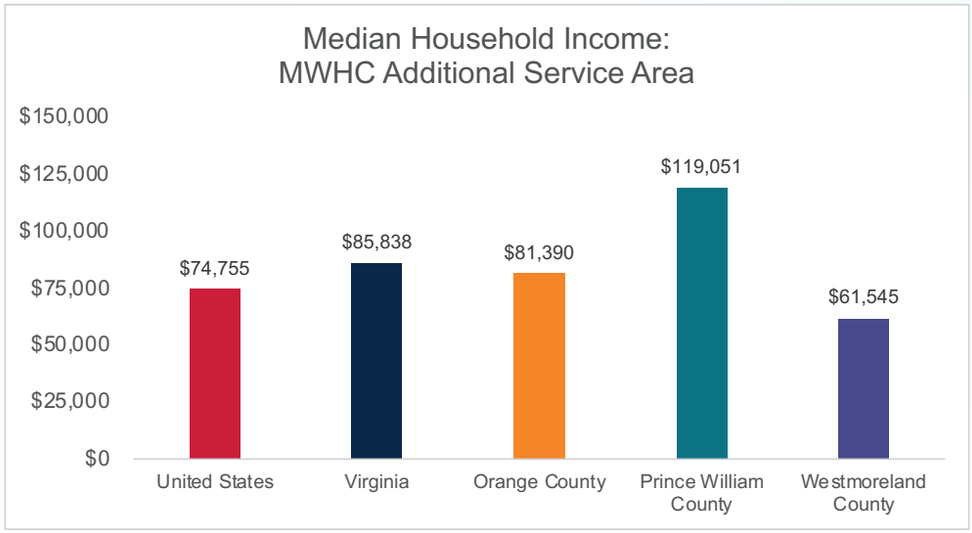
[9] US Census Bureau, American Community Survey, 2023.

## Median Household Income

Median household incomes vary across localities. Within RAHD, Caroline and Fredericksburg are below both the U.S. and Virginia figures. King George and Spotsylvania's median household incomes are above the Virginia average, and Stafford's median income exceeds the state average by nearly $50,000.

It is worth noting that Stafford has the highest number of persons per household in PD16, with 3.06 persons per household. The next highest is Spotsylvania with 2.80 persons per household. These larger households may provide additional context to the income levels in Stafford: when it comes to per capita income in 2023, Fredericksburg, King George, Spotsylvania, and Stafford all have similar per capita incomes, between $46,500 and $52,000. Caroline is lower, at $38,847 per capita[10].




[11]

[10] US Census Bureau, American Community 5-Year Estimates, 2019-2023
[11] US Census Bureau, American Community Survey 5-year Estimates, 2018-22.

## 2 – Health Status

### Life Expectancy

Stafford, Spotsylvania, and King George are above the Virginia life expectancy of 78.1 years, and Caroline and Fredericksburg's life expectancies are below this threshold.

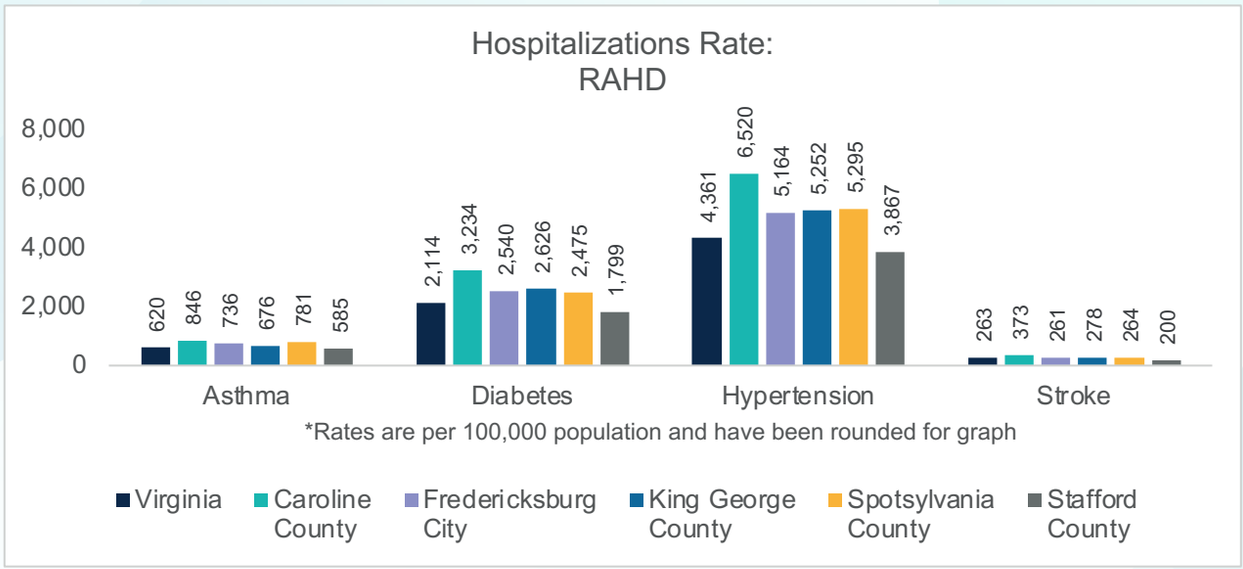
| | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|
| Life Expectancy[12] | Virginia | Caroline County | Fredericksburg City | King George County | Spotsylvania County | Stafford County | Orange County | Prince William County | Westmoreland County |
| Overall | 78.1 | 75.7 | 74.5 | 78.2 | 78.8 | 79.4 | 76.5 | 81.0 | 76.0 |
| Asian, non-Hispanic | * | * | * | * | 88.6 | 86.9 | * | 85.9 | * |
| Black/African American, non-Hispanic | * | 75.9 | 70.9 | 76.6 | 79.3 | 77.2 | 71.7 | 78.5 | 74.8 |
| Hispanic | * | 80.5 | 81.1 | 83.0 | 83.1 | 83.4 | 95.2 | 84.3 | * |
| White, non-Hispanic | * | 74.9 | 75.2 | 78.0 | 77.9 | 79.3 | 76.8 | 80.5 | 75.9 |

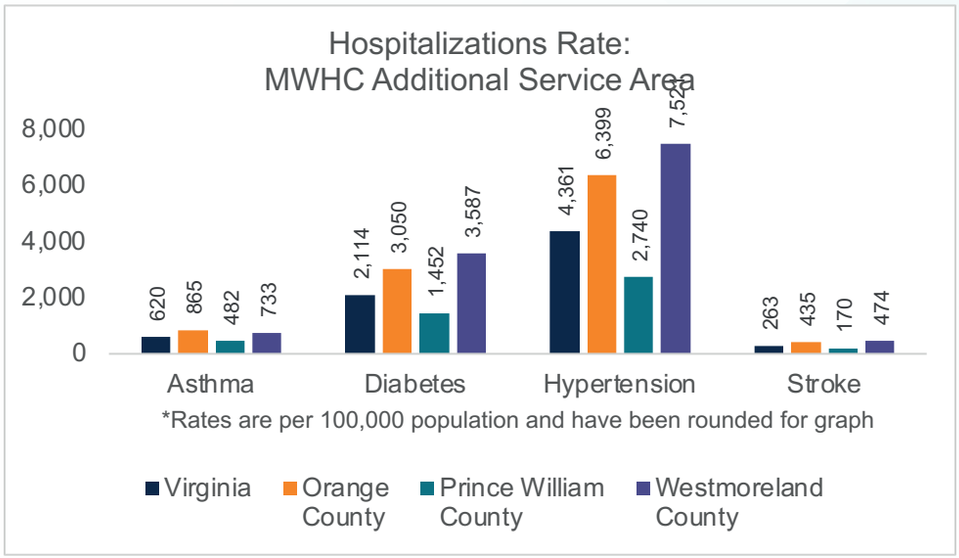
* Data are unavailable


[12] National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program, 2019-2021.

## Hospitalizations

Hospitalization rates vary both by locality and condition. Within RAHD, most localities had higher hospitalization rates across conditions compared to Virginia's. Caroline's hospitalization rates for all selected conditions shown here are higher than the rest of PD16, while Stafford's hospitalization rates are lower across conditions.




[13]

[13] VDH Inpatient Discharge Dataset, 2022. Data obtained via email.

## Injury & Violence

RAHD's overall injury hospitalization rate is below the state average, but the health district is higher than the state on ten of sixteen specific injury indicators, including adult or child abuse, animal bites and stings, drowning, non-drug poisoning, fire, and motor vehicle related injuries.

| Injury & Violence Hospitalizations Rate (per 100,000 population)[14] | Virginia | RAHD (PD16) |
|---|---|---|
| All Injury | 421.0 | 407.6 |
| Adult or child abuse | 2.4 | 3.4 |
| Animal bites and stings | 3.2 | 7.1 |
| Assault | 10.1 | 9.1 |
| Drowning | 0.2 | 0.3 |
| Firearm (all intents) | 9.7 | 5.7 |
| Self-harm | 28.1 | 28.5 |
| Nondrug poisoning | 4.7 | 5.5 |
| Traumatic brain injury | 64.0 | 52.8 |
| Falls (unintentional) | 230.7 | 220.7 |
| Fire (unintentional) | 2.6 | 2.9 |
| All motor vehicle traffic (unintentional) | 51.6 | 54.8 |
| Motor vehicle traffic - motorcyclists (unintentional) | 7.2 | 9.1 |
| Motor vehicle traffic - occupant (unintentional) | 37.9 | 40.0 |
| Motor vehicle traffic – pedal cyclist (unintentional) | 2.0 | 2.4 |
| Motor vehicle traffic - pedestrian (unintentional) | 4.7 | 3.9 |

Data points where PD16 and other MWHC Service Area localities fare worse than the Virginia average are in gray.

[14] VDH Injury and Violence Hospitalizations, 2023.

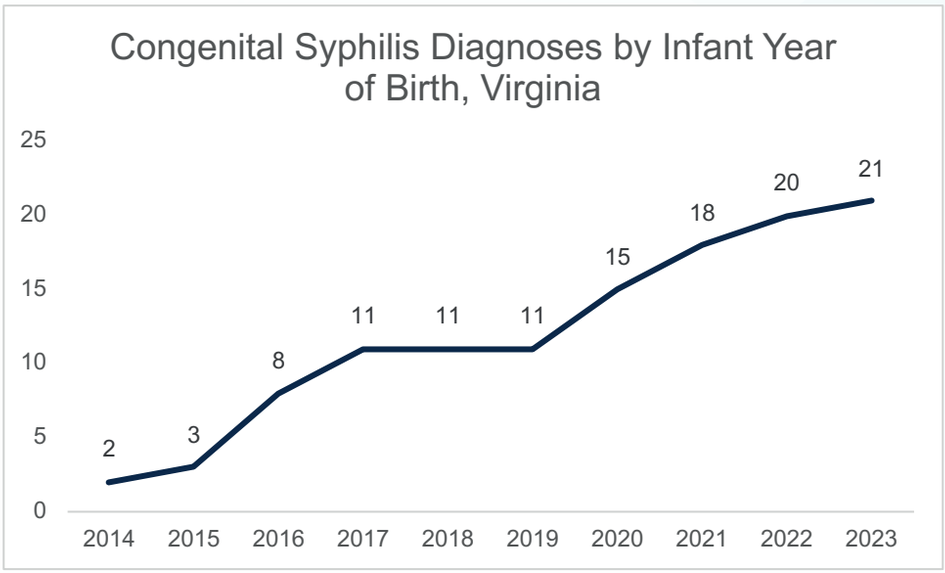
## STIs

In 2023, rates of new HIV diagnoses exceeded the state average in King George and Stafford. Rates of new chlamydia and gonorrhea cases were highest in Fredericksburg, while rates of early syphilis were highest in Caroline.

Trends for chlamydia decreased overall from 2019-2023 in PD16, while trends for gonorrhea and HIV increased over this time period and new early syphilis cases remained about the same. Importantly, the years captured for the trends were 2019-2023 which were the peak COVID-19 pandemic years, which may have affected the number of individuals seeking testing, identified, and connected to treatment.

Congenital syphilis cases have steadily increased in Virginia from 2014 to 2023. While rates remain relatively low compared to other STIs, any cases are notable because congenital syphilis can cause serious health problems for infants and is entirely preventable through testing and treatment during pregnancy.

| | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|
| **New Diagnoses in 2023, Rates per 100,000[16]** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| HIV | 10.0 | 3.2 | 7.1 | 18.2 | 2.8 | 13.7 | 5.4 | 7.4 | 16.0 |
| Chlamydia | 473.5 | 438.1 | 678.1 | 258.5 | 338.1 | 336.6 | 342.2 | 403.1 | 422.2 |
| Gonorrhea | 159.4 | 125.2 | 215.6 | 114.9 | 109.1 | 97.9 | 71.1 | 125.3 | 128.3 |
| Early Syphilis | 20.7 | 25.0 | 20.9 | 14.4 | 10.9 | 8.0 | 13.3 | 16.2 | 10.7 |




[17]

[16] VDH Disease Prevention - HIV & STDs, Data and Reports, 2023.
[17] VDH Disease Prevention - HIV & STDs, Data and Reports, 2023.

## Maternal & Child Health

Maternal and child health metrics for much of RAHD are worse than those for Virginia. Infant mortality rates and low birthweight deliveries are particularly concerning, as these measures indicate additional health concerns and disparities for both the mother and child. Virginia's infant mortality rate per 1,000 live births was 6.20. The only locality below this rate was Stafford (5.40). Virginia's low birthweight deliveries rate, by percent, is 8.50%. All localities were at or above this percentage. Similarly, racial disparities are present across these measures; however, some of this data is suppressed at the locality level due to low counts.

Low birthweight rates are higher among Black non-Hispanic infants in all localities. In Caroline, Hispanic infants have the highest low birthweight rate of all groups for which data is available.

| | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|
| **Indicator[18]** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Infant Mortality Rate (Per 1,000 Live Births) | 6.20 | 8.70 | 8.00 | 7.20 | 9.30 | 5.40 | 10.40 | 5.30 | 5.70 |
| Low Birthweight Deliveries (%) | 8.50% | 10.10% | 11.50% | 9.40% | 7.90% | 8.50% | 6.70% | 7.60% | 9.70% |
| Teen Pregnancy Rate (Per 1,000 Females Ages 15-19) | 15.60 | 21.00 | 33.30 | 8.10 | 10.70 | 7.20 | 24.50 | 14.40 | 31.60 |
| Preterm Births (%) | 9.60% | 12.50% | 12.00% | 10.50% | 10.60% | 9.80% | 8.40% | 8.90% | 12.60% |
| Late or No Prenatal Care (%) | 5.10% | 5.70% | 3.70% | 3.00% | 4.60% | 4.40% | 6.20% | 10.60% | 2.40% |
| Maternal Smoking (%) | 3.20% | 7.20% | 1.90% | 5.40% | 3.80% | 2.30% | 6.30% | 0.50% | 7.40% |

| | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|
| **Infant Mortality Rate (per 1,000 Live Births)** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| American Indian or Alaska Native, Non-Hispanic | 6.9 | * | No births | No births | 0.0 | 0.0 | No births | 0.0 | 0.0 |
| Asian or Pacific Islander, Non-Hispanic | 3.2 | 0.0 | 0.0 | 0.0 | * | 0.0 | 0.0 | 5.9 | 0.0 |
| Black, Non-Hispanic | 12.1 | * | * | * | 24.6 | * | 0.0 | 7.6 | * |
| Hispanic (All Races) | 6.1 | 0.0 | * | 0.0 | * | * | 0.0 | 7.4 | 0.0 |
| Unknown/Not Reported | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| White, Non-Hispanic | 4.9 | * | * | * | * | 6.8 | 14.2 | * | 0.0 |

* Data with counts less than 5 are suppressed to protect privacy

| | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|
| **Low Birthweight Deliveries (%)** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| American Indian or Alaska Native, Non-Hispanic | 7.6% | No births | No births | No births | 0.0% | 0.0% | No births | * | 0.0% |
| Asian or Pacific Islander, Non-Hispanic | 9.3% | * | * | 0.0% | 12.7% | 6.2% | 0.0% | 7.2% | 0.0% |
| Black, Non-Hispanic | 14.2% | 11.3% | 15.2% | 12.8% | 12.0% | 10.4% | 14.0% | 11.2% | * |
| Hispanic (All Races) | 7.4% | 16.1% | 10.4% | * | 8.7% | 6.8% | * | 7.5% | * |
| Unknown/Not Reported | 8.0% | * | 23.8% | 0.0% | * | 8.4% | 0.0% | 7.1% | 0.0% |
| White, Non-Hispanic | 6.6% | 8.5% | 8.0% | 9.8% | 6.3% | 8.8% | 6.2% | 5.6% | 10.1% |

* Data with counts less than 5 are suppressed to protect privacy

[18] VDH Maternal & Child Health, 2022.

## Mental & Physical Health

All PD16 localities performed worse than Virginia and the US averages when it comes to adults with poor mental health and adults with frequent mental distress. Spotsylvania, Stafford, and King George are above the state average on physical health indicators.

| | | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator[19]** | **United States** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Adults with Poor Mental Health [Age-Adjusted] (%) | 16.40% | 17.20% | 18.80% | 18.80% | 17.50% | 17.60% | 16.60% | 19.10% | 16.00% | 19.40% |
| Adults with Frequent Mental Distress [Crude] (%) | 15.80% | 16.50% | 17.80% | 20.30% | 16.90% | 16.90% | 16.50% | 17.30% | 16.00% | 17.10% |
| Adults with Poor or Fair Health [Age-Adjusted] (%) | 17.00% | 16.00% | 18.60% | 18.60% | 15.80% | 15.40% | 14.60% | 17.50% | 15.70% | 21.80% |
| Adults with Poor Physical Health Days [Age-Adjusted] (%) | 12.00% | 11.80% | 13.60% | 13.40% | 11.80% | 11.70% | 10.80% | 13.00% | 11.10% | 15.20% |

[19] CDC Behavioral Risk Factor Surveillance System (BRFSS), 2022.

## Uninsured & Access to Care

Uninsured percentages across the localities are roughly consistent with US (10%) and Virginia (8%) figures. The percentage of the population uninsured is lower than the state average in Stafford and King George, and higher in Caroline and Fredericksburg.

The ratio of populations per primary care, dentists, and mental health providers are very high in all counties, though there are a greater number of providers relative to the population in Fredericksburg. Ratios of mental health providers have improved in all localities since the 2022 CHA. Slight improvements were observed in the number of dental providers, but primary care physician ratios have worsened in all counties, although improved in Fredericksburg since the 2022 CHA.

| | | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **United States** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Uninsured (%)[20] | 10% | 8% | 9% | 10% | 6% | 8% | 6% | 9% | 10% | 10% |
| Primary Care Physicians (population per provider)[21] | 1,330 | 1,340 | 10,440 | 570 | 4,580 | 2,080 | 3,830 | 2,190 | 2,260 | 4,680 |
| Dentists (population per provider)[22] | 1,360 | 1,330 | 3,990 | 490 | 2,140 | 2,220 | 2,820 | 3,170 | 1,590 | 9,360 |
| Mental Health Providers (population per provider)[23] | 320 | 410 | 2,130 | 120 | 1,390 | 870 | 960 | 1,460 | 610 | 9,360 |

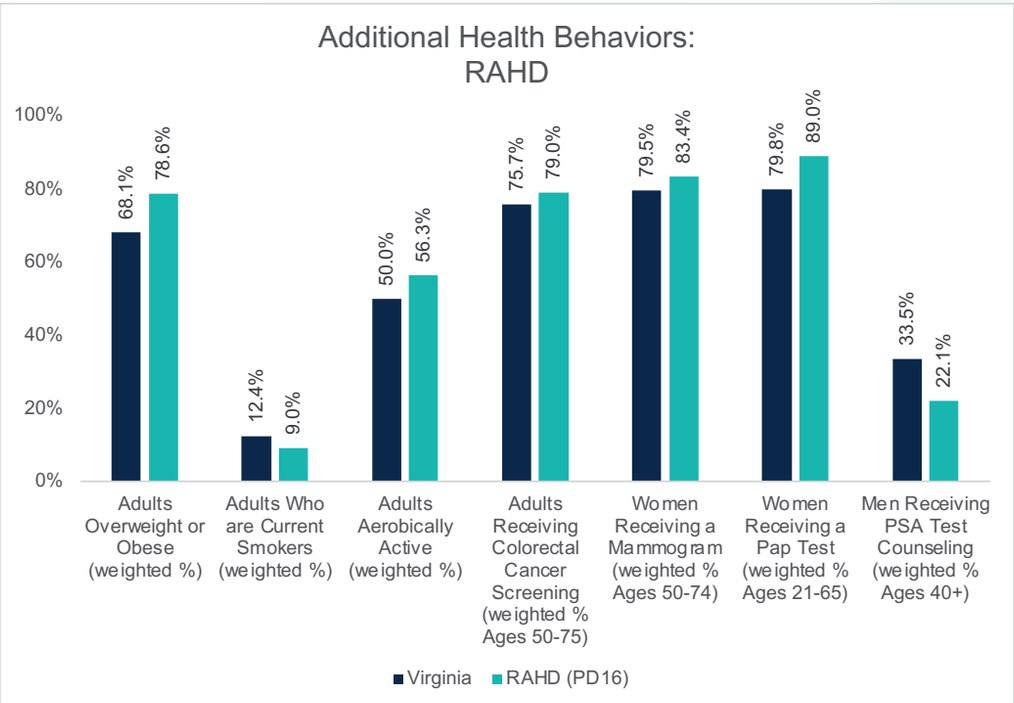
[20] US Census Bureau Small Area Health Insurance Estimates, 2021. Accessed via County Health Rankings and Roadmaps.
[21] Area Health Resource File/American Medical Association, 2021. Accessed via County Health Rankings and Roadmaps.
[22] Area Health Resource File/National Provider Identified Downloadable File, 2022. Accessed via County Health Rankings and Roadmaps.
[23] CMS, National Provider Identification, 2023. Accessed via County Health Rankings and Roadmaps.

## Health Behaviors

The percentage of adults 18+ was relatively close to the Virginia figures for binge drinking, current smoking, insufficient sleep, and no physical activity. Caroline and Fredericksburg had higher percentages for current smoking compared to both Virginia and the other localities. Except for King George, every locality had a greater percentage of individuals reporting insufficient sleep than Virginia (36.8%). All localities had the percentage of adults 18+ reporting no physical activity as 19.7% or greater, meaning that nearly one in five adults reported they are not physically active.

Screening, testing, and counseling behaviors tended to be slightly better than the percentages listed for Virginia. The exception to this observation in RAHD is for the measure of "Men receiving PSA Test Counseling," with just 22.10% compared to Virginia's 33.50%.

| | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|
| Indicator[24] | Virginia | Caroline County | Fredericksburg City | King George County | Spotsylvania County | Stafford County | Orange County | Prince William County | Westmoreland County |
| Adults 18+ Binge Drinking (Age-adjusted %) | 18.4% | 19.0% | 17.9% | 19.6% | 18.9% | 19.9% | 18.5% | 17.5% | 18.1% |
| Adults 18+ Current Smoking (Age-adjusted %) | 13.7% | 16.4% | 16.2% | 14.3% | 14.3% | 12.1% | 16.7% | 11.6% | 18.7% |
| Adults 18+ Insufficient Sleep (Age-adjusted %) | 36.8% | 39.1% | 40.5% | 34.9% | 41.1% | 37.6% | 39.2% | 38.1% | 40.1% |
| Adults 18+ No Physical Activity (Age-adjusted %) | 21.0% | 23.9% | 24.5% | 19.7% | 20.5% | 19.7% | 22.2% | 20.4% | 27.2% |




[25]

[24] VDH & CDC – Behavioral Risk Factor Surveillance Survey (BRFSS), 2020-2022.
[25] VDH & CDC – Behavioral Risk Factor Surveillance Survey (BRFSS), 2020-2022.

## Immunizations

Examination of immunization trends is focused on annual flu vaccines, measles, mumps, rubella (MMR), and tetanus, diphtheria, and pertussis (Tdap) vaccines for the purposes of this report.

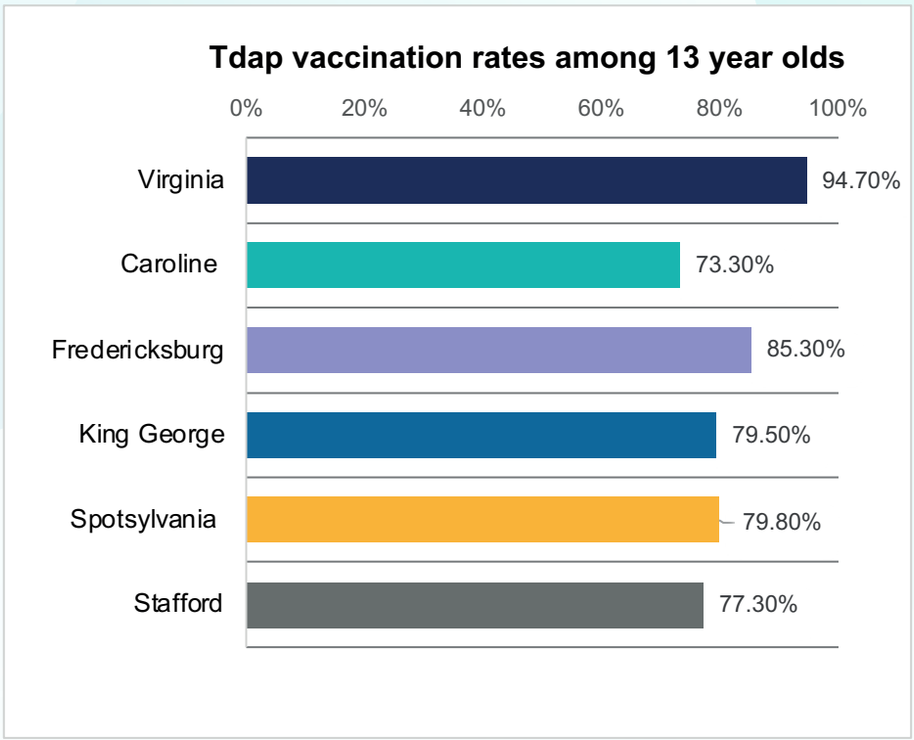
Annual flu vaccination rates are lower than the state average across all age groups and localities in RAHD. The lowest rates overall are seen in Caroline and King George.

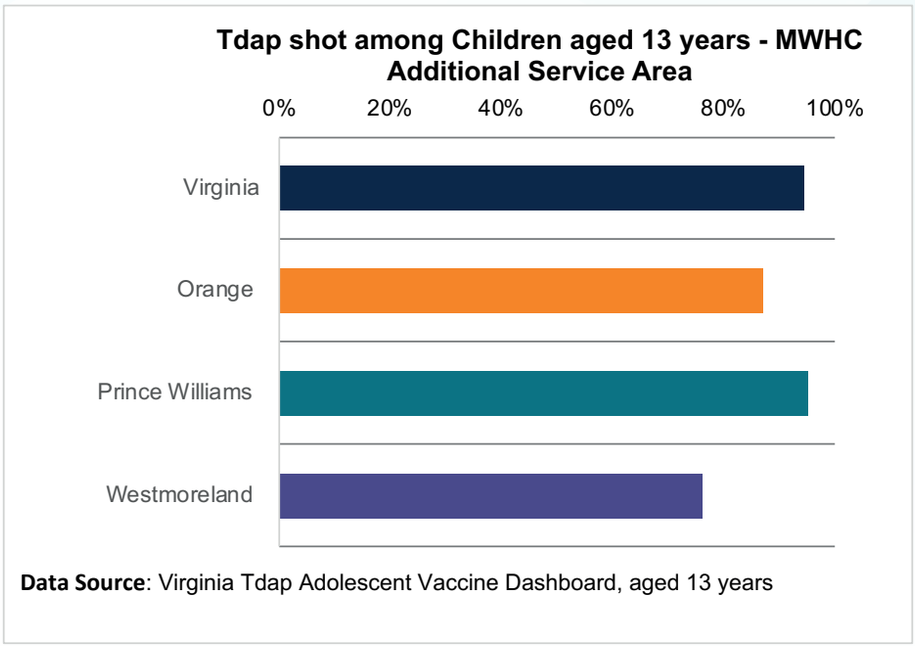
RAHD localities are also behind the state average on Tdap. Over the past year, RAHD has seen an elevated number of pertussis cases, which is particularly concerning as this disease can be deadly in young children.

A recent outbreak of measles in Texas at the time of this report has drawn interest in MMR vaccination rates. Statewide, Virginia has seen a decrease in children receiving their first dose of MMR by 24 months of age, from 95.3% for children born in 2019 to 86.7% for children born in 2021[26]. Two doses of MMR are a vaccine requirement among kindergarteners, and 90.0% of kindergarteners in PD16 school year were continued adequately immunized in the fall of 2024, slightly lower than the state average of 90.7%[27].

| | | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Age** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Flu Vaccination during 2024-2025 Flu Season[28] | 0 to 4 | 35.4% | 25.3% | 26.1% | 29.6% | 24.8% | 26.2% | 26.5% | 33.7% | 26.2% |
| | 5-11 | 28.0% | 11.6% | 16.4% | 17.3% | 14.6% | 18.1% | 17.9% | 27.6% | 14.1% |
| | 12 to 17 | 24.1% | 10.6% | 12.6% | 13.8% | 14.8% | 17.7% | 17.1% | 26.0% | 10.7% |
| | 18 to 30 | 18.1% | 7.9% | 8.3% | 9.8% | 11.8% | 13.0% | 11.9% | 17.3% | 9.4% |
| | 31 to 49 | 23.4% | 10.4% | 18.4% | 12.1% | 13.7% | 15.9% | 12.9% | 20.5% | 12.7% |
| | 50 to 64 | 33.5% | 21.4% | 30.4% | 21.3% | 24.9% | 28.0% | 23.7% | 32.2% | 22.9% |
| | 65 and above | 60.3% | 47.5% | 57.7% | 45.0% | 51.8% | 54.7% | 55.8% | 58.2% | 43.5% |
| | Overall | * | 19.6% | 22.0% | 20.0% | 22.3% | 23.2% | 25.5% | 28.7% | 23.8% |

[26] CDC, Vaccination Coverage among Young Children, ChildVaxView Interactive
[27] VDH, Virginia Student Immunization Status Survey, Fall 2024
[28] VDH, Virginia Respiratory Immunization Dashboards, accessed March 11, 2025




**Data Source**: Virginia Tdap Adolescent Vaccine Dashboard, aged 13 years

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[29]Virginia Tdap Adolescent Vaccine Dashboard, accessed March 11, 2025

## Vaping

Youth vaping was a concern raised in some community conversations. While data is limited at the health district or locality level, state data shows that the percentage of teens who have vaped in the past 30 days increases with age and is most common among white teens (4.7%) followed by Black teens (2.3%).

| | RAHD (PD16) | |
|---|---|---|
| **Indicator** | **Age** | **Virginia** |
| Vaping Among Youth (%)[30] | <15 Years | 1.0% |
| | 16 - 17 Years | 4.3% |
| | >18 Years | 8.4% |
| | **Race** | **Virginia** |
| | Asian | 0.0% |
| | Multiple Races | 1.7% |
| | Hispanic/Latino | 1.7% |
| | Black | 2.3% |
| | White | 4.7% |

[30] Virginia Youth Survey, 2023

## Social Determinants of Health

When it comes to social determinants of health, the greatest variation was seen within the poverty measures, with Fredericksburg seeing the largest percentage of the population below the Federal Poverty Line (FPL), followed by Caroline. Nearly one in three children in Fredericksburg live in poverty, and nearly one in four children in Caroline.

A notably smaller percentage of White and Asian populations tended to fall below 100% of the FPL compared to other race categories. Additionally, Hispanic or Latino populations generally had a larger percentage living below 100% FPL compared to Not Hispanic or Latino populations, with less disparity than seen among race categories.

| | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|
| **Indicator** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| Households with No Motor Vehicle (%) | 6.07% | 5.01% | 9.24% | 1.78% | 3.09% | 1.92% |
| Population Below 100% FPL (%) | 9.98% | 11.57% | 18.03% | 6.93% | 7.35% | 5.38% |
| Children in Poverty (% < Age 18) | 12.81% | 18.23% | 31.61% | 8.52% | 10.22% | 6.42% |
| Cost-burdened Households (%) [Housing is 30% or more of total household income] | 30.51% | 24.55% | 33.19% | 23.85% | 25.96% | 23.65% |
| Income Inequality [GINI Index] | 0.4724 | 0.4114 | 0.4579 | 0.3861 | 0.4049 | 0.3752 |
| Social Vulnerability Index | 0.39 | 0.40 | 0.76 | 0.05 | 0.27 | 0.24 |
| Food Insecurity | 11.1% | 9.8% | 14.5% | 8.6% | 8.8% | 7.3% |

| | | MWHC Additional Service Area | | |
|---|---|---|---|---|
| **Indicator** | **Virginia** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Households with No Motor Vehicle (%) | 6.07% | 3.86% | 2.35% | 6.09% |
| Population Below 100% FPL (%) | 9.98% | 12.99% | 6.05% | 16.04% |
| Children in Poverty (% < Age 18) | 12.81% | 21.10% | 7.79% | 21.95% |
| Cost-burdened Households (%) [Housing is 30% or more of total household income] | 30.51% | 21.62% | 29.35% | 31.51% |
| Income Inequality [GINI Index][31] | 0.4724 | 0.4089 | 0.3921 | 0.4876 |
| Social Vulnerability Index[32] | 0.39 | 0.26 | 0.41 | 0.82 |
| Food Insecurity[33] | 11.1% | 12.1% | 7.7% | 12.9% |

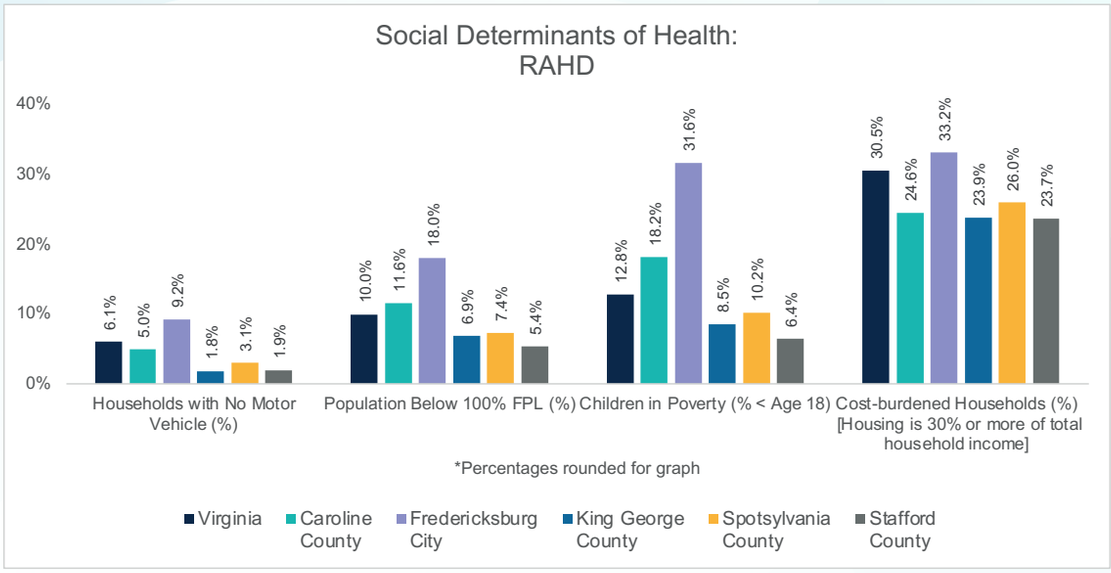
| | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|
| **Population Below FPL by Race & Ethnicity (%)[34]** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| White | 7.99% | 9.41% | 11.68% | 6.56% | 4.83% | 3.55% |
| Black or African American | 16.52% | 13.67% | 28.06% | 6.78% | 13.26% | 6.27% |
| American Indian or Alaska Native | 11.71% | 78.86% | 0.00% | 48.00% | 17.72% | 0.00% |
| Asian | 6.95% | 0.00% | 12.69% | 5.35% | 12.40% | 9.70% |
| Native Hawaiian or Pacific Islander | 9.91% | * | * | * | 27.38% | 36.84% |
| Some Other Race | 16.85% | 21.61% | 37.24% | 11.00% | 18.86% | 8.21% |
| Multiple Races | 10.25% | 16.43% | 25.30% | 8.91% | 6.75% | 10.95% |
| Hispanic or Latino | 13.15% | 23.46% | 18.50% | 11.76% | 11.94% | 11.72% |
| Not Hispanic or Latino | 9.63% | 10.94% | 17.97% | 6.60% | 6.76% | 4.26% |

* No data

[31]U.S. Census Bureau, American Community Survey, 2018-22.
[32]Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC – GRASP, 2022.
[33]Feeding America: Map the Meal Gap, 2022.
[34]U.S. Census Bureau, American Community Survey, 2018-22.

## Social Determinants of Health

| Population Below FPL by Race & Ethnicity (%)[35] | Virginia | MWHC Additional Service Area | | |
|---|---|---|---|---|
| | | Orange County | Prince William County | Westmoreland County |
| White | 7.99% | 8.49% | 5.00% | 16.77% |
| Black or African American | 16.52% | 41.06% | 5.69% | 15.53% |
| American Indian or Alaska Native | 11.71% | 0.00% | 4.35% | 66.67% |
| Asian | 6.95% | 1.47% | 6.62% | 0.00% |
| Native Hawaiian or Pacific Islander | 9.91% | * | 0.00% | * |
| Some Other Race | 16.85% | 1.20% | 14.98% | 7.49% |
| Multiple Races | 10.25% | 19.71% | 4.71% | 19.00% |
| Hispanic or Latino | 13.15% | 13.34% | 11.27% | 7.86% |
| Not Hispanic or Latino | 9.63% | 12.97% | 4.32% | 16.65% |

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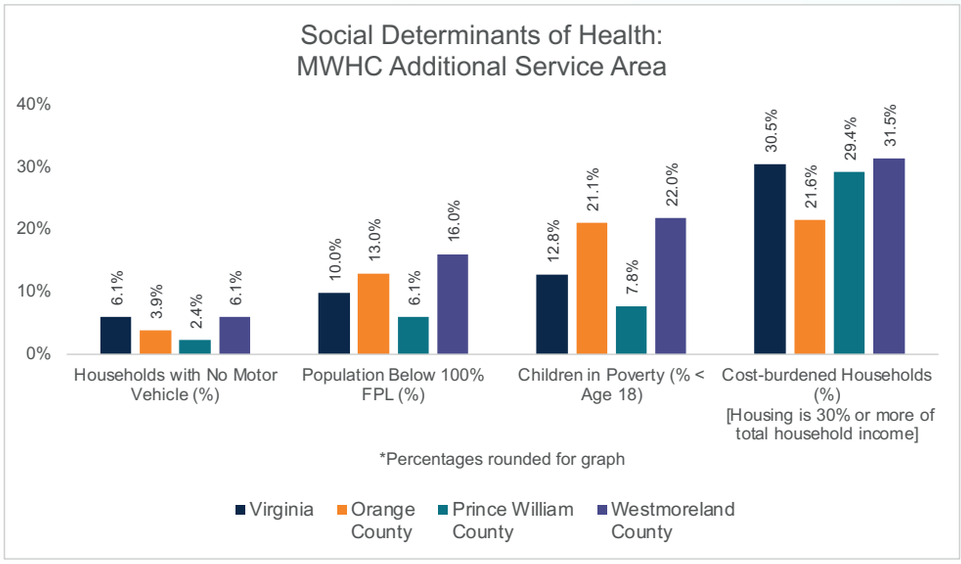


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[35] U.S. Census Bureau, American Community Survey, 2018-22.
[36] U.S. Census Bureau, American Community Survey, 2018-22.
[37] U.S. Census Bureau, American Community Survey, 2018-22.

## Housing

Housing was identified as a priority issue in the 2022 CHA/CHIP, and data shows this continues to be an issue for many residents. All localities, except for Fredericksburg, have a higher owner-occupied housing unit rate than Virginia (67.20%). Fredericksburg's rate was 41.60%, while the remaining localities ranged from 74.40% to 81.70%. Similarly, all localities, except for Fredericksburg, had severe housing problems percentages near or below Virginia's (14%). Fredericksburg lists severe housing problems of 20%, while the remaining localities range from 9% to 15%. Housing continues to be a major concern for this area, particularly as the region's population increases.

Median home sales prices as of December 2024 ranged from $365,900 in Caroline to $525,000 in Stafford. The Fredericksburg Area Association of Realtors reports that median home prices are up 55% since 2020.The median income needed to afford median home sales price ranged from $80,981 in Caroline to $116,193 in Stafford. The average asking rent ranged from $1,414 in King George to $1,847 in Stafford. The minimum income to afford the average asking rent ranged from $56,560 in King George to $73,880 in Stafford. Housing costs, whether to rent or own, will likely continue to increase in the years to come. If so, the minimum income needed to afford housing throughout our region will need to increase as well.

| | | RAHD (PD16) | | | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|---|---|---|---|
| **Indicator[38]** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Owner-occupied housing unit rate (2019-2023) | 67.20% | 81.70% | 41.60% | 76.10% | 79.60% | 80.80% | 77.80% | 74.40% | 79.10% |
| Severe housing problems (Percent of households with at least 1 of 4 housing problems: overcrowding, severe housing cost burden, lack of kitchen facilities, lack of plumbing) | 14% | 9% | 20% | 10% | 12% | 10% | 11% | 14% | 15% |

| | RAHD (PD16) | | | | |
|---|---|---|---|---|---|
| **Indicator[39]** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| Median home sales price | $365,900 | $449,999 | $465,00 | $454,000 | $525,000 |
| Minimum income needed to afford median sales price | $80,981 | $99,594 | $102,914 | $100,479 | $116,193 |
| Average asking rent | $1,493 | $1,725 | $1,414 | $1,780 | $1,847 |
| Minimum income needed to afford average asking rent | $59,720 | $71,840 | $56,560 | $71,200 | $73,880 |

[38] U.S. Census Bureau; Comprehensive Housing Affordability Strategy (CHAS) Data, U.S. Department of Housing and Urban Development, 2016-2020.

[39] Fredericksburg Area Association of Realtors, Fredericksburg Area Housing Gap Analysis and Fact Sheets, Dec. 2024

## Built Environment

The Food Environment Index lists factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). Virginia and the localities score well on this index. Access to exercise opportunities varied greatly across localities, ranging from 59% in Caroline to 100% in Fredericksburg. As will be discussed further in this assessment, access to a healthy food environment and exercise opportunities do not necessarily translate into healthy behaviors. Often, the barriers to engaging in healthy behaviors are more pervasive in a community and must be addressed beyond providing access to better choices. For instance, all localities reported that 65% or more of those who drive to work do so alone. Further, all localities, except for Fredericksburg, reported that at least 50% of those who drive alone also had a long commute (greater than 30 minutes). Such rates lay the groundwork for potential isolation and sedentary lifestyles.

| | | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **United States** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| Food Environment Index[40] | 9.1 | 9.0 | 9.3 | 8.2 | 9.6 | 9.1 | 9.5 |
| Access to Exercise Opportunities (%)[41] | 80% | 84% | 59% | 100% | 69% | 84% | 83% |
| Average Daily Air Pollution (PM2.5)[42] | 7.4 | 7.3 | 7.9 | 7.9 | 7.7 | 8.0 | 8.1 |
| Drive Alone to Work (%)[43] | 72% | 71% | 77% | 65% | 78% | 73% | 67% |
| Drives Alone & Long Commute (%)[44] | 36% | 40% | 64% | 40% | 51% | 50% | 54% |

| | | | MWHC Additional Service Area | | |
|---|---|---|---|---|---|
| **Indicator** | **United States** | **Virginia** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Food Environment Index[45] | 9.1 | 9.0 | 8.0 | 9.5 | * |
| Access to Exercise Opportunities (%)[46] | 80% | 84% | 58% | 97% | 22% |
| Average Daily Air Pollution (PM2.5)[47] | 7.4 | 7.3 | 7.7 | 8.5 | 7.4 |
| Drive Alone to Work (%)[48] | 72% | 71% | 75% | 68% | 75% |
| Drives Alone & Long Commute (%)[49] | 36% | 40% | 57% | 64% | 53% |

* Data are unavailable

[40] USDA Food Environment Atlas; Map the Meal Gap from Feeding America (2019 & 2020).
[41] ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles (2023, 2022, & 2020).
[42] Environmental Public Health Tracking Network (2019).
[43] American Community Survey, 5-year estimates (2018-2022).
[44] American Community Survey, 5-year estimates (2018-2022).
[45] USDA Food Environment Atlas; Map the Meal Gap from Feeding America (2019 & 2020).
[46] ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles (2023, 2022, & 2020).
[47] Environmental Public Health Tracking Network (2019).
[48] American Community Survey, 5-year estimates (2018-2022).
[49] American Community Survey, 5-year estimates (2018-2022).

## Adult Educational Attainment

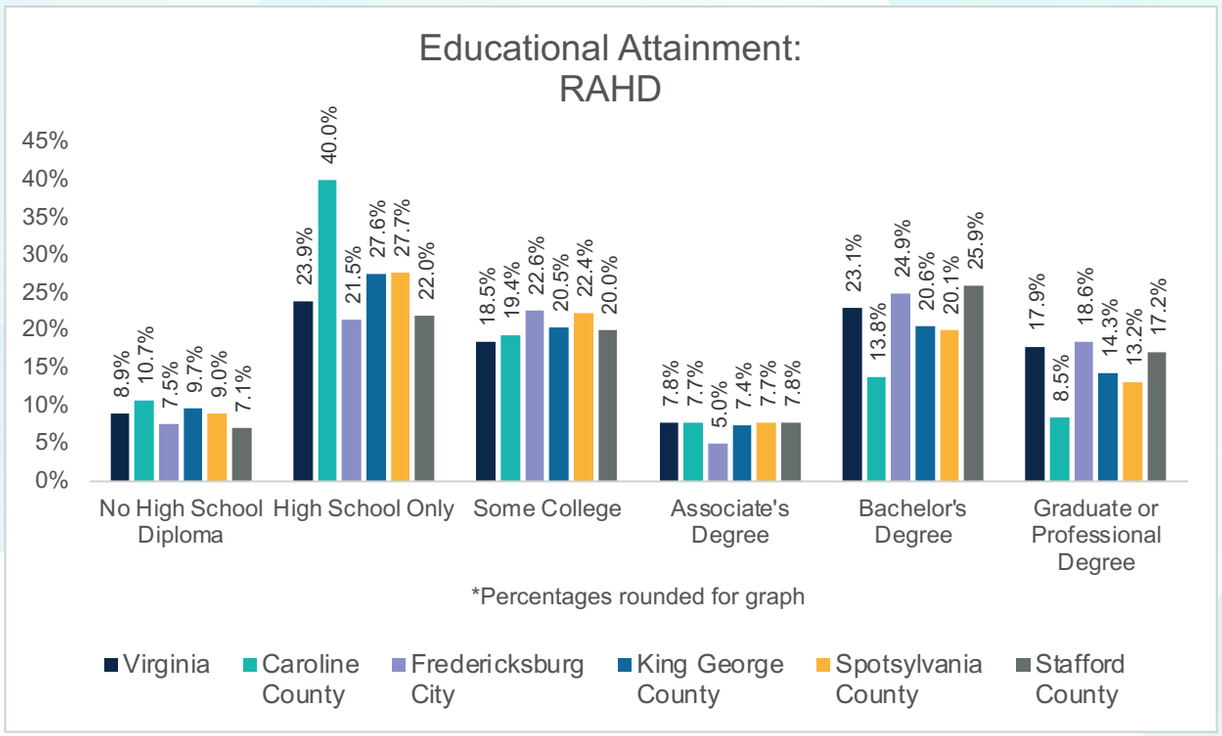
The more rural localities of Caroline, King George, and Spotsylvania had higher percentages of their populations with educational attainment of no high school diploma or high school only, compared to both the Virginia figures and the other localities. Parity between the more rural and more urban localities is exhibited for educational attainment of associate's degree and some college, with percentages around that of Virginia's. The more urban localities of Fredericksburg and Stafford had percentages of educational attainment near or above the Virginia figures for bachelor's degree and graduate or professional degree.

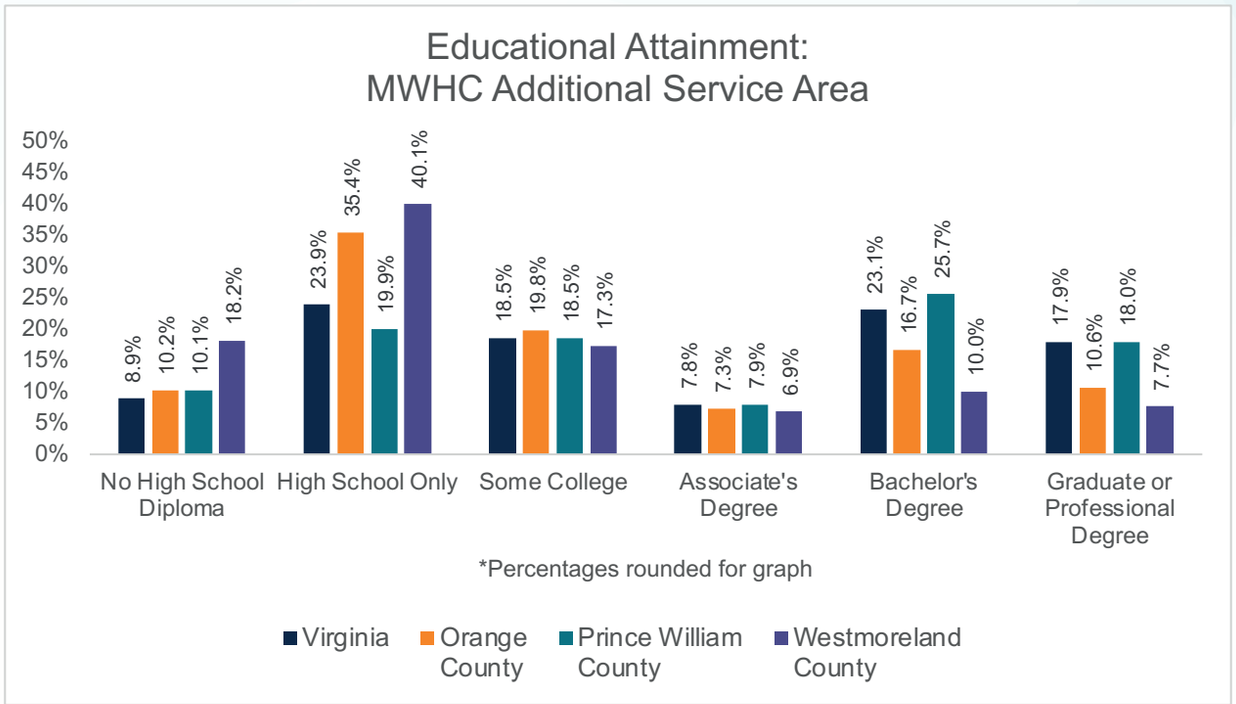
According to several studies, adults with higher educational attainment live healthier and longer lives compared to their less educated peers. The positive association between educational attainment and health outcomes/lifespan is well documented.

| | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|
| Indicator[50] | Virginia | Caroline County | Fredericksburg City | King George County | Spotsylvania County | Stafford County |
| No High School Diploma | 8.90% | 10.70% | 7.50% | 9.70% | 9.00% | 7.10% |
| High School Only | 23.90% | 40.00% | 21.50% | 27.60% | 27.70% | 22.00% |
| Some College | 18.50% | 19.40% | 22.60% | 20.50% | 22.40% | 20.00% |
| Associate's degree | 7.80% | 7.70% | 5.00% | 7.40% | 7.70% | 7.80% |
| Bachelor's Degree | 23.10% | 13.80% | 24.90% | 20.60% | 20.10% | 25.90% |
| Graduate or Professional Degree | 17.90% | 8.50% | 18.60% | 14.30% | 13.20% | 17.20% |

| | | MWHC Additional Service Area | | |
|---|---|---|---|---|
| Indicator | Virginia | Orange County | Prince William County | Westmoreland County |
| No High School Diploma | 8.90% | 10.20% | 10.10% | 18.20% |
| High School Only | 23.90% | 35.40% | 19.90% | 40.10% |
| Some College | 18.50% | 19.80% | 18.50% | 17.30% |
| Associate's degree | 7.80% | 7.30% | 7.90% | 6.90% |
| Bachelor's Degree | 23.10% | 16.70% | 25.70% | 10.00% |
| Graduate or Professional Degree | 17.90% | 10.60% | 18.00% | 7.70% |

[50] U.S. Census Bureau, American Community Survey, 2018-22.


Educational Attainment:
RAHD
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
8.9% 10.7% 7.5% 9.7% 9.0% 7.1%
23.9% 40.0% 21.5% 27.6% 27.7% 22.0%
18.5% 19.4% 22.6% 20.5% 22.4% 20.0%
7.8% 7.7% 5.0% 7.4% 7.7% 7.8%
23.1% 13.8% 24.9% 20.6% 20.1% 25.9%
17.9% 8.5% 18.6% 14.3% 13.2% 17.2%
No High School Diploma
High School Only
Some College
Associate's Degree
Bachelor's Degree
Graduate or Professional Degree
*Percentages rounded for graph
Virginia
Caroline County
Fredericksburg City
King George County
Spotsylvania County
Stafford County


Educational Attainment:
MWHC Additional Service Area
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
8.9% 10.2% 10.1% 18.2%
23.9% 35.4% 19.9% 40.1%
18.5% 19.8% 18.5% 17.3%
7.8% 7.3% 7.9% 6.9%
23.1% 16.7% 25.7% 10.0%
17.9% 10.6% 18.0% 7.7%
No High School Diploma
High School Only
Some College
Associate's Degree
Bachelor's Degree
Graduate or Professional Degree
*Percentages rounded for graph
Virginia
Orange County
Prince William County
Westmoreland County

## 3 – Health Outcomes

### Disease Prevalence

RAHD is above the state average for many chronic diseases. This elevated rate is particularly pronounced in Caroline and Fredericksburg, although King George and Spotsylvania see the highest incidence of cancer. Spotsylvania and Stafford see high rates of high cholesterol, and all counties other than King George are above the state average for obesity rates. **High blood pressure** is above the state level for all localities.

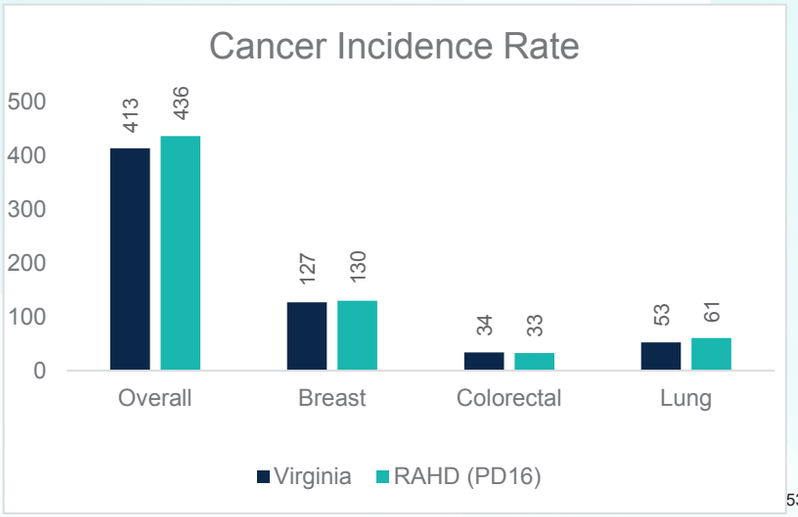
| | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|
| **Health Outcomes** | **State of Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| Cancer | 7.00% | 6.70% | 6.90% | 7.30% | 7.20% | 7.00% |
| Chronic Kidney Disease | 2.70% | 2.90% | 2.80% | 2.70% | 2.70% | 2.60% |
| Chronic Obstructive Pulmonary Disease* | 6.00% | 7.40% | 7.20% | 6.30% | 6.00% | 4.90% |
| Coronary Heart Disease | 5.40% | 6.10% | 6.10% | 5.60% | 5.40% | 5.00% |
| Current Asthma | 10.00% | 11.00% | 10.70% | 10.20% | 10.20% | 9.90% |
| Depression | 23.00% | 24.90% | 24.40% | 23.30% | 23.40% | 21.90% |
| Diabetes | 11.40% | 12.40% | 12.90% | 10.90% | 11.60% | 11.00% |
| High Blood Pressure * | 31.50% | 33.20% | 32.40% | 32.20% | 32.30% | 31.80% |
| High Cholesterol | 32.80% | 31.90% | 30.70% | 31.60% | 34.00% | 33.20% |
| Obesity | 35.30% | 41.60% | 38.20% | 35.20% | 38.30% | 37.00% |
| Stroke[51] | 3.00% | 3.60% | 3.50% | 3.00% | 2.90% | 2.60% |
| Alzheimer's Disease (65+)[52] | 11.7% | 12.9% | 12.0% | 11.3% | 11.1% | 10.5% |

| | | MWHC Additional Service Area | | |
|---|---|---|---|---|
| **Health Indictors** | **State of Virginia** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Cancer | 7.00% | 7.50% | 6.50% | 7.00% |
| Chronic Kidney Disease | 2.70% | 2.70% | 2.70% | 3.10% |
| Chronic Obstructive Pulmonary Disease* | 6.00% | 6.80% | 5.10% | 8.60% |
| Coronary Heart Disease | 5.40% | 5.70% | 5.10% | 6.80% |
| Current Asthma | 10.00% | 10.50% | 9.30% | 11.20% |
| Depression | 23.00% | 25.50% | 20.90% | 25.90% |
| Diabetes | 11.40% | 11.00% | 11.60% | 13.60% |
| High Blood Pressure * | 31.50% | 31.60% | 31.20% | 35.20% |
| High Cholesterol | 32.80% | 31.80% | 31.90% | 32.30% |
| Obesity | 35.30% | 36.80% | 33.10% | 41.70% |
| Stroke | 3.00% | 3.10% | 2.80% | 4.10% |
| Alzheimer's Disease (65+) | 11.7% | 11.3% | 11.0% | 12.1% |

[51] CDC BRFSS, 2022. Accessed via the PLACES Data Portal.
[52] Dhana et al., Alzheimer's & Dementia, 2023.

## Cancer

Overall cancer rates in RAHD are 5.4% higher than the Virginia average. Breast cancer rates are 2.5% higher, colorectal cancer rates are 3.2% lower, and lung cancer rates are 15.4% higher.



[53]

[53] Virginia Department of Health, Inpatient Discharge Dataset from Virginia Health Information (VHI), 2016-2020

## Mortality Rate

Mortality rates provide the number of deaths in a population over a specific period of time, calculated by dividing the number of deaths by the total population. The mortality rate pattern varies across RAHD localities. As the table shows, heart disease causes the largest number of deaths of any examined condition, followed by malignant neoplasms (cancer). COVID-19 mortality rates are lower in all Planning District 16 counties compared to the statewide average in Virginia.

| | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|
| **Mortality Indicator[54]** | **State of Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| Malignant Neoplasms | 154.16 | 153.62 | 162.08 | 170.04 | 149.69 | 141.00 |
| Diseases of the heart | 174.96 | 169.82 | 196.50 | 148.55 | 140.99 | 139.77 |
| Injuries | 72.63 | 87.22 | 82.12 | 46.77 | 69.94 | 44.39 |
| Cerebrovascular Disease | 44.89 | 43.19 | 32.11 | 31.29 | 34.13 | 34.46 |
| Chronic Lower Respiratory Disease | 39.52 | 51.15 | 47.31 | 37.78 | 29.50 | 28.85 |
| Alzheimer's | 32.31 | 33.41 | 62.30 | 30.78 | 39.06 | 46.70 |
| Diabetes Mellitus | 33.80 | 29.93 | 38.93 | 30.23 | 24.23 | 20.82 |
| Nephritis or Nephrosis Syndromes | 19.62 | 26.57 | 35.48 | 25.93 | 23.41 | 20.85 |
| Septicemia | 12.76 | 12.29 | * | * | 8.64 | 8.27 |
| Suicide | 16.82 | 19.05 | 18.42 | 22.37 | 12.98 | 12.34 |
| Influenza or Pneumonia | 13.95 | 16.54 | * | * | 8.14 | 10.07 |
| Chronic Liver Disease | 16.10 | 21.36 | * | * | 10.60 | 9.67 |
| Parkinson's Disease | 12.75 | 13.83 | * | 17.31 | 12.02 | 10.90 |
| Primary Hypertension and/or renal disease | 13.54 | 19.30 | * | 16.20 | 12.43 | 12.88 |
| COVID-19 | 82.44 | 76.57 | 41.88 | 62.52 | 62.74 | 52.76 |

| | | MWHC Additional Service Area | | |
|---|---|---|---|---|
| **Mortality Indicator[55]** | **State of Virginia** | **Orange County** | **Prince William County** | **Westmoreland County** |
| Malignant Neoplasms | 154.16 | 184.6 | 128.76 | 169.22 |
| Diseases of Heart | 174.96 | 189.84 | 117.54 | 181.51 |
| Injuries | 72.63 | 95.58 | 37.17 | 84.54 |
| Cerebrovascular Disease | 44.89 | 37.12 | 33.74 | 44.31 |
| Chronic Lower Respiratory Disease | 39.52 | 36.71 | 25.15 | 34.34 |
| Alzheimer's | 32.31 | 40.63 | 20.49 | 35.42 |
| Diabetes Mellitus | 33.80 | 22.74 | 18.75 | 46.03 |
| Nephritis or Nephrosis Syndromes | 19.62 | 21.46 | 18.73 | 42.91 |
| Septicemia | 12.76 | 9.52 | 8.26 | 13.25 |
| Suicide | 16.82 | 22.06 | 9.41 | * |
| Influenza or Pneumonia | 13.95 | 10.27 | 10.11 | 20.64 |
| Chronic Liver Disease | 16.10 | 15.18 | 8.96 | 14.26 |
| Parkinson's Disease | 12.75 | 15.60 | 11.64 | 19.49 |
| Primary Hypertension and/or renal disease | 13.54 | 23.50 | 6.94 | * |
| COVID-19 | 82.44 | 74.77 | 68.67 | 64.30 |

[54] Virginia Department of Health, Office of Information Management, Division of Health Statistics, 2022. Data obtained via email from Virginia Department of Health.

[55] VDH, Office of Information Management, Division of Health Statistics, 2022. Data obtained via email from VDH.

## Key Trends

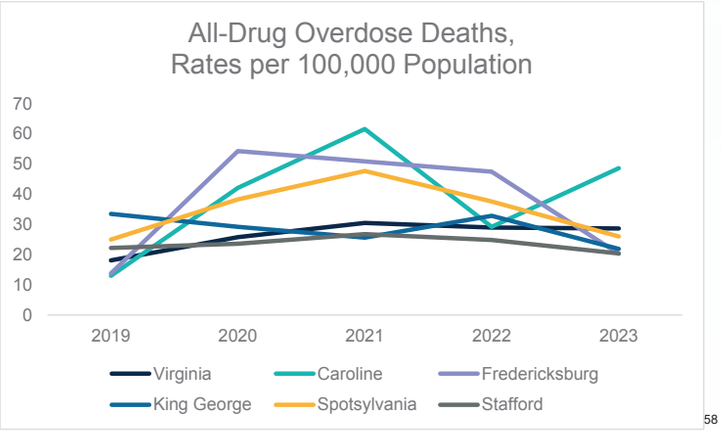
This section provides data on health outcomes that saw significant increases over the prior five-year period of available data.

### Overdoses

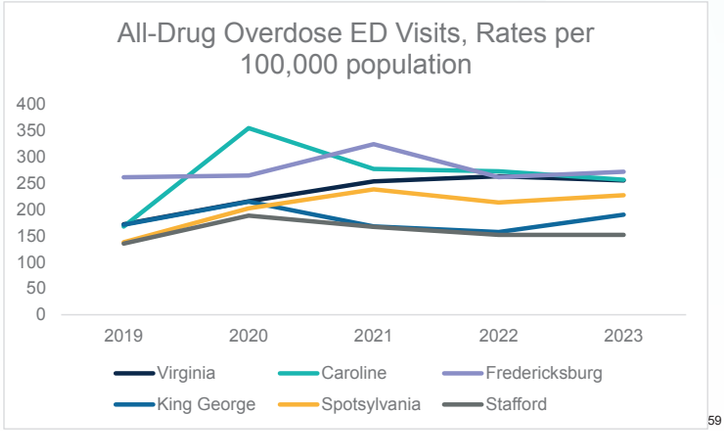
Drug related overdose deaths reached a peak for PD16 in 2021 but saw a gradual decrease in 2022 and 2023. This is consistent with state trends. A similar trend can also be seen when looking at overdose-related Emergency Department (ED) visits.

This data includes overdoses related to any drug, but opioids accounted for a majority of drug overdose deaths in PD16 throughout this time period.

| | | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Year** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| All Drug Overdose Death Rates[56] | 2019 | 18.1 | 13 | 13.8 | 33.5 | 25 | 22.2 |
| | 2020 | 25.8 | 42.1 | 54.3 | 29.2 | 38.3 | 23.6 |
| | 2021 | 30.5 | 61.6 | 50.9 | 25.6 | 47.7 | 26.8 |
| | 2022 | 29 | 29.2 | 47.5 | 32.9 | 37.6 | 24.9 |
| | 2023 | 28.7 | 48.6 | 20.3 | 21.9 | 26 | 20.4 |
| All Drug Overdose ED Visits, Rates per 100,000 population[57] | 2019 | 171.7 | 167.4 | 260.9 | 170.9 | 137.6 | 135 |
| | 2020 | 215.4 | 354.2 | 264.2 | 214.5 | 201.9 | 188.1 |
| | 2021 | 253.1 | 276.6 | 323.7 | 167.7 | 237.9 | 166.8 |
| | 2022 | 262.8 | 272.2 | 261.1 | 157 | 213.1 | 151.8 |
| | 2023 | 254.7 | 256 | 271.3 | 189.9 | 226.8 | 151.8 |



[58]



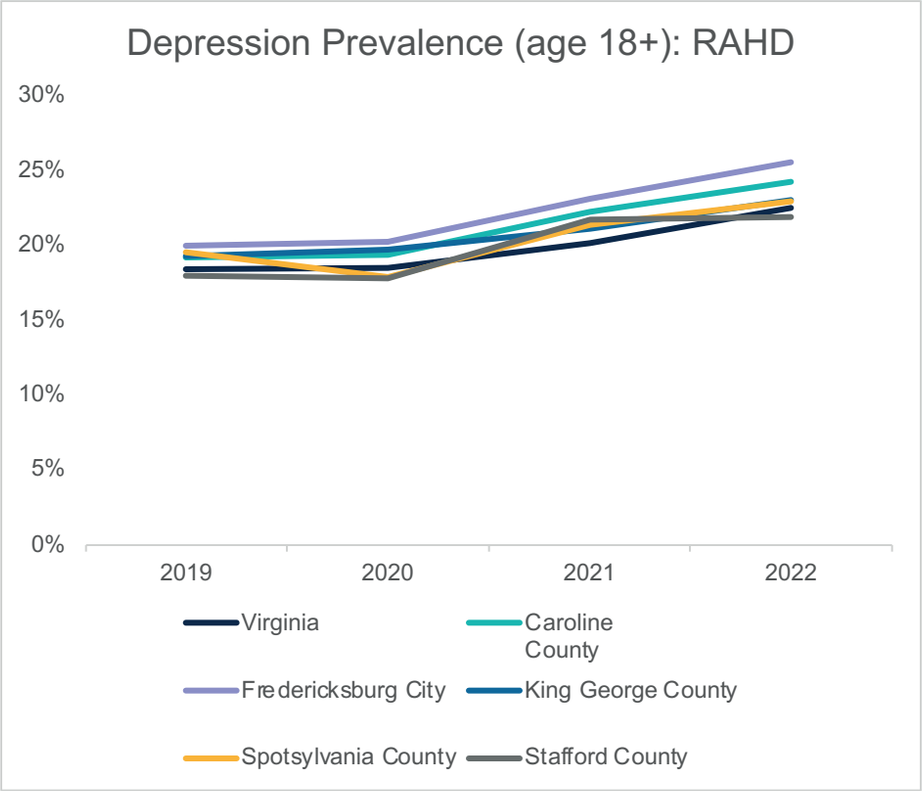
[59]

[56] VDH, Drug Overdose Data, Overdose Deaths, 2019-2023
[57] VDH, Syndromic Surveillance, ED Visits for Drug Overdose, Monthly & Annual Statistics
[58] VDH, Drug Overdose Data, Overdose Deaths, 2019-2023
[59] VDH, Syndromic Surveillance, ED Visits for Drug Overdose, Monthly & Annual Statistics

## Depression

Mental health was a priority in the 2022 CHA, in large part due to community feedback. Data now shows that all localities saw an increase in depression rates from 2019 to 2022, with the largest jump occurring from 2020 to 2021. The largest increase was seen in King George, with an increase of 27.5% over this four-year period.

| | | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Year** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| Depression (%)[60] | 2019 | 18.4% | 19.2% | 20.0% | 20.0% | 19.5% | 18.0% |
| | 2020 | 18.5% | 19.4% | 20.2% | 20.2% | 17.9% | 17.8% |
| | 2021 | 20.1% | 22.2% | 23.1% | 23.1% | 21.4% | 21.7% |
| | 2022 | 22.5% | 24.2% | 25.5% | 25.5% | 22.9% | 21.9% |




[60] CDC, Behavioral Risk Factor Surveillance System (BRFSS). Accessed via the PLACES Data Portal. 2022

## Suicides

The number of deaths by suicide has fluctuated for PD16 year over year, but the number of deaths remained constant at about 60 for both 2022 and 2023. Rates in recent years are particularly high in King George and Caroline, with King George's suicide death rate over twice as high as the Virginia average in 2023.

Deaths by suicide in PD16 disproportionately occur among white individuals (82% of suicide deaths in 2023) and older adults aged 65 and up (21% of suicides).

| | | RAHD (PD16) | | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Year** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** | **Total** |
| Suicide deaths (counts) [61] | 2019 | * | * | * | 18 | 12 | 30 |
| | 2020 | 6 | 6 | 7 | 16 | 25 | 60 |
| | 2021 | 6 | 3 | * | 16 | 16 | 41 |
| | 2022 | 6 | 7 | 7 | 23 | 17 | 60 |
| | 2023 | 7 | 5 | 9 | 22 | 18 | 61 |

*Counts less than 5 are suppressed to protect privacy

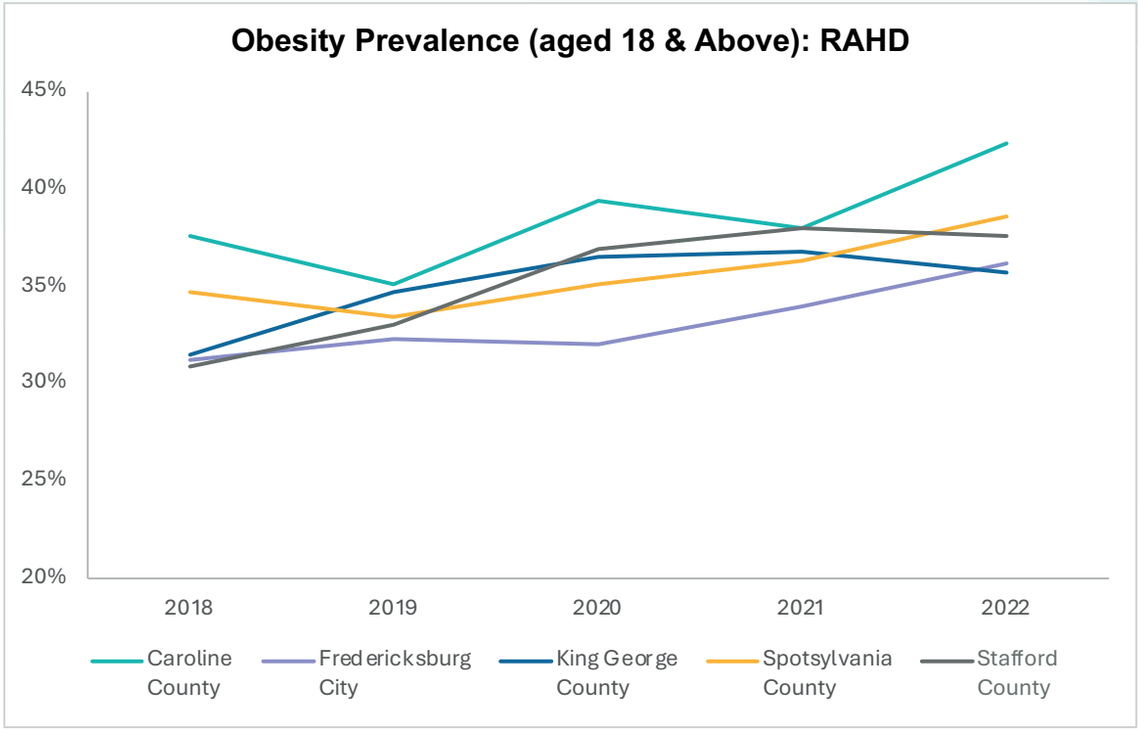
| | | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Year** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| 2023 Suicide Death Rates (per 100,000) | 2023 | 14.3 | 21.9 | 17.4 | 32.3 | 15.0 | 11.0 |

[61] Virginia Department of Health, 2019-2023. Data directly obtained via email.

## Obesity

Obesity rates have steadily increased in all PD16 localities over the past five years of available data. Although obesity rates are highest in Caroline, the sharpest increase from 2018-2022 occurred in Stafford, where obesity rates rose 21.7% over the five-year period.

| | | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|---|
| Indicator[62] | Year | Virginia | Caroline County | Fredericksburg City | King George County | Spotsylvania County | Stafford County |
| Obesity (%) | 2018 | 31.1% | 37.6% | 31.2% | 31.5% | 34.7% | 30.90% |
| | 2019 | 31.9% | 35.1% | 32.3% | 34.7% | 33.4% | 33.00% |
| | 2020 | 33.1% | 39.4% | 32.0% | 36.5% | 35.1% | 36.90% |
| | 2021 | 34.4% | 38.0% | 34.0% | 36.8% | 36.3% | 38.00% |
| | 2022 | 35.1% | 42.3% | 36.2% | 35.7% | 38.6% | 37.60% |

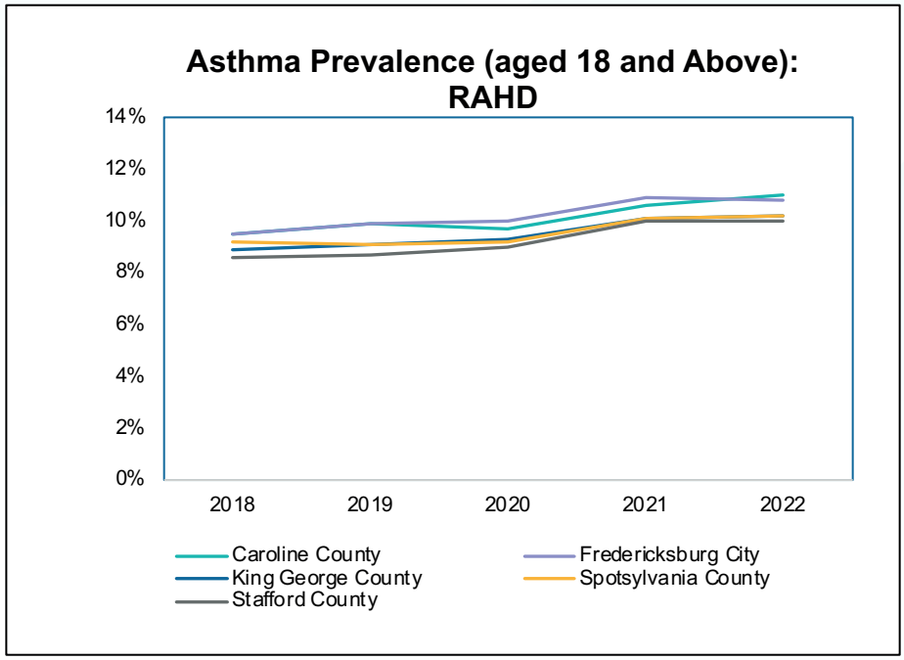



[62] CDC, Behavioral Risk Factor Surveillance System (BRFSS). Accessed via the PLACES Data Portal. 2022 .

## Asthma

Asthma rates increased for all localities in PD16 from 2018-2022. The highest asthma rates are in Caroline (11.0%), although Stafford saw the steepest increase in asthma rates with a 16.2% increase from 2018-2022.

| | | | RAHD (PD16) | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Year** | **Virginia** | **Caroline County** | **Fredericksburg City** | **King George County** | **Spotsylvania County** | **Stafford County** |
| Current Asthma (%)[63] | 2018 | 8.9% | 9.5% | 9.5% | 8.9% | 9.2% | 8.6% |
| | 2019 | 9.2% | 9.9% | 9.9% | 9.1% | 9.1% | 8.7% |
| | 2020 | 9.3% | 9.7% | 10.0% | 9.3% | 9.2% | 9.0% |
| | 2021 | 10.2% | 10.6% | 10.9% | 10.1% | 10.1% | 10.0% |
| | 2022 | 9.9% | 11.0% | 10.8% | 10.2% | 10.2% | 10.0% |




[63] CDC Behavioral Risk Factor Surveillance System (BRFSS). Accessed via the PLACES Data Portal, 2022

## Social Determinants of Health

Social determinants of health (SDOH) are fundamental factors that significantly impact health outcomes, often exerting a greater influence on overall health and well-being than medical care alone. These determinants—such as economic stability, access to education, healthcare, housing, and social support—are key drivers of health disparities and contribute to the development of chronic diseases and inequities in health outcomes. Addressing SDOH is essential for improving population health, as it provides a more comprehensive understanding of the root causes of health inequities and offers valuable insight into the broader factors that shape health beyond the four walls of the hospital.

In compliance with Centers of Medicare and Medicaid Services (CMS) and Joint Commission standards, MWHC implemented routine screening for five critical SDOH domains within its adult inpatient population:

- food insecurity
- housing instability
- interpersonal safety
- utilities
- transportation needs

The specific questions used to screen these domains can be found in Appendix C.

This initiative enables the organization to obtain a more holistic understanding of the social factors affecting a patient's health. By identifying and addressing unmet needs in these areas, MWHC can tailor interventions and services to better support patients' health and well-being. Moreover, this data provides valuable insights into the broader health needs of the community, helping to inform public health strategies and allocation to address the social factors that impact overall community health.

This map provides a visual representation of Social Determinants of Health (SDOH) needs across the Mary Washington Healthcare (MWHC) service area. The darker shades of blue indicate census tracts with higher rates of positive SDOH screenings, highlighting areas with greater social and economic challenges. As indicated above, the Fredericksburg area, including parts of Spotsylvania County, show the most significant areas of SDOH need (Census tracts: 51630400, 5117720313, 51630400). However, by using census tract level data we can also see higher concentrations of SDOH need in Westmoreland County, King George County, and parts of Prince William County. This data underscores the geographic differences in social and economic disparities that exist within the same localities.

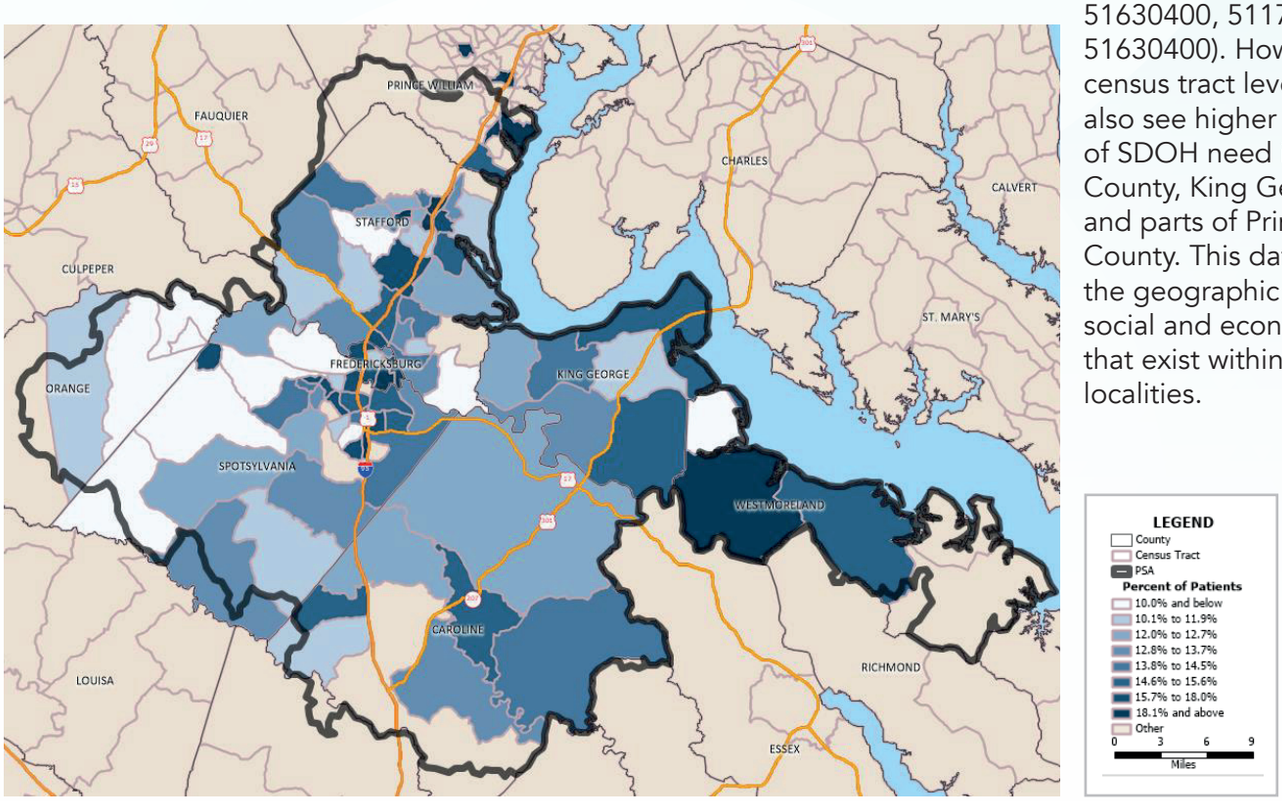



***Figure 2:*** *Positive SDOH Screening Rates by Census Tract (proportion of MWHC adult inpatients (18+) that screened positive for one or more SDOH needs)*

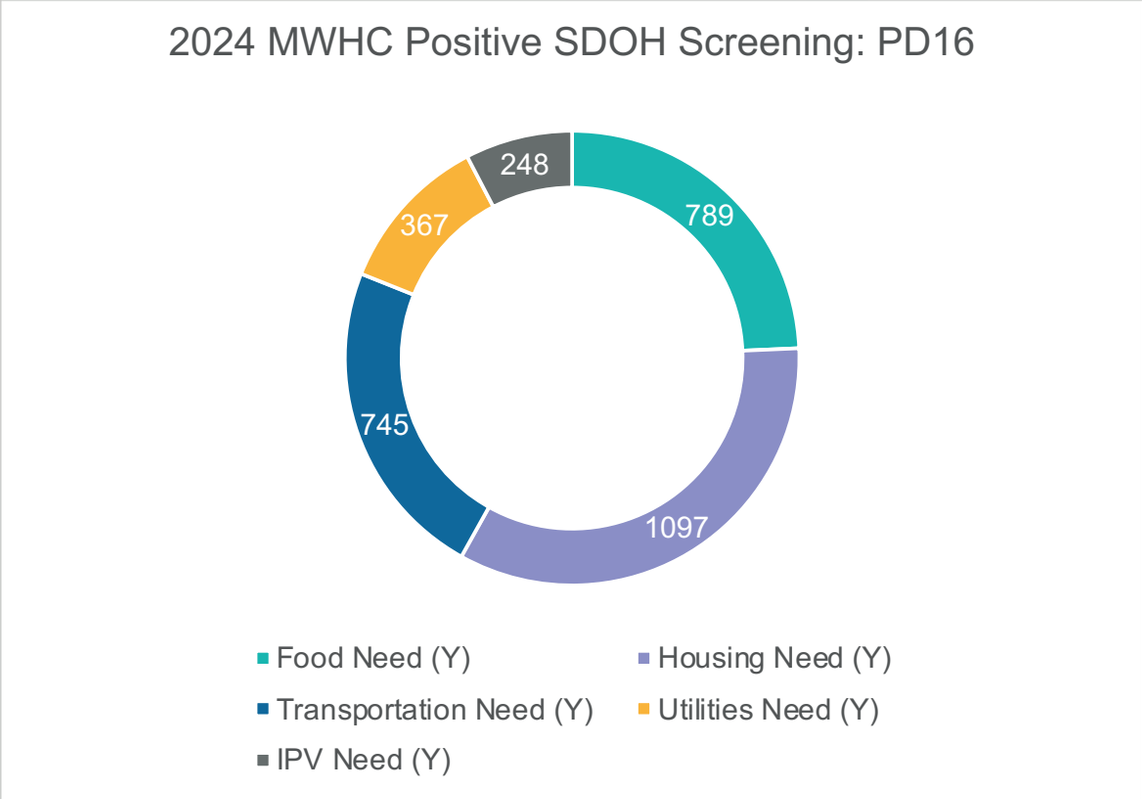



***Figure 3:*** *2024 MWHC Positive SDOH Screening in PD16*

**Figure 3** highlights the number of SDOH needs identified across each of the five domains screened for in MWHC's inpatient setting. The most prevalent need is housing assistance, specifically, difficulty in paying rent or mortgage, reported in 1,097 cases, followed by food insecurity (789 cases), and transportation needs (745 cases). Additionally, utilities assistance was identified in 367 cases, while intimate partner violence (IPV) support was noted in 248 cases. These findings underscore the significant social and economic barriers impacting community health in planning district 16.

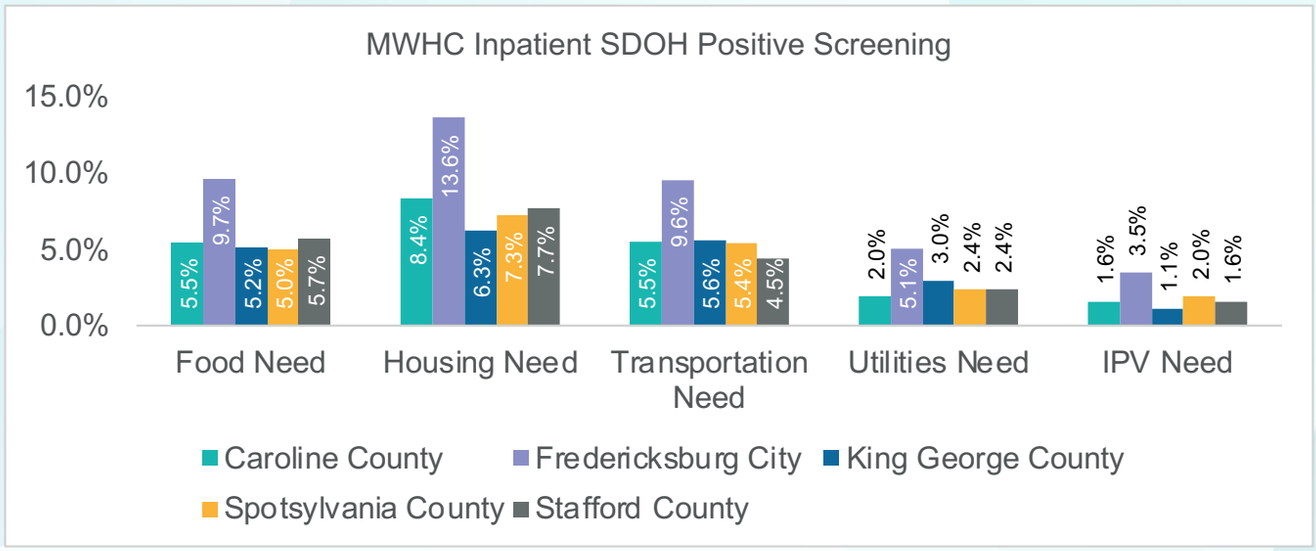



**Figure 4:** *2024 Positive SDOH Screening Rate by County*

The MWHC Inpatient Social Determinants of Health (SDOH) Positive Screening results indicate varying levels of need across different counties. Housing needs are the most prevalent concern, particularly in Fredericksburg (13.6%), followed by Caroline (8.4%). Food insecurity is another significant issue, with Fredericksburg (9.7%) reporting the highest percentage, followed by Stafford (5.7%) and Caroline (5.5%). Transportation needs are relatively consistent across the regions, with the exception of Fredericksburg, which is nearly double at 9.6%. Utilities assistance and Intimate partner violence (IPV) risk have the lowest positive screening rates, across PD16, with the highest rates observed in Fredericksburg.

Overall, this data highlights the significant social and economic barriers faced by communities within the MWHC service area, revealing notable disparities, particularly in Fredericksburg, which shows the highest percentages across multiple categories. This insight enables healthcare providers to offer personalized interventions, connect patients with vital community resources, and inform internal priorities and projects that address health disparities, ultimately fostering improved health outcomes and promoting more equitable care.

# Community Partner Assessment

This assessment examines local systems, processes, and capacities, as well as the collective capacity as a network of community partners to address health inequities. The results of this survey may provide additional depth to the health needs and strengths identified in other parts of the CHA. It may also aid understanding of community needs when developing the CHIP and other collaborative efforts.

### Background

MAPP 2.0 provides recommended questions for a community partner survey to inform this assessment. The Steering Committee assisted with reviewing the recommended questions, and feedback was incorporated to develop the final version of the survey.

Partners who make up the local public health system or work closely with that system were identified and invited to the CHA kickoff meetings. The CHA Community Partner Survey, as well as the Community Member Survey were announced at these meetings, and a link to complete the survey online was provided. Email follow-ups were sent as needed by members of the Core Team.


***Figure 5:*** *Local Public Health System, from MAPP 2.0 Handbook, p.19*

A total of 37 organizations completed the survey, including RAHD and MWHC. Survey respondents represented sectors such as healthcare, local and state government, emergency response, education, social services, housing, mental health, philanthropy, and faith-based organizations. Non-profits were the largest group represented, with a total of 16 respondents selecting this category.

Most organizations responding to the survey serve either all residents of PD16 or a specific locality within the area, with only a few serving neighboring counties in addition to PD16. This regional alignment facilitates the CHA/CHIP process as well as other collaborative efforts, as organizations are serving the same population.

A majority (81%) of respondents had participated in CHA/CHIP or a similar process before.

## Key themes

### Partnerships

Partnerships and collaboration between community partners came up repeatedly as a strength during the CHA kick-off meetings, as well as during the previous CHA/CHIP cycle launched in 2022. This desire for continued partnerships and collaborations was reflected in the survey responses.

When asked why they were interested in participating in the CHA/CHIP, the top responses were:

1. To deliver programs effectively and efficiently and avoid duplicated efforts
2. To create long-term, permanent social change
3. To plan and launch community-wide initiatives

These responses reflect the eagerness to work together and maximize resources to overcome challenges in the community.

Relationships between organizations were reflected as well, with 100% of respondents either agreeing or strongly agreeing that they have good relationships with other organizations to help share information.

### Priority Populations

Responding organizations were asked about their priority populations. While some organizations broadly identified serving all PD16 or a specific county, many organizations serve a specific subset of the population, such as individuals with behavioral health challenges, children, low-income individuals, uninsured/underinsured individuals, or unhoused individuals.

Notably, when asked who their priority populations were, several organizations specified Hispanic/Latino and Middle Eastern families, even though the organizations' missions are not focused solely on these groups. Sometimes these populations were described as the Spanish-speaking community, families from Afghanistan, or simply English learners.

Although neither of the identified groups make up a majority in PD16, this is in line with demographic changes in the area and may help better inform service needs for other partner organizations.

Since 2021, PD16 has seen many families from Afghanistan, many of whom are refugees, settle in Stafford, Spotsylvania, and Fredericksburg. There has been growth in the Hispanic/Latino community as well, with all localities seeing an increase in census estimates of Hispanic/Latino residents since the 2022 CHA was completed. Identifying these groups as priority populations may also speak to equity issues that these communities are experiencing, particularly if they are accessing services from non-profits and safety-net providers at a high rate.

Most organizations responding to the survey (78%) indicated they work with refugees, asylum seekers, and other populations who speak English as a second language.

### Language Access

81% of respondents have at least one staff member who speaks Spanish. Only 8.3% have a staff member who speaks Dari, and no respondents reported staff who speak Pashto, the two official languages of Afghanistan. 19% have a staff member who speaks Arabic.

Organizations noted in the comments section that it can be a challenge to hire bilingual staff, particularly for positions that require licensure or certification. They also noted efforts to provide materials in other languages, even if staff did not speak the language. However, only 9% of respondents translate all publicly available materials into other languages.

### Community Engagement Efforts

Respondents were asked what they do to reach/engage/work with their clientele and community. The top responses included working closely with community organizations from the target population(s) and conducting extensive outreach. The lowest responses were for hiring staff and leadership that speak the language of the target population(s) or look like the target population(s) and supposing leadership development in the target population(s).

Responses additionally reflected that administrative and frontline staff were more likely to reflect the demographics of the community served compared to organizational management or boards of directors. Several organizations highlighted efforts to hire individuals with relevant lived experience for the services provided.

This may present opportunities for improvement through strategies in the Community Health Improvement Plan (CHIP), particularly given the shifts in demographics in the area and growing number of non-English speakers identified by other partners.

## Communications

Most organizations agree that their organization has a strong presence in local earned media (print/radio/TV), that they have strong communications infrastructure and capacity, and that they have a clear communications strategy. However, community responses during the focus groups may indicate an ongoing opportunity for growth in this area, as many residents report being unaware of programs and resources.

Organizations reported the most common methods of communications and engagement to be social media, presentations, Memorandums of Understanding (MOUs) with community-based organizations, and customer satisfaction surveys. Few organizations engage in ethnicity-specific outreach in non-English language, data dashboards, and meeting to discuss narrative and messaging to the public.

## Organizational Capacities

Most organizations (71%) have at least one person in their organization dedicated to addressing inequities and inclusion internally in the organization, but only 45% have at least one person dedicated to addressing these issues externally in the community.

57% of organizations have an advisory board of community members, stakeholders, youth, or others impacted by the organizations.


Importantly, 83% of respondents indicated their organization does not have sufficient capacity to meet the needs of their clients or members. This was an optional question with only 23 respondents, but it may indicate staffing and funding needs as well as opportunities for increased collaboration and efficiency within the public health system to enhance support.

Organizations identified a number of capacities that they would like to grow:

- Communications
- Movement-building
- Advocacy
- Increased primary care and mental health providers
- Enhanced collaboration with mental health providers for crisis response
- Increased funding
- More health partners that bring care to people in their homes
- Community paramedicine
- Data analysis
- Health equity assessment capabilities
- Public education and prevention programs
- Centralize citizen assessment and referral to reduce the number of places a person might go for help
- Enhance collaboration to identify gaps in services
- Reduce duplicative efforts

These may indicate gaps in the local public health system and may be particularly informative in the development of the CHIP. Additional summary of strengths and gaps in the local public health system is available in Appendix D.

# Conclusion

This assessment utilized many perspectives and data sources to understand community health in PD16. While a number of strengths are identified, some key needs stood out across multiple data sources. These key issues are listed alphabetically.

- **Aging-related concerns**
  Aging-related concerns stood out in particular on the community member survey, where many respondents identified this as one of the biggest health concerns, but needs for older adults also came up in other data sources. In focus groups, some discussions centered on the mental health of older adults, particularly related to isolation and loneliness. Challenges with transportation may exacerbate this for some. Suicide rates are disproportionately high for older adults in the area, with 21% of the suicides in 2023 occurring among older adults, though only 13% of the population is age 65 and older.

  Chronic disease prevalence is higher than the state average in PD16, and since aging increases the risk of many chronic diseases, these rates are likely having a disproportionate impact on older adults.

  Communication also arose as a particular issue for older adults. Since this group may have lower access and comfort with the internet, they also report challenges with finding resources related to health challenges.

  > *"If you want to help someone who has lost the person they've lived with for 50 years... are they alone? Most folks have families. I didn't...I had a very good pastor who steered me toward getting some counseling....and I got some help that way."*
  >
  > *~Spotsylvania resident*

  As the population gets older in the coming years, these challenges are likely to become even more of an issue.

- **Behavioral health**
  Similar to the 2022 CHA/CHIP, behavioral health (inclusive of both mental health and substance use disorders) remains an issue in the community. Mental health was the top response as the biggest health concern on the community member survey across demographic groups, and substance use disorders was the 5th most common response to this question. Bullying, isolation or loneliness, and driving while drunk or high were among the top responses to behaviors that need to be addressed in the community. Community conversations discussed increasing rates of mental health issues as well as substance abuse issues and overdose.

  > "Many try to numb the pain with drugs or alcohol."
  >
  > ~Fredericksburg Resident

  In the secondary data, increasing depression rates, elevated suicide rates, and low numbers of mental health providers for the population were all observed. Additionally, behaviors which may elevate risks of mental health were identified, such as long commute times, large numbers of adults with no physical activity and too little sleep, and stressors associated with SDOH needs.

  While the number of mental health providers relative to the population has increased, mental health services were still identified by the community as a need to improve community health.

- **Healthcare utilization and access**
  Secondary data continues to show that there are few providers relative to the population, particularly in the counties within PD16, and this has worsened since the 2022 CHA. Community conversations discussed how this was particularly a problem in rural areas. Community members discussed a shortage of primary care providers and specialists and noted the long wait times and long driving distances that serve as a barrier to accessing care via the existing providers.

  In addition to primary care, maternal health and oral health came up as two specific areas of concern. Challenges with accessing maternity care were brought up by community members, and may be contributing to outcomes like higher rates of preterm births, low birthweight deliveries, and infant mortality across PD16, particularly impacting families of color and rural areas.

  > *"I have senior parents who are constantly having to drive to and from Fredericksburg for their doctor's appointments."*
  >
  > ~King George resident

  Oral health is a notable concern because it arose as an issue for specific groups.

  On the community survey, dental issues were a top issue specific to low-income respondents and Hispanic/Latino respondents. The ratio of population to dentists is also very high across the counties in PD16.

- **Physical Activity and Healthy Eating**
  Physical activity and healthy eating came up repeatedly in community feedback, both in the focus groups and community survey. Residents expressed concern about access to affordable, healthy foods. Lack of exercise and eating unhealthy foods were the top two behaviors to be addressed based on responses to the community member survey.

  Also importantly, a linkage between these health-related behaviors and chronic disease outcomes in PD16 arises in the data. Poor nutrition and a lack of exercise are major risk factors for chronic diseases ranging from cancer to high blood pressure to heart disease. The increase in obesity rates across the localities in just five years also points to a concerning pathway from unhealthy behaviors to an unhealthy weight to chronic disease outcomes.

  > *"I went to the grocery store, and I enjoyed my experience there, but I was thinking what if you don't have the resources to get what you need? The ability to afford the things you need to have a healthy life is so important."*
  >
  > ~Stafford resident

- **Social Determinants of Health**
  Housing and other social determinants of health needs also present as key issues impacting the community. Affordable housing was the top survey response regarding what would most improve health in the community. Housing costs have increased sharply in the area in recent years, with pricing placing homeownership out of reach for many. Even affording rent is a challenge for many families based on the data: in the City of Fredericksburg, the median household income is less than the minimum income needed to afford the average rent. Furthermore, difficulty paying rent or a mortgage was the top SDOH need identified by MWHC's social determinant of health screenings.

Economic issues more broadly also arise across the data. In addition to affordable housing, affordable healthy food and affordable childcare were also top five responses to the survey question of what would most improve health in the community. Residents discussed concerns related to poverty, rising living costs, and low wages, with few known resources in the community to address these needs.

> *"..lack of affordable housing. You can't talk about healthy initiatives without talking about housing."*
>
> ~Caroline resident

Transportation needs came up repeatedly in community conversations and focus groups, and food insecurity and transportation were the second and third most prevalent needs on MWHC's SDOH screening.

## Additional Themes

Communication through the region, including finding information about available resources, arose in community member and community partner feedback. Some are unable to access resources, and others may not be sure how to navigate resources or, for agencies, where to refer clients with certain needs. This is a cross-cutting factor that may impact all key issue areas.

As the population grows and changes, organizations and local resources may have to adapt to address the current population through expanded services, additional funding, and adjustments to best serve new communities, such as English learners.

Fortunately, community organizations expressed a strong desire to better align resources and minimize duplicative efforts, which may make this an easier process.

## Limitations

There are several limitations to the data provided. Most secondary data lags by two to three years, so the impact of current initiatives to address community problems including strategies from the 2022 CHIP, may not be reflected yet in this data. All data gathered directly from community members was collected by convenience sample, and while efforts were made to hear from various groups and achieve saturation in responses, some needs may not have been identified. SDOH data from MWHC reflects only the inpatient population at two local hospitals and therefore may not be representative of the whole population. Looking at this report holistically and examining issues across sources helps to overcome some of these limitations.

## Next Steps

This document presents a large amount of data, but the intention is not to simply point out problems without offering solutions. The CHIP process, set to be completed by July 2025, offers one vehicle for organizations to collaboratively address key health challenges.

Although not every issue can be addressed in the CHIP, the CHA report itself is also meant to generate enhanced understanding of what health looks like in the PD16 community. With this in mind, organizations, local governments, businesses, and neighborhoods can better understand what is taking place in the community and align resources to address the most pressing needs.

# Appendix A- Contributing Partners to CHA

## Core Team

**Allison Balmes-John**, Population Health Manager, Rappahannock Area Health District

**Briel Milroy,** Senior Analyst, Strategic Planning and Business Development, Mary Washington Healthcare

**Erin Perkins**, Population Health Coordinator, Rappahannock Area Health District

**Xavier Richardson**, Senior Vice President, Chief Development Officer, Mary Washington Healthcare; President, Mary Washington Hospital and Stafford Hospital Foundations

The Core Team would also like to give a special acknowledgement to Dan Czajka, Eric Fletcher, Ateeqa Ijaz, and Olugbenga Obasanjo for their contributions to this project.

## Steering Committee

Caroline County Department of Social Services
Caroline County Habitat for Humanity
Community Foundation of the Rappahannock River Region
Fredericksburg Christian Health Center
Fredericksburg City Public Schools
Fredericksburg Regional Food Bank
George Washington Regional Commission
Germanna Community College
HCA Spotsylvania Regional Medical Center
Healthy Generations Area Agency on Aging
King George County Department of Social Services
Mary Washington Healthcare
Mental Health America Fredericksburg Region
Rappahannock Area Community Services Board
Rappahannock Area Health District
Rappahannock Emergency Medical Services Council
Rappahannock United Way
Spotsylvania County Public Schools
Stafford County Government

## Participating Organizations

A. Ross Special Addiction Counseling
Alzheimer's Association
American Association of Retired Persons/Triad
American Legion 320
Big Brothers Big Sisters Greater Fredericksburg
Caroline County Department of Social Services
Caroline County Public Schools
Caroline County Sheriff's Office
Caroline Habitat for Humanity
Central Rappahannock River Habitat for Humanity
Comfort Keepers
Community Foundation of the Rappahannock River Region
Fredericksburg Christian Health Center
Fredericksburg City Council
Fredericksburg City Public Schools
Fredericksburg Department of Social Services
Fredericksburg Fire Department
Fredericksburg Regional Food Bank
Fredericksburg Area Health and Support Services
George Washington Regional Commission
Germanna Community College
Gwyneth's Gift
HCA Spotsylvania Regional Medical Center
Healthy Generations Area Agency on Aging
King George County Government
King George County Department of Social Services
King George County Economic Development Authority
Lloyd Moss Free Clinic
Loisann's Hope House
Mary Washington Healthcare
Mental Health America Fredericksburg Region
Micah Ecumenical Ministries
National Alliance on Mental Illness
NAACP Fredericksburg
NAACP Spotsylvania
Prince William Health District
Rappahannock Area Health District
Rappahannock Area YMCA
Rappahannock Big Brothers Big Sisters
Rappahannock CASA
Rappahannock Area Community Services Board
Rappahannock Education Farm
Rappahannock EMS Council
Rappahannock United Way
Stafford Emergency Relief through Volunteer Efforts (SERVE)
Spotsylvania County Department of Community Engagement
Spotsylvania County Department of Social Services
Spotsylvania County Public Schools
Spotsylvania County Sheriff's Office
Spotsylvania Fire, Rescue and Emergency Management
Stafford County Board of Supervisors
Stafford County Department of Social Services
Stafford County Fire, Rescue and Emergency Management
Stafford County Sheriff's Office
Stafford Education Foundation
Stafford Junction
The disAbility Resource Center
The Healing Station
Thurman Brisben Center
University of Mary Washington
Department of Veteran's Affairs
Vision Community Church
Zoe Freedom Center

# Appendix B- Community Member Survey Responses

| What are the BIGGEST HEALTH CONCERNS Area | Number | Percent |
|---|---|---|
| Mental health (depression, anxiety) | 730 | 55.8% |
| Chronic conditions (cancer, diabetes) | 432 | 33.0% |
| Aging-related concerns (dementia, falls) | 400 | 30.6% |
| Substance use disorders (opioids, alcohol) | 332 | 25.4% |
| Diseases that can spread (flu, tuberculosis) | 269 | 20.6% |
| Health differences by race/ethnicity or income | 235 | 18.0% |
| Dental problems | 185 | 14.1% |
| Violence and crime in the community | 158 | 12.1% |
| Discrimination or racism | 158 | 12.1% |
| Health of pregnant women and babies | 123 | 9.4% |
| Preventable injuries (car crashes, poisoning) | 117 | 8.9% |
| Safe drinking water | 114 | 8.7% |
| Food safety (at restaurants, food trucks) | 99 | 7.6% |
| Other health concern | 70 | 5.4% |
| Mold, radon, or lead exposure in the home | 65 | 5.0% |
| Weather-related concerns (heat stroke) | 31 | 2.4% |
| Sexually transmitted infections (chlamydia) | 23 | 1.8% |

| Which BEHAVIORS need to be addressed in the community where you live? | Number | Percent |
|---|---|---|
| Lack of exercise | 344 | 26.3% |
| Eating unhealthy foods | 341 | 26.1% |
| Bullying (physical, verbal, online) | 340 | 26.0% |
| Isolation or loneliness | 324 | 24.8% |
| Driving while drunk or high | 287 | 21.9% |
| Drug use / prescription drug misuse | 274 | 20.9% |
| Alcohol misuse (excessive drinking) | 239 | 18.3% |
| Domestic violence | 223 | 17.0% |
| Technology addiction | 192 | 14.7% |
| Vaping / e-cigarette use | 192 | 14.7% |
| Cannabis (marijuana) misuse | 130 | 9.9% |
| Not being up-to-date on vaccines | 125 | 9.6% |
| Elder abuse or neglect | 116 | 8.9% |
| Not safely storing guns | 104 | 8.0% |
| Drinking sugary beverages | 92 | 7.0% |
| Tobacco use (cigarettes, cigars, snuff) | 85 | 6.5% |
| Other behavior | 55 | 4.2% |
| Gaming or online gambling | 36 | 2.8% |
| Unsafe sex | 27 | 2.1% |

| What would MOST IMPROVE HEALTH in the community where you live? | Number | Percent |
|---|---|---|
| Affordable housing | 507 | 38.8% |
| Mental health services | 449 | 34.3% |
| Access to healthcare services | 420 | 32.1% |
| Affordable healthy food | 322 | 24.6% |
| Affordable childcare | 252 | 19.3% |
| Access to dental care | 203 | 15.5% |
| Transportation options (bus, train) | 168 | 12.8% |
| Sidewalks, bike lanes, and crosswalks | 159 | 12.2% |
| Programs for youth outside of school | 147 | 11.2% |
| Support for basic needs (food, clothing) | 124 | 9.5% |
| Community parks and gardens | 120 | 9.2% |
| Job training and business opportunities | 114 | 8.7% |
| Support for people living with disabilities | 109 | 8.3% |
| Community health education programs | 107 | 8.2% |
| Alcohol/drug treatment programs | 103 | 7.9% |
| Access to online services (internet) | 65 | 5.0% |
| Programs for parents and caregivers | 65 | 5.0% |
| Safety services (police, fire, rescue) | 64 | 4.9% |
| Other health improvement | 54 | 4.1% |
| Language interpreter services | 35 | 2.7% |

# Appendix C- MWHC SDOH Screening Questions

## Food Insecurity

- Within the past 12 months, you worried that your food would run out before you got the money to buy more.
- Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

## Intimate Partner Violence

- Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
- Within the last year, have you been afraid of your partner or ex-partner?
- Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
- Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

## Transportation Needs

- Has the lack of transportation kept you from medical appointments or from getting medications?
- Has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

## Housing Stability

- In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
- In the last 12 months, how many places have you lived?
- In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?

## Utilities

- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

# Appendix D- Summary of Strengths and Gaps in the Local Public Health System

**The following chart provides additional feedback collected from the Community Partners Survey.**

| Highest response rate | Lowest response rate |
|---|---|
| **Which categories does your organization work with?** | |
| Healthcare access/utilization<br>Food access and affordability<br>Family well-being<br>Human services<br>Seniors/elder care<br>Language interpreter services | Environmental justice/climate change<br>Food service/restaurants<br>Gender discrimination/equity |
| **Which health topics does your organization work on?** | |
| Healthcare access<br>Mental or behavioral health<br>Health insurance/Medicare/Medicaid | Cancer<br>HIV/STD prevention<br>Physical activity |
| **Which of the 10 essential public health services does your organization participate in?** | |
| Community engagement and partnerships<br>Assessment<br>Communication and education<br>Access to care | Legal and regulatory authority<br>Evaluation and research<br>Investigation of hazards |
| **Which strategies does your organization use to do their work?** | |
| Research and policy analysis<br>Communication<br>Alliance and coalition-building | Litigation<br>Arts and culture<br>Integrated voter engagement |
| **Which of the following methods does your organization use most often?** | |
| Presentations<br>MOUs/MOAs<br>Social media | Polling<br>Participatory budgeting<br>House meetings<br>Participatory action research |
| **What policy/advocacy work does your organization do?** | |
| Educate decision-makers and respond to their questions<br>Respond to requests from decision-makers<br>Advocate for policy change<br>Develop close relationships with elected officials | Contribute to political campaigns/PACs<br>Legal advocacy<br>Voter outreach and education<br>Mobilize public opinion on policies via media/communications |

Mary Washington Healthcare

RAPPAHANNOCK AREA HEALTH DISTRICT

RAHD

VIRGINIA DEPARTMENT OF HEALTH