2023

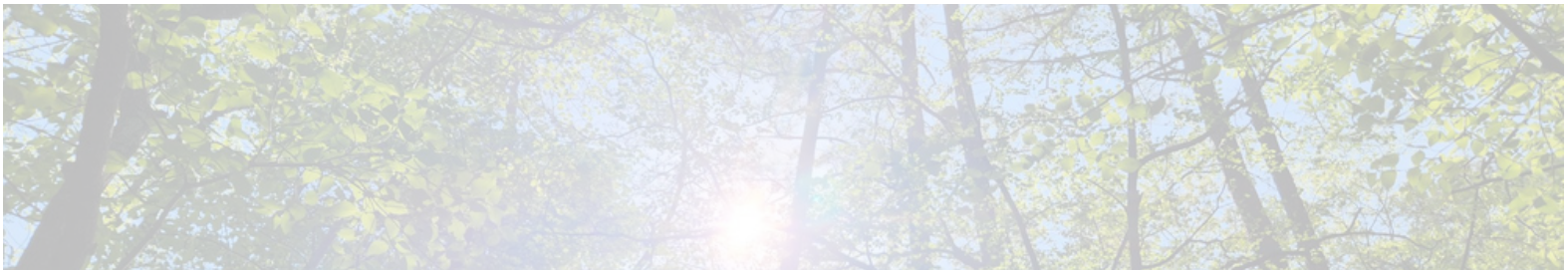
EXECUTIVE COMMUNITY HEALTH ASSESSMENT& IMPROVEMENT PLAN

THREE RIVERS HEALTH DISTRICT

A collaborative report with local partners highlighting community health assets & opportunities

Virginia Department of Health
Three Rivers Health District

Table of contents



EXECUTIVE SUMMARY

The true health of a community is defined not simply by access to health care services but by a variety of health and social factors such as health behaviors, living conditions, opportunities for employment, and housing. The Three Rivers Health District (TRHD) is dedicated to serving our communities and unique habitat by protecting our health and environment today and tomorrow.

To accomplish this mission, we strive to develop partnerships to provide an array of services to all counties of the Northern Neck and Middle Peninsula. By analyzing community health data and coordination with community partners, we seek to foster opportunities for innovative community interventions. Doing so ensures that resources for outreach, prevention, education, and wellness are focused where the greatest impact can be realized.

The goal of this Community Health Assessment (CHA) and Improvement Plan is for the Three Rivers Health District to highlight opportunities to improve community health. We examine qualitative and quantitative input collected and provided by community partners and members, nonprofit leaders, public health and government agency leaders, and community providers.

Several significant health needs were consistently identified as opportunities for growth through collaboration and partnership expansion:

- Access to Healthcare
- Chronic Disease
- Healthy Aging
- Infectious & Communicable Disease
- Maternal Health
- Mental Health & Substance Abuse Disorders
- Obesity, Nutrition & Exercise

BACKGROUND

Ten counties make up the Three Rivers Health District: Essex, Gloucester, King & Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond County, and Westmoreland. This 2,000 square mile area is located between the waters of the Potomac, Rappahannock, and York Rivers and borders the Chesapeake Bay on the east and is home to almost 145,000 residents. The region contains 3 Native American reservations and 9 incorporated towns while serving as the travel destination for thousands of visitors. To support those we serve, it is critical to leverage community health assessments as a means to focus resources.

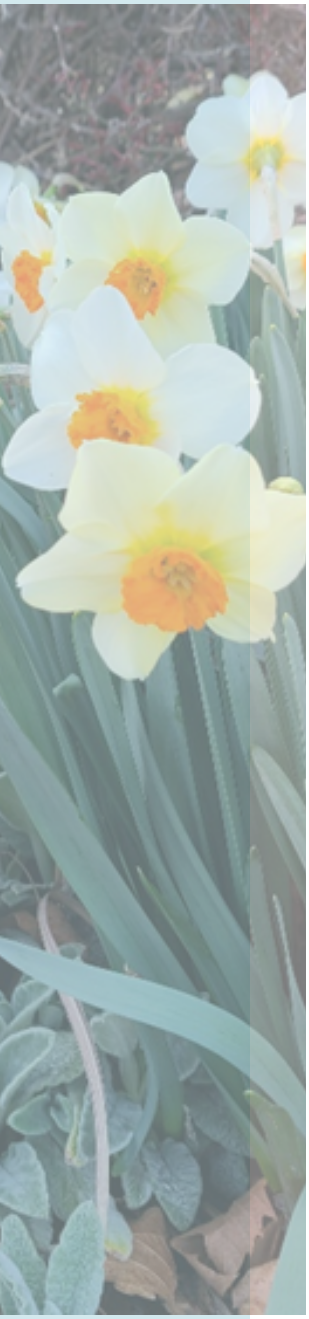
Community health assessments are careful, systematic examinations of the health status of communities that are used to identify leading health challenges and assets in the community. Data from the assessments will inform policy development, decision-making, prioritization of health challenges, and planning to improve opportunities for optimal health outcomes.

The Northern Neck and Middle Peninsula are fortunate to have many community partners that have facilitated community health assessments and countless community-based organizations that support the implementation of health improvement plans.

Recently, Bay Aging, Riverside Walter Reed Hospital, VCU Tappahannock, and Bon Secours Rappahannock General Hospital have completed community health assessments to better understand the needs of the region to support health planning efforts. This report, compiled by the Three Rivers Health District, highlights findings consistent across the regional health assessments to further leverage the critical work of the region's community partners to support health planning efforts.

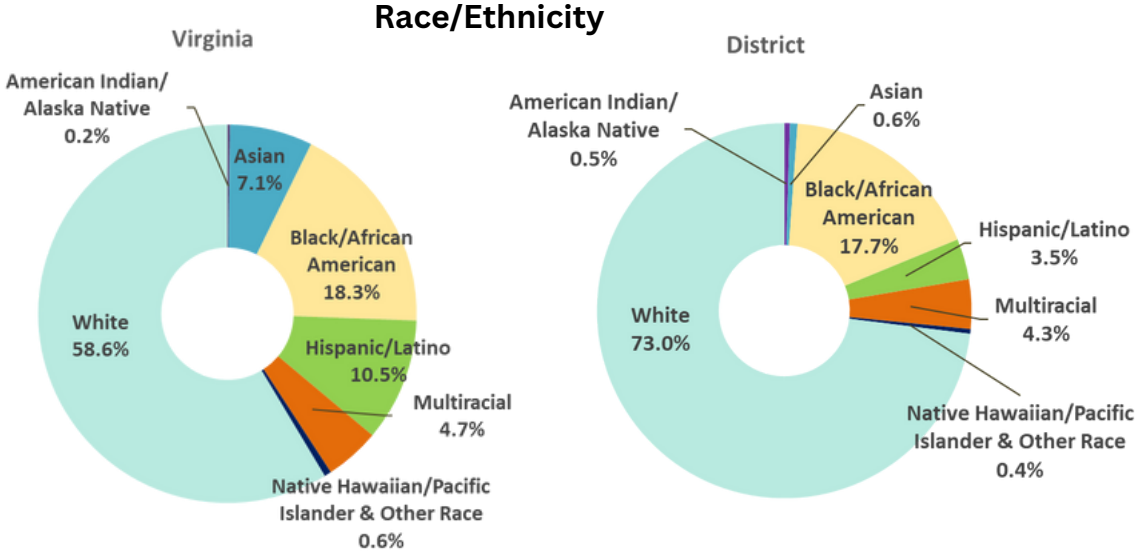
- Bay Aging Community Health Assessment
- Bon Secours Rappahannock General Hospital Community Health Assessment
- Riverside Walter Reed Hospital Community Health Assessment
- VCU Tappahannock Community Health Assessment

DEMOGRAPHICS



District Population
143,044

Race/Ethnicity

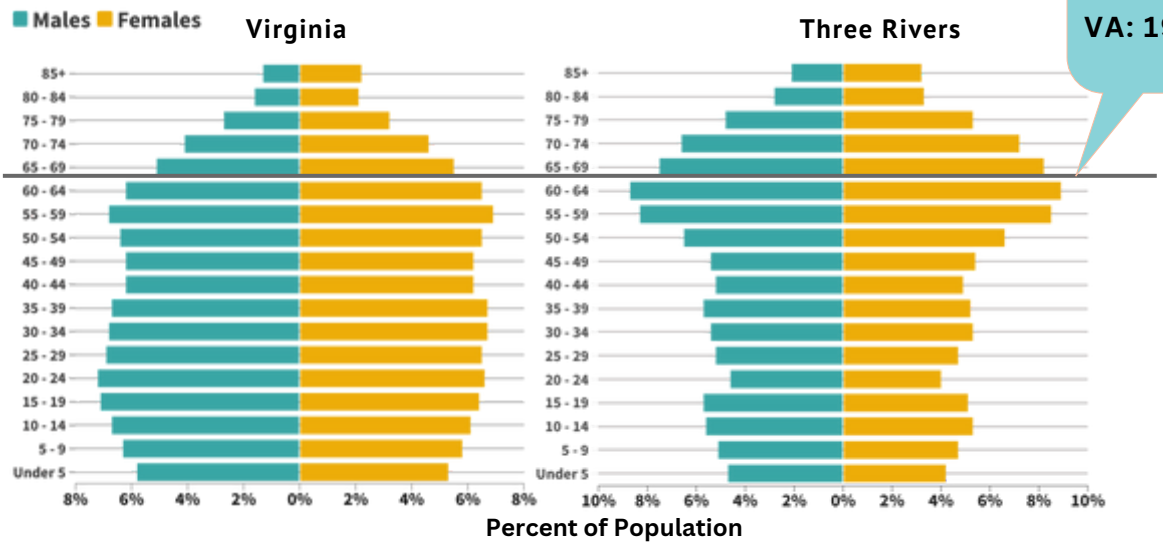


- 73% of the district population indicated White race alone on the 2020 census, compared with 58.6% of Virginians overall.
- A lower percentage of the district population indicated Hispanic ethnicity or Asian race than the state as a whole.

Age 65+

TRHD: 30%
VA: 19.7%

Age and Sex



The charts above show the differences in the distribution of age in 5-year increments among males and females in TRHD compared with Virginia.

- More of the district population are in older age groups than Virginia as a whole. Conversely, a lower percentage of the district population are children compared with Virginia.
- The district's population among agegroups 65+ consists of more men compared to Virginia as a whole.

KEY COMMUNITY HEALTH FINDINGS & TRENDS

The region's CHAs identified numerous consistent population trends, health needs, opportunities, and community assets. Among the key findings were:

Assets

- Multiple regional and local resource councils;
- Substantive opportunities for outdoor recreational activities;
- Non-profits and other government agencies that serve the community;
- Three hospitals and five free clinics within the TRHD service area;
- District-wide service organization for the aging population;
- District-wide mental health and substance use disorder provider; and
- Regional non-profit that facilitates the expansion of telehealth services across the Three Rivers Health District.

Challenges

- Accessing available and affordable health care, including mental health, oral health, and maternal health services;
- Advancing age of residents;
- Large number of unpaid caregivers who need respite services;
- Lower education attainment compared to state averages;
- Higher poverty rates than the state average in six of our ten counties;
- Median income lower than the state average;
- Higher proportion of population that is uninsured;
- Challenges with broadband access;
- Lack of affordable housing;
- Limited access to healthy food; and
- Limited access to higher education/vocational training.

KEY COMMUNITY HEALTH DRIVERS

The findings in community health assessments and population data may present more challenges than assets but they also point to opportunities for improvements. While there is no one way to address the challenges and amplify the assets, community-level interventions, especially community-driven and collaborative efforts, play a central role with each of the community health drivers described below.

- **Access to Healthcare-** The ability to obtain healthcare services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions. For healthcare to be accessible it must be affordable and convenient.
- **Chronic Disease** - The CDC defines chronic disease as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. The seven most common chronic diseases are heart disease, cancer, chronic lung disease, stroke, Alzheimer's, diabetes, and chronic kidney disease.
- **Healthy Aging -** The process of maintaining good physical, mental, and social well-being as people grow older. Maintaining a lifestyle with healthy behaviors and management of diseases helps to ensure independency as individuals age.
- **Infectious Disease Prevention** - Practical, evidence-based approach preventing patients and health workers from being harmed by avoidable infections.
- **Maternal Health- T**he well-being of women during pregnancy, childbirth and the postpartum period, encompassing the physical, emotional and social aspects of a woman's reproductive health with a goal of a safe and healthy outcome for both mother and newborn.
- **Mental Health & Substance Use Disorder (SUD) -** Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. SUD refers to the use of selected substances, including alcohol, tobacco products, drugs, inhalants, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body with possible dependence and other detrimental effects.
- **Obesity, Nutrition, and Exercise** - As noted by the National Institutes of Health, a healthy body weight, good nutrition, and physical activity can help prevent or manage serious and chronic cardiovascular diseases, high blood pressure, heart disease, and stroke. A healthy weight can also help reduce the risk of certain lung and sleep conditions, such as asthma and sleep apnea.

ACCESS TO HEALTHCARE

Across Three Rivers Health District, two factors restrict access to services: The lack of healthcare providers and facilities and socioeconomic factors, such as poverty and transportation barriers, which prevent individuals from seeking or accessing care. The institutional and individual factors exacerbate the other. This problem is, unfortunately, well known and recognized by the federal Health Resources and Services Administration (HRSA). HRSA categorizes the problem and refers to them as shortage areas. Two types of shortage areas (Medically Underserved Areas (MUAs) for primary care, and Health Provider Shortage Areas (HPSAs) for primary care, mental health, and oral health) are present in the district.

- Nine counties and the Gloucester subcomponent of Petsworth are designated as MUAs for primary care.
- All counties except for Mathews and Middlesex are designated as HSPAs for primary care.
- All 10 counties comprise the Middle Peninsula/Northern Neck MHCA (Mental Health Catchment Area), which is a High Needs Geographic HPSA for mental health.
- Northumberland and Lancaster are designated as HPSAs for dental health.
- Essex, King and Queen, Richmond and Westmoreland have HPSA designations for dental health for their Low Income Population.

Potentially Avoidable Hospitalizations in 2020

1,079

Rate per 100,000 Adults

District: 928

VA: 820

Admissions for certain acute illnesses and chronic conditions that might have otherwise been managed successfully in an outpatient setting.

Patients per PCP

District: 2,699

VA: 1,324

Patients per Dentist

District: 2,699

VA: 1,351

The number of patients per provider varies widely among the district's counties. The district has 53 Primary Care Physicians (PCPs) and 53 dentists. Most PCPs and dentists are located in Gloucester or Northumberland. The remaining eight counties have five or fewer PCPs each. King and Queen County does not have a dentist. **Northumberland** is the only county in the district with a better patient-to-dentist ratio (831:1) than the state as a whole or a patient-to-PCP ratio (1,341:1) similar to the state.

Adults Delayed Health Care due to Cost, 2020

District: 15.5%

VA: 10.4%

Uninsured Children (Ages 0-18)

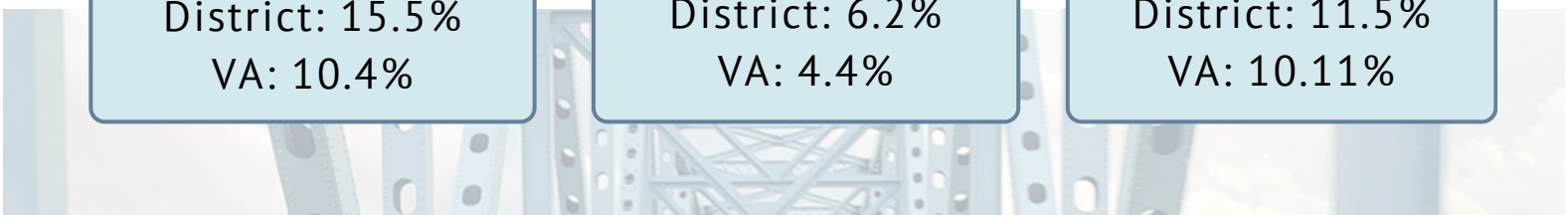
District: 6.2%

VA: 4.4%

Uninsured Adults (Ages 18-64)

District: 11.5%

VA: 10.11%



ACCESS TO HEALTHCARE

KEY RESOURCES & OPPORTUNITIES FOR GROWTH

Health Education and Literacy (HEAL) program: This program improves individuals' ability to understand basic health information and services to make appropriate health decisions for example when to go to urgent care versus the ER and reading and understanding medication instructions.

Remote Area Medical (RAM) Clinics: RAM is a major nonprofit provider of free pop-up clinics. They provide medical, dental, and vision services for no charge in many communities nationally. Every year we have a clinic in one of our 10 counties.

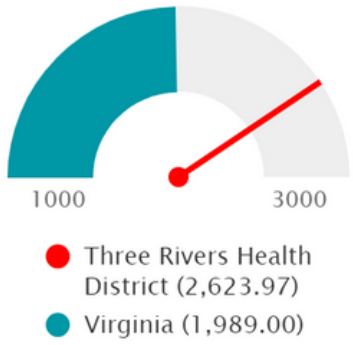
Free Clinics: Five free clinics in the district offer services at little to no cost for low income, uninsured and underinsured individuals.

Student Loan Repayment Program: The Virginia Student Loan Repayment Program is operated by the Virginia Department of Health-Office of Health Equity, providing a non-taxed incentive to qualified medical, dental, behavioral health and pharmaceutical (pharmacists) professionals in return for a minimum of two (2) years of service at an eligible practice site in one of the federally designated HPSAs.

CHRONIC DISEASE

As the leading causes of death in our community, chronic diseases are multifaceted and require tremendous attention and resources to address. Chronic disease can be measured by hospitalizations and prevalence data. When adequate access to outpatient care and other health supports are available, additional issues may present such the lack of insurance or the misunderstanding of a healthcare professional's instruction. One local hospital noted in its CHNA that the leading diagnoses for preventable hospitalizations were for chronic diseases such as congestive heart failure, diabetes, COPD, or asthma in older adults. The crude rates for these hospitalizations were higher in the study region than for Virginia as a whole for all diagnoses where a rate was calculated. These factors indicate opportunities to increase patient self-management and education.

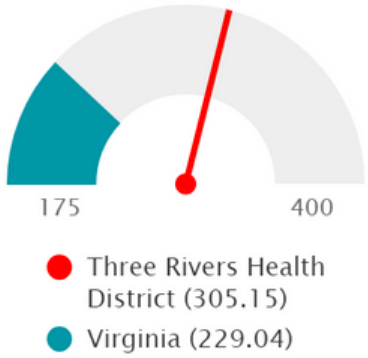
Hospitalizations with Diabetes rate per 100,000 total population



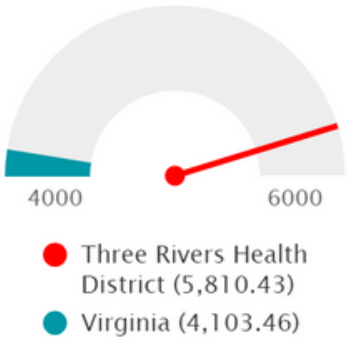
Count of Hypertension Hospitalizations

8,264

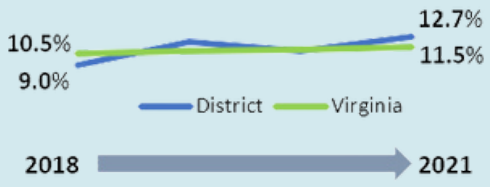
Hospitalizations with Stroke rate per 100,000 total population



Hospitalizations with Hypertension rate per 100,000 total population

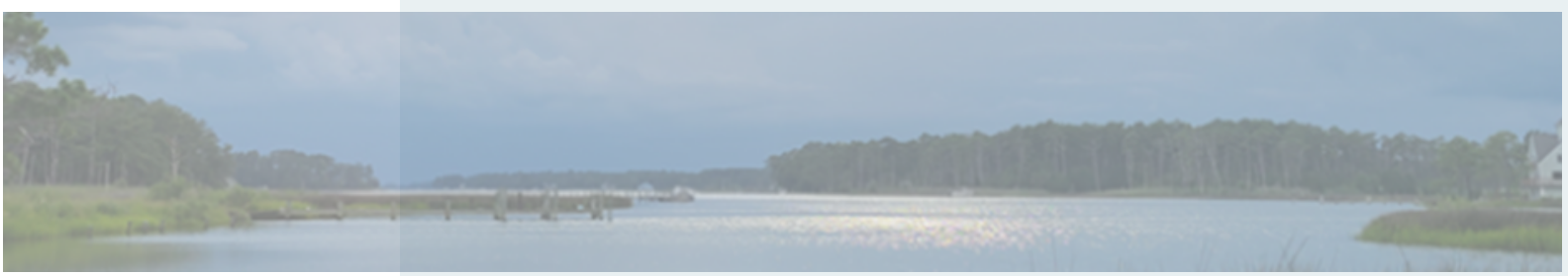


Adults with Diabetes



Adults with High Blood Pressure, 2021

District: 45.3%
VA: 34.4%



CHRONIC DISEASE

According to the Centers for Disease Control and Prevention*, heart disease, cancer and diabetes are either caused or exacerbated by lifestyle choices. Unhealthy lifestyles include any tobacco use, excessive alcohol use, a diet high in processed foods and lack of exercise. Over time, these poor lifestyle choices can lead to heart disease, Type 2 diabetes, an increased risk of stroke, liver disease and cancer.

COPD, Emphysema, Chronic Bronchitis Prevalence

District: 7.9%
VA: 6.4%

Heart Attack Prevalence Among Adults

Lung Cancer Diagnosis per 100,000

District: 578.1
VA: 319.8

Adults Who Currently Smoke

TRHD: 18.6%
VA: 13.6%

E-cig TRHD: 9.5%
E-cig VA: 5.2%

Deaths from Liver Disease/Cirrhosis per 100,000

District: 19.2
VA: 11.9

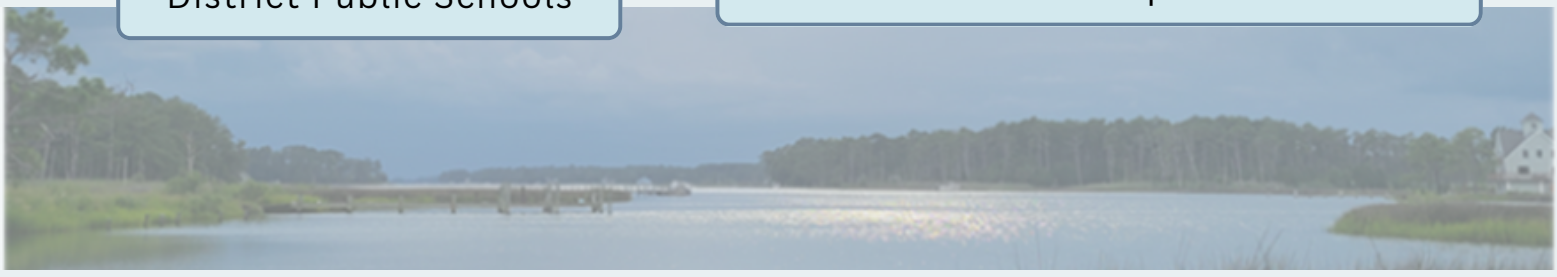
Reported School Disciplinary Events for Tobacco/Vape/E-Cig

351

2021-22 School Year
District Public Schools

Factors contributing to these trends:

- an aging population
- unhealthy lifestyles
- lack of access to healthcare
- low health literacy
- socioeconomic disparities



*https://www.cdc.gov/heartdisease/index.htm

CHRONIC DISEASE

KEY RESOURCES & OPPORTUNITIES FOR GROWTH

Strategies to alleviate the impact of these diseases on the individual and the local healthcare system include preventative measures, early detection, and effective management. These interventions for individuals must be accompanied by collaborative efforts between medical professionals, community organizations, local health departments, and policy makers. Such collaboration is necessary to address the multifaceted factor contributing to chronic disease prevalence within the district.

Blood Pressure Program: Three Rivers' offers free blood pressure screenings and education. We provide resources to promote blood pressure conversations with a health care provider and education and tools to manage a diagnosis.

BEAT Diabetes Programs: This program delivers diabetes prevention or management tips directly to a mobile phone by text and offers financial rewards to help motivate individuals to take action for 12- months free of charge for people with Type 2 and prediabetes.

Health Education and Literacy (HEAL) Program: This program improves individuals' ability to understand basic health information and services to make appropriate health decisions for example when to get screening tests for chronic diseases, medication management, and how family history and risk factors affect health.

Expand Partnerships for Prevention Programs: Healthy eating and physical activity are natural prevention methods for chronic diseases. Engaging communities in active programs through local YMCAs and Parks and Recreation can improve health opportunities.

HEALTHY AGING

Healthy aging refers to the process of maintaining good physical, mental, and social well-being as people grow older. As people age the risk of chronic diseases such as dementia, heart disease, Type 2 diabetes, arthritis, and cancers increase.

With proactive behavior, individuals can mitigate the risks. Mitigation, in the form of a healthy lifestyle and behaviors, includes regular health screenings for early detection, managing chronic health conditions, adhering to prescribed treatments, and seeking medical advice before things get worse.

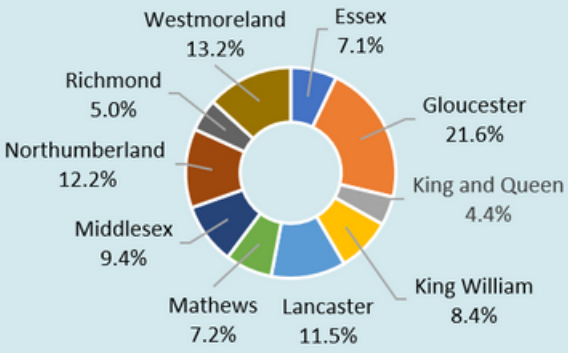
In a similar way, communities can be healthy when they are proactive. Proactive communities adopt quality of life, independence, and overall well-being during the later stages of life.

Percent Age 65+
TRHD: 25.6%
VA: 16.2%

>30% of County Age 65+
Lancaster: 38.4%
Northumberland: 37.6%
Middlesex: 32.3%
Mathews: 31.0%

Adults Ages 65+
36,592

Where They Live



Preventable Hospitalization*
Rate per 100,000 Medicare Enrollees

TRHD: 2,443
VA: 2,902

Westmoreland: 4,280
King & Queen: 3,073

*Hospital stays for ambulatory-care sensitive conditions

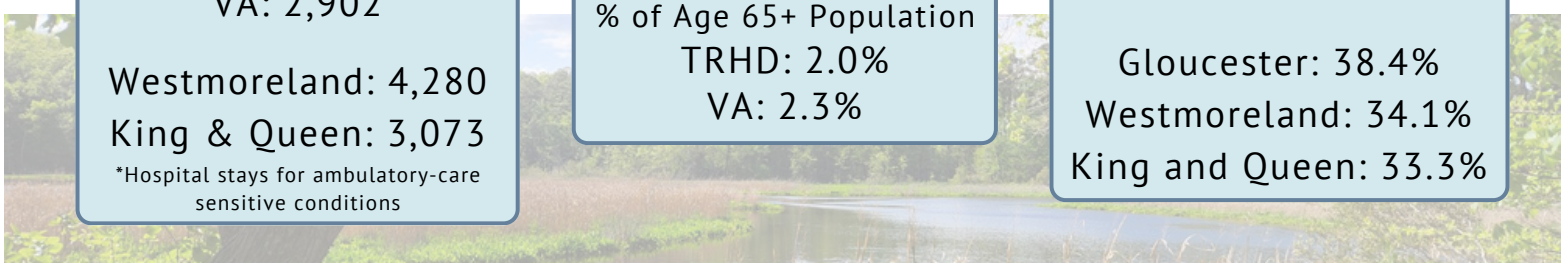
Adults Ages 65+ in Nursing Facilities/ Skilled Nursing
733

% of Age 65+ Population
TRHD: 2.0%
VA: 2.3%

Percent of Age 65+ Population with a Disability

TRHD: 31.3%
VA: 32.0%

Gloucester: 38.4%
Westmoreland: 34.1%
King and Queen: 33.3%



HEALTHY AGING

KEY RESOURCES & OPPORTUNITIES FOR GROWTH

Continued Engagement of Community Partners: Many counties have local Parks and Recreation programs, libraries, YMCAs, senior centers, and/or adult day centers that provide a variety of activities that support social, mental, physical, and emotional dimensions of wellness for all ages.

Bay Aging: Bay Aging provides programs and services people of all ages need to live independently in their communities. The services include transportation, housing, caregivers or aids, and much more.

Disability, Access, and Functional Needs (DAFN) Program: Three Rivers' DAFN program seeks to provide aide in various ways to those who maybe more vulnerable than others. The program can potentially assist with clothing, food, and transportation services; referrals for health services, family counseling, and career skill development; along with other support capabilities.

INFECTIOUS & REPORTABLE DISEASE

Infectious diseases are the leading causes of illness, disability, infertility and death around the world. The diversity of diseases and their ability to adapt presents ongoing and evolving challenges to prevent and control infectious disease outbreaks. An infectious disease is a condition in which a microorganism (virus, bacterium, or parasite) manages to penetrate and multiply in the human body, causing direct damage to the body's cells. Although COVID-19 has received much attention since 2019, 79 infectious diseases are reportable to local public health authorities in Virginia, with 31 requiring immediate reporting and 48 requiring reporting within 3 days. Each year, outbreaks or cases occur in the district for diseases such as Influenza (flu), Salmonellosis, and early syphilis. Besides COVID-19, the most commonly reported infectious disease during 2022 were Chlamydia trachomatis, chronic Hepatitis C, Gonorrhea.

- The top eight reportable conditions are infectious diseases, and they account for 90% of cases reported for TRHD.
- Two food-borne illness were among the top five reportable diseases in the district during 2022, Salmonellosis (28 cases, 3.1%) and Campylobacteriosis (27 cases, 3%). These disease were 8th and 6th most common reportable diseases in Virginia respectively.

Reportable Condition*	TRHD		Virginia		TRHD % of Virginia Cases *
	Cases	%	Cases	%	
Chlamydia trachomatis	453	49.8%	40,344	54.7%	1.1%
Hepatitis C, chronic	144	15.8%	5,955	8.1%	2.4%
Gonorrhea	128	14.1%	13,266	18.0%	1.0%
Salmonellosis	28	3.1%	1,197	1.6%	2.3%
Campylobacteriosis	27	3.0%	1,472	2.0%	1.8%
Syphilis, early	13	1.4%	1,564	2.1%	0.8%
Hepatitis B, chronic	13	1.4%	1,662	2.3%	0.8%
HIV	12	1.3%	838	1.1%	1.4%
Neonatal Abstinence Syndrome	12	1.3%	158	0.2%	7.6%
Lead, elevated levels	11	1.2%	919	1.2%	1.2%
All Other Reportable Conditions	68	7.5%	1,423	1.9%	4.8%
TOTAL	909	100.0%	73,799	100.0%	1.2%

COVID-19 (2022)

Cases
16,235

Hospitalizations
228

Deaths
154

*** Infectious diseases are bolded. TRHD represents 1.7% of the Virginia population. Gold highlight indicates that TRHD cases represent greater than 1.7% of the Virginia cases.**

INFECTIOUS DISEASE

KEY RESOURCES & OPPORTUNITIES FOR GROWTH

Family Planning Clinics: Three Rivers' nursing team provides education and counseling about reproductive health to all clients. Services include clinical assessments such as pap smears; birth control services using a client-centered approach and testing for sexually transmitted infections (STI).

Ryan White Program: The TRHD Ryan White program currently serves 72 clients and provides a wide range of services to our HIV positive eligible clients. These services include, with the help of outside providers, medical and dental care, medications, transportation to services, food assistance, referral for mental health services and other support services.

Immunization Clinics: The TRHD offers a variety of vaccines including Influenza (Flu); Human Papillomavirus (HPV), Hepatitis; Tetanus, Diphtheria, Pertussis (DTaP); Measles, Mumps, Rubella (MMR); Meningococcal, and several others.

Epidemiology Coordination: The health district investigates cases of reportable diseases and provides education to reduce the spread of illness across the community while providing outreach and resources to prevent the onset of disease outbreaks.

MATERNAL HEALTH

Maternal health refers to a woman's health and well-being before, during, and after pregnancy and encompasses aspects of physical, mental, emotional, and social health. In rural settings like the Three Rivers Health District, several challenges can impact maternal health. Eight out of 10 counties in the Middle Peninsula and Northern Neck have no prenatal care provider. Local hospitals deliver infants on an emergency basis only, and no birthing centers are located in the district. Shortages in prenatal providers and the lack of birthing facilities mean that women may need to travel long distances to access appropriate care, which may lead to undetected health issues for both mother and fetus. This situation also leads to delays in receiving medical attention during labor and delivery. Inadequate or limited access to healthcare services, facilities, and skilled birth attendants can lead to higher maternal and infant mortality rates. The limited access to prenatal care, poor nutrition and lack of awareness can contribute to low birth weight among newborns, increasing their vulnerability to health issues and developmental delays. Addressing these challenges requires community level education and outreach combined with investments in new providers and innovative delivery models, such as telehealth.

Mothers with Late or No Prenatal Care
Percent of Live Births

District: 3.7%
VA: 4.1%

King & Queen: 7.1%
Richmond: 5.4%

Maternal Mortality Rate
Per 100,000 Live Births

District: 59.6
VA: 47.9

Teen Pregnancies
Per 100,000 Females Ages 15-19

District: 20.8
VA: 17.3

Middlesex: 40.4
Westmoreland: 31.6

Preterm Births
Percent of Live Births

District: 11.2%
VA: 9.6%

Essex: 16.7%
Northumberland: 15.2%

Infant Mortality Rate
per 1,000 Live Births

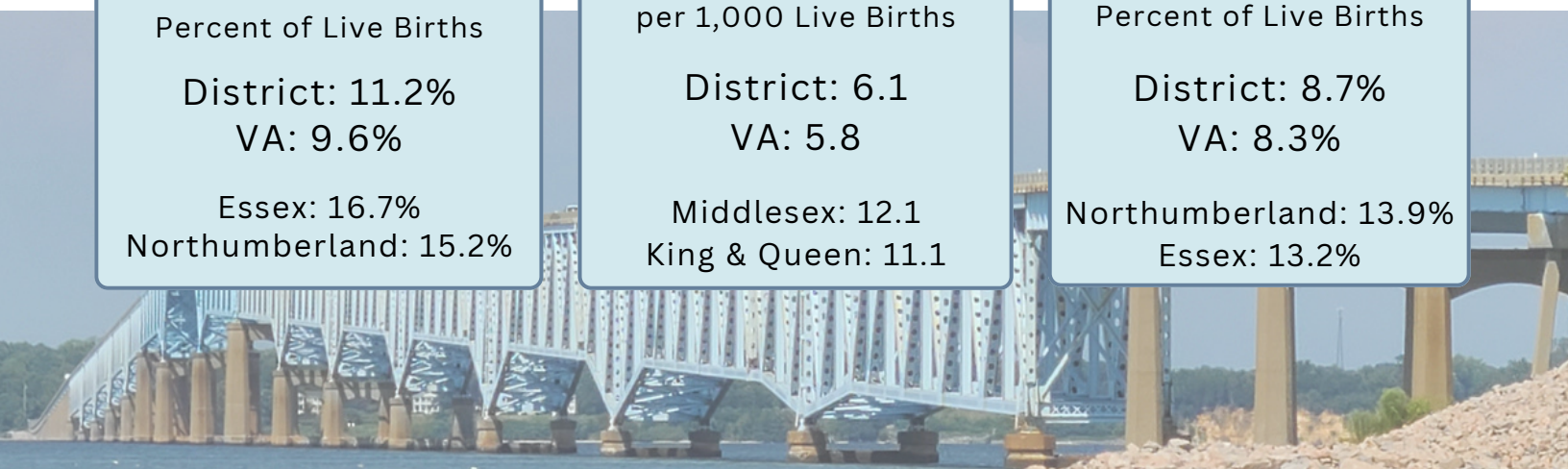
District: 6.1
VA: 5.8

Middlesex: 12.1
King & Queen: 11.1

Low Birth Weight
Percent of Live Births

District: 8.7%
VA: 8.3%

Northumberland: 13.9%
Essex: 13.2%



MATERNAL HEALTH

KEY RESOURCES & OPPORTUNITIES FOR GROWTH

Resource Mothers: This free home-visiting program offers mentorship and support for first-time pregnant teens 19 years of age or younger. It adds resilience by providing individuals with support, education, and encouragement to achieve their life goals.

Family Planning: The Three Rivers Health District and other community partners provide family Planning services to male and female clients for reproductive health, including Birth Control, testing and treatment for STI's, and education/counseling.

Women, Infant and Children (WIC) program: Provides nutritious supplemental foods for eligible pregnant women and new moms. It also educates about nutrition and health, with personalized assessments, counseling and support. It offers referrals to additional services and health resources.

Doulas: Doula's provide practical and emotional support to a pregnant individual, their partner, and family members. Doulas are not medical professionals, and they don't deliver babies or provide medical care, but they can help the pregnant person communicate with the health care team. They are available to support a woman during pregnancy, delivery and afterwards. Doulas are trained and certified for their position. Currently there are 107 state-certified doulas within the Commonwealth, 57 of which are also certified to accept Medicaid.

MENTAL HEALTH

Mental health encompasses emotional, psychological, and social wellbeing, effecting how people think, react, and process stress. In the district, there are many gaps in mental health services including lack of available providers and affordable services. Increasing the number of mental/behavioral health providers is a top health priority across the district. Although the entire district has a shortage of mental health providers, the distribution among counties is varied. Almost 60% of mental health providers in the district are located in Gloucester County; whereas, none are located in King and Queen County.

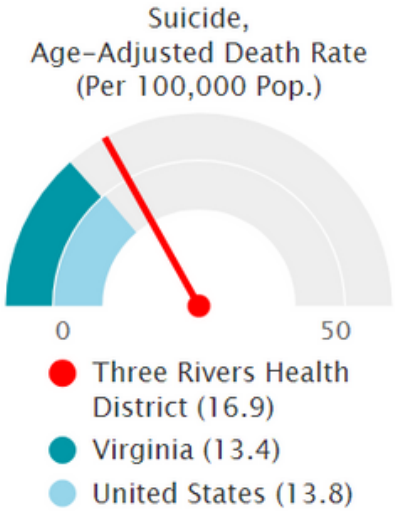
Ratio of Population to Mental Health Providers
TRHD: 1,060:1
VA: 447:1

Adults with Depressive Disorder
TRHD: 23.2%
VA: 17.2%

Frequent Mental Distress
(14+ Days Last Month, 2020 Survey)

Percentage of Adults
TRHD: 14.6%
VA: 12.6%
Essex: 15.7%
Westmoreland: 15.4%

* Includes self-reported stress, depression or problems with emotions



Self-Harm/Suicide-Related ED Visits, 2021
774

Rate per 100,000 Age 5+
TRHD: 571.1
VA: 680.9
King William: 730.5

SUBSTANCE USE DISORDERS

Substance abuse, particularly opioid abuse, is a quiet but persistent problem in the district. Opioid-related overdose deaths have increased in recent years, and the area has seen an increase in the number of individuals seeking treatment for substance abuse disorders. The problem transcends age, gender and socioeconomic backgrounds. Recognizing the urgency of the situation, Three Rivers Health Department has taken a proactive approach, partnering with law enforcement, public schools and community groups and partners, to develop a comprehensive strategy that combines education, prevention, intervention and support. While the specific services may vary between counties, there are several common elements in the region's approach to addiction treatment support.

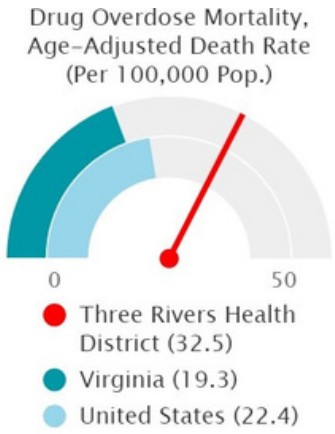
Neonatal Abstinence Syndrome (NAS), 2020

12

Rate per 1,000 Birth Hospitalizations

TRHD: 10.3

VA: 5.7



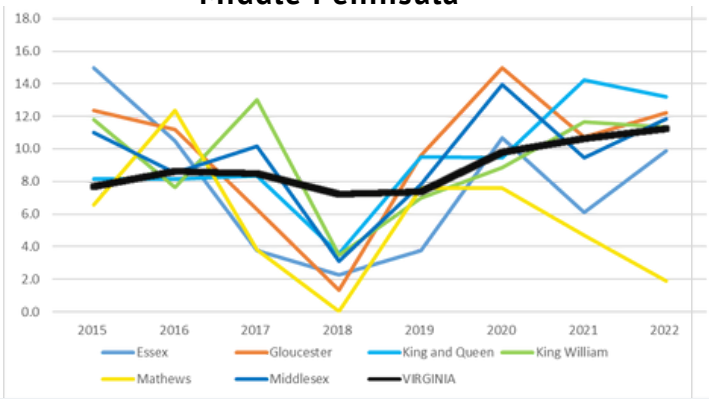
Overdose Deaths in TRHD, 2022 by Substance

Fentanyl: 22
Cocaine: 14
Meth: 8
Prescription Opioid (not Fentanyl): 6

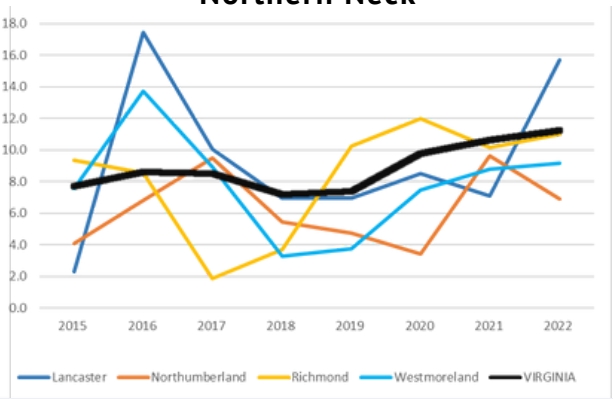
182 Opioid Overdose ED Visits among TRHD Residents in 2022

Average Monthly Opioid Overdose ED Visit per Year: Rate per 100,000 Population

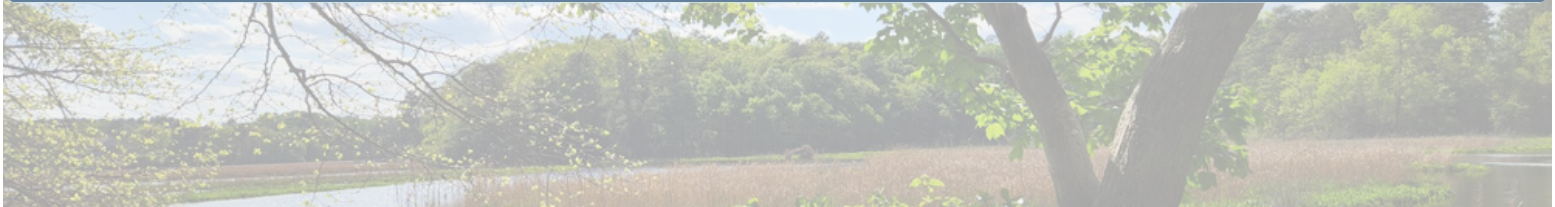
Middle Peninsula



Northern Neck



County and Virginia rates were lowest in 2018, but this improvement was lost for some counties during and after the COVID pandemic and as fentanyl use increased.



MENTAL HEALTH AND SUBSTANCE USE DISORDER

KEY RESOURCES & OPPORTUNITIES FOR GROWTH

Enhance outreach, education, and access to available trainings: There are many trainings with techniques that can be used during mental health crisis situations. Some of these trainings include Mental Health First Aid (MHFA) Trainings; QPR (Question, Persuade & Refer) Trainings and ASIST (Applied Suicide Intervention Skills Training). Many of these trainings can be accessed through the local Community Service Boards (CSB)

Increase utilization of treatment centers: The district boasts several addiction treatment centers that provide a range of addiction treatment services including; assessments, detoxification programs, outpatient treatment, counseling, cognitive behavioral therapy and motivational interviewing, Medical-Assisted Treatment (MAT) and aftercare support. In addition, the district has two residential treatment facilities which offer individual and small group therapy, clinical therapy, MAT and continual care management.

Expand REVIVE! Training Capacity & Naloxone Availability: REVIVE! is a program designed to teach individuals how to recognize and respond to an opioid overdose emergency with Naloxone or Narcan. It can be taught in a 30 minute classroom setting or in a 15 minute rapid in the field training setting. The program has been successful in decreasing the number of deaths from opioid overdoses.

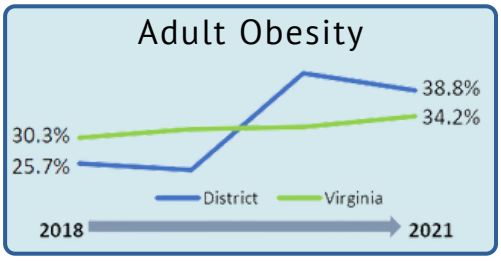
Drug Take Back Programs: THRD works with law enforcement agencies to ensure that each county is actively participating in the federal Drug Take-Back initiative. Law enforcement collects drugs on a regular basis and participates in two national prescription drug take-back days each year. The purpose of this effort is to anonymously collect and properly dispose of unused and unwanted prescription medications which can be accidentally ingested, stolen, misused and abused. In addition, TRHD is working with the communities to provide drug disposal pouches for destroying prescription medications.

988 Suicide & Crisis Lifeline: Calling or texting the 988 line gives individuals access to a 24-hour service that provides free and confidential support during suicidal crisis or emotional distress.

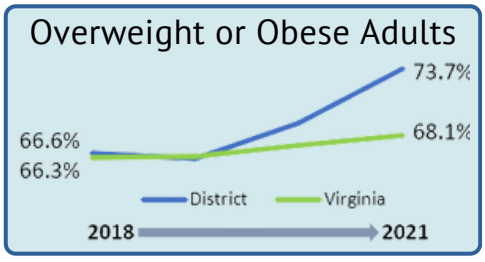
OBESITY, NUTRITION, EXERCISE

Obesity, poor nutrition, and lack of exercise opportunities are significant health concerns in the region. The prevalence of obesity and related chronic diseases is high and access to healthy food options is limited in many areas. Having a low income and not living close to a grocery store limits access to healthy foods. This issue is further compounded by the lack of resources and education on healthy eating and lifestyle habits. Many residents living in rural counties do not live close to a park or exercise facility to have adequate access to exercise opportunities. In addition, rural areas have less sidewalks and bike paths. Having a healthy weight, exercising and eating a balanced diet is a natural form of prevention for many chronic diseases. Increased physical activity can reduce the risk of type 2 diabetes, cancer, hypertension, and heart disease.

Obesity is an issue among youth as well as adults. When Body-Mass Index (BMI) was calculated for 2,708 Virginia high school students during the 2021 Youth Risk Behavior Survey, 15.3% of high schoolers were overweight and 16.4% were obese according to age and sex-specific CDC growth charts. Although BMI was not reported for middle schoolers during the survey, 29% of 1,472 surveyed middle schoolers described themselves as slightly or very overweight.



Body mass index 30.0-99.8



Body mass index greater than 25.0

No Physical Activity in Last Month	Limited Access to Healthy Foods	Access to Exercise Opportunities
District: 22.6% Virginia: 20.4%	Essex: 16.6% Virginia: 4.4%	King & Queen: 22.3% Virginia: 83.4%

OBESITY, NUTRITION, & EXERCISE

KEY RESOURCES & OPPORTUNITIES FOR GROWTH

Expand the Development and Availability of Resource Guides: List of Local food banks and farmers markets that offer free, or reduced-price items.

Expand Health Education and Literacy (HEAL) & Other Education Program Participation: This program improves individuals' ability to understand basic health information and services to make appropriate health decisions. For example, reading nutrition labels and preparing healthy meals.

Engaging community partners: Partnerships with organizations such as the YMCA, Boys and Girls Clubs, and Fitness and wellness centers can help to increase participation in programs and education classes which can improve overall health.

ADDITIONAL COMMUNITY HEALTH FACTORS

The region's community health assessments and data identified numerous drivers of individual and community health that are multifaceted and require complex social, political, and cultural interventions to address. Three Rivers Health District is committed to continuing to highlight these challenges and leverage community partnerships and resources to address these complex factors:

- Coastal Resilience and Adaptation
- Educational Attainment
- Poverty
- Affordable Housing
- Broadband
- Environmental Health?
- Crime
- Food Access

NEXT STEPS

Addressing health disparities requires coordination across sectors and effective outreach and communication. To help address the health needs identified by the community, the Three Rivers Health District is committed to facilitating discussions across the district to develop strategies that address opportunities for growth. Furthermore, the Three Rivers team has developed, and will maintain, a data portal on its website presenting community level data to facilitate program planning in addition to a menu of community resources. These resources can be found at https://www.vdh.virginia.gov/three-rivers/healthy-community/.

DATA SOURCES/FURTHER READING

Data Topics by Source	Page	Data Timeframe
University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation, 2023 County Health Rankings, https://www.countyhealthrankings.org. (This source provides a single access point for data compiled from multiple primary data sources listed below.)		
Health Resources and Services Administration (HRSA), Area Health Resource Files. https://data.hrsa.gov/topics/health-workforce/ahrf.		
• Patients per PCP and county location narrative: American Medical Association Masterfile.	8	2020
• Patients per Dentist and county location narrative: National Provider Identifier Downloadable File.	8	2021
Centers for Medicare and Medicaid Services (CMS)		
CMS, Mapping Medicare Disparities Tool. • Preventable hospitalizations by county among Medicare enrollees and numerator for calculated district rate (Definition: Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees) **CMS, Medicare Enrollment Dashboard,** https://data.cms.gov/tools/medicare-enrollment-dashboard, accessed 8/7/3023. • Medicare Enrollees (Fee-for-service and Medicare Advantage sum) used in weighting county rates to calculate denominator for district rate	13	2020
CMS, National Provider Identification. • Patients per Mental Health Provider (Denominator of district rate was calculated using Census Bureau, 2020 Decennial Census, Demographic Profile, see full citation.)	19	2022
ArcGIS Business Analyst and Living Atlas of the World; YMCA • Access to Exercise Opportunities	22	2020
Behavior Risk Factor Surveillance System, Centers for Disease Control		
• Frequent Mental Distress (Defined as 14 or more days of self-reported stress, depression or problems with emotions within the last 30 days. Denominator of district rate was calculated using Census Bureau, 2020 Decennial Census, Demographic Profile, see full citation.)	19	2020
• No Physical Activity (Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted))	22	2020
U.S. Department of Agriculture (USDA). Food Environment Atlas. • Limited Access to Healthy Foods (Defined as percentage of population who are low-income and do not live close to a grocery store.)	22	2019

DATA SOURCES/FURTHER READING

Data Topics by Source (continued)	Page	Data Timeframe
U.S. Census Bureau (USCB). Multiple tables were accessed from https://data.census.gov and are cited below.		
USCB, American Community Survey (ACS) 5-year Estimate (2021). Table ID: S1810: Disability Characteristics. • Percent of Age 65+ Population with a Disability	13	2021
USCB, 2020 Decennial Census, Demographic Profile, Table ID: DP1.		
• Race/ethnicity • Population by age and sex	5	2020
• Adults age 65+ population, county of residence	12	2020
USCB, 2020 Decennial Census, Demographic and Housing Characteristics, Table ID: P18.Population in Group Quarters. • Population Age 65+ in Nursing Facilities/Skilled Nursing	13	2020
U.S. Health Resources and Services Administration (HRSA). Source for multiple topics below.		
Health Professional Shortage Areas for primary care, dental, mental health, https://data.hrsa.gov/tools/shortage-area/hpsa-find	8	as of 9/6/23
Medically Underserved Areas, https://data.hrsa.gov/tools/shortage-area/mua-find	8	as of 9/6/23
Narrative regarding impact of few rural prenatal care providers: Rural Health Information Hub, Need for Maternal Health Programs in Rural Areas, https://www.ruralhealthinfo.org/toolkits/maternal-health/1/need-in-rural	17	Published 5/17/2021
County Prenatal Care Provider statistics narrative: https://data.HRSA.gov, Selected Filters: M.D., Obstetrics and Gynecology, Population, All (County Level File); Primary data source: AMA Physician Masterfile.	17	2020
Virginia Department of Health (VDH), Behavior Risk Factor Surveillance Survey (BRFSS), https://www.vdh.virginia.gov/data/health-behavior/chronic-disease-map-by-district/.		
• Adults with Diabetes trend	10	2018-2021
• Adults with High Blood Pressure	10	2021
• COPD, Emphysema, Chronic Bronchitis Prevalence	11	2021
• Adult Heart Attack Prevalence	11	2018-2021
• Adult Obesity • Obese or Overweight Adults	22	2018-2021

Topics by Data Source (Continued)		Page	Date Timeframe
Virginia Department of Health (VDH), Office of Information Management, Division of Health Statistics, Plan for Well-being, Assessment website: https://virginiawellbeing.com/virginia-community-health-improvement-data-portal/vdh-assessment/. (This source provides a single access point for data compiled from multiple primary data sources listed below.)			
	VDH Division of Health Statistics, Inpatient Discharge Dataset		
	• Potentially Avoidable Hospitalizations	8	2020
	• Hospitalizations by Condition (Diabetes, Hypertension, Stroke)	10	2020
	Behavior Risk Factor Surveillance Survey (BRFSS), Virginia Department of Health		2020
	• Adults Delaying Care due to Cost	8	
	• Adults Who Currently Smoke	11	
	• Adults with Depressive Disorder	19	
	Centers for Disease Control and Prevention (CDC), National Vital Statistics, via CDC WONDER		2016-2020
	• Deaths from Liver Disease/Cirrhosis (crude rate)	11	
	• Suicide, Age-Adjusted Death Rate	19	
	• Drug Overdose Mortality, Age-Adjusted Death Rate	20	
	U.S. Census Small Area Health Insurance Estimates • Uninsured Children • Uninsured Adults	8	2020
	VDH Office of Information Management, Vital Event Statistics Program.		
	• Infant Mortality Rate • Maternal Mortality Rate	17	2018-2020
	• Mothers with Late/No Prenatal Care • Preterm Births • Teen Pregnancies • Low Birth Weight	17	2020
	• Neonatal Abstinence Syndrome (NAS) Births	20	2020
	VDH, Office of Epidemiology, Division of Surveillance and Investigation. • Self-Harm /Suicide-Related ED Visits	19	2021

Topics by Data Source (Continued)	Page	Date Timeframe
Virginia Department of Education, Student Behavior and Administrative Response Collection. https://www.doe.virginia.gov/data-policy-funding/data-reports/data-collection/student-behavior-and-administrative-response-collection, (Behavior Code: BSC5, Tobacco: Possessing/Using/Distributing tobacco products, possessing tobacco paraphernalia, electronic cigarettes, vaping equipment.) • Reported School Disciplinary Events for Tobacco/Vape/E-Cig	11	2021-2022 School Year
Virginia Department of Health (VDH), Forensic Epidemiology, https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/. • Overdose Deaths by Substance	20	2022
VDH, Virginia Cancer Registry. Updated June 2023. • Lung Cancer Diagnosis Rates	11	2016-2020
VDH, Office of Epidemiology, Division of Surveillance and Investigation, Syndromic Surveillance Data, https://www.vdh.virginia.gov/surveillance-and-investigation/syndromic-surveillance/drug-overdose-surveillance/, 5/5/23. • Opioid Overdose ED Visits: District total, Average monthly ED visits per county	20	2022
VDH, Office of Epidemiology, Division of Surveillance and Investigation, *Virginia Department of Health Reportable Disease Monthly Surveillance Report*, https://www.vdh.virginia.gov/surveillance-and-investigation/virginia-reportable-disease-surveillance-data/virginia-monthly-morbidity-surveillance-report-2018/ • Reportable Conditions	15	2022
VDH, Office of Family Services, *Youth Risk Behavior Survey*, https://www.vdh.virginia.gov/virginia-youth-survey/data-tables/. High School Summary Tables, 2021VAH-Summary-Tables.pdf; Middle School Summary Tables, 2021VAM-Summary-Tables.pdf. • Obesity among Middle and High Schoolers, narrative	22	2021
VDH, *Tobacco Control Program Dashboard*, Tableau Server, dataviz.vdh.virginia.gov, accessed 8/10/2023. • Adult E-Cig Use	11	2020
VDH New Releases, https://www.vdh.virginia.gov/news/2023-news-releases, Governor Glenn Youngkin Announces A Commonwealth Milestone: Over 100 Doulas Certified A Year After The Establishment Of The Commonwealth's Certification Program, April 19, 2023. • Doulas, narrative	18	April 2023
VDH, Virginia Open Data Portal, VDH-COVID-19-PublicUseDataset-Cases_By-District-Death-Hospitalization, https://data.virginia.gov/Government/VDH-COVID-19-PublicUseDataset-Cases_By-District-De/v5a8-4ahw/data. • COVID cases, deaths and hospitalizations	15	2022