2025
Community Health Assessment








Lord Fairfax Health District

ValleyHealth
Healthier, together.

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Letter from the Core Team

To the Community Members of the Northern Shenandoah Valley,

We are pleased to share with you the **2026 Community Health Assessment (CHA) -** a vital resource to guide our collective efforts toward a healthier, more equitable region. This report is the result of a meaningful collaboration between **Valley Health** and the **Lord Fairfax Health District (LFHD)**, undertaken with the shared goal of understanding and improving the health and well-being of everyone in the Northern Shenandoah Valley.

This assessment reflects more than just data—it reflects the lived experiences, challenges, and strengths of our community. It examines the factors that influence health in our region, identifies priority areas of need, and outlines opportunities for community-driven action. In short, it provides a guide to help us understand where we are, where we want to go, and how we can move forward—together.

This marks the first time Valley Health and LFHD have partnered on a CHA, recognizing that no single organization can achieve health equity alone. Our collaboration reflects a growing recognition that addressing the root causes of health outcomes requires **broad-based engagement and shared responsibility** across the public health system, healthcare, and community-based organizations. By joining forces, we were able to deepen community input, better align resources, and elevate a more **comprehensive, inclusive, and public health–centered** approach to the assessment.

A key shift in this CHA is the move away from a traditional healthcare-centric lens to one that centers on **health equity and the social drivers of health** - the conditions in which people live, learn, work, and play. We acknowledge that access to medical care is only one component of health. Equally, if not more important, are the structural and systemic factors such as education, housing, employment, transportation, food security, and access to safe and supportive environments. These social conditions disproportionately affect certain populations in our region, leading to **persistent health disparities** that must be addressed through intentional, collaborative action.

Understanding these disparities is a critical first step, but it is not enough. Achieving health equity means we must actively work to **remove barriers**, **amplify community voices**, and **strengthen partnerships** with those who are most impacted. We are committed to continuing this work alongside our **community partners**, who bring essential insight, leadership, and trust to the process.

We invite you to explore the findings in this report with a shared sense of purpose and possibility. Let it be a catalyst for conversation, collaboration, and action across all sectors of our community. We are deeply grateful to our local government agencies, nonprofit organizations, community groups, and residents who contributed their time, perspectives, and expertise to this assessment.

Together, we can build a healthier, more just future for all who call the Northern Shenandoah Valley home.

In partnership,

The Core Team

Context & Background

Context and Background

This document has been written by public health and healthcare professionals. Though conscious efforts have been made to make this information as accessible and understandable as possible, some concepts may be unfamiliar to some. We recognize the need for clear explanations regarding key terminology and abbreviations and the following subsections include such.

Key Terminology

Below are terms and the associated definitions of those terms. These are included to provide additional background for terms that may not be commonly used and understood by those with limited understanding of public health language.

Age-Adjusted Rate – Almost all diseases or health outcomes occur at different rates in different age groups. For example, most chronic diseases, including most cancers, occur more often among older people. Other outcomes, such as many types of injuries, occur more often among younger people. Observing age-adjusted rates allows public health officials to view a clearer picture of common health problems in a community by removing age differences that could impact health trends and patterns. In chronic diseases and injuries, rates are usually expressed in terms of the number of cases/deaths per 100,000 people per year.

Built Environment – The human-made surroundings that influence overall community health, including the individual behaviors that drive health. The built environment includes many types of physical elements, such as homes, sidewalks, and public transportation.

Case Count – Public health uses surveillance case definitions, which are a uniform set of criteria to define a disease. Case definitions enable public health officials to classify and count cases consistently across jurisdictions. A case count is the total number of occurrences for a disease or condition that public health has determined meets the surveillance case definition.

Crude Rate – The calculation of the number of times an event (cases of disease, deaths, etc.) occurs in the population of interest during a given time period. Crude rates do not account for confounding factors such as an individual's age. A standard practice in health statistics is to present rates per 100,000 population. Since the number of events depends, in part, on the size of the population, crude rates provide a standardized way to compare outcomes between groups. For example: comparing rates among counties.

Data Suppression - The counts for many data indicators can be small. This can present a problem not only related to confidentiality protection but also for data interpretation. Rates based on small numbers can be unstable, fluctuating a lot from year to year, and unreliable, not providing the true picture of the health problem. To overcome these potential problems, indicators at the locality level with small numbers are suppressed by the data source's standards.

Health Disparities – The differences in health outcomes, such as life expectancy, mortality, health status, and prevalence of health conditions. These disparities can be driven by many factors, like social or economic inequities.

Health Equity – This is the state in which everyone has a fair opportunity to attain their full potential for health and wellbeing.

Health Outcome – The health impacts of an individual resulting from a condition, event, or intervention. These impacts can be measured in terms of social, psychological, and physical wellbeing, with an emphasis on the patient's subjective experience of a life worth living.

Incidence – The number of new cases of disease having their onset during a prescribed period of time. It is often expressed as a rate.

Indicator – A measure or data that describe community conditions currently and over time (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate).

Prevalence – The number of cases of a disease, number of infected people, or number of people with another attribute present during a particular interval of time. It is often expressed as a rate.

Primary Data – Data collected directly, for example through surveys, listening sessions, interviews, or observations.

Qualitative Data – Information that is summarized without numbers and typically in textual or narrative format (e.g., focus group notes, questionnaire responses, or observational notes).

Quantitative data – Data expressing a certain quantity, amount, or range. Usually there are numerical measurements associated with the data.

Secondary Data – Data that have already been collected by another group or for another purpose.

Social Drivers of Health (SDOH) – The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into five domains: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. This concept may also be referred to as Social Determinants of Health.

List of Abbreviations

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

ADA – Americans with Disabilities Act
AIDS – Acquired Immunodeficiency Syndrome
ALICE – Asset Limited, Income Constrained, and Employed
CDC – Centers for Disease Control and Prevention
CHA – Community Health Assessment
CHIP – Community Health Improvement Plan
CHW – Community Health Workers
COPD – Chronic Obstructive Pulmonary Disease
COVID-19 – Coronavirus Disease 2019
CPA – Community Partner Assessment
FPL – Federal Poverty Line
GED – General Education Development
HIV – Human Immunodeficiency Virus
LFHD – Lord Fairfax Health District
LGBTQ+ – Lesbian, Gay, Bisexual, Transgender, Queer, Plus
MAPP – Mobilizing for Action through Planning and Partnerships
MMR – Measles, Mumps, and Rubella
MMRV – Measles, Mumps, Rubella, and Varicella
NACCHO – National Association of County and City Health Officials
NAS – Neonatal Abstinence Syndrome
OCD – Obsessive-Compulsive Disorder
OD – Overdose
OUD – Opioid Use Disorder
PCP – Primary Care Provider
SDOH – Social Drivers of Health
SES – Socioeconomic Status
STI – Sexually Transmitted Infection
TB - Tuberculosis
TES – Total Early Syphilis
TSVI – Tiered Social Vulnerability Index
US – United States of America
VA – Virginia
VDH – Virginia Department of Health
WV – West Virginia

Purpose

A CHA is a careful, systematic examination of the health status of the community that is used to identify key health problems and assets in the community. The information gathered through this assessment is valuable to community organizations and agencies and allows for updated and timely data regarding the community and its wellbeing. The data collected from this assessment informs decision-making, prioritization of health problems, and development of plans for continuous improvement of the health of the community.

As part of this process, a community health steering committee was established with a guiding mission and vision in order to prioritize the array of needs that presented throughout the assessment process.

Project Mission Statement: "Our mission is to collaboratively assess, understand, and address the health needs of our community by engaging diverse stakeholders, gathering data, advocating for policies and programs and using evidence-based strategies to improve the overall health and well-being of all community members."

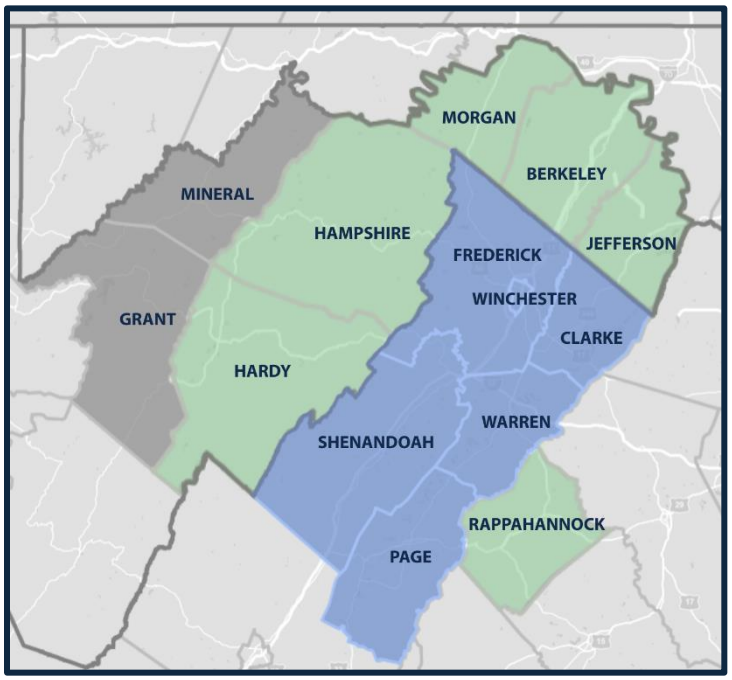
Project Vision Statement: "Our vision is to foster a community where innovative, evidence-based health solutions are embraced, and where collaborative partnerships lead to sustainable improvements in optimal health and quality of life for every resident."

Federal regulations require that tax-exempt hospital facilities, such as Valley Health, conduct a CHA every three years and develop an implementation strategy that addresses priority community health needs. Tax-exempt hospitals are also required to report information about community benefits they provide on IRS Form 990, Schedule H. As specified in the instructions to IRS Form 990, Schedule H, community benefits are defined as programs or activities that provide treatment and/or promote health and healing as a response to identified community needs.

Service Area

The following report focuses on the shared service areas of the Lord Fairfax Health District and Valley Health (indicated below in blue). This area includes Clarke, Frederick, Page, Shenandoah, and Warren counties and the City of Winchester. These localities are nestled in the northwestern corner of Virginia and encompass a 1,632 square mile area of the Northern Shenandoah Valley. This area encompasses a mix of rural communities and suburban areas and has seen a growth of its population by 8.1% from 2014 to 2023.[1]

[1] Virginia Department of Health, Demographics Dashboard, 2014 – 2023.



An additional report encompassing the entire Valley Health service area, including its primary and secondary service areas, is available online at [Community Health Needs | Valley Health](#).

Legend:

- Shared primary service areas between Valley Health & LFHD
- Additional Valley Health primary service areas
- Valley Health secondary service areas

Frederick County, VA

CHA Methodology

CHA Methodology

MAPP 2.0 Process

The primary framework used for this assessment was the Mobilizing for Action through Planning and Partnerships (MAPP 2.0) framework designed by the National Association of County and City Health Officials (NACCHO). MAPP 2.0 is a community-driven strategic planning process to achieve health equity. MAPP 2.0 provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action, resulting in a community health assessment (CHA) and a community health implementation plan (CHIP).

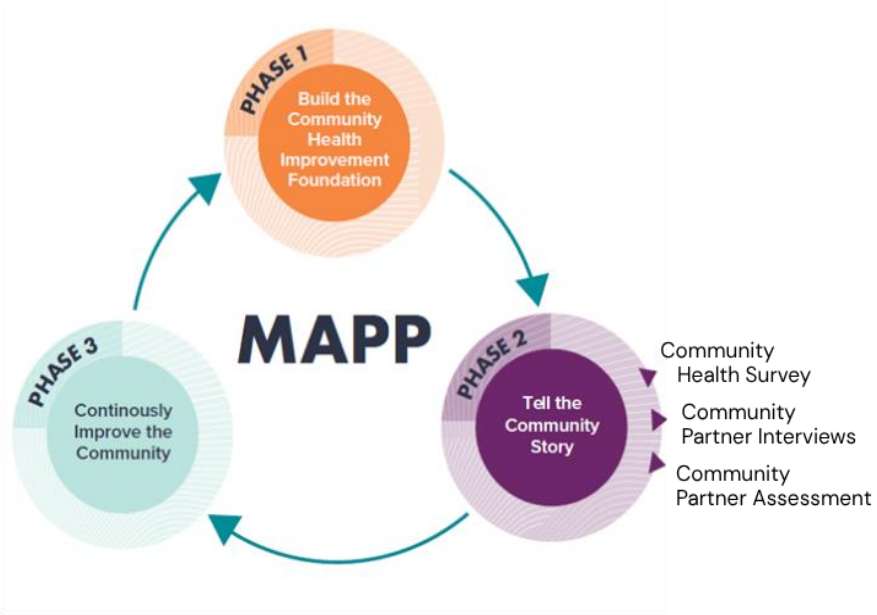


Figure 1: MAPP 2.0 Process

The MAPP process consists of three phases:

1. **Build the Community Health Improvement Foundation**: This phase brings together partner organizations and people to plan the CHA/CHIP and establish the goals and to define the tasks, timeline, and expectations of the process.
2. **Tell the Community Story:** This phase gathers data through its three assessments and analyzes the collected 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 details the data collected from the three assessments of Phase 2:

- **Community Health Survey**: Data collected directly from community members from a survey to gain insight into the needs of the community and its significant community health concerns and the most impactful ways to respond to those problems.
- **Community Partner Interviews:** Data collected through focus groups and interview sessions to better understand the impact of community health concerns in the surrounding area.

- **Community Partner Assessment:** Data collected from community organizations through survey responses about organizational services and capacity to address community concerns.

While the MAPP 2.0 process provided significant guidelines while conducting this process, alterations to the process were made to best fit the needs, desires, and capabilities of the community. Specifically, the names of the MAPP 2.0 assessments were changed to better reflect the efforts and goals of each assessment.

Structure

Two primary groups of individuals assisted in the planning of this CHA, the Core Team and the Steering Committee. These groups gave input about conducting the assessments, what the community would like to see, and provided essential feedback regarding our progress and in the development of this report. In addition to these groups, a broad group of community organizations were involved quarterly and updated on the Core Team's progress and next steps.

Core Team: This group lays the groundwork for MAPP by devoting initial resources such as staff time or funding. Regularly supports and leads the MAPP process to ensure it moves forward. The Core Team consists of leaders from both Lord Fairfax Health District and Valley Health:

Tara Blackley, MA, MPH, MBA, Health Director, LFHD

Jason Craig, EdD, Director of Community Health, Valley Health

Katherine Schroeder, MPH, Population Health Manager, LFHD

Clarissa Bonnefond, MPH, Epidemiologist, LFHD

Leea Shirley, RN, Nurse Manager, LFHD

Susie Hammock, MS, Change Management Specialist, LFHD

Steering Committee: This group gives the MAPP process direction and represents the community's populations and organizations. This team included individuals from the following organizations:

Amie Fuller, Frederick County Emergency Management

Andy Gail, United Way of the Northern Shenandoah Valley

Megan Gordon, Page Alliance for Community Action (PACA)

Ellen Harrison, Northwestern Community Services Board

Katie Moffitt, Blue Ridge Area Food Bank

Brandon Rhodes, Jefferson County Health Department

Katie Vance, AIDS Response Effort (ARE)

The Core Team would like to give special thanks to the many staff members across the VDH that support the efforts of this report, LFHD staff members for submitting the photographs featured in this report, and the community partners that provided valuable feedback.

City of Winchester, VA

Clarke County, VA

Community Health Survey

Community Health Survey

Background: This survey is intended to better understand the perceived health needs within the community. This assessment process allows community members and organizations to become involved in community health improvement by providing feedback but also allows them to understand the needs of their community through the CHA report.

Survey Distribution: The Community Health Survey was able to be completed from November 1, 2024 to March 1, 2025, and was available online and in paper copies in both English and Spanish. A link to the survey was sent to anyone who has a registered 'MyChart' account associated with Valley Health. Outreach from Community Health Workers (CHWs) was used to share the survey with traditionally underrepresented populations. These CHWs used small incentive items, like gift cards, to gain more interest for the survey.

Methodology: The data analysis of this survey involved needing to consolidate and adjust responses to appropriately account for or exclude responses. Some reasons for the variability in answers include misspellings, misinterpretation of what was being asked, and incomplete responses. Spelling errors were corrected to the response it most closely resembled; this appeared frequently in any areas with free text options.

Demographics

Across all LFHD and Valley Health survey areas, 3,636 total surveys were collected. Of those, 2,572 were assigned to LFHD localities. Survey respondents were asked to provide basic demographic information regarding their age, sex, race/ethnicity, zip code, education level, annual household income, and number of people in household. The following table details the demographics of those LFHD survey respondents.

Strengths

- Robust Response Volume: A total of 3,636 surveys were collected, with 3,557 attributed to Valley Health's primary and secondary service areas—providing a strong foundation for analysis.
- Comprehensive Geographic Coverage: High participation from Virginia localities—especially Frederick (30.7%), Shenandoah (13.2%), and Warren (12.1%)—ensures regional Virginia representation.

Limitations

- Underrepresentation of Younger Adults: Only 11.1% of respondents were under age 35, limiting insights into the health needs and behaviors of younger populations.
- Gender Imbalance: Male respondents accounted for just 26.2% of the sample, which leads findings toward female health priorities.
- Educational Underrepresentation: The high proportion of college-educated respondents may not reflect the broader community's educational attainment.

	Attribute	Respondents (#)	Percentage (%)
Locality	Clarke	149	5.79%
	Frederick	1080	42.62%
	Page	252	14.96%
	Shenandoah	464	25.75%
	Warren	425	24.55%
	Winchester City	202	10.97%
Age Range	15-24	111	4.32%
	25-34	230	8.95%
	35-44	370	14.40%
	45-54	393	15.30%
	55-64	536	20.86%
	65-74	572	22.27%
	75+	357	13.90%
Sex	Another	13	0.50%
	Female	1910	74.30%
	Male	649	25.20%
Race/Ethnicity	Black/ African American	72	2.80%
	Hispanic/Latino	96	3.70%
	Other	141	5.50%
	White	2261	88.00%
Language	English	2512	97.78%
	Non-English	57	2.22%
Education	Did not complete High School	63	2.50%
	High School Diploma/GED	444	17.30%
	Some College	566	22.10%
	College Degree or higher	1492	58.20%
Employment	Not employed	209	8.14%
	Part-Time	228	8.89%
	Full-Time	1173	45.71%
	Retired	915	35.66%
	Student	41	1.60%
Annual Household Income	Less than $14,500	171	6.69%
	$14,501 - $32,000	263	10.29%
	$32,001 - $50,000	421	16.46%
	$50,001 - $95,000	700	27.38%
	Over $95,000	1002	39.19%
Number of People in the Home	1	456	17.95%
	2	1130	44.49%
	3	384	15.12%
	4	320	12.60%
	5	165	6.50%
	6 or more	85	3.35%

Results

The Community Health Survey featured seven primary questions to gain insight towards the needs of the community and its significant community health concerns and the most impactful ways to respond to those problems. Below are visualizations for the results of the survey. The survey given, a full analysis of the results, and full response totals can be found in Appendix A, B, & C.

For each question, survey takers were asked to select the priority health concern(s) in their community. Some questions asked for more than one item to be chosen.

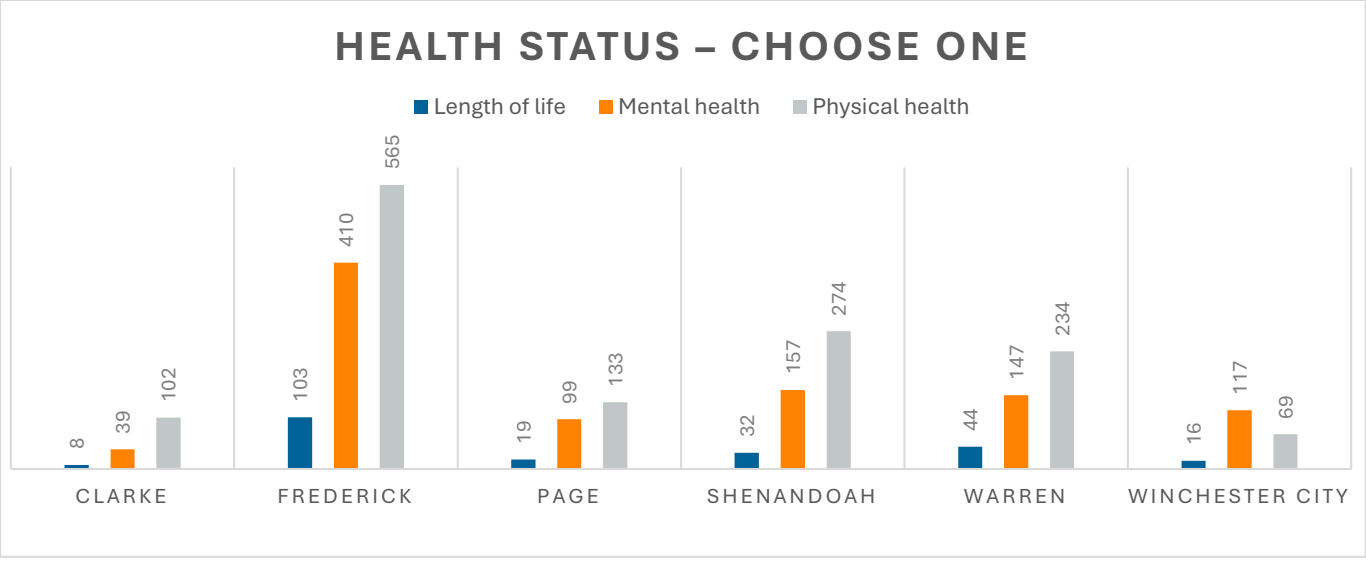
Responses are organized by the survey respondent's locality of residence.

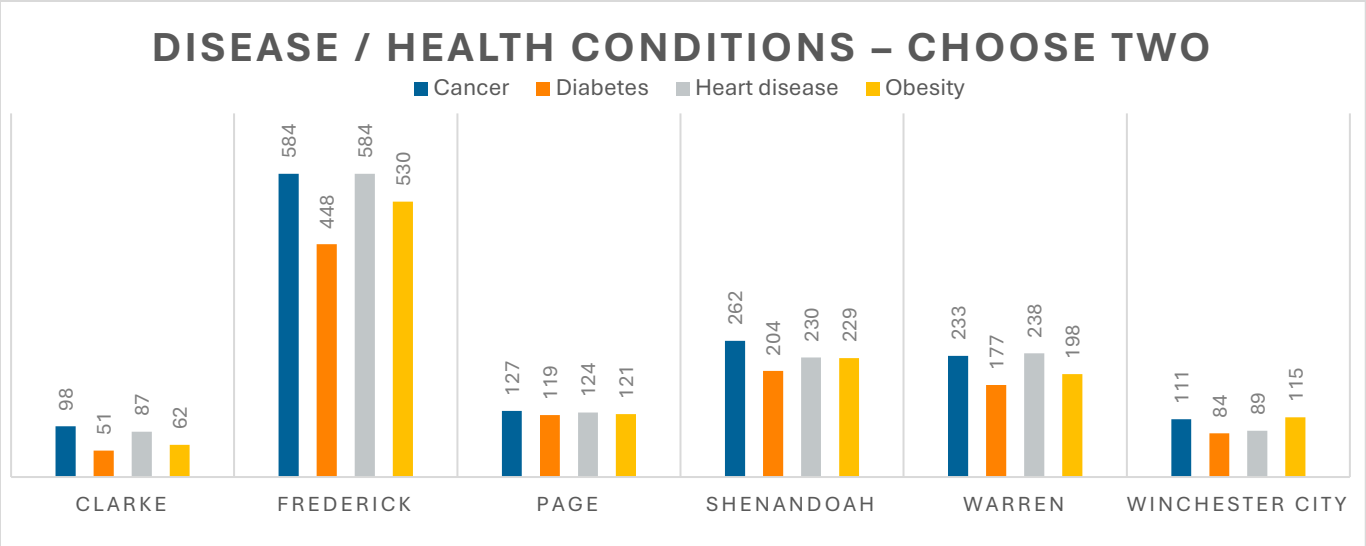
These results provide context for the state of health within our community but also will be instrumental when building a Community Health Improvement Plan (CHIP) with the goal of addressing community health concerns.

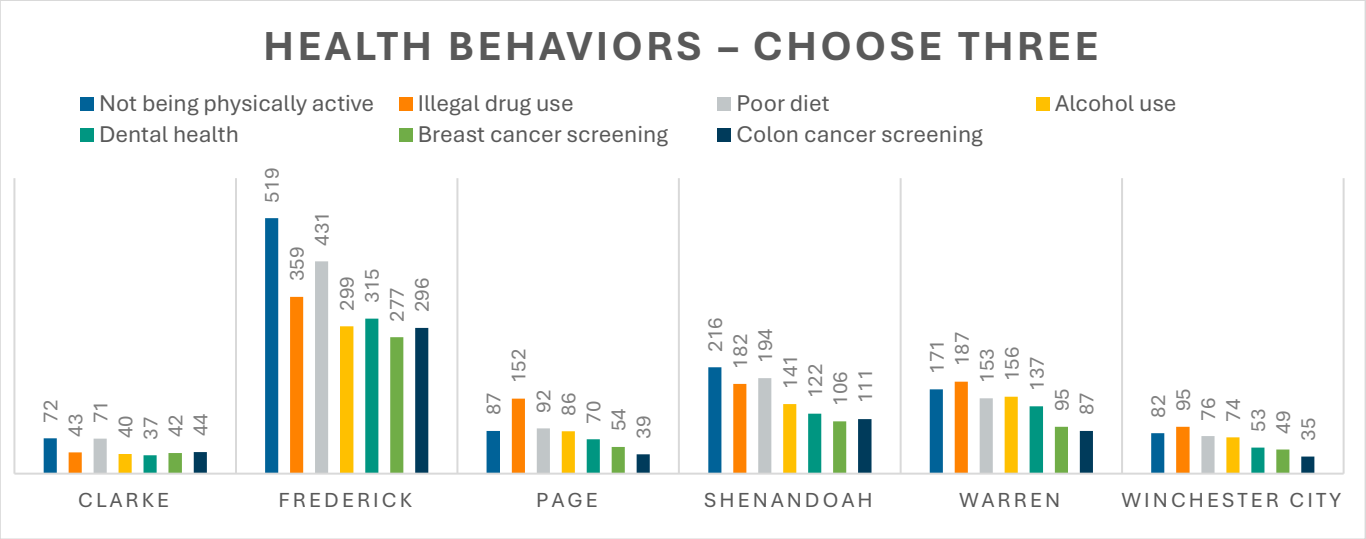
Summary

Many of the most-commonly selected concerns were consistent across all localities. Some deviations occurred across the localities, and that indicated a specific need for that locality for those concerns. The primary themes identified by the most chosen concerns are those regarding healthy living and healthy eating and the overall impact of it on a person's health. This theme appears in the responses of physical health, heart disease, cancer, not being physically active, poor diet, and access to healthy foods.

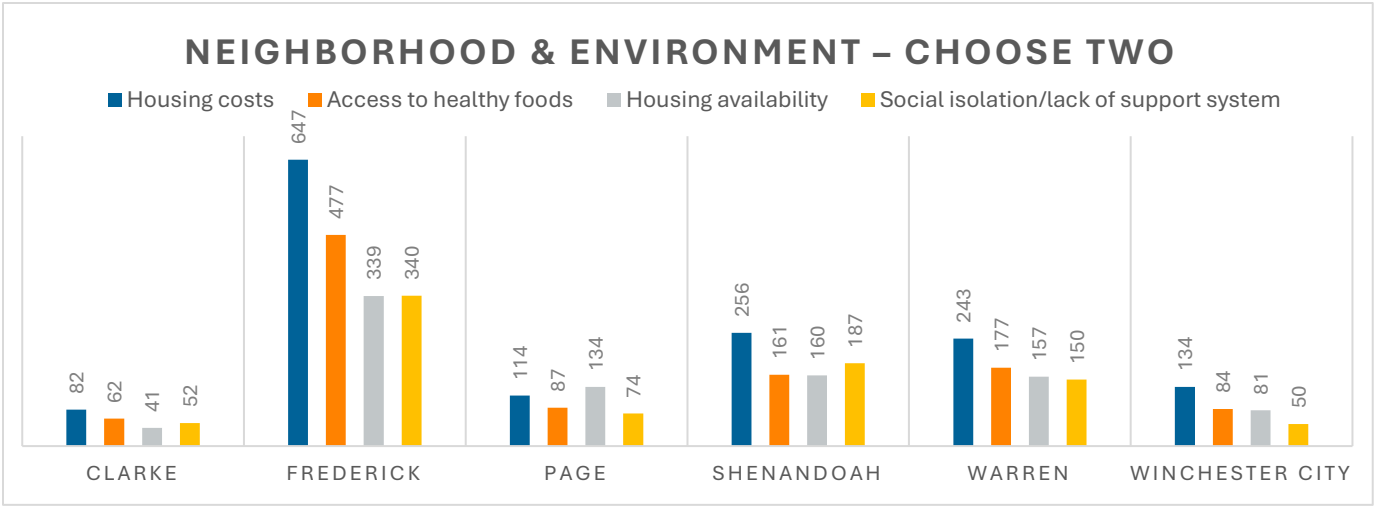
These responses allow for an understanding of what the community perceives as the most significant health concerns within the community. By analyzing these perceptions, much of the community has concerns regarding their physical wellbeing and the care that is available to them and their community members. In terms of solutions to these problems, increasing access to medical and behavioral healthcare is identified and affordability are recurring themes.



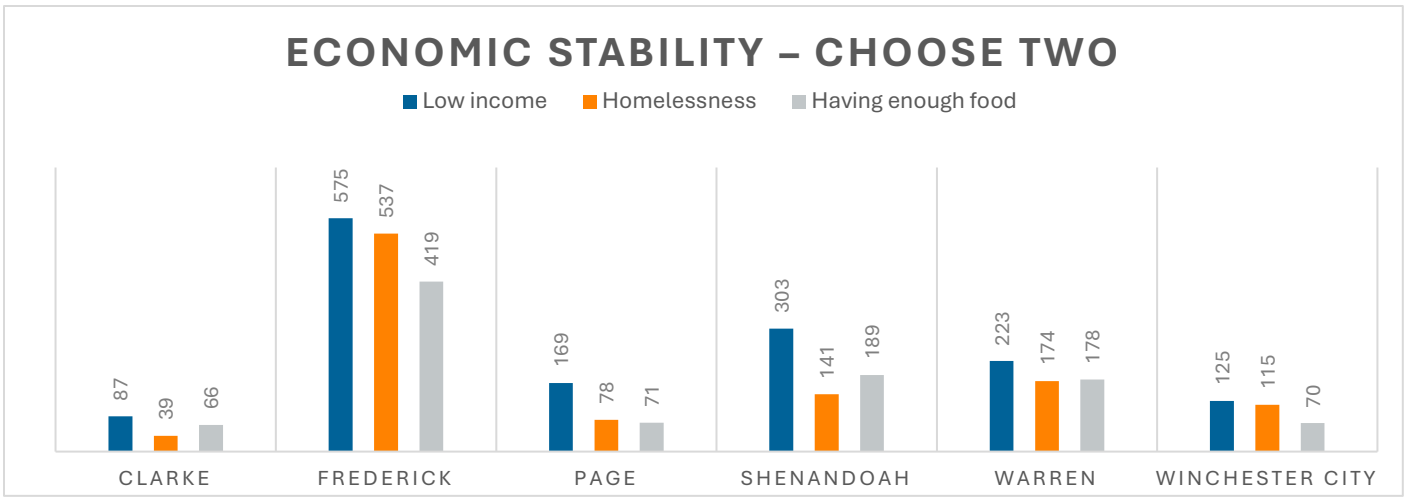


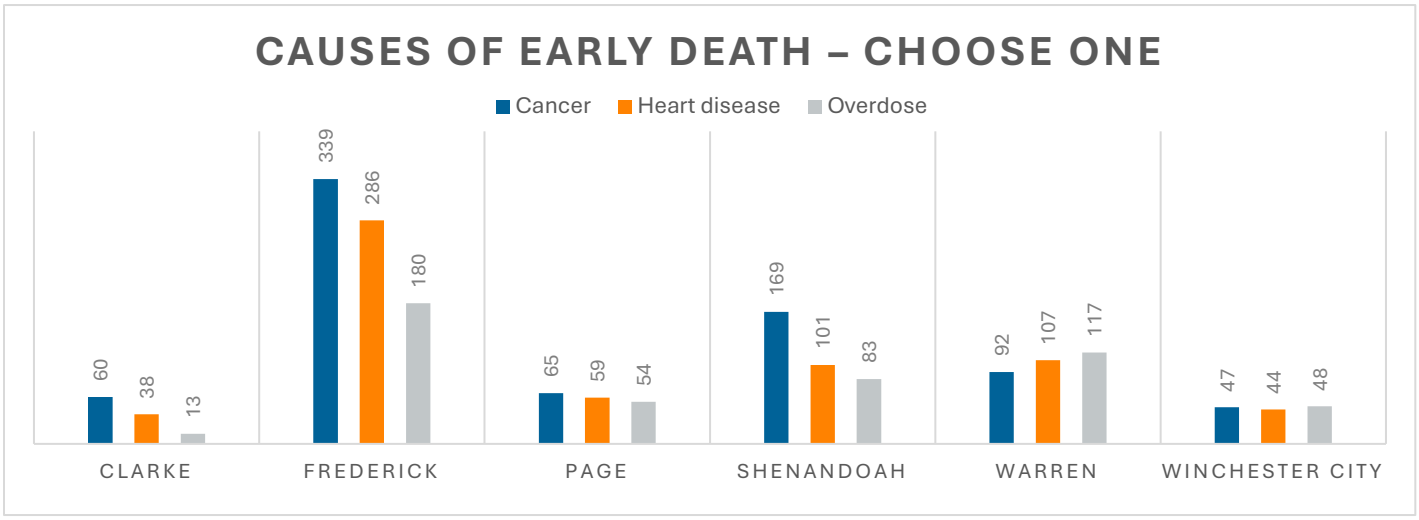


(Other options: smoking & tobacco, vaccinations, vape use, marijuana use, sexual activity)

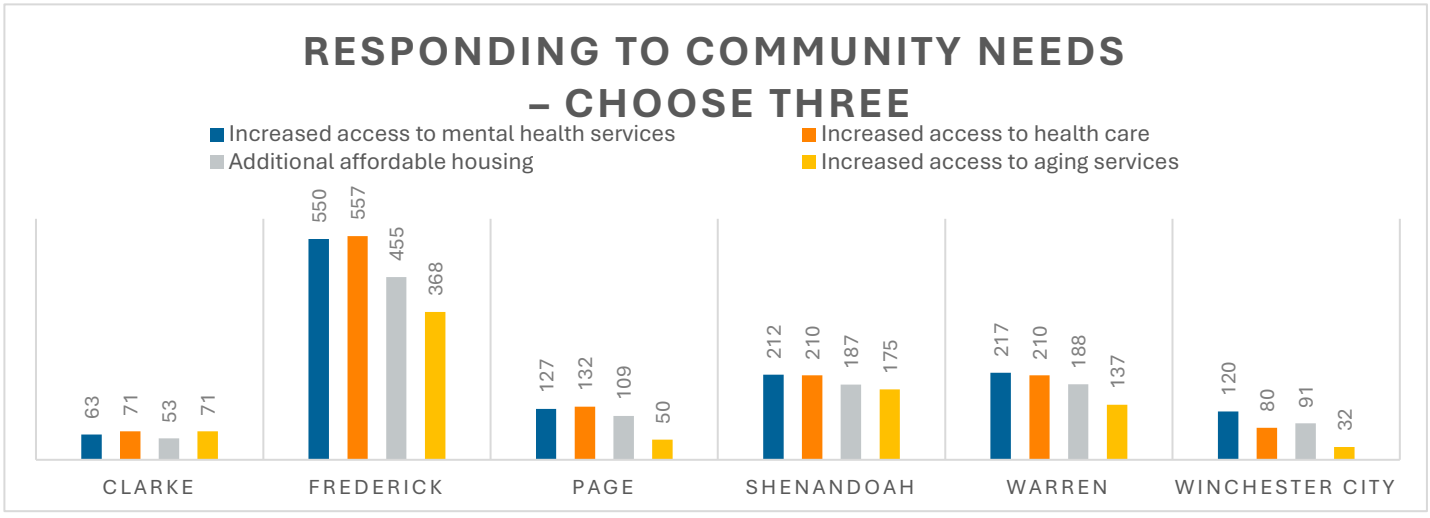


(Other options: access to parks, community access, and internet access)





(Other options: suicide, diabetes, and injuries/accidents)



(Other options: Increased access to healthy foods, increased access to substance use services, increased access to community-based services, additional workforce opportunities, improved transportation options, increased access to parks and recreation, reading & language services, and other—please specify)

Community Partner Interviews

Community Partner Interviews

Introduction

Background: Community Partner Interview Sessions, also known as Community Context Assessment in the MAPP 2.0 process, were conducted as a portion of the 2026 Community Health Needs Assessment to better understand the factors affecting health within the community. Each interview was in a group setting for 60 minutes where individuals were asked various questions framed around community health concerns, the populations it affects, whether the concern has gotten better or worse, and potential solutions for these concerns.

Methodology: Concerns from all localities within the service area are included in these summaries. These generalizations may not be accurate for all localities but may be associated with one geographic area (ex. rural areas). Quotes were given by community members during these interview sessions.

Below is a list of community organizations that participated in community interviews. This is not an exhaustive list of participants. Community members not affiliated with an organization were also welcome to participate and share their experiences.

Participating Organizations:	
AIDS Response Effort (ARE)	Seniors First
Blue Ridge Habitat for Humanity	Shenandoah Alliance for Shelter
Blue Ridge Independence at Home	Shenandoah University
E.A. Hawes Health Center	United Way of the Northern Shenandoah Valley
Frederick County Public Schools	Valley Health
Hampshire County Health Department	Virginia Cooperative Extension
Healthy Families	Winchester Area NAACP
Lord Fairfax Health District	Winchester Public Schools
Page County Community Action Team (CAT)	

Key Themes

Health & Health Care: Concerns regarding healthcare within the service area primarily surround the access of care for primary, specialist, and diagnostic care for those trying to access it. Individuals participating in interviews noted the need for mental health care providers and support for aging individuals, given the growing concern for mental health problems and the increase in aging populations in the service area. Overall support for healthy lifestyles was identified as a need amongst the community. Rural areas were identified as areas particularly burdened by these concerns.

"If providers exist, they're all backed up, completely booked, or you have difficulty getting into a specialist"

Neighborhood & Built Environment: The primary infrastructural concern within the service area was transportation. Many people identified having insufficient transportation options and it creates significant barriers for individuals to access healthcare, groceries, employment, and other services. The effects of this concern particularly burdens those of low socioeconomic status and pose more difficult barriers for those in rural areas because there are fewer options and longer distances to travel.

"There is a distinct difference in access to transportation between the rural poor and the urban poor. People with low socioeconomic status (SES) will have better access to transportation if they live in an urban area than people with low SES that live in a rural area."

Economic Stability: Financial difficulties across the region have caused strains on a variety of individuals' ability to afford the necessities to live healthy lives. High costs of medical care, with or without insurance, high housing and rent prices, and inability to afford healthy foods were mentioned across the region. These financial difficulties affect a large group of the population, especially families or those with a fixed income.

"There isn't enough affordable housing anywhere. Limited housing inventory and high prices are significant issues."

Social & Community Context: Support systems within a community can be very impactful to a person's health. Many individuals noted that many people feel a sense of social isolation within the community, especially amongst the aging population, which can impact mental and physical health. A positive aspect of the status of the region's community is its many active nonprofit organizations that work to improve life for community members in many ways and sectors.

"Social isolation is a growing concern affecting community health"

Education: The educational level with the community was mentioned as a concern for the community, especially health illiteracy and the lack of knowledge regarding available services. These concerns make it difficult for individuals to advocate for themselves and their own health in appropriate situations and leads people to believe that they cannot influence their own health outcomes.

"One of the huge things that I noticed is lack of health literacy. Many people do not even know how to cook a meal and thus limit their ability to prepare healthy foods"

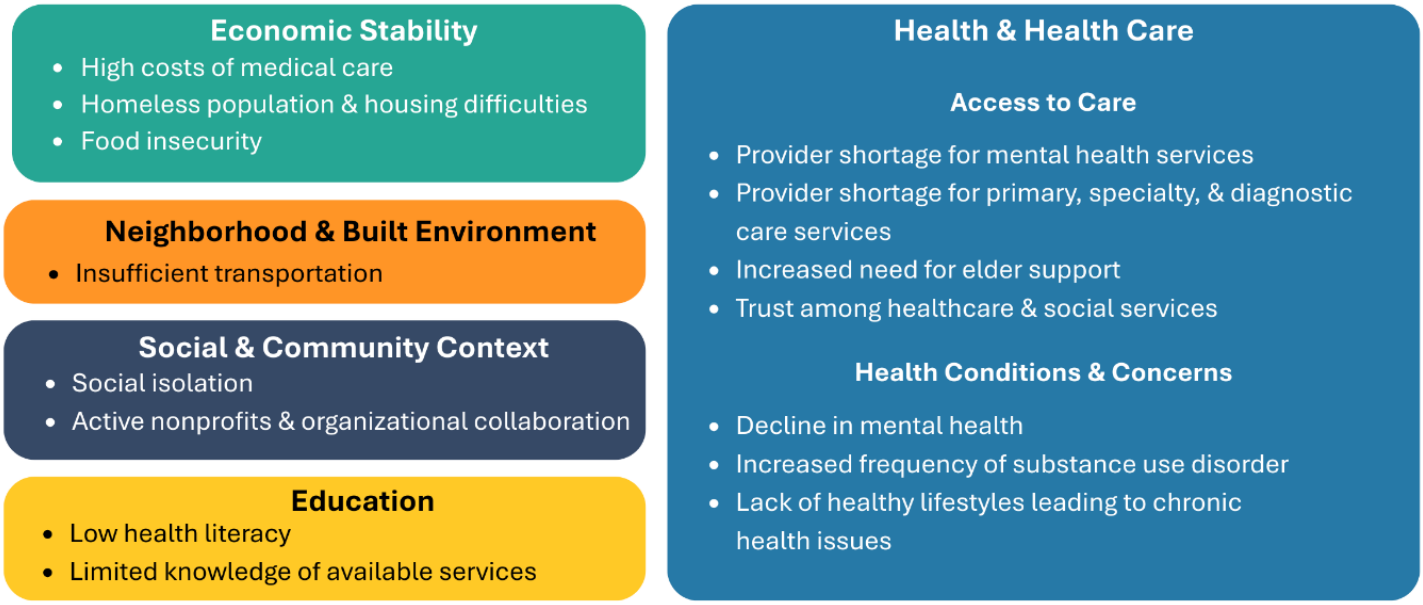


Figure 2. Identified concerns from interviews

Community Partner Assessment

Community Partner Assessment

Introduction

Background: The Community Partner Assessment (CPA) is a survey directed towards community organizations, agencies, businesses, and others to share information about the services that they provide, whom they serve, and their capacity to do so. The information collected provides context for what is the local capacity to address the concerns identified in other aspects of the CHA. The survey used for this assessment will be included in Appendix E.

Methodology: The 22 questions asked were analyzed to better understand the current landscape of organizations within the community. Questions were narratively summarized into common topics.

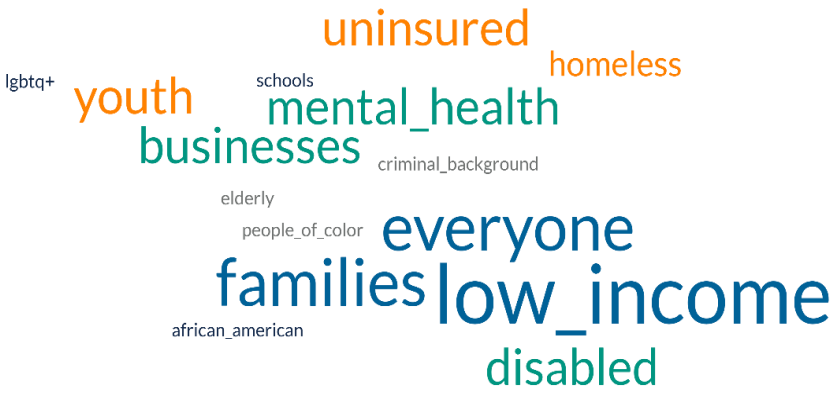
Results

A total of 24 unique organizations completed the CPA survey within the CHA service areas. The survey respondents represented sectors such as local and state government, public clinics, education, social services, housing, mental health, faith-based organizations, and independent living. Nonprofits represented the largest group, with 77% of respondents identifying as such.

Populations Served: Multiple questions focused on the understanding of who is and can be served by these community organizations. Roughly 80% of organizations noted that they serve all individuals, regardless of race or racial identity. 63% of organizations indicated that they have the capacity to serve individuals who speak English as a second language. Of those organizations, three mention having bilingual staff, and four have access to a medical translation line.

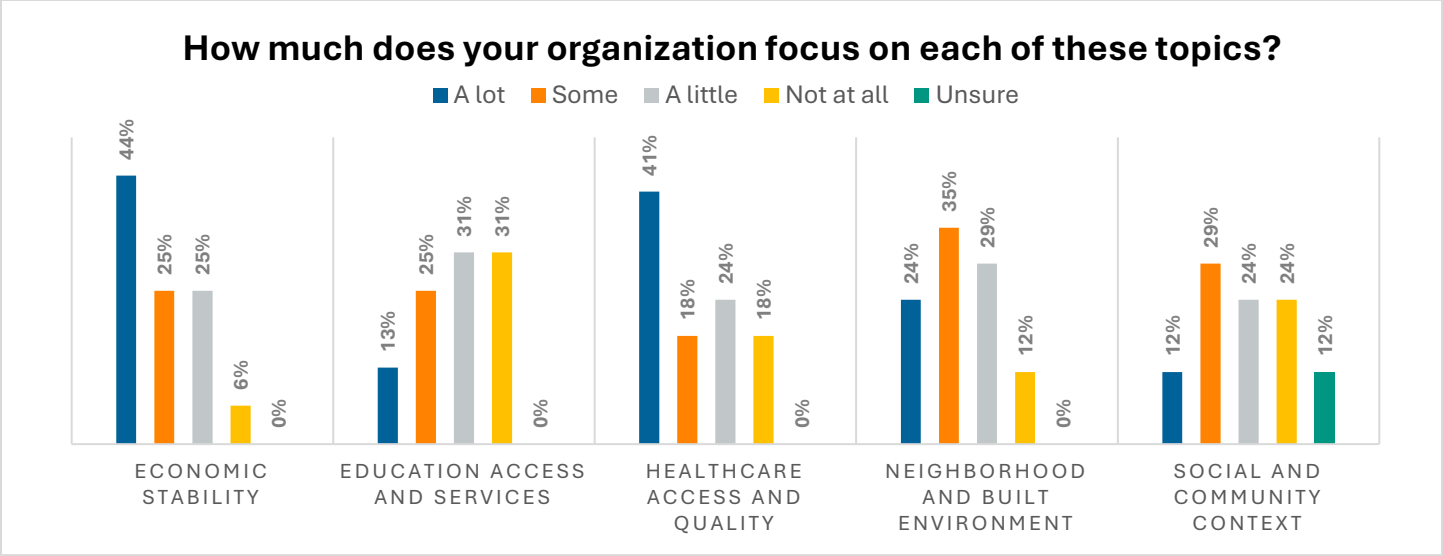
All organizations identified that their organizations provide services to members of the LGBTQ+ community. 21% of organizations indicated that they are not ADA accessible and therefore cannot provide adequate services to those with disabilities. Qualitative information shared by the respondents indicated that most organizations make conscious efforts to provide services to any individual that requires it and can assist in making accommodations in order provide services.

Priority Populations:
Respondents were asked to identify the priority populations of their organizations, and many different groups were mentioned. The word cloud to the right depicts the population groups identified and the frequency of its mention.



Organizational Focuses: Respondents were asked to indicate where the efforts of their organization fall in the categories of social drivers of health: economic stability, education access and services, healthcare access and services, neighborhood and built environment, and social and community context.

The primary focus of the respondents was in the areas of economic stability and healthcare access and services. The focus areas with fewer indications of organizational priority were education access and services and social and community context.

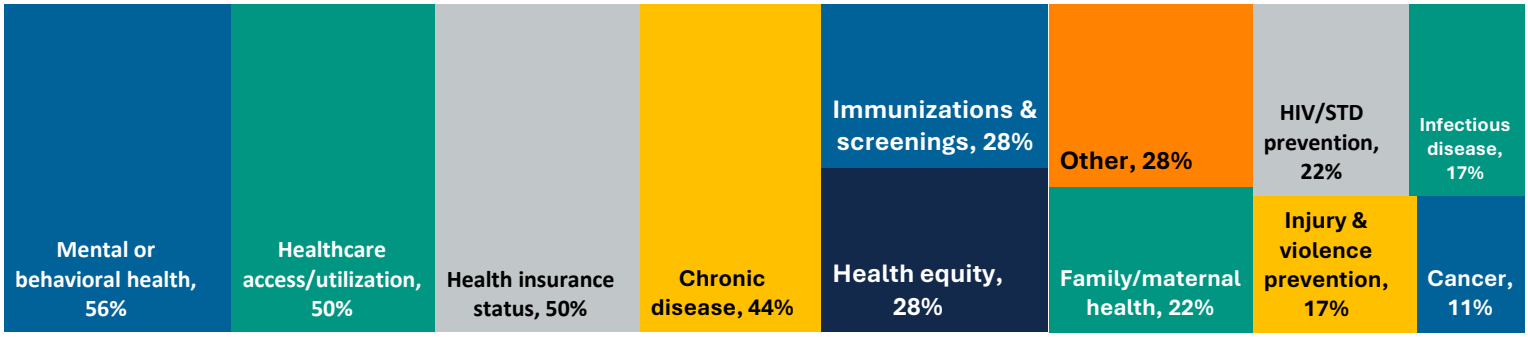


Organizational Capacity: Of the surveyed organizations, there was an even split between organizations that believe they have sufficient capacity to meet the needs of their clients and those who believe the opposite. The factors that contribute to the inability to meet the needs of their clientele are needing more funding to support the work, inability to fill vacant positions, and needing more volunteers.

Health Focuses: Below are the identified health focuses of the responding organizations, if any. Other responses were environmental & soil health, healthy eating, nutrition, and physical activity.

Which of the following health topics does your organization work on?

(check all that apply)



City of Winchester, VA

Clarke County, VA

Community Data Profile

Background

This section aims to identify patterns and trends in community health by utilizing secondary, quantitative data. Much of this data is collected from state or federal organizations, like the Virginia Department of Health (VDH) or Centers for Disease Control (CDC), or other public health organizations such as County Health Ranking and Roadmaps. The data below reflects the most up to date information at the time of writing. Secondary data can take years to compile and publish, so this may result in data from 2022 or 2023 being the most recent year.

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.

Demographics

Demographic data is essential for understanding the context of the health and social data we collect, as it helps identify who is most affected by specific issues and reveals patterns across age, race, income, education, and other factors. By analyzing this information, we can tailor programs, policies, and resources better to meet the unique needs of different groups within a community.

Total Population per Locality

The resident population of LFHD varies across its localities and is comprised of both rural and urban areas. The majority of LFHD's population resides in urban and surrounding suburban areas.

The population of LFHD over time has increased by 8.1% from 2014 to 2023 which indicates a faster growing population than the Virginia population increase (4.8%) over the same timeframe.[2] Among the LFHD localities, Frederick County has the fastest growing population with an increase of 16% from 2024 to 2023.

Total Population[3]	
Virginia	**8,624,499**
LFHD	**245,880**
Clarke Co.	15,060
Frederick Co.	93,355
Page Co.	23,750
Shenandoah Co.	44,630
Warren Co.	41,104
Winchester City	27,981

City of Winchester, VA

[2] Virginia Department of Health, Population Demographics Dashboard. 2014-2023.
[3] US Census Bureau, American Community Survey. 2019-23.

Age Distribution

When comparing the age distribution between LFHD and Virginia, LFHD has an older population than the Virginia averages. Rural localities have a noticeably higher percentage of older individuals than Virginia's average. Similarly, all localities except Winchester City have fewer younger individuals (ages 0-44) than Virginia's average. This indicates that much of the district has an aging population and there are fewer young families living in LFHD.

Total Population by Age Group, Percent[4]	**Virginia**	**LFHD**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Age 0-4	**5.7%**	**5.4%**	3.7%	5.6%	5.0%	5.6%	5.2%	6.1%
Age 5-17	**16.2%**	**16.4%**	15.3%	17.3%	14.9%	15.8%	16.4%	16.3%
Age 18-24	**9.3%**	**7.8%**	7.3%	7.4%	6.9%	7.4%	7.7%	11.2%
Age 25-34	**13.6%**	**12.0%**	9.1%	12.1%	11.2%	11.1%	13.5%	13.4%
Age 35-44	**13.5%**	**12.4%**	10.8%	13.1%	11.4%	11.9%	12.5%	12.6%
Age 45-54	**12.6%**	**12.6%**	14.4%	12.6%	13.2%	11.9%	13.0%	11.3%
Age 55-64	**12.9%**	**14.3%**	17.6%	13.8%	15.7%	14.5%	15.0%	12.0%
Age 65+	**16.3%**	**19.1%**	21.8%	18.2%	21.8%	21.9%	16.7%	17.1%

Sex

The makeup of Virginia and the LFHD localities have a relatively even split between male and female. The term gender is frequently used as an interchangeable name to 'sex', though, the term 'sex' refers to the biological classification according to reproductive organs and 'gender' refers to a person's self-representation.

Total Population by Sex[5]	**Virginia**	**LFHD**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Male	**49.4%**	**50.0%**	48.7%	50.4%	50.0%	49.1%	50.8%	49.8%
Female	**50.6%**	**50.0%**	51.3%	49.6%	50.0%	50.9%	49.2%	50.2%

[4] US Census Bureau, American Community Survey. 2019-23.
[5] US Census Bureau, American Community Survey. 2019-23.

Race

Race is used to group people based on shared physical or social qualities into categories within a community. Though race does not have biological meaning, it can help to understand the makeup of a community and shared ancestry. In comparison to Virginia averages, the localities in LFHD have a higher percentage of White residents and a lower percentage of other racial groups—particularly Black and Asian racial groups.

When looking at the localities in LFHD there are further differences in these averages. The rural localities—particularly Page and Shenandoah counties—see even fewer percentages of these racial groups. Understanding the difference in racial makeup is beneficial to better understand the district as a whole, but also each locality and what the potential implications may be. Certain racial groups can be predisposed to health conditions, and understanding a community and its makeup is essential to addressing these health disparities.

Total Population by Race Alone[6]	**Virginia**	**LFHD**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
White	**61.7%**	**83.0%**	84.7%	82.4%	92.5%	86.9%	83.7%	69.0%
Black	**18.8%**	**4.6%**	6.0%	4.2%	1.9%	2.9%	5.1%	9.2%
Asian	**6.9%**	**1.5%**	1.3%	1.9%	0.4%	1.3%	1.2%	2.3%
American Indian or Alaska Native	**0.3%**	**0.3%**	0.3%	0.5%	0.1%	0.1%	0.1%	0.3%
Native Hawaiian or Pacific Islander	**0.1%**	**0.0%**	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
Some Other Race	**4.1%**	**4.6%**	4.3%	5.4%	1.2%	2.7%	4.4%	8.1%
Two or More Races	**8.2%**	**6.0%**	3.5%	5.5%	4.0%	6.1%	5.5%	11.2%

Ethnicity

Ethnicity refers to a group of people who share a common culture, including language, customs, religion, history, and/or ancestry. Though there are multiple ethnicities, in the US, Hispanic/Latino and Non-Hispanic are the most measured ethnicities.

When comparing the Virginia averages to LFHD, they are relatively similar. Though, when looking individually at the LFHD localities, the percentages differ. The urban areas of LFHD have higher percentages of Hispanic & Latino populations and contribute to the average consistent with Virginia's average.

[6] US Census Bureau, American Community Survey. 2019-23.

Total Population by Ethnicity Alone[7]	Virginia	LFHD	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
Hispanic or Latino Population	**10.7%**	**10.1%**	7.1%	11.7%	2.4%	8.8%	6.7%	20.1%
Non-Hispanic Population	**89.3%**	**89.9%**	92.9%	88.3%	97.6%	91.2%	93.3%	80.0%

Language Spoken at Home

Across the LFHD localities, the primary language that is spoken is English. The locality with the highest non-English speakers is Winchester and has a larger Spanish speaking population than the other localities and the Virginia average. Excluding Winchester, the LFHD localities have fewer non-English languages spoken than the Virginia averages.

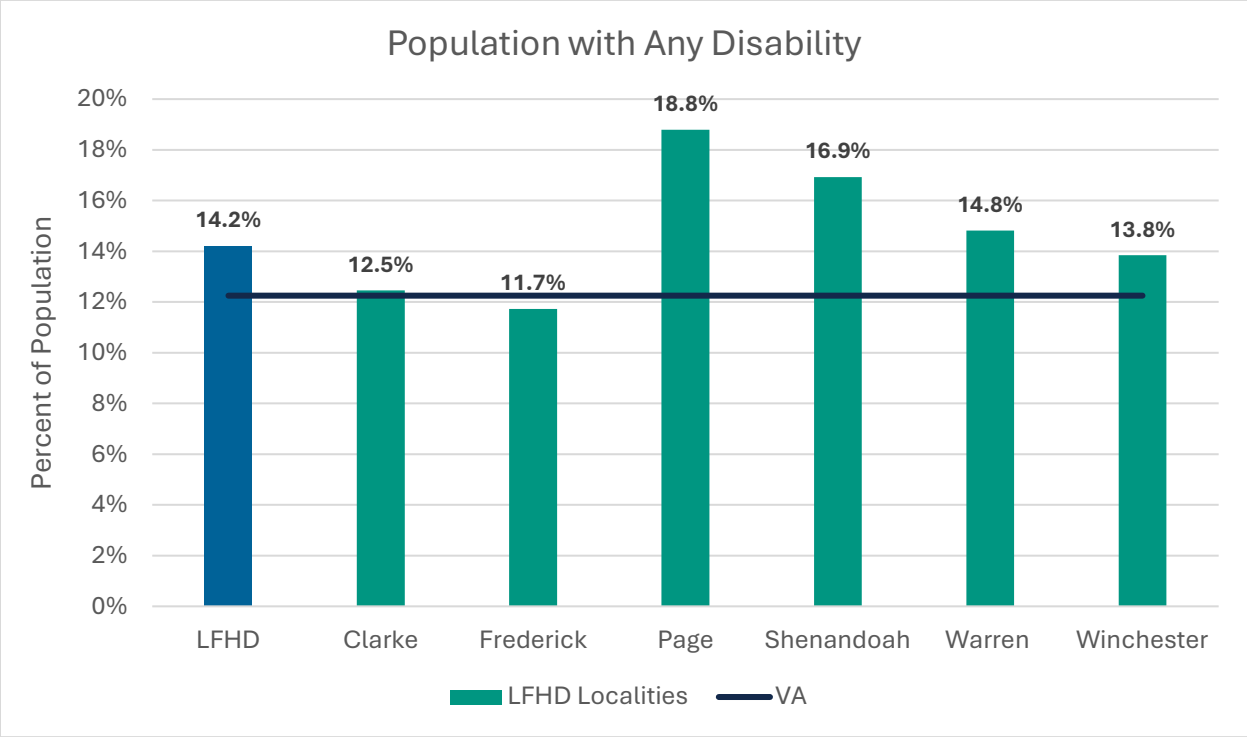
Language Spoken at Home[8]	Virginia	LFHD	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
English Only	**82.8%**	**89.4%**	90.4%	88.3%	96.6%	90.2%	93.2%	79.5%
Non-English, All	**17.2%**	**10.6%**	9.6%	11.7%	3.4%	9.8%	6.8%	20.5%
Spanish	**7.9%**	**8.0%**	6.7%	9.3%	2.2%	7.2%	4.6%	15.6%
Other Indo-European languages	**3.8%**	**1.5%**	1.9%	1.3%	0.4%	1.2%	1.5%	3.7%
Asian and Pacific Islander languages	**3.8%**	**0.7%**	0.8%	0.9%	0.3%	0.6%	0.5%	0.7%
Other languages	**1.8%**	**0.4%**	0.2%	0.2%	0.4%	0.7%	0.1%	0.6%

Warren County, VA

[7] US Census Bureau, American Community Survey. 2019-23.
[8] US Census Bureau, American Community Survey. 2019-23.

Population with Any Disability, Percent[9]

Understanding the status of disability within a community allows for recognition of a community's support needs. These types of disabilities may include mobility, hearing, vision, cognitive, and others. Localities like Page and Shenandoah County have higher levels of disability, which may be a result of its aging populations. Though Clarke and Frederick have percentages very close to the Virginia average (12.3%), the overall average of LFHD remains higher than Virginia indicating the overall need for more supportive services.



Frederick County, VA

Clarke County, VA

[9] US Census Bureau, American Community Survey. 2019-23.

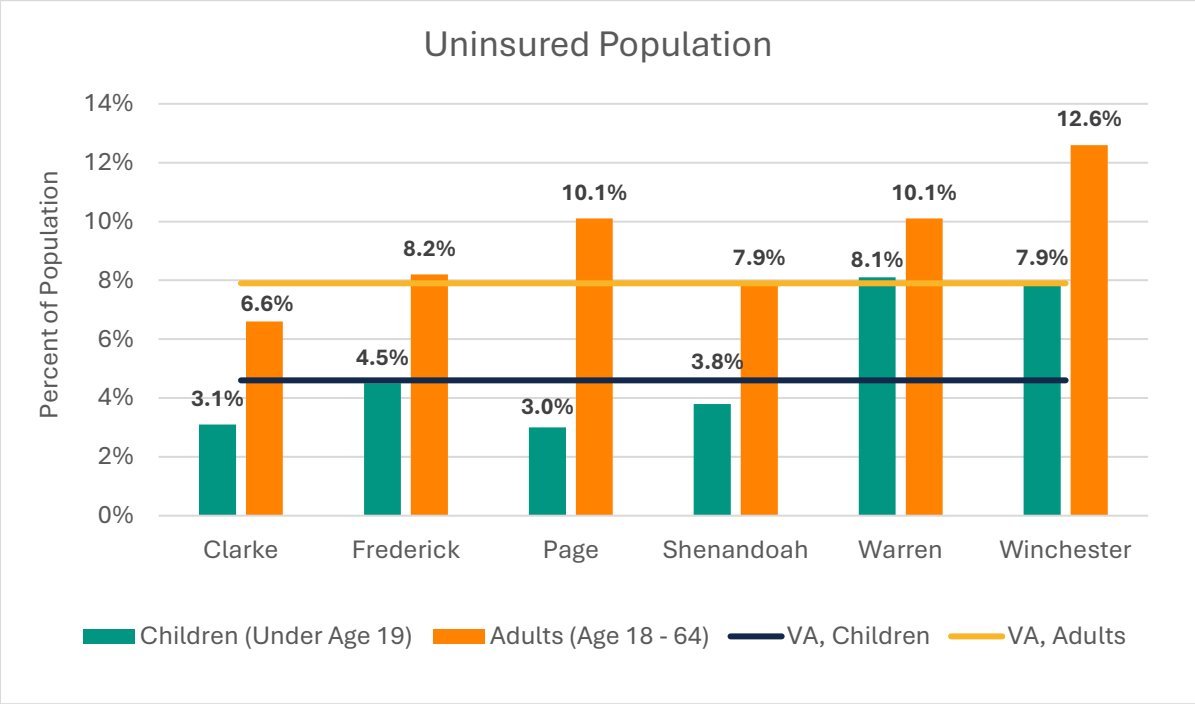
Access to Care

Uninsured Population

The percentage of the population under age 19 without health insurance coverage is near the average for Virginia (4.6%). Winchester and Warren County are the exception for this measure because their percentage of uninsured children is nearly double the percentage for Virginia.

Among adults aged 18-64, the percentage of those without health insurance is either at or slightly above the Virginia average for all localities except for Winchester City. Winchester City has the highest percentage of uninsured adults and is moderately higher than the Virginia average (7.9%).[10]

This measure is important when assessing the community members that may delay or avoid medical care because of their lack of insurance coverage in fear of the high costs. This serves as a barrier for individuals to access quality and affordable healthcare. Uninsured populations are also less likely to seek preventative healthcare services which include screenings and recommendations to help patients live healthier lives.



Healthcare Providers

The following chart illustrates the number of patients for each type of healthcare provider in each locality, per 100,000 population. For every 100,000 people in Page County, there are approximately 25 Primary Care Providers (PCPs), while in Winchester City, there are 256 PCPs for every 100,000 population. This means that people who live in certain localities may have to wait longer to see a

[10] US Census Bureau, American Community Survey. 2019-23.

doctor or may have to drive a longer distance to see one. This becomes even more important when you consider access to transportation, the ability to miss work to see a doctor that may be an hour drive from where you live, as well as childcare availability. It should be noted that although Frederick County has low numbers for all provider types, Winchester City, located within Frederick County, has a much higher number of providers of all types than average in Virginia.

Healthcare Providers, Rate per 100,000 Population	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Primary Care Providers[11]	**74.6**	33.6	44.8	25.2	33.5	58.6	255.9
Mental Health Providers[12]	**264.0**	91.0	102.0	55.0	82.0	122.0	822.0
Dental Providers[13]	**75.0**	33.0	13.0	17.0	33.0	36.0	243.0

Life Expectancy at Birth

Life expectancy at birth is the prediction of the probability of surviving successive years of life, based on age-specific mortality rates. These rates are determined based on several factors, many of which are covered in this report. Frederick County has the highest life expectancy, at 78.5 years, and Page County has the lowest at 73.9 years.

Life Expectancy at Birth, Years	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Life Expectancy[14]	**77.6**	77.3	78.5	73.9	76.6	74.7	74.2

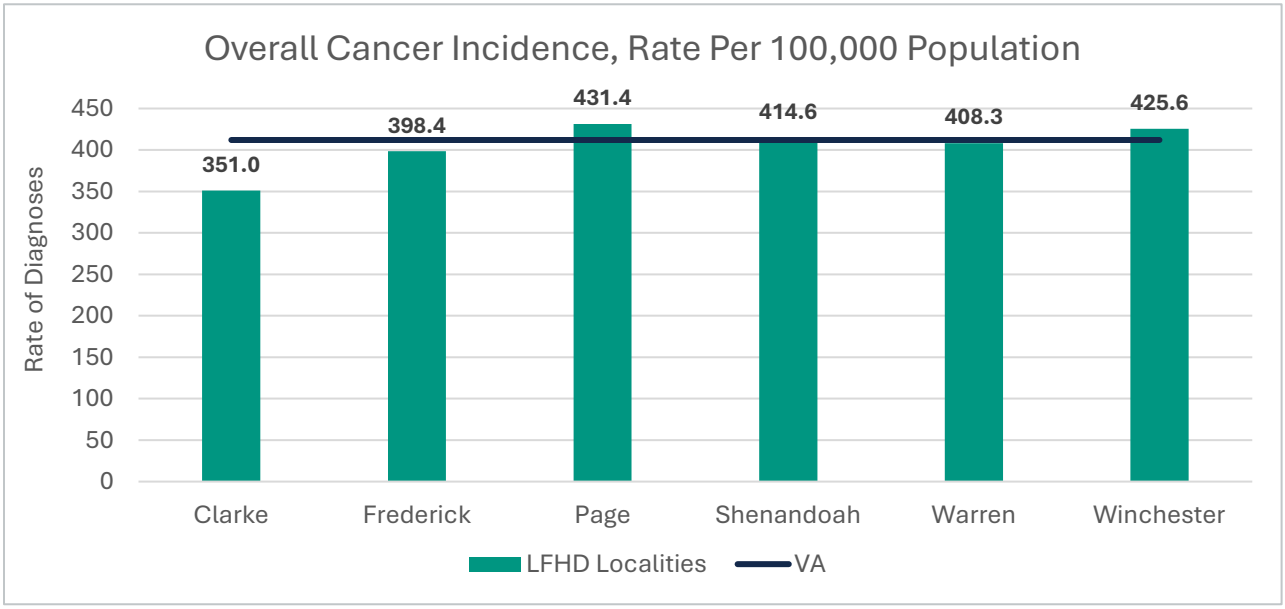
City of Winchester, VA

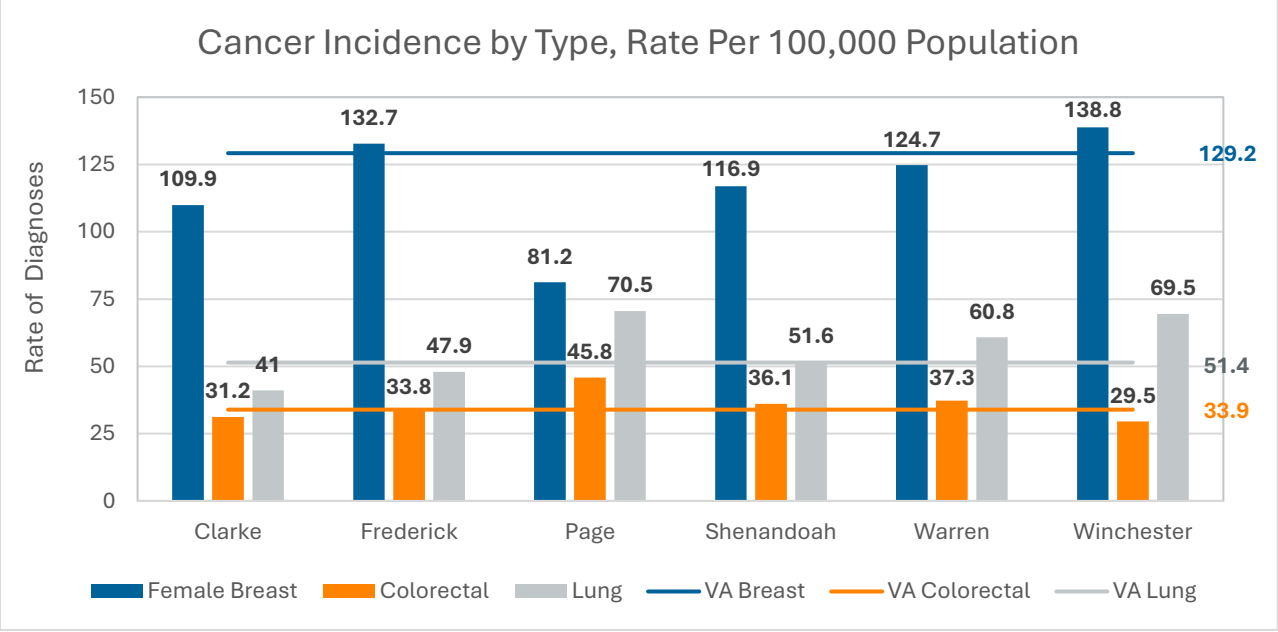
Frederick County, VA

[11] US Department of Health & Human Services, Health Resources and Services Administration, HRSA. 2021.
[12] Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). 2024.
[13] US Department of Health & Human Services, Health Resources and Services Administration, HRSA. 2022.
[14] National Center for Health Statistics, National Vital Statistics System. 2020-2022.

Cancer

The bar chart below shows the overall cancer incidence rates per 100,000 population in Virginia and by LFHD locality. LFHD has lower overall cancer incidence rates than Virginia (412.0). Among the localities, Clarke County has the lowest incidence rate, while Page County has the highest, though all localities fall near the state average. When broken down by type, female breast cancer is the most common type across all regions, with Winchester City having the highest rate. Lung cancer rates vary more widely, with Page County having a relatively high incidence compared to others. Colorectal cancer is the least common among the three types.[15]





[15] Virginia Cancer Registry. 2017-2021.

Chronic Conditions

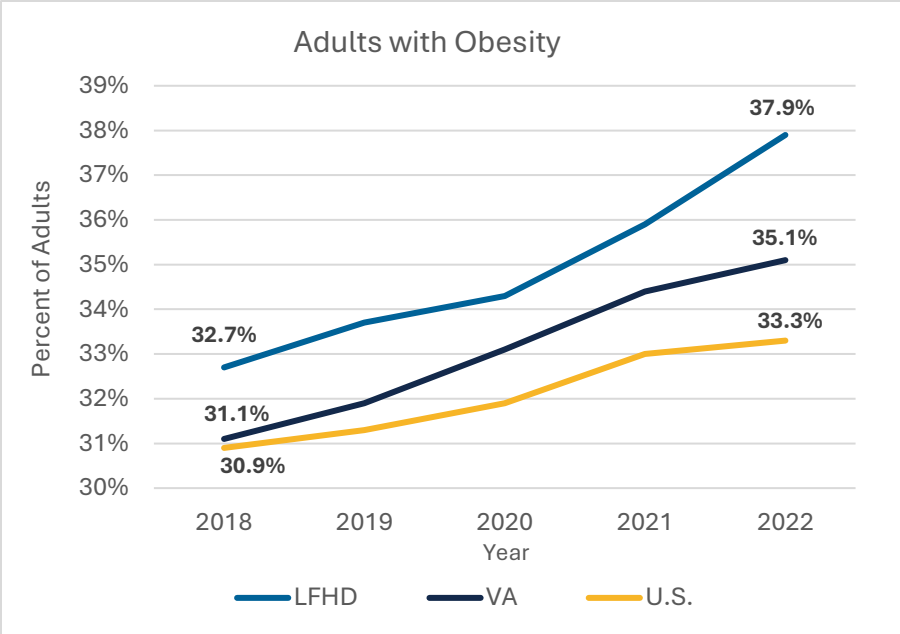
The average Virginia rates for chronic conditions are generally lower than LFHD localities, which can point to poorer health outcomes for individuals in LFHD. Some measures show the Virginia and LFHD percentages being relatively similar, as is the case for chronic kidney disease, asthma, high cholesterol, stroke, and diabetes.

The measures slightly above the Virginia percentage, coronary heart disease and high blood pressure, are both conditions affecting the heart which indicate a growing concern for the heart health of LFHD residents. In Virginia, heart disease is the leading cause of death.[16]

The remaining measures show a much greater concern regarding these chronic conditions. Chronic Obstructive Pulmonary Disease (COPD) is significantly higher for Page, Warren and Shenandoah—all localities that have significantly higher percentages of smokers (see page 45). Similarly, those localities also have high percentages of total teeth loss, those who have lost all their teeth due to tooth decay or gum disease, a common result of smoking. The percentage of those with obesity are significantly higher as well. The following page displays the increase of obesity in LFHD over the past 5 years.

Chronic Conditions, Percent of Population (Age Adjusted)	**Indicator Attribute**	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Chronic Kidney Disease[17]	Adults Age 18+ with	**2.7%**	2.5%	2.6%	2.8%	2.8%	2.7%	2.8%
Chronic Obstructive Pulmonary Disease (COPD)[18]	Adults Age 18+ with	**6.0%**	6.0%	6.9%	8.2%	8.0%	7.9%	7.1%
Coronary Heart Disease [18]	Adults Age 18+ Ever Diagnosed	**5.4%**	5.3%	5.7%	6.4%	6.3%	6.2%	6.0%
Current Asthma [18]	Adults Age 18+ with	**10.0%**	9.8%	10.5%	10.6%	10.5%	10.6%	10.4%
High Blood Pressure[17]	Adults Age 18+ with	**31.5%**	29.9%	32.0%	32.7%	32.4%	31.5%	33.1%
High Cholesterol [17]	Adults Age 18+ with	**32.8%**	32.0%	31.6%	32.7%	32.3%	32.6%	32.9%
Obesity [18]	Adults Age 18+ with	**35.3%**	34.1%	37.6%	40.2%	37.9%	38.1%	37.9%
Ever Having a Stroke[18]	Adults Age 18+	**3.0%**	2.7%	2.9%	3.3%	3.4%	3.3%	3.3%
Total Teeth Lost[18]	Adults Age 65+	**11.4%**	7.3%	7.4%	16.4%	11.7%	15.4%	11.0%
Diabetes[18]	Adults Age 18+ Ever Diagnosed	**11.4%**	9.7%	11.0%	11.1%	11.4%	11.2%	12.3%

[16] Centers for Disease Control and Prevention, CDC - National Vital Statistics System. 2022
[17] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2021.
[18] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.



The percentage of adults in LFHD with obesity has been steadily increasing and has increased by 5% in the last 5 years. This is a more dramatic increase than both the VA and US averages.[19]

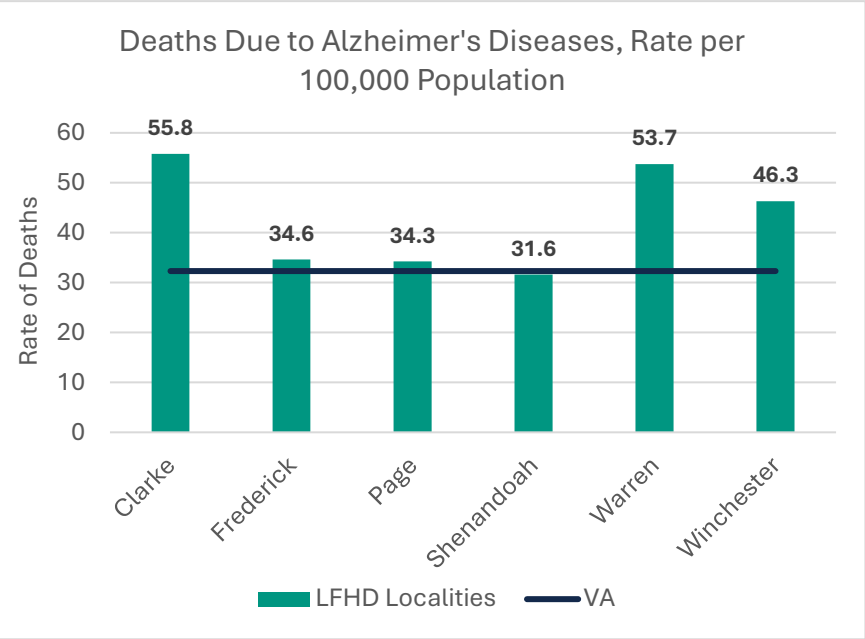
Understanding multi-year trends regarding community health is valuable when aiming to understand how a condition like obesity is progressing and whether interventions have been impactful.

The long-term effects of poorly controlled diabetes have the potential to lead to other health outcomes that may require hospitalization or lead to death. Poorly controlled diabetes refers to a situation where blood sugar levels are not maintained within a target range and can lead to potential long-term complications. Complications of poorly controlled diabetes may include heart disease or stroke, kidney disease, nerve damage, vision loss, or other complications. Poor adherence to medication, an unhealthy diet, lack of physical exercise and stress are all factors that can contribute to uncontrolled diabetes.

Apart from Frederick County, all LFHD localities have a higher rate of both hospitalizations due to diabetes and death due to diabetes. Page County has a dramatically higher rate of hospitalizations due to diabetes and Winchester a dramatically higher rate of deaths due to diabetes.

Diabetes Related Outcomes, Rate per 100,000 Population	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Hospitalizations Due to Diabetes[20]	**2114.2**	2674.1	2113.7	3693.6	3036.1	2705.4	2743.7
Deaths Due to Diabetes[21]	**33.8**	37.1	33.7	39.1	36.6	39.8	52.5

[19] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.
[20] Virginia Department of Health, Inpatient Discharge Dataset from Virginia Health Information (VHI). 2022.
[21] Virginia Department of Health, Virginia Department of Health, Office of Information Management, Division of Health Statistics. 2022.



Alzheimer's disease is a brain disorder that slowly and progressively destroys memory and other important mental functions. Alzheimer's disease is the most common form of dementia and symptoms typically appear later in life. Influential factors that can affect a person's risk of developing Alzheimer's disease are genetics, environmental factors, and other demographic or socioeconomic factors.

When comparing the LFHD localities to Virginia's average for deaths due to Alzheimer's disease, three localities are very close to the VA average and three are much higher.[22] Clarke, Warren, and Winchester are all much higher than the Virginia average (32.3).

Frederick County, VA

[22] Virginia Department of Health, Virginia Department of Health, Office of Information Management, Division of Health Statistics. 2022.

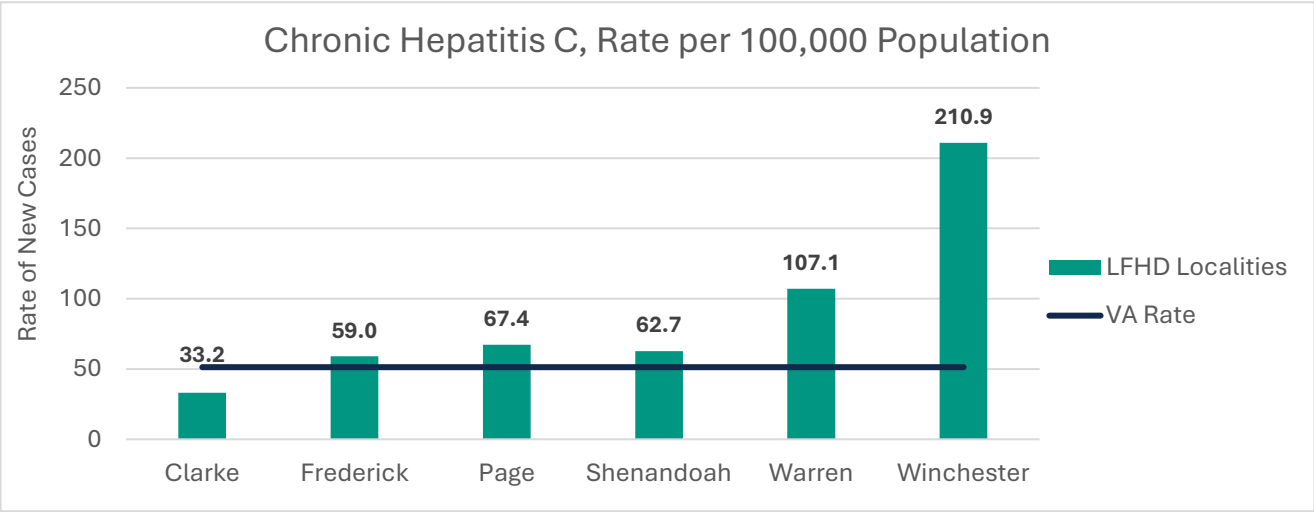
Infectious Diseases

Sexually transmitted infections (STIs) represent a significant public health concern within our community, affecting individuals across all age groups, genders, and backgrounds. These infections, which are primarily spread through sexual contact, can lead to serious health complications if left untreated, including infertility, chronic pain, and increased risk of acquiring or transmitting HIV.

Cases of Disease, Rates per 100,000 Population	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Acute Hepatitis C[23]	**0.4**	0.0	1.1	0.0	0.0	2.4	3.6
Chronic Hepatitis C[23]	**51.3**	33.2	59.0	67.4	62.7	107.1	210.9
Total Early Syphilis[23]	**20.8**	0.0	4.3	12.6	6.7	4.9	25.0
Chlamydia[24]	**472.8**	116.4	237.5	172.7	272.0	253.3	525.0
Gonorrhea[24]	**158.3**	38.8	29.2	33.7	31.0	66.9	123.1
HIV Infections[25]	**10.0**	0.0	4.3	8.4	11.2	2.4	7.1

The table above presents the rates of new reports for various diseases, expressed as cases per 100,000 population, in Virginia and LFHD as a whole, and specific local jurisdictions within LFHD, including Clarke, Frederick, Page, Shenandoah, Warren, and Winchester. This data is specific to 2023 and therefore is only a snapshot of the disease burden.

Acute Hepatitis C shows generally low rates, with no reports in Clarke, Page, or Shenandoah, but higher rates in Warren (2.4) and Winchester (3.6).



[23] VDH, Virginia Electronic Disease Surveillance System (VEDSS). Assessed via VEDSS, 2023.
[24] Virginia Department of Health, Annual HIV Report. 2023.
[25] Virginia Department of Health, Division of Disease Prevention, 2017-2023.

Chronic Hepatitis C has significantly higher rates compared to acute cases, with Winchester experiencing the highest rate (210.9), well above the Virginia state average (51.3). All localities except Clarke have rates above the state average.

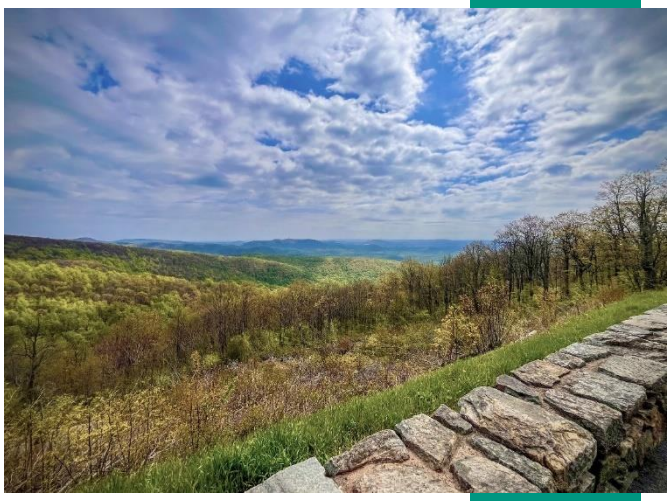
Total Early Syphilis (TES) includes the three most infectious stages of syphilis: primary, secondary, and early non-primary non-secondary. TES rates are relatively low, with all localities, except Winchester, reporting cases below the state average of 20.8. Winchester reports the highest rates within the district (25.0) followed by Page (12.6).

It is important to note that syphilis rates have increased substantially in Virginia in the past 10 years. Rates of TES have increased 229% among women and have increased by 107% among men.[26] Total early syphilis cases increased 14% from 2018 to 2022[27]. Most TES cases are diagnosed among men (84% in 2022); however, cases among women are on the rise (70% increase from 2018-2022).[26]

Chlamydia is the most frequently reported disease, with very high rates statewide (472.8) and especially elevated in Winchester (525.0). Clarke has the lowest rate (116.4) in the district.

Gonorrhea rates vary widely, with Virginia at 158.3 and Winchester showing elevated rates (123.1) compared to other localities, which are mostly below 70.

HIV infection rates are highest in Shenandoah (11.2), with all other local areas reporting lower rates than the Virginia average (10.0).



Warren County, VA

Overall, the data highlights significant variability in disease rates across localities, with Winchester consistently showing higher rates for several infections, particularly chronic Hepatitis C and Chlamydia.

It is important to note the impact of COVID-19 on STI testing and reporting. Testing access was reduced during the heigh of the pandemic (2020–2021), many clinics reduced hours or temporarily closed, limiting access to routine STI screening and treatment. Resources and personnel were diverted toward COVID-19 response, reducing capacity for STI services. This resulted in reduced testing which led to fewer diagnosed cases in official surveillance data, causing underreporting that masked true STI prevalence.

[26] Virginia Department of Health, Congenital Syphilis in Virginia, 2013-2022. Published 2024.
[27] Virginia Department of Health, Syphilis Data in Virginia. 2025.

Communities with limited healthcare access faced greater disruptions, worsening existing health disparities. Marginalized groups, including young people, LGBTQ+ individuals, and racial/ethnic minorities, experienced disproportionate impacts.[28]

Tuberculosis (TB) remains a critical public health issue within our community, particularly affecting vulnerable populations such as individuals with compromised immune systems, those experiencing homelessness, and recent immigrants from regions with high TB prevalence. TB is a contagious bacterial infection that primarily impacts the lungs but can affect other parts of the body. Despite advances in diagnosis and treatment, TB continues to pose challenges due to delayed detection, treatment adherence barriers, and the emergence of drug-resistant strains.

New Reports of Tuberculosis, Rates per 100,000 Population[29]	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
2020	**2.0**	0.0	2.2	0.0	2.3	0.0	0.0
2021	**1.9**	0.0	0.0	0.0	2.3	0.0	0.0
2022	**2.3**	0.0	1.1	0.0	0.0	0.0	10.7
2023	**2.4**	0.0	1.1	0.0	4.4	2.4	3.6
2024	**2.6**	0.0	0.0	0.0	2.2	0.0	0.0

When analyzing the rates of tuberculosis from 2020 to 2024 in LFHD, Winchester and Shenandoah tend to have a higher disease burden than other localities and above the VA averages. Winchester City reported a notable spike in 2022, with a rate of 10.7, the highest single-year rate in the district. This may reflect a localized outbreak, unique exposure event, or may point to social drivers of health to potentially include high-density populations, possibly related to housing, access to care, or co-occurring risk factors.

City of Winchester, VA

[28] Mheidly N, Fares NY, Fares MY, Fares J. Emerging Health Disparities during the COVID-19 Pandemic. *Avicenna J Med*. 2022;13(1):60-64.

[29] Virginia Department of Health, 2020-2024 Local TB Counts and Rates. 2025

Health Behaviors

The health behaviors of a community have a direct impact on its overall health outcomes. Risky behaviors, such as smoking or physical inactivity, tend to worsen health outcomes, while preventative behaviors, like regular screenings and healthy eating, contribute to improved health. This relationship is illustrated in the data: Page County has the highest rate of current smokers and has the highest incidence rate of lung cancer in LFHD (see page 38). While not every case of lung cancer is caused by smoking, a higher prevalence of smokers in a population is often associated with increased rates of smoking-related diseases, including cancer.

Clarke County, VA

Risky Behaviors

Risky behaviors are those that generally lead to an increase in disease or injury, which may ultimately lead to disability death or social problems. Identifying communities with higher rates of risky health behaviors allows for appropriate funding to be secured and for the most impactful programs to be offered in areas with the highest need.

Percent of Adults Age 18+ Engaging in Health Behavior – Risky	**Virginia**	**LFHD**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Current Smokers[30]	**13.7%**	**16.7%**	14.3%	15.5%	19.0%	17.3%	18.8%	15.7%
Current E-Cigarette Users[31]	**7.7%**	**9.3%**	-	-	-	-	-	-
Smokeless Tobacco Users[31]	**3.1%**	**4.5%**	-	-	-	-	-	-
Binge Drinking in the Past 30 Days[30]	**18.4%**	**19.7%**	21.1%	19.7%	20.0%	19.6%	19.9%	18.2%
Insufficient Sleep[30]	**36.8%**	**37.1%**	36.5%	36.1%	36.9%	38.1%	39.0%	36.4%
No Leisure-Time Physical Activity[30]	**21.0%**	**23.2%**	20.2%	22.6%	23.9%	23.9%	23.7%	24.1%

-Data unavailable or unreliable at locality level

[30] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.
[31] Virginia Department of Health, Division of Population Health Data, Behavioral Risk Factor Surveillance Survey, 2022.

LFHD shows higher rates of several risky health behaviors compared to the Virginia average. Smoking is more common in the region, with Page (19.0%) and Warren (18.8%) well above the state's 13.7%. Binge drinking is also elevated, especially in Clarke (21.1%), compared to 18.4% statewide. Physical inactivity is widespread, with all localities except Clarke exceeding the state average of 21.0%. These patterns highlight clear areas for targeted health promotion across LFHD.

Preventative Behaviors

While risky behaviors tend to increase the likelihood of injury, disease and death, preventative behaviors tend to increase positive health outcomes. Early detection from screenings and regular check-ups can make a significant difference in the health outcomes of a community.

Preventive health behaviors across LFHD generally trail state averages, with some notable gaps. Blood pressure medication use is fairly consistent, ranging from 59.4% in Clarke to 61.5% in Winchester and Virginia overall. Mammography rates dip in Page (72.9%) and Shenandoah (73.0%), several points below the state average of 78.3%. Colorectal screenings are lowest in Shenandoah (58.0%), compared to 62.8% statewide. Dental visits fall below the state average, across the board, especially in Page (63.3%) and Shenandoah (63.2%), versus 67.5% in Virginia. Annual checkups hover just under the state average (77.7%), with Warren having the lowest average, at 75.2%.

Percent of Population Engaging in Health Behavior - Preventative	**Indicator Attribute**	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Taking Blood Pressure Medicine[32]	Adults Age 18+ with Hypertension	**61.5%**	59.4%	59.7%	60.2%	61.3%	59.7%	61.5%
Recent Mammography[33]	Females Age 50-74	**78.3%**	78.2%	78.7%	72.9%	73.0%	73.4%	74.6%
Colorectal Cancer Screening[33]	Adults Age 45-75	**62.8%**	63.6%	63.7%	61.5%	58.0%	59.8%	61.0%
Cervical Cancer Screening[34]	Females Age 21-65	**84.3%**	85.3%	84.3%	82.2%	82.6%	83.3%	83.2%
Recent Dental Visit[33]	Adults Age 18+	**67.5%**	69.0%	66.0%	63.3%	63.2%	63.8%	64.0%
Recent Cholesterol Screening[32]	Adults Age 18+	**86.2%**	84.9%	85.8%	83.5%	83.9%	82.4%	84.5%
Annual Checkup in the Past Year[33]	Adults Age 18+	**77.7%**	76.3%	76.2%	76.2%	76.3%	75.2%	77.6%

[32] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2021.
[33] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.
[34] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2020.

Immunization rates are particularly low with flu shot participation ranging from 21.4% in Page to 27.3% in Frederick and Winchester, far below the 32.3% state average. COVID-19 vaccinations are also strikingly low, especially in Page (6.8%). These trends suggest room for improvement in encouraging routine preventive care throughout the region. Vaccine-preventable diseases are infectious diseases caused by viruses or bacteria that can be prevented with vaccines, like COVID-19, seasonal influenza (flu), measles, and others.

At the time of writing this report, there is an increased concern regarding measles, mumps, and rubella (MMR) vaccination rates because of the 2025 measles outbreak in West Texas. Measles is a very contagious disease caused by a virus that lives in the nose and throat of an infected person and can cause complications that lead to hospitalization and even death.[37]

A safe and effective vaccine that prevents measles is given as part of the MMR vaccine or the measles, mumps, rubella, and varicella (MMRV) vaccine series. Since measles-containing vaccines became available in the United States (1968), the disease has become rare in this country. A person is considered immune and protected against measles if they have received two doses of a measles-containing vaccine, like MMR, or have had measles at some point in their life. Virginia code requires children to be properly immunized against measles to enter kindergarten.[38]

In LFHD, most localities have a lower percentage of the population immunized against MMR than the VA percentage. The localities furthest from the VA average percentage are Clarke and Warren counties. These low percentages may be due to rising rates of vaccine exemptions in VA and US.[39]

Vaccination Rate, Percent of Total Population	**Indicator Attribute**	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
COVID-19[35]		**13.7%**	12.4%	9.8%	6.8%	9.2%	8.1%	10.4%
Flu[35]		**32.3%**	26.3%	27.3%	21.4%	23.4%	22.4%	27.3%
MMR[36]	2 year olds, at least 1 dose	**89.3%**	83.4%	92.4%	84.1%	76.1%	81.2%	86.3%
	5 year olds, series complete	**76.3%**	67.3%	64.0%	81.2%	65.5%	61.2%	75.7%
	7 year olds, at least 1 dose	**>95%**	76.9%	81.5%	93.4%	79.2%	78.3%	93.5%
	7 year olds, series complete	**84.5%**	69.8%	72.9%	83.5%	68.5%	64.7%	82.8%

[35] Virginia Department of Health, Respiratory Disease Dashboard
[36] Virginia Department of Health, Virginia MMR Vaccine Dashboard
[37] Virginia Department of Health, Measles. 2025. www.vdh.virginia.gov/measles/
[38] Code of Virginia, § 22.1-271.2
[39] Centers for Disease Control, School Vax View Dashboard, 2011-2024.

Injury and Violence

Injury Deaths and Hospitalizations*

Overall, LFHD has high rates among its injury deaths and hospitalization measures. Regarding all injury hospitalizations, all localities are higher than the VA average rate. Specifically, Clarke, Winchester, and Page are all much higher than VA. Only Clarke and Page have rates of unintentional injury deaths higher than the VA average, these are deaths caused by falls, fire, or motor vehicle traffic accidents.

Regarding fall-related injury hospitalizations, Clarke, Page, and Winchester have the highest rates, though all LFHD localities are above the VA average rate. Fall-related hospitalizations are commonly seen among older adults[40] and Clarke and Page's age demographics indicate that this may be a primary contributor to their high rates.

Among firearm injury hospitalizations, all LFHD localities fall below the VA average rate.

Injury Indicators, Rate Per 100,000 Population	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
All Injury Hospitalizations[41]	**421.0**	756.5	472.9	623.4	590.3	521.0	716.9
Unintentional Injury Death[42]	**80.3**	122.9	65.6	101.1	79.6	69.3	65.2
Fall-related Injury Hospitalizations[41]	**230.7**	478.5	295.9	404.4	331.7	298.7	383.8
Firearm Injury Hospitalizations[41]	**9.7**	6.5	3.1	0.0	6.6	4.8	0.0

City of Winchester, VA

Warren County, VA

*Data includes fatal and non-fatal hospitalizations

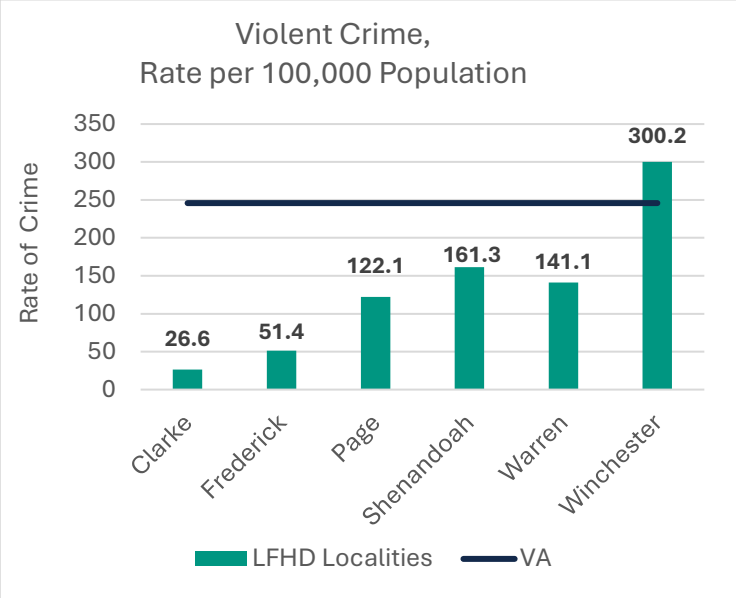
[40] CDC, Facts About Falls. 2024.

[41] Virginia Department of Health, Division of Population Health Data. 2023.

[42] Virginia Department of Health, Injury and Violence Deaths Dashboard. 2023.

Violent Crime[43]

When comparing the presence of violent crime within our communities, Winchester City displays the highest rate of incidents of violent crime across LFHD and has a higher rate than the Virginia average (245.8). This rate of violent crime includes incidents of murder and nonnegligent manslaughter, all rape, aggravated assault, and robbery. All other LFHD localities have low violence crime rates in comparison to the VA average and the Winchester rate. Clarke and Frederick have the lowest rates across LFHD.



Motor Vehicle Crash Deaths and Hospitalizations*

Across LFHD, each locality has a higher rate of motor vehicle crash deaths when compared to the Virginia average. The highest rate is within Clarke County which has a rate three times that of the Virginia average. Similarly, all LFHD localities, except for Warren, have a higher rate of motor vehicle crash hospitalizations higher than the VA average. Factors that may influence these rates are rural areas, larger vehicles, human error, or road conditions: all of which may influence LFHD to have generally higher rates than VA.

Additional data regarding Virginia traffic crashes can be found through the Virginia Department of Motor Vehicles and their Yearly Traffic Crash publications. These annual reports provide a comprehensive analysis of driving trends, crashes, fatalities, and associated causal factors.

Motor Vehicle Injury Indicators, Rate per 100,000 Population	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Motor Vehicle Traffic Crash Deaths[44]	**10.8**	32.3	13.5	12.6	15.5	14.3	14.5
Motor Vehicle Traffic Crash Hospitalizations[45]	**51.6**	77.6	68.8	67.4	75.2	38.2	76.0

*Data includes fatal and non-fatal hospitalizations

[43] Virginia State Police, Virginia Crime Online. 2023

[44] Virginia Department of Health, Injury and Violence Deaths Dashboard. 2023.

[45] Virginia Department of Health, Division of Population Health Data. 2023.

Maternal and Child Health

Ensuring the health and wellbeing of mothers and children is essential to building healthy communities. Maternal and child health is highly variable between localities and individual indicators in LFHD. Understanding these indicators is critical to identifying health disparities and targeting interventions to improve outcomes for mothers and infants.

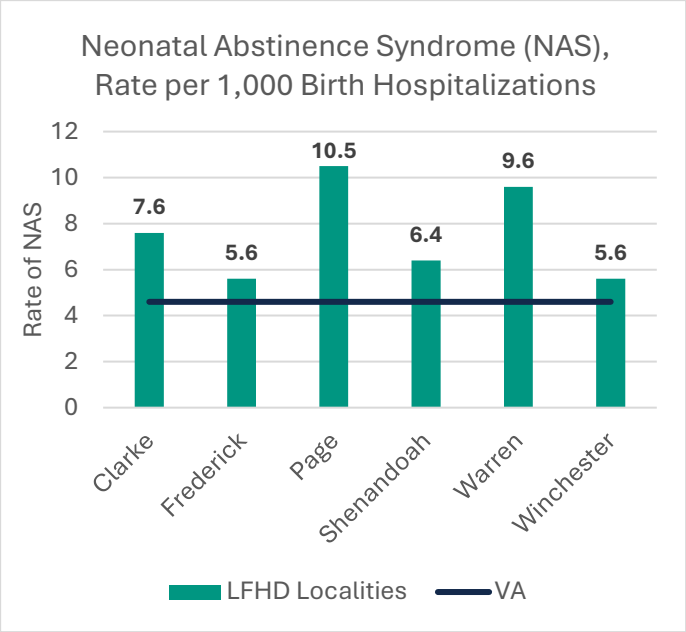
The infant mortality rate, an important marker of the overall health of a society, for LFHD (4.4) is slightly lower than the state average (5.8). At the locality level, however, there is significant variation, and the infant mortality rate in Page and Shenandoah counties (9.6) is much higher than the state average.

There are racial disparities observed in maternal mortality rates in Virginia. The overall VA maternal mortality rate per 100,000 live births for 2019-2023 was 34.5.[46] However, the maternal mortality rate for Black or African Americans (62.3) was significantly higher than all other race/ethnicity groups.[46] All LFHD localities, except Frederick (21.0), had a rate of 0 per 100,000 live births for 2019-2023.

Maternal & Child Health Indicators	Indicator Attribute	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
Infant Mortality[46]	Rate per 1,000 Live Births	**5.8**	0.0	5.2	9.6	9.6	2.0	0.0
Maternal Mortality[47]	Rate Per 100,000 Live Births	**34.5**	0.0	21.0	0.0	0.0	0.0	0.0
Low Birth Weight[46]	Percent of Total Live Births	**8.5%**	1.3%	6.9%	7.2%	7.8%	6.1%	9.7%
Preterm Births[46]	Percent of Total Live Births	**9.8%**	2.6%	9.0%	8.1%	12.3%	9.0%	10.2%
Neonatal Abstinence Syndrome (NAS)[46]	Rate per 1,000 Birth Hospitalizations	**4.6**	7.6	5.6	10.5	6.4	9.6	5.6
Teen Pregnancy[46]	Age 15-19, Rate Per 1,000 Females	**15.2**	8.4	10.7	21.2	16.4	12.9	28.4
Mothers with Late or No Prenatal Care[46]	Percent of Total Live Births	**5.8%**	4.0%	5.3%	10.7%	9.6%	9.1%	9.8%
Maternal Opioid Use Disorder[48]	Rate Per 1,000 Delivery Hospitalizations	**5.0**	7.6	6.7	15.4	4.3	25.8	5.9
Smoking During Pregnancy[46]	Percent of Total Live Births	**2.6%**	0.7%	1.3%	5.7%	2.9%	4.3%	3.8%

[46] Virginia Department of Health, Maternal & Child Health Indicator Dashboard. 2023.
[47] Virginia Department of Health, Maternal & Child Health Indicator Dashboard. 2019-2023
[48] Virginia Department of Health, Division of Population Health Data. 2023

Low birth weight and preterm births, key predictors of infant health complications, vary among counties. Clarke County reports the lowest low birth weight percentage at 1.3%, while Winchester has the highest at 9.7% slightly above the state average of 8.5%. Preterm birth rates range from 12.3% in Winchester to 2.6% in Clarke, indicating differing risk profiles across communities.

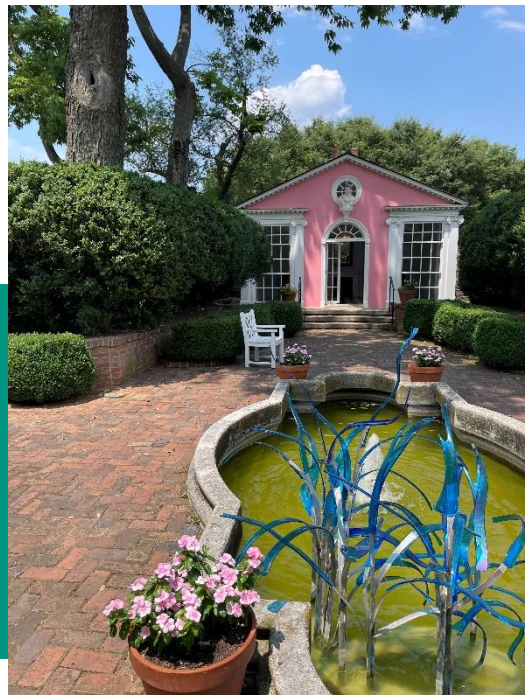


Neonatal Abstinence Syndrome (NAS) is a condition when babies are exposed to certain drugs in the womb before birth. Drugs, such as pain medications (opioids) or stimulants (like cocaine or meth), can cause NAS. When a baby is born, they are no longer getting the drug they used to get in the womb, which can cause withdrawal symptoms. All localities have higher rates of NAS rates per 1,000 birth hospitalizations than the State; the NAS rate in Page (10.5) roughly double the State rate (4.6). NAS rates can be influenced by maternal opioid use disorder rates, and only Shenandoah have rates lower than the state average.

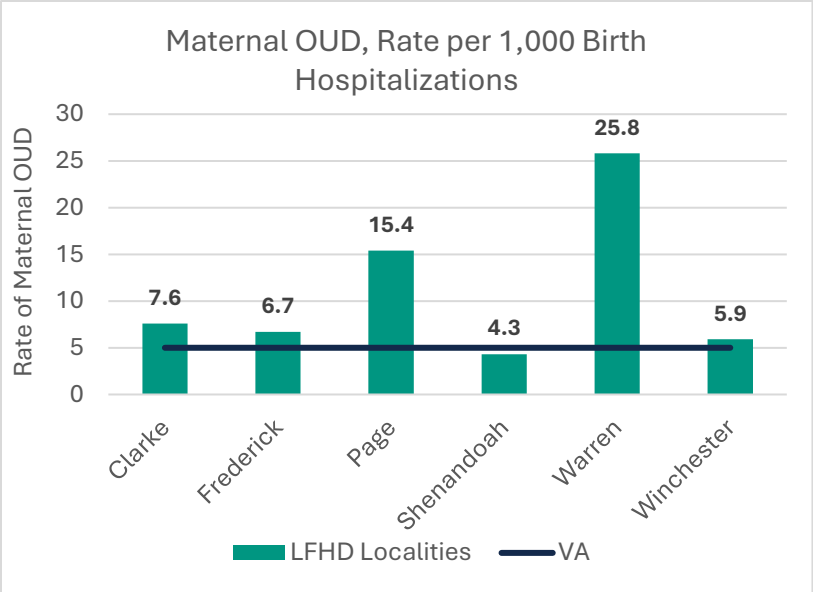
Teen pregnancy rates vary across the District, with all localities, except Clarke, Frederick, and Warren, exceeding the Virginia average of 15.2 pregnancies per 1,000 teen females. Elevated teen pregnancy rates are associated with increased risks of poor maternal and infant health outcomes and often reflect gaps in sexual health education and access to reproductive services.

The percentage of mothers receiving late or no prenatal care is highest in Page County (10.7%), suggesting barriers to timely healthcare access. Timely prenatal care is vital for monitoring pregnancy progression and mitigating potential complications.

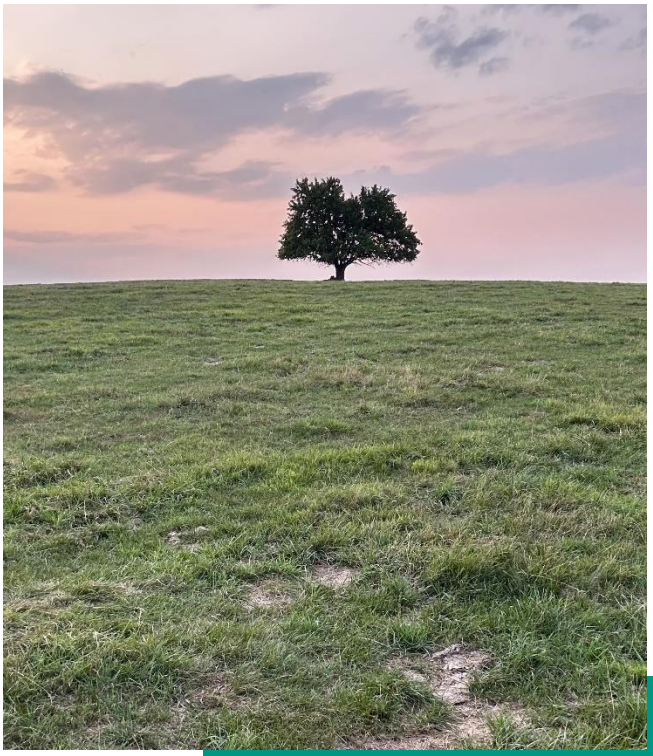
City of Winchester, VA



The data also reveals notable differences in maternal opioid use disorder (OUD) rates, highest in Warren (25.8 per 1,000 delivery hospitalizations) and Page (15.4), mirroring NAS trends and emphasizing the impact of the opioid crisis on maternal health in these communities. All localities except Shenandoah have rates above the VA average rate (5.0).



Smoking during pregnancy data follows a similar trend as the percent of current smokers in each locality; though all localities have higher rates of current smokers, only Clarke and Frederick fall below the state average (2.6%) for smoking during pregnancy. Page County reports a rate of 5.7%, which is nearly double the state average. Maternal smoking is a preventable risk factor contributing to low birth weight and other adverse outcomes.



The disparities observed in maternal and child health indicators across this region highlight the need for targeted public health strategies. Priority areas include addressing opioid use among pregnant women, improving access to prenatal care, enhancing teen pregnancy prevention programs, and promoting smoking cessation during pregnancy.

Collaboration between healthcare providers, community organizations, and government is essential to develop culturally appropriate interventions and expand resources. Continued surveillance and data completeness are also critical to monitor progress and guide evidence-based decision-making.

Clarke County, VA

Mental Health and Substance Use Disorders

Mental health is a vital component of overall health, influencing how people think, feel, and act in their daily lives. It is closely linked to conditions such as depression, anxiety, and obsessive-compulsive disorder (OCD), which are common and serious mental health challenges. However, the impact of mental health extends even further, connecting to issues like substance abuse and overdose. People experiencing untreated mental health conditions may turn to drugs or alcohol to cope, increasing the risk of addiction and overdose. These interrelated issues highlight the importance of addressing mental health not just through clinical care, but also by improving access to support services, reducing stigma, and understanding the broader social and environmental factors that contribute to emotional well-being.

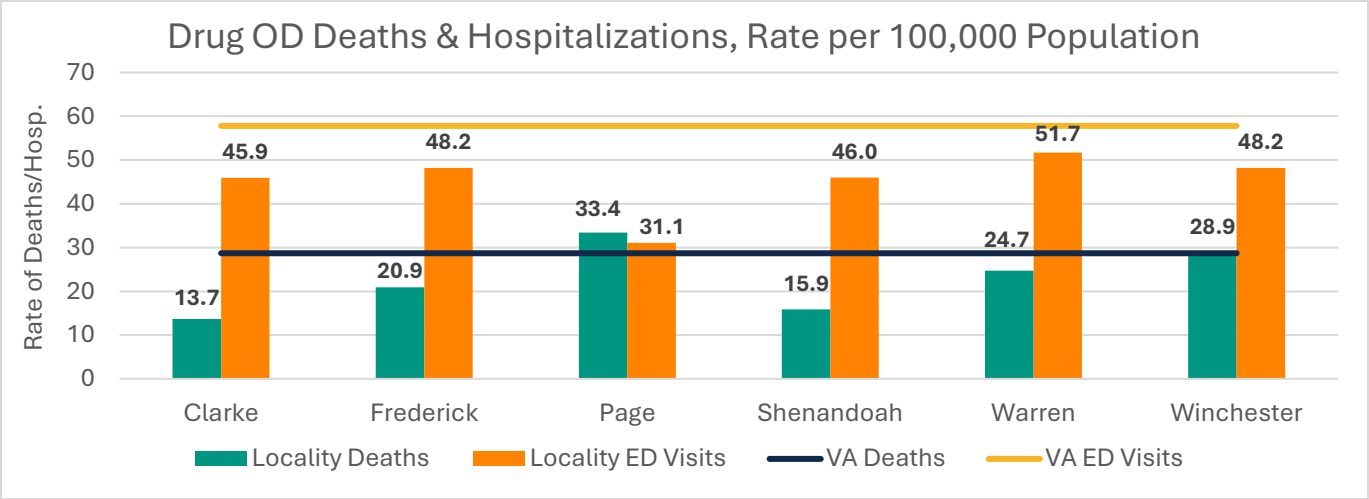
Mental Health Indicators	Indicator Attribute	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
Adults Reporting Frequent Mental Distress[49]	Percent	**17.0%**	18.0%	19.0%	20.0%	19.0%	20.0%	18.0%
Self-Harm and Suicide-Related ED Visits[50]	Rate Per 100,000 Population, Age 5+	**680.9**	416.9	864*	759.0	940.9	833.6	864*
Depression[49]	Percent, Adults Age 18+	**23.0%**	25.2%	26.5%	27.0%	26.3%	26.3%	24.5%
Deaths Due to Suicide[51]	Rate Per 100,000 Population	**14.2**	32.3	16.7	21.1	13.3	11.9	10.9
Drug Overdose Deaths (All Substances)[52]	Rate per 100,000 Population	**28.7**	13.7	20.9	33.4	15.9	24.7	28.9
Drug Overdose ED Visits[52]	Rate per 100,000 Population	**57.8**	45.9	48.2*	31.1	46.0	51.7	48.2*
Alcohol-Impaired Driving Deaths[53]	Rate per 100,000 Population	**1.6**	5.4	3.9	3.4	3.2	1.0	0.0
Deaths from Liver Disease and Cirrhosis[54]	Rate per 100,000 Population	**13.5**	-	13.8	19.3	22.0	20.0	15.1

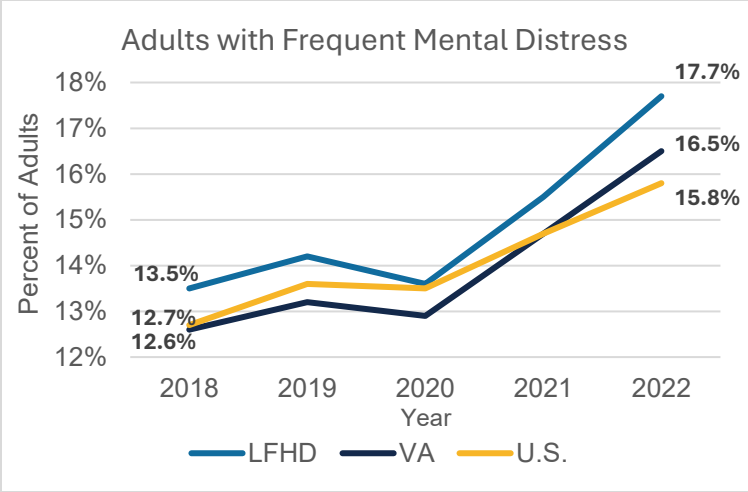
-Data unavailable

*Frederick and Winchester are combined due to zip codes spanning multiple localities.

[49] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.
[50] Virginia Department of Health, Division of Surveillance and Investigation, Syndromic Surveillance Data. 2023.
[51] Virginia Department of Health, Injury and Violence Deaths Dashboard. 2023.
[52] Virginia Department of Health, Drug Overdose Dashboards. 2023.
[53] US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2018-2022.
[54] Centers for Disease Control and Prevention, CDC - National Vital Statistics System. 2019-2023.

The graph below shows the drug overdose (OD) deaths and hospitalizations in LFHD. Warren, Winchester, and Page all have higher rates than the state average (28.7) in drug overdose deaths. Page, Shenandoah, Warren, and Winchester all have higher rates of drug overdose hospitalizations, with Page County having a significantly higher rate.[55] When reviewing the table on page 53, which contains several mental health and substance abuse indicators, you can see that Page County also has the highest rates of adults with poor mental health, depression, and deaths due to suicide. These indicators are important to consider when reviewing local funding for support services and other organizations that deal with mental health and substance abuse, particularly in areas with extremely high rates.





City of Winchester, VA

The graph above shows that after 2020, the number of adults with frequent mental distress has increased significantly in LFHD, Virginia, and the United States.[56]

[55] Virginia Department of Health, Drug Overdose Dashboards. 2023.
[56] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2022.

Social Drivers of Health

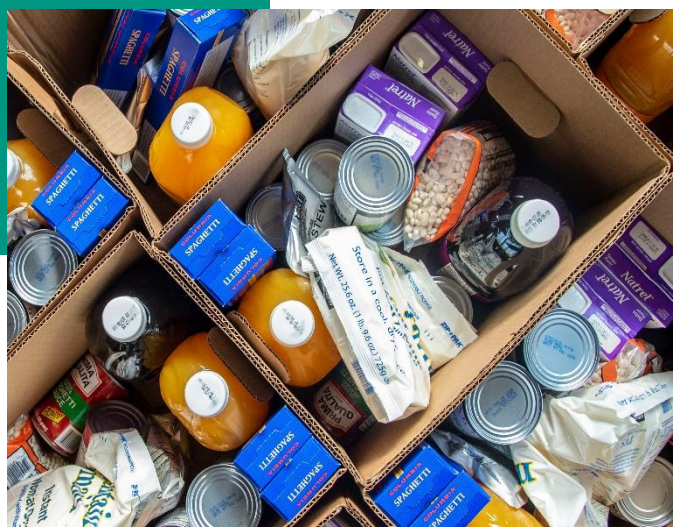
Social Drivers of Health (also referred to as *Social Determinants of Health*) are the conditions in which people are born, grow, live, work, and age. These include five key domains: economic stability, education, healthcare, neighborhood and built environment, and social/community context. While these factors might not seem directly related to health at first glance, they are powerful indicators of a community's overall well-being. For example, poor housing conditions, such as mold, asbestos, or poor ventilation, can lead to chronic health issues like asthma in children. Chronic asthma may cause frequent school absences, which impact educational attainment, increasing risk of lower graduation rates and outcomes such as higher teen pregnancy rates. By measuring data related to the social drivers of health, we can better understand these connections and more effectively address root causes of health disparities in our communities.

Economic Stability

Poverty, Percent	**Indicator Attribute**	**Virginia**	**Clarke**	**Frederick**	**Page**	**Shenandoah**	**Warren**	**Winchester**
Total Population in Poverty[57]		**9.9%**	6.9%	7.1%	9.5%	12.3%	11.3%	19.3%
Children in Poverty[58]	Total	**12.7%**	8.8%	9.0%	7.4%	20.0%	17.5%	29.2%
	Hispanic or Latino	**17.2%**	33.3%	20.7%	2.1%	23.9%	12.3%	33.1%
	Not Hispanic or Latino	**11.9%**	5.4%	6.3%	7.6%	19.4%	18.0%	27.1%
	Non-Hispanic White	**8.1%**	4.6%	6.2%	8.0%	18.8%	19.0%	21.8%
	Black or African American	**24.2%**	36.3%	7.4%	0.0%	71.7%	9.0%	18.6%
	American Indian or Alaska Native	**17.7%**	0.0%	47.9%	-	0.0%	0.0%	0.0%
	Asian	**6.6%**	0.0%	11.6%	-	0.0%	77.9%	45.3%
	Native Hawaiian or Pacific Islander	**5.9%**	-	0.0%	-	-	-	-
	Some Other Race	**21.4%**	22.6%	15.5%	0.0%	45.9%	13.4%	34.0%
	Multiple Race	**11.7%**	16.5%	13.5%	2.9%	1.9%	4.2%	44.2%

-Data unavailable

[57] US Census Bureau, American Community Survey. 2019-23.
[58] US Census Bureau, American Community Survey. 2019-23.



This poverty dataset highlights important economic challenges affecting people across LFHD. Poverty is a well-established social driver of health that profoundly influences access to resources, healthcare, education, and overall well-being.

Virginia's overall poverty rate stands at 9.9%, with local variation ranging from a low of 6.9% in Clarke County to a high of 19.3% in Winchester city. These disparities reflect differing economic conditions and resource availability, which are foundational to community health.

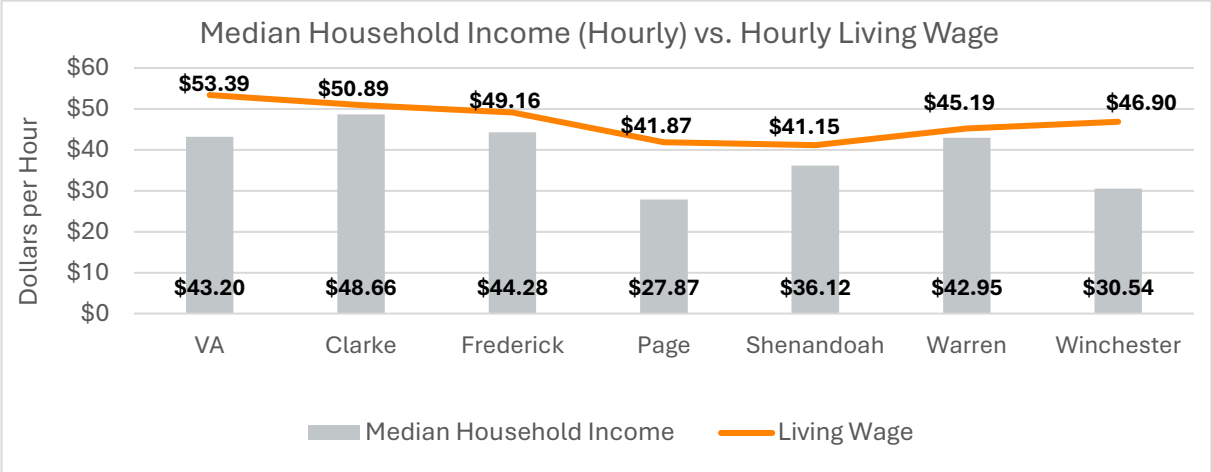
Children experience poverty at higher rates than the general population, with Virginia's child poverty rate at 12.7%. In the LFHD region, rates vary dramatically—from as low as 7.4% in Page County to a concerning 29.2% in Winchester. Childhood poverty is strongly linked to adverse health outcomes, including developmental delays, chronic disease risk, and educational challenges.

The data reveal significant racial and ethnic disparities in child poverty rates, underscoring persistent inequities:

- Hispanic or Latino children experience child poverty rates as high as 33.3% in Clarke and 33.1% in Winchester, notably higher than the Virginia average of 17.2%.
- Black or African American children face alarmingly high poverty rates in some areas, peaking at 71.7% in Shenandoah and 36.3% in Clarke, compared to 24.2% statewide.
- Non-Hispanic White children generally have lower poverty rates but still face elevated risks in Shenandoah (18.8%) and Warren (19.0%).
- Other groups such as American Indian/Alaska Native and Asian populations show marked disparities, though smaller population sizes may influence variability.

City of Winchester, VA

Economic hardship directly influences access to nutritious food, stable housing, quality education, and healthcare services. Children in poverty are especially vulnerable, with long-term implications for physical, emotional, and cognitive development. These disparities are intertwined with structural factors such as systemic racism, employment, educational inequities.



In every locality, the median household income[59] falls below what is considered a living minimum wage for a household with one adult and two children.[60]

Social Factors

Social Drivers of Health Indicators, Percent[61]	Indicator Attribute	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
Cost Burdened Households		**26.7%**	21.8%	19.2%	24.9%	24.7%	25.3%	33.8%
Children in Single-Parent Households		**23.6%**	12.6%	21.6%	17.3%	25.3%	19.3%	32.7%
Children Enrolled in Preschool	Age 3-4	**46.1%**	41.2%	40.5%	46.7%	50.9%	41.0%	41.2%
Grandparents Responsible for Grandchildren		**35.0%**	14.5%	37.3%	34.3%	18.1%	41.0%	41.9%
Households with No Motor Vehicle		**6.0%**	2.1%	3.5%	7.4%	5.3%	4.9%	8.9%
Long Commute Driving Alone		**40.0%**	54.0%	40.0%	48.0%	46.0%	59.0%	21.0%
Food Insecurity[62]		**12.1%**	9.9%	10.3%	13.8%	13.9%	12.6%	17.1%

[59] US Census Bureau, Small Area Income and Poverty Estimates. 2023.
[60] Living Wage Institute, Inc. "Benchmark Living Wage Data Series". 2024.
[61] US Census Bureau, American Community Survey. 2019-23.
[62] Feeding America, Map the Meal Gap. 2023.

Across the region, several key social factors help us understand where communities may be facing more challenges, these social factors include neighborhood and built environment and community context data. Winchester consistently shows higher levels of vulnerability, with more households struggling with housing costs, higher rates of single-parent families, more grandparents raising grandchildren, and greater food insecurity. In contrast, Clarke County tends to show lower levels of social stress, with fewer cost-burdened households, fewer single-parent homes, and better access to transportation. Warren County stands out for having the longest commute times, which can impact quality of life. These differences highlight where additional support and resources may be most needed to improve overall community health.

Tiered Social Vulnerability Index

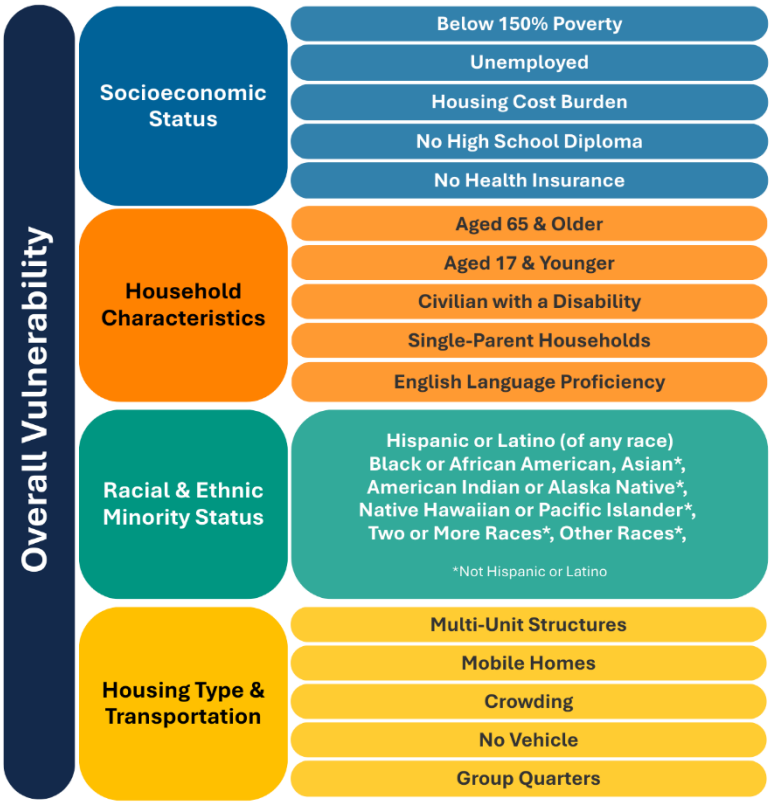


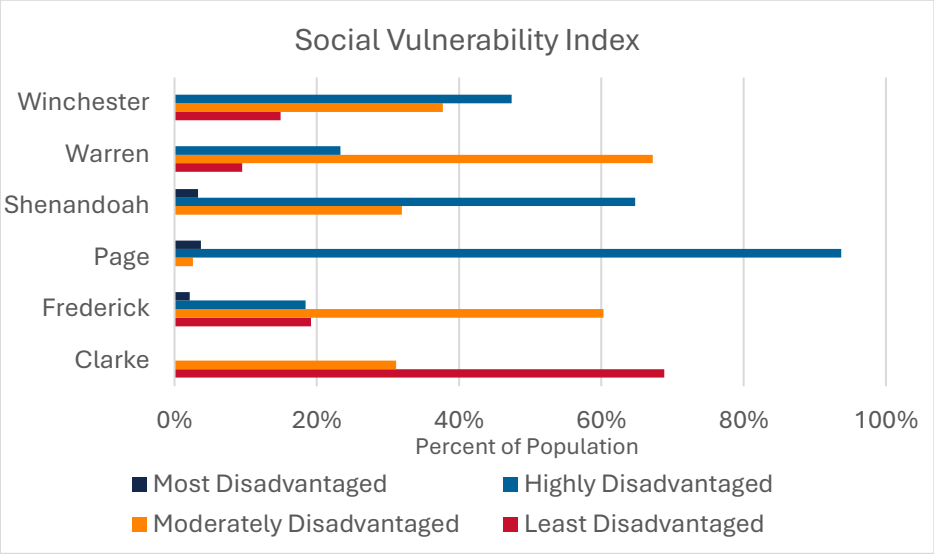
Figure 3 Social Vulnerability Index variables grouped into four themes

One way to further assess how well a community is doing is by examining the Tiered Social Vulnerability Index (TSVI). According to the CDC[63], this tool "...assesses social vulnerability based on 16 U.S. Census variables from the American Community Survey, grouped into four themes: socioeconomic status, household composition and disability, minority status and language, housing and transportation".

The image to the left illustrates the four themes of the TSVI, along with the variables that fall under each category. Together, these indicators provide a more comprehensive view of a community's overall health.

[63] ATSDR, Place and Health. 2024. www.atsdr.cdc.gov/place-health/php/svi/index.html

Page and Shenandoah counties show the greatest concentration of social disadvantage, suggesting higher needs for community support and resources; nearly 95% of the total population in Page County is considered "highly disadvantaged" based on the variables described above. In Shenandoah County, approximately 60% of the population falls into the same, "highly disadvantaged" category. In contrast, Clarke County appears to be the most socially stable and least vulnerable locality in the region, with no significant number of people who would be considered "highly disadvantaged" or "most disadvantaged."[64]



Education

Adult education levels are closely linked to the overall health and well-being of a community. Higher educational attainment is associated with better health outcomes, greater access to healthcare, and healthier lifestyles. In contrast, communities with lower education levels often face economic challenges, limited job opportunities, and increased rates of chronic illness. Education also plays a key role in shaping the health and future success of the next generation. Expanding adult education opportunities can help reduce health disparities and strengthen a community's long-term resilience.

Adult Education Level, Percent[65]	Virginia	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
No High School Diploma	**8.7%**	7.2%	10.9%	16.1%	11.0%	11.0%	13.5%
High School Only	**23.9%**	27.7%	30.8%	46.1%	41.1%	34.6%	28.8%
Some College	**18.2%**	20.9%	20.6%	16.9%	18.3%	23.4%	20.1%
Associate's Degree	**7.8%**	7.0%	7.4%	5.7%	8.3%	6.5%	6.0%
Bachelor's Degree	**23.3%**	23.2%	17.9%	9.4%	12.3%	15.0%	18.0%
Graduate or Professional Degree	**18.2%**	14.1%	12.4%	5.9%	9.1%	9.6%	13.6%

[64] Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP. 2022.
[65] US Census Bureau, American Community Survey. 2019-23.

In the table above, Page County stands out with the highest percentage of adults without a high school diploma (16.1%) and the most adult residents with only a high school education (46.1%), far above Virginia's averages. In contrast, Clarke County closely mirrors the state, with strong rates of bachelor's (23.2%) and graduate degrees (14.1%).

City of Winchester, VA

Winchester, Frederick, Shenandoah, and Warren all fall short in higher education, with Page particularly low, with 9.4% earning a bachelor's and 5.9% earning a graduate degree. Warren leads in residents with some college (23.4%), suggesting potential for growth.

These gaps highlight how educational attainment, and the opportunities it brings, varies widely across the region.

Moving Forward:

Building a Healthier Northern Shenandoah Valley

This Community Health Assessment provides a snapshot of our community's health at this point in time. While it offers important data and insights, the true value lies in using these findings to **drive meaningful, actionable change**. Identifying challenges without planning solutions does not move us forward—our commitment is to translate knowledge into collective impact.

As outlined on page 13, the MAPP 2.0 framework guides us beyond this assessment phase into the crucial stage of **Continuously Improving the Community**. The next step in this journey is the development of the **Community Health Improvement Plan (CHIP)** - a dynamic, community-informed roadmap designed to address the priority health issues identified in the CHA.

The Role of the Steering Committee

A **steering committee** composed of diverse community members, public health professionals, healthcare providers, local organizations, and other stakeholders will be formed to lead the CHIP process. This committee will:

- **Prioritize Issues:** Using the CHA data, the committee will collectively select three to five key health priorities that represent the most pressing challenges in our community.
- **Analyze Root Causes:** For each priority, the committee will explore the social, economic, and institutional factors influencing these issues, emphasizing the role of systemic drivers and health equity.
- **Engage the Community:** The committee will actively involve residents, community groups, and partners in setting goals, crafting strategies, and designing objectives that reflect community values and needs.
- **Develop Action Plans:** Subcommittees will establish measurable goals, identify strategies to achieve them, assign responsibilities, and outline timelines—ensuring clear accountability.
- **Implement & Evaluate:** The steering committee will oversee ongoing implementation, using continuous evaluation and a plan-do-study-act cycle to monitor progress, make adjustments, and celebrate successes.

Next Steps for Community Engagement

- **Broad Participation:** Success depends on the voices and expertise of the entire community. We encourage individuals, neighborhood groups, businesses, faith organizations, schools, and local government agencies across the Northern Shenandoah Valley to get involved.

- **Transparent Communication:** The CHA and CHIP reports will be published simultaneously on the websites of both Valley Health and the Lord Fairfax Health District, ensuring accessible and transparent information for all.
- **Ongoing Collaboration:** We commit to maintaining an open, inclusive process that fosters partnership, trust, and shared ownership of health improvement efforts.

Together, through this community-driven process, we will address health disparities, promote equity, and build a vibrant, healthy future for all residents of the Northern Shenandoah Valley.

To learn more about how to engage with the CHA/CHIP process, visit the Valley Health or Lord Fairfax Health District websites or contact any member of the Core Team. Your participation is vital to making this work successful.

Appendices

Appendix A: Community Health Survey

ValleyHealth
Healthier, together.

SHENANDOAH UNIVERSITY

VDH VIRGINIA DEPARTMENT OF HEALTH

2025 Community Health Survey

This survey is intended to gather your feedback and input about health needs in the community where you live. The results will be used to find the most pressing concerns that can be addressed through the community working together. Please use the QR code on the reverse side if you would like to complete the survey online. ***Thank you!***

Significant Community Health Concerns

In each category, select the priority health concern(s) in your community. (Please check only the number shown.)

1. Health Status (Choose **ONE**)
   - ☐ Length of life
   - ☐ Physical health
   - ☐ Mental health

2. Disease/Health Conditions (Choose **TWO**)
   - ☐ Cancer
   - ☐ Diabetes
   - ☐ Heart disease
   - ☐ Obesity

3. Health Behaviors (Choose **THREE**)
   - ☐ Alcohol use
   - ☐ Breast cancer screening
   - ☐ Colon cancer screening
   - ☐ Dental health
   - ☐ Illegal drug use
   - ☐ Marijuana use
   - ☐ Not being physically active
   - ☐ Poor diet
   - ☐ Sexual activity
   - ☐ Smoking and tobacco use
   - ☐ Vaccinations
   - ☐ Vape use

4. Neighborhood and Environment (Choose **TWO**)
   - ☐ Access to healthy foods
   - ☐ Access to parks
   - ☐ Community access
   - ☐ Housing availability
   - ☐ Housing costs
   - ☐ Internet access
   - ☐ Social isolation/lack of support system

5. Economic Stability (Choose **TWO**)
   - ☐ Having enough food
   - ☐ Homelessness
   - ☐ Long commute (30+ Min)
   - ☐ Low income
   - ☐ Unemployment
   - ☐ Violence within home/family
   - ☐ Violent crime

6. Causes of Early Death (Choose **ONE**)
   - ☐ Cancer
   - ☐ Diabetes
   - ☐ Heart Disease
   - ☐ Injuries/accidents
   - ☐ Overdose
   - ☐ Suicide

Responding to Community Health Needs

Which of the following actions would have the biggest impact on the health concerns you identified above? (Choose **THREE**)

- ☐ Increased access to health care
- ☐ Increased access to mental health services
- ☐ Increased access to substance use services
- ☐ Increased access to aging services
- ☐ Additional workforce opportunities
- ☐ Improved transportation options
- ☐ Increased access to healthy foods
- ☐ Increased access to community based services
- ☐ Increased access to parks and recreation
- ☐ Additional affordable housing
- ☐ Reading and language resources
- ☐ Other: _____

Please complete the remainder of survey on reverse side.

General Demographic Information:

City: _____

State: _____ Zip Code: _____

County:_____

Sex:
☐ Male
☐ Female
☐ Another

Age:
☐ 15-24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65-74
☐ 75+

Race/Ethnicity:
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Hispanic/Latino
☐ Middle Eastern/N. African
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Two or More Races

Primary Language:_____

Education:
☐ Did not complete HS
☐ HS Diploma/GED
☐ Some College
☐ College Degree or Higher

Household Income:
☐ Less than $14,500
☐ $14,501 - $32,000
☐ $32,001 - $50,000
☐ $50,001 - $95,000
☐ Over $95,000

Number of People in Home: _____

Employment:
☐ Full-Time
☐ Part-Time
☐ Student
☐ Retired
☐ Not employed

Thank you for your responses. Please return completed surveys to the address below by January 31, 2025. If you would like more information about this community project, please contact us at communityhealth@valleyhealthlink.com.

ATTN: COMMUNITY HEALTH SURVEY
VALLEY HEALTH
PO BOX 3340
WINCHESTER, VA 22604-9836

Prefer to complete the survey online?
Use QR code to the right or visit valleyhealthlink.com/survey.

Would you like to receive the survey results?

Please provide your email address: _____

Appendix B: Additional Community Health Survey Analysis

Purpose of Community Health Assessment survey (CHA)

A joint Community Health Assessment was conducted because of the mutual interest in the process between both organizations and the concern regarding community burnout regarding surveys if separate CHAs were conducted.

Following the three-year cycle of Community Health Needs Assessments required by the Internal Revenue Service (IRS), non-profit hospital systems must conduct a thorough review of the health of its community in order to guide improvement efforts. The CHA is comprised of multiple assessment types, one of which, a survey asking about the perceived health needs within the community. This assessment process allows for community members and organizations to involve themselves in providing feedback but also allows them to understand the community needs as a whole with the final analysis within the CHA report.

Survey Development

The core group, or the team leading the community health assessment, was comprised of the Valley Health director of community health and the LFHD health director and population health team. Supplemental guidance was provided by Winchester Department of Social Services and Shenandoah University.

The current Community Health Assessment survey was adapted from Valley Health's previous survey with changes made to identify more community-based health concerns. The process has used principles of MAPP 2.0 as guidance in this process with adaptions made to better suit the abilities and needs of the core group.

Sampling Methods

The survey sampling methods most closely align with the principles of convenience sampling and purposive sampling. These two sampling methods are both non-probability sampling methods and therefore have some level of biases associated with them. Though biases may be present, anyone who was interested in participating was invited to do so by completing the survey.

Survey Administration

The Community Health Survey was primarily administered online, via the Valley Health website and was available in English and Spanish. A link to the survey was sent to anyone who has a registered 'MyChart' account associated with Valley Health. Flyers detailing the purpose of the CHA survey with QR codes were distributed across the district to community organizations and businesses. Social media posts with the same content were posted to Facebook

Outreach was conducted by community health workers (CHWs) to garner participation from at-risk populations. CHWs gave individuals the option of taking the survey either digitally or printed. Small gift card incentives were used to gain interest from hesitant individuals and proved successful. Paper surveys were provided to all clients at local health departments.

Some of the limitations regarding the survey administration include having limited community support subsequently preventing outreach in more locations, emails sent to MyChart holders only include individuals who seek care at Valley Health, and language barriers prevented more people

from completing the survey. These limitations created barriers during this survey administration but are also lessons learned and will assist in upcoming CHAs.

Data Analysis Methodology

Because several general demographic information questions on the survey were not multiple choice and allowed respondents to provide free text answers, responses to these questions were highly variable. Some reasons for the variability in answers include misspellings, misinterpretation of what was being asked, and incomplete responses. The methods used to consolidate variable answers for these survey questions are described below.

Determining Locality

Localities were determined by the county of residence entered by the respondent. If a response was blank for county, then the zip code was used to determine the county. Some zip codes in LFHD are not confined to a single county (e.g. 22601), so the county that holds the majority of the population was used. If a response was blank for both county and zip code, then the city was used to determine the county.

If any of the responses necessary to determine the locality were misspelled, the spelling was corrected to the response it most closely resembled (e.g. Ferderick corrected to Frederick).

Primary Language

Misspellings and variations of languages provided were corrected (e.g. Eng corrected to English). If multiple languages were provided, that response was coded as "multiple languages" for data analysis purposes.

Number of People in Home

For answers that did not list a whole integer or a range of numbers, those responses were rounded up to the nearest whole number (e.g. 2.5 was rounded to 3, 4-5 was rounded to 5).

Results

Of 3,636 total surveys collected, 2,572 were included in analysis for the Lord Fairfax Health District (LFHD) based on the respondent county of residence. Of the 2,572 LFHD surveys, 7 were Spanish-version surveys. 82 surveys could not be assigned to a locality and were excluded, and the remaining surveys were from respondents outside of the health district.

The following demographic groups are overrepresented in the survey sample: age ranges 55 - 64 and 65 – 74 years old, female, college degree or higher, and white.

Locality	Survey Responses
Clarke	149
Frederick	1080
Page	252
Shenandoah	464
Warren	425
Winchester City	202
Grand Total	**2572**

Below includes common themes and some of the key findings from the survey:

Health Status

- All localities choose physical health as the priority concern except for Winchester City where mental health was the most reported priority. This is likely due to 68.3% of respondents from Winchester City were between 15 – 54 years old and these age ranges predominantly choose mental health as the top concern.

Disease/Health Conditions

- Cancer followed by heart disease were the most reported health conditions by the district. They were the top two responses for all localities except Winchester City where obesity was the top concern; obesity was also the top concern for respondents aged 35 – 54 years old, full-time workers, and household income over $95,000.
- Cancer was not included in the top two responses for 15 – 24 year olds and respondents with a college degree or higher.
- Heart disease was the most reported concern respondents 65 years and older and individuals reported as retired.
- Diabetes was the priority health condition for Black/African American and Hispanic/Latino respondents.

Health Behaviors

- All localities had the same top three reported health behaviors except Clarke County (colon cancer screening instead of illegal drug use) and Warren County (alcohol use instead of poor diet).
- Alcohol use was the top health behavior reported by 15 – 24 year olds, and illegal drug use was the most reported behavior for ranges within 25 – 54 years old and individuals with a high school diploma or GED.

Neighborhood and Environment

- Housing costs and access to healthy foods were the most reported factors for all localities except Page County (house availability instead of access to healthy foods) and Shenandoah County (social isolation instead of access to healthy foods).
- There was little variation across demographic groups for this question.
- Housing costs and housing availability were the top two factors for the following groups: household income between $14,501 - $32,000, high school diploma or GED, and 1-person households.

Economic Stability

- All localities reported low income as the top concern related to economic stability.
- This is only one of two questions where responses varied between sexes. Males reported low income and having enough food and females reported low income and homelessness as the top two priorities.

Causes of Early Death

- All localities reported cancer as the top cause of early death except Warren County and Winchester City where respondents chose overdose.

- Overdose was the top cause of early death reported by 15 – 44 year olds, households with 5 or more people, and Black/African American respondents.
- Heart disease was the top cause of death for respondents with a college degree of higher.
- Students reported suicide as the top cause of early death though this group had a small sample size.

Responding to Community Health Needs

- The top three actions that would have the biggest impact on identified health concerns were increased access to mental health services, increased access to health care, and additional affordable housing.
- All localities had the same top three responses except for Clarke County where increased access to aging services was tied with increased access to health care. Clarke County has an older population compared to other LFHD localities as reflected by the responses by county residents.
- Male respondents chose increased access to aging services instead of additional affordable housing.
- The top two priorities for non-English speakers included increased access to health care and additional workforce opportunities.
- The only education level that differed from the top three actions was respondents that did not complete high school; increased access to healthy foods was chosen instead of additional affordable housing.

Appendix C: Complete Community Health Survey Results

Survey Questions	LFHD Total	Clarke	Frederick	Page	Shenandoah	Warren	Winchester
In each category, select the priority health concern(s) in your community.							
1. Health Status (1)							
Physical health	1377	102	565	133	274	234	69
Mental health	969	39	410	99	157	147	117
Length of life	222	8	103	19	32	44	16
Total	**2568**	**149**	**1078**	**251**	**463**	**425**	**202**
2. Disease & Health Conditions (2)							
Cancer	1415	98	584	127	262	233	111
Heart disease	1352	87	584	124	230	238	89
Obesity	1255	62	530	121	229	198	115
Diabetes	1083	51	448	119	204	177	84
Total	**5105**	**298**	**2146**	**491**	**925**	**846**	**399**
3. Health Behaviors (3)							
Not being physically active	1147	72	519	87	216	171	82
Illegal drug use	1018	43	359	152	182	187	95
Poor diet	1017	71	431	92	194	153	76
Alcohol use	796	40	299	86	141	156	74
Dental health	734	37	315	70	122	137	53
Breast cancer screening	623	42	277	54	106	95	49
Colon cancer screening	612	44	296	39	111	87	35
Smoking and tobacco use	535	27	214	57	106	89	42
Vaccinations	475	37	211	40	84	75	28
Vape use	412	23	158	37	86	73	35
Marijuana use	177	4	86	12	24	33	18
Sexual activity	138	6	65	11	17	20	19
Total	**7684**	**446**	**3230**	**737**	**1389**	**1276**	**606**
4. Neighborhood & Environment (2)							
Housing costs	1476	82	647	114	256	243	134
Access to healthy foods	1048	62	477	87	161	177	84
Housing availability	912	41	339	134	160	157	81
Social isolation/lack of support system	853	52	340	74	187	150	50
Community access	322	16	138	24	69	51	24
Internet access	281	39	116	45	35	40	6
Access to parks	243	6	106	14	61	36	20
Total	**5135**	**298**	**2163**	**492**	**929**	**854**	**399**
5. Economic Stability (2)							
Low income	1482	87	575	169	303	223	125

Homelessness	1084	39	537	78	141	174	115
Having enough food	993	66	419	71	189	178	70
Long commute (30+ Min)	573	52	212	68	120	104	17
Unemployment	426	21	184	48	65	66	42
Violence within home/family	329	19	112	49	69	61	19
Violent crime	243	14	122	8	41	45	13
Total	**5130**	**298**	**2161**	**491**	**928**	**851**	**401**
6. Cause of Early Death (1)							
Cancer	772	60	339	65	169	92	47
Heart disease	635	38	286	59	101	107	44
Overdose	495	13	180	54	83	117	48
Suicide	293	7	131	32	48	51	24
Diabetes	224	19	75	21	44	38	27
Injuries/accidents	132	12	62	13	17	18	10
Total	**2551**	**149**	**1073**	**244**	**462**	**423**	**200**
7. Which of the following actions would have the biggest impact on the health concerns you identified above? (3)							
Increased access to mental health services	1289	63	550	127	212	217	120
Increased access to health care	1260	71	557	132	210	210	80
Additional affordable housing	1083	53	455	109	187	188	91
Increased access to aging services	833	71	368	50	175	137	32
Increased access to healthy foods	768	51	370	52	127	109	59
Increased access to substance use services	603	20	197	67	117	140	62
Increased access to community based services	558	47	223	37	121	78	52
Additional workforce opportunities	476	25	162	81	93	63	52
Improved transportation options	421	29	172	56	67	64	33
Increased access to parks and recreation	208	9	97	17	45	29	11
Other (please specify)	129	3	54	10	28	30	4
Reading and language resources	66	5	33	2	10	7	9
Total	**7694**	**447**	**3238**	**740**	**1392**	**1272**	**605**

Number in parentheses indicates the number of selections each respondent was instructed to choose for the question.

Full Demographic results of the survey are available on page 18 within the Community Health Survey Analysis.

Appendix D: Community Partner Interview Facilitation Guide

1. What services are provided as part of your organization's mission and where do you provide those services?
2. In your opinion, what are the **biggest issues or concerns** facing the people served by your organization, as well and community you serve*?*
    - *<u>Additional Prompts</u>: How do aspects of our 'built environment' (like housing, schools, neighborhoods, infrastructure, and open spaces) influence these issues or concerns in the surrounding community?*
    - *How have items like recent economic development, zoning, transportation, and safety changes impacted the community's ability to live healthy lives?*
3. Over the past couple years, have these issues been **improving, staying the same or getting worse, and why**?
    - *<u>Additional Prompts:</u> Have the populations in need changed or do we have different populations that we need to make sure we pay attention to?*
4. **Where** and for what **population groups** in the community are each of these issues most pronounced? (City/Town, County, road corridor, hospital service area, …)
5. What issues do people served by your organization encounter when attempting to **access health or social services** for themselves and/or their families? (Not available, travel to get, where to, …)
6. Please discuss the major **factors that are contributing to (driving) poor health status** among people served by your organization (or population groups about which you have particular knowledge).
    - *<u>Additional Prompts</u>: When examining the healthcare system of the community, what barriers limit access to care when needed?*
7. What organizations (including coalitions and informal groups) are working to collaboratively address any of the problems mentioned?
8. What community assets could play a role in addressing these needs?
    - *<u>Additional Prompts:</u> What is supportive of health and well-being in your community?*
9. What specific initiative(s) would you recommend be implemented to address the most pressing access or health status problems in the community (or for population groups about which you have particular knowledge)?
    - *<u>Additional Prompts:</u> What areas of public health disease prevention would be most beneficial to your community?*

Appendix E: Community Partner Assessment survey

Your Organization

1. What is the full name of your organization?

2. Which best describes your position or role in your organization?
   - ○ Administrative staff
   - ○ Front line staff
   - ○ Supervisor (not senior management)
   - ○ Senior management level/unit or program lead
   - ○ Leadership team
   - ○ Community member
   - ○ Community leader
   - ○ Other

3. Which of the following best describe(s) your organization? (check all that apply)
   - ○ Local health department
   - ○ State health department
   - ○ Other city government agency
   - ○ Other county government agency
   - ○ Other state government agency
   - ○ Private hospital
   - ○ Public hospital
   - ○ Private clinic
   - ○ Public clinic
   - ○ Emergency response
   - ○ Schools/education (PK–12)
   - ○ College/university
   - ○ Library
   - ○ Non-profit organization
   - ○ Grassroots community organizing group/organization
   - ○ Social service provider
   - ○ Housing provider
   - ○ Mental health provider
   - ○ Neighborhood association
   - ○ Foundation/philanthropy
   - ○ For-profit organization/private business
   - ○ Faith-based organization
   - ○ Center for Independent Living
   - ○ Other:

4. What racial/ethnic populations does your organization work with? (check all that apply)
   - ○ Black/African American
   - ○ African
   - ○ Native American/Indigenous/Alaska Native
   - ○ Latinx/Hispanic
   - ○ Asian f. Asian American
   - ○ Pacific Islander/Native Hawaiian
   - ○ Middle Eastern/North African
   - ○ White/European
   - ○ Other:

5. Does your organization work with immigrants, refugees, asylum seekers, and other populations who speak English as a second language?
   - ○ Yes. Please specify:
   - ○ No
   - ○ Unsure

6. Does your organization offer services for transgender, nonbinary, and other members of the LGBTQIA+ community?
   - ○ Yes—we provide services specifically for the LGBTQIA+ community
   - ○ Somewhat—we provide general services and LGBTQIA+ individuals could use those services
   - ○ No—LGBTQIA+ populations are not welcome
   - ○ Unsure

7. Does your organization offer services specifically for people with disabilities?
   - ○ Yes—we provide services specifically for people with disabilities
   - ○ Somewhat—we are wheelchair accessible and compliant with the American Disabilities Act but are not specifically designed to serve people with disabilities
   - ○ No—our organization is not specifically designed to serve people with disabilities
   - ○ Unsure

8. Does your organization work with other populations or groups who are not addressed in the previous questions? For example, groups identifiable by gender, socioeconomic status, education, disability, immigration status, religion, insurance status, housing status, occupation, age, neighborhood, and involvement in the criminal legal system.
    - Yes. Please specify:
    - No
    - Unsure

9. Does your organization have access to interpretation and translation services?
    - Yes. Please specify:
    - No
    - Unsure

10. Who are your priority populations?

11. Do the staff and others in your organization reflect the demographics of the community you serve?
    - Yes
    - No
    - Unsure

Topic Area Focus

12. How much does your organization focus on each of these topics?
    - Economic Stability: The connection between people's financial resources—income, cost of living, and socioeconomic status—and their health. This includes issues such as poverty, employment, food security, and housing stability

      a) A lot **b) A little** **c) Not at all** **d) Unsure**

    - Education Access and Services: The connection of education to health and well-being. This includes issues such as graduating from high school, educational attainment in general, language and literacy, and early childhood education and development.

      a) A lot **b) A little** **c) Not at all** **d) Unsure**

    - Healthcare Access and Quality: The connection between people's access to and understanding of health services and their own health. This includes issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.

      a) A lot **b) A little** **c) Not at all** **d) Unsure**

    - Neighborhood and Built Environment: The connection between where a person lives—housing, neighborhood, and environment— and their health and well-being. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and public safety.

      a) A lot **b) A little** **c) Not at all** **d) Unsure**

    - Social and Community Context: The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and well-being. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, violence, and incarceration.

      a) A lot **b) A little** **c) Not at all** **d) Unsure**

13. Which of the following categories does your organization work on/with? (check all that apply)
    - Arts and culture
    - Businesses and for-profit organizations
    - Criminal legal system
    - Disability/independent living
    - Early childhood development/childcare
    - Education
    - Community economic development
    - Economic security
    - Environmental justice/climate change
    - Faith communities
    - Family well-being
    - Financial institutions (e.g., banks, credit unions)
    - Food access and affordability (e.g., food bank)
    - Food service/restaurants
    - Gender discrimination/equity
    - Government accountability
    - Healthcare access/utilization
    - Housing
    - Human services
    - Immigration
    - Jobs/labor conditions/wages and income
    - Land use planning/development
    - LGBTQIA+ discrimination/equity
    - Parks, recreation, and open space
    - Public health
    - Public safety/violence
    - Racial justice
    - Seniors/elder care
    - Transportation
    - Utilities
    - Veterans' issues
    - Violence
    - Youth development and leadership
    - Other

14. Which of the following health topics does your organization work on? (check all that apply)
    - Cancer
    - Chronic disease (e.g., asthma, diabetes/obesity, cardiovascular disease)
    - Family/maternal health
    - Immunizations and screenings
    - Infectious disease
    - Injury and violence prevention
    - HIV/STD prevention
    - Healthcare access/utilization
    - Health equity
    - Health insurance/Medicare/Medicaid
    - Mental or behavioral health (e.g., PTSD, anxiety, trauma)
    - Physical activity m. Tobacco and substance use and prevention
    - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)/food stamps
    - None of the above/Not applicable
    - Other:

Organizational accountability & Capacities

15. In 1–2 sentences, describe the people impacted by your organization and the work you are doing.

16. Does your organization have an advisory board of community members, stakeholders, youth, or others who are impacted by your organization?
    - Yes
    - No
    - Unsure

17. Does your organization have sufficient capacity to meet the needs of your clients/ members? For example, do you have enough staff/funding/support to do your work?
    - Yes
    - No
    - Unsure. Please elaborate:

Data & Systems

18. Does your organization conduct assessments (e.g., of basic needs, community health, neighborhood)?
    - Yes. Please describe what they assess:
    - No
    - Unsure.

19. What data does your organization collect? (check all that apply)
    - Demographic information about clients or members
    - Access and utilization data about services provided and to whom
    - Evaluation, performance management, or quality improvement information about services offered
    - Data about health status
    - Data about health behaviors
    - Data about conditions and social determinants of health (e.g., housing, education, or other conditions)
    - Data about systems of power, privilege, and oppression
    - We don't collect data
    - Other:

20. What policy/advocacy work does your organization do? (check all that apply)
    - Develop close relationships with elected officials
    - Educate decision-makers and respond to their questions
    - Respond to requests from decision-makers
    - Use relationships to access decision-makers
    - Write or develop policy
    - Advocate for policy change
    - Build capacity of impacted individuals/communities to advocate for policy change
    - Lobby for policy change
    - Mobilize public opinion on policies via media/communications
    - Contribute to political campaigns/political action committees (PACs)
    - Voter outreach and education
    - Legal advocacy
    - Other:

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