Henry County-Martinsville Community Health Equity Assessment

2023
Full Report

A collaborative community health equity project

Welcome

The Henry Martinsville Equity Collaborative invites you to view the Community Health Equity Assessment (2023). This report provides guidance to policy makers, community members, and partners who wish to start or continue to engage in health equity improvements throughout the Henry County and Martinsville City communities. Drawing data from the Henry County and Martinsville City area, which has various services, resources, and efforts already in place to address health equity from numerous perspectives, the survey confirmed data from secondary sources as well as a public opinion survey. Using community health workers, graduate students and nonprofit agencies in the Henry and Martinsville area to reach underserved and at-risk populations where voices needed to be heard in the community, a more targeted approach was able to provide survey results with an equitable lens.

The survey shows practically significant results where all census tracts are heard and each demographic, including race, age, income, disability, and ethnicity is represented. Using these insights from the health equity report and secondary data analyzed by the Equity Collaborative led to the identification of six main priority areas:

- **the presence of chronic disease,**
- **maternal health disparities,**
- **the need for mental health services,**
- **a better understanding of and response to substance use and overdoses,**
- **transportation needs and,**
- **the number of persons considered "unhoused".**

These priority areas are the foundation for the next phase of this on-going process – the Community Health Equity Implementation/Improvement Plan.

No single organization or program alone can solve a community health issue, but together, through coordination and communication, we can each play a part in affecting change that collectively helps resolve issues. The health equity report is a starting point for work with a focus in the priority areas over the next three years. This report, along with the improvement/implementation plan, are living documents, meaning that they will continue to be revisited, revised, and built upon as needed to assure progress in the priority areas.

The West Piedmont Health District (WPHD), the Harvest Foundation of the Piedmont (Harvest), and a group of citizens called the Equity Collaborative have been working for months to better understand the needs of citizens from every census tract, ethnic, racial and income group.

Two separate but complementary studies uncover the health outcomes local residents experience. Information on infant mortality, chronic health conditions, education, economic wellbeing, housing, food access, transportation and other issues are included in the data sets.

To review the Harvest Foundation's report, visit www.theharvestfoundation.org/mhc-health-equity-report. To view this report online, visit www.vdh.virginia.gov/west-piedmont/Community-Health.

Inquiries regarding this report may be directed to: Pamela Chitwood, Community Health Community Coordinator-Health Equity Specialist West Piedmont Health District Virginia Department of Health, Pamela.Chitwood@vdh.virginia.gov

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Sprinkled throughout the pages of this report are photos of some public art murals painted by local artists on buildings and structures in Martinsville and Henry County. They are vibrant examples and representations of community members coming together to demonstrate pride of home and the power of a beautiful place. To learn more about these murals, turn to page 78.

Acknowledgements

We would like to thank all the partners and individuals who participated in this process. Their knowledge, collaboration, and commitment to advance police reform, build public trust, and continue to make efforts toward better public safety while also working on the betterment of the education available here in Henry County and Martinsville are what made all of this possible.

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Special thanks to the Virginia Museum of Natural History for hosting Equity Collaborative meetings.

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What's it All About?

The Community Health Equity Assessment (CHEA) for Henry County and Martinsville City has met since 2020 looking for a process to evaluate and improve the outcomes and opportunities of both communities. The process of evaluating health outcomes and moving communities toward more equitable lifespans and better prevention strategies has been in the works for decades longer. In a medical news release from the Institute of Medicine, Washington, DC the Healthy People 2000 a nationally recognized health indicator model is mentioned in the article below.

PUBLIC HEALTH ASSESSMENT IN THE 1990s

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KEY WORDS: health objectives, *Healthy People 2000*, surveillance, health status indicators

INTRODUCTION

In 1990, the Secretary of Health and Human Services unveiled *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (46), which is a milestone in public health. *Healthy People 2000* identifies three national health goals: increase the span of healthy life, reduce health disparities among Americans, and achieve access to preventive services for all Americans. The report also details 300 specific objectives for health promotion and disease prevention programs with quantitative targets to be achieved by the year 2000. Meeting these objectives requires agreement by public health statisticians on measures of individual and community health status to guide public health policy development and priorities, especially for state and local areas, and improvement in the methods for tracking these measures.

Healthy People 2000 challenges public health practitioners to develop surveillance systems that are both meaningful in a public health sense and statistically sound. To clarify this challenge and outline some possible responses, I begin with some background on the public health assessment activities on which the year 2000 health objectives build and considerations that should guide public health assessment efforts. The next section presents general statistical issues in formulating measurable and meaningful objectives. Other sections are devoted to two specific issues: the development of a small set of health status indicators that is both meaningful and feasible to monitor and special issues associated with setting objectives and determining appropriate targets for state and local areas.

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This assessment was based on secondary data collection, which is data previously collected by and readily available from other sources. Indicators were selected to describe the demographic characteristics as well as the main factors that influence a community's health, including how long and how well people live in Henry County and Martinsville City. Data synthesis and secondary analysis were conducted using a variety of available local, state, and national sources.

Health equity analysis should ideally be guided by a shared understanding of core concepts underlying the work. This project was guided by a set of working definitions from the field as follows.

Health Equity. Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (RWJ Foundation)

Social Determinants of Health. Social determinants of health include those inter-related social and economic factors that influence health. (VDH) Such factors may include education, employment, food, housing, neighborhood safety, social supports, and digital access (access to internet and related supports)

The Equity Collaborative is comprised of nonprofits, business leaders, policy makers and persons with lived experience in all walks of life from the Henry County and Martinsville City area. There are experts from across many fields of study also included in the work being done by the Equity Collaborative all aimed to identify the most relevant issues related to community health in this locality. The process of identifying issues will be followed with portioning out into committees each dedicated to one of the six identified key focus areas highlighted by this equity report. From the implementation and improvement planning done by the collaborative many suggestions, educational efforts and healing processes will be offered as deliverable to the Henry County and Martinsville community. Throughout this process as outcomes are measured, we will be able to disaggregate by relevant demographic characteristics (if available) to highlight disparities and inequities as they move toward positive change.

Shared Mission and Purpose

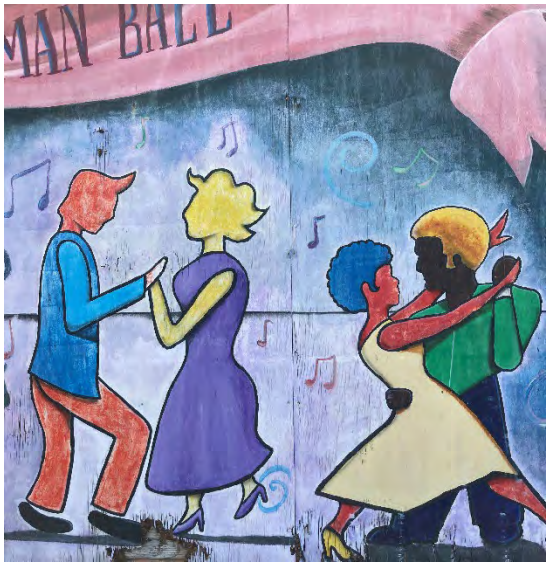
The shared Mission and Values statements are a reminder that each person is working toward shared goals, and that regardless of the focus of any single citizen, each has something valuable to contribute to a healthier community. The Equity Collaborative developed the statements below to guide the Community Health Equity Assessment (CHEA) process.

Mission Statement:

Henry County/ Martinsville will be a community where inequities no longer exist.

Purpose Statement:

We strive to identify and understand inequities in our community and to involve those suffering inequities in policies and solutions that result in impartiality, fairness and justice for all citizens.



The West Piedmont Health District and community partners developed an equity study for Henry County and Martinsville City. The project report includes providing statistically relevant secondary data and demographic specific public opinion data that identify causes of health inequities, determining who is affected by the social determinants of health with an equity lens, where they live, what barriers they face, and what supports they need. Eventually, workgroups will begin recommending steps to introduce equity into the community to develop an equitable implementation/improvement plan using this report.

To do this, community partners and the health district conducted a health equity analysis with assistance from an outside contracted vendor using published data on health and social indicators as well as insights from locally sourced survey data. All data was analyzed and presented to community stakeholders to assess the community and determine the most important health issues to address in the equity implementation/improvement plan.

Community Overview

About Henry County/Martinsville

Martinsville City and Henry County are in southern Virginia, along and north of the Virginia-North Carolina border. The county comprises 384 square miles, and the city has an area of 11 square miles. To the north of Henry County is Franklin County; east is Pittsylvania County; and west is Patrick County. In addition to Martinsville, other urban areas within the county are the Town of Ridgeway and Collinsville, a census-designated place (CDP) and part of the Martinsville Micropolitan Statistical Area. Collinsville is also where the administration building and county courthouse of Henry County are located (although nearby Martinsville - an independent city which is not technically part of the county - is usually identified as the county seat).

Residents enjoy the beautiful, open landscapes of the county while having easy access to the amenities in Martinsville and nearby counties. In addition to the rolling hills that grace the countryside, the Smith River runs through both the city and the county and, along with Philpott Lake, provides beautiful scenery and numerous opportunities for outdoor recreation.

County Health Rankings classifies both Henry County and Martinsville City as a Micropolitan (intersecting an urban core of at least 10,000 but less than 50,000 population). In Martinsville City, 100% of the population lives in an urban area (more than 500 people per square mile or more than 2,500 people).

Both Martinsville City and Henry County have been losing population over the past 20+ years. Henry County's population in 2000, according to the US Census was 57,930; the 2010 Census population was 54,151; and the 2020 population was 50,309 according to the Census Bureau. Statistics provided by Environmental System Research Institute (ERSI) show Henry County's population at 50,046 for 2022.

Similarly, Martinsville's population has been dwindling. According to the US Census Bureau, the city's residents have diminished from a relative high of 15,349 in 2000 to a low of 13,325 in 2022 (ERSI). Interim Census counts are 13,821 in 2010 and 13,485 in 2020. Data provided by ERSI show that the combined populations of Martinsville City and Henry County (63,371) are growing older, largely between the ages of 40 and 79 with the highest percentage (15.2%) aged 60-69.

Other combined data show that residents are mostly White (63.2%) and Black (26.9%)*; with a median household income of $43,039. The numbers of males and females are somewhat matched (48% and 52%), and 86.3% of the population were listed as "on-time" high school graduates in 2022. (ERSI tables from EDC) *US Census Bureau data for Martinsville show almost equal percentages of White and Black citizens (45.4% and 45.3% respectively), and a larger White population than Black (74.1% and 22.8%) for Henry County.

Martinsville City and Henry County are among the least healthy of Virginia's ranked counties. Coming in at 130 and 119 of 133, the city and county are in the lowest quartile (0-25%).
County Health Rankings 2023 (University of Wisconsin-Madison Population Health Institute).

https://www.census.gov/quickfacts/martinsvillecityvirginia https://www.census.gov/quickfacts/henrycountyvirginia

Going forward it is important to note that this report measures disparities between racial and ethnic groups, age groups, and genders. While these are not the only groups experiencing inequities, we acknowledge these disparities have compounding effects, such as socioeconomics, gender, sexual orientation, and disabilities that exacerbate such gaps. Given the report's diversity of cultural groups, sub-population groups used for each indicator were to illustrate the greatest disparity for that indicator (or for those who demonstrate the widest gap within an outcome). **Notations have been made throughout to highlight where margins are significant.**

Not all charts show disparities but show representation of differences between localities, state and national figures for comparisons.

**** The content of each chart is also presented in paragraph form for readers who use accessibility devices.***

Total Population by Gender, Counts and Percents

This indicator reports the total population of the report area by gender.

Report Area	Male, Percent	Female, Percent
Henry County, VA and Martinsville City, VA Total	47.49%	52.51%
Henry County, VA	47.79%	52.21%
Martinsville City, VA	46.35%	53.65%
Virginia	49.46%	50.54%
United States	49.50%	50.50%

Data Source: US Census Bureau, American Community Survey. 2017-21.

The percentage values could be interpreted as, of all the population within the report area, Henry County and Martinsville City, the male population is 47.49%; the female population is 52.51%. The population within Henry County is 47.79% male and 52.21%. Within Martinsville City, the male population is 46.35% and the female is 53.65%. Of all the population in Virginia, the male population is 49.46 and the female population is 50.54%. For the United States, the population consists of 49.50% male and 50.50% female.

Total Population by Age Groups, Percent

This indicator reports the percentage of age groups in the population of the report area.
The percentage values could be interpreted as, for example, *"Of the total population in the report area, the percentage of population age 0-4 is (value)."*

Report Area	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+
Henry County & Martinsville City, Total	5.19%	15.62%	7.40%	9.83%	10.67%	13.47%	15.37%	22.45%
Henry County, VA	4.63%	15.01%	7.07%	9.72%	10.51%	13.58%	15.71%	23.78%
Martinsville City, VA	7.33%	17.93%	8.63%	10.26%	11.28%	13.05%	14.11%	17.42%
Virginia	5.84%	16.21%	9.41%	13.70%	13.24%	13.05%	13.08%	15.48%
United States	5.89%	16.62%	9.20%	13.76%	12.87%	12.63%	12.99%	16.04%

In Henry County and Martinsville City combined, 5.19% of the population is ages 0-4, 15.62% of the population is ages 5-17, 7.40% is ages 18-24, 9.83% is ages 25-34, 10.67% is ages 35-44, 13.47% is ages 45-54, 15.37% is ages 55-64, and 22.45% of the population in Henry County and Martinsville is ages 65 or older. In Henry County, 4.63% of the population is ages 0-4, 15.01% of the population is ages 5-17, 7.07% is ages 18-24, 9.72% is ages 25-34, 10.51% is ages 35-44, 13.58% is ages 45-54, 15.71% is ages 55-64, and 23.78% of the population in Henry County is ages 65 or older. In Martinsville, 7.33% of the population is ages 0-4, 17.93% of the population is ages 5-17, 8.63% is ages 18-24, 10.26% is ages 25-34, 11.28% is ages 35-44, 13.05% is ages 45-54, 14.11% is ages 55-64, and 17.42% of the population in Martinsville is ages 65 or older. In Virginia, 5.84% of the population is ages 0-4, 16.21% of the population is ages 5-17, 9.41% is ages 18-24, 13.70% is ages 25-34, 13.24% is ages 35-44, 13.05% is ages 45-54, 13.08% is ages 55-64, and 15.48% of the population in Virginia is ages 65 or older. In the United States, 5.89% of the population is ages 0-4, 16.62% of the population is ages 5-17, 9.20% is ages 18-24, 13.76% is ages 25-34, 12.87% is ages 35-44, 12.63% is ages 45-54, 12.99% is ages 55-64, and 16.04% of the population in Martinsville is ages 65 or older.

Data Source: US Census Bureau, American Community Survey. 2017-21.

Total Population by Race Alone, Percent

Of all the population in Henry County and Martinsville City area the largest population totals are White.

Broken out, Henry has are larger population of White than any other race. Martinsville has a population of White at 45.44% and Black at 45.27% showing only a .17% difference for largest population.

Report Area	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Henry County & Martinsville City, Total	66.33%	27.52%	0.64%	0.12%	0.02%	1.84%	3.52%
Henry County, VA	71.83%	22.84%	0.58%	0.01%	0.00%	1.58%	3.16%
Martinsville City, VA	45.44%	45.27%	0.90%	0.56%	0.11%	2.83%	4.89%
Virginia	64.95%	19.01%	6.74%	0.28%	0.06%	3.09%	5.86%
United States	68.17%	12.55%	5.70%	0.83%	0.19%	5.58%	6.99%

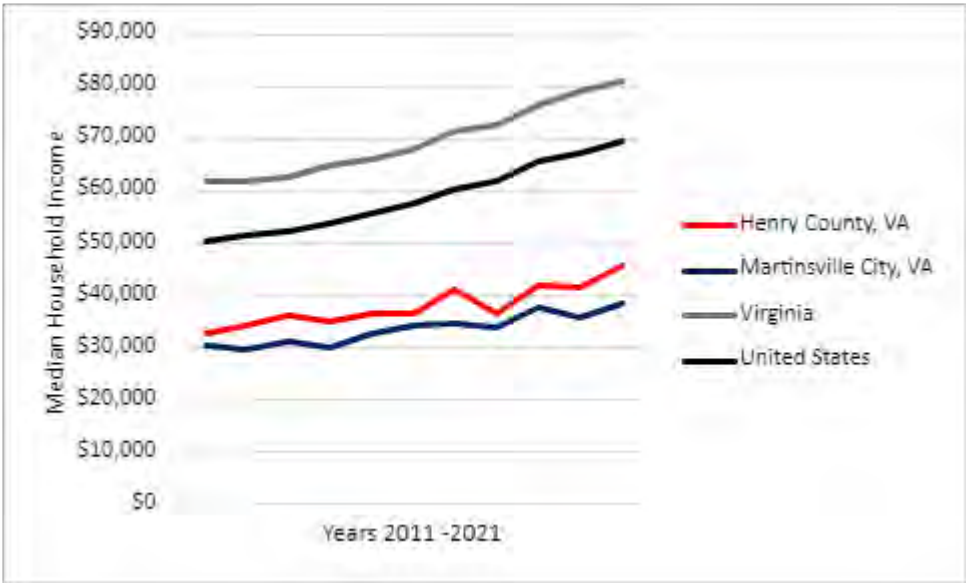
In the combined population of Henry County and Martinsville, the percentage that is white is 66.33%, 27.52% is black, 0.64% is Asian, 0.12% is Native American or Alaska Native, 0.02% is Native Hawaiian or Pacific Islander, 1.84% is another race, and 3.52% of the combined population is multiple races. In Henry County, 71.83% of the population is white, 22.84% is black, 0.58% is Asian, 0.01% is Native American or Alaska Native, 0.00% is Native Hawaiian or Pacific Islander, 1.58% is some other race, and 3.16% of the population is multiple races. In Martinsville, 45.44% of the population is white, 45.27% is black, 0.90% is Asian, 0.56% is Native American or Alaska Native, 0.11% is Native Hawaiian or Pacific Islander, 2.83% is another race, and 4.89% is multiple races. In Virginia, 64.95% of the population is white, 19.01% is black, 6.74% is Asian, 0.28% is Native American or Alaska Native, 0.06% is Native Hawaiian or Pacific Islander, 3.09% is another race, and 5.86% is multiple races. In the United States, 68.17% of the population is white, 12.55% is black, 5.70% is Asian, 0.83% is Native American or Alaska Native, 0.19% is Native Hawaiian or Pacific Islander, 5.58% is another race, and 6.99% is multiple

Data Source: US Census Bureau, American Community Survey. 2017-21

Median Household Income

The following indicator reports the median household income trend data from 2011-2021.

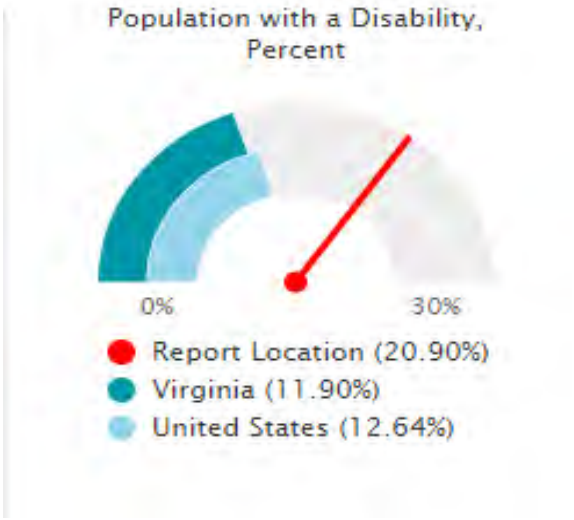
The median income as of 2021 for Henry County is $45,784 and the median income for Martinsville is $38,571. This is roughly half of Virginia's median income of $80,926 and significantly less than the United States' median income of $69,717.



The progression of median income for Henry County goes as follows from 2011-2021: $32,596, $34,232, $36,066, $34,842, $36,695, $36,703, $41,206, $36,471, $41,908, $41,706, $45,784. The progression of median income for Martinsville goes as follows: $30,227, $29,550, $31,046, $29,971, $32,541, $34,262, $34,463, $33,892, $37,814, $35,715, $38,571. The median income progression for Virginia goes as follows: $61,877, $61,782, $62,745, $64,923, $66,263, $68,127, $71,518, $72,600, $76,471, $79,154, $80,926. The median income progression for the United States goes as follows: $50,502, $51,371, $52,250, $53,657, $55,775, $57,617, $60,336, $61,937, $65,712, $67,340, $69,717.

Data Source: US Census Bureau, Small Area Income and Poverty Estimates. 2021. Source geography: County

Population With Any Disability



This indicator reports the population with a disability as of 2021. 20.90% of the combined population of Martinsville and Henry County have a disability compared to the 11.90% of the population of Virginia and 12.64% of the population for the United States.

Data Source: US Census Bureau, American Community Survey. 2017-21

Unemployment Rate

The unemployment rate as of 2021 is consistent for Henry County (3.0%) and Martinsville (3.1%) compared to Virginia (3.0%) and United States (3.9%)

Report Location	Unemployment Rate for 2021
Henry County, VA	3.0%
Martinsville City, VA	3.1%
Virginia	3.0%
United States	3.9%

Data Source: United States Census Bureau, 2021 ACS 1-Year Estimates Data Profiles

Life Expectancy by Locality

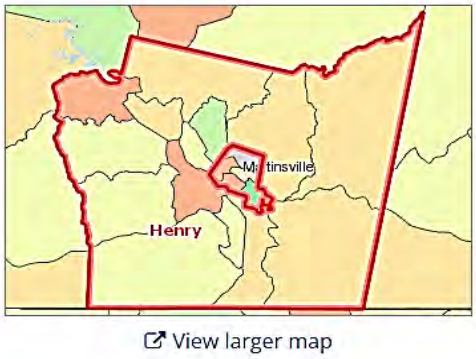
The average life expectancy of a Henry County or Martinsville City citizen is 70.905 years.

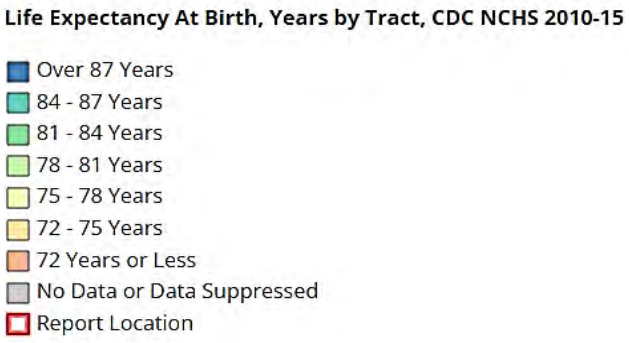
Local citizens can expect to lose 8 years of life according to the current mortality experience (age-specific death rates) of the population.

Report Area	Total Population (2010-2015)	Life Expectancy at Birth (2010-2015)
Henry County and Martinsville City, Total	66,204	70.8
Henry County, VA	52,580	74.4
Martinsville City, VA	13,624	67.2
Virginia	8,256,630	79.1

Life expectancy for Henry County for population of 52,580 is 74.4 years. Martinsville City population of 13,624 is 67.2 years and for Virginia's population of 8,256,630 will live approximately 79.1 years.

Data Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project. 2010-15. Source geography





Data Source: Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project. 2010-15. Source geography

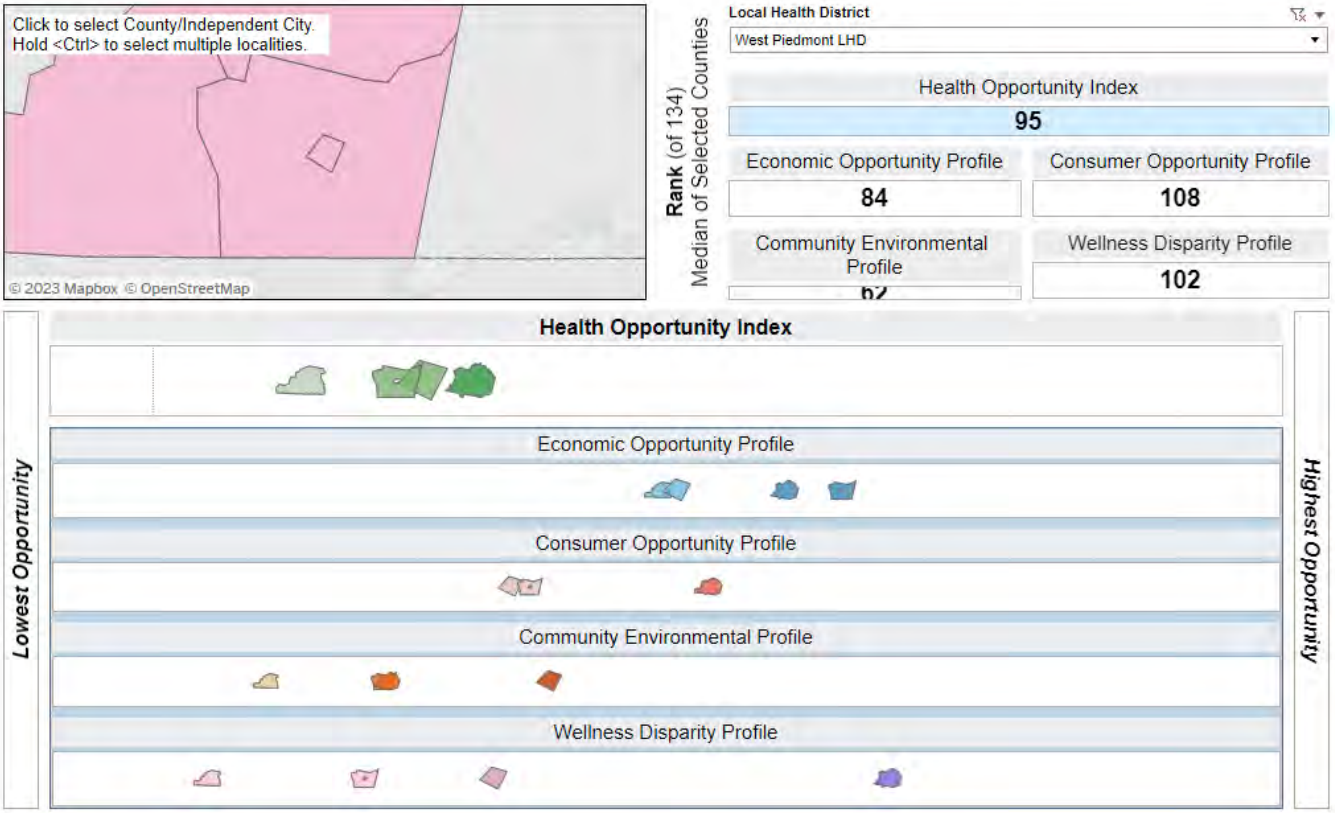
Health Opportunity Index

The Virginia Health Opportunity Index (HOI) is a group of indicators that provide broad insight into the overall opportunity Virginians have to live long and healthy lives based on the Social Determinants of Health. It is a hierarchical index that allows users to examine social determinants of health at multiple levels of detail in Virginia. It is made up of over 30 variables, combined into 13 indicators, grouped into four profiles, which are aggregated into a single Health Opportunity Index. The HOI is reported at both the census tract and county/independent city level.

Shown as a combined total for Henry Count and Martinsville City, the totals in the chart represent the profiles listed below which include the thirteen essential indicators for equality.
Community Environmental Profile includes Air quality, Population Churning, Population Density and Walkability Indicators
Consumer Opportunity Profile includes-Affordability, Education, Food Accessibility, Material Deprivation Indicators
Economic Opportunity Profile includes-Employment Accessibility, Income Inequality, Job Participation Indicators
Wellness Disparity Profile includes- Access to Care, Segregation Indicators

West Piedmont Health District is ranked 95th for Health Opportunity Index, 84th for Economic Opportunity Profile, 108th for Consumer Opportunity Profile, 62nd for the Community Environmental Profile and 102nd for the Wellness Disparity Profile.

Data Source: Virginia Department of Health, Virginia Health Opportunity Index [Counties – Virginia Health Opportunity Index]



Community Identified Priorities

Health outcomes are based on many things, including where we live. Social determinants to health are barriers that make good health harder to achieve – like lack of transportation or access to care. We have herein identified these indicators at the neighborhood level. However, the goal of this study is not merely to provide data. Working together, a wide range of community partners studied the data and collaborated to identify the following priority areas. Over the next year, root causes and solutions will be identified for the social determinants of health they have prioritized:

- **the presence of chronic disease,**
- **maternal health disparities,**
- **the need for mental health services,**
- **a better understanding of and response to substance use and overdose,**
- **transportation needs and,**
- **the number of persons considered "unhoused".**

The recurring relationships between the social determinants of health and health outcomes are important considerations for the health equity for Henry County and Martinsville City.

Chronic Diseases

The following indicator examines the prevalence of chronic conditions in percentages. The following data can be read as, "In report location, the population with chronic condition is (value)."

The risk potential for citizen living in Martinsville and Henry is double the rate of Virginia residents for Diabetes. This risk can be further explored on page 22 looking at the ages and minority status of citizens. Martinsville and Henry are also experiencing hypertension at higher rates then compared to state averages.

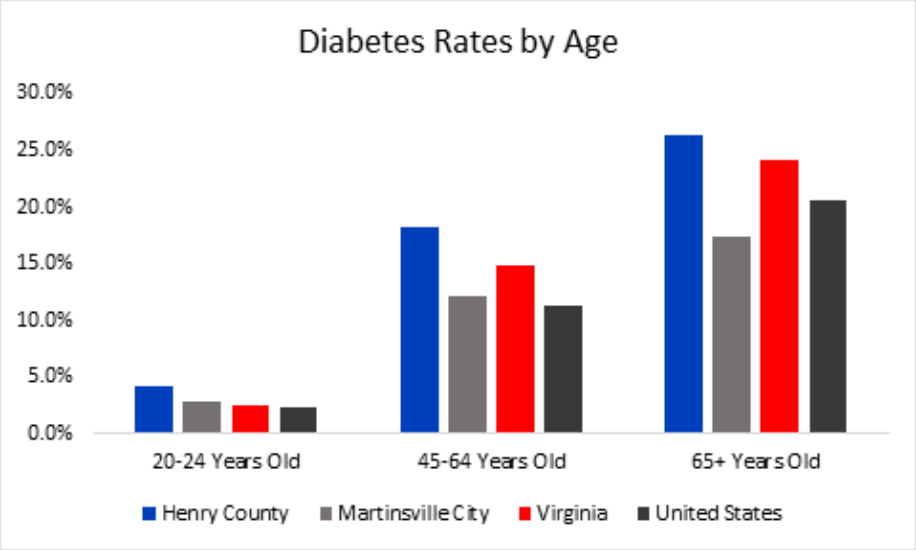
Location	Asthma	Heart Disease	Diabetes	Stroke	COPD (Chronic Obstructive Lung Disease)	Hypertension
Henry County	15.7%	10.1%	23.2%	5.3%	11.2%	44.9%
Martinsville City	12.4%	8.4%	22.0%	5.2%	9.8%	45.1%
Virginia	13.5%	5.9%	11.1%	3.0%	5.3%	32.4%
United States	9.2%	6.4%	11.1%	3.2%	6.4%	32.6%

For chronic diseases, 15.7% of Henry County's population and 12.4% of Martinsville population is diagnosed with asthma which is higher than Virginia (13.5%) and the United States (9.2%). 10.1% of Henry County's population and 8.4% of Martinsville's population is diagnosed with heart disease which is higher than Virginia (5.9%) and the United States (6.4%). 23.2% of Henry County's population and 22.0% of Martinsville's population is diagnosed with diabetes which is almost double the rates for Virginia (11.1%) and the United States (11.1%). 5.3% of Henry County's population and 5.2% of Martinsville's population has had a stroke which is higher than Virginia (3.0%) and the United States (3.2%). 11.2% of Henry County's population and 9.8% of Martinsville's population has Chronic Obstructive Lung Disease (COPD) which is higher than Virginia (5.3%) and the United States (6.4%). 44.9% of Henry County's population and 45.1% of Martinsville's population has hypertension which is greater than Virginia (32.4%) and the United States (32.6%).

Data Source: Virginia Department of Health, Behavioral Risk Factor Surveillance Survey. Data directly obtained via email from Virginia BRFSS 2020. Source geography: County, Health District and Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jun 09 2023]. URL: https://www.cdc.gov/PLACES

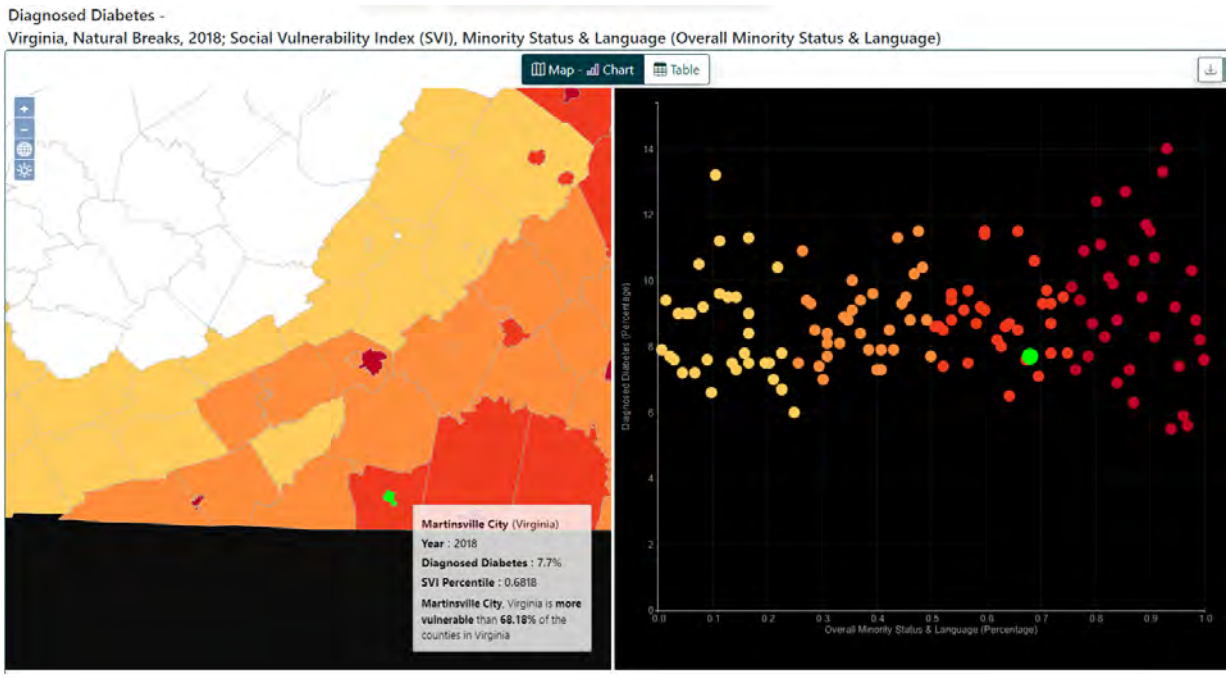
Diabetes

When broken down by age, the diabetes rates for Henry County and Martinsville 65-year-olds and higher.



Data Source: Centers for Disease Control and Prevention. US Diabetes Surveillance System website. Available at https://www.cdc.gov/diabetes/data.

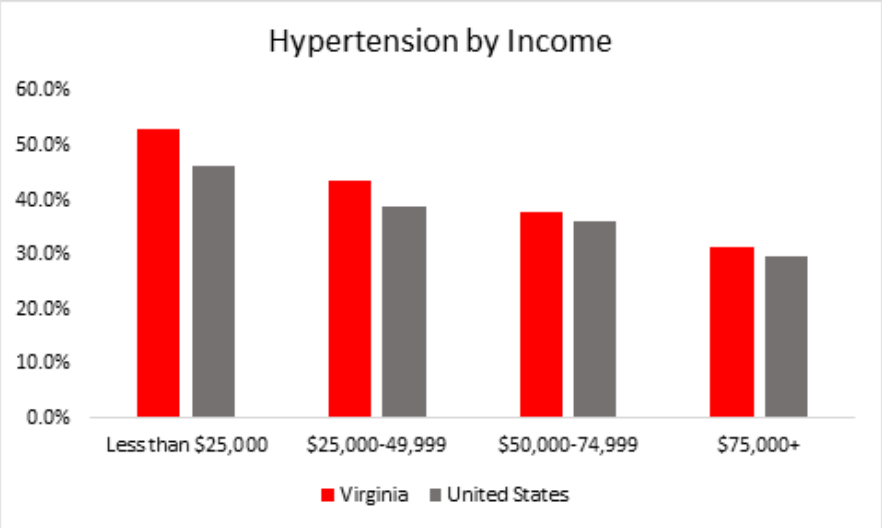
When broken down by age, the diabetes rates for Henry County are 4.2% for 20–24-year-olds, 18.2% for 45–64-year-olds, and 26.4% for 65-year-olds and higher. For Martinsville, 2.8% for 20–24-year-olds, 12.1% for 45–64-year-olds, and 17.3% for 65-year-olds and higher. For Virginia, 2.4% for 20–24-year-olds, 14.9% for 45–64-year-olds, and 24.1% for 65-year-olds and higher. For the United States, 2.3% for 20–24-year-olds, 11.3% for 45–64-year-olds, and 20.6% for 65-year-olds and higher.



Henry County is more vulnerable than 59.85% of the counties in Virginia to be diagnosed with Diabetes for those considered to have minority status or speak a minority language. While Martinsville City is 68.18% more vulnerable to minority status individuals.

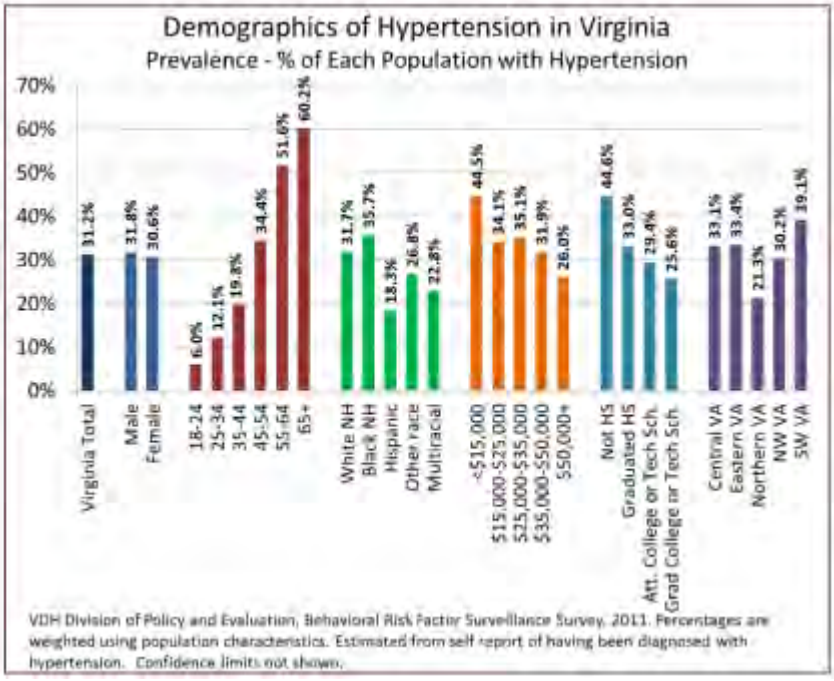
Hypertension

Rates across Virginia are demonstrated to be higher for individuals who are in lower income brackets. Access and consumption of healthy foods has a direct correlation to hypertension in majority of cases.



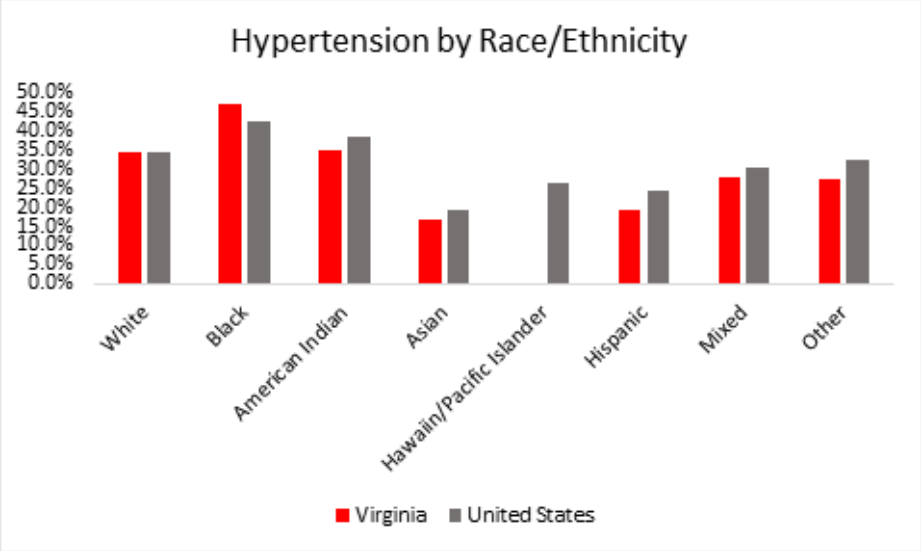
For Virginia, the population that makes less than $25,000, 53.1% have hypertension, of the population that makes $25,000-49,999, 43.4% , of the population that makes $50,000-74,999, 37.8% , and of the population that makes more than $75,000, 31.3% . For the United States, of the population that makes less than $25,000, 46.1% have hypertension, of the population that makes $25,000-49,999, 38.8%, of the population that makes $50,000-74,999, 36.1%, and of the population that makes more than $75,000, 29.5%

Data Source: America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, accessed 2023.



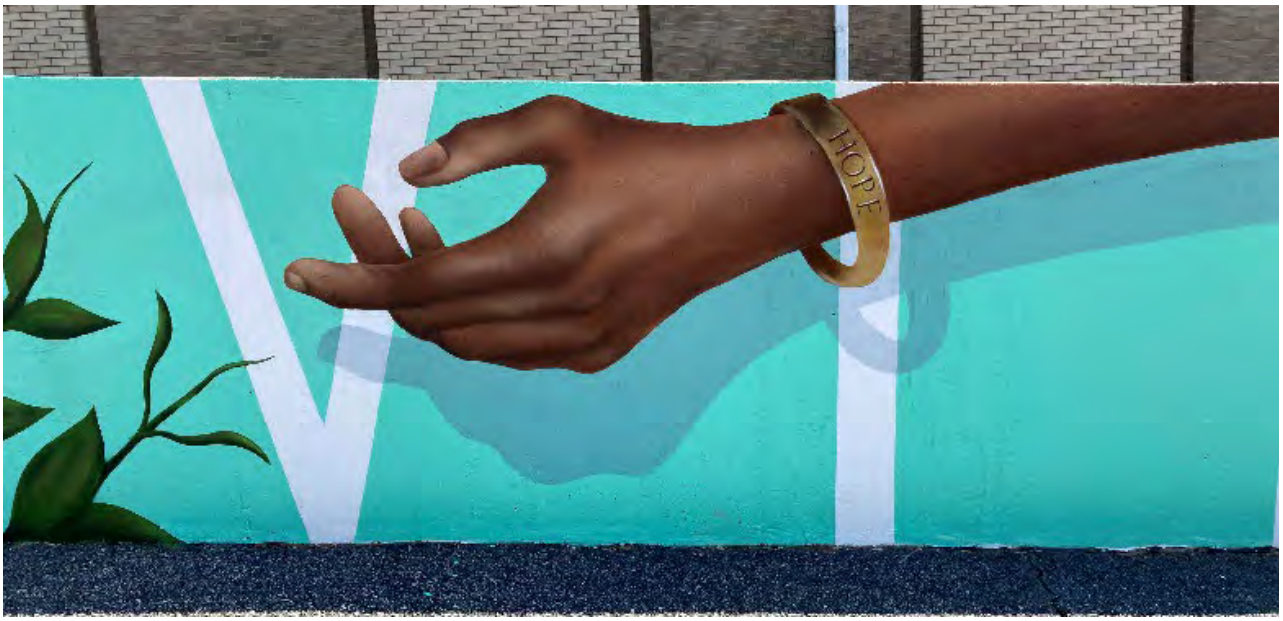
From a study by the Virginia Health Department, those with no high school diploma were 44.6% more likely to have hypertension compared to the prevalence of their 25.6% college graduate or tech school counterparts.

When broken out by race, Black citizens in Virginia and the United States present with higher rates of Hypertension than their other race / ethnicity counterparts.



Hypertension by race and ethnicity. The white population, 34.6% for Virginia and 34.5% for the United States have hypertension, black population, 47.0% (VA) and 42.8% (US) the American Indian population, 35.1% (Virginia) and 38.4% (Untied States), Asian population, 16.7% (VA) and 19.4% (US) , Hawaiian/Pacific Islander, 26.5% (US) have hypertension. The Hispanic population, 19.3% (VA) and 24.4% (US) have hypertension, Mixed 28.0% (VA) and 30.4% (US),population that identifies themselves as other, 27.3% (VA) and 32.6% (US).

Data Source: America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, accessed 2023.



Obesity Rates, General
Obesity rates have a direct correlation to risk factors of all chronic diseases.

Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems (such as asthma), osteoarthritis, and poor health status.

Location	General Obesity Rate
Henry County, VA	40%
Martinsville City, VA	43%
Virginia	34.2%
United States	33.0%

This indicator reports the percentage of the adult population (18+) that reports a body mass index (BMI) greater than or equal to 30. In 2022, Center for Disease Control and Prevention report that 40% of the population in Henry County and 43% of the population in Martinsville are obese. This is higher compared to Virginia (34.2%) and the United States (33.0%) rates of obesity.

Data Source: Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Data, Trend and Maps [online]. https://www.cdc.gov/nccdphp/dnpao/data-trends-maps/index.html.

Obesity Rates by Gender

Location	Male Population Obesity Rate	Female Population Obesity Rate
Virginia	33.6%	34.9%
United States	32.3%	33.7%

Data Source: Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Data, Trend and Maps [online].

Virginia male obesity rates are 33.6% just under the female rates at 34.9%. The United States comes in at 32.3% for males and 32.3%% for the females again scoring less for the state then United States at 33.7%.for females.

Obesity Rates by Age

Location	18-24	25-34	35-44	45-54	55-64	65+
Virginia	17.4%	32.9%	36.7%	42.7%	41.4%	31.6%
United States	20.7%	32.0%	36.8%	39.3%	38.1%	29.5%

Data Source: Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity .Data, Trend and Maps [online].

Obesity rates by age are lower at ages 10-24years at 17.4% for Virginia and 20.7% for US. Rising to Virginia highest rate in 45-54 year olds at 42.7%. In the US the lowest is the 18-24 year olds and highest obesity rate is the 39.3% shown in the 35-44 year olds.

Obesity Rates by Ethnicity/Race

Location	Non-Hispanic White	Non-Hispanic Black	Hispanic	Asian	Hawaiian/ Pacific Islander	American Indian	2 or more Races	Other
Virginia	33.3%	46.7%	30.2%	15.1%	No data	No data	24.7%	35.9%
United States	32.0%	42.9%	37.1%	11.8%	42.9%	38.7%	33.1%	30.9%

Data Source: Centers for Disease Control and Prevention.National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity.Data, Trend and Maps [online].

In Virginia groups of Non-Hispanic Blacks lead the obesity rate group, with second going to 35.9% going to others category. For the United States, Hispanic Black African Americans and Hawaiian/ Pacific Americans each tied the top rankings with 42.9%

Maternal Health

Infant Mortality

This indicator rate of infant deaths from 2021. Infant mortality is defined as deaths of children under one year of age, some of whom may have been born in the previous year. The leading causes of infant death include birth defects, preterm birth and low birth weight, sudden infant death syndrome, injuries (e.g., suffocation), and maternal pregnancy complications**. High rates of infant mortality indicate the existence of broader issues pertaining to access of care of maternal and child health. Henry County experienced 14.6 per 1K infant deaths in 2021. More than twice the state rate, there is limited maternity care in the Henry County or Martinsville City area for expecting mothers.**

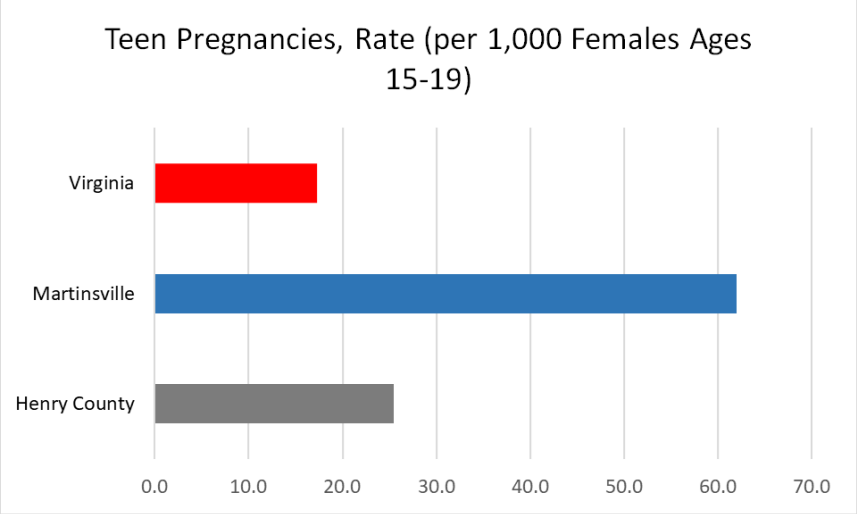
Report Area	Infant Deaths, Rate (per 1,000 Total Live Births)
Henry County, VA	14.6
Martinsville City, VA	4.0
Virginia	5.7

Data Source: Virginia Department of Health, Virginia Maternal and Child Health, 2021, Maternal and Child Health (virginia.gov)

Henry County reported 14.6 infant deaths per 1,000 live births, while Martinsville reported 4.0. The state of Virginia reported a total of 5.7 infant deaths per 1,000 live births.

Teen Pregnancy

This indicator reports the teen pregnancy rate from 2021.

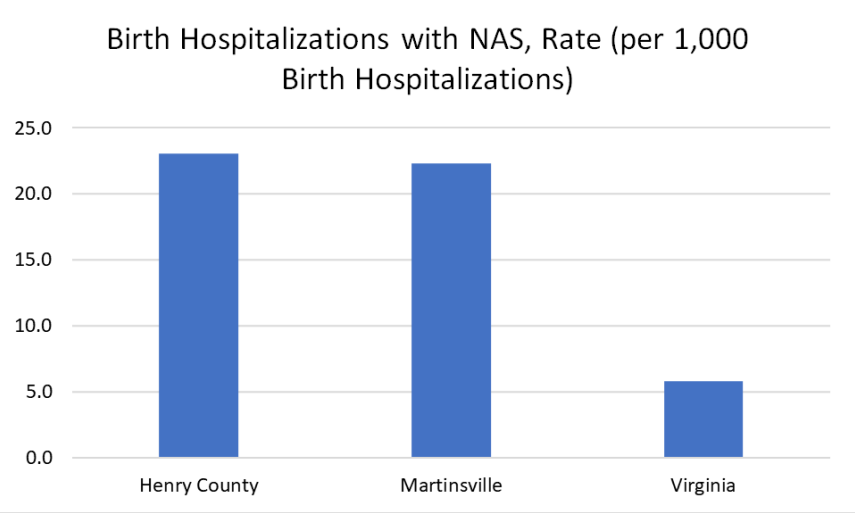


Data Source: Virginia Department of Health, Virginia Maternal and Child Health, 2021, Maternal and Child Health (virginia.gov)

The teen pregnancy rate for Henry County is 25.5 and for Martinsville is 62.0 per 1,000 females, which both are greater than Virginia (17.0).

Neonatal Abstinence Syndrome (NAS), Rate per 1,000 Birth Hospitalizations

This indicator reports the number and rate of hospital inpatient stays due to neonatal abstinence syndrome (NAS), per 1,000 birth hospitalizations. Neonatal Abstinence Syndrome (NAS) is also known as neonatal drug dependency or withdrawal symptoms, and predominantly occurs from maternal use of opiates, such as heroin, or opioids such as methadone, fentanyl, and prescription pain medications during pregnancy. Babies with NAS are at increased risk of low birthweight, jaundice, seizures, and sudden infant death syndrome (SIDS), in addition to withdrawal symptoms. NAS represents a significant public health concern given the association of opioid exposure and adverse maternal and neonatal outcomes, including preterm labor, stillbirth, neonatal abstinence syndrome, and maternal mortality.



Data Source: Virginia Department of Health, Virginia Maternal and Child Health, 2021, [Maternal and Child Health (virginia.gov)]

The NAS Rate for Henry County is 23.1 and for Martinsville is 22.3 which are significantly higher than Virginia's NAS rate of 5.8.

Smoking during Pregnancy, Percent of Total Live Births

This indicator reports the percentage of women who smoke during pregnancy of total live births with Virginia residence in 2020. Smoking during pregnancy harms both mother and baby, increasing the risk of miscarriage, pregnancy complications, preterm delivery, low birth weight, defects in the lung and brain of the unborn baby, and sudden infant death syndrome (SIDS). To be safe, any kind of cigarettes at any amount should be completely quit during pregnancy.

Report Area	Women Smoking during Pregnancy, Percent of Total Live Births
Henry County, VA	14.5%
Martinsville City, VA	12.8%
Virginia	5.0%

In Henry County 14.5% of births were to women who reported smoking during pregnancy and in Martinsville 12.8% of the births were to women who reported smoking during pregnancy. Both are higher than the 5.0% total reported in the State of Virginia.

Data Source: Virginia Department of Health, Virginia Maternal and Child Health, 2021, Maternal and Child Health (virginia.gov)

All Cancer Incidence including breast Cancer

The following indicator gives all sites cancer incidence by race and locality. Rates are per 100,000 population.

Location	All	Black	White
Henry County, VA	248.4	146.6	273.1
Martinsville City, VA	794.5	666	872
Virginia	384.8	391.7	378.7

Henry County reports of cancer incidence for all races at 248.4 per 100,000 under the 794.5 per 100,000 reported by Martinsville. The incidence for White Americans in Henry per 100,000 was reported at 273.1 while Black Americans was reported at 146.6. In Martinsville, the incidence of Cancer per 100,000 for White Americans was reported at 872 while Black Americans was reported at 666. Virginia reports All Cancer Incidence at rate of 384.8 per 100,000. Margins for Black Americans were reported as 391.7 per 100,000 and White Americans 378.7 per 100,000.

Data Source: Virginia Cancer Registry, SEER, all COD, aggregated with State.

All Cancer Mortality including breast cancer

The following indicator reports all sites cancer mortality by locality and race.

Location	All	White	Black
Henry County, VA	165.9	175.4	130.8
Martinsville City, VA	273.9	244.5	339.7
Virginia	149.7	149.1	173.2

The rates are per 100,000 population. Henry County reports a cancer mortality rate for all of 165.9 per 100,000. When broken down by race, the mortality rate is 175.4 per 100,000 for the white population and 130.8 per 100,000 for the black population. Martinsville reports a mortality rate of 273.9 per 100,000 for all. By race, the rate is 244.5 per 100,000 for the white population and is 339.7 per 100,000 for the black population. For Virginia, the mortality rate for all is 149.7 per 100,000, for the white population is 149.1 per 100,000, and for the black population is 173.2 per 100,000.

Data Source: Virginia Cancer Registry, SEER, all COD, aggregated with State.

Mental Health

This indicator reports the 2016-2020 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Rates are summarized for report areas from county level data, only where data is available.

This indicator is relevant because suicide is an indicator of poor mental health. In the combined total for Henry and Martinsville of 20.7 the rate is 6.8% above the rate of Virginia's total.

Report Area	Crude Death Rate (Per 100,000 Population)
Henry County and Martinsville City, Total	20.7
Henry County, VA	20.8
Martinsville City, VA	No data
Virginia	13.9
United States	14.3

For Henry County and Martinsville combined, the crude death rate by suicide is 20.7 per 100,000. The rate for Henry County is 20.8 per 100,000. The rate for Martinsville has been suppressed. The rate for Virginia is 13.9 per 100,000. The rate for the United States is 14.3 per 100,000.

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-20. Source geography: County

More racial and ethnic diversity is needed in Virginia's licensed BH workforce. Currently, it does not reflect the diversity of Virginia's population (*see table below*). Therapy is most effective when the BH professional can personally relate to a client's circumstances. This is especially true when a person's stressors are related to racial and ethnicity-related issues.

Race/ Ethnicity	Virginia	Licensed Clinical Psychologist	Licensed Clinical Social Worker	Licensed Professional Counselor
	2020 Census	*2020 Virginia Department of Health Professions Reports*		
White	**60.3%**	82%	79%	76%
Black	**18.6%**	7%	14%	16%
Hispanic	**10.5%**	4%	3%	4%
Asian	**7.1%**	4%	2%	1%
2+ Races	**8.2%**	2%	2%	2%
Other	**5.8%**	1%	1%	1%

Race/Ethnicity of Licensed Clinical Psychologist in Virginia -- White 60.3%, Black 18.6%, Hispanic 10.5%, Asian 7.1%, Two+ Races 8.25 Other 5.8%

Adults with Depressive Disorder

This indicator reports the percentage of adults in Virginia who have ever been told they have a depressive disorder. Depression or depressive disorder is a common and serious medical illness that negatively affects how one feels, the way one thinks and how one acts. Depression causes feelings of sadness and/or a loss of interest in activities one once enjoyed. It can lead to a variety of emotional and physical problems and can decrease one's ability to function at work and at home. Depression could be treated by medication and lifestyle therapies.

Report Area	Weighted Percent
Henry County, VA	23.5%
Martinsville City, VA	27.3%
Virginia	17.2%

23.5% of the total population in Henry County has a depressive disorder. 27.3% of the population in Martinsville has a depressive disorder. Both percentages are higher than Virginia (17.2%).

While rates of mental health treatment are low for all youth with major depression, youth of color are significantly less likely to receive depression treatment than white youth. Asian youth were least likely to have seen a health professional or received medication for their depression (8.30%), followed by Black or African American youth (9.40%) and Hispanic youth (9.50%).

Of Youth With MDE: Did you see a Health Professional or Receive Medication for Depression in the Past Year?		Asian	Black or African American (non-Hispanic)	Hispanic	More than one race	White (non-Hispanic)	Native American or Alaska Native	Native Hawaiian or Other Pacific Islander
Yes	Percentage	8.30%	9.40%	9.50%	15.60%	22.00%	15.20%	*
	Count	16,000	33,000	89,000	25,000	424,000	4,000	*
No	Percentage	91.70%	90.60%	90.50%	84.40%	78.00%	84.80%	*
	Count	175,000	316,000	849,000	133,000	1,503,000	21,000	*

*Data suppressed due to small sample size.

These analyses not only reflect disparities in who gets to receive mental health treatment, but what kinds of services they are able to receive and where they can access care. Youth of color with major depression were less likely to receive specialty mental health care than white youth. Specialty mental health treatment is defined as staying overnight in a hospital, staying in a residential treatment facility, spending time in a day treatment facility, receiving treatment from a mental health clinic, receiving treatment from a private therapist, or receiving treatment from an in-home therapist. Asian youth with a past year major depressive episode were least likely to have received specialty mental health care (71% did not receive care), followed by Native American or Alaska Native youth (68%), and Black or African American Youth (68%). White youth with MDE were most likely to receive specialty mental health care, but still over half of white youth with a past year major depressive episode did not receive treatment (54%).

Youth Behavioral Risk Results

Twelve students from the Martinsville Henry Middle School and High school reported attempting suicide from 2019-2021. The attempt resulted in being treated by medical professional in the report timeframe.

26. Percentage of students who reported a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a medical professional during the past 12 months.

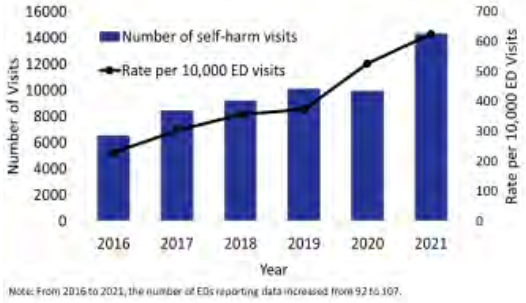
	MHS '19	MMS '21	MHS '21
Number of Students	8	4	0
Percent	4.2%	4.5%	0.0%

27. Percentage of students who ever felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.

	MHS '19	MMS '21	MHS '21
Number of Students	56	33	53
Percent	29.0%	37.1%	42.1%

Self-harm ED visits more than doubled among Virginia youth aged 9-18 years from 6,520 visits in 2016 to 14,298 visits in 2021 (Figure 1).

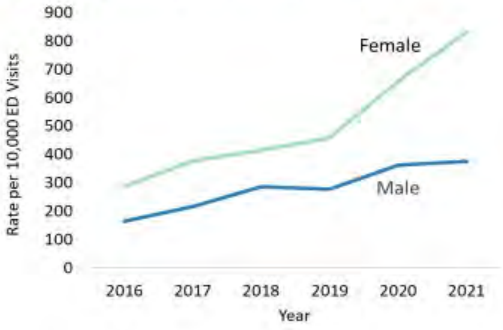
Figure 1. ED visits related to suicidal thoughts, self-harm, and suicide attempts among Virginia youth aged 9-18 years, 2016-2021



Note: From 2016 to 2021, the number of EDs reporting data increased from 92 to 107.

During 2016-2021, 68% of self-harm ED visits in 9-18 year olds were among females. Between 2016 and 2021, self-harm ED visit rates increased among both males (129%) and females (190%; Figure 2).

Figure 2. ED visit rates for suicidal thoughts, self-harm, or suicide attempts among Virginia youth aged 9-18 years, by sex, 2016-2021

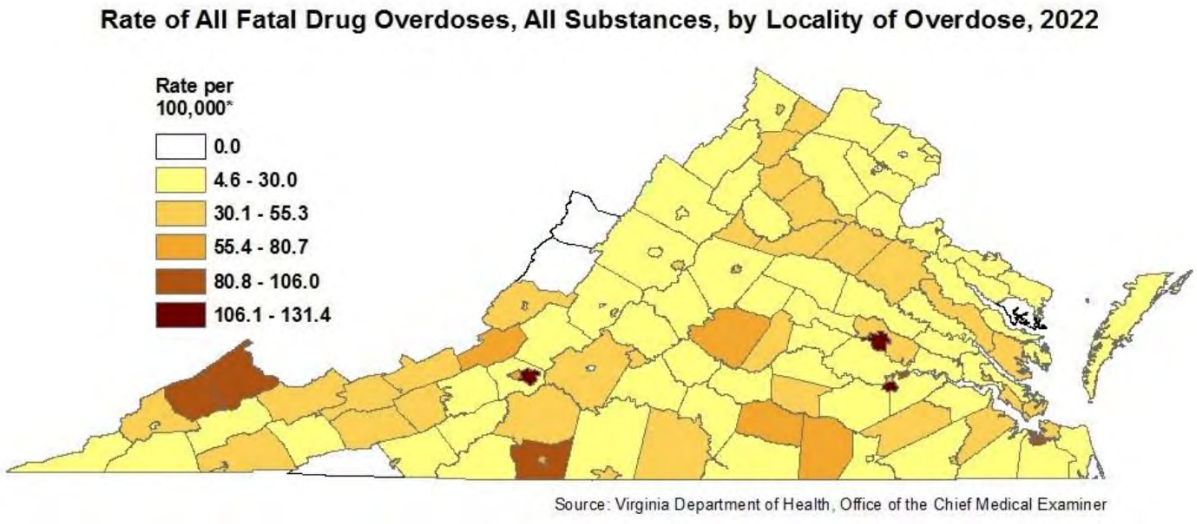


Source for charts: Youth Behavioral Risk Data.

Substance Use/Overdose

Overdose

Henry County rated between 80.8-106.0 per 100,000 of all fatal drug overdoses, all substances, by Locality of Overdoses, 2022. **Henry rated in the top ten counties in Virginia for overdose numbers for the year 2022 and is on par for being named again in 2023.**



This indicator reports the 2016-2020 five-year average rate of death due to drug overdose of all substances per 100,000 population. Figures are reported as crude rates to year 2000 standard. Rates are summarized for report areas from county-level data, only where data is available**. This indicator is relevant because drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.**

Report Area	Crude Death Rate (Per 100,000 Population)
Henry County and Martinsville City, Total	36.1
Henry County, VA	33.0
Martinsville City, VA	48.1
Virginia	19.2
United States	22.3

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

The Crude Death Rate for fatal drug overdoses for Henry County and Martinsville combined in 36.1 per 100,000. For Henry County, 33.0 per 100,000. Martinsville's crude death rate is 48.1 per 100,00. Virginia's crude death rate is 19.2 per 100,000 and the United States is 22.3 per 100,000.

All Drug		2018			2019			2020			2021			2022		
Demographic Characteristcs		Overdose Visits	Rate per 10k ED Visits	Rate per 100k Pop	Overdose Visits	Rate per 10k ED Visits	Rate per 100k Pop	Overdose Visits	Rate per 10k ED Visits	Rate per 100k Pop	Overdose Visits	Rate per 10k ED Visits	Rate per 100k Pop	Overdose Visits	Rate per 10k ED Visits	Rate per 100k Pop
Sex	Female	6387	35.3	147.6	6974	36.3	160.9	7828	48.7	179.4	9425	51.3	216.0	9617	48.2	220.4
	Male	7130	52.2	170.1	7664	52.5	182.5	10626	83.7	251.4	11942	82.5	282.5	12869	81.9	304.4
Race/Ethnicity	American Indian or Alaska Native	11	35.2	42.6	19	49.3	73.3	24	71.3	92.2	19	39.7	73.0	33	56.2	126.7
	Asian or Pacific Islander	199	33.3	31.7	207	31.2	32.9	238	40.9	36.6	288	38.8	44.3	319	35.9	49.1
	Black	2756	32.5	162.1	3295	34.0	193.0	5199	59.4	301.9	6855	64.6	398.1	7492	66.1	435.1
	Hispanic or Latino	555	29.5	67.6	567	26.3	68.0	832	43.6	97.3	1037	43.4	121.2	1346	46.4	157.4
	Other	457	45.2	N/A	503	47.0	N/A	569	66.3	N/A	559	63.0	N/A	518	50.0	N/A
	Not Reported	1615	36.2	N/A	1178	35.2	N/A	1012	52.1	N/A	476	76.9	N/A	404	66.3	N/A
	White	7928	51.7	148.4	8875	52.7	166.2	10589	71.9	198.4	12144	69.3	227.5	12389	65.7	232.1
Age Group	0-14	1189	25.3	232.7	1289	26.1	255.0	1341	45.5	266.4	1736	44.8	344.8	2040	38.8	405.2
	15-19	1207	73.4	88.8	1274	73.8	94.0	1496	109.3	109.8	1663	103.9	122.0	1769	100.5	129.8
	20-24	1349	59.9	167.6	1417	60.6	177.5	1871	89.7	234.1	1916	82.6	239.7	1913	80.1	239.3
	25-34	3127	64.3	262.7	3176	62.7	266.8	4395	96.2	367.6	4597	92.6	384.5	4481	88.7	374.8
	35-44	2142	53.9	193.9	2443	58.1	219.6	3332	86.3	295.6	3813	87.8	338.3	3875	85.5	343.8
	45-54	1725	44.5	153.3	1866	46.3	169.6	2342	65.4	216.0	2804	72.4	258.6	2916	73.8	268.9
	55-64	1417	37.3	128.0	1574	37.9	141.2	2033	53.5	182.0	2624	62.2	235.0	2894	66.4	259.1
	65+	1341	20.1	101.9	1594	21.7	117.3	1626	24.7	116.1	2203	28.8	157.2	2571	30.8	183.5
VIRGINIA		13521	42.5	158.7	14644	43.3	171.6	18463	64.1	214.9	21378	65.1	248.9	22501	63.1	261.9

Values where sex or age were unknown were excluded from those groups but included in the total row.

Discharge diagnosis data quality improved from 2018 to 2022 and may contribute to increases in overdose visits.

Race and ethnicity data quality improved from 2018 to 2022 and may affect interpretation of trends. Other race includes those with a race of Other or Middle Eastern or North African

During the Coronavirus Disease 2019 (COVID-19) pandemic, a decrease in the total number of ED visits occurred in Virginia. Because of this change in health care seeking behavior, VDH urges caution when comparing 2020 statistics to other years.

[Published 4/13/23] Report includes statewide demographic data for each year from 2018-2022 by overdose category (all drug, opioid, heroin, stimulant), sex, age, and race/ethnicity. A data portal presenting health outcomes in Virginia related to opioid addiction and overdose, including an interactive data page for Emergency Department Visits that summarizes Virginia residents who sought care at EDs for unintentional overdose as identified by the chief complaint or discharge diagnosis. ED visits are categorized into three unintentional drug overdose case definitions: all drug overdose, opioid or unspecified substance overdose, and heroin overdose.

Rates of Emergency department visits for unintentional drug overdose amount Virginia residents by county and state are increasing each year. Henry County and Martinsville City had a reported 242 overdoses in 2022.

December 2022		2022 Total				January 2023				February 2023				March 2023			
Rate per 10k ED Visits	Rate per 100k Pop	Annual Overdose Visits	Avg Monthly Overdose Visits	Avg Monthly Rate per 10k ED Visits	Avg Monthly Rate per 100k Pop	Overdose Visits	Previous 12 Month Avg	Rate per 10k ED Visits	Rate per 100k Pop	Overdose Visits	Previous 12 Month Avg	Rate per 10k ED Visits	Rate per 100k Pop	Overdose Visits	Previous 12 Month Avg	Rate per 10k ED Visits	Rate per 100k Pop
Henry County[i]	51089	242	20	69.3	32.2	22	20	73.1	35.1	23	20	85.7	36.7	18	20	58.9	28.7
Martinsville City[i]	51690	242	20	69.3	32.2	22	20	73.1	35.1	23	20	85.7	36.7	18	20	58.9	28.7
VIRGINIA		22580	1882	63.7	21.9	1937	1882	62.6	22.5	1864	1908	65.8	21.7	1982	1927	63.2	23.1

Transportation

Number of Vehicles *in a Home*

The following indicator reports how many vehicles are in a single home as a percentage. In Henry County the number of homes with 0 vehicles is 6.3% and Martinsville City the number of homes with 0 vehicles is 13.6%.

Location	No Vehicle	One Vehicle	Two Vehicles
Henry County, VA	6.3%	31.2%	30.7%
Martinsville City, VA	13.6%	44.3%	28.4%
Virginia	6.0%	30.0%	37.8%
United States	8.3%	32.5%	37.1%

Data Source: United States Census Bureau- Latest ACS 5-Year Estimates Data Profiles/Housing Characteristics

In Henry County, the percentage of homes with no vehicle is 6.3%, with one vehicle is 31.2%, and with two vehicles is 30.7%. In Martinsville, the percentage of homes with no vehicle is 13.6%, with one vehicle is 44.3%, and with two vehicles is 28.4%. In Virginia, the percentage of homes with no vehicle is 6.0%, with one vehicle is 30.0%, and with two vehicles is 37.8%. In the United States, the percentage of homes with no vehicle is 8.3%, with one vehicle is 32.5%, and with two vehicles is 37.1%.

According to Data USA Henry, VA residents made an average commute of 24.4 minutes daily to work and they drove personal vehicles. Car ownership met the national average of 2 cars per household.

Workers Who Use Public Transportation

In the Henry County and Martinsville City locality, the use of public transportation is remarkably low.

Location	Workers Who Use Public Transportation
Henry County, VA	0.3%
Martinsville City, VA	1.1%
Virginia	3.4%
United States	4.2%

In Henry County, the percentage of workers who use public transportation is 0.3%, in Martinsville is 1.1%, in Virginia is 3.4%, and in the United States is 4.2%.

Data Source: United States Census Bureau- ACS 5-Year Estimates Data Profiles/Economic Characteristics

Included with transportation are internet access, food insecurity and income due to their close relationship with social determinants of health. Having transportation can be deferred if internet access is readily available to access necessary goods and food access is within walking distance.

Due to a locality's poor internet access and limited access to healthy foods, transportation becomes even more important.

Internet Access

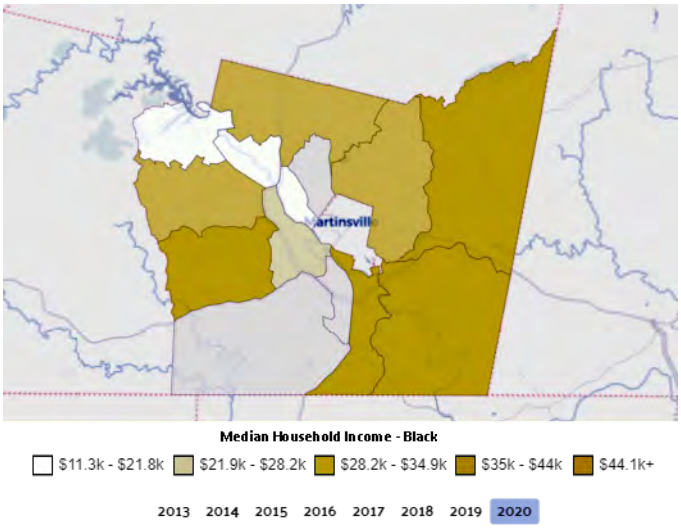
The following indicator is internet access within the report locations. It examines the percentage of the total population within the report area that has computer access or broadband. It also identifies the percentage of people in the 65+ population who do not have a computer in their residence.

Location	Households With a Computer	Households with Broadband	Population 65+ With No Computer in the Home
Henry County, VA	81.9%	72.4%	28.8%
Martinsville City, VA	88.3%	80.2%	26.8%
Virginia	93.4%	87.6%	13.9%
United States	93.1%	87.0%	13.5%

Data Source: United States Census Bureau: Latest ACS 5-Year Estimates Data Profiles/Social Characteristics

In Henry County, the percentage of households with a computer is 81.9%, the percentage of households with Broadband is 72.4%, and percentage of the population 65+ with no computer in the home is 28.8%. In Martinsville, the percentage of households with a computer is 88.3%, the percentage of households with Broadband is 80.2%, and percentage of the population 65+ with no computer in the home is 26.8%. In Virginia, the percentage of households with a computer is 93.4%, the percentage of households with Broadband is 87.6%, and percentage of the population 65+ with no computer in the home is 13.9%. In the United States, the percentage of households with a computer is 93.1%, the percentage of households with Broadband is 87.0%, and percentage of the population 65+ with no computer in the home is 13.5%

Median Household Income by Race [Income by Location for Henry, VA]



Median Household Income - Black

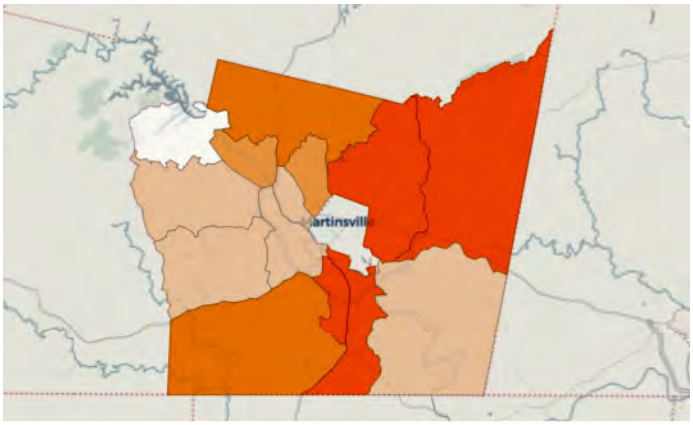
$11.3k - $21.8k $21.9k - $28.2k $28.2k - $34.9k $35k - $44k $44.1k+

2013 2014 2015 2016 2017 2018 2019 2020

Median Household Income - Hispanic

$2.5k - $21.8k $21.9k - $32.2k $32.2k - $44.7k $44.8k - $118k $119k+

2013 2014 2015 2016 2017 2018 2019 2020



Median Household Income - White

$25.7k - $33.1k $33.2k - $39.1k $39.1k - $44.7k $44.8k - $54.5k $54.6k+

2013 2014 2015 2016 2017 2018 2019 2020

Food Deserts

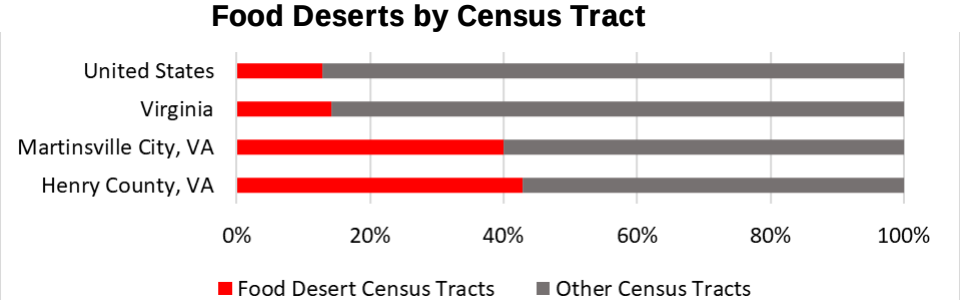
A mass of 42.9% of the combined areas are in food desert lacking access to healthy food sources.

This indicator reports the number of neighborhoods in the report area that are within food deserts. The USDA Food Access Research Atlas defines a food desert as any neighborhood that lacks healthy food sources due to income level, distance to supermarkets, or vehicle access. The report area has a population of 28,296 living in food deserts and a total of 8 census tracts classified as food deserts by the USDA.

Report Area	Food Desert Census Tracts	Other Census Tracts
Henry County and Martinsville City, Total	8	11
Henry County, VA	6	8
Martinsville City, VA	2	3
Virginia	269	1,617
United States	9,293	63,238

Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas 2019. Source geography: Tract

In Henry County and Martinsville combined, there are 8 census tracts that are considered a food desert and 11. Then 6 census tracts that are considered a food desert and 8 that are not Henry. In Martinsville, there are 2 census tracts that are a food desert and 3 that are not, that is 40% food desert. In Virginia there are 269 census tracts that are considered a food desert and 1,617 that are not, covering only 14%. In the United States, there are 9,293 census tracts that are considered a food desert and 63,238 that are not, a portion of only 12.8%



Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract

Unhoused

Population Below 200% Federal Poverty Line

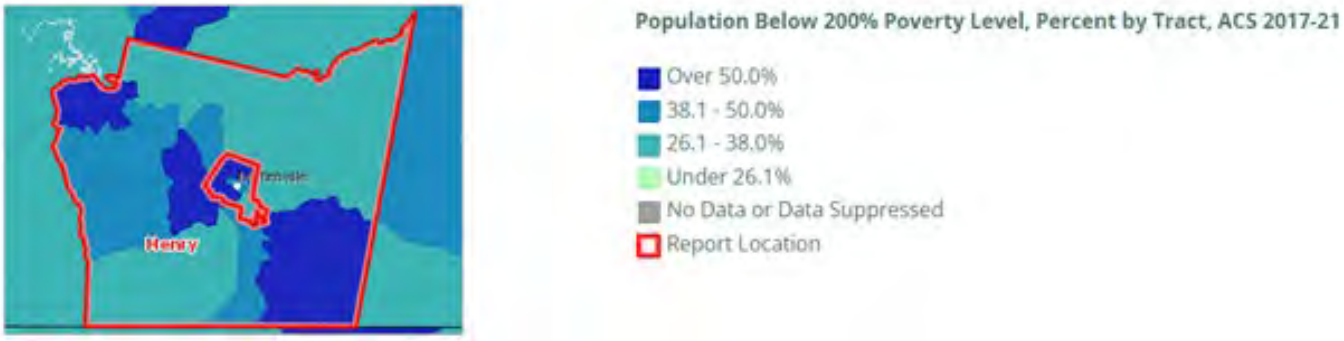
In the report area 46.40% or 29,371 individuals for whom poverty status is determined are living in households with income below 200% of the Federal Poverty Level (FPL).

This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Population with Income Below 200% FPL, Percent
Henry County and Martinsville City, Total	46.40%
Henry County, VA	44.49%
Martinsville City, VA	53.72%
Virginia	23.59%
United States	29.21%

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

16.40% of the total population in Henry County and Martinsville have an income 200% below federal poverty level. In Henry County alone, 44.49% of the population live 200% below federal poverty level and in Martinsville alone, 53.72% make 200% below federal poverty level. These are significantly higher than the Virginia percentage of 23.59% and the national rate of 29.21%



Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

Point-in-Time Count

The Point-in-Time Count is conducted once a year, each January, when the number of unhoused persons are physically counted and turned in by each locality to State for totals

In January of 2023, 139 persons were recognized as being unhoused by the West Piedmont Better Housing Coalition. Martinsville and Henry are a part of their catchment area.

West Piedmont Better Housing Coalition- 2023 Point-in-Time Count Summary
Date of PIT Count: 1/25/2023
Population: Sheltered and Unsheltered Count

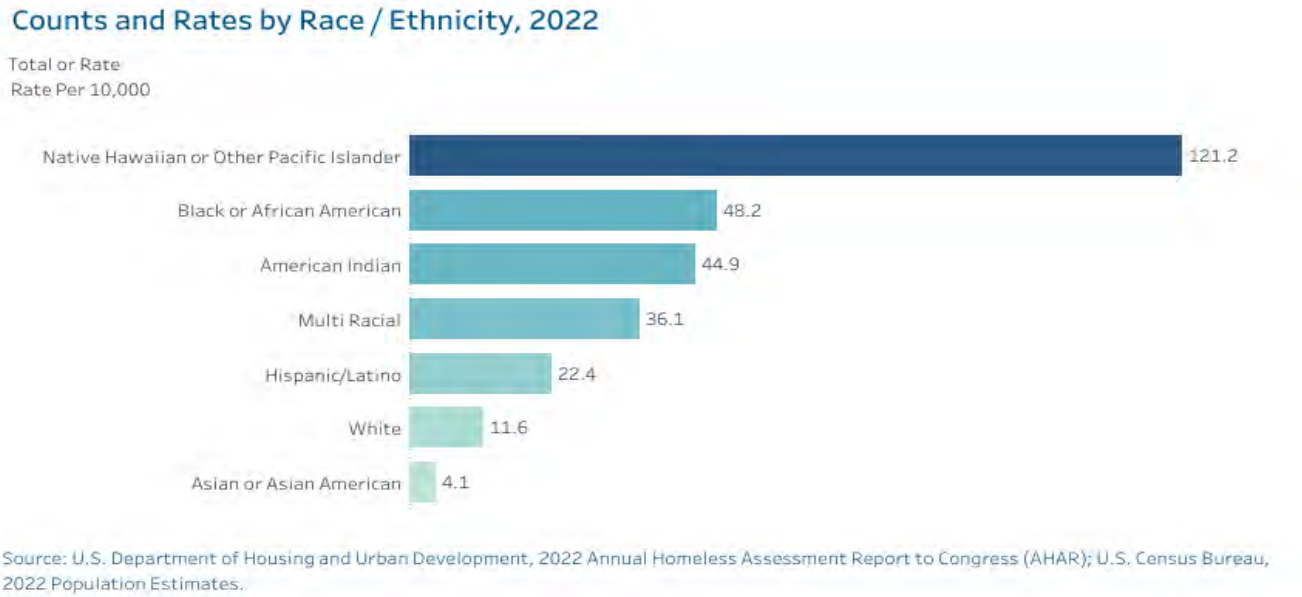
Total Households and Persons

	Sheltered			Unsheltered	Total
	Emergency	Transitional	Safe Haven		
Total Number of Households	37	21	0	21	79
Total Number of Persons	48	46	0	26	120
Number of Children (under age 18)	11	3	0	5	19

Data Source: Point-in-Time Count 2/23/23 West Piedmont Better Housing Coalition

In January of 2023, the total number of households that were unhoused was 79 with 120 individual persons being unhoused. Of these 79 households, 37 were in emergency shelters, 21 in transitional shelters, and 21 unsheltered. Of the 120 total persons, 48 were in emergency shelters, 46 were in transitional shelters, and 26 were unsheltered. The number of children unhoused was 19 with 11 being in emergency shelters, 3 being in transitional shelters and 5 being unsheltered.

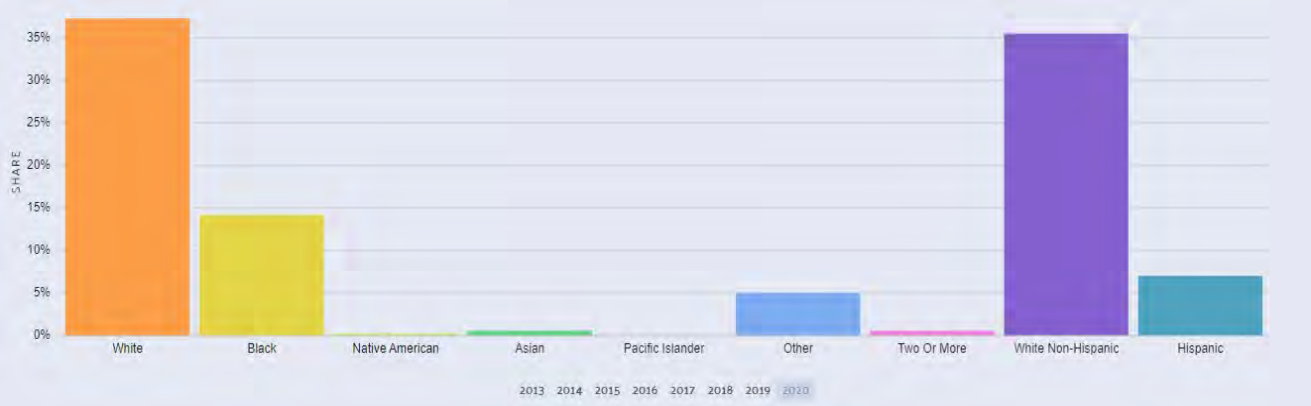
Unhoused Citizens by Race



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR); U.S. Census Bureau, 2022 Population Estimates.

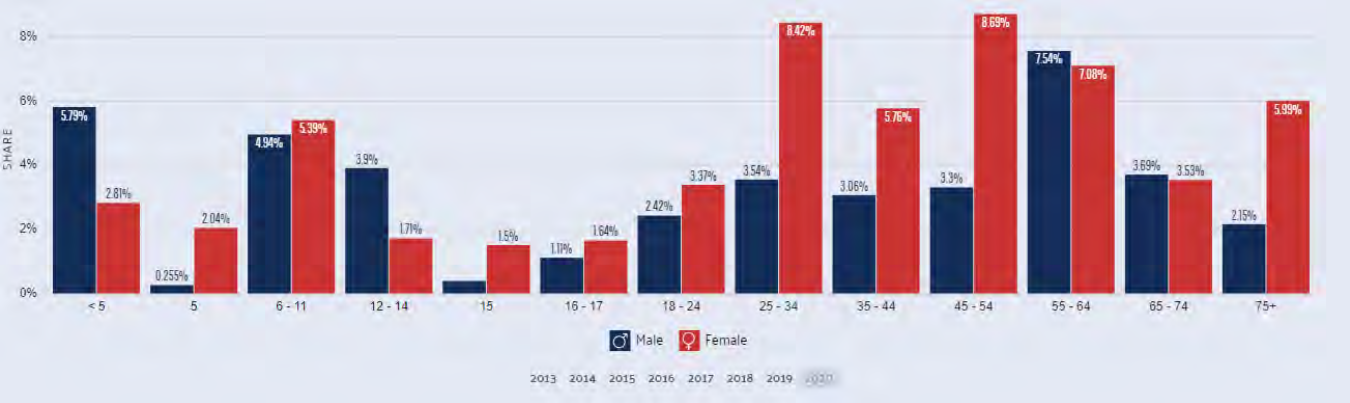
By comparison across the United States Native Hawaiian or Other Pacific Islanders are listed at 121.2 per 10,000. Next Black or African American citizens are estimated to be a rate of 48.2 unhoused per 10,000 compared to Asian or Asian Americans who are 4.1 unhoused per 10,000. . Others lister were American Indian at 44.9 per 10,000, Multi Racial with 36.1 per 10,000, Hispanic/Latino at 22.4 per 10,000 and White at 11.6 per 10,000.

The most common racial or ethnic group living below the poverty line in Henry County, VA is White, followed by Black then Hispanic.



More than 35% white Henry County residents live below the poverty line followed by 14% black residents then 7% percent Hispanic, Native Americans 2%, Asians #%, Pacific Islanders are not tallied, Others are listed at 5%, Two or more races have 2%.

A little over twenty percent (20.3%) of the population for whom poverty status is determined in Henry County, VA (10.3k out of 50.9k people) live below the poverty line, a number that is higher than the national average of 12.8%. The largest demographic living in poverty are Females 45 - 54, followed by Females 25 - 34 and then Males 55 - 64.



Males less than age 5 are 5.79% likely to live below poverty line while those 5 years are 0255%. Males ages 6-11 are 4.94%, ages 12-14 are 3.9%, 15 years are less than 1%, 16-17 years 1.11%, 18-24 years are 2.42 %, 25-34 years are 3.54%, 35-44 years are 3.06% 45.54 years are 3.3%, while 55-64 years are 7.54%, 65-74 years are 3.69% and 75+ years are 2.15%. Females less that age 5 are 2.18% likely to live below poverty line while those 5 years are 2.04%. Males ages 6-11 are 5.39%, ages 12-14 are 1.71%, 15 years are 1.5%, 16-17 years 1.64%, 18-24 years are 3.37 %, 25-34 years are 8.42%,35-44years are 5.76% 45.54 years are 8.69%, while 55-64 years are 7.08%, 65-74 years are 3.53% and 75+ years are 5.99%.

Children in Poverty

In Henry County and Martinsville 26.85% or 3,539 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Population < Age 18 in Poverty, Percent
Henry County, VA	21.36%
Martinsville City, VA	42.73%
Virginia	13.02%
United States	17.05%

Data Source: US Census Bureau, American Community Survey. 2017-21. Source geography: Tract

In Henry County, 21.36% of the population under 18 lived in poverty. In Martinsville, 42.73% lived in poverty. Both are higher than Virginia percentage (13.02%) and national (17.05%) of the population under 18 living in poverty.

The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who classifies as impoverished. If a family's total income is less than the family's threshold than that family and every individual in it is considered to be living in poverty.

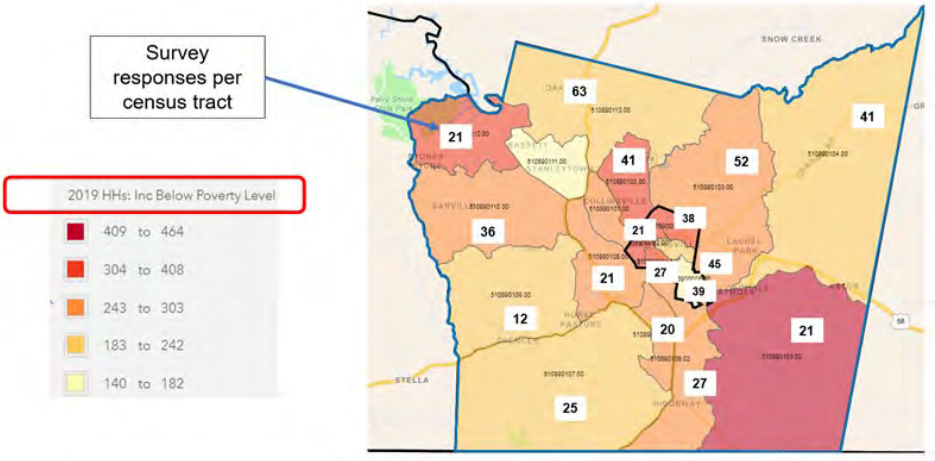
How Did We Get Here?

Community Survey Outreach

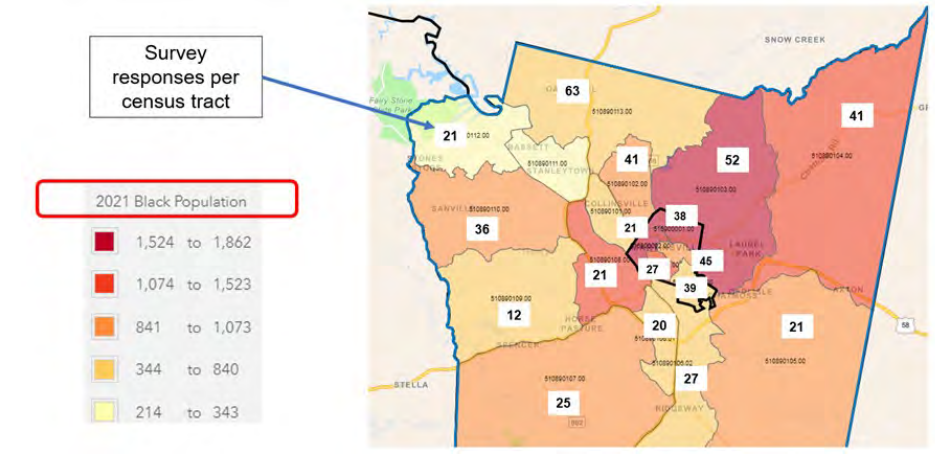
A key element of the survey effort was the decision to **target survey outreach within census tracts having a higher prevalence of populations at potential risk for health inequities**. With this objective in mind, the survey was conducted using nonprobability sampling (or convenience sampling) to assure that surveyors were able to reach as many members of these groups as possible.

Of particular value was the strategy to deploy community health workers (CHWs) in selected census tracts to engage community residents as survey respondents. Consequently, the survey results include substantial numbers of responses from low-income households and the Black/African American population.

To illustrate the importance of this outreach, **Maps 1 & 2** show the distribution of confirmed survey responses from each census tract within the boundaries of Henry County or Martinsville. The maps show that relatively speaking, the survey effort yielded substantial numbers of responses from census tracts with these characteristics.



Map 1



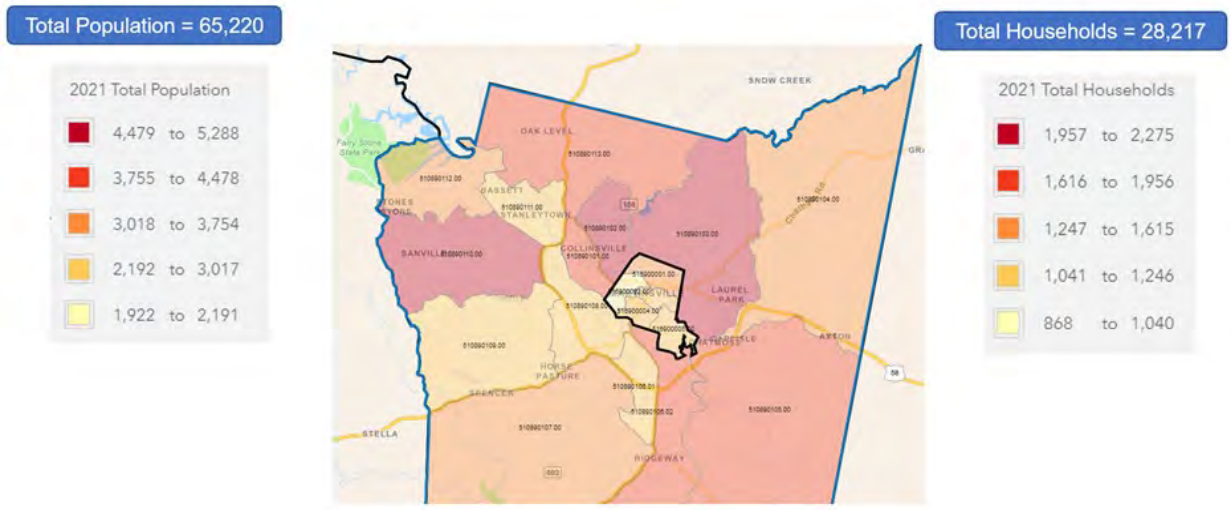
Map 2

Source: CHS analysis of community demographic data from ESRI, Inc via ArcGIS Business software.

The results outlined suggest there are demographic groups that may be at risk for health inequities. For purposes of local survey outreach, strategic planning and targeted action models, it can be helpful to know where these populations reside within the region. The following maps, showing combined data for Henry and Martinsville illustrate the local distribution of potentially at-risk populations for whom data are available. Within each map, the darker shading shows census tracts with a higher prevalence of the population or indicator of interest.

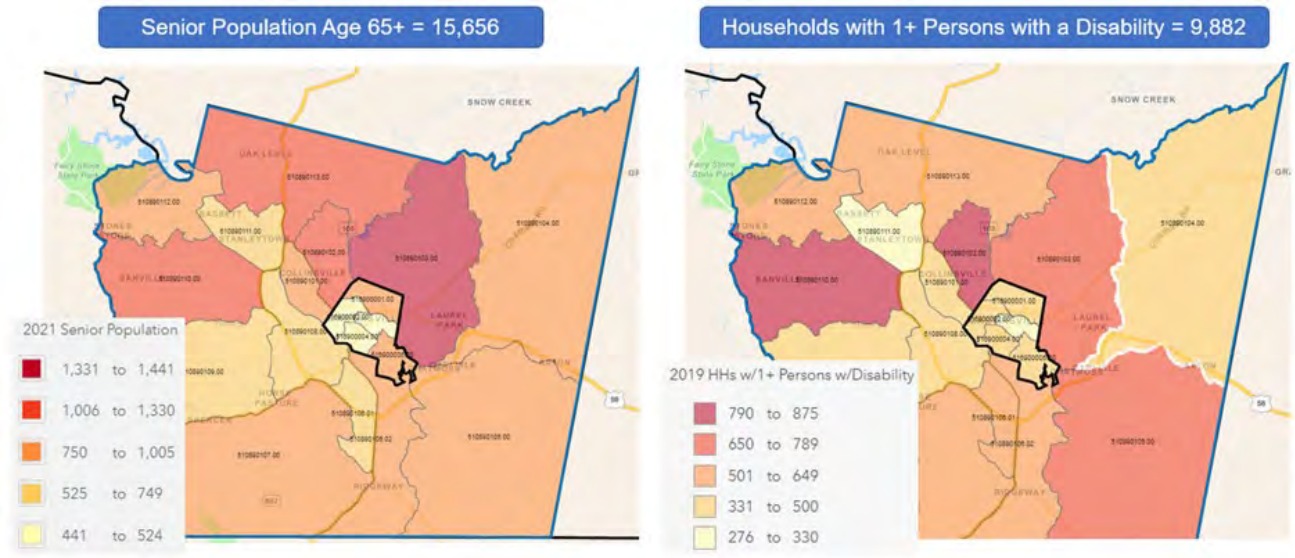
Map 3 ***Estimated Total Population and Total Households (2021)***

Local distribution of the total population (65,220) and total households (28,717). (Darker shading indicates more, lighter shading indicates fewer).



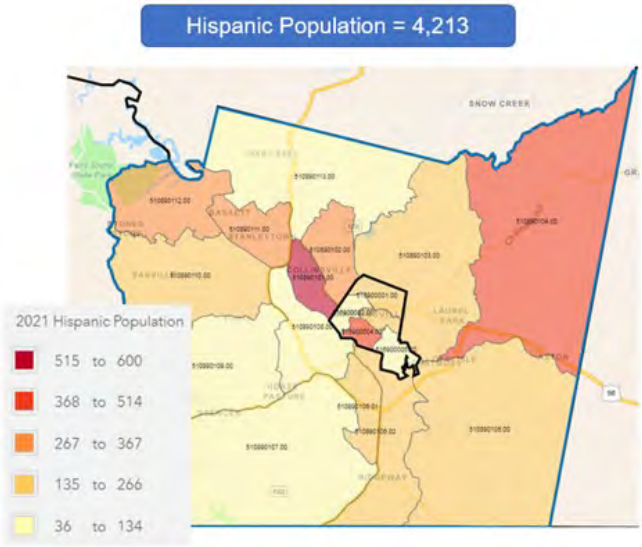
Maps 4 & 5 - ***Estimated Senior Population (2021) and Households with 1+ Persons with a Disability (2019)***

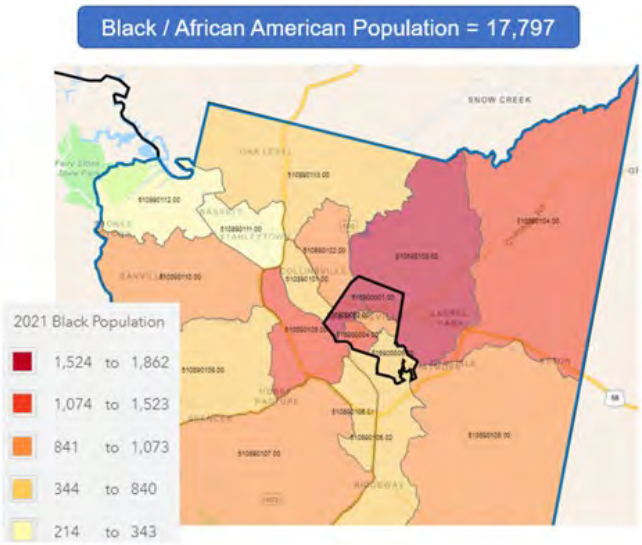
Local distribution of the senior population (15,656) and households with a person having a disability (9,882). (Darker shading indicates more, lighter shading indicates fewer).



Maps 6 & 7 - ***Estimated Hispanic Population and Black / African American Population (2021)***

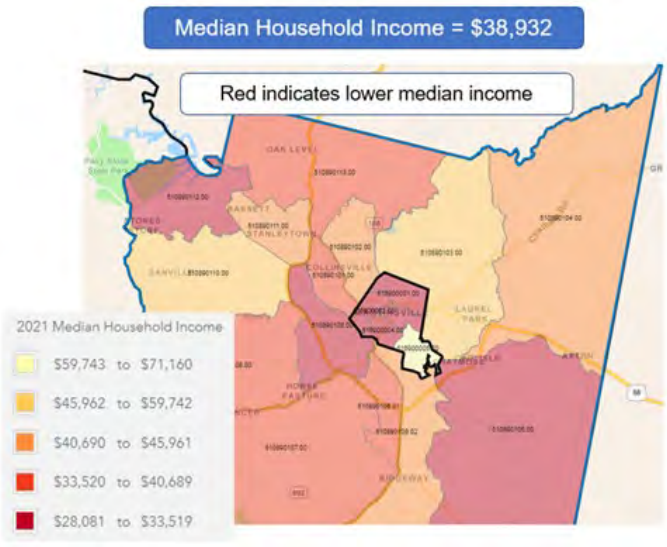
Local distribution of the Hispanic population (4,213) and the Black/African American population (17,797). (Darker shading indicates more, lighter shading indicates fewer).

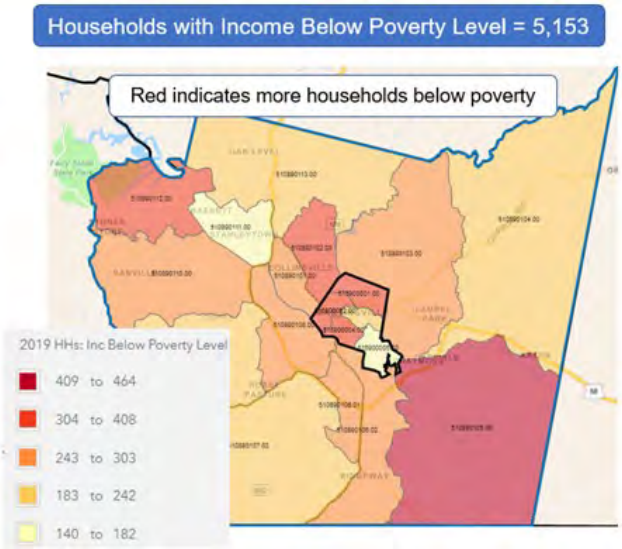




Maps 8 & 9 - ***Estimated Median Household Income (2021) and Households with Income Below Poverty Level (2019)***

Local distribution of households by median household income ($38,932) and households with income below poverty level (5,153). (In this map, darker shading indicates lower income, and lighter shading indicators higher income).





Source: CHS analysis of community demographic data from ESRI, Inc via ArcGIS Business software.

Community Health Survey Results

By gaining additional insight into potential health inequities, West Piedmont Health District and its community partners obtained insights from local residents. These results are explained in this section. **These public opinion surveys used in tandem with secondary data were able to direct the equity collaborative in identifying priorities**. These priorities will be used to direct the process of building the implementation/improvement plan for Henry Count and Martinsville City.

Summarizing the survey approach:

- The survey was distributed through multiple methods, and results were captured in a survey database for analysis. A total of 645 surveys were returned (although not every respondent answered every question).
- A key element of the survey effort was the decision to target survey outreach within census tracts having a higher prevalence of populations at potential risk for health inequities. With this objective in mind, the survey was conducted using nonprobability sampling (or convenience sampling) to assure that surveyors were able to reach as many members of these groups as possible.
- Because this was not a randomized probability sample, it is not possible to generate results that meet conventional criteria of 'statistical significance.' However, the results are still instructive for practical purposes, or what could be called 'practically significant.' This means the results are adequate for understanding patterns in community needs and insights, and for informing community planning efforts.

The analysis is focused on three groups of interest in health equity analysis: Very low-income, Black / African American, and Hispanic. As context, the number of survey responses by category of income and race were fairly robust, with 234 very-low-income respondents, and 276 Black /African American respondents. The number of surveys received from Hispanic respondents was considerably smaller at a total of 30. Although a small group it is important noting, Hispanic respondents mentioned the importance of English Second Language service. Translation services in healthcare and for community programs is a program that will receive attention as part of the implementation/improvement planning process. To be conservative, the analysis only cites differences of at least five percent between the comparison groups. Although these differences do not meet textbook standards of statistical significance for reasons outlined above, for practical purposes they are still worth considering in community efforts to address health equity.

Equity-Related Group Differences in Survey Results

As a starting point for exploring potential health inequities, it can be helpful to examine health disparities between the local region and Virginia as a whole.

- Focusing on health status indicators, Henry County and Martinsville have lower life expectancy, higher years of potential life lost, and higher rates of infant mortality, avoidable hospitalizations, smoking, overweight, diabetes, and depression.

- Looking at health-related social factors, Henry County and Martinsville have a higher prevalence of low-income population, Black/African American population, population age 65+, and population with a disability. Each of these populations has been identified as at relatively higher risk for health inequities based on published studies.

In reviewing these indicators, it is important to note the analysis does not include all possible health and social indicators. Also, the presence of a disparity (or difference) in a given indicator does not automatically mean the difference is due to systemic inequity. However, based on what is known from national studies about health disparities, it is fair to hypothesize that local disparities in health status indicators may be linked to disparities in health-related social indicators. Further research within the local region could be helpful for exploring whether disparities may be linked to inequities in access and related factors.

A Statewide Lens: Selected Indicators Henry County and Martinsville Compared to Virginia

	Henry County	Martinsville	Combined	Virginia
Total Population	**51,077**	**13,476**	**64,553**	**8.6 million**
Health Status Indicators				
Life Expectancy at Birth (2010-2015)	75	74	**75**	79
Years of Potential Life Lost Before Age 75 per 100,000 Population (2018-2020)	11,896	17,250	**12,998**	6,707
Infant Mortality Rate per 1,000 Live Births (2018-2020)	13.95	7.07	**--**	5.75
Avoidable Hospitalizations per 100,000 Population Age 18+ (2020)	1,352	5,360	**2,097**	820
Adults 18+ Who Are Current Smokers (2020)	16%	16%	**--**	14%
Adults 18+ Who Are Overweight or Obese (2020)	75%	71%	**--**	67%
Adults 18+ Diagnosed with Diabetes (2020)	23%	22%	**--**	11%
Adults with Depressive Disorder (2020)	24%	27%	**--**	17%
Health-Related Social Indicators				
Population Below 100% Poverty (2017-2021)	15%	25%	**17%**	10%
Population Below 200% Poverty (2017-2021)	44%	54%	**46%**	24%
Black/African American Population (2017-2021)	23%	45%	**28%**	19%
Population Age 65+	24%	17%	**22%**	15%
Population with Any Disability (2017-2021)	21%	20%	**21%**	12%
Population with Any Disability Age 18-64 (2017-2021)19%	20%	19%	**19%**	10%
Population with Any Disability Age 65+	41%	45%	**41%**	32%

Source: CHS analysis of community survey data and comparison with available state data

Survey Item	*Very-low income compared to higher income*	*Black/African American compared to White*	*Hispanic compared to non-Hispanic*
	Very low income respondents ($0-30,000) were more likely to select…	***Black/ African American respondents were more likely to select…***	***Hispanic respondents were more likely to select…***
Most important issues…	**1. Access to healthy foods 2. Domestic violence 3. Harm reduction resources 4. Homelessness services 5. Housing affordability and availability**	**6. Access to healthy foods 7. Lack of exercise 8. Transportation 9. Blood pressure/diabetes 10. Homelessness services 11. Re-entry programs**	**12. English second language services**
Hard to find resources…	**13. Dental 14. Chiropractic 15. Medications/medical supplies**	**16. Cancer care 17. Eldercare 18. Inpatient hospital procedures 19. Medications/medical supplies**	**20. Dental 21. End of life care / hospice 22. Chiropractic 23. Treatment of STD**
Last healthcare visit within the past year…	**1. No visit in past year**	**None identified**	**2. No visit in past year**
Conditions diagnosed by a doctor…	**3. High blood pressure 4. Depression / anxiety 5. High blood sugar / diabetes 6. Mental health issues 7. Asthma 8. Heart disease 9. Drug or alcohol issues**	**10. High blood pressure 11. High blood sugar / diabetes**	**None identified**
Neighborhood safety…	**1. Not feeling safe in neighborhood**	**None identified**	**2. Not feeling safe in neighborhood**
Transportation…	**3. Walking or riding with friends / family (vs. driving self)**	**4. Riding with friends / family (vs. driving self)**	**5. Ride sharing / carpooling (vs. driving self)**
Source: CHS analysis of community survey data provided by West Piedmont Health District.			

Survey Response Comparisons

Most Important Issues

Most Important Issues	All by Income	$0-$30,000	$31-$60,000	$61,000+	All by Race	Black	White	Other	All by Hispanic	Hispanic	Non-Hispanic
Total Responses	*634*	*234*	*174*	*226*	*641*	*276*	*320*	*45*	*641*	*30*	*611*
Access to Healthy Foods	59%	68%	52%	54%	59%	63%	58%	33%	59%	20%	61%
Alcohol or Illegal Drugs	56%	49%	62%	60%	56%	49%	65%	47%	56%	40%	57%
Texting / Distracted Driving	24%	20%	21%	29%	23%	21%	27%	11%	23%	17%	24%
Child Abuse / Neglect	27%	22%	24%	34%	27%	20%	33%	24%	27%	23%	27%
Domestic Violence	34%	39%	28%	34%	34%	30%	38%	29%	34%	37%	34%
Homicide	13%	12%	12%	15%	13%	14%	13%	7%	13%	13%	13%
Lack of Exercise	41%	31%	46%	46%	41%	47%	37%	29%	41%	20%	42%
Obesity / Overweight	48%	38%	55%	55%	48%	46%	52%	33%	48%	30%	49%
Prescription Drug Misuse	39%	33%	37%	46%	39%	30%	47%	33%	39%	17%	40%
Sexual Assault	17%	20%	16%	15%	17%	16%	18%	20%	17%	20%	17%
Transportation	54%	56%	51%	54%	54%	61%	49%	40%	54%	47%	54%
Tobacco Use / Vaping	28%	23%	30%	32%	28%	28%	29%	18%	28%	13%	28%
Unsafe Sex	17%	17%	13%	20%	17%	17%	18%	16%	17%	17%	17%
Baby / Mother Care	22%	18%	19%	27%	22%	17%	24%	29%	22%	23%	21%
Suicide	28%	27%	25%	31%	28%	28%	30%	18%	28%	23%	28%
Blood Pressure / Diabetes	45%	37%	50%	49%	45%	54%	41%	18%	45%	17%	46%
Religious Freedoms	7%	7%	5%	7%	7%	6%	8%	0%	7%	3%	7%
Mental Health	67%	58%	68%	75%	67%	67%	70%	49%	67%	33%	69%
Access to Technologies	20%	17%	18%	23%	20%	22%	19%	2%	20%	3%	20%
Child Care	31%	22%	29%	42%	32%	25%	38%	29%	32%	30%	32%
Harm Reduction Resources	14%	15%	10%	15%	14%	13%	16%	7%	14%	10%	14%
English Second Language Services	13%	9%	14%	17%	13%	11%	12%	33%	13%	47%	12%
Homelessness Services	61%	65%	61%	56%	61%	66%	57%	60%	61%	50%	62%
Tax and Fee Relieve Assistance	13%	15%	13%	11%	13%	15%	11%	11%	13%	7%	13%
Education	36%	28%	40%	41%	36%	36%	37%	24%	36%	13%	37%
Housing Affordability and Availability	43%	53%	33%	40%	43%	45%	42%	40%	43%	30%	44%
Re-Entry Programs	30%	23%	36%	32%	29%	38%	24%	20%	29%	23%	30%
I prefer not to answer	2%	2%	1%	1%	2%	1%	1%	7%	2%	7%	1%

Hard to Find Resources

Hard to Find Resources	All by Income	$0-$30,000	$31-$60,000	$61,000+	All by Race	Black	White	Other	All by Hispanic	Hispanic	Non-Hispanic
Total Responses	*618*	*229*	*169*	*220*	*625*	*270*	*310*	*45*	*625*	*29*	*596*
Dental	49%	67%	48%	30%	49%	48%	48%	58%	49%	62%	48%
End of Life Care / Hospice	9%	8%	11%	9%	9%	9%	9%	13%	9%	17%	9%
Alternative Therapy / Massage / Yoga	14%	12%	11%	18%	14%	9%	15%	27%	14%	17%	13%
Ambulance Services	9%	9%	8%	11%	9%	9%	11%	2%	9%	3%	10%
Cancer Care	27%	25%	30%	25%	26%	31%	24%	18%	26%	24%	27%
Chiropractic	8%	12%	8%	4%	8%	8%	8%	11%	8%	17%	8%
Dermatology	20%	14%	21%	25%	20%	19%	20%	22%	20%	17%	20%
Eldercare	38%	33%	46%	39%	38%	43%	36%	27%	38%	24%	39%
Baby / Mother care	19%	16%	15%	24%	19%	17%	20%	20%	19%	17%	19%
Immunizations	6%	7%	5%	6%	6%	8%	5%	0%	6%	3%	6%
Lab Work / X-Rays	10%	9%	9%	11%	10%	10%	10%	4%	10%	3%	10%
Inpatient Hospital Procedures	20%	16%	24%	21%	20%	28%	15%	9%	20%	10%	20%
Medications / Medical Supplies	18%	22%	18%	13%	18%	21%	16%	9%	18%	10%	18%
Treatment for Sexually Transmitted Disease	6%	7%	5%	5%	6%	6%	5%	9%	6%	10%	5%

Feeling Safe in Your Neighborhood

Feeling Safe in Your Neighborhood	All by Income	$0-$30,000	$31-$60,000	$61,000+	All by Race	Black	White	Other	All by Hispanic	Hispanic	Non-Hispanic
Total Responses	*620*	*232*	*165*	*223*	*627*	*271*	*310*	*46*	*627*	*30*	*597*
No	11%	15%	10%	8%	11%	8%	13%	17%	11%	17%	11%

Last Healthcare Visit

Last Healthcare Visit	All by Income	$0-$30,000	$31-$60,000	$61,000+	All by Race	Black	White	Other	All by Hispanic	Hispanic	Non-Hispanic
Total Responses	*634*	*233*	*173*	*228*	*640*	*273*	*321*	*46*	*640*	*30*	*610*
Within the past year (1-12 months)	83%	78%	80%	89%	83%	84%	84%	65%	83%	60%	84%

Conditions Diagnosed by a Doctor

Conditions Diagnosed by a Doctor	All by Income	$0-$30,000	$31-$60,000	$61,000+	All by Race	Black	White	Other	All by Hispanic	Hispanic	Non-Hispanic
Total Responses	*613*	*234*	*167*	*212*	*620*	*269*	*306*	*45*	*620*	*30*	*590*
High Blood Pressure	54%	59%	54%	48%	54%	64%	46%	40%	54%	30%	55%
Depression/Anxiety	33%	37%	38%	26%	34%	28%	38%	36%	34%	30%	34%
High Cholesterol	32%	33%	31%	32%	32%	31%	35%	16%	32%	13%	33%
High Blood Sugar / Diabetes	28%	35%	26%	21%	28%	33%	25%	18%	28%	20%	28%
Obesity / Overweight	28%	26%	28%	29%	28%	19%	36%	27%	28%	27%	28%
Mental Health Issues	19%	24%	19%	15%	19%	17%	22%	13%	19%	10%	20%
Asthma	17%	25%	13%	11%	17%	16%	17%	16%	17%	10%	17%
I have no health problems mentioned by doctor or healthcare provider	14%	11%	13%	18%	14%	12%	13%	33%	14%	40%	13%
Heart Disease	12%	17%	11%	7%	12%	11%	14%	7%	12%	7%	12%
Cancer	9%	8%	10%	10%	9%	6%	12%	9%	9%	7%	9%
Drug or Alcohol Issues	7%	12%	5%	2%	7%	6%	8%	7%	7%	7%	7%
COPD / Chronic Bronchitis / Emphysema	6%	8%	6%	4%	6%	4%	8%	4%	6%	3%	6%
Stroke	5%	6%	4%	5%	5%	6%	4%	9%	5%	10%	5%

Transportation Used

Transportation Used	All by Income	$0-$30,000	$31-$60,000	$61,000+	All by Race	Black	White	Other	All by Hispanic	Hispanic	Non-Hispanic
Total Responses	*630*	*232*	*171*	*227*	*637*	*276*	*315*	*46*	*637*	*30*	*607*
I drive	86%	70%	92%	97%	86%	84%	90%	70%	86%	80%	86%
Taxi	0%	1%	0%	0%	1%	0%	0%	7%	1%	3%	0%
Bike	1%	0%	1%	1%	1%	1%	1%	2%	1%	3%	1%
Walk	7%	16%	2%	2%	7%	7%	6%	11%	7%	7%	7%
Ride Sharing / Carpooling	2%	3%	2%	1%	2%	1%	2%	11%	2%	10%	2%
Friends / Family	14%	25%	9%	5%	14%	15%	10%	28%	14%	13%	14%
Uber / Lyft	0%	1%	0%	0%	0%	0%	0%	4%	0%	0%	0%

Source: CHS analysis of data from the Virginia Community Health Improvement Data Portal. Indictors of life expectancy, years of potential life lost, and infant mortality produced by Virginia Department of Health (VDH) based on mortality records. Avoidable hospitalization indicators produced by VDH using hospital discharge records from Virginia Health Information (VHI) Inc. Indicators of smoking, overweight, diabetes, and depressive disorder are estimates produced by VDH using data from the Virginia Behavioral Risk Factor Surveillance Survey. Health-related social indicators are estimates published by VDH based on US Census Bureau data.

Next Steps

A Call to Action

The HCM Equity Collaborative will continue meeting monthly at the Virginia Natural History Museum to work with community health equity reports and implementation strategy plans to address identified priorities. The participating health districts and district health systems will work very closely with their staff to address health needs by providing programs, resources, and opportunities for collaboration with all partners. Every participating community service board and health care system will review the Equity report data and findings in accordance with their own patient communities and principal functions and evaluate opportunities for next steps to address the identified health needs in their respective patient communities. The report will be made available as a resource to the broader community and is intended to serve as a useful resource to both residents and community partners to further communitywide improvement efforts. Equitable access to programs and planning meetings will be available to community members and partners to advance the policy changes, create healing and develop sustainable processes to introduce education around health equity.

The Henry Martinsville Equity Collaborative and Virginia Department of Health are proud of their collaborative relationships with local organizations and are committed to regularly seeking input from the community to inform community health equity strategies.

The **top six issues** as identified by the Equity Collaborative will be divided among committees for further work and implementation/improvement planning. Space is available at the table for anyone who would like to join in this work as progress is being made. Once vetted, plans will be released to community leaders, partners and the community at large for decisions.

The wheel illustrates a repeatable process for community innovation that can be applied to address any need. As guidance for applying this process:

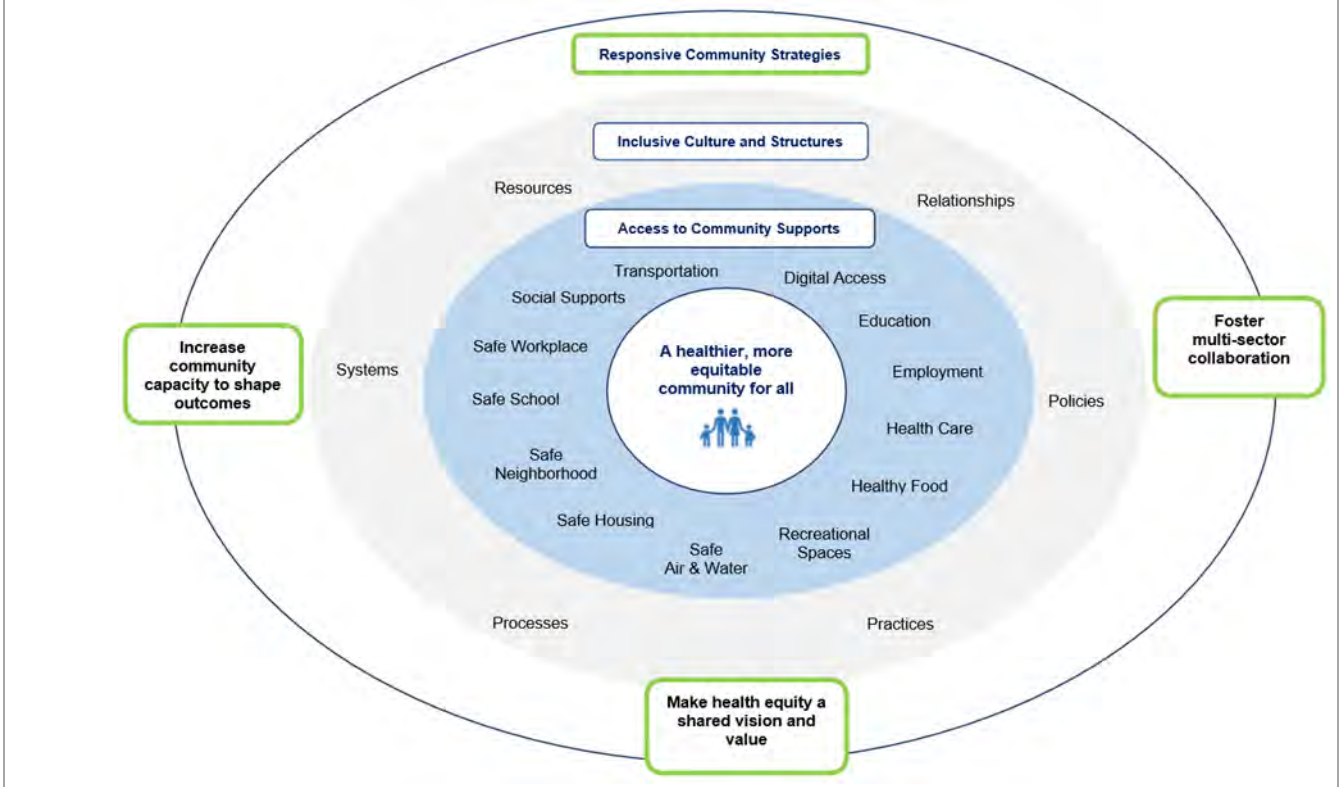
- Experience shows the work of community innovation is often best done when it is focused on one or a few issues at a time, at least at the outset.
- The action steps include engaging partners; assessing the obstacles and opportunities; designing and developing improvements; evaluating results; and then scaling, sustaining, and spreading what works.

By repeatedly applying this process to address priority issues over time, community stakeholders can create a continuous stream of innovation resulting in greater health equity for residents of Henry County and the City of Martinsville.

As a starting point for promoting community health equity, it can be helpful to work from a collaborative vision. The work plan being developed within Equity Collaborative meetings should be considered by stakeholders in Henry County and Martinsville:

- The vision is centered on a healthier, more equitable community for all.
- This vision can be achieved by applying responsive community strategies to assure access to community supports within an inclusive culture and set of structures.
- "**Access to community supports**" means access to health care services plus a spectrum of health-related social supports as shown in the blue oval.
- "**Inclusive culture and structures**" means inclusive community relationships, policies, practices, processes, systems, and resource allocations, as shown in the grey oval.
- "**Responsive community strategies**" means people and organizations working together to foster multi-sector collaboration, make health equity a shared vision and value, and increase community capacity to shape outcomes, as shown in the green boxes.

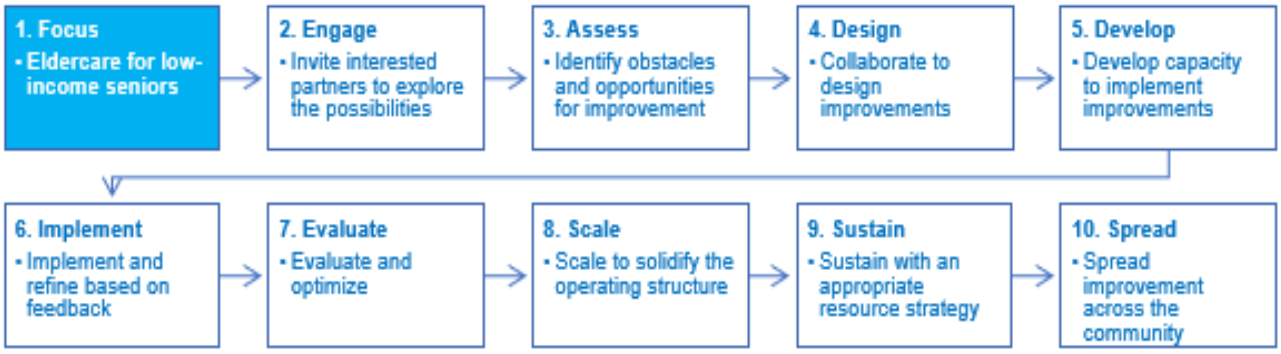
Collaborative Vision for Promoting Community Health Equity



Source and visioning: Adapted from the National Academies for Science, Engineering, and Medicine, *Communities in Action: Pathways to Health Equity* (2017). https://nap.nationalacademies.org/catalog/24624/communities-in-action-pathways-to-health-equity

The implementation/improvement plan by example will be created using programs/tactics, purposes and key performance indicators like the examples shown in the table that follows.

Illustration of a Community Innovation Process for One Example Issue



Implementation/Improvement Plan Ideas

Program/Tactic	Purpose	Key Performance Indicators
Social Work Student Rotation	Increase access to social support in the community and for patients through a social work student rotation program that focuses on the influence of social determinants of health on health outcomes.	• Profile of participants and high-risk zip codes served • Student hours served by project type
Opioid Steering Committee	Address the opioid epidemic by leading and collaborating with providers, patients, and the communities we serve to help reduce opioid misuse, abuse, and addiction.	• Reduction in opioid prescriptions • Reduction in co-prescribed medications • Implement Fentanyl testing across the system
Zero Suicide Initiative	Lead system-wide, organizational commitment to safer suicide care and set aggressive, but achievable goals to eliminate suicide attempts and deaths and organizing service delivery and support accordingly.	• Use of standardized risk screening in the Emergency Department • Safety Plan competition for all patients evaluated in the Emergency Department by a behavioral health team member
Community Development	Increase corporate investments to the community and provide positive social value through partnerships and sponsorships.	• Have partnerships that support behavioral health • Have strategic partnerships and sponsorships with high social value
Community Development	Increase business investments to the community and provide positive social value through partnerships and sponsorships.	• Have partnerships that improve access to healthy food and wellness programs • Have partnerships and sponsorships with high social value • Have volunteer hours that support access to healthy food and wellness organizations
Community Foundation	Increase investments from the philanthropic community that support equitable access to healthy food and wellness programs.	• Have partnerships that improve healthy food and wellness programs • Have philanthropic partnerships and their investments in access at high schools locally

Data Sources & References

American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

The Institute for Health Metrics and Evaluation (IHME) at the University of Washington analyzed the performance of all 3,142 US counties or county-equivalents in terms of life expectancy at birth, mortality rates for select causes, alcohol use, smoking prevalence, obesity prevalence, and recommended physical activity using novel small area estimation techniques and the most up-to-date county-level information. Explore more results using the interactive US Health Map data visualization (http://vizhub.healthdata.org/subnational/usa).

United States Census Bureau. The vision for data dissemination through data.census.gov is to improve the customer experience by making data available from one centralized place so that data users spend less time searching for data content and more time using it. The Census Bureau continues to work on the customer experience so that it is not necessary for data users to know the Census Bureau jargon or perform a complicated search to find the data that they need. As more data and content become available in the standardized format through the Census Data API and, subsequently, data.census.gov, data users will discover that they have more choices and greater flexibility.

United States Department of Housing and Urban Development HUD's mission is to create strong, sustainable, inclusive communities and quality affordable homes for all. HUD is working to strengthen the housing market to bolster the economy and protect consumers; meet the need for quality affordable rental homes; utilize housing as a platform for improving quality of life; build inclusive and sustainable communities free from discrimination, and transform the way HUD does business.

U.S. Small-area Life Expectancy Estimates Project (USALEEP) is a partnership of NCHS, the Robert Wood Johnson Foundation (RWJF), and the National Association for Public Health Statistics and Information Systems (NAPHSIS) to produce a new measure of health for where you live. The USALEEP project produced estimates of life expectancy at birth—the average number of years a person can expect to live—for most of the census tracts in the United States for the period 2010-2015.[2]
This indicator reports the average life expectancy at birth. Life expectancy measures the average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population. Life expectancy takes into account the number of deaths in a given time period and the average number of people at risk of dying during that period, allowing us to compare data across census tracts with different population sizes.

Virginia Health Opportunity Index
(HOI) consists of 13 indicators that act as the building blocks of the HOI. These indicators were chosen by our expert work group following an extensive review of the literature on the Social Determinants of Health (SDOH). Although there are innumerable variables and indicators that could be included, indicators were chosen based on the following criteria:

- Influence on health as expressed in the literature.
- Input from Local Health Districts and other stakeholders.
- Availability of data of consistent quality at the Census Tract level for all Census Tracts in Virginia.

It is important to note that each indicator, the profiles, and the HOI itself, are conceived as indications of the opportunity to live a long and healthy life in each area.

West Piedmont Better Housing Coalition The West Piedmont Better Housing Coalition, Inc. was organized to develop the West Piedmont Planning District's Continuum of Care planning and implementation of services to address homelessness in the area. The organization evolved from a Steering Committee made up of representatives from a wide variety of public and private agencies and organizations to address the needs of homeless individuals from the cities of Danville and Martinsville as well as the counties of Franklin, Henry, Patrick and Pittsylvania, Virginia. The West Piedmont Better Housing Coalition, Inc. seeks to assure that every individual and family, including the at-risk, has a safe, quality, and affordable place to live. We seek to provide a continuum of Care for the citizens of these areas. The Coalition will advocate for safe, quality and affordable housing for those in need, including the homeless, through leadership, assessment, coordination and expansion of existing services and creation of new resources.

Virginia Behavioral Risk Factor Surveillance Survey (BRFSS), also known as Virginia Adult Health Survey (VAHS), is a telephone survey continuously conducted by Virginia Department of Health. The Virginia BRFSS is the primary source of information for Virginia on the health-related behaviors of adults. Data are collected through monthly interviews with adults aged 18 years or older. BRFSS interviewers ask questions related to behaviors that are associated with preventable chronic diseases, injuries and infectious diseases.

The annual rate of health district and state came from the corresponding Virginia BRFSS year dataset, as obtained from Virginia Department of Health, Division of Policy and Evaluation.

The 2020 locality rate was provided by Abt Associates Inc. for Virginia Department of Health, Office of Family Health Services in January 2022.

Vital Event Statistics Program is to assure access to timely, comprehensive population-based health data to support community needs assessments, evidence-based policy and program decisions, and evaluations of health outcomes and services. This mission is accomplished through the collection, analysis, and dissemination of population-based health data. Our goal is to provide appropriate access that is balanced with the need to protect the privacy of individuals. Data is collected via vital records, through the use of surveys, and by partnerships with other public and private entities such as the U.S. Census Bureau. Customers for our information include the general public, other legislative and executive branch agencies (both state and federal), local communities and researchers.

Glossary

Health Equity Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (RWJ Foundation)

Social Determinants of Health Social determinants of health (SDOH) include those inter-related social and economic factors that influence health. (VDH) Such factors may include education, employment, food, housing, neighborhood safety, social supports, and digital access (access to internet and related supports). SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Equitable
1: having or exhibiting equity: dealing fairly and equally with all concerned an equitable settlement of the dispute
2: existing or valid in equity as distinguished from law an equitable defense

Unhoused The label of “homeless” has derogatory connotations. It implies that one is “less than”, and it undermines self-esteem and progressive change. The use of the term "Unhoused", instead, has a profound personal impact upon those in insecure housing situations. It implies that there is a moral and social assumption that everyone should be housed in the first place.

Stigma
The underlying theme of stigma and the barriers it creates arose across conversations as surveys were collected and secondary data was analyzed. Stigma impacts the way people access needed services (clinical health, mental health, other economic support) that address the social determinants of health. This consequentially impacts the ability of people to improve and successfully manage health conditions. Community engagement participants expressed concerns about the impact of stigma in relation to specific populations, including LGBTQ+ communities, people experiencing homelessness, people of color, seniors, SNAP beneficiaries, and survivors of domestic violence and human trafficking. Stigma was also discussed in relation to specific health conditions such as behavioral health, cancer, diabetes, and obesity. The existing stigma that had prevented community members from accessing needed services led to even more dangerous outcomes amidst the pandemic, as people became more desperate and felt they had fewer options.

Trauma
In addition, an underlying theme of trauma was shared across community engagement efforts. The impact of trauma has been demonstrated to increase health disparities and inequities. Community engagement participants noted trauma as a nearly universally shared experience that added intensity to the identified community needs. Trauma and vicarious trauma were also cited as factors that contributed to compassion fatigue and overdose. Our community has experienced trauma both at work and at home, and consequently, there is often no escape and no downtime from traumatic experiences. This shared trauma interacts with every aspect of the identified community needs. Traumatized community members are seeking assistance from health care providers and community-based organizations who themselves have experienced ongoing trauma since the start of the pandemic.

Health Disparities. Health disparities are differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities. (VDH)

Health Inequities. Health inequities are disparities in health [or health care] that are systemic and avoidable and, therefore, considered unfair or unjust. (VDH)

Demographics are the **various characteristics of a population**. Examples of demographics can include factors such as the race, sex and age of a population that is being studied. The statistical information on the population's socioeconomic conditions is known as demographic data.

Socioeconomic-relating to or concerned with the interaction of social and economic factors as in: *"socioeconomic change" and"people in lower socioeconomic groups".*

Food Desert an urban area in which it is difficult to buy affordable or good-quality fresh food: *“many poor people live in food deserts—where they have plenty of food but none of it healthy".*

Disaggregated data refers to numerical or non-numerical information that has been (1) collected from multiple sources and/or on multiple measures, variables, or individuals; (2) compiled into aggregate data. i.e., summaries of data—typically for the purposes of public reporting or statistical analysis; and then (3) broken down in component parts or smaller units of data.

Neonatal Abstinence Syndrome - is also known as neonatal drug dependency or withdrawal symptoms, and predominantly occurs from maternal use of opiates, such as heroin, or opioids such as methadone, fentanyl, and prescription pain medications during pregnancy. Babies with NAS are at increased risk of low birthweight, jaundice, seizures, and sudden infant death syndrome (SIDS).

Appendices

Appendix A
List of Resources Used During the Community Health Equity Assessment

- *US Census Bureau, American Community Survey. 2017-21.*
- *US Census Bureau, Small Area Income and Poverty Estimates. 2021. Source geography: County*
- *United States Census Bureau, 2021 ACS 1-Year Estimates Data Profiles*
- *Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project. 2010-15. Source geography*
- *Virginia Department of Health, Virginia Health Opportunity Index Counties – Virginia Health Opportunity Index*
- *Virginia Department of Health, Behavioral Risk Factor Surveillance Survey. Data directly obtained via email from Virginia BRFSS 2020. Source geography: County, Health District*
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jun 09 2023]. URL: https://www.cdc.gov/PLACES
- *Centers for Disease Control and Prevention. US Diabetes Surveillance System website. Available at https://www.cdc.gov/diabetes/data.*
- *America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, accessed 2023.*
- *Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Data, Trend and Maps [online].*
- *Virginia Department of Health, Virginia Maternal and Child Health, 2021, Maternal and Child Health (virginia.gov)*
- *Virginia Cancer Registry, SEER, all COD, aggregated with state*
- *Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-20. Source geography: County*
- *Virginia Department of Health, Behavioral Risk Factor Surveillance Survey. Data directly obtained via email from Virginia BRFSS 2020. Source geography: County, Health District*
- *Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County*
- *United States Census Bureau- Latest ACS 5-Year Estimates Data Profiles/Housing Characteristics*
- *United States Census Bureau- ACS 5-Year Estimates Data Profiles/Economic Characteristics*
- *US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract*
- Point-in-Time Count 1/25/23, Published 2/23/23 from West Piedmont Better Housing Coalition
- *CHS analysis of community demographic data from ESRI, Inc via ArcGIS Business software.*
- *CHS analysis of community survey data provided by West Piedmont Health District.*
- *Institute for Health Metrics and Evaluation (IHME). United States Mortality Rates and Life Expectancy by County, Race, and Ethnicity 2000-2019. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2022.*
- *Hypertension in Virginia Key facts and Prevalence Hypertension-Burden-Report-.pdf (virginia.gov)*
- *Capacity of Virginia's Licensed Behavioral Health Workforce 2022, Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce (vhcf.org)*

Appendix B
Community Health Equity Survey Tables

Race

Please choose which race you identify with the most (You may select up to two options):	%	Count
White and European Americans	52%	336
Native Hawaiians and other Pacific Islanders	0%	2
Middle Easterners and North Africans	0%	2
Latino	4%	29
Black and African American	44%	287
Asian American	0%	1
American Indian or Alaska Native	1%	9
Total	100%	645

Ethnicity

Ethnicity	%	Count
Hispanic	5%	30
Non-Hispanic	95%	615
Total	100%	645

Average Household Income

Average Household Income per Year:	%	Count
$120,000 and above	8%	54
$91,000-$120,000	9%	58
$61,000-$90,000	18%	116
$31,000-$60,000	27%	174
$0-$30,000	37%	236
Total	100%	638

Number in Household

Number of People in Household	%	Count
1	24%	153
2	36%	232
3	21%	134
4	11%	68
5	5%	34
6 or more	4%	23
Total	100%	644

Most Important Issues

Which do you think are the most important issues that affect all of the people in your community? Please select ALL that apply.	%	Count
Mental Health	67%	430
Homelessness Services	61%	392
Access to Healthy Foods	59%	376
Alcohol or Illegal Drugs	56%	362
Transportation	54%	344
Obesity/Overweight	48%	310
Blood Pressure/Diabetes	45%	287
Housing Affordability and Availability	43%	277
Lack of exercise	41%	261
Prescription Drug Misuse	39%	248
Education	36%	228
Domestic Violence	34%	218
Childcare	32%	202
Re-Entry Programs	29%	189
Suicide	28%	181
Tobacco Use/Vaping	28%	178
Child Abuse/Neglect	27%	173
Texting/Distracted Driving	23%	149
Baby/Mother Care	22%	138

Most Important Issues (continued)

Access to Technologies	20%	125
Sexual Assault	17%	110
Unsafe Sex	17%	109
Harm Reduction Resources	14%	88
English Second Language Services	13%	85
Homicide	13%	82
Tax and Fee Relief Assistance	13%	82
Religious Freedoms	7%	42
I prefer not to answer	2%	10
Total	100%	641

Hard to Find Resources

What resources/ providers are hard to find in your community? Please select ALL that apply	%	Count
Dental	49%	305
Eldercare	38%	240
Cancer Care	26%	165
Inpatient Hospital Procedures	20%	125
Dermatology	20%	122
Baby/Mother care	19%	117
Medications/ Medical Supplies	18%	111
Alternative Therapy/ Massage/Yoga	14%	85
Lab Work/X-rays	10%	61
I prefer not to answer	10%	61
Ambulance Services	9%	59
End of Life Care/Hospice	9%	58
Chiropractic	8%	51
Immunizations	6%	37
Treatment for Sexually Transmitted Diseases	6%	35
Total	100%	625

Community Needs

Tell us about people in your community who need help with needs and better health. Please describe their need.	%	Count
(Note: List includes thematically coded categories for 250 respondents that answered the question).		
Health Care Services	36%	89
Health Equity	29%	73
Low Income Population	25%	63
Community and Social Services	22%	55
Housing	22%	54
Elderly Population	21%	53
Mental Health or Substance Use Concerns	18%	46
Children and Families	12%	30
Healthy Food	7%	17
Minority Population	6%	16
Employment	4%	9
Lifestyle Risk Factors	4%	9
Education	3%	8
Women's Health	3%	8
Chronic or Infectious Disease	2%	4
People with Disabilities	2%	6
Other not coded	5%	12
Total	100%	250

Last Doctor Visit

When was the last time you saw a doctor or other healthcare provider for a well check/exam and not a sick visit?	%	Count
Within the past year (1-12 months)	83%	530
Within the past 2 years (13 months to 24 months)	7%	44
Within the past 5 years (25 months to 5 years)	2%	12
More than 5 years ago	1%	6
I only see a doctor or healthcare provider when I am sick not for routine well checks.	6%	38
I prefer not to answer	2%	10
Total	100%	640

Diagnoses

Have you been told by a doctor or healthcare provider that someone in your household is a person with any of the following (Please select ALL that apply):	%	Count
High Blood Pressure	54%	333
Depression/Anxiety	34%	208
High Cholesterol	32%	198
High Blood Sugar/Diabetes	28%	173
Obesity/Overweight	28%	171
Mental Health Issues	19%	120
Asthma	17%	103
I have no health problems mentioned by doctor or healthcare provider	14%	87
Heart Disease	12%	75
Cancer	9%	57
Drug or Alcohol Issues	7%	44
COPD/Chronic bronchitis/Emphysema	6%	38
Stroke	5%	32
I prefer not to answer	2%	15
Cerebral Palsy	0%	2
HIV/AIDS	0%	1
Other	0%	0
Total	100%	620

Lifestyle

Please select ALL of the statements below that describe your lifestyle during the last 30 days.	%	Count
None of the above statements apply to my last 30 days.	77%	419
I have used marijuana in any form.	9%	51
I have had 5 or more alcoholic drinks if male or 4 or more alcoholic drinks if female during one sitting or occasion	9%	50
I prefer not to answer	7%	38
I have used prescription medications to get high or for purpose they were not prescribed.	2%	11
I have used drugs like meth, cocaine, heroin, ecstasy, LSD or similar.	0%	0
I have used tobacco products like cigarettes, smokeless tobacco, vaping devices etc.	0%	0
Total	100%	544

Diet

During the past 7 days, how many times did you eat fruit or vegetables? Please do not count fruit or vegetable juices.	%	Count
I did not eat fruits or vegetables during the past 7 days.	3%	18
4-6 times in the last 7 days	24%	152
1-3 times in the last 7 days	20%	127
4 times per day	4%	27
3 times per day	13%	82
2 times per day	21%	133
1 time per day	15%	94
I prefer not to answer	1%	9
Total	100%	642

Neighborhood Safety

Do you feel safe in your neighborhood to walk, find help and live?	%	Count
Yes	88%	552
No	11%	71
I prefer not to answer	1%	4
Other	0%	0
Total	100%	627

Transportation

What type of transportation do you typically use? (Please select ALL that apply.)	%	Count
I drive	86%	547
Friends/Family	14%	86
Walk	7%	44
Ridesharing/Carpooling	2%	14
Bike	1%	5
I prefer not to answer	1%	5
Taxi	1%	4
Uber/Lift	0%	3
Other	0%	0
Total	100%	637

Community Health Issues

Describe how help is needed for any health issues in the community where you live?	%	Count
(Note: List includes thematically coded categories for 242 respondents that answered the question).		
Health Care Services	34%	82
Community and Social Services	28%	68
Mental Health or Substance Use Concerns	15%	36
Low Income Population	9%	22
Lifestyle Risk Factors	8%	20
Elderly Population	7%	18
Healthy Food	7%	17
Education	7%	16
Housing	7%	16
Community Engagement	5%	13
Children and Families	5%	11
Healthy Lifestyle Supports	5%	11
Women's Health	5%	11
Health Equity	4%	10
Chronic Conditions and Infectious Disease	3%	7
Community Safety	2%	6
COVID-19	1%	3
Employment	1%	3
Other not coded	16%	38
Total	100%	242

APPENDIX C
COMMUNITY HEALTH SURVEY-ENGLISH

Community Care Assessment for Henry Co. Martinsville
Conducted by Henry Co. Martinsville Collaborative and partners.

The address will be used for mapping data purposes only and will not be attached to answers given on the survey below. *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Please choose which race you identify with the most (You may select up to two options): *

- ☐ American Indian or Alaska Native
- ☐ Asian American
- ☐ Black and African American
- ☐ Middle Easterners and North Africans
- ☐ Native Hawaiians and other Pacific Islanders
- ☐ White and European Americans
- ☐ Latino

Ethnicity *

- ☐ Hispanic
- ☐ Non-Hispanic

Average Household Income per Year: *

- ☐ $0-$30,000
- ☐ $31,000-$60,000
- ☐ $61,000-$90,000
- ☐ $91,000-$120,000
- ☐ $120,000 and above

Number of People in Household *

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

1

Which do you think are the most important issues that affect all of the people in your community? Please select ALL that apply. *

- ☐ Access to Healthy Foods
- ☐ Alcohol or Illegal Drugs
- ☐ Texting/Distracted Driving
- ☐ Child Abuse/Neglect
- ☐ Domestic Violence
- ☐ Homicide
- ☐ Lack of exercise
- ☐ Obesity/Overweight
- ☐ Prescription Drug Misuse
- ☐ Sexual Assault
- ☐ Transportation
- ☐ Tobacco Use/Vaping
- ☐ Unsafe Sex
- ☐ Baby/Mother Care
- ☐ Suicide
- ☐ Blood Pressure/Diabetes
- ☐ Religious Freedoms
- ☐ Mental Health
- ☐ Access to Technologies
- ☐ Childcare
- ☐ Harm Reduction Resources
- ☐ English Second Language Services
- ☐ Homelessness Services
- ☐ Tax and Fee Relief Assistance
- ☐ Education
- ☐ Housing Affordability and Availability
- ☐ Re-Entry Programs
- ☐ I prefer not to answer

What resources/ providers are hard to find in your community? Please select ALL that apply. *

- ☐ Dental
- ☐ End of Life Care/Hospice
- ☐ Alternative Therapy/ Massage/Yoga
- ☐ Ambulance Services
- ☐ Cancer Care
- ☐ Chiropractic
- ☐ Dermatology
- ☐ Eldercare
- ☐ Baby/Mother care
- ☐ Immunizations
- ☐ Lab Work/X-rays

2

- [ ] Inpatient Hospital Procedures
- [ ] Medications/ Medical Supplies
- [ ] Treatment for Sexually Transmitted Diseases
- [ ] I prefer not to answer

Tell us about people in your community who need help with needs and better health. Please describe their need.

When was the last time you saw a doctor or other healthcare provider for a well check/exam and not for a sick visit? *

- [ ] Within the past year (1-12 months)
- [ ] Within the past 2 years (13 months to 24 months)
- [ ] Within the past 5 years (25 months to 5 years)
- [ ] More than 5 years ago
- [ ] I only see a doctor or healthcare provider when I am sick not for routine well checks.
- [ ] I prefer not to answer

Have you been told by a doctor or healthcare provider that someone in your household is a person with any of the following (Please select ALL that apply): *

- [ ] Asthma
- [ ] Cancer
- [ ] Cerebral Palsy
- [ ] COPD/Chronic bronchitis/Emphysema
- [ ] Depression/Anxiety
- [ ] Drug or Alcohol Issues
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] High Blood Sugar/Diabetes
- [ ] High Cholesterol
- [ ] HIV/AIDS
- [ ] Mental Health Issues
- [ ] Obesity/Overweight
- [ ] Stroke
- [ ] I have no health problems mentioned by doctor or healthcare provider
- [ ] I prefer not to answer
- [ ]

Please select ALL of the statements below that describe your lifestyle during the last 30 days. *

- [ ] I have had 5 or more alcoholic drinks if male or 4 or more alcoholic drinks if female during one sitting or occasion
- [ ] I have used drugs like meth, cocaine, heroin, ecstasy, LSD or similar.
- [ ] I have used marijuana in any form.
- [ ] I have used prescription medications to get high or for purpose they were not prescribed.

3

- [ ] I have used tobacco products like cigarettes, smokeless tobacco, vaping devices etc.
- [ ] None of the above statements apply to my last 30 days.
- [ ] I prefer not to answer

During the past 7 days, how many times did you eat fruit or vegetables? Please do not count fruit or vegetable juices. *

- [ ] I did not eat fruits or vegetables during the past 7 days.
- [ ] 4-6 times in the last 7 days
- [ ] 1-3 times in the last 7 days
- [ ] 4 times per day
- [ ] 3 times per day
- [ ] 2 times per day
- [ ] 1 time per day
- [ ] I prefer not to answer

Do you feel safe in your neighborhood to walk, find help and live? *

- [ ] Yes
- [ ] No
- [ ] I prefer not to answer
- [ ] _____

What type of transportation do you typically use? (Please select ALL that apply.) *

- [ ] I drive
- [ ] Taxi
- [ ] Bike
- [ ] Walk
- [ ] Ridesharing/Carpooling
- [ ] Friends/Family
- [ ] Uber/Lift
- [ ] I prefer not to answer
- [ ] _____

Describe how help is needed for any health issues in the community where you live?

Submit

4

APPENDIX D
COMMUNITY HEALTH SURVEY-SPANISH

La dirección se utilizará únicamente para fines de datos de mapeo y no se adjuntará a las respuestas dadas en la encuesta a continuación. *

Dirección de la calle

Dirección de la calle Línea 2

Ciudad

Estado / Provincia

Código Postal

Por favor, elige con qué raza te identificas más (puedes seleccionar hasta dos opciones): *

- [ ] Indio americano o nativo de Alaska
- [ ] Asiático Americano
- [ ] Negro y afroamericano
- [ ] De Oriente Medio y África del Norte
- [ ] Hawaianos nativos y otros isleños del Pacífico
- [ ] Blancos y europeos americanos

- [ ] Latino

Origen étnico *

- [ ] Hispánico
- [ ] No hispano

Ingreso familiar promedio por año: *

- [ ] $0-$30,000
- [ ] $31,000-$60,000
- [ ] $61,000-$90,000
- [ ] $91,000-$120,000
- [ ] $120,000 and above

Número de personas en el hogar *

- [ ] Uno
- [ ] Dos
- [ ] Tres
- [ ] Cuatro
- [ ] Cinco
- [ ] 6 o más

¿Cuáles crees que son los problemas más importantes que afectan la vida en tu comunidad? Seleccione TODAS las que correspondan. *

- [ ] Vivienda asequible
- [ ] Alcohol o drogas ilegales
- [ ] Mensajes de texto/conducción distraída
- [ ] Abuso/Negligencia Infantil
- [ ] Violencia doméstica
- [ ] Homicidio
- [ ] Falta de ejercicio
- [ ] Obesidad/Sobrepeso
- [ ] Uso indebido de medicamentos recetados
- [ ] Agresión sexual
- [ ] Transporte
- [ ] Consumo de tabaco/vapeo
- [ ] Sexo inseguro
- [ ] Cuidado del bebé/madre
- [ ] Suicidio
- [ ] Presión arterial/diabetes
- [ ] Libertades religiosas
- [ ] Salud mental
- [ ] Acceso a las tecnologías
- [ ] Cuidado de niños

- [ ] Recursos para la reducción de daños
- [ ] Servicios de Inglés Segundo Idioma
- [ ] Servicios para personas sin hogar
- [ ] Asistencia para el alivio de impuestos y tarifas
- [ ] Educación
- [ ] Asequibilidad y disponibilidad de viviendas
- [ ] Programas de reingreso
- [ ] Prefiero no responder

¿Qué asistencia es difícil de obtener en su comunidad? Seleccione TODAS las que correspondan. *

- [ ] Dental
- [ ] Cuidados al final de la vida/hospicio
- [ ] Terapia alternativa / Masaje / Yoga
- [ ] Servicios de ambulancia
- [ ] Cuidado del cáncer
- [ ] Quiropráctica
- [ ] Dermatología
- [ ] Cuidado de ancianos
- [ ] Atención al bebé/madre
- [ ] Vacunas
- [ ] Análisis de laboratorio/radiografías
- [ ] Hospitalizaciones para pacientes hospitalizados

- [ ] Medicamentos/suministros médicos
- [ ] Tratamiento de enfermedades de transmisión sexual
- [ ] Prefiero no responder

Cuéntenos sobre las personas en su comunidad que necesitan ayuda con las necesidades y una mejor salud. Sírvase describir su necesidad.

¿Cuándo fue la última vez que vio a un médico u otro proveedor de atención médica para un chequeo / examen de bienestar y no para una visita por enfermedad? *

- [ ] En el último año (1-12 meses)
- [ ] En los últimos 2 años (13 meses a 24 meses)
- [ ] En los últimos 5 años (25 meses a 5 años)
- [ ] Hace más de 5 años
- [ ] Solo veo a un médico o proveedor de atención médica cuando estoy enfermo, no para controles de rutina de bienestar.
- [ ] Prefiero no responder

¿Usted o alguien en su hogar ha sido informado por un médico o proveedor de atención médica como una persona con cualquiera de los siguientes (seleccione TODOS los que correspondan):* *

- [ ] Asma
- [ ] Cáncer
- [ ] Parálisis cerebral
- [ ] EPOC/bronquitis crónica/enfisema
- [ ] Depresión/ansiedad
- [ ] Problemas de drogas o alcohol
- [ ] Enfermedad cardíaca
- [ ] Presión arterial alta
- [ ] Alto nivel de azúcar en la sangre/diabetes
- [ ] Colesterol alto
- [ ] VIH/SIDA
- [ ] Problemas de salud mental
- [ ] Obesidad/Sobrepeso
- [ ] Golpe
- [ ] No tengo problemas de salud mencionados por el médico o proveedor de atención médica
- [ ] Prefiero no responder
- [ ] Otro

Seleccione TODAS las declaraciones a continuación que describen su estilo de vida durante los últimos 30 días.* *

- [ ] He tomado 5 o más bebidas alcohólicas si es hombre o 4 o más bebidas alcohólicas si es mujer durante una sesión u ocasión
- [ ] He usado drogas como metanfetamina, cocaína, heroína, éxtasis, LSD o similares
- [ ] He usado marihuana en cualquier forma.

que describen su estilo de vida durante los últimos 30 días.* *

- [ ] He usado drogas como metanfetamina, cocaína, heroína, éxtasis, LSD o similares
- [ ] He usado marihuana en cualquier forma.
- [ ] He usado medicamentos recetados para drogarme o para un propósito que no me recetaron.
- [ ] He usado productos de tabaco como cigarrillos, tabaco sin humo, dispositivos de vapeo, etc.
- [ ] Ninguna de las declaraciones anteriores se aplica a mis últimos 30 días.
- [ ] Prefiero no responder

Durante los últimos 7 días, ¿cuántas veces comiste frutas o verduras? Por favor, no cuente los jugos de frutas o verduras. *

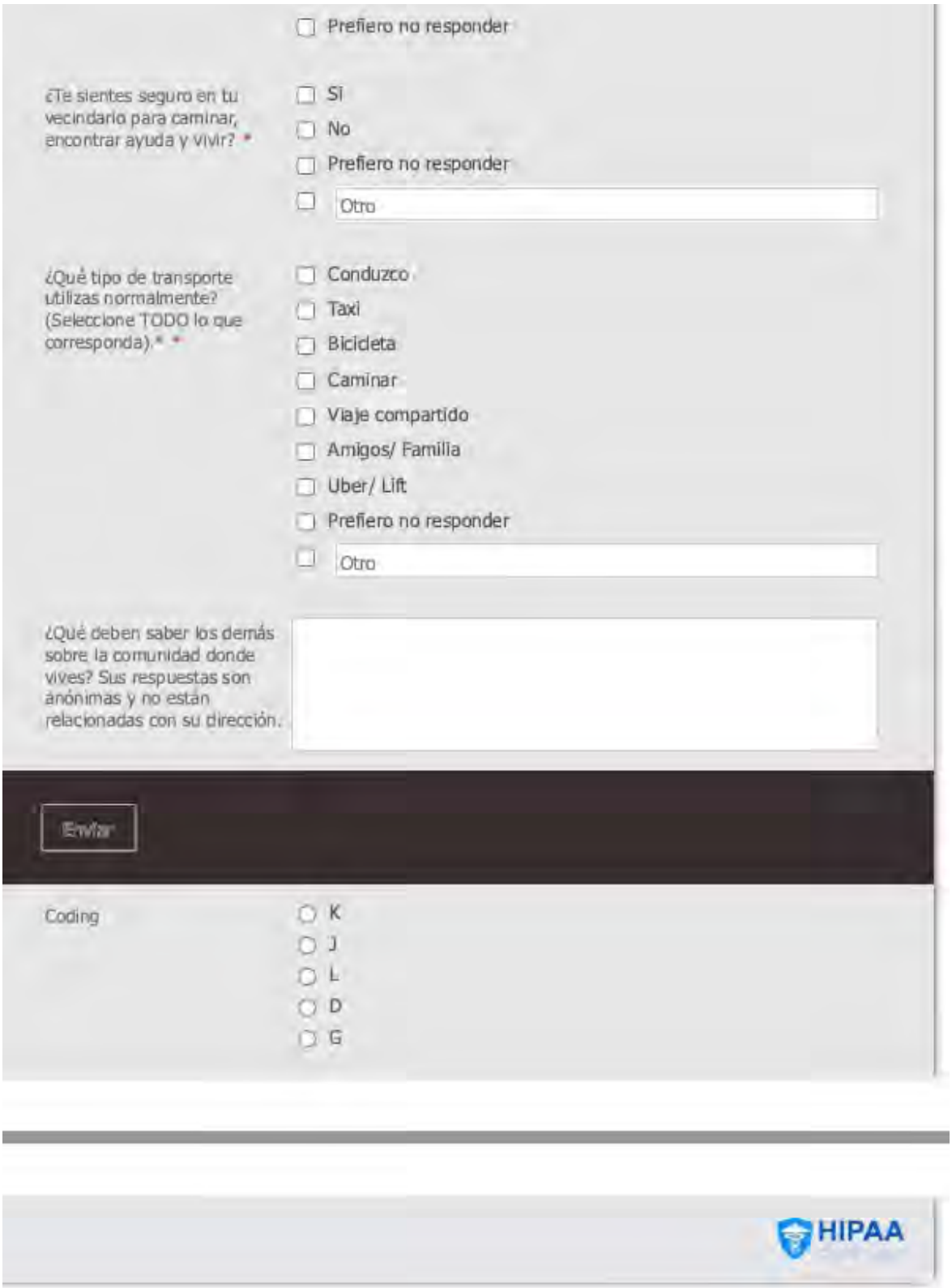
- [ ] No comí frutas ni verduras durante los últimos 7 días.
- [ ] 4-6 veces en los últimos 7 días
- [ ] 1-3 veces en los últimos 7 días
- [ ] 4 veces al día
- [ ] 3 veces al día
- [ ] 2 veces al día
- [ ] 1 vez al día
- [ ] Prefiero no responder

¿Te sientes seguro en tu vecindario para caminar, encontrar ayuda y vivir? *

- [ ] Si
- [ ] No
- [ ] Prefiero no responder
- [ ] Otro

¿Qué tipo de transporte utilizas normalmente? (Seleccione TODO lo que corresponda).* *

- [ ] Conduzco
- [ ] Taxi
- [ ] Bicicleta
- [ ] Caminar
- [ ] Viaje compartido
- [ ] Amigos/ Familia
- [ ] Uber/ Lift
- [ ] Prefiero no responder
- [ ] Otro


Prefiero no responder
¿Te sientes seguro en tu vecindario para caminar, encontrar ayuda y vivir? *
Sí
No
Prefiero no responder
Otro
¿Qué tipo de transporte utilizas normalmente? (Seleccione TODO lo que corresponda).* *
Conduzco
Taxi
Bicicleta
Caminar
Viaje compartido
Amigos/ Familia
Uber/ Lift
Prefiero no responder
Otro
¿Qué deben saber los demás sobre la comunidad donde vives? Sus respuestas son anónimas y no están relacionadas con su dirección.
Enviar
Coding
K
J
L
D
G
HIPAA

About the murals

These murals are featured in full and in part throughout this report. For more information about them, visit Things to Do - Arts & Cultural - Official Tourism Site for Martinsville-Henry County Virginia (visitmartinsville.com) and Piedmont Arts - Martinsville, VA

To navigate to the mural, click on the page number.

Elephants on Parade ~ pp. 4, 57
John Stiles, Jessie Ward, 2009
NCI King Building, 30 Franklin Street, Martinsville, VA

This mural was inspired by an historic photograph taken around 1920, featuring a parade of elephants, clowns and performers advertising the arrival of a circus in Martinsville. The photograph was adapted into a vibrant and detailed mural.

Farmers Market ~ pp. 15, 39
Betty LaDuke, 2009
Uptown Farmers Market, 60 West Church Street, Martinsville

Artist Betty LaDuke toured Martinsville-Henry County to create sketches of local people and places. These sketches were the inspiration for *Farmers Market*, the large-scale mural LaDuke created especially for the Uptown Farmers' Market.

Growing Together ~ p. 41
Carlisle School 5th grade, Middle, and Upper School Art students
Uptown Farmer's Market, 65 W. Main Street, Martinsville

This huge, colorful, and beautiful and conveys a positive message to the community that together, we can grow a healthy community and be pollinator-friendly and environmentally conscious.

Old Glory ~ p. 28
Scott LoBaido, 2012
TheatreWorks, 44 Franklin Street, Martinsville, VA

Renowned artist Scott LoBaido, whose depictions of the American flag can be seen all across America, used his patriotic artistry to create, *Old Glory*, an American flag mural on the outer wall of TheatreWorks in Uptown Martinsville.

June German Ball ~ pp. 8, 48
Community Project, 2014
Fayette Square, 53 Fayette Street, Martinsville, VA

This mural celebrates the culture and heritage of Martinsville's historic Fayette Street and depicts a fictional scene from one of Martinsville's famed June German Balls, which were popular within the African American community in the early part of the 20th century. The mural was designed and painted by Abigail Kieselbach, Briana Amos, Charles Hill, Iris Gillispie, Lex Hairston, Katie Croft, Ally Sneed and Bernadette Moore.

Uptown Connection Trail ~ p. 42
Amanda Honore Donley, Aleen Wilson, 2015
Uptown Pocket Park, 41 Fayette Street, Martinsville, VA

Located in one of Martinsville's Uptown pocket parks, this mural shows a cyclist taking a ride on the Uptown Connection Trail.

Project Hope Mural ~ pp. 4, 18, 22, 33
Jonathan Murrill, 2023
Bridge Street Parking Lot, Uptown Martinsville, VA

This mural spans 300 feet in Uptown Martinsville to represent growth and inclusivity for all in Martinsville-Henry County.

Manufacture of Furniture ~ pp. 7, 35
Walter Carnelli, 1939
3465 Fairystone Park Highway, Bassett

This public art mural is located in the lobby of the historic Bassett post office. The Section of Fine Arts, a division of the WPA, under the Treasury Department funded the painting of the mural as well as other public art murals in other post offices across the state of Virginia.

The Baldwin Block Canvases ~ p. 14
Amanda Honore' Donley
New College Institute, Market Street, Martinsville

These three murals depict a streetscape view of buildings and places significant to the history of this location on Fayette Street and the culture, including the Baldwin Pharmacy, Jobbers Pants Co., and Saint Mary's Hospital among others.

Ready, Set, Go Healthy ~ Front cover, pp. 10, 24, 54
Charles Hill
14 W. Main Street, Martinsville

This mural shows healthy activities residents and visitors can partake in throughout Martinsville-Henry County including bike riding, kayaking, running/jogging/walking on paved trails, playing soccer, gardening, and picnicking.