Wythe-Bland™ Foundation | Providing pathways for a healthier tomorrow

COMMUNITY HEALTH NEEDS ASSESSMENT

2026

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Introduction

The Wythe-Bland Foundation was originally established in 1991 as the Wythe County Community Hospital Foundation (WCCH Foundation) to support the charitable needs of Wythe County Community Hospital. On May 31, 2005, the Hospital leased its buildings and related real property and sold all other assets substantially to a subsidiary of LifePoint Hospitals, Inc. Proceeds from the prepaid lease, asset sale, and existing Foundation funds were transferred to establish a new, independent foundation.

Reorganized on June 1, 2005, the Foundation is no longer affiliated with the Hospital and is recognized as a health conversion foundation, sometimes referred to as a health legacy foundation. The charitable assets created through the transaction generate investment earnings that provide grant resources for eligible nonprofit organizations serving Wythe and Bland Counties. In 2010, the organization changed its name from the Wythe Bland Community Foundation to the Wythe-Bland Foundation following an IRS determination regarding its classification, as its primary source of revenue is derived from investment income.

Today, the Wythe-Bland Foundation is an independent Virginia non-stock, non-operating foundation exempt from income taxation under Section 501(c)(3) of the Internal Revenue Code. The Foundation is governed by a 13-member Board of Directors comprised of community leaders from Wythe and Bland Counties who serve without compensation.

The Foundation's mission is to improve health, education, and wellness throughout Wythe and Bland Counties, with a particular emphasis on advancing population health and addressing the needs of vulnerable residents. Grants are awarded annually to qualified nonprofit organizations and public entities providing programs and services that strengthen the communities we serve.

The Foundation's spending policies and community investment strategies are designed to preserve its charitable assets as an enduring endowment while providing meaningful resources to address current community needs. At least 5% of the Foundation's asset base is made available annually for grants and Foundation operations.

Since its reorganization in 2005, the Wythe-Bland Foundation has invested more than $50.6 million in the communities of Wythe and Bland Counties. This investment includes support for a wide range of initiatives addressing health, education, wellness, human services, community development, and quality of life.

Because federal law requires that proceeds from the sale or lease of assets of healthcare tax-exempt entities be directed toward charitable purposes with a primary focus on health, the Foundation remains committed to investing in strategies that improve the health and wellness of the communities it serves.

Responding to the health, education, and wellness needs of our communities—particularly the needs of our most vulnerable residents—is central to the Wythe-Bland Foundation's mission. The Foundation recognizes that meaningful and lasting community change requires a deep understanding of local needs, strong partnerships, strategic investments, and ongoing evaluation.

For more than two decades, the Foundation has used a structured approach to understanding and addressing community needs. That approach is grounded in four key principles:

- **Community collaboration and partnerships**
- **Data-driven needs assessment**
- **A systematic approach to addressing identified needs**
- **Continual measurement and evaluation**

The Community Health Needs Assessment is a critical component of this process. By combining quantitative data with community input and the perspectives of local stakeholders, the Foundation seeks to identify the most significant challenges affecting the health and wellness of Wythe and Bland County residents. The findings of this assessment will help guide future community investments, strengthen collaborative efforts, and inform strategies designed to improve population health and quality of life throughout the region.

Wythe-Bland™ Foundation | Providing pathways for a healthier tomorrow

MISSION

Providing opportunities for innovation and collaboration to promote a healthier community

VISION

Our vision is to be a part of a thriving community that meets the health, education, and wellness needs of all citizens

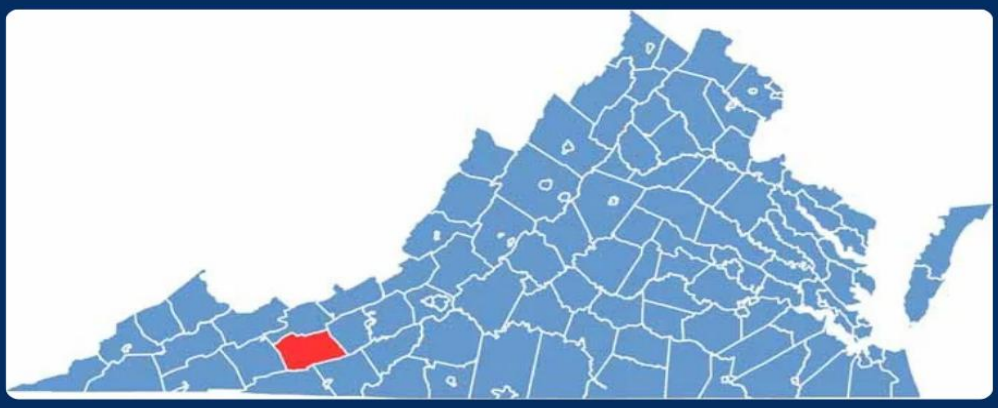
CORE VALUES

We value above all else:

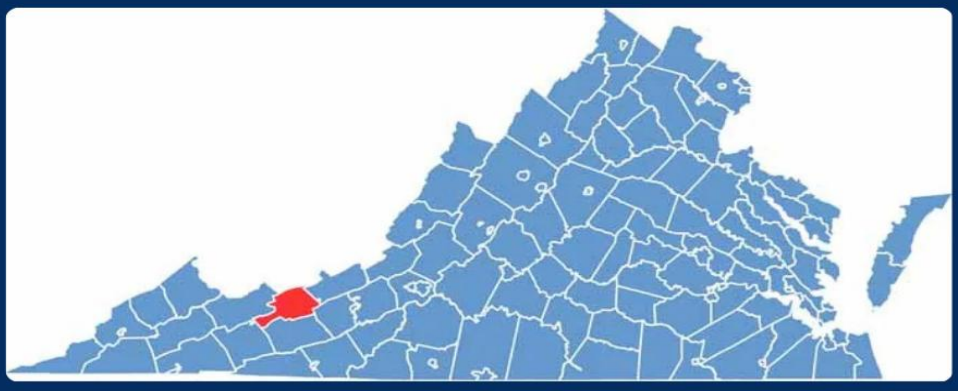
- Integrity
- Fairness
- Innovation and Collaboration
- Compassion and Commitment
- Our Partners' Missions

Wythe-Bland Foundation™

SERVICE AREA



WYTHE COUNTY, VIRGINIA



BLAND COUNTY, VIRGINIA

Executive Summary

Understanding the health and wellness of a community requires looking beyond individual health outcomes. Regional, state, and national datasets—including the County Health Rankings, the Virginia Department of Health (VDH) Health Opportunity Index (HOI), and the U.S. Health Equity Atlas—provide critical context on the systemic and environmental drivers of well-being. When integrated with local stakeholder input from the Community Health Needs Assessment (CHNA) survey, these data sources form a comprehensive profile of Wythe and Bland Counties. This executive summary synthesizes secondary health metrics with local community perspectives to help community leaders, local governments, healthcare providers, and nonprofit partners make informed, evidence-based decisions regarding programs and investments.

Socioeconomic conditions remain a primary driver of health outcomes across both counties. According to state and national equity metrics, median household incomes in Wythe and Bland Counties lag behind the Virginia statewide median, while child poverty continues to impact local families. The VDH Health Opportunity Index highlights regional disparities in economic opportunity, educational attainment, and healthcare access that directly influence health trajectories. Furthermore, County Health Rankings data place Wythe and Bland Counties predominantly in the middle-to-lower-middle quartiles statewide across key health outcomes and health factors, driven by an aging population, elevated adult obesity rates, and persistent behavioral health needs. Local survey input reinforces these secondary data patterns, with over 77% of respondents rating overall community health as fair or poor.

Quantitative Data Indicators

To evaluate the health landscape of Wythe and Bland Counties, this analysis synthesizes data across four complementary frameworks. By combining local population demographics with state and national health metrics, these sources provide a comprehensive view of community well-being, structural equities, and area-specific health outcomes.

- **US Census Bureau Data:** Establishes the baseline demographic and economic foundation for Wythe and Bland Counties, including age distribution, median household income, poverty levels, and rural population density.
- **County Health Rankings & Roadmaps:** Evaluates overall community wellness by comparing health outcomes (length and quality of life) against health factors (health behaviors, clinical care, social and economic factors, and physical environment) relative to other Virginia localities.
- **Virginia Department of Health (VDOH) Health Opportunity Index (HOI):** Measures how social determinants of health—such as housing affordability, educational attainment, access to care, and economic opportunity—impact life expectancy and health outcomes at a localized census-tract level.
- **U.S. Health Equity Atlas:** Contextualizes local data within broader regional and national trends, identifying systemic disparities, access gaps, and targeted areas where structural interventions can drive health equity.

Wythe & Bland County, VA - Population Profiles
US Census Bureau Data

Population	Bland County	Wythe County
Population Estimates, July 1, 2025	6,151	27,983
Population Estimates, April 1, 2020	6,272	28,292
Population percent change – April 1, 2020 – July 1, 2025	-1.9%	-1.1%
Population Census, April 1, 2020	6,270	28,290
Population Census, April 1, 2010	6,824	29,235

Age and Sex	Bland County	Wythe County
Persons under 5 years, percent	3.9%	4.9%
Persons under 18 years, percent	14.5%	19.0%
Persons 65 years and over, percent	26.9%	24.3%
Female persons, percent	44.9%	51.4%

Race and Hispanic Origin	Bland County	Wythe County
White alone, percent	93.9%	93.1%
Black alone, percent	3.1%	2.8%
American Indian and Alaska Native alone, percent	0.2%	0.4%
Asian alone, percent	0.4%	0.5%
Two or more races, percent	3.0%	3.2%
Hispanic or Latino, percent	1.1%	1.5%

Population Characteristics	Bland County	Wythe County
Veterans, 2020-2024	362	1,636
Foreign-born persons, percent, 2020-2024	0.3%	1.4%

Housing	Bland County	Wythe County
Housing Units, July 1, 2025	3,241	14,209
Owner-occupied housing unit rate, 2020-2024	86.5%	77.0%
Median value of owner-occupied housing units, 2020-2024	$152,100	$171,200
Median selected monthly owner costs – with a mortgage, 2020-2024	$1,158	$1,129
Median selected monthly owner costs – without a mortgage, 2020-2024	$332	$383
Median gross rent, 2020-2024	$644	$764
Building permits, 2025	10	81

Families & Living Arrangements	Bland County	Wythe County
Households, 2020-2024	2,376	12,533
Persons per household, 2020-2024	2.27	2.23
Living in the same house 1 year ago, percent of persons age 1 year+, 2020-2024	86.7%	92.5%
Language other than English spoken at home, percent of persons age 5+	2.3%	1.8%

Computer and Internet Use	Bland County	Wythe County
Households with a computer, percent, 2020-2024	81.4%	91.2%
Households with a broadband Internet subscription, percent, 2020-2024	70.5%	82.9%

Education	Bland County	Wythe County
High school graduate or higher, percent of persons age 25+, 2020-2024	92.4%	90.2%
Bachelor's degree or higher, percent of persons age 25+ years, 2020-2024	18.4%	19.4%
Health	**Bland County**	**Wythe County**
With a disability, under age of 65 years, 2020-2024	10.5%	13.7%
Persons without health insurance, under age of 65 years, 2017-2021	6.4%	8.6%
Economy	**Bland County**	**Wythe County**
In civilian labor force, total, percent of population age 16+ years, 2020-2024	43.0%	55.6%
In civilian labor force, female, percent of population age 16+ years, 2020-2024	41.6%	50.0%
Total health care and social assistance receipts/revenue, 2022 ($1,000)		152,513
Total transportation and warehousing receipts/revenue, 2022 ($1,000)	4,239	59,420
Total retail sales, 2022 ($1,000)	121,477	1,162,367
Total retail sales per capita, 2022 ($1,000)	$19,791	$41,343
Transportation	**Bland County**	**Wythe County**
Mean travel time to work (minutes), workers ages 16+, 2020-2024	27.5	24.3
Income and Poverty	**Bland County**	**Wythe County**
Median household income (in 2024 dollars), 2020-2024	$61,216	$57,745
Per capita income in past 12 months (in 2024 dollars), 2020-2024	$30,833	$34,875
Persons in poverty, percent	14.6%	11.8%
Businesses	**Bland County**	**Wythe County**
Total employer establishments, 2023	70	691
Total employment, 2023	1,282	9,944
Total annual payroll, 2023 ($1,000)	105,936	446,041
Total employment, percent change, 2022-2023	5.1%	2.0%
Total non-employer establishments, 2023	285	1,685
All employer firms, Reference year 2023	58	531
Geography	**Bland County**	**Wythe County**
Population per square mile, 2020	17.5	61.2
Population per square mile, 2010	19.1	63.3
Land area in square miles, 2020	357.65	461.95
Land area in square miles, 2010	357.73	461.82
FIPS Code	51021	51197

Source: United States Census – Quick Facts

Health Ranking Comparison
County Health Rankings and Roadmaps

	Bland County	Wythe County	Virginia	United States
Health Outcomes				
Premature Death	8,300	12,100	6,700	8,100
Poor or Fair Health	19%	20%	20%	20%
Poor Physical Health Days	4.7	5.0	4.6	4.5
Poor Mental Health Days	5.9	6.3	5.8	5.7
Low Birthweight	11%	9%	8%	8%
Health Factors				
Adult Smoking	16%	17%	15%	16%
Adult Obesity	36%	38%	38%	38%
Food Insecurity	13%	16%	12%	14%
Physical Inactivity	24%	26%	26%	27%
Access to Exercise Opportunities	90%	71%	84%	84%
Alcohol-Impaired Driving Deaths	14%	15%	29%	26%
Sexually Transmitted Infections	161.8	195.7	472.8	492.2
Teen Births	15	25	12	15
Clinical Care				
Uninsured	6%	8%	7%	9%
Primary Care Physicians		2,160:1	1,320:1	1,310:1
Dentists	2,060:1	2,810:1	1,310:1	1,340:1
Mental Health Providers	1,240:1	360:1	350:1	290:1
Preventable Hospital Stays	2,811	3,201	2,649	2,769
Mammography Screening	43%	40%	47%	46%
Flu Vaccines	34%	44%	47%	44%
Access to Exercise Opportunities	90%	71%	84%	84%
Social & Economic Factors				
High School Completion	91%	90%	91%	89%
Some college	39%	57%	72%	68%
Unemployment	3.3%	3.0%	2.9%	4.0%
Children in Poverty	17%	25%	13%	17%
Income Inequality	3.9	5.0	4.8	4.9
Children in Poverty	16%	19%	13%	16%
Social Associations	9.7	11.4	11.1	9.1
Injury Deaths	106	104	78	87
Physical Environment				
Air Pollution – Particulate Matter	6.3	6.4	6.7	7.3
Broadband Access	70%	83%	91%	91%
Severe Housing Problems	10%	9%	14%	17%
Driving Alone to Work	82%	83%	69%	70%
Long Commute – Driving Alone	41%	28%	40%	37%

Source: www.countyhealthrankings.com

VDH VIRGINIA DEPARTMENT OF HEALTH — HEALTH OPPORTUNITY INDEX

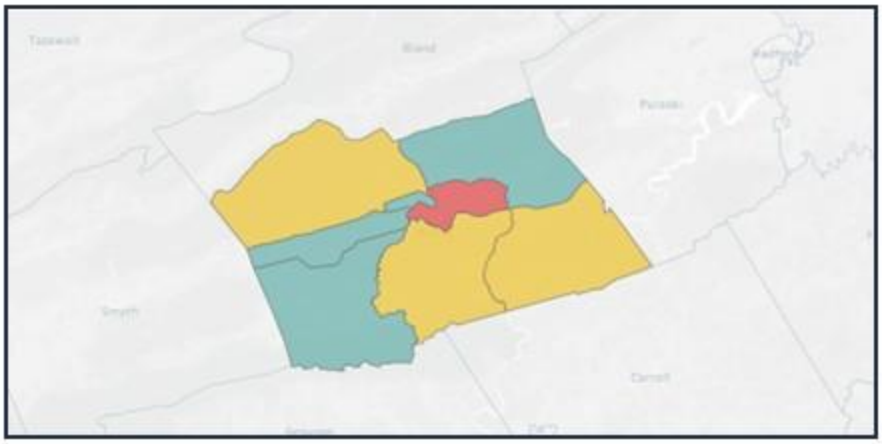
Health Matters, Place Matters

Wythe County

Health District: **Mount Rogers**

This report was created January 29, 2025

Census Tracts in **Wythe County** by HOI Composite Quintile:



Count of census tracts in the county by HOI Composite Quintile:

Quintile 5	Quintile 4	Quintile 3	Quintile 2	Quintile 1
Very High	High	Moderate	Low	Very Low
0	0	4	3	1

HOI composite score and profile scores range from 0 to 1. The closer the score is to zero, the lower the chances for residents in the census tract to experience the opportunity for good health. Conversely, the closer the score is to 1, the greater the chances that residents will experience high opportunities for good health. You can also gauge health opportunity by looking at the Quintile. Quintile 5 reflects very high health opportunity. Quintile 1 reflects very low health opportunity. Life expectancy can also help gauge health opportunity.

For more detail about each tract, launch the interactive HOI map:
https://apps.vdh.virginia.gov/omhhe/hoi/hoi-dashboard

CHRONIC DISEASE PREVALENCE

Orange indicates rate at highest/worst level (Top 20%)

Arthritis: **33.7**	COPD: **8.9**
Binge Drinking: **17.2**	Smoking: **14.6**
High BP*: **41.6**	Diabetes: **13.9**
Cancer: **11**	HCHOL*: **41.5**
Asthma: **10.6**	Obesity: **38.4**
Heart Disease: **8.3**	Stroke: **4.1**

* BP = Blood Pressure, HCHOL = High Cholesterol

% COUNTY POP BY RACE

Population of 1 Race Alone

AIAN*: **0.22%**
% Total Pop AIAN in VA: 0.46%

Asian: **0.42%**
% Total Pop Asian in VA: 7.13%

Black or AA*: **2.50%**
% Total Pop Black or AA in VA: 18.62%

NH or PI*: **0.01%**
% Total Pop NH or PI in VA: 0.08%

Some Other Race: **0.56%**
% Total Pop Some Other Race in VA: 5.17%

Two or More Races: **3.81%**
% Total Pop Two or More Races in VA: 8.18%

White: **92.49%**
% Total Pop White in VA: 60.35%

% COUNTY POPULATION BY GENERATION

County Overview

Total Land Area: **461.9 sq mi**
Total Land Area in VA: 39,490 sq mi

Total Census Tracts: **8**
Total Census Tracts in VA: 2,168

Total Population: **28,290**
Total Population in VA: 8,631,393

Median Age: **45.9**
Median Age in VA: 39.3

Average Life Expectancy: **73.7**
Life Expectancy in VA: 78.1

Total Housing Units: **13,990**
Total Housing Units in VA: 3,618,247

Total Households: **12,396**
Total Households in VA: 3,402,670

Median HH Income: **$55,359**
Median Household Inc. in VA: $89,931

Disabled Population: **19.7%**
Disabled Population in VA: 12.8%

No Health Coverage: **6.0%**
Pop with No Health Coverage in VA: 6.4%

Poverty Rate: **15.6%**
Poverty Rate in VA: 10.2%

Pop 25+ w/HS Deg or Less: **47.3%**
Pop age 25+ with HS Deg or Less in VA: 32.5%

* AIAN = American Indian or Alaska Native, AA = African American, NH or PI = Native Hawaiian or Pacific Islander

Data Sources: 2024 CDC PLACES, 2018 NCHS, 2020 US Census and 2022 American Community Survey (ACS) 5-Year

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VDH VIRGINIA DEPARTMENT OF HEALTH | HEALTH OPPORTUNITY INDEX

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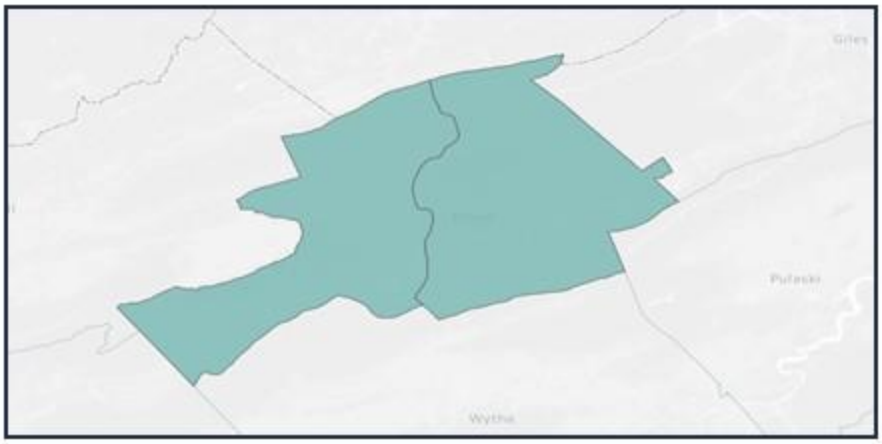

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Very High	High	Moderate	Low	Very Low
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For more detail about each tract, launch the interactive HOI map:
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CHRONIC DISEASE PREVALENCE

Orange indicates rate at highest/worst level (Top 20%)

Arthritis: **34.3**	COPD: **9.3**
Binge Drinking: **17.9**	Smoking: **16.3**
High BP*: **39.8**	Diabetes: **13.9**
Cancer: **10.7**	HCHOL*: **41.5**
Asthma: **9.8**	Obesity: **39.8**
Heart Disease: **8.6**	Stroke: **4.2**

* BP = Blood Pressure, HCHOL = High Cholesterol

% COUNTY POP BY RACE

Population of 1 Race Alone

- AIAN*: **0.00%** — % Total Pop AIAN in VA: 0.46%
- Asian: **0.10%** — % Total Pop Asian in VA: 7.13%
- Black or AA*: **2.70%** — % Total Pop Black or AA in VA: 18.62%
- NH or PI*: **0.00%** — % Total Pop NH or PI in VA: 0.08%
- Some Other Race: **0.11%** — % Total Pop Some Other Race in VA: 5.17%
- Two or More Races: **3.41%** — % Total Pop Two or More Races in VA: 8.18%
- White: **93.68%** — % Total Pop White in VA: 60.35%

% COUNTY POPULATION BY GENERATION

County Overview

- Total Land Area: **357.6 sq mi**
  Total Land Area in VA: 39,490 sq mi
- Total Census Tracts: **2**
  Total Census Tracts in VA: 2,168
- Total Population: **6,270**
  Total Population in VA: 8,631,393
- Median Age: **47.1**
  Median Age in VA: 39.3
- Average Life Expectancy: **75.7**
  Life Expectancy in VA: 78.1
- Total Housing Units: **3,200**
  Total Housing Units in VA: 3,618,247
- Total Households: **2,345**
  Total Households in VA: 3,402,670
- Median HH Income: $**61,375**
  Median Household Inc. in VA: $89,931
- Disabled Population: **16.7%**
  Disabled Population in VA: 12.8%
- No Health Coverage: **2.7%**
  Pop with No Health Coverage in VA: 6.4%
- Poverty Rate: **12.7%**
  Poverty Rate in VA: 10.2%
- Pop 25+ w/HS Deg or Less: **53.5%**
  Pop age 25+ with HS Deg or Less in VA: 32.5%

* AIAN = American Indian or Alaska Native, AA = African American, NH or PI = Native Hawaiian or Pacific Islander

Data Sources: 2024 CDC PLACES, 2018 NCHS, 2020 US Census and 2022 American Community Survey (ACS) 5-Year

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PULSE: U.S. HEALTH EQUITY ATLAS

Bland County, Virginia

Community Health Needs Assessment

Grant-ready data and partnership opportunities

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HOW TO READ THIS SCORE

The composite Gap Score ranks this county against all 3,144 U.S. counties on 8 equally-weighted dimensions. A lower (greener) score means a smaller gap relative to peers - not that no gap exists. Use it to spot patterns, then drill into individual dimensions and the methods.

Community Need Narrative

Bland County, Virginia is a rural community of 6,179 residents facing moderate but persistent health equity challenges. With a Health Equity Gap Score of 42.7/100, it ranks #80 among 133 counties in Virginia for overall health need.

Residents live an average of 75.5 years - 2.9 years shorter than the national average. 5.7% lack health insurance, and 12.5% experience food insecurity.

Affected Population Profile

* Total population: 6,179
* Classification: Rural
* Estimated uninsured residents: 352
* Social Vulnerability Index: 0.10 (0-1 scale; higher = more vulnerable)
* Socioeconomic vulnerability: 0.05
* Minority status vulnerability: 0.13
* Housing & transportation vulnerability: 0.62
* Limited English proficiency: 0.0%
* No-vehicle households: 8.1%
* Food insecurity: 12.5%

Key Health Disparities

* Uninsured Rate: 5.7% (national: 9.2%)
* Maternal Mortality: 31.2 per 100k births (national: 22.3 per 100k births) - DISPARITY
* Diabetes: 10.5% (national: 10.9%)
* Hypertension: 32.9% (national: 32.5%) - DISPARITY
* Obesity: 36.2% (national: 31.9%) - DISPARITY
* Life Expectancy: 75.5 years (national: 78.4 years) - DISPARITY

PULSE: U.S. HEALTH EQUITY ATLAS

Wythe County, Virginia

Community Health Needs Assessment

Grant-ready data and partnership opportunities

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HOW TO READ THIS SCORE

The composite Gap Score ranks this county against all 3,144 U.S. counties on 8 equally-weighted dimensions. A lower (greener) score means a smaller gap relative to peers - not that no gap exists. Use it to spot patterns, then drill into individual dimensions and the methods.

Community Need Narrative

Wythe County, Virginia is a micropolitan community of 28,104 residents facing moderate but persistent health equity challenges. With a Health Equity Gap Score of 40.9/100, it ranks #90 among 133 counties in Virginia for overall health need.

Residents live an average of 72.6 years - 5.8 years shorter than the national average. 7.5% lack health insurance, and 15.9% experience food insecurity.

Affected Population Profile

- Total population: 28,104
- Classification: Micropolitan
- Estimated uninsured residents: 2,108
- Social Vulnerability Index: 0.41 (0-1 scale; higher = more vulnerable)
- Socioeconomic vulnerability: 0.38
- Minority status vulnerability: 0.13
- Housing & transportation vulnerability: 0.40
- Limited English proficiency: 1.0%
- No-vehicle households: 7.6%
- Food insecurity: 15.9%

Key Health Disparities

- Uninsured Rate: 7.5% (national: 9.2%)
- Maternal Mortality: 19.0 per 100k births (national: 22.3 per 100k births)
- Diabetes: 11.0% (national: 10.9%) - DISPARITY
- Hypertension: 33.4% (national: 32.5%) - DISPARITY
- Obesity: 38.4% (national: 31.9%) - DISPARITY
- Life Expectancy: 72.6 years (national: 78.4 years) - DISPARITY

Community Health Needs Assessment Stakeholder Survey Methodology & Survey Results

A fundamental component of the Community Health Needs Assessment (CHNA) is gathering direct primary data from community members, organizational leaders, and healthcare stakeholders across Wythe and Bland Counties. The primary objective of the survey was to capture qualitative and quantitative insights into pressing community health concerns, system gaps, barriers to care, and social determinants of health.

1. Survey Methodology & Sample Overview

- Instrument Design: The 2026 survey instrument comprised 45 structured questions incorporating multiple-choice items, multi-select checkboxes, Likert-scale ratings, priority ranking lists, and open-ended qualitative prompts.
- Data Collection & Distribution: The survey was administered electronically and distributed through community partner meetings, regional health networks, nonprofit leadership coalitions, and direct stakeholder outreach.
- Respondent Sample: A total of 109 completed survey responses were recorded.
- Geographic Distribution: Respondents represented all primary service jurisdictions across both counties:
    - Wythe County: 66.1%
    - Bland County: 18.3%
    - Town of Wytheville: 11.9%
    - Town of Rural Retreat: 3.7%

The survey structure guided participants through four primary domains:

- Perceived Health Status & Access Barriers: Ratings of individual and community health, healthcare access quality, and specific service gaps (e.g., specialty care, psychiatry, women's health).
- Behavioral Health & Addiction Metrics: Dedicated evaluations of mental health impacts, specific substances of concern (e.g., methamphetamine, opioids), and barriers to treatment (e.g., cost, stigma, provider shortages).
- Social Determinants of Health (SDOH): Ranking of structural community issues, including affordable housing, employment opportunities, childcare, and transportation.
- Strategic Priority Ranking: Forced-choice prioritization of Foundation investment areas and identification of populations requiring targeted support.

2. Detailed Survey Results

Community Health Perceptions

- Overall Community Health Rating: 77.1% of stakeholders rated the overall health of their community as "Fair" (56.0%), "Poor" (20.2%), or "Very Poor" (0.9%). Only 22.9% rated community health as "Good," with zero respondents selecting "Excellent."
- Top Overall Health Concerns**:** When asked to select up to 3 health issues that most affect the community today, respondents identified:
    1. Adult Obesity: 56.9%
    2. Substance Use / Addiction: 54.1%
    3. Mental Health Concerns: 54.1%
    4. Heart Disease: 37.6%
    5. Cancer: 31.2%
    6. Aging-Related Issues: 29.4%

Healthcare Access & Service Gaps

- Healthcare Access Ratings: 38.5% rated overall community healthcare access as "Good," 26.6% as "Fair," 24.8% as "Very Good," 7.3% as "Poor," and 2.8% as "Excellent."
- Most Difficult Healthcare Services to Access:
    - Specialty Medical Care: 58.7%
    - Mental Health Counseling: 34.9%
    - Women's Health Services: 31.2%
    - Psychiatry: 30.3%
    - Substance Use Treatment: 28.4%
    - Dental Care: 26.6%
- Primary Barriers to Treatment Access: Financial Cost (59.6%), Lack of Local Providers (50.5%), Lack of Resource Information (49.5%), Social Stigma (47.7%), and Transportation Limitations (46.8%).

Behavioral Health & Substance Threats

- Community Impact Severity: 63.3% of stakeholders rated mental health concerns as a "Significant" (35.8%) or "Very Significant" (27.5%) community concern. Similarly, 68.8% rated substance abuse/addiction as "Very Significant" (38.5%) or "Significant" (30.3%).
- Substances of Primary Concern:
    - Methamphetamine: 87.2%
    - Opioids: 70.6%
    - Alcohol: 58.7%

- Prescription Drug Misuse: 52.3%

Social Determinants of Health (SDOH) & Targeted Populations

- Top Community Infrastructure Issues Needing Attention:
  - Affordable Housing: 63.3%
  - Employment & Economic Opportunities: 46.8%
  - Childcare Availability: 44.0%
  - Transportation Infrastructure: 35.8%
  - Senior Services: 35.8%
- Populations Needing Additional Support: Older Adults (75.2%), Low-Income Families (55.0%), and People with Disabilities (51.4%).

Priority Focus Areas

Synthesizing secondary health metrics with local stakeholder input reveals four strategic priority areas:

- **Healthcare Access & Specialty Provider Capacity:** County Health Rankings and U.S. Health Equity Atlas data highlight geographic and economic barriers to clinical care in rural Southwest Virginia. Stakeholders identified specialty care, mental health counseling, women's health, and psychiatry as the most difficult local services to access. These access gaps are amplified by out-of-pocket costs, provider shortages, transportation limitations, and appointment wait times.
- **Chronic Disease Prevention & Healthy Living:** Elevated rates of adult obesity, cardiovascular disease, and cancer reflected in state health databases align with community concerns. Shifting long-term population outcomes requires proactive chronic disease management, improved access to nutritious foods, and safe opportunities for physical activity.
- **Behavioral Health and Substance Abuse**: Regional health statistics, state equity metrics, and local survey data demonstrate that mental health conditions and substance use disorders represent one of the area's most pressing health priorities.
- **Social Determinants of Health & Community Infrastructure:** The VDH Health Opportunity Index underscores that community health is fundamentally linked to broader environmental conditions. Stakeholders emphasized that health improvements depend heavily on structural infrastructure, prioritizing affordable housing, economic and employment development, childcare availability, and reliable public transportation.

The table below maps the primary priority focus areas identified by stakeholders to corresponding quantitative sub-measures and secondary data indicators tracked across regional health systems:

Priority Focus Areas	Core Survey Findings & Sub-measures	Secondary Data Tracking Indicators
Healthcare Access & Specialty Provider Capacity	-58.7% reported specialty care as difficult to access -Primary barriers: Cost (59.6%), Provider shortages (50.5%), Transportation (46.8%)	-Primary care provider-to-patient ratio -Mental health provider-to-patient ratio -Uninsured rate (% under 65) -Preventable hospital stays
Chronic Disease & Healthy Living	-Concerns: Obesity (56.9%) , Heart Disease (37.6%), Cancer (31.2%), Aging Issues (29.4%) -51.4% of respondents find it difficult or very difficult to access healthy foods locally	-Adult obesity prevalence (% BMI ≥ 30) -Diabetes and cardiovascular mortality rates -Food Insecurity Index score -Physical inactivity rates
Behavioral Health & Substance Use	-Mental health (54.1%) and Substance Abuse (54.1%) identified as top concerns -Key threats reported: Methamphetamine (87.2%), Opiods (70.6%), Prescription misuse (52.3%) -Over 68% of respondents rated addiction as significant or very significant	-Drug overdose mortality rate -Poor mental health days (per month) -Suicide mortality rate -Children with Neonatal Abstinence Syndrome (NAS)
Social Determinants of Health & Community Infrastructure	-Top Social Determinants of Health needs reported: Affordable Housing (63.3%), Employment (46.8%), Childcare (44.0%), Transportation (35.8%) -Priority groups: Older Adults (75.2%), Low-Income Families (55.0%)	-VDH Health Opportunity Index score -Median household income -Child poverty rate -Severe housing cost burden
	Source: -2026 Wythe-Bland Foundation Community Health Needs Assessment survey results	Sources: -County Health Rankings -Virginia Department of Health -Health Equity Atlas

Results of Gaps and Assets Analysis

A core requirement of the Community Health Needs Assessment (CHNA) is synthesizing system deficiencies and unmet community needs (**Gaps**) alongside existing local resources and programs (**Assets**). This updated analysis blends quantitative data from state and national databases—including the County Health Rankings, the Virginia Department of Health (VDH) Health Opportunity Index (HOI), and the U.S. Health Equity Atlas—with local stakeholder survey findings across Wythe and Bland Counties.

Priority Focus Areas	Quantitative Baseline Metrics	Community Assets	Community Survey Respondent Identified Gaps
Healthcare Access & Specialty Provider Capacity	Below-average provider ratios; elevated uninsured and preventable hospital stay rates	-Hospital Emergency Department -Urgent care -Primary care practices -Federally Qualified Health Center -Quasi-free health clinic -Nonprofit Dental clinics -Medical transportation program	Specialty care wait times (58.7%); cost barriers (59.6%); provider shortages (50.5%)
Chronic Disease & Healthy Living	Adult obesity rates above state median; elevated heart disease & cancer mortality	-Walking trails -Nonprofit food access and distribution programs -Community Farmers Markets SNAP vouchers -Food pantries -Nutrition classes -Community wellness program -Wellness Center scholarships -Emergency Services access	High obesity prevalence (56.9%); food costs (51.4%); screening gaps
Behavioral Health & Substance Use	Higher overdose death rates; elevated suicide rates; NAS occurrence in births	-Community Services Board -Peer support groups -Hospital Emergency Department -Law enforcement -Health provider intervention -VA 211	Meth/opioid impact (87.2%)/(70.6%); stigma (47.7%); shortage of counselors/psychiatrists (34.9%)
Social Determinants of Health & Community Infrastructure	Lower HOI economic mobility; median income below state average; child poverty	-Wytheville Community College scholarship for Wythe County & Bland County graduates -Department of Social Services -Public transportation system -Nonprofit food delivery program -Virginia Employment Commission -Workforce Development programs	Affordable housing deficits (63.3%); childcare shortages (44.0%); lack of public transit (35.8%)

Conclusion

As hospitals, health systems, and community partners continue working to improve health outcomes across their primary service areas, identifying and prioritizing population health issues remains essential for strategic impact. Wythe and Bland Counties operate within a collaborative regional network where population health is supported through the shared leadership of local governments—including Bland County, Wythe County, the Town of Rural Retreat, and the Town of Wytheville—alongside regional healthcare anchors such as Wythe County Community Hospital and local primary care networks.

Because Wythe and Bland Counties face complex, interconnected health and social challenges, strategic prioritization is vital to deploying limited resources effectively. Aligning health system resources with multi-sector partnerships across local government, social services, philanthropy, and grassroots community organizations builds a sustainable foundation for long-term community well-being.

Key findings from the Community Health Needs Assessment highlight specific focus areas for healthcare service delivery, behavioral health, and non-clinical community infrastructure:

- **Healthcare Service Access & Specialist Capacity:**
    - **Specialty Care:** Local access to specialized medical services remains a primary concern, driven by long wait times and the need to travel outside the immediate area for advanced care.
    - **Behavioral Health & Psychiatry:** Broadening outpatient mental health counseling and psychiatric care continues to be a critical priority across all age demographics.
    - **Women's Health & Primary Care:** Sustained efforts are needed to recruit and retain primary care providers, obstetricians, and gynecologists to ensure local continuity of care.
    - **Dental Health:** Expanding access to affordable, routine, and restorative dental services remains a key barrier for many community members.
- **Population Health & Socioeconomic Focus Areas:**
    - **Behavioral Health & Substance Use:** Addressing substance use disorders and mental health challenges requires comprehensive attention, with a focus on prevention, treatment, and recovery support.
    - **Chronic Disease & Healthy Living:** Proactive focus must remain on reducing the burden of chronic conditions—such as obesity, heart disease, diabetes, and cancer—by expanding access to healthy foods and wellness opportunities.
    - **Community Infrastructure & Economic Drivers:** Long-term population health depends heavily on addressing non-clinical drivers, specifically workforce affordable housing, economic and job growth, accessible childcare, and rural transportation options.

Improving population health across Wythe and Bland Counties is a shared commitment that requires sustained alignment across health systems, local government, philanthropy, and community partners. This assessment serves as a shared framework to guide joint investments, align community assets, and build a healthier, more resilient region for every resident.

Glossary of Key Terms

- **Adverse Childhood Experiences (ACEs):** Potentially traumatic events that occur in childhood—such as experiencing abuse or neglect, witnessing violence, or growing up in a household with substance use or mental health problems—which can have lifelong impacts on health and opportunity.
- **Behavioral Health:** A broad term covering the promotion of mental well-being, the treatment of mental health conditions, and interventions for substance use disorders.
- **Clinical Care:** Medical services provided by healthcare professionals, including access to primary care doctors, specialty physicians, mental health clinicians, urgent care, preventive screenings, and hospital services.
- **Health Behaviors:** Individual actions and lifestyle choices that affect personal and public health, such as physical activity levels, diet and nutrition, tobacco use, alcohol consumption, and medication adherence.
- **Health Disparities:** Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.
- **Health Opportunity Index (HOI):** A composite metric developed by the Virginia Department of Health (VDH) that measures complex social, economic, and environmental factors at the census-tract level to determine a community's overall opportunity for health and well-being.
- **Neonatal Abstinence Syndrome (NAS):** A drug withdrawal syndrome occurring in newborns exposed to addictive substances (most commonly opioids) while in the womb.
- **Physical Environment:** The natural and built surroundings in which people live, including air and water quality, housing safety, access to parks and recreational areas, walkability, transit options, and exposure to environmental hazards.
- **Social Determinants of Health (SDOH):** The non-medical conditions in which people are born, grow, live, work, and age—including household income, education, stable housing, reliable transportation, food security, and social support networks—that shape daily health outcomes.
- **Social and Economic Factors:** Community-level socioeconomic drivers such as employment opportunities, poverty rates, median household income, educational attainment, community safety, and family support systems.
- **Substance Use Disorder (SUD):** A complex clinical condition characterized by the uncontrollable use of substances (such as opioids, methamphetamine, alcohol, or prescription drugs) despite harmful consequences to physical, mental, or social health.

2026 Community Health Needs Assessment Survey

The Wythe-Bland Foundation is conducting this survey to better understand the health needs, concerns, and priorities of residents in Wythe and Bland Counties. Your responses will help guide future investments, programs, and partnerships to improve community health and well-being.
This survey is anonymous. Intended participants are residents of Wythe and Bland Counties and participation is voluntary. The survey takes approximately 10-15 minutes to complete.

* Required

About You

1. In which locality do you live? *

- ◯ Wythe County
- ◯ Bland County
- ◯ Town of Wytheville
- ◯ Town of Rural Retreat

2. How long have you lived in the area? *

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ More than 10 years
- ◯ Lifelong resident

3. What is your age? *

- ◯ Under 18
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65-74
- ◯ 75+

4. What is your gender? *

- ◯ Female
- ◯ Male
- ◯ Prefer not to answer
- ◯ Other

5. Which best describes your race/ethnicity? (Select all that apply) *

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Prefer not to answer
- ☐ Other

6. What is your household income? *

- ◯ Under $25,000
- ◯ $25,000-$49,999
- ◯ $50,000-$74,999
- ◯ $75,000-$99,999
- ◯ $100,000+
- ◯ Prefer not to answer

Section 2: Overall Health

7. How would you rate your overall health? *

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Very good

8. How would you rate the overall health of your community? *

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Very poor

9. Based on your experience and observations, what do you feel are the three health issues that most affect our community today? (Select up to 3.) *

Please select 3 options.

- ☐ Heart disease
- ☐ Cancer
- ☐ Obesity
- ☐ Substance use/addiction
- ☐ Mental health concerns
- ☐ Tobacco use
- ☐ Chronic pain
- ☐ Respiratory diseases
- ☐ Alzheimer's/dementia
- ☐ Maternal and infant health
- ☐ Aging-related issues
- ☐ Other

Access to Healthcare

10. Do you have health insurance? *

- ◯ Yes
- ◯ No

11. When you get sick, where do you go? *

- ◯ Clinic/Doctor's office
- ◯ Urgent Care
- ◯ Emergency Department (ER)
- ◯ Health Department
- ◯ I don't seek medical attention.
- ◯ Other

12. Do you have a primary care provider? *

- ◯ Yes
- ◯ No

13. In the past 12 months, was there a time when you needed healthcare, but could not get it? *

- ◯ Yes
- ◯ No

14. If yes, what were the reasons? (Select all that apply.)

- [ ] Cost
- [ ] Lack of insurance
- [ ] Could not get an appointment
- [ ] Transportation problems
- [ ] Distance to provider
- [ ] Childcare responsibilities
- [ ] Work schedule
- [ ] Lack of needed specialist nearby

15. How would you rate access to healthcare services in the community? *

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

16. Which healthcare services are most difficult to access locally? (Select all that apply.) *

- [ ] Primary care
- [ ] Mental health counseling
- [ ] Psychiatry
- [ ] Substance use treatment
- [ ] Dental care
- [ ] Vision care
- [ ] Specialty care
- [ ] Women's health services
- [ ] Pediatric care
- [ ] Home health services
- [ ] Senior care services
- [ ] Other

Mental Health and Substance Use

17. Based on your experience and observations, how would you rate the impact of mental health concerns in your community? *

- ◯ Not a concern
- ◯ Slight concern
- ◯ Moderate concern
- ◯ Significant concern
- ◯ Very significant concern
- ◯ Don't know/Unsure

18. Based on your experience and observations, how would you rate the impact of substance abuse or addiction in your community? *

- ◯ Not a concern
- ◯ Slight concern
- ◯ Moderate concern
- ◯ Significant concern
- ◯ Very significant concern
- ◯ Don't know/Unsure

19. Which substances are most concerning in your community? (Select all that apply.) *

- [ ] Opioids
- [ ] Methamphetamine
- [ ] Alcohol
- [ ] Prescription drug misuse
- [ ] Marijuana
- [ ] Tobacco/Nicotine
- [ ] Other

20. What barriers prevent people from seeking mental health or addiction treatment? (Select all that apply.) *

- [ ] Cost
- [ ] Lack of providers
- [ ] Transportation
- [ ] Stigma
- [ ] Privacy concerns
- [ ] Long wait times for appointments
- [ ] Lack of information
- [ ] Other

Healthy Living and Chronic Disease

21. How easy is it for residents to access healthy foods? *

- ◯ Very easy
- ◯ Easy
- ◯ Difficult
- ◯ Very Difficult

22. How easy is it to find safe places to exercise or be physically active? *

- ◯ Very easy
- ◯ Easy
- ◯ Difficult
- ◯ Very difficult

Community Conditions and Social Determinants of Health

23. How much do the following affect health in Wythe and Bland Counties? *

	Major Impact	Some Impact	Little/No Impact
Affordable Housing	◯	◯	◯
Transportation	◯	◯	◯
Employment Opportunities	◯	◯	◯
Access to broadband/ internet	◯	◯	◯
Education	◯	◯	◯
Childcare availability	◯	◯	◯
Food access	◯	◯	◯
Social isolation	◯	◯	◯
Availability of healthcare providers	◯	◯	◯

24. Based on your experience and observations, which of these community issues most need attention? (Select up to 3.) *

Please select 3 options.

- [ ] Affordable housing
- [ ] Transportation
- [ ] Employment opportunities
- [ ] Childcare
- [ ] Senior services
- [ ] Youth opportunities
- [ ] Public safety
- [ ] Recreation and wellness
- [ ] Other

25. Are there specific areas or populations that need additional support? (Select up to 3.) *

Please select 3 options.

- [ ] Older adults
- [ ] Children
- [ ] Teenagers
- [ ] Young adults
- [ ] Veterans
- [ ] People with disabilities
- [ ] Low-income families

26. What health-related strengths make Wythe and Bland Counties good places to live? *

27. What health-related challenges are unique to your community? *

28. What health services or programs would you most like to see expanded, improved, or added in Wythe and Bland Counties? *

Prioritization

29. Please rank the following priorities from 1 (highest priority) to 5 (lowest priority). *

- Access to healthcare
- Chronic disease prevention
- Healthy aging/senior services
- Mental health
- Substance use treatment

30. If the Wythe-Bland Foundation could invest in one health-related issue over the next five years, what should it be? *

Final Comments

31. Is there anything else that the Wythe-Bland Foundation should know about health and quality of life in Wythe and Bland Counties *