the
HEALTH
collaborative

Dan River Region

HEALTH

Equity Report

2021

EXECUTIVE SUMMARY

UNC GREENSBORO
Center *for* Housing
& Community Studies

the HEALTH collaborative

CONTENTS

INTRODUCTION 1
- Objectives 2
- Geography 3

Current Health Status 5
- Life Expectancy 5
- Chronic Health Issues 7
- Insurance & Medicaid Access 9
- Community Amenities & Resources 10
- Inequities in Health Access & Care 10
- Health Equity Score 12

Determinants of Health 14
- Poverty & Economic Disparities 14
- Rurality as a Social Determinant of Health Inequities 21
- Structural Impediments of Transportation & Housing 22
- Community Safety 25

Eliminating Barriers 27
- Suggestions from Key Informants & Participants 27
  - Universal Coverage 27
  - Funding for More Specialists 28
  - Transportation 28
  - Mobile Clinics & Outreach 29
  - Addressing Food Systems & Housing 31
  - Caring & Resilience 32
- Feedback from the Health Collaborative's Summit 33
  - Setting Priorities 33
  - Balancing Rural vs Urban Communities 34
  - Working Upstream 35

Racial Dimensions of Inequity 36

Recommended Next Steps 41
- ISSUE #1: Racial Disparities in Health Care 41
- ISSUE #2: Poverty as the Root Cause of Disparity 42
- ISSUE #3: Housing Quality, Availability, & Costs 43
- ISSUE #4: Transportation Access 45
- ISSUE #5: Insurance & Health Systems Navigators 46

FIGURES

Figure 1 - Health Equity Assessment Process 1
Figure 2. Danville Census Tracts 3
Figure 3. Dan River Region Census Tracts 4
Figure 4. Map of Life Expectancy, CDC USALEEP 6
Figure 5 Population and Health Characteristics 8
Figure 6 - Health Equity Score Map of Dan River Region 13
Figure 7. Federal Poverty Guideline, 2021 14
Figure 8. Racial composition by City/County, ACS 2019 15
Figure 9. Age-Sex Pyramid, ACS 2019 16
Figure 10. Map of Household Income, ACS 2019 18
Figure 11. Map of Population in Poverty, ACS 2019 19
Figure 12. Educational Attainment by City/County, ACS 2019 20
Figure 13. Map of Cost-Burdened Renters, ACS 2019 23
Figure 14. Map of Households with No Vehicle, ACS 2019 24
Figure 15. Map of Violent Crime 2016-2020 26

INTRODUCTION

This study was conducted by the Center for Housing and Community Studies (CHCS) of the University of North Carolina Greensboro (UNCG) in response to a request from the Health Collaborative, a cross-sector group of residents working together to improve the health and well-being of the Dan River Region. The study reflects a process of community engagement and provides a health equity assessment and health equity report for the Dan River Region, building upon the Danville Pittsylvania County Health Needs Assessment and the Dan River Region Health Equity Report, both conducted in 2017 by the Health Collaborative.

A health equity assessment is a process used by public health organizations to determine priorities, make improvements, or allocate resources on the basis of inequalities in health outcomes. It may be used to determine gaps between community health assets and needs of residents disproportionately impacted

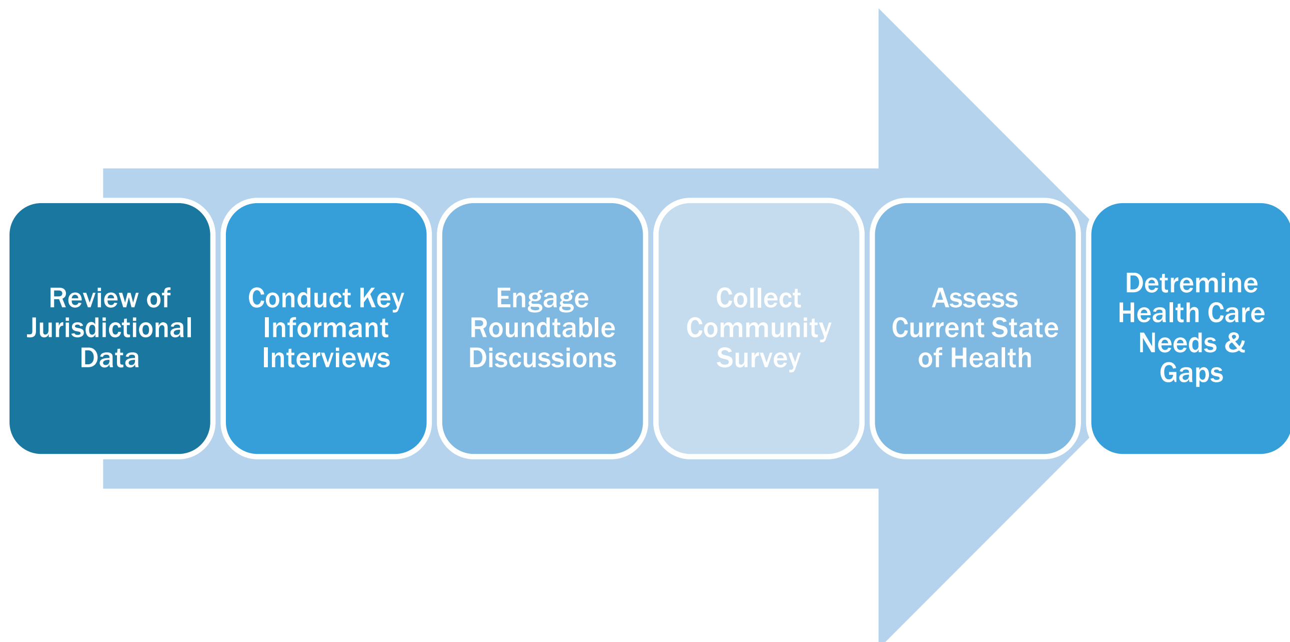


Figure 1. Health Equity Assessment Process

by health issues. The health equity assessment process is collaborative, proactive, multisector, and data driven. It provides an opportunity for building stakeholder support, engaging residents and social service agencies, eliciting health system feedback, and promoting community support. It also provides an opportunity to identify barriers that health impacted communities face in accessing primary health services or addressing Social Determinants of Health (SDOH) such as economic stability, educational and employment opportunities, healthy housing, nutritious foods, active lifestyles, and overall wellbeing.

The Dan River Regional Health Collaborative is a cross-sector group of residents and institutions working to improve the health and well-being of the Dan River Region. To accomplish this work, they have built teams of dedicated volunteers to work on the topics of healthy eating, active living, access to healthcare and creating healthy spaces. In 2017, the Health Collaborative released its first Health Equity Report. Data for the report was gathering data from secondary sources such as the Virginia Department of Health, the North Carolina State Center for Health Statistics, the U.S. Census Bureau, and the U.S. Department of Agriculture as well as from residents through a community health survey, key informant interviews, and focus groups.

Objectives

Our objective in this report was to find out more about people's access to quality health care, whether there are disparities in access to health care and health outcomes based on income, race, gender, age, immigration status or sexual orientation, and what can be done to improve health equity in the region. To do this, we sought information, perspectives and insights from health care providers, public administrators, nonprofit staff members, church and business leaders, community organizers and residents through interview, focus group,

and survey research. We utilized secondary data from local agencies, law enforcement, and health departments, as well as state sources like the Office of Vital Records at the Virginia Department of Public Health and the North Carolina State Center for Health Statistics. We also drew upon data from federal and national sources such as the Center for Disease Control, the American Community Survey, PolicyMap, etc. Our findings may be used to raise awareness about the current state of health care access, assess health care needs and gaps, and to develop recommendations to improve health equity throughout the region.

Geography

The primary administrative districts within the Dan River Region are the counties of Caswell, in North Carolina, and Pittsylvania, in Virginia and the City of Danville in Virginia. Other notable towns include Yanceyville, Blanch, Milton, and Pelham in Caswell County, and Ringgold, Mt. Cross, Dry Fork, Chatham, Gretna, and Hurt in Pittsylvania County.

Danville, VA

Census Tract Boundaries
Data Source: US Census

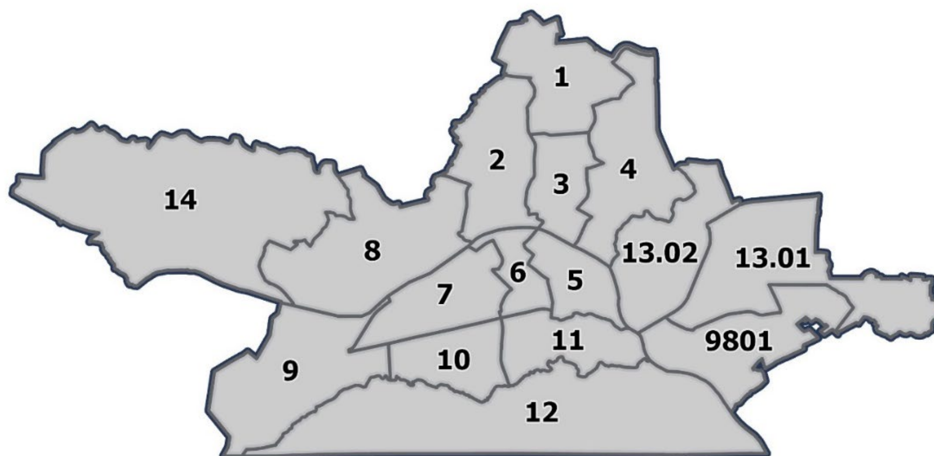
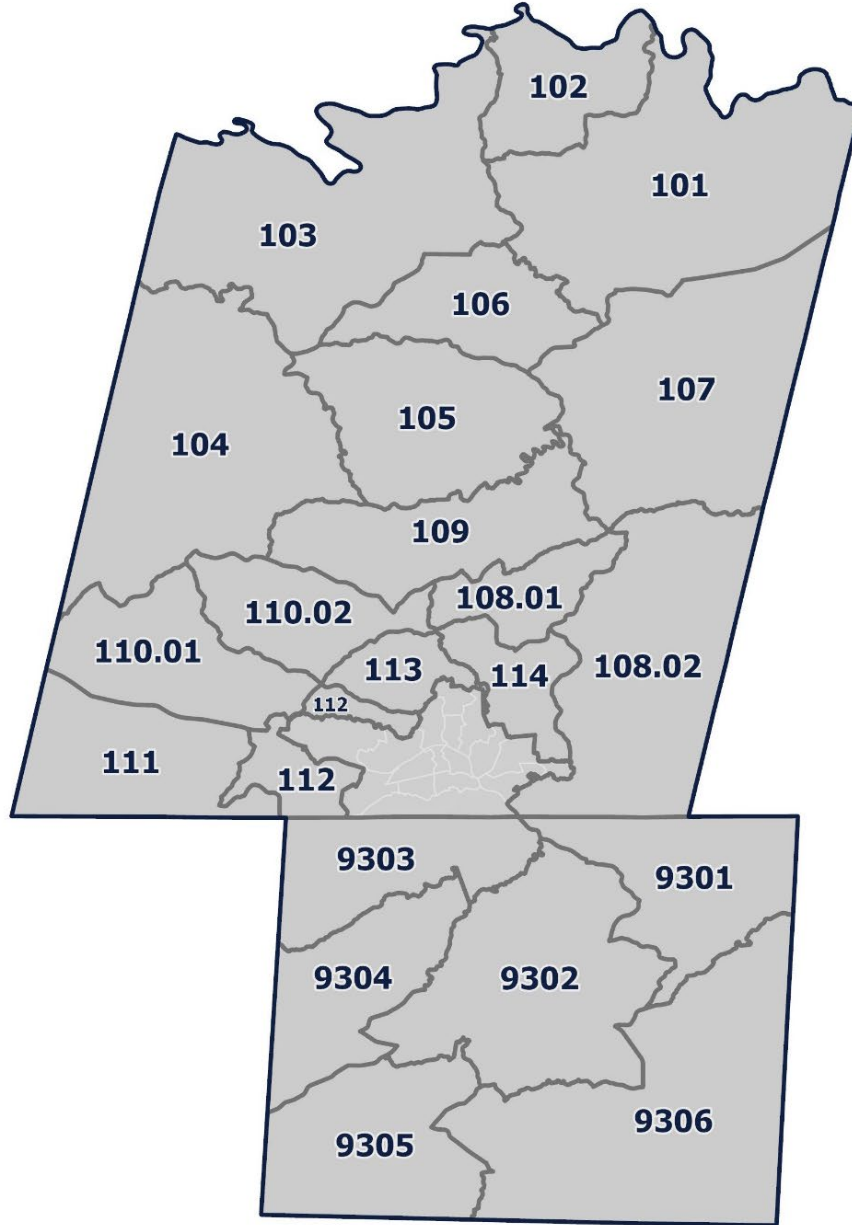


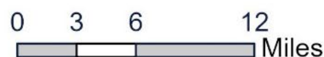
Figure 2. Danville Census Tracts

the HEALTH collaborative

Dan River Region

Census Tract Boundaries
Data Source: US Census





UNC GREENSBORO
Center *for* Housing & Community Studies

Date Created: 8/6/2021

Figure 3. Dan River Region Census Tracts

CURRENT HEALTH STATUS

Life Expectancy

Life expectancy is the average number of years individuals are expected to live in each community. These estimates are influenced by a number of factors such as personal habits (healthy and unhealthy behaviors), genetics, environmental factors, education, income, and place among others. It should be noted that during the study period the national life expectancies fell by an average of 1.5 years due to the emergence of COVID-19. The life expectancy at birth of residents of Virginia is 79.5 and for residents of North Carolina it is 78.1, on par with the national life expectancy of 78.7.

Almost all tracts within the Dan River Region fell below the estimated life expectancy for their respective state. The average (mean) life expectancy in the Region was 74.8 years with a range of 10 years from 68.0 years to 78.2 years. Life expectancy for white residented was 75.0 years on average compared to 73.9 years for African Americans. Life expectancy was used as the outcome variable in the Health Equity Score and was highly correlated with social determinants such as poverty, home ownership, access to preventative care, prevalence of chronic health issues, and community safety. Preventative healthcare in the Region was positively associated with longer life expectancy and better health equity within a neighborhood. Currently, 82% of residents get an annual physical and 61% get annual dental care.

Doctor Checkups

About 82% of the population gets an annual physical.

Dental Checkups

About 61% of the population gets an annual dental care.

Dan River Region

Average Number of Years a Person Can Expect to Live at Birth by Census Tract
Data Source: CDC USALEEP, 2010-2015

US-29N
Hurt
PITTSYLVANIA COUNTY
VA-40E
Gretna
US-29S
Chatham
VA-57E
Dry Fork
VA-41N
DANVILLE
VA-41S
US-58W
US-311N
VA-62
VA-119N
US-29 BUS
VA-86S
NC-62
Pelham
NC-86
Yanceyville
NC-86
NC-62
NC-119
CASWELL COUNTY
NC-86

Life Expectancy

- 68.0 - 72.5
- 72.6 - 74.7
- 74.8 - 75.6
- 75.7 - 76.2
- 76.3 - 78.7

0 3 6 12 Miles

UNC GREENSBORO
Center for Housing & Community Studies

Date Created: 6/30/2021

Figure 4. Map of Life Expectancy, CDC USALEEP

Chronic Health Issues

We asked our interview subjects what they thought were the major health problems in the communities they're a part of or represent. They accurately identified many of the chronic diseases that are prevalent in the Region. One interviewee for example said, "Hypertension, diabetes, COPD, mental health illnesses, kidney disease, those are the major ones right there." Others identified contributing factors such as obesity that are associated to both social determinants and chronic health outcomes as a causal linkage. Behavioral health issues, depression, and substance misuse were also discussed. "We also see plenty of addiction, primarily alcohol and secondarily we see crack and opioids, but primarily alcohol is the most common thing we run into in terms of addiction." Some saw links from substance abuse to other social forces.

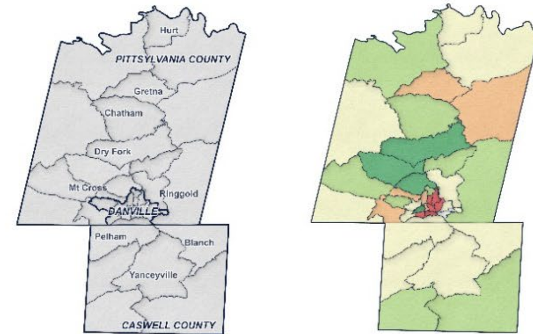
In review of secondary data from the CDC and state health sources we saw that the leading causes of death in the Region were cancer, heart disease, chronic lower respiratory diseases, and unintentional injuries in various orders for each jurisdiction. The prevalence of high blood pressure, high cholesterol, and arthritis were between a third and two-fifths of the population. While the data bears out the evidence of need, there is a lack awareness of personal health issues in the population. One key informant said: "When people have like high blood pressure or diabetes, a lot of times they don't know they have it, because it has become – they can function with it, so a lot of times people don't know until they fall out or they have a stroke or something like that." In the Health Equity Score analysis, we saw very strong statistical correlations between declines in life expectancy at the Census Tract level and diabetes, stroke, coronary heart disease, asthma, high blood pressure, COPD, mental health

UNC GREENSBORO Center *for* Housing & Community Studies

DAN RIVER REGION

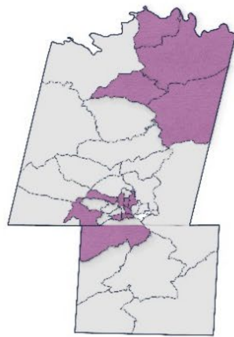
Population & Health Characteristics

Explore and compare the geographic intersections of population characteristics with various health outcomes in the map series below. Each map in the rows below depicts the top two quantiles for each category. Data Sources: UNCG CHCS, 2021; American Community Survey, 2015-2019; CDC Places, 2020

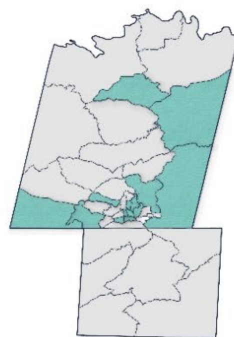


Counties & Townships

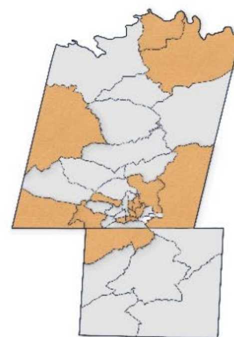
Health Equity Score



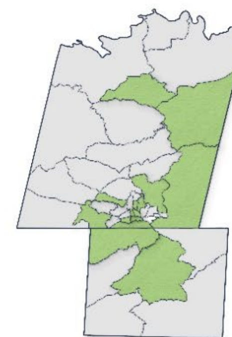
Heart Disease



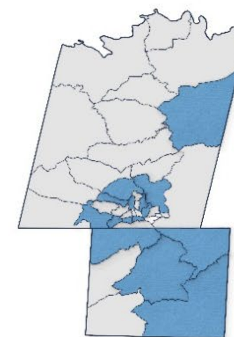
Obesity



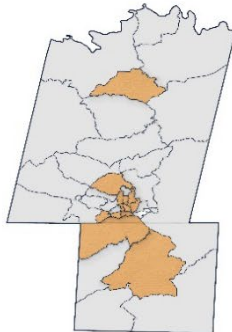
Poor Mental Health



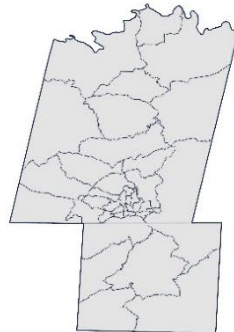
Adults in Poverty



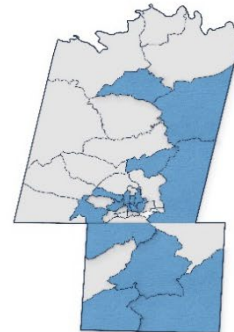
Cost-Burdened Renters



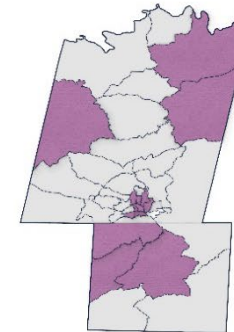
HH without Vehicles



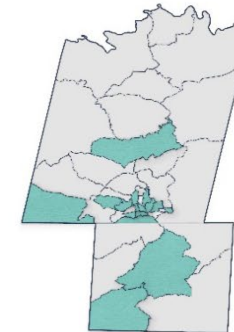
Food Deserts



Lack Internet Access



Lack Health Insurance



Lowest Life Expectancy

Figure 5 Population and Health Characteristics

issues, arthritis, high cholesterol, and obesity ($r > .370$, $p > .05$). Unhealthy lifestyles (binge drinking, smoking, getting less than seven hours of sleep, lack of physical activity, etc.) are also associate with higher BMI and lifestyle diseases like diabetes and heart disease. About 36.5% of the population in the Region were considered obese.

Insurance & Medicaid Access

Employment, income, and health care are bound together, so that better job opportunities mean higher income scales, and that puts people in reach of better insurance and higher quality health care. If you don't have insurance, you almost literally don't have access to health care and about 8% of the population in the Region lacks any sort of coverage while 19.2% of those in Pittsylvania, 20.8% of those in Danville, and 12.4% of those in Caswell have Medicare coverage. Similarly, 19.0% in Pittsylvania, 22.1% of those in Danville, and 22.5% of those in Caswell have Medicaid coverage.[1] None-the-less Medicaid itself carries a stigma, we were told, which can be dangerous. Among survey respondents (564 or 97.4%) had some type of health coverage. About half (286 or 49.4%) had private insurance, over a fourth (164 or 28.3%) had Medicare, less than a fifth (79 or 13.6%) reported enrolled in Medicaid or Other (35 or 6.0%) type of insurance. Furthermore, while coverage is better than none, in the worst cases, the doctors' medical judgment is distorted by insurance requirements. "Some of the physicians, I would say, tend to put a time stamp on when a client should be better, based on the insurance that they have." Also, as a survey respondent points out, "The price of insurance for a spouse through the workplace is unaffordable and takes half of the paycheck causing less money to spend on housing and groceries."

[1] Centers for Medicare and Medicaid Services

Community Amenities & Resources

A community's built environment impacts obesity and other health outcomes and includes issues like food access (33% of residents live in food deserts) as well as access to bike routes, trails, greenways, parks, other play spaces, and sidewalks. Survey respondents reported insufficient specialist or hospitals, a lack of grocery stores and healthy food options, and al ack of mental health facilities as missing resources. Food access within a reasonable distance was often highlighted in all data sources: "When you look at the microcosm of individual neighborhoods, you don't have access to a grocery store as close as you would need it." A lack of youth recreation opportunity was also brought up. This was especially an issue for more rural areas as there are few safe places for walking and recreation on a daily basis.

Inequities in Health Access & Care

Individuals experience access and quality of health care differently on the basis of social characteristics such as age, race/ethnicity, gender or sexual identity, and other social statuses. Over three-fourths (350 or 76.4%) of the survey respondents reported that they believed that some groups get better health care than others. Nearly 90% of respondents in Caswell County believed this to be true.

The conversations about race as a social determinant were at times terse, sometimes tense, and often skirted as talking about racial issues directly caused some respondents to be uncomfortable. Often, the conversations were shifted to talk about the correlation between poverty and race which still clearly translated to racial health disparities. As one interviewer said, "a lot of the African Americans are living in the poorer or low-income {areas}, so I think there's just that division there." African American respondents on the

community survey reported higher rates of experiences of discrimination in Health Care settings and Community Agency/Organization setting than white respondents.

Disparities in health care were also noted in the roundtables where we heard about differential treatment by race, mistrust of health care professionals among people of color, and negative health outcomes in the African American community that were related to discrimination in health care settings. Yet, some we spoke with saw health equity as taking a back seat to immediate needs: “A lot of people in the community, they’re in survival mode, so their main issue is their day-to-day, as opposed to how they’re going to change something ten to fifteen years down the road.”

Some gains were recognized in events and trainings held in 2019 to improve LGBTQ+ community relations and health outreach. However, the transgender community was specifically named as having more disparities in access, treatment, and care. One respondent explained: “Trans people aren’t getting health care in Danville. We have to go to Greensboro, we have to go to Lynchburg, we have to go to all of these different communities.” A community survey respondent elaborated: “When trans folks seek healthcare in our community, they are treated with less respect and treated as if they have mental health issues.”

It was recognized among some that the work on equity begins within organizations charged with addressing disparity in the community. One person told us, “We have an equity initiative right now that we’re working through. We’ve been doing this since I’ve been back, providing training for our staff around equity.” But, he said, “as far as health equity, we haven’t been focusing on that.” Moreover, those working on health equity must face the political

reality that the real work is in addressing social disparities. As one said, “we’re dealing with it on a surface and not at its roots.”

Health Equity Score

A Health Equity Score was computed and mapped for the Dan River Region. This score compares health and wellbeing relative to other census tracts within the region. The socio-demographic, community safety, preventative health care, chronic disease, and wellness indicators compiled for the previous sections of this report were aggregated into a single data set of 92 variable for each of the 38 Census Tract within the region.

Pearson’s Correlations were computed using all variables from the compiled data looking at their statistical association with life expectancy. Pearson correlation coefficients[2] were computed to observe the strength of the bivariate linear association between variables as they related to the mean tax value, most recent sales price, and estimated median gross rents for each block group. Statistically significant variables ($p<.05$ level) with correlations above $r \geq .3$ were kept while statistically insignificant variables were dropped.

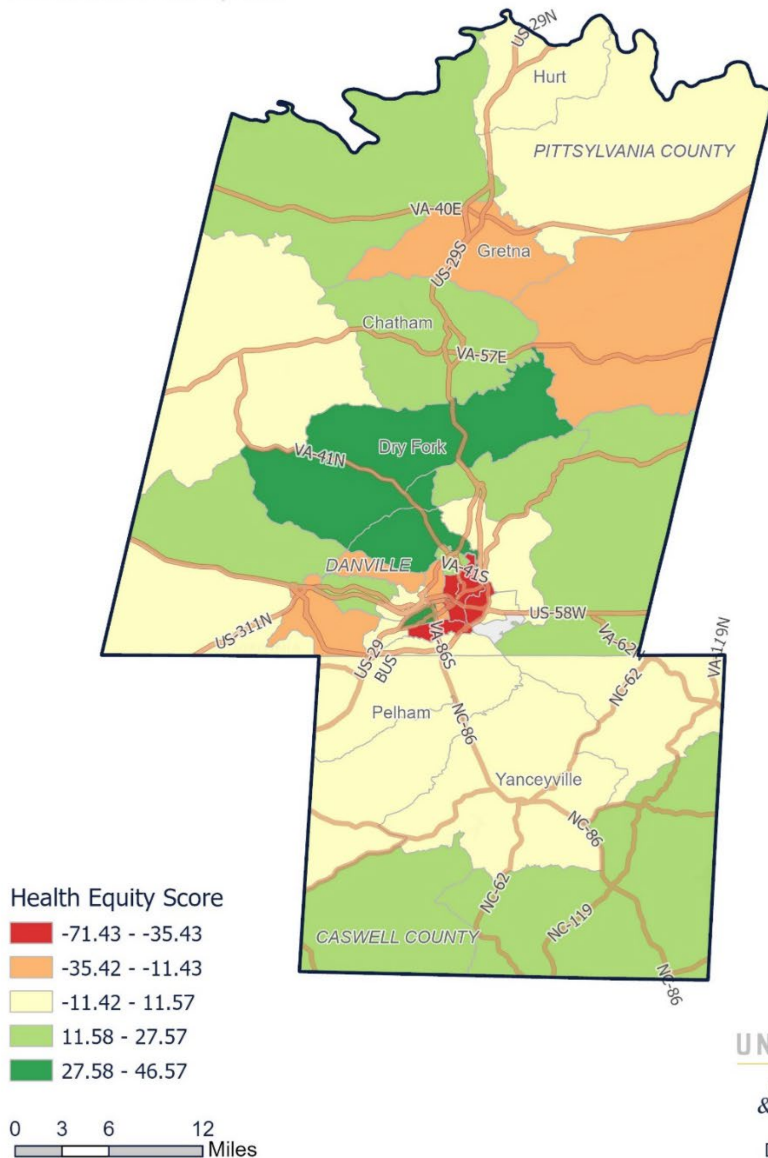
The final 38 measures were added together to create a summative index. The mean of the index was computed and the difference between the mean and zero was then added to center scores. Thus, the final scale compares Dan River Region Census Tracts to other Dan River Region Census Tracts and a score of 0 is an average tract for the region. Above 0 means more protective factors related to health outcomes and below 0 means more negative population health metrics or social determinants. From the map you can see that relative to other tracts in the region, those in eastern Danville, NE Pittsylvania County,

[2] https://www.statisticshowto.com/probability-and-statistics/correlation-coefficient-formula/

and SW Pittsylvania County have worst health outcomes and health equity issues.

Dan River Region

Health Equity Score by Census Tract
Data Source: CHCS, 2021



Date Created: 8/20/2021

Figure 6. Health Equity Score Map of Dan River Region

DETERMINANTS OF HEALTH

Poverty & Economic Disparities

The Dan River Region has an estimated population of 125,010 residents who primarily identify as white (63%) and black (32%). There is a small, but growing Latinx population (3.4%). The population in the region has been declining as a result of lower fertility, an aging population with increased mortality, and outward migration of younger cohorts.

Poverty is the most significant driver of health disparities affecting both urban neighborhoods in Danville as well as rural areas in both counties. Interviewees noted that "If people do get sick, or they need even just to go get check-ups or anything like that, they feel like they don't have the funding nor the health insurance to be able to do so, so they don't go" and said that economic considerations were the major factor in explaining health inequities. Among our respondents to the community survey, Not having enough money to pay for medical bills was the leading issue identified by 31.1% of respondents.

With a household median income about 30-35% lower than state averages, many are left out of systems of care. One survey respondent explained, "I have a master's degree and work full-time and still cannot afford co-pay insurance and only have a high-deductible plan which means I do not go to the doctor if I can help it. I do not have a primary care doctor because I am scared of the

POVERTY GUIDELINE

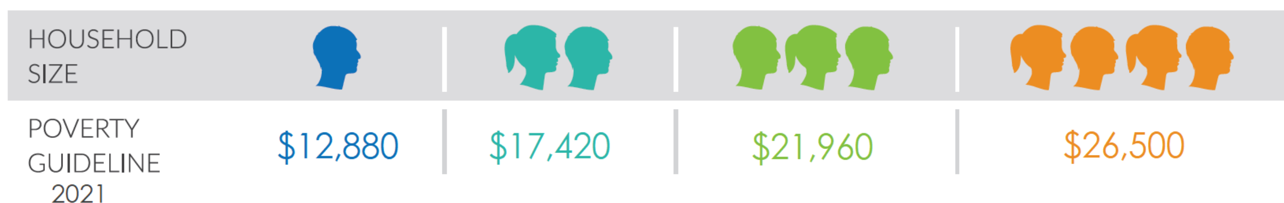
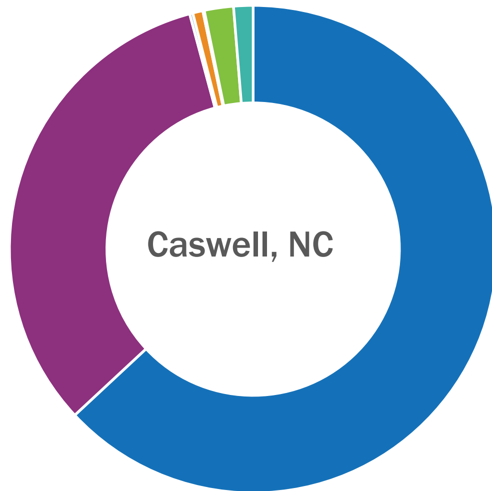
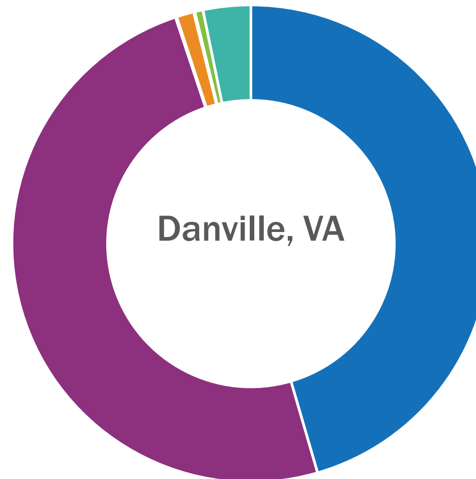
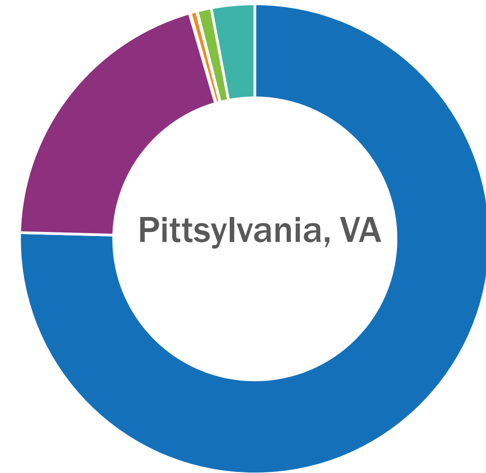


Figure 7. Federal Poverty Guideline, 2021







- White Alone
- Black/African American Alone
- Asian Alone
- Two or More Races
- Some Other Race
- Native American/Alaskan/Hawaiian/Pacific Islander

Figure 8. Racial composition by City/County, ACS 2019

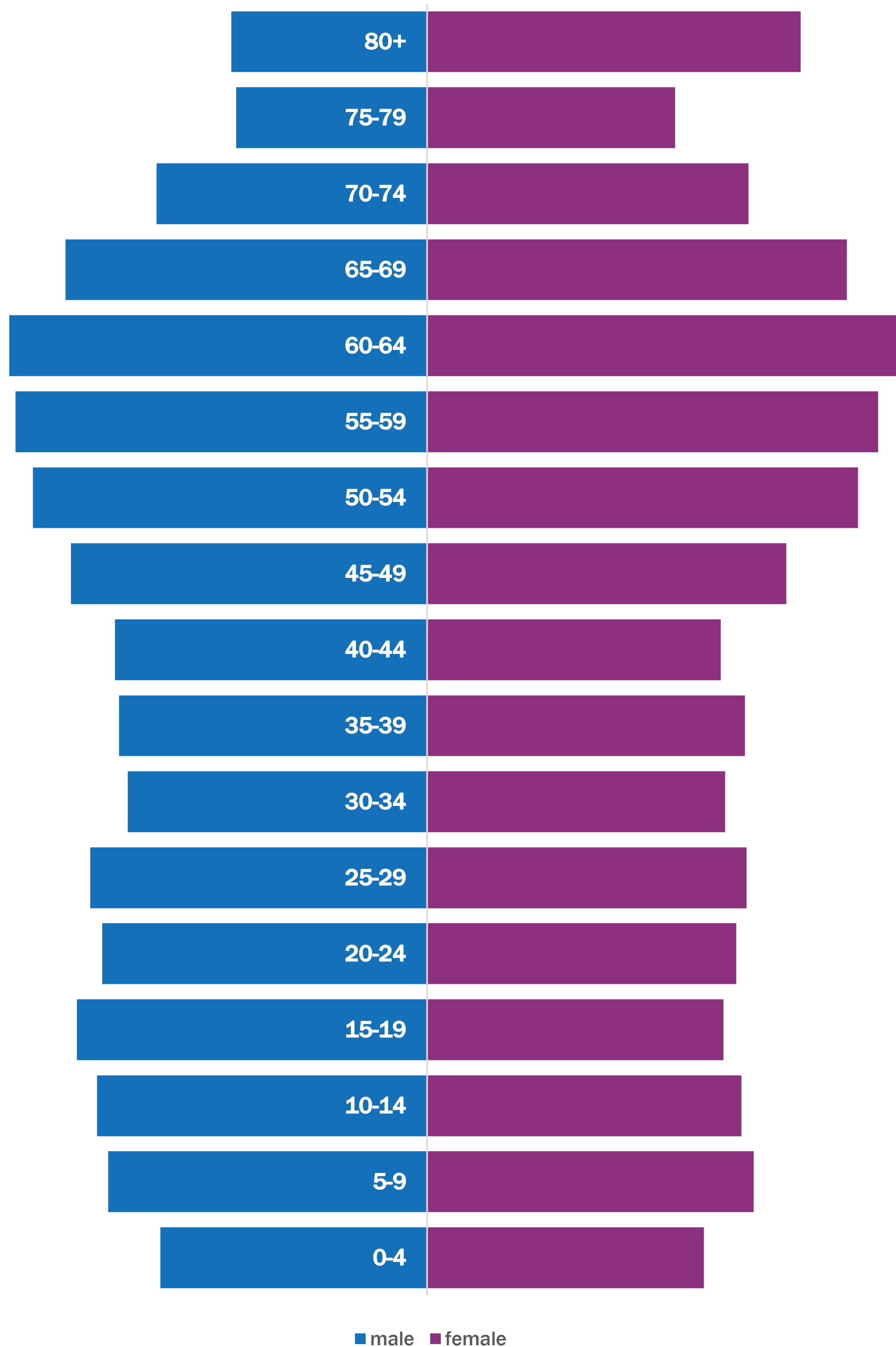


Figure 9. Age-Sex Pyramid, ACS 2019

costs." Yet, there is also great variability within the region and a few Danville neighborhoods in particular have high median household incomes (above $80,000 per household) while other neighborhoods have a median of less than $13,500. About thirty percent of households live on less than $25,000 and one-in-five households in the region are below the federal poverty line. These income differences are key factors of the Health Equity Score and median household income was found to be one of the strongest predictors of life expectancy ($r=.661$, $p>.01$).

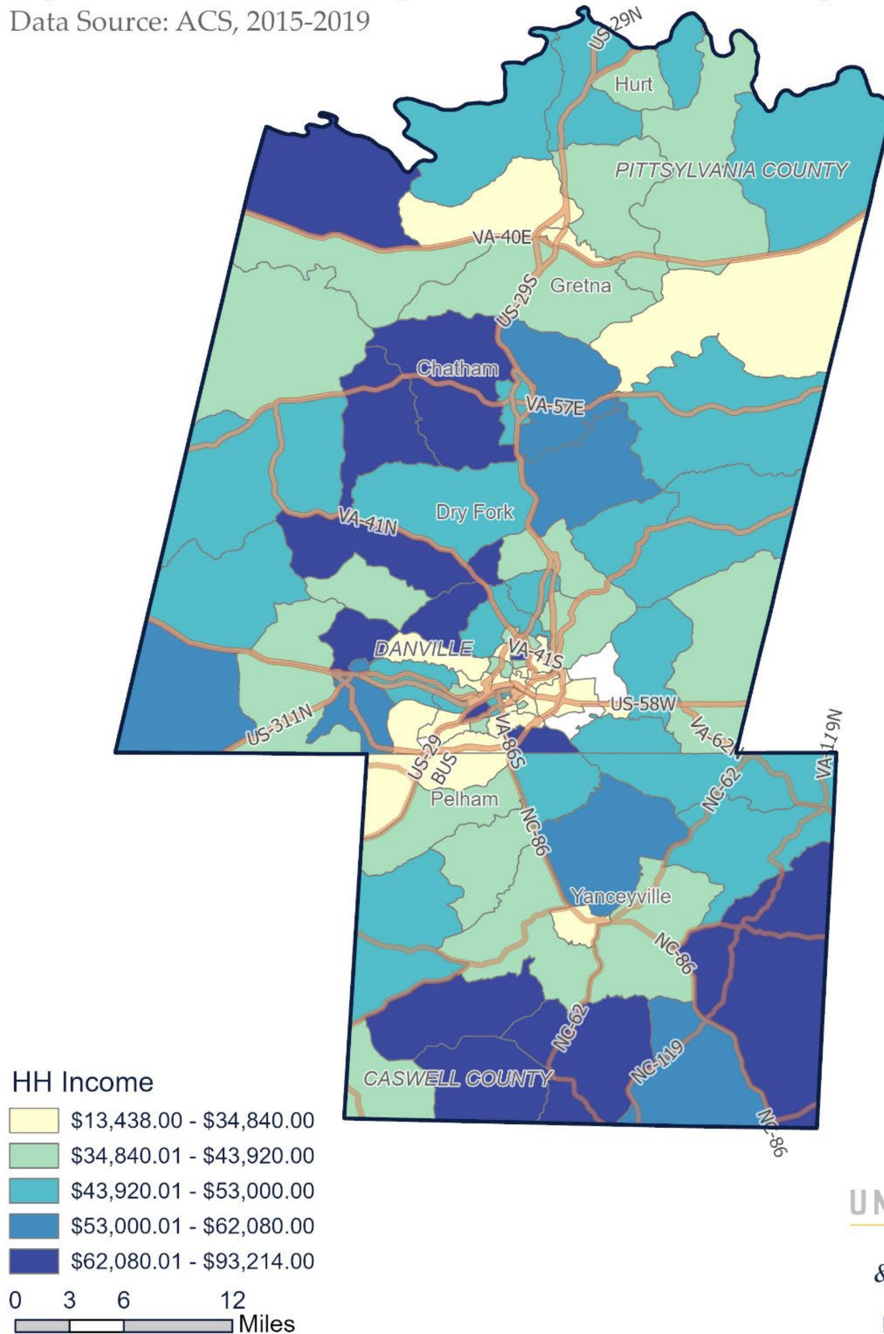
Income is linked both to economic opportunity as well as educational attainment. One-in-five (18.0%) of the population has less than a high school education. Perceptions of the quality of the local k-12 Public Schools are low. As one interviewee explained, "We just got, it's our certification that we just got taken away, from the Danville public schools, so our education system is extremely, extremely low within Danville." Only 33.6% of survey respondents believe that the area has good quality public schools.

As a result, the proportion of the population with a college degree (BA or higher) is about 5% less than NC or VA State averages. Moreover, limited local college options are associated with higher migration rates for college-aged populations interested in attending college or other post-secondary education. For those who stay locally, there is little in the way of opportunity: "Job security here is low as well, so once they graduate, unless they go off to college, there's not much to offer, unless they already have a skill."

Unemployment has almost returned to pre-pandemic levels (between 4% to 5%), but there are some localities within Danville where the jobless rate is around 20-25%. As noted in the Key Informant Interviews conducted in the

Dan River Region

Median Household Income by Block Group
(represented as Income Limits per household size for Food Stamp Benefits)
Data Source: ACS, 2015-2019



UNC GREENSBORO
Center *for* Housing & Community Studies

Date Created: 6/14/2021

Figure 10. Map of Household Income, ACS 2019

Dan River Region

Percent of the Population in Poverty by Census Tract
Data Source: ACS, 2015-2019

US-29N
Hurt
PITTSYLVANIA COUNTY
VA-40E
US-29S
Gretna
Chatham
VA-57E
Dry Fork
VA-41N
DANVILLE
VA-41S
US-58W
US-311N
VA-62N
VA-119N
US-29 BUS
VA-86S
Pelham
NC-62
NC-86
Yanceyville
NC-86
NC-62
NC-119
CASWELL COUNTY
NC-86

% Pop. In Poverty

- 8.3% - 12%
- 12.1% - 16.3%
- 16.4% - 20%
- 20.1% - 22.5%
- 22.6% - 38.6%

0 3 6 12 Miles

UNC GREENSBORO
Center *for* Housing & Community Studies

Date Created: 6/14/2021

Figure 11. Map of Population in Poverty, ACS 2019

Educational Attainment

	Less than High School	High school graduate/equivalent	Some college (no degree)	Associates degree	BACHELOR'S degree	Graduate or professional degrees
Caswell	19.6%	33.6%	20.1%	10.8%	11.0%	4.9%
Pittsylvania	17.3%	35.0%	23.2%	9.9%	9.7%	4.9%
Danville	18.3%	31.5%	23.7%	8.9%	11.1%	6.5%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Figure 12. Educational Attainment by City/County, ACS 2019

region, local employment opportunities are limited and therefore many people commute elsewhere making employment heavily reliant on access to transportation: “There’s no job opportunities close by here. They have to go to Burlington, Greensboro, Durham or Raleigh.” Most jobs available in the region are in the public sector (schools, social services, law enforcement, local government, etc.). While the tobacco industry’s presence has decreased in the past decade, a new casino is anticipated to bring 2,200 new jobs to the region with potential career advancement opportunities in the fields of hospitality, sales and marketing, entertainment, transportation, information technology and security, human resources, and construction.

Rurality as a Social Determinant of Health Inequities

Nearly two-thirds (62%) of the population in the region live in ‘rural’ settings as defined by the Census Bureau. The rurality of Caswell County, NC and Pittsylvania County, VA contribute to an environment where amenities such as grocery stores, medical facilities, and jobs require greater travel time as the distance from towns and major roads increase. Social cohesion, isolation, lack of resources, deep intergenerational poverty, and mental health needs were recognized repeatedly by stakeholders in interviews and focus groups.

It is noted that rurality itself may be a fundamental cause of health disparities as only 9% of the nation’s physicians practice in rural areas (Rosenblatt and Hart 2000), the shortage of mental health professionals in rural areas is even more severe.[3] Areas considered to be rural are typically characterized by varying degrees of geographic, economic, and social isolation, which in turn can shape development of value systems that emphasize individualism,

[3] See Rosenblatt, R.A., & Hart, L.G. (2000). “Physicians and rural America.” *Western Journal of Medicine,* 173(5), 348-351. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071163/

traditionalism, and the importance of primary relationships as well as the physical access to and distribution of resources and demographic characteristics of rural populations.

Structural Impediments of Transportation & Housing

Half of disposable income of most households goes to transportation and housing costs. Transportation is a big factor in both urban and rural areas in whether people have access to care. Transportation choice is limited. “There is a substantial number of people in our community that rely on public transportation. It’s limited, and so does everyone have access to the same resources? No, clearly they don’t.” Among survey respondents, we saw that 16.8% did not have reliable transportation to get to medical appointments or picking up prescriptions. In several neighborhoods in Danville, more than 30% of households have no access to a vehicle, but they may have access to some limited public offerings: “There’s no public transportation to speak of, outside of very limited places within the city of Danville.” Even when there may be access to medical transit through Medicare/Medicaid, there are reportedly some rural areas where transit will not go as a result of how remote it is or due to the conditions of the roads.

About 18% of homeowners and about two-fifths of renters are cost-burdened, meaning gross rent and utility expenses make up 30% or more of the household income. Two-thirds of cost-burdened renter households make less than $20,000 annually. Our survey underscores just how tight it is for many families as 23.4% of survey respondents indicated not having enough money to pay for rent or mortgage and 44% said that there are not enough affordable housing options for people making at least minimum wage. The conditions of housing is another related factor. One interviewee explained: “We run into

Dan River Region

Percent of Renters who are Cost-Burdened by Housing by Census Tract
Data Source: ACS, 2015-2019

US-29N
Hurt
PITTSYLVANIA COUNTY
VA-40E
US-29S
Gretna
Chatham
VA-57E
Dry Fork
VA-41N
DANVILLE
VA-41S
US-58W
US-311N
VA-62N
VA-119N
US-29 BUS
VA-86S
Pelham
NC-62
NC-86
Yanceyville
NC-86
NC-62
NC-119
CASWELL COUNTY
NC-86

Cost-Burdened Renters

- 15.3% - 29.1%
- 29.2% - 39.5%
- 39.6% - 43.8%
- 43.9% - 53.5%
- 53.6% - 69.6%

0 3 6 12 Miles

UNC GREENSBORO
Center *for* Housing & Community Studies

Date Created: 6/15/2021

Figure 13. Map of Cost-Burdened Renters, ACS 2019

Dan River Region

Percent of Households with No Vehicle by Census Tract
Data Source: ACS, 2015-2019

US-29N
Hurt
PITTSYLVANIA COUNTY
VA-40E
US-29S
Gretna
Chatham
VA-57E
Dry Fork
VA-41N
DANVILLE
VA-41S
US-58W
US-311N
VA-62
VA-119N
US-29 BUS
VA-86S
NC-62
Pelham
NC-86
Yanceyville
NC-86
NC-62
NC-119
CASWELL COUNTY
NC-86

% No Vehicles
- 2.3% - 4.6%
- 4.7% - 6.7%
- 6.8% - 9.7%
- 9.8% - 14.2%
- 14.3% - 37%

0 3 6 12 Miles

UNC GREENSBORO
Center *for* Housing & Community Studies

Date Created: 6/30/2021

Figure 14. Map of Households with No Vehicle, ACS 2019

issues with people trying to live in campers, and living in sheds, and pretty much anything that they can find to live in, so we see people that are struggling to get access to health care and their lack of housing contributes to their inability to live healthy lives as well."

Community Safety

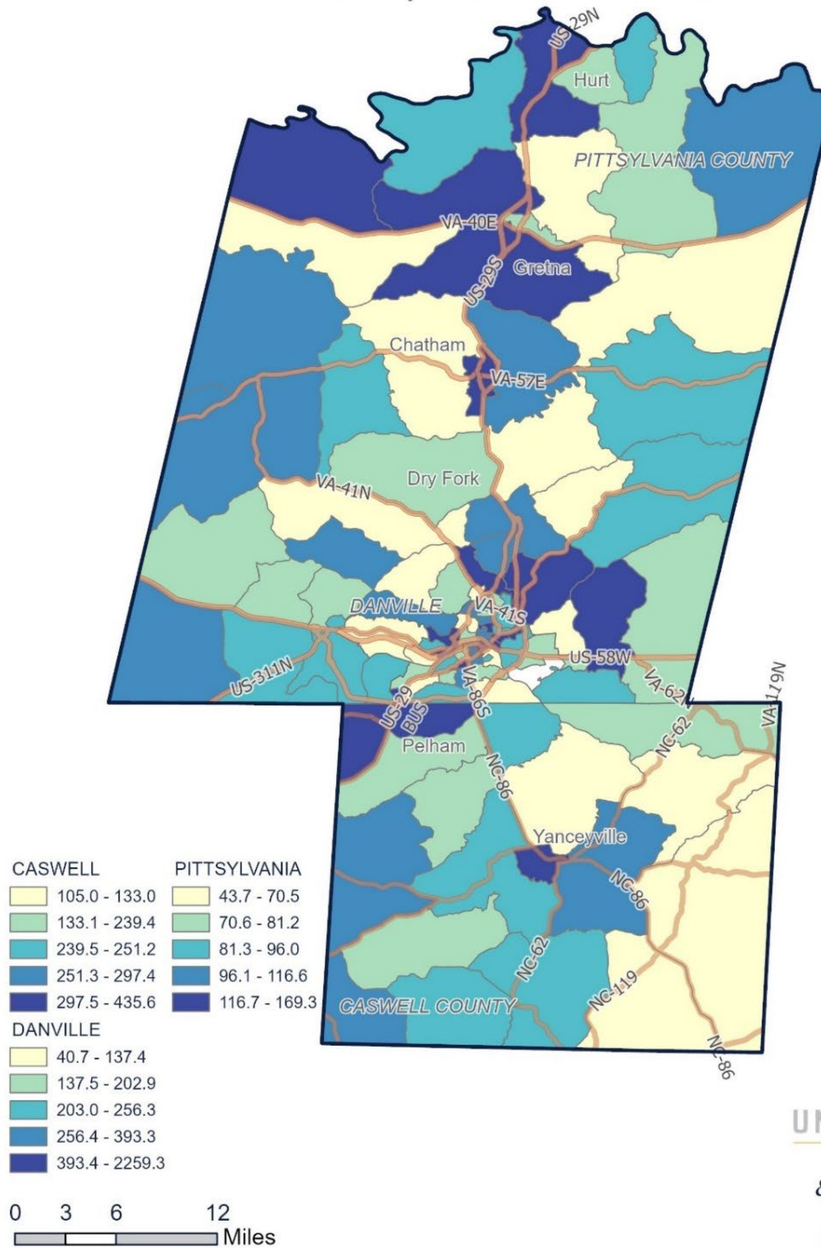
Community violence impacts health in a number of different ways such as premature death, fear of victimization, and long-lasting trauma stemming from exposure to violent events. The fear of crime has been shown to negatively impact physical activity opportunities by leaving residents feeling that it is not safe enough to allow children to play unsupervised at neighborhood parks or take evening walks as a family. This finding was supported by sentiment shared in focus groups especially as it pertained to violence during the pandemic. Even without criminal intent, the likelihood of an accidental death by shooting is four times higher in residences where a firearm is present. We saw in our Health Equity Score that local data on violent crimes, weapons-related crimes, overdoses, and mental-health related service calls to public safety were all statistically correlated with declining life expectancies at the neighborhood level. The perception across most of our qualitative data collection was that the Dan River Area was a safe and peaceful place to live, though one respondent noted that "crime is a bigger issue than anyone here wanted to admit." A majority of survey respondents (61.7%) said that the Dan River Region is a safe place to live and play, but only 17.9% said the area has adequate police protection. In general, discussions indicated an improving situation: "I think the violence has gotten better, as far as some of the shootings and those things. And there are

68%
of overdoses
in Danville were due to suspected Opioid Involvement (2019-2021

places in Danville from the downtown revitalization, you know, everybody talks about they used to be a very scary place to be was down on Crackhead Street and it's not like that anymore."

Dan River Region

Annualized Violent Crime Rate per 10,000 Population by Block Group
Data Source: Caswell Sheriff, Pittsylvania Communications, & Danville Police, 2016-2020



UNC GREENSBORO
Center *for* Housing & Community Studies

Date Created: 6/14/2021

Figure 15. Map of Violent Crime 2016-2020

ELIMINATING BARRIERS

Suggestions from Key Informants & Participants

At the end of each interview, we asked our subjects to tell us one thing they would do, one new program they would implement, or one policy they would change, if they were in charge and money were no object, to promote health equity. We received compelling and creative responses.

Universal Coverage

"Health care for everybody, I guess, I don't know," said one person. "Universal health care, I'll go with that." Several respondents expressed similar ambitions. "To provide health care for everybody at no cost," said another. "Not to be political, that's why I think the Affordable Care Act is important, because it gives people the opportunity to get affordable health care so they don't have to worry about it." Another person recommended, "Expanding the resources like PATHS and other sort of sliding-scale and low-cost health access, so that they're no longer sort of resource-burdened, but they're able to actually provide a higher quality of care." Another put it simply, "I think we need more health services."

This sentiment was also expressed in roundtables as the adoption of some form of universal health care. "I would say free insurance for everybody," one person said. "I would say free co-pays for all your medications," said another. "I would base it on the need," said another. "I would love to see that everybody be treated equal," said another. "My biggest thing would be," said another, "taking just even another step back, to make sure that everyone had access to health care." He continued, "Sometimes it seems so challenging that there are people who would rather just not deal with it and sit and home and die of some preventable disease because it's scary to go out into that world of health care, and I think if you had universal health care and you just told people, don't worry

about it, just show up at the doctor and you're going to get covered, I mean, to me that's the ideal."

Funding for More Specialists

One of the respondents pointed to the shortage of specialist providers. "I really wish that there was more opportunities, more specialists that were more easily accessible to parents, when it comes to mental health, physical health, that there was more specialists and if they can't access more specialists, that there was more funding." Funding, not surprisingly, was itself a recurring theme. "It has to be economic resources," one person said. "We've got to create economic, educational resources so people could be empowered. And then economic resources will allow us to put more transportation in the area, put more doctors, more help there for individuals. It does really boil down to the dollars." He added, "They have to reinvest in the people in those communities."

Transportation

Just as it has been throughout our conversations, transportation was mentioned often in these responses. "Honestly," one person said, "probably the most simple thing to get these people what they need when they need it would be transportation. That's my biggest headache with everything, because if they could get to their doctor, get their food." Another said, "Strongly increasing public transportation would make a huge impact." Said a third person, "I think if that was there, you know, to buy extra bus or to buy extra van to transport people." Roundtable participants agreed. "Transportation for the ones that don't have a vehicle," said one person.

On the flip side of transportation resources are mobile vans, which several of our respondents mentioned. "It would be nice if we had some type of mobile healthcare van," said one, "that, say, set up in each of our schools, and let parents know, 'On Wednesday, January the whatever, we're going to be at such-and-such school.' You know, if you have issues that you need addressed. And I don't know if it's just for the children or if it's for the families as well." Said another, "It may be important for health-related organizations to have health-related buses that can go into communities and provide and arrange the services."

"It would be nice if we had some type of mobile healthcare van, that, say, set up in each of our schools, and let parents know, 'On Wednesday, January the whatever, we're going to be at such-and-such school.'"

Mobile Clinics & Outreach

Mobile facilities get health care to where people live, and so do neighborhood clinics. For one of our respondents, either would do. "Making sure that we have health care buses, or clinics or facilities that people have access to within a reasonable distance from where they live." Another urged, "To add more community centers where people could go in their communities." Another envisioned a center that would provide health care and much more. "A real live community health center," she said. "with all these things – that has transportation, to be able to go out and pick up these people and carry these people on job searches, to actually inform them of medical concerns. We could have aerobics program. We could have someone there to help them fill out applications, understand what a resume is."

Others thought of education and outreach. "I'm gonna go back to the education piece," said one, "to make sure the word gets out because I think we have great ideas and there's great programs, but what is that if everybody doesn't know

about it?" Said another, "I think we need more health services, and then we need the marketing, or we need to make sure that people are aware of the available services and how to access those services." Several recommendations focused on the school system. "Maybe we work to have clinics, health clinics, where kids are given physical exams, types of things, in our schools, and take that off of families," said one person. "Maybe we could do like a division-wide physical fitness program that was really rich and really consistent across the different schools, and something that kids bought into and kids enjoyed." Another suggestion was to bring in "more social, emotional counselors there who are skilled at working with kids with mental health issues."

Educational outreach was also a theme in the roundtables. "It needs to be more prevention as well," said another, "because if you do it on the front end and you provide the information." Information and education were on quite a few participants' minds. "More awareness about the situations that people are experiencing," said one. "Education." Another suggested, "Teaching people to advocate for themselves when they going to the doctor, instead of just accepting whatever." Better education for providers, some said. "I don't know how often physicians continue with their professional development," one said. "This is something where once they go to school, where they have a certain amount of hours that they got to do, with diversity and meeting the needs of their community." Said another, "We could host seminars for each medical facility. That would be a thing that each doctor's office could reach out to our community, or our foundation or whatever, to host those seminars for their medical staff, to teach them about the ethics and culture of transgender medicine and transgender care." One person said we need more doctors. "More doctors, and doctors that stick around for more than a couple of years." Another

wanted more of a particular type of medicine. “I would bring a Planned Parenthood here,” she said.

Addressing Food Systems & Housing

Food security was the focus for some of our respondents. “It would be nice if we could provide families with good foods,” said one, “if we could provide families with fresh vegetables.” Said another, “I think I would probably focus on food access, because people don’t have access to fresh food, don’t have easy access, I think if you could work with some of these community stores, to provide fresh fruits and vegetables, or even work with local farmers, you know, we have a large ag population in the county, you could work with them to do roadside stands or something, in places that don’t—you know people have transportation issues, and you don’t have stores that sell fresh fruits and vegetables. I think that’s probably where you would see the biggest, you would be able to make the biggest difference in the county.”

Others focused on housing for people experiencing homelessness. “If I had the money right now,” said one, “I would run a housing first pilot, starting tomorrow, to demonstrate the data necessary to prove the efficacy for a place like Danville.” Said another, recommending more transitional housing, “Say for instance if somebody was homeless, you know, thirty days, if they leave or whatever, I know in reality, I know after their thirty days, they're probably going to need somebody else, like they’re going to need some help.”

Caring & Resilience

Several of our respondents thought more of social than of material resources. For the LGBTQ+ community, one person recommended more cohesion. "They need to have more stuff going on, and they need to be more vocal about it, and support, support, support. The community needs to come together a little bit over something. It's so absurd, how distant everyone is. They're arguing." Another looked to the community leadership, urging new blood. "Open the doors to a flood of thinking that's available but is being limited by the old guard," one person said. "That's the first thing I would do. And then I would figure out how to utilize folks like DRF, who have been instrumental in many, many things, to be even more focused in attacking some of these issues without the limits being put on by narrow-minded people." And for others, it came down to just making people feel like somebody cares. "Somebody there that actually cares and is not there for a check, to be able to look at them and say 'have you ever thought about this?' or 'I've noticed so-and-so.' Somebody cares." Another expressed a wish, "To be able to go out into the community so that people knew that other people care. To be able to make sure that people have the food they need to eat that will help them be healthier, that they're not going without their medication, regardless of their age, because they can't afford it, or the power's been cut off because they can't pay the power bill. If they need to get to the doctor, we would be able to get them to the doctor." This person continued, "The only reason that I would want to win a lottery, a very large, in-the-millions lottery, is to put money in this county, to help anybody and everybody who needs it."

> *"And people realize, like OK, this person really does care, and I know they're in it for the long run."*

Feedback from the Health Collaborative's Summit

On Tuesday, November 30, 2021, the UNC Greensboro team presented findings from the Health Equity Report at the 2021 Health Summit Series.[4] The presentation was conducted via zoom with participants from across the Dan Region representing health, business, non-profit, and government. The presentation of data was followed by breakout discussions on how the Health Collaborative can use this information on health disparities to guide work going forward. In particular, we discuss ways to treat the root causes of health inequalities.

Setting Priorities

Participants in the discussion identified the need to prioritize finding solutions to the systemic and structural issues of poverty and racism. As noted by one respondent, the CDC now recognizes racism as a public health issue central to explaining health disparities..[5] Participants discussed both the evidence of perception of discrimination in healthcare, in particular among African Americans, but also how the data presented reinforces the claim of racial inequities. They noted how the data contained in this report clearly identifies specific communities that are marginalize and they strongly urged that the report be used as a platform for having 'honest conversations' with community members. The participants felt it is not enough to simply identify these populations with information from the Dan River report or other forms of literature. Respondents harked upon the need to inquire about community needs before reaching a consensus on priorities. One suggested "taking the information to the community and asking them what the priorities should be."

[4] A recording of this presentation may be found at: https://video.vt.edu/media/2021+Health+Equity+Report+Presentation_Edited/1_c85z4boo
[5] See: https://www.cdc.gov/healthequity/racism-disparities/index.html

The intersectionality of race, gender, sexuality, poverty, and health produce a myriad of issues for marginalized communities. To tackle these interrelated issues, it was suggested that the health collaborative take advantage of their relationship within each of these communities. Considering how to interact with the community was a recurring theme for this segment. There were several possible actions for the Collaborative that were suggested including hosting equity trainings specifically for community leaders and having trained facilitators who have rapport with marginalized communities present at community meetings. The participants also noted that logistical considerations such as place and time of meetings should favor the residents and community members needs.

Short-term and long-term priorities issues are likely to arise. It is essential that leaders do not undermine the immediate needs of folks for the sake of structural change. Once a plan or program is created, an evaluative protocol should be implemented to ensure this balance. Developing metrics for action plans allows leaders to track progress of priority areas.

Besides the dissemination of information to populations, there was regard for the economic barriers that exist. Housing and food insecurity can stifle people from focusing on healthcare needs. Members called for attention to affordable housing and assistance with food insecurity. The ultimate question brought forth was whether the focus should just be on access to healthcare services or upstream on larger political and economic reforms.

Balancing Rural vs Urban Communities

The inequities between rural and urban communities can be dismissed unintentionally. To prevent this, having a community-based entity that is visible and constantly communicating with groups is essential. The ability for the entity

to listen to community members allows for collaboration with stakeholders. Simply asking "what can we all do?" can empower communities to become involved in problem solving. Especially in rural communities, this communication can provide insight to community gaps, such as food deserts with Dollar Generals serving as primary groceries. When these problems are identified, it will call for some unique problem-solving. Instead of working in silos, it was encouraged that leaders from the health department, city government, and physicians coordinate an action plan. It is integral that any feasible plans, such as subsidizing paratransit in rural communities, gain political support from all.

Working Upstream

Discussion participants noted that working *upstream* requires more agreement, cooperation, solidarity and thus the data can be used in promoting understanding that there is more commonality than groups have been led to believe. They suggested working to address mistrust between racial groups and finding consensus on what to prioritize. They also argued that there are active gate keepers within leadership positions who must be shown what inequality looks like and understand that the system itself is inequitable.

The first thing that can be done is to question institutions about their diversity, equity, and inclusion practices. As one member explained, plans to address racial equity can be pretentiously discussed without the readiness to grapple the issues. To hold institutions accountable, the media can play a key role in activism. Oftentimes younger people are the pioneers of social change, so using social media to mobilize them can be powerful. Repetition of different forms of communication, including social media, to stress these inequalities to different stakeholders can advance the community push. Calling out institutions that

aren't behaving well can be effective strategy. Finding the potential easy wins and fast successes need to be discussed to build momentum.

RACIAL DIMENSIONS OF INEQUITY

Everyone can understand that lower-income people have less access to health care services, and to the housing, transportation, recreational and educational resources that in turn affect health and health care outcomes. But when we asked whether "race" might also be a factor, there was less clarity. Some agreed, some were uncomfortable with the subject, and some recounted personal experiences, but race didn't emerge as a dominant frame in the way that income had. We were told that this subject is too sensitive for many people and that the social and political institutions of the region don't yet adequately support a strong discourse of racial equity.

Yet our survey data shows a strong perception of discrimination in health care among Black respondents. Moreover, the secondary data we present makes clear that Black residents of the Dan River Region experience worse health outcomes than white ones. And researchers in other parts of the country have consistently found discrimination in health care and disparate health outcomes. Race is a key driver of health inequity, even accounting for differences in income and however comfortable people may be about it. In this section, we'll dig deeper into the racial dimension of health equity, with emphasis on the different experiences of Black and white individuals, and how this knowledge might inform our efforts to find remedies.

The data we reviewed show that Black people consistently receive a lower quality of health care than whites, have less access to care, and have worse health outcomes – even when controlling for income and other factors unrelated to race. This racial dimension of health equity is manifested across

all health categories. Danville residents shared with us their concerns about "maternal mortality rates in African Americans," for example, and we know that Black patients fare significantly worse than whites in other key categories including infant mortality, HIV/AIDS, cardiovascular disease, cancer screening and management, adult and child immunizations, and diabetes; and in asthma, sickle cell anemia and end-stage renal disease; in neonatal health; in low birth weight, nutritional risk, breast cancer as well as anxiety and depression and substance abuse; in atrial fibrillation management, and in mortality, debility and destitution of elderly women following major bone fractures. Black Medicare participants have significantly less access to costly supplemental insurance policies than can be explained by income alone, and correspondingly less utilization of services. In the worst case, having experienced adverse health as a result of unfairness in the health care system, some high-need patients may be avoided altogether by providers looking to save costs.

As we've noted, "controlling" for income – and for age, sex, region, and differences in access – is critical as a matter of research methodology. But income is too important a framing device for many observers, as we discovered in our conversations with residents of the Dan River Region who insisted that "income probably has more to do with it than race" and "we don't really see this as a racial issue, per se." This tendency to conflate race and income can lead us to fallacy, because the two categories are both over- and under-inclusive: some low-income white people have poor health outcomes and limited access relative to more affluent whites; while affluent Black people as a group have poor health outcomes and limited access relative to affluent whites. Racial disparities in health outcomes don't mirror socioeconomic inequality.

There is a difference between saying "race" drives health inequity and saying "racism" drives health inequity. We speak of "race" as a "risk factor" or "predictor" of health inequity – not entirely unreasonably, as members of a racial group do actually have worse health outcomes and worse access to health care services, as we have mentioned. But this framing is careless and leads to confusion and can be a barrier to remedial action. "Race" is a vague descriptor, with almost no basis in genetic taxonomy; it defies the binary classifications we tend to attribute to it; and when used as a diagnostic tool may lead to mistakes and inappropriate treatment. The health equity data are often based on individual racial self-identifications which are themselves imprecise. Most importantly, this way of speaking leads us to think of the racial group members as somehow at fault or as different from the "normal." Instead, we should understand race not as a "risk factor," but as a shorthand for the social and structural disadvantages experienced by persons of that race, or in other words, for the effects of racism.

When we reframe the discussion in this way, we gain clarity in our understanding of health inequity. The object is not to attribute racism to health care providers; that may or may not be present. The object is to trace health outcomes back to the forces operating throughout history and social and political systems and, in this way, we can begin to see the effects of racism in places where it had remained hidden. Consider, for example, minority neighborhoods suffering from underinvestment in transportation infrastructure; residents in those neighborhoods suffer a disproportionate number of pedestrian injuries and are more likely to die from such injuries; weakened transit systems afford residents less access to educational, employment and recreational opportunities. This way of thinking about the social determinants of health inequity forms an integral part of our study, in

relation not only to transportation but also to housing, recreation, food security and education.

These lines of inquiry reveal that the experience of racism on an individual level is itself harmful to health. The everyday, chronic, routine perception of mistreatment – less courtesy or respect, poorer service at a restaurant or store, being called names or being considered threatening or dishonest – is a source of stress which predisposes individuals to poor health. Our data, both qualitative and quantitative, confirm that Black respondents have much more daily experiences of this kind than white respondents. Other data which we've reviewed show that racism in housing, employment, education and criminal justice causes stress that adversely affects health in innumerable ways, from anxiety, depression, cognitive function, PTSD, intimate partner violence, high blood pressure, low birth weight, breast cancer, substance use and other health behaviors; to reduced health care utilization, delays in seeking treatment, non-adherence to health screenings, and lack of trust in the health care system.

And yet, we are told, race is hard to talk about. We see this in our own work in the Dan River Region. In a representative remark, one person told us, "For whatever reason, we cannot talk about race, without folks really polarizing. I don't think we understand how to have that conversation, or we're struggling on having the conversation." Dan River Region stakeholders working toward equity in health care should take affirmative steps to overcome this reticence about race.

An unwillingness or inability to comprehend the experiences and perspectives of Black patients makes providers less effective in treatment and less effective communicators of health care information and can lead them to blame patients for their choices and to discount their narratives of discrimination. One

of the people we spoke to explained that it “goes back to looking into the historical trauma of people of color and how they were treated before.”

Those pursuing solutions to health inequity will have to consider new approaches to policy development, research and community engagement that could shift the culture from the old approaches. A new paradigm will emphasize the perspectives of marginalized groups and prioritize their perspectives and experiential knowledge; move away from colorblind principles and instead cultivate in each person an awareness of their racial position and position in the social hierarchy and the processes of racial stratification at work in the health care system; place each situation in its larger historical context; acknowledge the fundamental role of systemic forces as opposed to immediate interpersonal interactions; and promote collaborative partnerships among members and groups within the community.

RECOMMENDED NEXT STEPS

ISSUE #1: Racial Disparities in Health Care

While 36.5% of the population is non-white, African Americans are especially geographically concentrated in a few neighborhoods in Danville and Yanceyville. Neighborhoods of color were geo-spatially correlated with higher rates of poverty, lack of insurance and lower health opportunity indices, greater disease morbidity and mortality, higher risk for COVID-19, etc. This translated clearly into lower Health Equity Scores for these neighborhoods relative to other parts of the region. While some interviewees and focus group participants were hesitant to attribute inequalities to race, there was clear evidence of the experience of inequity in healthcare, and in the society at large, from Black participants. This was also dramatically illustrated in the survey where twice as many Black respondents said they had experienced discriminatory treatment in interactions with health care settings.

SUGGESTED ACTIONS:

1. ***Require*** *Diversity Equity and Inclusion (DEI) training starting at the executive and board levels of health and social service organizations and moving then to program staff and frontline healthcare staff (CNAs, RNs, doctors, social workers, receptionists, etc.).*
2. ***Engage*** *residents in high-need, minority communities in dialogue with healthcare providers and social service agencies through community-advisory groups that provide direct input to decision making on programs and policies related to community health.*
3. ***Promote*** *diversity within leadership by hiring more members from communities of color into senior policymaking, executive administration positions, and healthcare provider roles.*

ISSUE #2: Poverty as the Root Cause of Disparity

We found that poverty is the most significant driver of health disparities affecting both urban neighborhoods in Danville as well as rural areas in both counties. Approximately one-in-five of the population was below the poverty line in 2019 (23,647 individuals) and 15% of households have less than $15,000 in income (ACS 2019). Several tracts in Danville and in the Milton/Semora area saw child poverty levels above 50%. Poverty in these areas was correlated with high unemployment, fewer vehicles, lower educational levels, and food deserts. Poverty was also one of the strongest negative correlates of life expectancy. Inability to pay for insurance, co-pays, prescriptions, and other health-related costs was a theme in stakeholder interviews and community focus groups. Interviewees noted that "If people do get sick, or they need even just to go get check-ups or anything like that, they feel like they don't have the funding nor the health insurance to be able to do so, so they don't go" and said that economic considerations were the major factor in explaining health inequities. Among our respondents to the community survey, not having enough money to pay for medical bills was the leading issue identified by 31.1% of respondents.

SUGGESTED ACTIONS:

1. ***Increase*** *participation in current and expanding Federal safety net programs* including *Temporary Assistance to Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), the earned income tax credit (EITC), Medicaid, and the Special Supplemental Food Program for Women, Infants, and Children (WIC).*
2. ***Explore*** *the feasibility of Guaranteed Income (GI) programs. GI is a type of cash transfer program that provides continuous unconditional and unrestricted cash transfers to individuals or households which may help with the cost burden of individuals. These "no strings attached" infusions*

of cash are similar to the COVID-19 Economic Impact Payments or "stimulus checks." More than 32 cities across the US are currently offering programs such as this to tackle extreme poverty.[6]

3. ***Increase** living wage jobs starting with those employed in the lowest rungs of social and health systems (CNAs, orderlies, janitorial staff, etc.). Setting minimum cost of living standards within these sectors will promote other sectors to increase wages. According to the Living Wage Calculation for Pittsylvania County, Virginia, $27.40 is the hourly living wage for a single-parent with one child.*[7] *At minimum wage, a single-parent with one child would need to work 151 hrs. a week to keep up with the cost of living.*

ISSUE #3: Housing Quality, Availability, & Costs

While housing in the Dan River Region is perceived to be more affordable, we find that more than half of renters (42%) were cost burdened paying more than 30% of their income towards rent. The lack of affordable choices in neighborhoods with goods schools, nearby employment, full-service supermarkets, and low crime rates is an underlying issue causing those with low incomes to be further segregated and concentrated in precarious communities with neighborhood resources. Interviewees agreed that the scarcity and bad condition of much housing is a contributor to poor health outcomes. Overcrowding, lack of plumbing (5% of homes), lack of complete kitchen (6.5% of homes), high lead exposure risk, and other severe problems plagued the housing stock. Participants discussed people living in substandard housing, especially in rural areas.

SUGGESTED ACTIONS:

[6] Lalljee, Jason. (2021). "32 basic and guaranteed income programs where cities and states give direct payments to residents, no strings attached." *Business Insider.* https://www.businessinsider.com/how-many-ubi-guaranteed-basic-income-programs-us-cities-states-2021-12

[7] https://livingwage.mit.edu/counties/51143

1. ***Fund** affordable rental housing units especially for households whose incomes are less than 50% of the Area Median Income in high opportunity areas by means of expansion of public housing, voucher programs, and affordable units in the $400 or less range for those with fixed incomes, disability, social security, or other limited means. Developing more affordable rental housing options requires a cooperative approach between private developers, non-profits, public housing authorities, county and municipal governments, and social impact investors helping to make low-interest funds available to for-profit developers helping to off-set the high cost of building affordable units in high market value neighborhoods. A revolving loan fund for affordable housing managed by philanthropy is one potential solution.*

2. ***Petition** for local inclusionary zoning ordinances and elimination of single-family zoning preferences may open new opportunities for development outside of existing low-income neighborhoods. Aligning land-use policy, significant funding, political will, and public support will take a coordinated effort.*

3. ***Expand** the City of Danville rehabilitation loan program, the Pittsylvania County emergency home repair program, and the Piedmont Triad Regional Council of Government repair program in Caswell County. These programs are funded by federal Community Development Block Grant (CDBG) and HOME Investment Partnership (HOME) funds, but need added capacity and funding. While they are intended for low- and moderate-income homeowners, they could be expanded to landlord of affordable rental housing with qualifying tenants. The repair and rehabilitation of homes located in disinvested neighborhoods improve the chances of neighborhood revitalization and the return of private investment. Partnership with Habitat and other volunteer rehab programs is possible.*

4. ***Develop** healthy homes criteria for minimum housing standards and train code compliance departments in the administration of health homes inspections. Further, conduct healthy homes workshops and trainings for healthcare providers, social workers, and the general public.*

ISSUE #4: Transportation Access

Transportation issues emerged in all contexts. While 16.3% of households in Danville have no vehicle, 9.1% of Caswell households, and 5.7% of Pittsylvania households also are without transportation. There are some census tracts where more than a third of households are without a car. Having a vehicle was a protective factor in our Health Equity Score with a very high statistical correlation to life expectancy. Lack of transportation was an overarching obstacle and social determinant, having a decisive effect on access not only to health care but to social services, education, employment, recreation, food and people's ability to connect with others in their communities.

Focus group participants noted that "strongly increasing public transportation would make a huge impact." Said another person, "I think if that was there, you know, to buy extra bus or to buy extra van to transport people." Roundtable participants agreed. "Transportation for the ones that don't have a vehicle," said one person. While it would be optimal to increase the number of these high value assets in low income communities (via mobile clinics or scattered fixed locations), it may be more affordable to first increase access by reducing the barriers to utilizing mass transit within Danville and collective transportation such a more vans in rural areas.

SUGGESTED ACTIONS:

1. ***Promote*** *the use of Danville's Mass Transit System among all social service agencies, government services, medical and health facilities, and even retail establishments by providing subsidized or free unlimited ride 30-day passes to families in target neighborhoods.*
2. ***Encourage*** *Medicare recipients, senior citizens (age 60 and over) and disabled persons to take advantage of the Transit System's half-fare program as well as the Handivan Service. By increased ridership,*

institutional partnerships, and through increased public petitioning to the Mass Transit System for more frequent service, later evening service, and more routes may be established.

3. ***Subsidize*** *rides to large employers, health systems, or retail centers may also encourage more ridership. In studies where low-income people were given half price transit fares, they used mass transit for about 30% more trips per week than the control group paying full price.*[8]

ISSUE #5: Insurance & Health Systems Navigators

The updated 2020 health ranking for Danville remained unchanged as one of the least healthy areas in Virginia (lowest 0-25%) in both health factors and health outcomes. Pittsylvania County fell from 75th to 90th out of 133 and Caswell County fell from 54th to 78th out of 100 in North Carolina, becoming more high risk for adverse health factors and outcomes. Insurance is a key factor. Throughout our conversations, the blunt truth kept repeating itself, that if you don't have insurance, you almost literally don't have access to healthcare. 8.6% of Pittsylvania, 9.0% of Danville, and 7.4% of Caswell residents are completely without insurance. Even then, some with private insurance policies don't have excellent coverage: "I have insurance, and there are times when I don't take myself or take my children to the doctor, because of the cost." Those purchasing coverage through the marketplace may face the reality that not all services are covered, or they have high premiums and deductibles or out-of-pocket costs. More low-to-moderate income people fall into a gap, "People who make too much money to qualify for Medicaid and not enough money to pay for a private insurance." For those who are eligible, Medicaid is a bridge over

[8] Jeffrey Rosenblum et al. (2019). "How Low-income Transit Riders in Boston Respond to Discounted Fares: A Randomized Controlled Evaluation." Department of Urban Studies and Planning Massachusetts Institute of Technology. http://equitytransit.mit.edu/wp-content/uploads/2019/06/whitepaper_v8.pdf

many of the obstacles, but there are drawbacks, among them limits to what doctors will accept it and limits to what it will cover.

SUGGESTED ACTIONS:

1. ***Support and Expand*** *the Regional Engagement to Advance Community Health (REACH) Partnership (formerly the Community Health Worker Project). Community Health Workers*[9] *are essential in helping patients and families navigate healthcare systems and in providing linkages to social services. They will work in tandem with Care Coordinators*[10] *and Community Paramedics*[11] *to address the systematic barriers preventing positive health outcomes and create a system of care that provides equitable access to all residents in the region. While this program recently received a $6.3 million grant from the Danville Regional Foundation, ongoing and sustainable financial support will be needed.*
2. ***Assist*** *members of the public who may be eligible for the Children's Health Insurance Program (CHIP), Medicaid, and subsidized premiums through the Affordable Care Act (ACA). As noted in Health Affairs, "health insurance enrollment process places significant burdens on eligible individuals, who must navigate a complex range of options and successfully connect to coverage."*[12] *Federal Health Insurance Marketplace navigation may be leveraged through Enroll Virginia!*[13] *and NC Navigator Consortium*[14] *with targeted outreach to the uninsured.*
3. ***Create*** *a regional community care network that provides individuals who do not have other forms of public or private insurance to have a medical home with care management including referrals to specialty care. Programs like this are often funded by local health foundations and other philanthropic funding as well as by providers accepting lower fees for services.* [15]

---

[9] https://www.ruralhealthinfo.org/toolkits/community-health-workers
[10] https://www.ruralhealthinfo.org/toolkits/care-coordination/
[11] https://www.ruralhealthinfo.org/topics/community-paramedicine
[12] https://www.healthaffairs.org/do/10.1377/hblog20200814.107187/full/
[13] http://www.enrollva.org/
[14] https://www.ncnavigator.net/
[15] https://guilfordccn.org/