



Major Health Indicators 2019	Berkeley	Jefferson	Morgan	West Virginia	United States
Poor or fair health	22 %	18 %	20 %	24 %	12 %
Poor physical health days	4.9 %	4.4 %	5 %	5.2 %	3 %
Poor mental health days	5.2 %	4.5 %	4.9 %	5.2 %	3.1 %
Low birthweight	8 %	8 %	10 %	9 %	6 %
Life expectancy	75.6	77.9	74.8	75	81
Premature age-adjusted mortality	440	380	470	490	280
Child mortality	60	30	80	60	40
Frequent physical distress	14 %	13 %	14 %	17 %	9 %
Frequent mental distress	15 %	13 %	14 %	17 %	10 %
Diabetes prevalence	12 %	10 %	16 %	14 %	9 %
HIV prevalence	156	79	39	113	49
Adult smoking	23 %	19 %	20 %	25 %	14 %
Adult obesity	35 %	35 %	38 %	36 %	26 %
Physical inactivity	28 %	22 %	25 %	28 %	19 %
Access to exercise opportunities	44 %	55 %	63 %	60 %	91 %
Excessive drinking	13 %	16 %	12 %	12 %	13 %
Sexually transmitted infections	277.9	263.8	97	261.4	152.8
Teen births	31	19	23	36	14
Drug overdose deaths	66	44	45	47	10
Insufficient sleep	43 %	35 %	36 %	40 %	27 %
Uninsured	6 %	6 %	7 %	7 %	6 %
Preventable hospital stays	5,194	4,060	3,641	5,683	2,765
Mammography screenings	36 %	33 %	33 %	38 %	49 %
Flu vaccinations	46 %	39 %	42 %	41 %	52 %

Source: 2019 US County Health Rankings (<http://www.countyhealthrankings.org/explore-health-rankings>)

Top Health Concerns					
Berkeley (N= 2059)		Jefferson (N=1263)		Morgan (N=96)	
Drug addiction and/or dependence	73%	Drug addiction and/or dependence	60%	Drug addiction and/or dependence	73%
Obesity	49%	Obesity	49%	Obesity	44%
Mental Health Problems	30%	Diabetes	30%	Mental Health Problems	33%
Diabetes	27%	Mental Health Problems	28%	Aging Problems	27%
Aging problems (arthritis, hearing/vision loss)	21%	Aging Problems	26%	Diabetes	27%

Source: 2018 Community Health Needs Assessment, WVU School of Public Health Health Research Center

- *Develop* a strategic health communication and outreach plan to improve health literacy and promote partner services, programs, education, and training opportunities for all partners and beneficiaries.
- *Create* a resource directory for providers to refer patients to social services and train social services personnel on how to coordinate services and use analytics to improve the health of populations.
- *Facilitate* closing gaps between clinical care and community services by advocating for programs to help providers and patients with screening, referral, and community navigation services.
- *Establish* coalitions or communities of solutions to promote chronic disease prevention and close the gaps on targeted needs such as Adverse Childhood Experiences, trauma informed care, toxic stress, and substance abuse.
- *Expand* access to primary care services, integrate behavioral health, social, and faith-based services.

Success

The Health Work Group was able to ensure that questions about Adverse Childhood Experiences (ACEs) were included in the Community Health Needs Assessment conducted by West Virginia University School of Public Health for WVU Medicine Berkeley Medical Center and Jefferson Medical Center.

