Virginia's Plan for Well-Being

2025-2029

Partnering for a Healthy Virginia

VDH VIRGINIA DEPARTMENT OF HEALTH

Our vision is to be the healthiest state in the nation.

Virginia's Plan for Well-Being
2025–2029

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Exploring Emotions Through Color and Shape

All illustrations in this publication are from the students of Jennifer Harrelson's art class at Madison Elementary in Caroline County, Virginia. Their art prompt was to express emotions through color and shape using cut paper collage. Some layouts and colors were altered to better integrate into this publication.

The cover illustration represents "Happy."

A special "thank you" to Allison, Anabelle, Anneva, Ava, Kaelin, Olivia, Perla, and Sasha for letting us use your wonderful artwork.

Go Mustangs!

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> "Health is shaped by the places where we live, learn, work, and play. This means every community has its own unique challenges and opportunities for health and well-being.
>
> We need to look around our communities to see what's shaping our health — like a good education, a good job, access to quality housing, and quality healthcare."

—National Association of City and County Health Officials, 2018

Letter From Leadership

In 2019, Partnering for a Healthy Virginia (PHV) embarked on the State Health Assessment (SHA) process. The SHA is a compilation of trends and comparisons from many data sources that together paint a picture of Virginia's health. The completion of the SHA informed the development of the 2025–2029 Plan for Well-Being (PfWB), which serves as Virginia's State Health Improvement Plan. Priorities in the PfWB were chosen based on data described in the SHA. Members of the PHV Advisory Council guided the process using their experience and statewide perspective. We are grateful for their work and commitment.

Virginia's Plan for Well-Being 2025–2029 is a shared vision to improve the health of all Virginians. It outlines priority areas and includes strategies to improve the health of all people in Virginia. It is a tool for health care professionals, government agencies, community-based organizations, advocates, academia, policymakers, and other stakeholders to use to catalyze action that will leverage resources and focus work on measurable improvement. The PfWB's success depends on the contribution of many organizations essential to ensuring all Virginians reach their optimal health. Putting this plan into action can bring us together to achieve outcomes desired by organizations across multiple sectors.

This plan represents the culmination of a process in which stakeholders are committed to bringing their ideas and expertise to the table to protect the health and promote the well-being of all people in Virginia. We appreciate the work that went into creating the State Health Assessment and the Plan for Well-Being; it was a genuinely collaborative effort.

B. Cameron Webb, MD, JD
State Health Commissioner

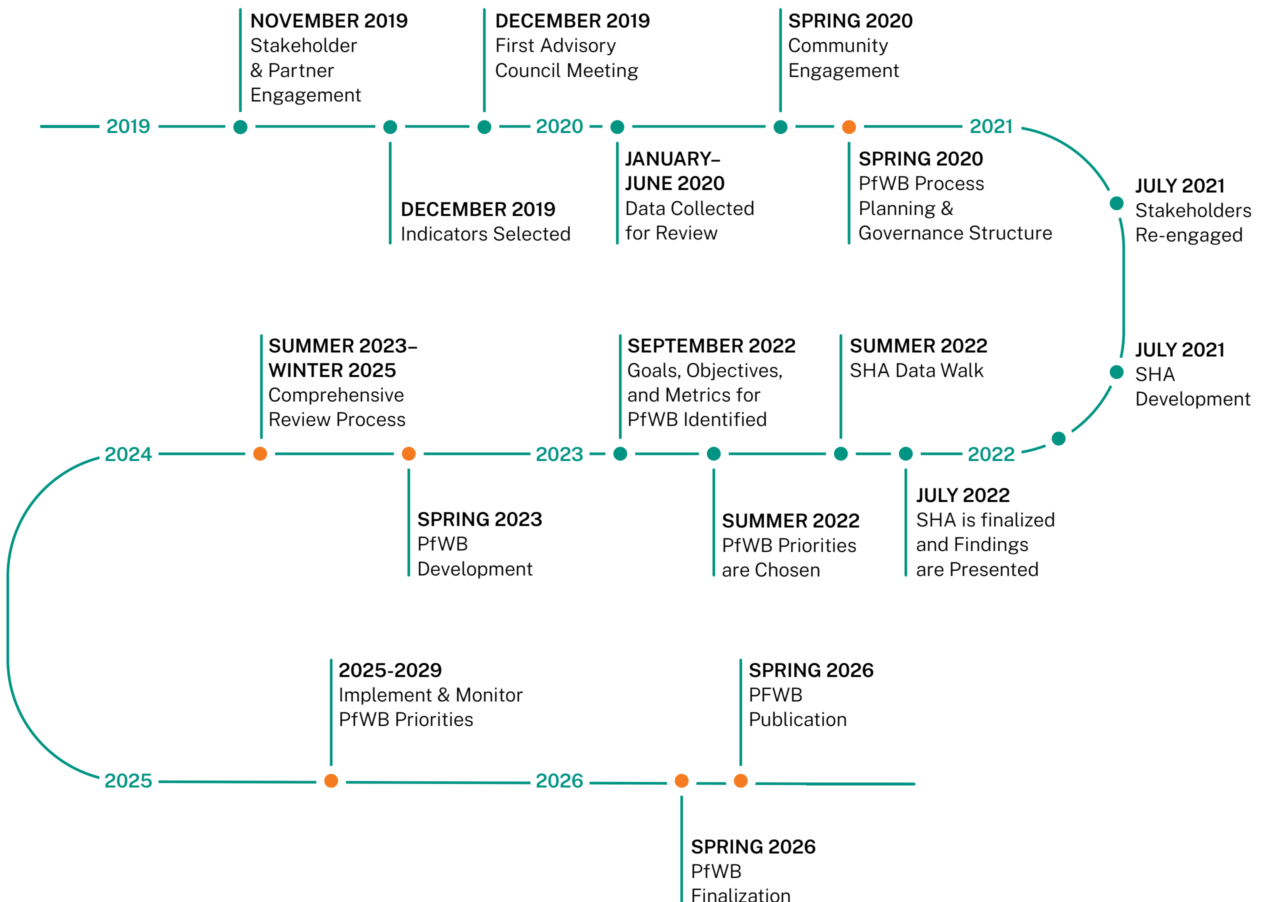
Sean T. Connaughton
President & CEO, Virginia Hospital & Healthcare Association

Development Process

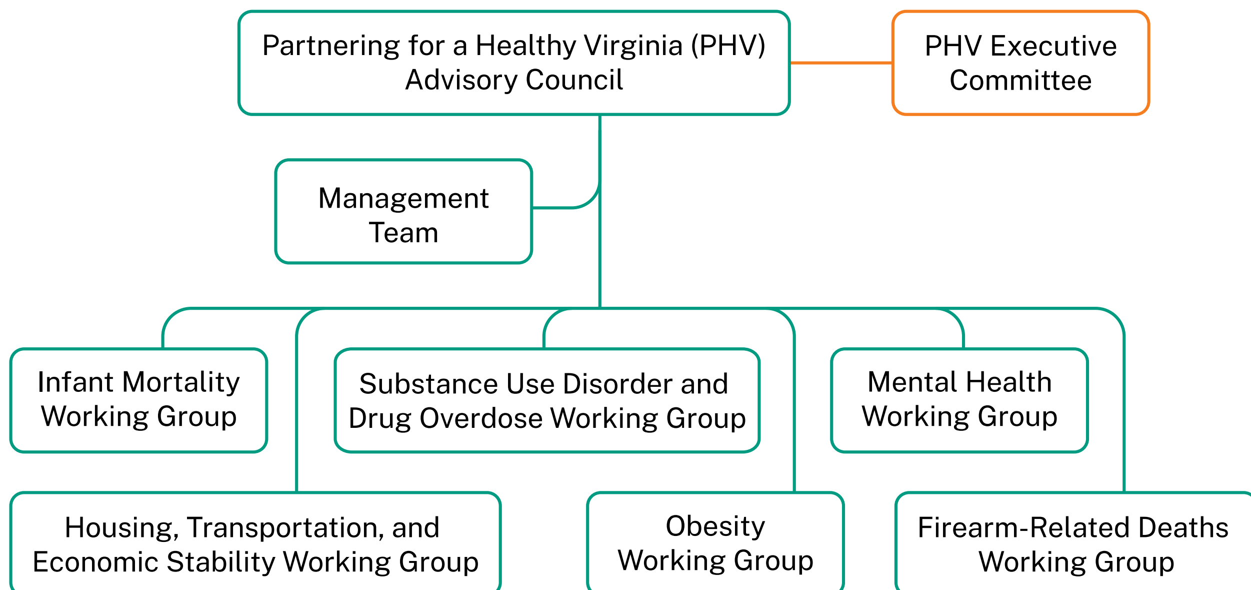
Health Assessment and Improvement Process

In 2019, the Virginia Department of Health (VDH) convened an advisory committee of over 50 wide-ranging organizations and partners to develop the State Health Assessment (SHA) and the Plan for Well-Being (PfWB). The 2022 SHA describes what we know about the health of Virginians at a point in time. It provides data for examining health inequities and serves as the basis for identifying the priority issues to be addressed in the PfWB document.

A modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) framework that was developed by the National Association of City and County Health Officials informed the 2022 SHA and the planning process for the PfWB. The Partnering for a Healthy Virginia (PHV) Advisory Council provided guidance, direction, and decision-making for the SHA. Working groups comprised of subject matter experts in each of the priority areas oversaw the development of comprehensive and measurable goals, objectives and strategies that outline the path forward for improving the health of all Virginians.



Development Structure



Plan for Well-Being Working Group Activities

The Plan for Well-Being (PfWB) outlines strategies and priorities that will guide our work for the next five years. Together, partners are already working on some of these strategies, while others will require further refinement and action planning.

If we understand why some people live long and healthy lives while others do not, we can be more strategic in developing actions and policies to address these challenges. This framework identifies contributors to health outcomes and the different strategies to move us from traditional downstream to upstream approaches.

The first year of this five-year plan includes:

- Shared Agenda – Developing relationships, building partnerships, and developing a shared agenda and implementation plan.
- Partners – Identifying partners that will carry forward the work and be accountable for progress.
- Actions – Outlining the actions needed to implement strategies at the different levels of the Centers for Disease Control and Prevention's Three Buckets of Prevention.
- Performance Measures – Developing and monitoring scorecards that will help track progress toward population health improvement, to include health outcomes and performance measures.

Determinants

Three Buckets of Prevention[1]

Traditional Clinical Prevention

Increase the use of clinical preventive services delivered to individuals

Health Care

Innovative Clinical Prevention

Provide services delivered to individuals that extend care outside the clinical setting

Health Care and **Public Health**

Community-wide Prevention

Implement interventions that reach whole populations

Public Health

1. J. A. (n.d.). Centers for Disease Control and Prevention. Retrieved from cdc.gov

Health Equity Statement

Every individual, family, and community in Virginia should have a fair and just opportunity to achieve optimal health, and no one's health should be limited by race, ethnicity, income, geography, disability status, or social and economic conditions.

Despite meaningful progress, significant disparities persist across Virginia. Differences in life expectancy, maternal and infant outcomes, mental health access, chronic disease burden, and exposure to community-level risks continue to disproportionately affect communities of color, rural populations, and historically under-resourced areas of Virginia. For example, racial disparities in maternal and infant outcomes, geographic differences in behavioral health access, and higher rates of chronic disease in economically disadvantaged communities reflect longstanding inequities in opportunity, access, and systemic investment.

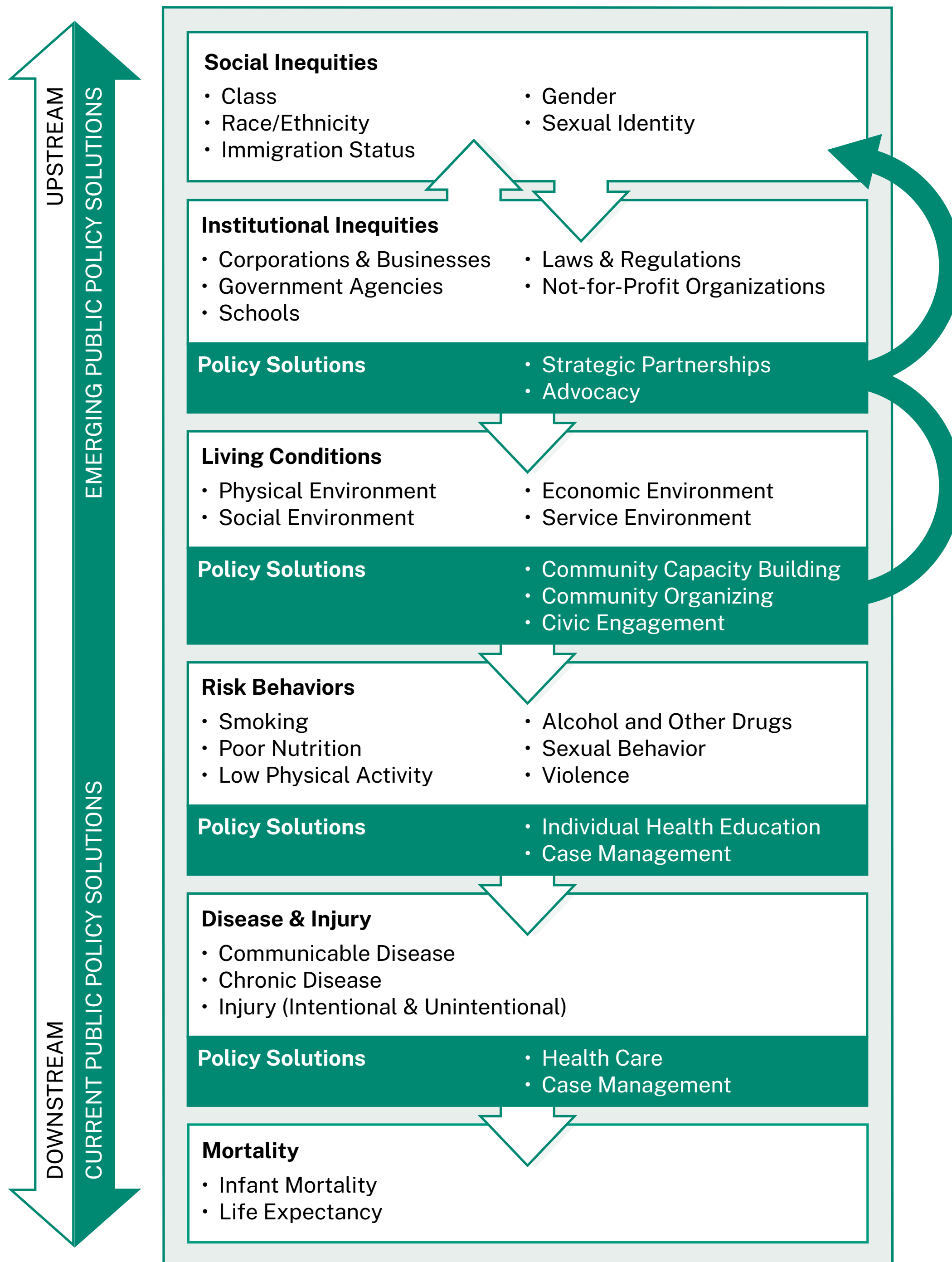
Virginia's Plan for Well-Being recognizes that health outcomes are shaped not only by clinical care, but by the conditions in which people are born, grow, live, work, play, and age. Inequities in housing stability, educational opportunity, transportation access, economic mobility, community safety, and access to health services contribute directly to disparities in health and well-being. Addressing these upstream drivers is essential to advancing population health across the Commonwealth and achieving our goal of making Virginia the healthiest state in the nation.

The Plan for Well-Being's commitment to health equity is operationalized through:

- Data-driven decision making using disaggregated and community-informed data.
- Cross-sector collaboration that addresses social, economic, and environmental drivers of health.
- Community engagement that centers lived experience.
- Prevention-focused strategies that reduce disparities while improving outcomes for all.
- Systems alignment that embeds equity into policy.

Our intent is that equity is not treated as a standalone initiative, but as an integrated principle across all priority areas, including mental health and well-being, substance use, maternal and child health, chronic disease prevention, community safety, and the social and economic conditions that shape health.

The PfWB uses a whole community approach to improving health, by strengthening communities, expanding access to opportunity, and investing in prevention and system-level solutions. Advancing health equity requires sustained leadership, accountability, and partnership. Through this plan, we commit to continuously examining disparities, addressing systemic barriers, and prioritizing equitable outcomes in policy, programming, and resource decisions.

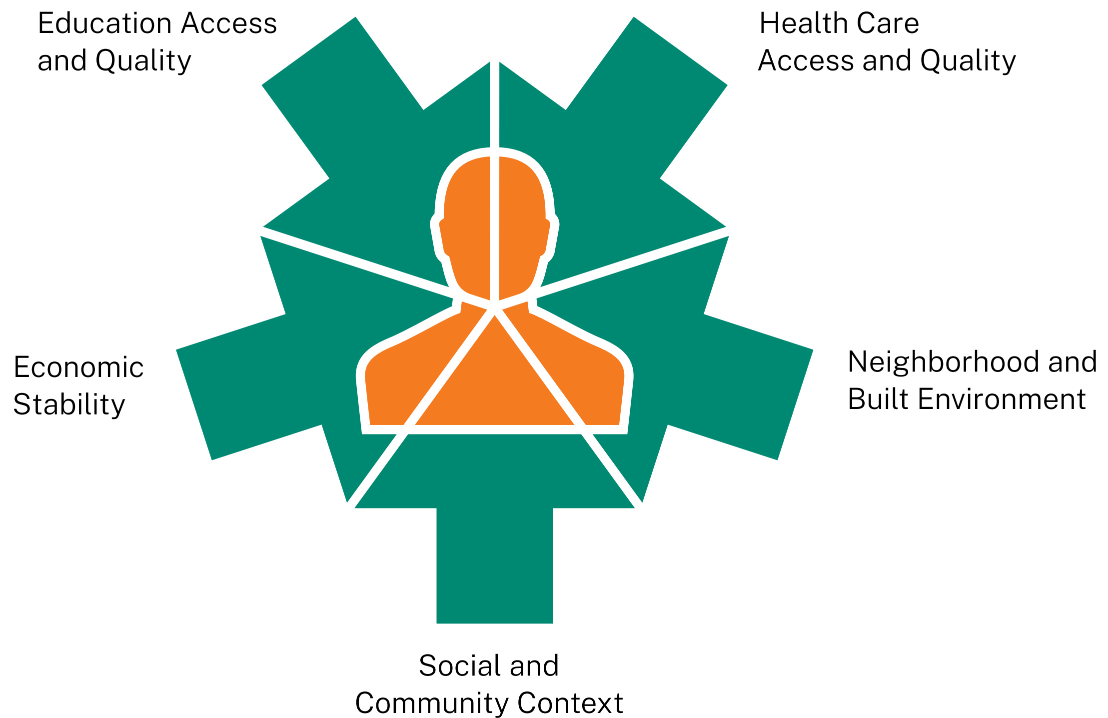


This image is adapted from Bay Areas Regional Health Inequities Framework.

The nationally recognized BARHII framework for health equity provides the path to health equity in our lifetime. It is used by thousands of government and community leaders throughout the country to guide their equity transformations. The framework serves as a foundational document in the American Medical Association's Health Equity strategy, was the foundation for the formation of the State of California Department of Public Health's Office of Health Equity, and has shaped the strategic planning of national, state, and local health jurisdictions.

Social Determinants of Health

Diagram Of Different Areas That Make Up The Social Determinants Of Health



The conditions in which we live, work, and play have an enormous impact on our health. These influences, known as the social determinants of health, are important to consider when thinking about improving the health of a population. Who our parents are, how far we advance in school, our income level, what we eat, whether we exercise or smoke or drink, the conditions of our homes and neighborhoods, and if we have access to health care and nutritious food all contribute to our overall health.

Data Walk

A data walk was used to present data to inform, educate, and engage stakeholders in a discussion about health outcomes in Virginia. A data walk is an interactive way for stakeholders to engage in dialogue around data about their community. These events were held twice in the summer of 2022. Members of the PHV Advisory Council and the Virginia Health Commissioner's Leadership Team participated. Members based their selection of the priorities for the PfWB on their review of the SHA findings using the below criteria.

Ability to Change
Does the health indicator measure health issues that are feasible to change? Are other groups able to provide resources that support change?

Health Disparity
Does the health indicator measure issues that disproportionately affect population subgroups?

Availability of Data
Are there data available to measure, track, and compare to other states?

Seriousness
Does the health indicator reflect health issues with high severity, such as high mortality or morbidity rate?

Magnitude
Does the health indicator measure health issues that affect a large proportion of the population?

Social Determinant
Does the health issue affect multiple health outcomes?

Grounded in data, the PfWB identifies strategies to improve outcomes around six priority areas identified by the SHA Advisory Council in August 2022.

- Infant Mortality
- Firearm-Related Deaths
- Obesity
- Mental Health
- Substance Use Disorder and Drug Overdose
- Housing, Transportation and Economic Stability

In fall 2022, working groups convened to develop strategies and priorities for the PfWB. The working groups included subject matter experts and members of coalitions already working on priority areas. The working groups focused on identifying goals, objectives, and strategies to inform implementation. Descriptions of these terms are below.

Goals
Goals are statements of vision or intent, often pertaining to a broad health outcome.

Objectives
Objectives are more focused steps that help us reach the overarching goals. Most objectives help us measure progress toward a goal over time; however, some objectives are not specifically measurable and are instead presented as general benchmarks that would demonstrate progress.

Strategies
Strategies describe components of how partners will aim to meet objectives and goals. Strategies within this document are not exhaustive and may adjust over time as objectives and goals are met.

Goals and objectives were established from 2020 baseline data unless otherwise specified in the PfWB. Finally, a core group of staff within VDH provided overall coordination support to the planning process, including staffing the advisory council and subcommittee meetings.

Healthy People 2030

The U.S. Department of Health and Human Services provides science-based, 10-year national objectives for improving the health of all Americans. The current objectives are called Healthy People 2030. Healthy People 2030 (HP 2030) establishes targets that are measurable, achievable, and applicable at the national, state, and local levels to improve health and well-being over the next decade. The 2025–2029 PfWB used HP2030 targets as benchmarks to establish its goals.

Priority

Infant Mortality

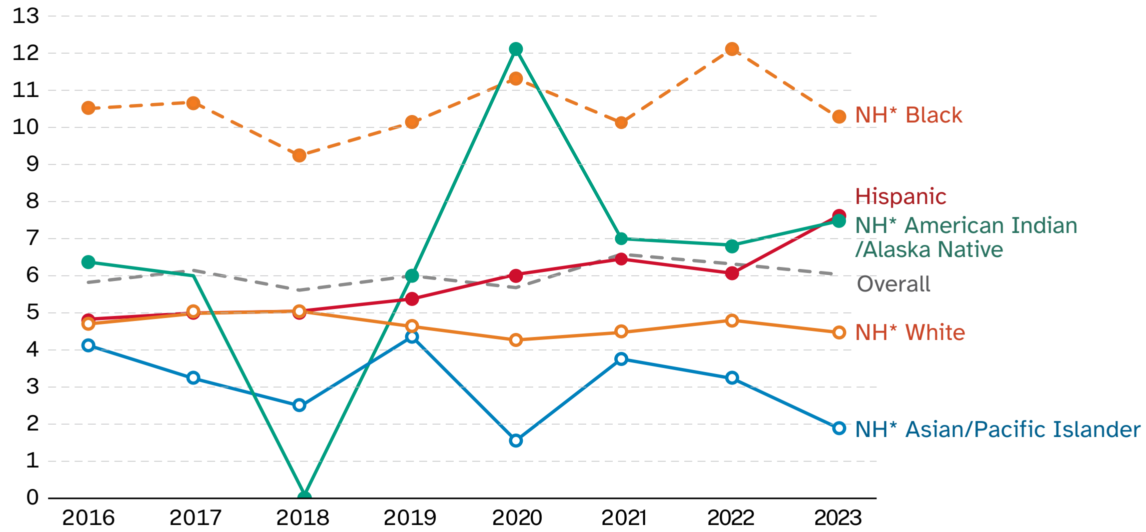
Infant mortality is a hallmark of overall health status of a population, which is why it has remained an objective of Healthy People 2030 and the Title V Maternal and Child Health Block Grant.

The health of mothers is also linked to the health of the infants, and risk factors of infant mortality are shared with risk factors of maternal mortality.

In 2020, 542 infants died before their first birthday in Virginia, making the overall infant mortality rate across all races 5.7 per 1,000 live births. This is a decline from an infant mortality rate of 5.9 in 2019. Since 2011, the overall infant mortality numbers have remained relatively constant, with a slight downward trend in recent years. However, this rate varies by race and ethnicity. For example, in 2020, the infant mortality rate among the non-Hispanic White population was 4.4, while the rate among non-Hispanic Black infants was 10.6. This disparity in infant mortality rates shows that Black infants were 2.4 times more likely to experience mortality than their white counterparts. To eliminate this disparity, the disparity ratio must be reduced to 1.0. Innovative care models such as the use of telehealth and doulas may address contributors to poor birth outcomes such as chronic disease and reduce disparities in maternal and infant care.

Rate of Infant Mortality by Race/Ethnicity, Virginia

(Rate per 1,000 live births, 2016–2023)

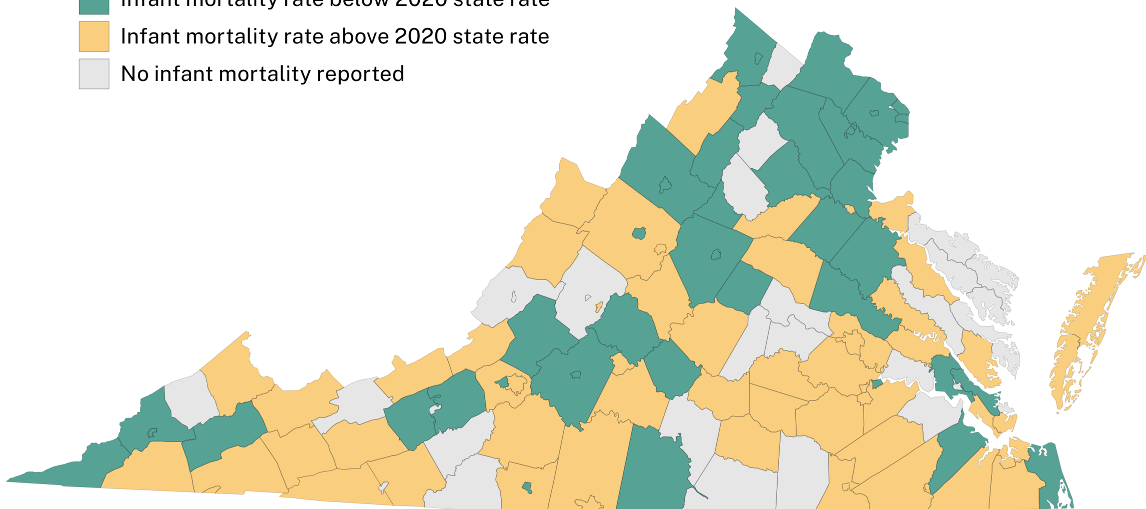


Source: Virginia Department of Health, Virginia Vital Statistics

*Non-Hispanic

Rate of Infant Mortality by Locality, Virginia

(2020)

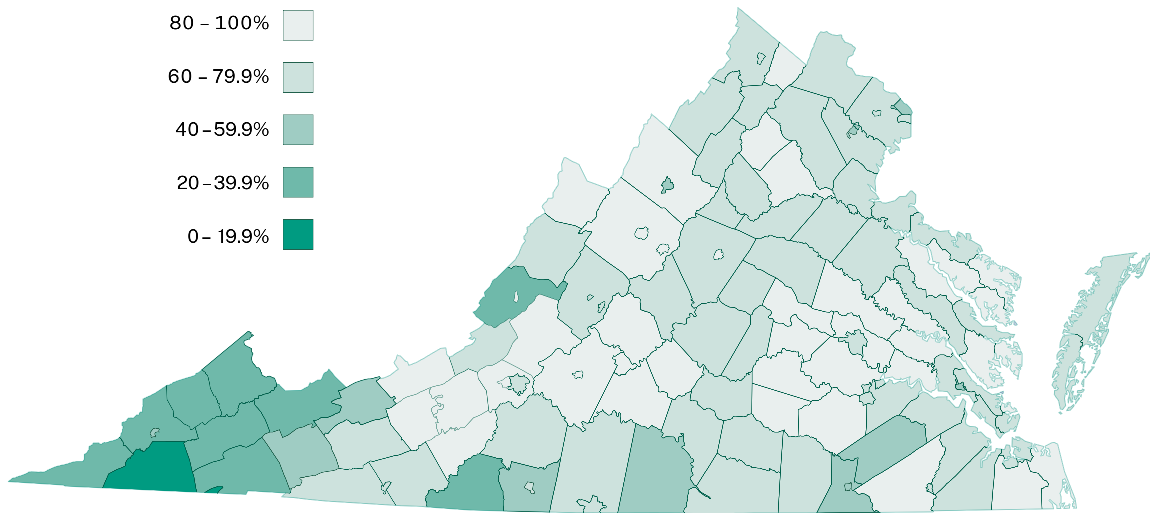


Source: Virginia Department of Health, Virginia Vital Statistics

Kotelchuck Index

Receipt of timely and adequate prenatal care is an important factor in improving the health of mothers and babies. The Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization, accounts for when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services), both documented on the birth record. Adequacy of initiation is classified as months 1-2, months 3-4, months 5-6, and months 7-9 of pregnancy. Adequacy of received services is classified by comparing the number of prenatal visits to the expected number of visits for the period between when care began and the delivery date, based on the American College of Obstetricians and Gynecologists prenatal care standards, and adjusted for gestational age when care began and at delivery. Adequate prenatal care is receiving 80% of expected visits. The Kotelchuck Index does not measure quality of prenatal care. Overall, in 2020, nearly three-quarters (73.1%) of the birthing population received at least adequate prenatal care in Virginia, as measured by the Kotelchuck Index. However, this percentage varied by locality, from less than 25% to 91.1%.

Percentage of Births that Received Adequate Prenatal Care by Locality, Virginia
(Percentage of care utilized from beginning to delivery, 2023)



Source: Virginia Department of Health, Vital Statistics

Goal

By 2029, reduce the infant mortality rate in Virginia from the baseline of 5.73 deaths per 1,000 live births to below the HP2030 target of 5.0 deaths per 1,000 live births.

Objective One

By 2029, decrease the percentage of infants born preterm from the baseline of 9.9% to below the HP2030 target of 9.4%.

Strategies

- Assess availability and utilization of prenatal care across the Commonwealth.
- Partner with health care providers, home visiting programs, doulas, and community organizations to encourage healthy behaviors in pregnancy.
- Assess the impact of social determinants of health (e.g., neighborhood, environment) on birth outcomes.

Objective Two

By 2029, reduce the Black-White infant mortality disparity ratio from the baseline of 2.4 to 1.0.

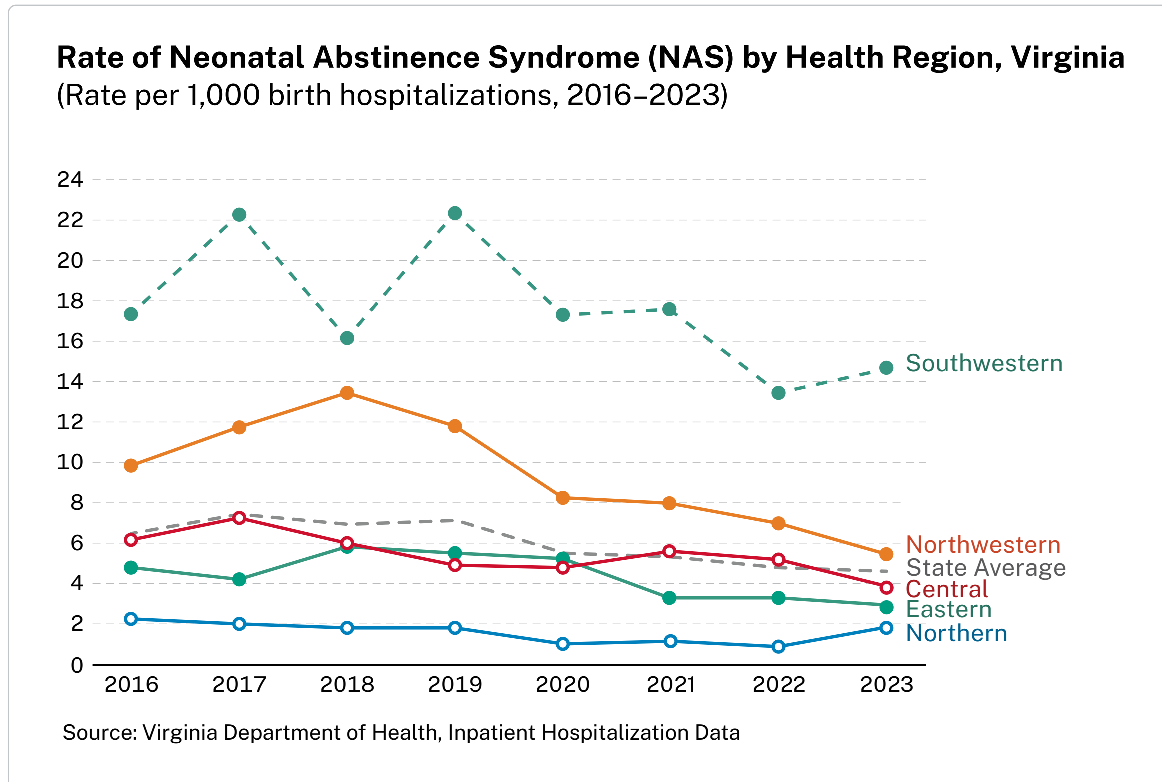
Strategies

- Assess the impact of environmental health on infant mortality.
- Reestablish the state Fetal Infant Mortality Review Team.[1]
- Conduct listening sessions and focus groups to understand barriers to implementing safe sleep strategies (e.g., parenting styles, cultural barriers, transient lifestyles, and parental age).
- Partner with home visiting programs, doulas, early childhood centers, childcare providers, lactation consultants, community organizations, and caregivers to promote Safe Sleep interventions.

1. Fetal and Infant Mortality Review (FIMR) is a community based, action-oriented process to examine confidential, de-identified cases of fetal and infant deaths with the goal of identifying ways to prevent these deaths for women, infants, and families.

Objective Three

By 2029, decrease the rate of babies born with Neonatal Abstinence Syndrome (NAS) among birth hospitalizations by 10% (from the baseline of 5.8 to 4.64 per 1,000 birth hospitalizations).



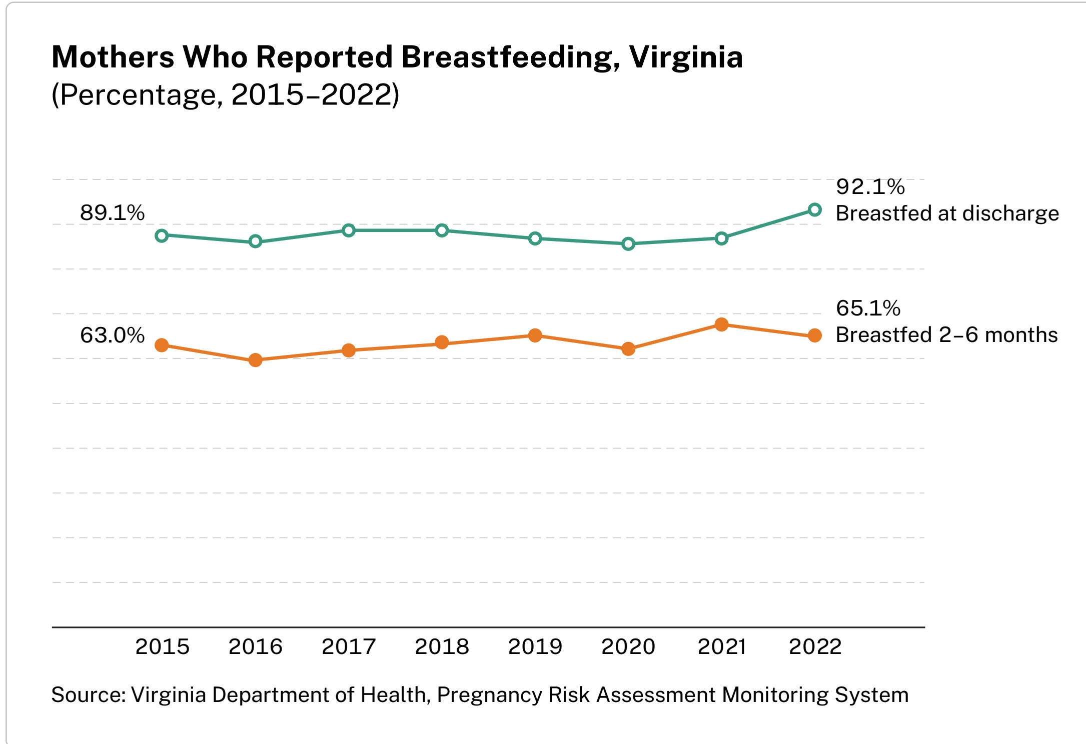
Strategies

- Develop a state strategy on perinatal substance use.
- Enhance state practices for the accurate and comprehensive collection of Neonatal Abstinence Syndrome (NAS) cases, and improve the quality, consistency, and reliability of the data collected.
- Develop a standardized tool for assessing Neonatal Opioid Withdrawal Syndrome (NOWS)/ NAS/substance-exposed infants.[2]
- Ensure prevention education is given to providers and the pregnant population about the benefits of human milk feeding to mitigate effects of infant withdrawal symptoms during the early postpartum period.

2. Neonatal Opioid Withdrawal Syndrome (NOWS) is included under the umbrella of Neonatal Abstinence Syndrome (NAS). Whereas NAS refers to withdrawal due to exposure of multiple substances, NOWS refers to withdrawal due to exposure to opioids (www.MarchofDimes.org).

Objective Four

By 2029, increase the percentage of mothers who report breastfeeding at 2–6 months by 10% (from the baseline of 62.7% to 68.97%), with targeted strategies for Black and Hispanic infants.



Strategies

- Increase participation and awareness for child care facilities about the Virginia Breastfeeding Early Care Recognition.
- Develop a state strategic plan for breastfeeding.
- Increase hospital participation in the Virginia Maternity Center Breastfeeding-Friendly Designation Program to promote exclusive breastfeeding, increase patient education on breastfeeding, and enhance provider preparedness to educate families on breastfeeding.
- Initiate collaboration opportunities for consistent safe sleep messaging across home visiting, WIC, and doula programs at VDH, as well as with other state agencies.
- Create culturally responsive safe sleep educational materials for local health district partners to utilize for the families they serve.

Objective Five

By 2029, reduce the maternal mortality Black-White disparity ratio from the baseline of 2.1 to 1.0.

Strategies

- Recognize chronic disease as a factor in maternal mortality, and partner with existing organizations to develop and coordinate regional systems for risk-appropriate care that addresses chronic disease in the pregnant population.
- Expand innovative delivery methods and telehealth options, especially in rural and underserved areas, to ensure that pregnant women receive care for chronic health conditions.
- Increase utilization of early prenatal and postpartum care.
- Strengthen coordinated care models between clinical and community-based systems.
- Strengthen the doula workforce by increasing the number of doulas overall, and the number of certified doulas that can be reimbursed by Medicaid.
- Initiate and develop Community Health Worker workforce that focuses with the pregnant and postpartum population.

Priority

Firearm-Related Deaths

Firearm-Related Injury and Death

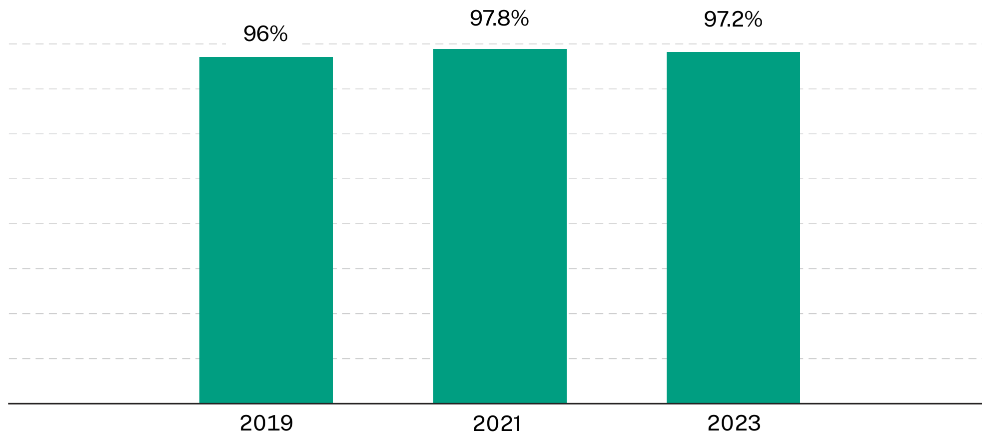
Firearm-related injuries are a major public health concern in both the United States and Virginia. These injuries and deaths may be intentionally self-inflicted (suicide), assault-related (homicide), unintentional, related to legal intervention, or of undetermined intent. Beyond the direct health impacts, these events affect individuals, families, neighborhoods, and entire communities. Comprehensive prevention strategies at both the state and community level are essential to reducing firearm-related injury and death. Virginia should take a public health approach to preventing all kinds of violence, by leveraging data, partnerships, and evidence-based strategies to address root causes of violence, prevent future violence, and strengthen community resilience, with a focus on improving health outcomes. Through collaboration across sectors, the Commonwealth can reduce the public health impacts of violence and support safer, healthier communities for all Virginians.

When environments are safe, people can flourish, injuries and violence decline, and communities grow stronger and more resilient. Promoting safety and well-being calls for a broad approach – one that brings together local agencies, community organizations, and other partners to implement proven strategies that foster equity and health across all groups. Social, economic, and environmental factors shape many health outcomes at once, and tackling shared risk and protective factors is essential. Challenges like violence, injury, and poor mental health often have similar underlying causes, including substance use, low social support, and poverty. By nurturing protective influences—such as strong family ties, connected communities, access to education, and economic opportunity—we help individuals, families, and neighborhoods thrive. Working together to reduce risks and strengthen protective factors across all levels can build safer communities and lower rates of violence and injury for everyone.

Key statistics for Virginia (2019–2023):

- Non-fatal firearm-related hospitalizations increased by 12%, peaking in 2022 at 845 hospitalizations.
- On average, three Virginians died by firearm every day.
- Total firearm-related deaths were 5,978 (average 1,196 per year).
- Firearm-related deaths rose by 20%, reaching 1,309 in 2022.
- Most deaths involved suicide (59%) and homicide (39%).
- Firearm-related homicides increased 39% (from 342 to 475 deaths).
- Firearm-related suicides increased 10% (from 662 to 727 deaths)

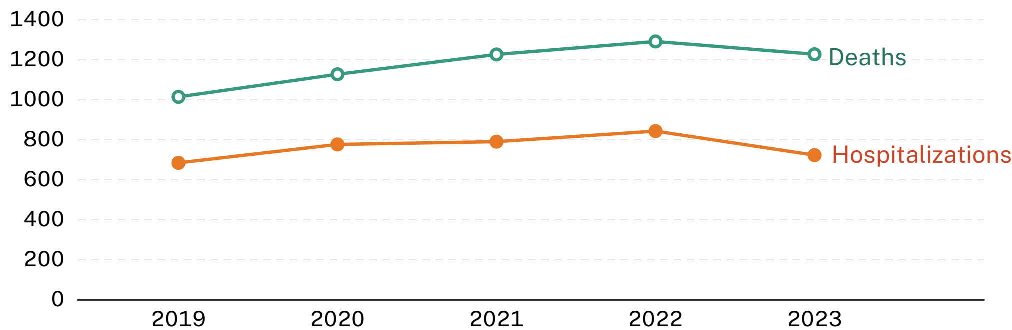
Public High School Students Who Did Not Carry a Gun[1]
(Percentage, 2019–2023)



Source: Virginia Youth Survey

1. Not counting the days when they carried a gun only for hunting or for a sport such as target shooting, on at least one day during the 12 months before the survey

Nonfatal Firearm-Related Injury Hospitalizations and Firearm-Related Deaths among Virginia Residents
(Number of Hospitalizations and Deaths, 2019–2023)



Source: Virginia Vital Events and Screening Tracking System (VESTS)

Goals

By 2029, reduce firearm-related death rate from the baseline of 14.4 deaths per 100,000 people to below the HP2030 target of 11.9 deaths per 100,000 people.

Objective One

By 2029, enhance and expand ongoing prevention efforts to address firearm-related deaths.

Strategies

- Develop and share firearm-related injury data products (e.g., dashboards, data briefs) to raise awareness of the burden of firearm-related injuries and deaths. Use these insights to guide community partners and policymakers in creating program roadmaps for both unintentional and intentional injury prevention.
- Support implementation of Counseling on Access to Lethal Means (CALM)[1] training across health systems, equipping providers to help clients at risk for suicide reduce access to lethal means. Promote suicide prevention hotlines, such as the 988 Lifeline, to provide immediate resources for individuals and families.
- Collaborate with diverse, multi-sectoral partners to implement interventions across the Social Ecological Model. These efforts seek to decrease risk factors and increase protective factors at individual, family, community, and public levels.

Objective Two

By December 2026, VDH will convene partners and localities to share evidence-based strategies specifically for preventing community violence and firearm-related injuries that improve public health outcomes, recognizing violence prevention as a public health issue and strengthening collaboration between stakeholders working on this issue across Virginia.

Strategies

- Convene partners across sectors to participate in a statewide learning forum focused on community violence and firearm-related injury prevention, with a focus on improving public health outcomes.
- Identify and compile evidence-based and promising practices related to community violence and firearm-related injury prevention and share them through the statewide convening and partner networks.
- Facilitate opportunities for ongoing knowledge exchange among partners by connecting localities, hospitals, and community organizations working on violence prevention to strengthen collaboration and learning across Virginia.

1. Counseling on Access to Lethal Means is a free, self-paced, online course for healthcare and social service providers.

Priority

Obesity

Obesity affects an estimated 40% of adults in the United States. Obesity is linked to physical, metabolic, and psychological health and is a chronic disease. Obesity disproportionately affects certain groups. Factors such as age, educational attainment and household income can influence prevalence.[1]

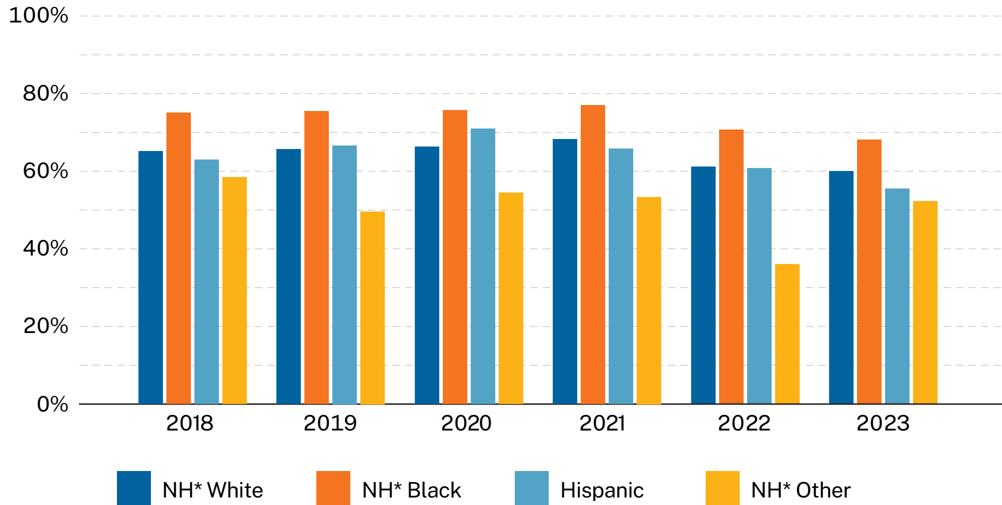
Diets high in fruits and vegetables reduce the risk of many chronic diseases such as Type 2 diabetes, obesity, heart disease, and stroke. Barriers to regular consumption of fruits and vegetables include access to fresh produce, cost, perceived lack of preparation time, and cooking knowledge. Regular physical activity can improve all ages' health and quality of life.

According to the CDC, physical inactivity is one of the leading risk factors for non-communicable disease mortality among adults. The American Heart Association's recommendation for an adult's physical activity is to get at least 150 minutes per week of moderate-intensity aerobic exercise or 75 minutes of vigorous aerobic activity per week. Aerobic exercise includes three components: intensity, frequency, and duration. Regular physical activity will improve the health and well-being of all adults regardless of age.

Physical activity can lower the risk of premature death, disability, heart disease, cancer, stroke, high blood pressure, and other chronic health conditions. The percentage of adults in Virginia who are overweight or obese slightly increased from 2016 (65.4%) to 2021 (68.1%). In 2021, 34.0% of adults in Virginia were obese which met the HP 2030 target of reducing the proportion of adults with obesity to less than 36%.

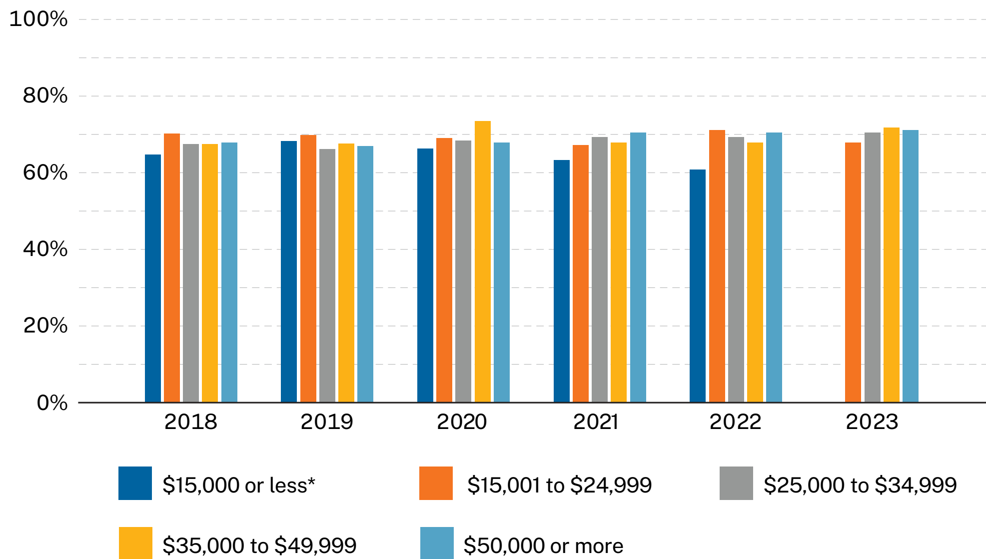
1. Centers for Disease Control and Prevention, 2020

Adults Who Are Overweight or Obese by Race/Ethnicity
(Weighted Percentage, 2018–2023)

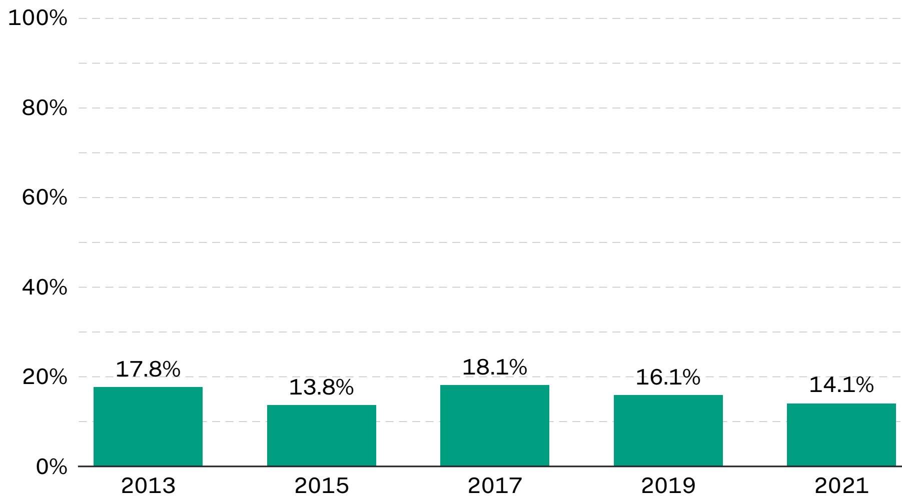


Source: Virginia Department of Health, Behavioral Risk Factor Surveillance System
*Non-Hispanic

Adults Who Are Overweight or Obese by Income
(Weighted Percentage, 2018–2023)



Source: Virginia Department of Health, Behavioral Risk Factor Surveillance System
*Where the unweighted sample size for the denominator is <20 or the confidence interval-half-width is more than 10, data are suppressed.



Goals

By 2029, reduce the proportion of adults with obesity below the target of 31% (baseline 32.2%).

By 2029, reduce the percent of children and adolescents (ages 10–17) with obesity below the HP2030 target of 14.5% (baseline 14.9%).

Objective One

By 2029, increase the proportion of adults and youth who eat at least five servings of fruits and vegetables per day by 5% (from the baseline of 16.1% to 21%).

Strategies

- Promote the adoption of food service/nutrition standards in schools and worksites.
- Promote healthy eating via incentives in employer wellness programs.
- Implement policies and practices that create a supportive nutrition environment.

Objective Two

By 2029, address social determinants of food access by increasing the number of communities that participate in community-based programs that support education to reduce chronic diseases.

Strategies

- Explore opportunities to re-establish programming efforts such as the Million Hearts program[1].
- Increase community education and awareness about healthy and active living through community education and communication strategies.
- Encourage adoption of community designs that support active living.
- Increase the number of evidence-based employee wellness programs to include opportunities for fitness classes during the workday.

Objective Three

By 2029, decrease the percent of adults who report having type 2 diabetes by 5% (from the baseline of 11.1% to 10.5%.

Strategies

- Increase the proportion of eligible Virginians that complete a CDC-recognized type 2 diabetes prevention program.
- Engage Community Health Workers to connect underserved communities to health care systems and diabetes prevention programs.
- Increase the number of participants in programs such as the Walk with Ease program[2].
- Promote the adoption of multi-component physical education policies for schools.
- Provide exercise and physical activities at senior and community centers.

1. Million Hearts® is a national initiative to prevent one million heart attacks and strokes within five years. It focuses on implementing a small set of evidence-based priorities and targets that can improve cardiovascular health for all.
2. Walk With Ease Program is a community-based physical activity and self-management education program. While walking is the central activity, Walk With Ease is a multi-component program that also includes health education, stretching and strengthening exercises, and motivational strategies. The program includes a guidebook and a walking schedule to get you safely moving toward better health.

Objective Four

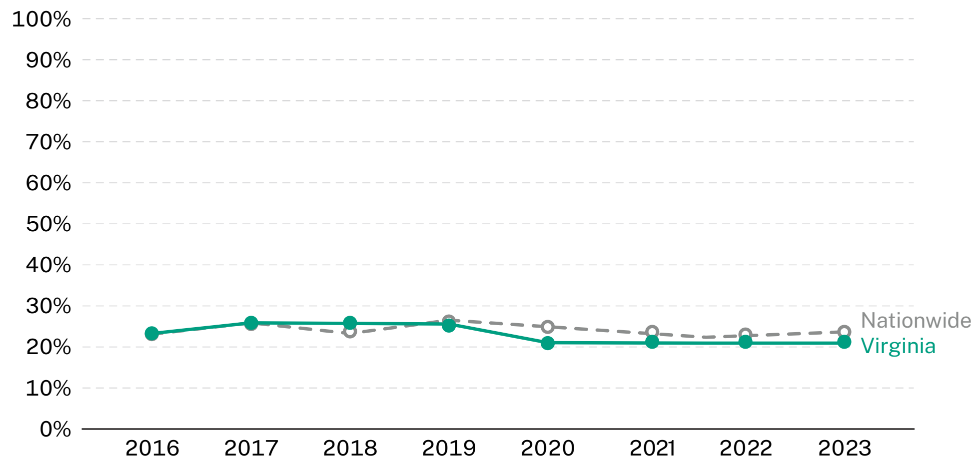
By 2029, continue to implement programs, services, and policies to sustain the proportion of adults who do no physical activity in their free time in Virginia at or below the HP2030 target of 21.8% (baseline 20.88%).

Strategies

- Identify and promote programs and policies to increase physical activity among Virginians.
- Assist communities in establishing walking groups and walk-friendly communities.
- Partner with organizations and departments to offer free physical activities in rural communities.
- Create a statewide physical resource guide for rural communities.
- Collaborate with partners to install outdoor exercise equipment in at least one public park in a low socioeconomic area.

The Percent of Adults With No Leisure Time Physical Activity in the Past Month

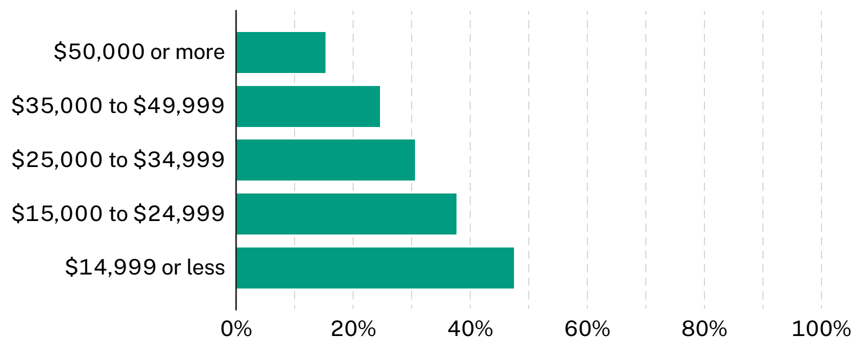
(Percentage between 2016–2023)



Source: Virginia Department of Health, Behavioral Risk Factor Surveillance System

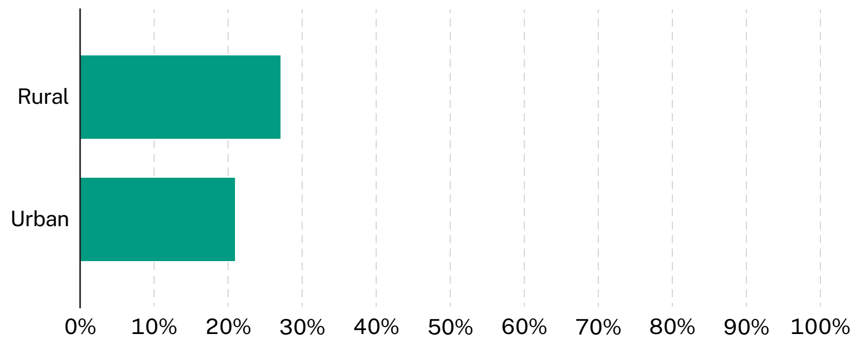
Adult Virginians With No Leisure Time Physical Activity in The Past Month by Income

(Percentage, 2022)



Source: Virginia Department of Health, Behavioral Risk Factor Surveillance System

Adult Virginians With No Leisure Time Physical Activity in The Past Month by Urban/Rural Status
(Percentage, 2023)



Source: Virginia Department of Health, Behavioral Risk Factor Surveillance System

Objective Five

By 2029, increase the proportion of adolescents who do enough aerobic and muscle-strengthening activity from a baseline of 22% to above the HP2030 target of 24.1%.

Strategies

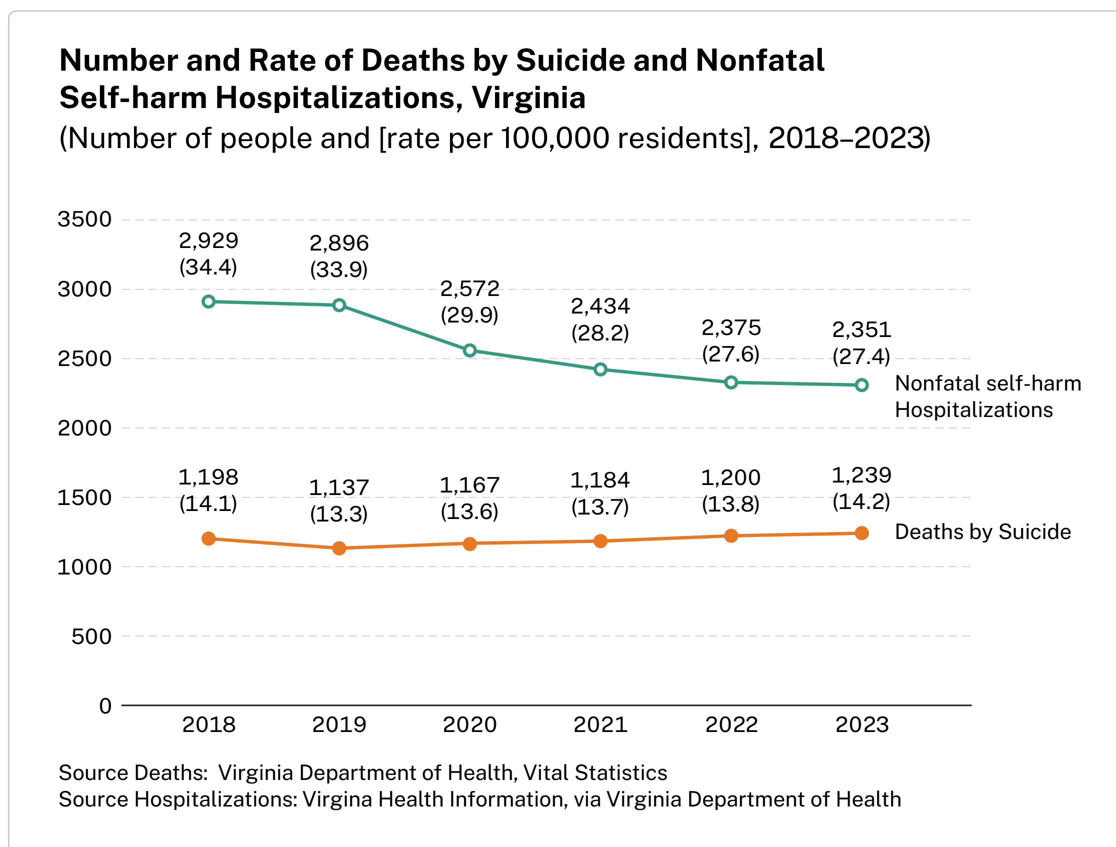
- Increase the number of schools that incorporate education for safe walking and biking by partnering with walking/biking organizations to bring programming to schools.
- Develop campaign to promote less screen time and more physical activity.
- Develop family-based exercise programs that encourage families to move together.
- Develop virtual exercise programs where youth/families can exercise from their homes with a virtual coach or group.
- Promote the adoption of recess policies for schools.
- Reduce social media use by adolescents.

Priority

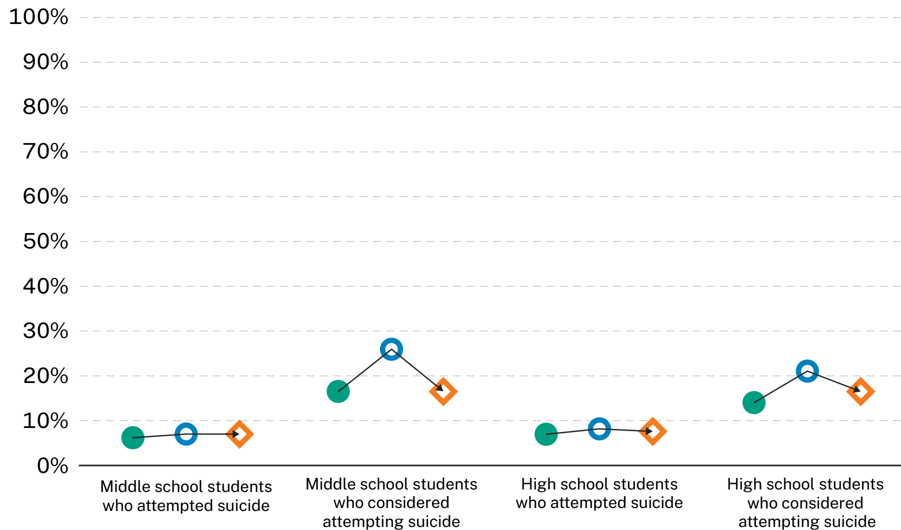
Mental Health

Mental health is defined by emotional, psychological, and social well-being, which can be influenced by what an individual does to impact their well-being.[1] It can also be attributed to how a person handles stress and makes healthy choices.

Mental health is essential in every stage of life, from childhood and adolescence through adulthood. Mental and physical health are both essentially important components of overall health. Mental and physical health conditions can increase the risk for developing many types of chronic conditions. Some mental health conditions are associated with an increased risk of suicide, but it is important to note that not all deaths by suicide are due to a mental health condition.



1. Centers for Disease Control and Prevention, 2021



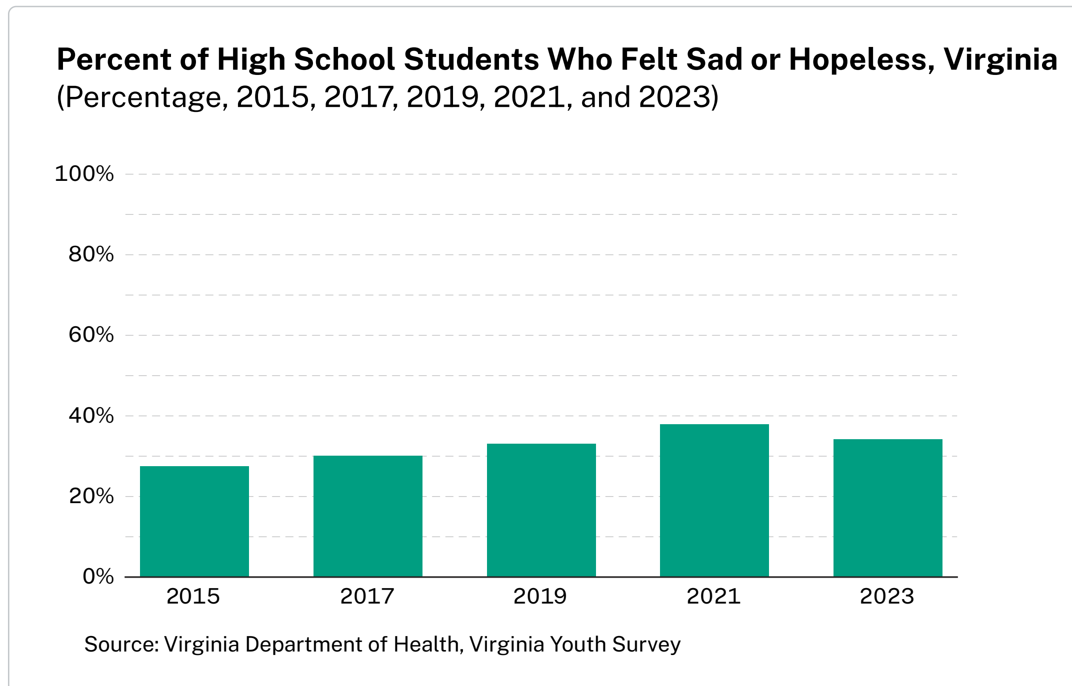
- Almost two out of 10 adult Virginians reported having depression, and more than one out of 10 adults reported 14+ days of poor mental health in the past 30 days.
- Virginia high school students who reported feeling sad or hopeless every day for 2+ weeks in a row increased from 2013 (25.7%) to 2019 (32.4%).
- The percentage of adults who reported three or more adverse childhood experiences (ACEs) remained stable from 2016 (8.20%) to 2019 (8.0%).
- In 2016, 2017, and 2019, a higher percentage of Hispanic adults reported three or more ACEs compared with other racial and ethnic groups.
- More middle and high school students in 2021 reported suicidal ideation compared to 2015.
- Nonfatal self-harm hospitalizations decreased by 25%, and deaths by suicide remained stable in Virginia from 2016 to 2021.

Goal

By 2029, decrease the rate of deaths by suicide in adults from the baseline of 13.4 deaths per 100,000 people to below the HP2030 target of 12.8 deaths per 100,000 people.

Objective One

By 2029, decrease the percentage of high school students who reported feeling sad or hopeless every day for two or more weeks by 5% from the baseline of 38.5%.



Strategies

- Increase the number of school districts and community groups that use evidence-based and best practice programs that promote resilience and healthy decision-making.
- Explore avenues for expanding after-school programming.
- Continue to provide, and where not available develop, prevention and early intervention services to middle and high school students.
- Identify evidence-based strategies and tools to use in prevention and intervention services for middle and high school students.
- Plan in-person and virtual education sessions using approved resources and programs to educate students on the importance of mental wellness.

Objective Two

By 2029, increase same-day care for individuals experiencing behavioral health crises.

Strategies

- Enhance mobile crisis team capacity.
- Enhance crisis receiving and stabilization capacity.

- Provide training and support to Community Service Boards (CSBs).
- Expand community-based models.
- Empower communities to address the substance use crisis.
- Support public campaigns to increase the attractiveness of behavioral health roles in the workforce.
- Increase cross-agency referrals for social needs utilizing Virginia's e-referral platform.

Objective Three

By December 2029, continue programs and services that support a decline in non-fatal self-harm hospitalizations and deaths by suicide.

Strategies

- Increase community follow up and connection to care following a suicide attempt or crisis through improved collaboration among first responders, hospitals, emergency rooms, inpatient mental health programs, and local crisis service providers.
- Increase mental health provider availability in underserved areas.
- Continue to support the multi-agency response for the U.S. and Virginia transition from the 11–digit National Suicide Prevention Lifeline to 988, an easy-to-remember three-digit number for 24/7 crisis care, and the Veteran Crisis Line.
- Provide training to mental health professionals to increase support and referral options for Virginians at risk of suicide or experiencing unmet mental health needs.
- Promote suicide prevention as a core component of health care services.
- Continue to address the social determinants of health that increase the risk of suicide, self-harm, and adverse health consequences such as adequate housing and economic opportunities and provide support to address food security.
- Continue to heighten public awareness of lethal means storage and increase help seeking.
- Continue to support Virginia Mental Health Access Program to reduce wait time for mental health assessment and treatment of moms' young children, minimize barriers to treatment, and provide support to local pediatricians who see children with mental health issues.
- Continue to support Collaborative Care models as a systematic strategy for treating behavioral health conditions in primary care through the integration of care managers and psychiatric consultants.

Objective Four

By 2029, reduce barriers to employment and increase employment among Virginians with a mental health disorder.

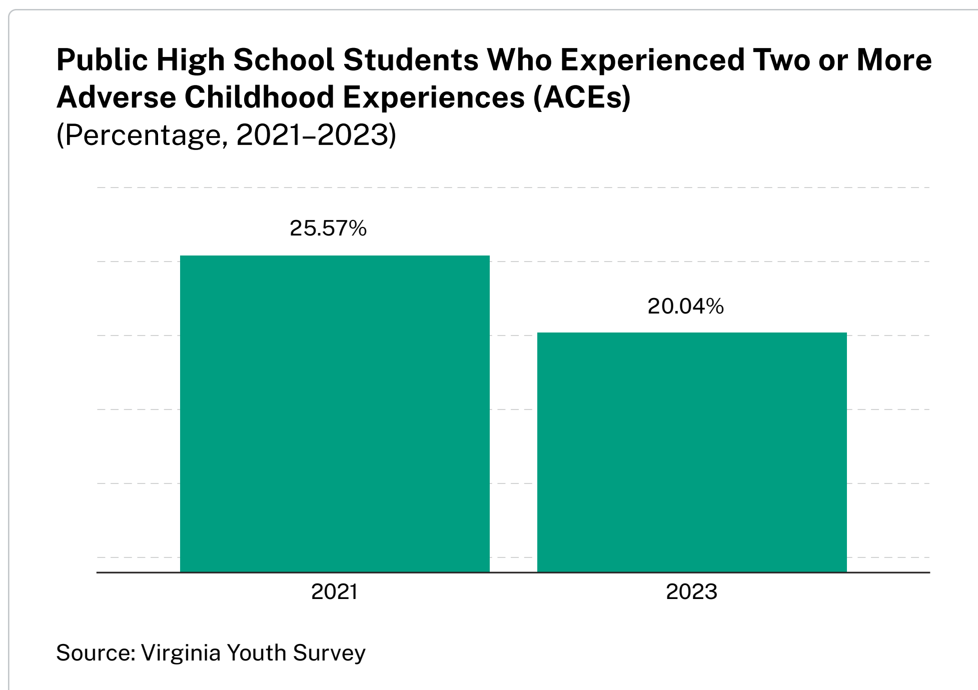
Strategies

- Assist in finding adequate employment opportunities for Virginians diagnosed with a mental disorder who are unemployed.
- Educate providers on the Virginia e-referral platform and the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) screening tool to provide coordinated care and address social needs for Virginians seeking behavioral health services.[1]
- Promote and increase the use of screenings via Virginia's e-referral platform to provide housing and employment resources as part of treatment plan.

Adverse Childhood Experiences (ACEs)

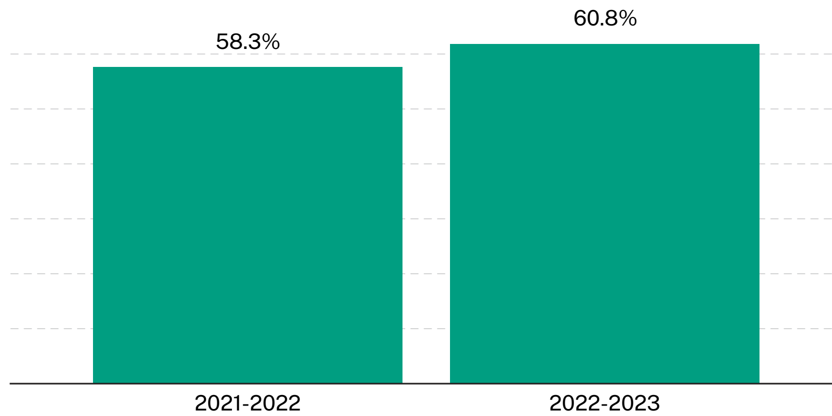
Adverse childhood experiences (ACEs) are potentially traumatic or stressful events that occur before age 18 and can have long-lasting effects on emotional, behavioral, and physical health and well-being. ACEs include household experiences, such as emotional, physical, or sexual abuse; neglect; witnessing domestic violence; or living with caregivers who face substance misuse, mental illness, divorce, or incarceration. Some ACEs are also rooted in the broader community, like witnessing neighborhood violence.

Exposure to ACEs increases the risk of chronic diseases, mental health challenges, and health-harming behaviors. By preventing and addressing ACEs early through supportive services, trauma-informed care, and strong early childhood programs, communities can reduce long-term negative impacts and build safe, healthy communities.



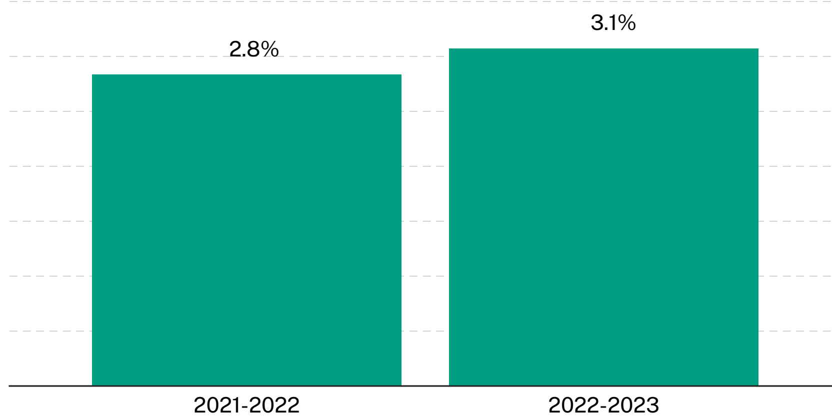
1. PRAPARE is a national standardized patient risk assessment protocol designed to engage patients in assessing & addressing social drivers of health (SDOH).

Percent Who Responded "Yes" to the Question, "Does This Child Live in a Supportive Neighborhood?
(Percentage, 2021–2023)



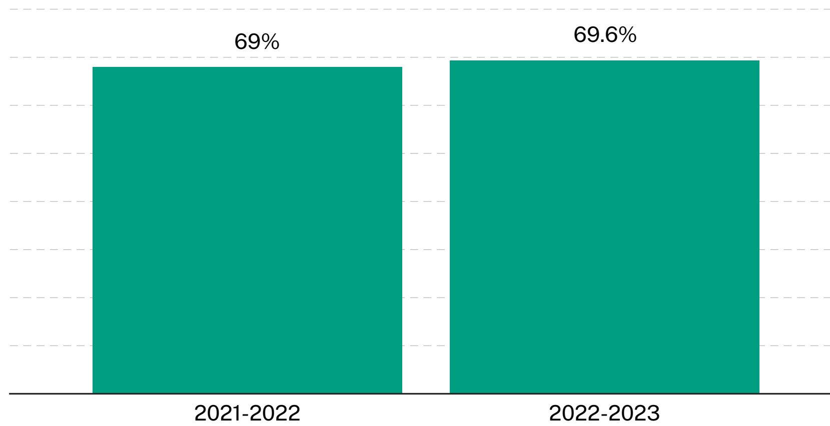
Source: National Survey of Children's Health

Percent Who Responded "Yes" to the Question, "To the Best of Your Knowledge, Has This Child Ever Experienced the Following: Was a Victim of Violence or Witnessed Violence in Neighborhood?"
(Percentage, 2021–2023)



Source: National Survey of Children's Health

Percent Who Responded, "Definitely Agree" to the Question "Does This Child Live in a Safe Neighborhood?"
(Percentage, 2021–2023)



Source: National Survey of Children's Health

Goal

By 2029, decrease the percentage of children ages (<18) who report two or more Adverse Childhood Experiences (ACEs) from the baseline of 20% by 5%

Objective

By December 2029, establish systems to promote life skills and building resilience for children younger than 18 years old.

Strategies

- Integrate family resilience screening in primary care by encouraging pediatricians and family physicians to screen for family strengths and refer families to parenting support, education, and crisis assistance services, including community-based hubs like Richmond SCAN.
- Partner with schools, early childhood centers, and community-based organizations to offer positive parenting programs and expand mentoring opportunities in community or virtual settings.
- Strengthen economic support by supporting policies like child tax credits, affordable childcare, and housing assistance.
- Launch public awareness campaigns on ACEs, resilience, and available parenting and family resources.

Priority

Substance Use Disorder and Drug Overdose

Substance use disorder and drug overdoses have been increasing in the Commonwealth for many years, and the COVID-19 pandemic accelerated this trend. Drug overdoses increased 78% from 2017 to 2021, with 2,622 drug overdose deaths among Virginians in 2021. Seventy-eight percent of drug overdose deaths in 2021 involved synthetic opioids, which include fentanyl, fentanyl analogs, and tramadol. From 2017 to 2021, drug overdoses involving synthetic opioids increased 157%.

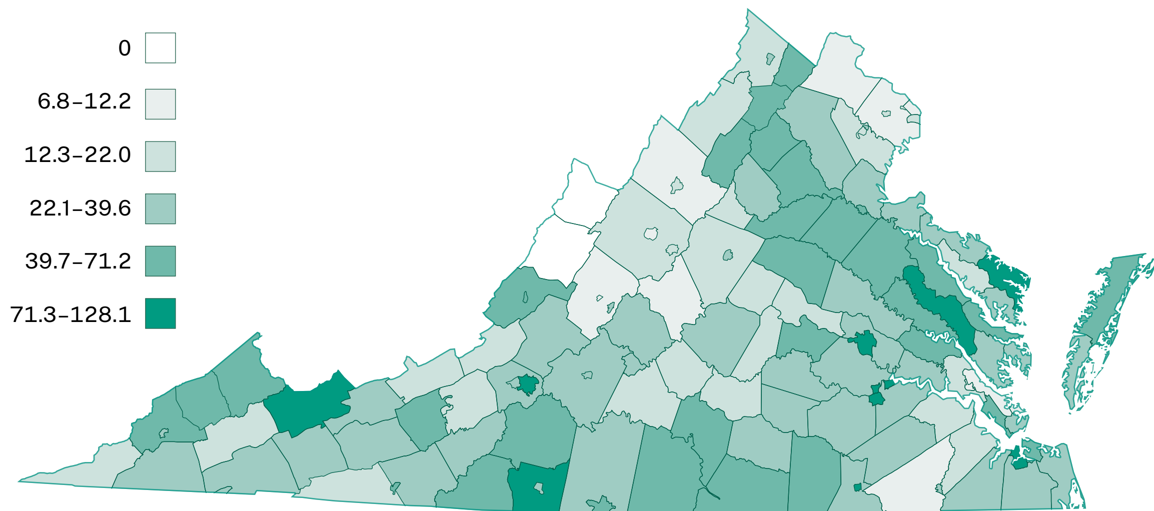
Substance use affects not only the individual, but their family and loved ones, and the community. Babies born to mothers who use substances during pregnancy may experience withdrawal symptoms at birth; people who use drugs may require extensive medical treatment for complications associated with drug use like injection-related wounds or hepatitis; communities with high rates of substance use disorder may struggle to find an adequate workforce; and the emotional toll on loved ones of people struggling with substance use, or who have died from an overdose, cannot be quantified.

Virginia is not alone in this—more than 20 million adults and adolescents in the United States have had a substance use disorder in the past year.[1] Strategies to prevent substance use disorder and to mitigate the harm of substance use will improve the health of individuals and the overall well-being of communities across the Commonwealth.

1. Healthy People 2030

Rate of Drug Overdose Deaths in Virginia

(Per 100,000 residents, 2021)



Source: Virginia Department of Health, Vital Statistics

Goal

By 2029, reduce the rate of drug overdose deaths among Virginians from the baseline of 23.6 deaths per 100,000 people to below the HP2030 target of 20.7 deaths per 100,000 people.

Objective One

By 2029, reduce the number of opioids prescribed per capita in Virginia by 20% (from baseline of 37.6 to 25).

Strategies

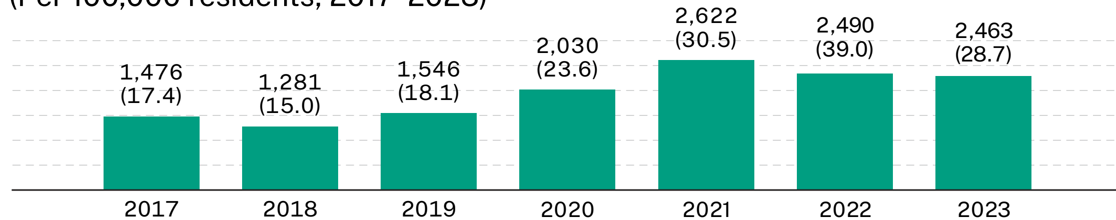
- Train providers in safe prescribing practices.
- Promote the use of the Prescription Monitoring Program among providers to prevent patients from getting prescriptions from multiple providers.
- Identify providers who are high prescribers and encourage use of non-opioid prescriptions and pain management alternatives to prescriptions.

Objective Two

By 2029, reduce drug overdose deaths involving opioids from the baseline of 20.0 per 100,000 to below the HP2030 target of 13.1 per 100,000.

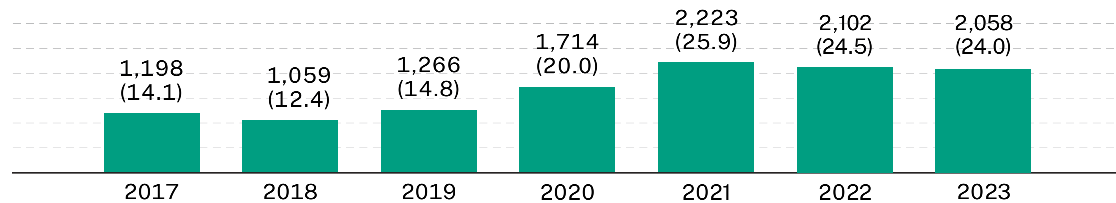
Number and Rate of Overdose Deaths, Virginia

(Per 100,000 residents, 2017–2023)



Count and Rate of Deaths Involving Opioids, Virginia

(Per 100,000 residents, 2017–2021)



Source: Virginia Department of Health

Strategies

- Develop and implement a statewide media campaign on safe storage and disposal of medication.
- Increase distribution of naloxone statewide, ensure provision of fentanyl test strips to populations at high risk to prevent fentanyl poisoning, and educate people who use drugs on the dangers of fentanyl in Virginia's drug supply.
- Increase access to effective substance use treatment, including medication assisted treatment (MAT).
- Develop prevention education programming for middle and high school students about the prevalence and dangers of fentanyl and scale up the best-practice of Fentanyl Awareness Days in high schools by expanding programming initiated in Southwest Virginia to educate parents and mentors.
- Strategically increase authorized Comprehensive Harm Reduction (CHR) programs and support current CHR programs.
- Partner with statewide organizations and local school boards to develop policies ensuring staff and students are trained to use naloxone to reverse opioid drug overdoses, and ensure naloxone is available in education settings.
- Partner with law enforcement and other community members to identify data gaps and critical needs in drug overdose response.
- Address barriers to receiving care and Increase linkage to care programs for persons presenting to an emergency department with an overdose.

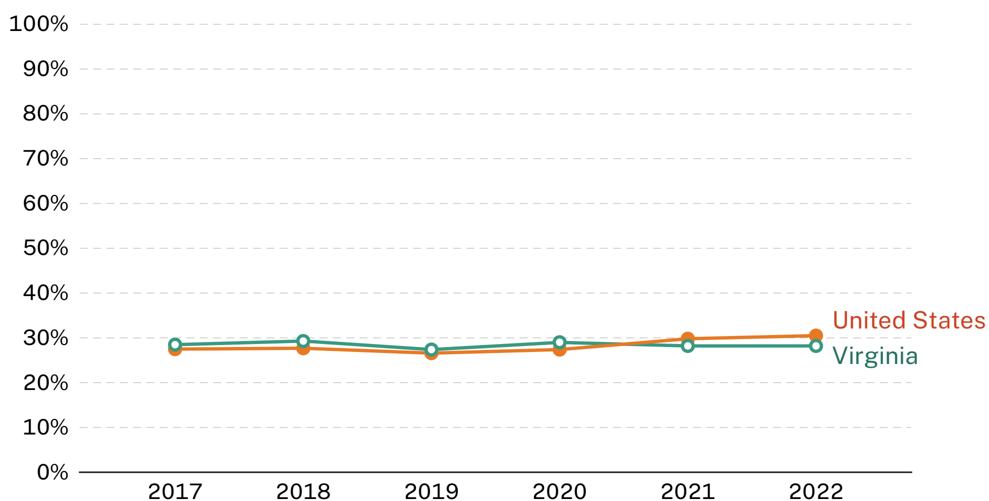
Priority

Housing, Transportation and Economic Stability

According to the U.S. Department of Housing and Urban Development, a household is cost-burdened if they spend more than 30% of their income on housing costs. The percentage of cost-burdened households in Virginia increased from 2017 (28.5%) to 2020 (29.0%). Additionally, the number of houseless students in Virginia increased from 2011 (7,663) to 2020 (10,268). When families must spend a large part of their income on housing, they may not have enough money to pay for healthy food, health care, and other necessities. This deficit increases their risk of emotional health problems and chronic disease.

Transportation impacts various aspects of daily life and is fundamental to a person's health and well-being. In Virginia, the proportion of households with no available vehicle showed little to no change from 2010 (6.3%) to 2020 (6.1%). Transportation issues can affect a person's access to health care services, which can lead to missed or delayed health care.

Percent of Cost-Burdened Households, Virginia
(Weighted Percentage, 2017–2022)



Source: American Community Survey

Goal

By 2029, reduce the proportion of families that spend more than 30% of their monthly income on housing by 10% (from the baseline of 29% to 26%).

Objective One

By 2029, increase the number of affordable and available homes per 100 renter households earning up to 100% of Area Median Income from 103 (2023 baseline) to 108.

Strategies

- Explore partnerships to help increase affordable housing with close access to safe public transportation options.
- Expand programs designed to increase house ownership for minority and rural populations.
- Expand co-housing and multi-generational housing options.

Objective Two

By 2029, reduce the number of Virginia students that are houseless by 10% (from the baseline of 10,268 students to 9,241 students).

Strategies

- Assess the extent of need for housing-related services.
- Expand re-housing programs to transition families experiencing houselessness into permanent housing.
- Increase access to personal finance classes for Virginians.
- Increase the number of affordable housing units available in the state by developing innovative public-private partnerships.

Goal

By 2029, increase employment in the working age population from the baseline of 64.1% to above the HP2030 target of 75.0%.

Objective One

By 2029, establish improved pathways to employment and the ability to earn a living wage for Virginians.

Strategies

- Increase public-private partnerships throughout the state, with particular attention to those areas with a high unemployment rate, to create more jobs, attract outside talent and business, and generate investments into the workforce.
- Collaborate with community-based organizations to connect diverse residents from high-poverty neighborhoods to available employment opportunities.
- Increase awareness, uptake, and utilization of benefits such as the Supplemental Nutrition Assistance Program (SNAP)[1], Child and Adult Care Food Program (CACFP)[2], Special Supplemental Nutrition for Woman, Infants, and Children (WIC)[3], and other benefit programs.

Objective Two

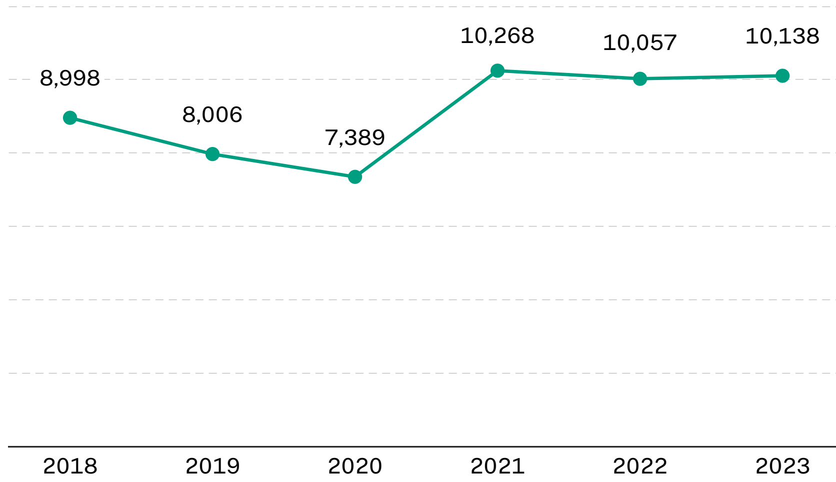
By 2029, increase the proportion of houseless adults with mental health needs who receive mental health services.

Strategies

- Educate providers on Virginia's e-referral platform and the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool to provide coordinated care and address social needs for Virginians seeking behavioral health services.
- Promote and increase the use of screenings via Virginia's e-referral platform to provide housing and employment resources as part of treatment plan.

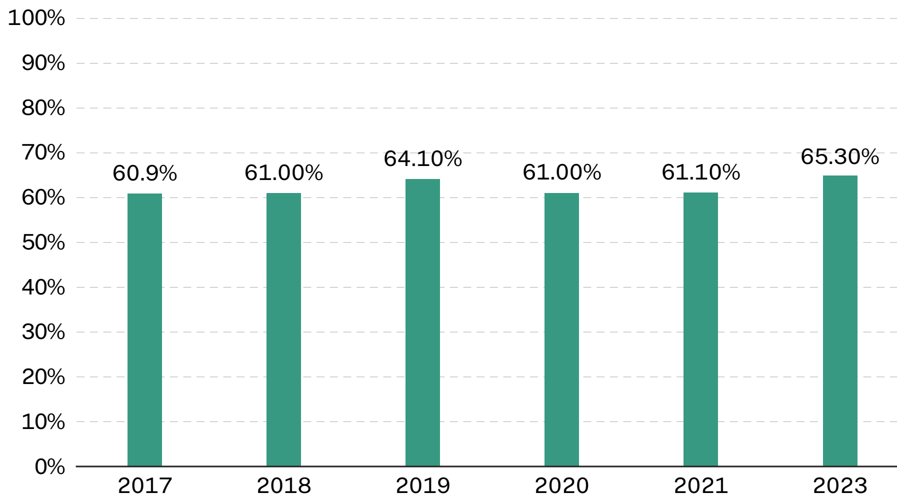
1. SNAP provides food benefits to low-income families to supplement their grocery budget so they can afford the nutritious food essential to health and well-being.
2. The Child and Adult Care Food Program (CACFP) is a federal program that provides reimbursements for nutritious meals and snacks to eligible children and adults who are enrolled for care at participating childcare centers, day care homes, and adult day care centers. CACFP also provides reimbursements for meals served to children and youth participating in after school care programs, children residing in emergency shelters, and adults over the age of 60 or living with a disability and enrolled in day care facilities.
3. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk.

Number of Houseless Students, Virginia
(Number of students, 2017–2023)

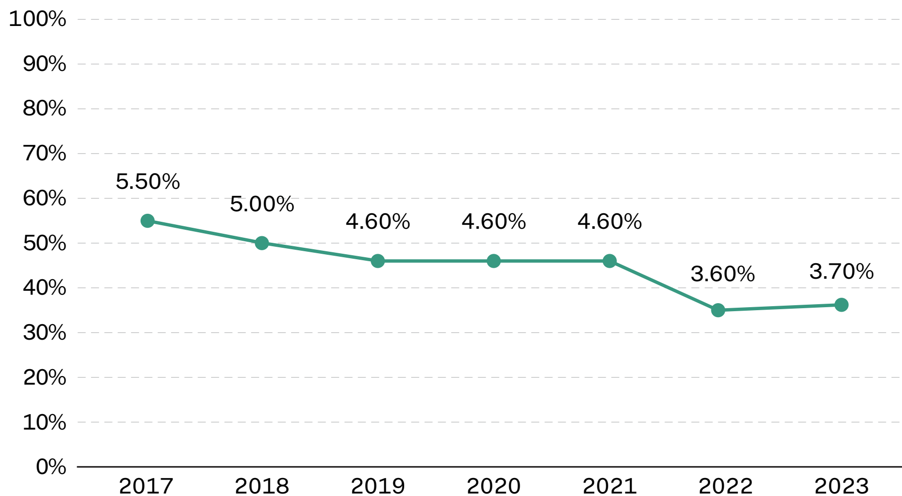


Source: American Community Survey

Percent of Civilians Aged 16 and Older Who Are Employed, Virginia
(Percentage, 2017–2023)



Source: American Community Survey



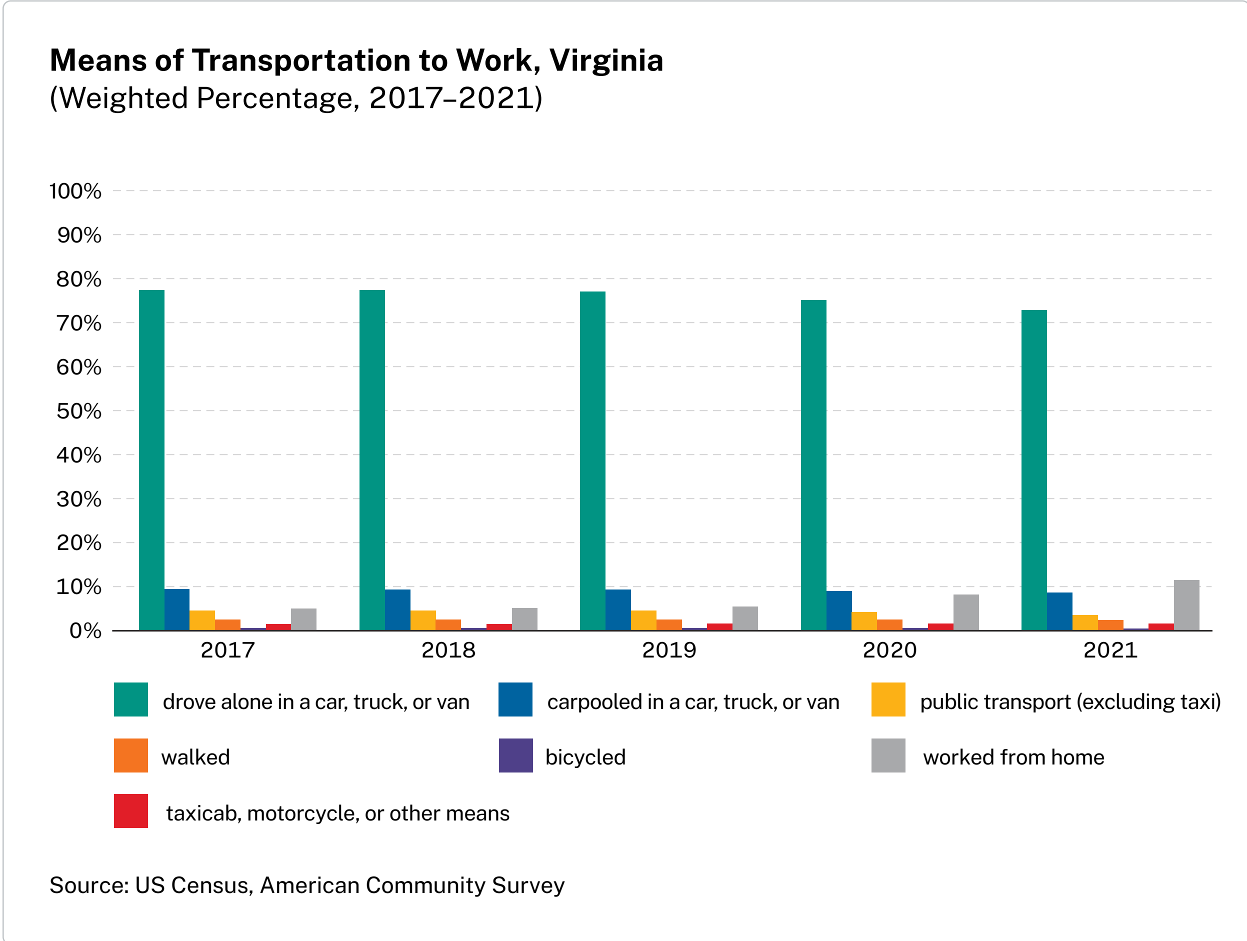
Goal

By 2029 increase the proportion of adults who walk or bike to get places from the baseline of 22.5% to above the HP2030 target of 26.8% and increase the proportion of adults that use public transit to get to work by 5% (from the baseline of 4% to 4.2%).

Strategies

- Enhance active transportation infrastructure by encouraging utilization and seeking opportunities to expand existing networks.
- Encourage public and private sector businesses to develop or adopt programs to utilize alternative commuting methods and promote carpooling programs.
- Seek opportunities to enhance active transportation through grant funding.
- Develop and implement policies or projects designed to increase or improve street connectivity, sidewalk and trail infrastructure, bicycle infrastructure, and public transit infrastructure and access.

- Develop training programs to increase capacity of communities to achieve bicycle and pedestrian-friendly designations or policies.
- Assist communities in creating Active Transportation Plans,[1] Complete Street Policies,[2] and Vision Zero Plans.[3]



1. An Active Transportation Plan is a comprehensive set of strategies to ensure better options for biking, walking, and transit. Active Transportation Plans include recommendations for prioritizing infrastructure improvements and outline recommendations for new policies, processes, and infrastructure based on public and stakeholder input.
2. Complete Streets is an approach to planning, designing, and building streets that enables safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities. This approach also emphasizes the needs of those who have experienced underinvestment, or those whose needs have not been met through a traditional transportation approach. A Complete Streets policy specifies how a community will plan, design, and maintain streets so they are safe for all users of all ages and abilities. A strong policy begins transforming a community's practices, processes, and plans.
3. Vision Zero is an international movement that aims to reduce traffic deaths and life-changing injuries to zero, while increasing safe, healthy, equitable mobility for all. It addresses all collisions, whether people travel by foot, wheelchair, bike, motorcycle, car, or truck.

Plan for Well-Being Measures Baseline Report Card

Virginia's Plan for Well-Being Measures	2025–2029 Goal	2020 Baseline
Priority One: Infant Mortality		
Infant Mortality Rate	5.00	5.73
Percentage of Infants Born Preterm	9.40%	9.90%
Black–White infant mortality disparity ratio	1.00	2.40
The rate of babies born with Neonatal Abstinence Syndrome (NAS) among birth hospitalizations	4.64	5.80
Percent of mothers who report breastfeeding at 2-6 months postpartum	68.97%	62.70% (2020)
Maternal Mortality Black-White Disparity	1.00	2.10
Priority Two: Firearm-Related Deaths		
Firearm-Related Death Rate (per 100,000)	11.9	13.7 (2019)
Priority Three: Obesity		
Proportion of Adults with Obesity	31.00%	32.20%
Proportion of Children and Adolescents (Ages 10–17) With Obesity	14.50%	14.90% (19–20)
Proportion of Adults Who Eat At Least Five Servings of Fruits and Vegetables	21.00%	16.10%
Percent of Adults who reported having Type 2 Diabetes	10.50%	11.10%
Proportion of adults with no leisure time physical activity in the past month	21.80%	20.88%
Proportion of Adolescents Who Do Enough Aerobic and Muscle-Strengthening Activity	24.10%	22.00%
Priority Four: Mental Health		
Rate of Deaths by Suicide in Adults (per 100,000)	12.80	13.40
Percent of High School Students Who Felt Sad or Hopeless	33.50%	38.50% (2020)
Percentage of children who experienced two or more ACEs	11.80%	No data in 2019
Priority Five: Substance Use Disorder and Drug Overdose		
Rate of Drug Overdose Deaths Among Virginians (per 100,000)	20.70	23.60
Number of Opioids Prescribed Per Capita in Virginia	25.00	37.60
Drug Overdose Deaths Involving Opioids (100,000 people)	13.10	20.00
Priority Six: Housing, Transportation and Economic Stability		
Proportion of Families That Spend More Than 30% of Their Monthly Income On Housing	19.00%	29.00%
Virginia Students That Are Houseless	9241	10268 (2021)
Employment Among The Working-Age Population	75.00%	64.10%
Proportion of Adults Who Walk and Bike to Get Places	26.80%	22.50%
Proportion of Adults that use Public Transit To Get To Work	9.00%	4.00%

Virginia's Plan for Well-Being Measures	2023 Update		2024 Update	
Priority One: Infant Mortality				
Infant Mortality Rate	6.20	(2022)	6.0	(2023)
Percentage of Infants Born Preterm	10.10%	(2022)	9.70%	(2023)
Black–White infant mortality disparity ratio	2.90	(2022)	2.3	(2023)
The rate of babies born with Neonatal Abstinence Syndrome (NAS) among birth hospitalizations	4.80	(2022)	4.60	(2023)
Percent of mothers who report breastfeeding at 2-6 months postpartum	62.70%	(2021)	65.10%	(2022)
Maternal Mortality Black-White Disparity	3.40	(2022)	1.70	(2023)
Priority Two: Firearm-Related Deaths				
Firearm-Related Death Rate (per 100,000)	14.6	(2021)	15.3	(2022)
Priority Three: Obesity				
Proportion of Adults with Obesity	34.20%	(2021)	34.27%	(2023)
Proportion of Children and Adolescents (Ages 10–17) With Obesity	17.60%	(20–21)	11.10%	(22–23)
Proportion of Adults Who Eat At Least Five Servings of Fruits and Vegetables	14.07%	(2021)	No data in 22-23	
Percent of Adults who reported having Type 2 Diabetes	11.50%	(2021)	6.10%	(2023)
Proportion of adults with no leisure time physical activity in the past month	20.92%	(2021)	11.85%	(2023)
Proportion of Adolescents Who Do Enough Aerobic and Muscle-Strengthening Activity	No data in 2021		No data in 2023	
Priority Four: Mental Health				
Rate of Deaths by Suicide in Adults (per 100,000)	13.80	(2022)	14.20	(2022)
Percent of High School Students Who Felt Sad or Hopeless	33.40%	(2023)	33.40%	(2023)
Priority Five: Substance Use Disorder and Drug Overdose				
Rate of Drug Overdose Deaths Among Virginians (per 100,000)	29.00	(2022)	28.70	(2023)
Number of Opioids Prescribed Per Capita in Virginia	34.10	(2022)	32.50	(2023)
Drug Overdose Deaths Involving Opioids (100,000 people)	24.50	(2022)	24.00	(2023)
Percentage of children who experienced two or more ACEs	25.6	(2021)	4.60	(2023)
Priority Six: Housing, Transportation and Economic Stability				
Proportion of Families That Spend More Than 30% of Their Monthly Income On Housing	28.20%	(2022)	74.00%	(2023)
Virginia Students That Are	8998 22–23 School Year		10138 23–24 School Year	
Employment Among The Working-Age Population	61.10%	(2021)	65.30%	(2023)
Proportion of Adults Who Walk and Bike to Get Places	No data in 2021		2.30%	(2023)
Proportion of Adults that use Public Transit To Get To Work	3.40%	(2021)	2.50%	(2023)

Acknowledgments

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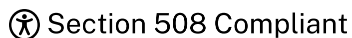

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